Abstract

The population of older adults has grown rapidly in recent years and is expected to continue to grow into the middle of this century. The aging of the population means that nurses need to have specialized gerontological knowledge in order to properly care for older adults. In spite of the current need for specialists in this field, gerontological nursing is not a popular choice and nurses often lack adequate preparation to care for older adults. The complex reasons behind these issues are rooted in the history of the development of this specialty.

This study takes a historical look at the development of gerontological nursing in British Columbia through the stories of seven nurse educators who were leaders and innovators in their field. The findings of the study tell a story of the nurses’ work to change unacceptable nursing practice, improve standards of care and professional status of gerontological nursing and advocate for older adults. In doing so, these nurses challenged cultural values about aging and care of older adults and worked toward giving gerontological nurses a voice in policy and decision-making. The findings from this study can be used to guide today’s gerontological nurses as they continue to develop this specialized field of nursing knowledge.
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Dedication

To my family, whose love and support sustained me through many hours of study, research, and writing.
Chapter I: About the Study

Introduction

Canada's population is aging rapidly. By 2031, 28.5% of Canadians will be over the age of 60 (Romanow, 2002). According to Statistics Canada (2000, cited in Romanow), in 2051, 18.14% of the population will be 70 years or older and 8.71% of the population of Canadians will be 80 years and older. As Romanow points out, this means that although Canada's population is increasingly healthier than in previous generations, there will still be greater demands for health care services for older adults than there are now. Nurses are the largest group of professional workers in the health care system and newly graduated nurses will need to have thorough gerontological knowledge and experience to provide competent care for older adults (Baumbusch and Goldenberg, 2000; Mahoney, 1993).

The impetus for this study came from my experience as a gerontological nurse in British Columbia. I noticed that many nurses seemed to be inadequately prepared to care for older adults. I wondered whether this was supported in the literature and whether there was literature that explored the historical reasons for this issue, particularly in relation to Canadian nursing education. Although there is a growing scholarship on the history of nursing and nursing education (McPherson, 1996; Boschma, 2005) very little is written about gerontological nursing. I found that the history of gerontological nursing and education has been studied and described by a few authors (Davis, 1971; Mahoney, 1993; Ebersole, Hess, Touhy, & Jett, 2005), but the story was incomplete. The authors briefly describe some seminal events in American and Canadian gerontological nursing history and some of the nurses that participated in those events. However, I wanted to know more about the
experiences of some of the nursing leaders in developing the relatively new field of gerontological nursing, particularly in British Columbia, since that is where I have most of my experience. A focus on British Columbia was useful for two other reasons. First, several key events in the development of gerontological nursing knowledge in Canada occurred in British Columbia. Second, since post secondary education (including nursing education) is provincially controlled in Canada, a focus on the development of gerontological nursing in one particular province is worthy of study. This study was carried out to gain historical insight into the development of gerontological nursing in British Columbia and the relationship to gerontological nursing education. In the end, I gained some very interesting insights into how the development of gerontological nursing knowledge and education had multiple purposes, not only in enhancing clinical practice but also in promoting professionalization of the specialty and providing nurses a voice for political action.

In this chapter I will describe the reasons why I chose a historical approach, the purpose of the study, and the research questions. I will then discuss the review of related literature in the background section. As I will explain later, historical studies require a framework to direct the study. The next section of the chapter will discuss the components of the framework I used to develop the questions and guide my analysis and findings. I will also describe the oral history research method I used for this study, including the method of participant selection and a description of the study participants, ethical considerations of the study and data collection and analysis. The last section of the chapter will discuss the credibility and reliability of the study findings.
Chapters two, three, and four tell a story about the educators’ experiences in developing the specialty of gerontological nursing in British Columbia. Chapter two describes the movement towards humanizing care for older adults that characterized the early efforts of the gerontological nurse educators to develop their specialty field of nursing. Chapter three tells of the shift in focus toward science and professionalism that occurred as gerontological nurses realized the need for new knowledge and improved professional status. Chapter four describes the ambivalence that the nurses experienced toward both their chosen specialty and toward older adults in general and how those nurses chose to address that ambivalence and the challenges it presented. I included this theme as a separate chapter because it appeared as a thread that was interwoven throughout the story and that gave further significance to the stories of the nurse educators I interviewed. Discussion of the study findings and how those findings might be considered in light of the literature occurs throughout these three chapters. In chapter five I will provide a summary of the findings, discuss the usefulness of the study findings and provide suggestions for areas for further research.

Why use a historical approach?

In order to understand the complexities around the inclusion of gerontology in basic nursing curricula and how gerontological nursing itself was understood, a historical approach to examining the development of gerontology and its relation to nursing education is vital to my study. Hamilton (1993) states that “for nursing, an understanding of the profession’s past can provide an analysis of its beliefs, its leaders, its institutions and its work in a way that demonstrates that nursing, as a set of ideas, is a living force of continuous existence” (p.45). There is little in the literature describing the experiences and perceptions of educators who
have been involved in developing and promoting gerontology as a legitimate and necessary field of nursing knowledge and study. Hamilton states that historical inquiry allows us to analyze questions regarding the nature of nursing and its relationship with the culture in which it exists. Understanding individual nurse educators' experiences and perspectives helped me to understand some of the aspects of nursing, education and culture that have affected the inclusion of gerontology in basic nursing curricula. A deeper understanding of the historical aspects of the issue will help nursing educators contribute to the development of gerontological content in nursing curricula and beyond that to the ability of the nursing profession to meet the challenges of the twenty first century.

Study Purpose

The purpose of this study is to gain insight into the grassroots development of gerontological nursing, in particular the relationship between preparation and education for gerontological nursing practice and the practice itself. Insight will be gained through the experiences and perspectives of selected British Columbia nurse educators who were involved in the last 30 years in developing gerontology as an area of nursing education and practice. The main research question is: How are the development of gerontological nursing knowledge and gerontological education related? A corollary question is: How has the way nurses have been prepared to care for older adults influenced current gerontological nursing education? The study uses nursing educators' experiences to achieve a better understanding of the development of gerontological nursing in British Columbia.
Background

History of gerontology

Gerontology is a multidisciplinary field (Mahoney, 1993), which has grown rapidly during the twentieth century (Gruman, 1979). Before the twentieth century, there were a few physicians interested in issues related to aging (Freeman, 1979, originally published in 1938), and according to Freeman, “the writings of Sir John Floyer of Lichfield in 1724 have generally been accredited as the beginning of modern geriatrics” (p.328). (According to Gruman, in 1938, the year Freeman’s article was originally published, the term geriatrics had not yet been restricted to its present meaning of the medical treatment of the aged. Today the term gerontology is used to refer to the interdisciplinary branch of science with a broad focus on older adults and aging including normal and successful aging). Gruman describes several events that helped gerontology become a recognized and well organized specialty in the United States of America: the American Gerontological Society was organized in 1945 and the United States federal government established a Committee on Aging in 1951. In 1946, the Journal of Gerontology was first published (Gruman, 1979). The number of gerontological journals has increased considerably in the last few decades. For example, the gerontology library at the University of Southern California holds 155 gerontology journals in their collection (USC, 2006).

By 1971, Canadian gerontologists determined the need for an association focussed on Canadian gerontological issues and held the founding meeting for establishing an association in Montreal (Canadian Association on Gerontology, no date). The Canadian Association on
Gerontology (CAG) was officially incorporated in 1973 (CAG). The CAG is a national, multidisciplinary, scientific and educational association with the goal of “improving the lives of older Canadians through the creation and dissemination of knowledge in gerontological policy, practice, research and education” (CAG).

History of the specialty of gerontological nursing

Nurses’ interest in the health of older adults was first documented in 1908 when Lavinia Dock, who was the editor of the American Journal of Nursing, wrote an article about poor conditions in almshouses and called for these institutions to be staffed by trained nurses (Ebersole et al, 2005). A few other articles calling for special education for nurses caring for the aged appeared in the nursing literature in the first half of the twentieth century, but there was no significant gerontological nursing literature until 1950 when the first book on gerontological nursing was published (Ebersole et al). According to Ebersole et al, until then, nursing care of older adults was thought of as simply the application of nursing principles to older adults and not as a specialty in and of itself. In 1966, the ANA created the Division of Geriatric Nursing which was re-named in 1976 as the Gerontological Division (LeSage, 1993). In 1967 the executive of this division appointed a committee to work on standards of practice for geriatric nursing which were completed in 1969 (LeSage) They have been reviewed and revised approximately every five years since then (Lesage), most recently in 2001 (Ebersole et al.).

In Canada, the development and promotion of gerontological nursing as a specialty occurred later than in the USA. The First National Conference on Gerontological Nursing was held in 1983 in Victoria B.C. (Gallagher, Jackson, & Zilm, 1983). “The purpose of the
conference was to investigate the nature of, and promote the development of, Gerontological Nursing in Canada” (Gallagher et al., p.iii). At the end of the conference, a committee was formed to gather information on the feasibility of a national network of gerontological nurses which would provide mutual support and a mechanism whereby nurses could advocate for improved quality health care for older adults (Gallagher et al.). In 1984, at the second national conference on gerontology, a committee was formed to develop a constitution and bylaws for a national association (Canadian Gerontological Nursing Association, 2005). The Canadian Gerontological Nursing Association (CGNA) was formally constituted at the third conference of gerontological nurses in 1985 in Hamilton, Ontario (CGNA, 2005)). In 1986, the CGNA became one of the first interest groups of the CNA (CGNA, 2000). The first group of gerontological nurses were certified by the CNA in 1999 (CGNA, 2000). The CGNA now has affiliated groups in most provinces. The affiliated group in British Columbia is the Gerontological Nurses Group of British Columbia (GNGBC).

Standards of gerontological nursing practice had not been adopted by the CGNA before 1989, although provincial associations, such as the Gerontological Nursing Association of Ontario (GNAO), had their own standards (CGNA, 1996). In 1989, the CGNA accepted the standards of the GNAO as its own (CGNA, 1996). The CGNA published a new set of standards of practice in 1996 (CGNA, 1996).

The field of gerontological nursing has gained professional recognition through certification both in Canada and USA (Ebersole, Hess, Touhy, & Jett, 2005). For example, the Canadian Nurses Association (CNA) offers specialty certification in gerontology to RN’s (CNA, 2006). In 2005, there were 1,822 certified gerontological nurses in Canada (CNA).
The American Nurses Credentialing Center (ANCC), which is the credentialing arm of the American Nurses Association (ANA), offers certification in gerontology at associate degree, baccalaureate degree and two advanced practice levels (ANCC, 2006).

**Education and gerontology**

The connection between nursing education and gerontology is an important one. In spite of the certification in gerontological nursing and standards for gerontological nursing practice, nurse educators have long been concerned about newly graduated nurses' preparation to apply the standards in practice (Baumbusch & Goldenberg, 2000; Kaasalainen et al., 2006; Pringle, 1983; Rosenfeld, Bottrell, Fulmer, & Mezey, 1999). According to Baumbusch and Goldenberg, "development of gerontological nursing education in Canada has not kept pace with the need" (p.12). It seems that it has also not kept pace with the professional trends of specialization and recognition of gerontological nursing. The issues involved in the inclusion of gerontology in basic nursing education are complex. They include the history of nursing education and how knowledge was historically acquired and transmitted to students, how gerontological knowledge was developed and taught, and the history of the place and treatment of older adults in the health care system, all of which interact with cultural values around old age and the care of older adults.

**Framework**

In order to better understand the complex situation just described, I used a historical approach in my study, drawing on oral history and published and publicly available records. In historical research researchers must have a framework that directs the study and frames the questions, the analysis, and the interpretation of the findings (Hamilton, 1993). Hamilton
describes the framework as establishing the historian’s lens by which all aspects of the study are seen. My framework for this study included several components: the history of nursing education and the transmission of nursing knowledge, the history of the development and professionalization of gerontological nursing, social history including the history of care of older adults in British Columbia and cultural values regarding old age, and oral history.

**History of nursing education**

The history of nursing education in Canada was an important part of my framework. Understanding the changes that nursing education has undergone, particularly through to the mid-twentieth century, assisted me to frame questions for the educators and interpret the study data (McPherson, 1996 and Boschma, 2005). For example Mussallem (1965) undertook a study of the existing formal nursing education programs in Canada for the Royal Commission on Health Services. Her report called for sweeping changes in the way nurses were educated. One of the main changes she called for was moving from the hospital based training programs to diploma programs in colleges and degree programs in universities. The specialty of geriatrics or gerontology was not mentioned in Mussallem’s report. In fact, included in the many criticisms she made was the fragmentation of the curriculum into short specialty courses. Interestingly, her report came out only one year before the ANA created its Division of Geriatric Nursing. One can imagine that the American nurses’ ideas for acknowledging and promoting gerontological nursing as a distinct practice area were lost in the upheavals to come in the system of educating nurses in Canada. Five years later, Kergin (1970) noted the slow acceptance among nurses of the need for changes in nursing education in Canada and promoted the need for more university education for professional nurses. King
(1970) notes that university programs had been established slowly in Canada, but in parallel with diploma programs.

History of gerontological nursing education

Ebersole et al (2005) state that mentoring has played a predominant role in the professional growth and development of gerontological nursing, which points to its grass roots development. They explain that since there were few courses in gerontological nursing in preparatory programs, many nurses relied on experienced and dedicated mentors for guidance. Mahoney (1993) mentions an early educator’s call for the inclusion of gerontology in the baccalaureate curriculum in the 1960’s U.S.A. She further notes that in the late 1970’s the first generation of nurses who learned gerontology by extensive experience began to write gerontological textbooks. The first journal article discussing specialization at the Master’s level appeared in 1977 (Mahoney). According to Mahoney, the call to teach gerontological nursing within the nursing curriculum was made again in the 1980’s. Mahoney states that, in the USA by 1990, strategies and models for the inclusion of gerontology in the nursing curriculum had been developed by the Association for Gerontology in Higher Education in conjunction with the ANA and the National League for Nursing. Yet, as mentioned previously, educators are still concerned that nurses are not adequately prepared for caring for the complex needs of older adults. Clearly, nursing educators in Canada were not alone in their slow response to demographic changes and professional trends. The perspective of the educators I interviewed helped to shed some light on this historical enigma and on the grassroots development of gerontology.
Social history of old age in British Columbia

My framework was also informed by the history of the care of older adults in British Columbia and their interactions with the health care system and health care professionals. According to Thompson (1988) the analysis of the data in an oral history study must include consideration of historical and social context. The history of residential care was included in the framework for my study because the residential care facilities of the 1940’s and 1950’s (or old age homes as they were called then) reveal the historical roots of the current professional belief system about older adults (Davies, 2001). Davies explains that residential care facilities rank low on the institutional hierarchy in health care, reflecting their low status and the low status of dependent older adults in society. Snell (1997) and Davies (2003) both describe the poorhouse system, which was imported from Britain, as the beginning of the current residential care system for older adults in Canada. They contend that the system is reflective of the way older adults have been viewed in the last two hundred years and forms the basis of the way we care for older adults today.

The historical context of cultural values regarding old age is also an important part of my framework. Snell (1997) describes the concept of old age as an evolving, multifaceted, social and political construction. He claims that western ideas about ageing changed beginning in the nineteenth century and that by the middle of the twentieth century, ageism was firmly entrenched in Canadian society. Davies (2003) maintains that older adults are invisible in society. She also claims that ageism is pervasive in academia. Matzo (1995) has suggested that ageism has been one of the barriers to including gerontology in nursing curricula. As residential care facilities are often used for clinical placement (particularly
initial clinical experiences) in nursing programs, understanding their history and the influence of cultural values about aging may assist in understanding the development of gerontological nursing education.

**Oral history**

In this study, oral history was both part of the framework and a method. Thompson (1988) explains that oral history “can give back to the people who made and experienced history, through their own words, a central place” (p.2). According to Thompson, most existing historical records give the point of view of people in authority, but oral history can achieve an account of history that challenges the established and accepted accounts and provides a more realistic reconstruction of the past. In doing this, oral history shifts the focus from the people in powerful positions to those who may not have been previously heard and can open up important new areas of inquiry, adding a new and more vivid historical dimension to what is already known (Thompson). Thompson also suggests that oral history can be an important resource when formal documentation is lacking.

Since this study used the experience of nurse educators to examine the process of grassroots development of gerontological nursing, an oral history approach gave this study a focus and dimension not previously studied. “Oral sources tell us not just what people did, but what they wanted to do, what they believed they were doing, and what they now think they did” (Portelli, 1998, p. 67). The personal challenges, frustrations, triumphs and mundane daily experiences of the educators who told their stories will enhance our understanding of the daily, grass roots work that was done to develop gerontological nursing education. Rather than just survey results or guesses about barriers to acceptance of gerontology in educational
programs that other studies have provided (Earthy, 1993; Rosenfeld, Bottrell, Fulmer, & Mezey. M., 1999), this study generated new data to enable further understanding of this issue and possibly allow for some creative solutions. Davies (2003) states that there has been little work done on the social history of older adults’ lives and experiences. The educators I interviewed all had long careers in gerontological nursing. The fact that they have or are soon to become older adults in the meantime gives further dimension to the culturally embedded values around old age.

Study method

Type of study

The method I used for this study was oral history. Speziale and Carpenter (2003) state that oral histories can provide useful data for studying nursing history. Portelli (1998) reminds us that oral historical sources are narrative sources and he refers to informants or participants as narrators. Narrative refers to something that is narrated, a story or account; to narrate means to tell, as a story, in detail (Merriam-Webster, 2006). Kirby (1997) explains that the interview is not, however, simply one sided story telling, but is “the product of an interaction between two people” (no page number) during which the interviewer prompts the subject to expand on certain subjects and draws out events or remarks that seem significant.

Selection of study participants

The Oral History Association (OHA) (2002) guidelines for selection of participants state that the researcher must consider the ways in which the informants are appropriate to the purposes and objectives of the study. The researcher must also identify significant omissions and the reasons for those omissions (OHA). The study participants, or narrators
were nurse educators with long careers in gerontology, who had participated in developing gerontology as an area of special nursing knowledge in British Columbia. Some were retired or semi-retired and some still had an active role in nursing education at the time of the study.

For the purposes of this study, the term nurse educator was not restricted to nurses who have had formal faculty appointments at postsecondary institutions. As mentioned previously, mentoring in the workplace has played a predominant role in the professional growth and development of gerontological nursing. For this reason, educators were also selected from among nurses who did not have direct ties to educational institutions, but whose work in developing and advancing gerontological nursing contributed to the education of registered nursing students and practicing registered nurses. Nurse educators involved with the education of practical nurses or nursing aides were not be considered unless they also taught registered nurses or students in programs preparatory to registered nursing qualifications. I chose this limitation for two reasons: to keep the scope of the study manageable, and because my interest was specifically in registered nursing preparation.

In historical studies, like other qualitative studies, participants are selected based on their experience with the topic being studied, a process known as purposeful sampling (Speziale & Carpenter, 2003). Ritchie (2003) suggests that potential informants who participated in the events at the time of the study can be identified through research into the topic, word of mouth referrals, and individuals within organizations. Contacts in the GNGBC and in the gerontological community were asked to identify potential participants. Some potential participants were identified through initial research into the topic and my study participants suggested others.
Study participants

I interviewed seven gerontological nurse educators for this study. A very brief summary biography of each participant follows. One of the participants requested that her name not be identified so the initial C will identify her. The information in the biographies was taken from biographical profiles supplied by the participants and occasionally supplemented with documented information. Each participant had many qualifications, achievements, and nursing experiences, however, I include only some of each participant’s accomplishments in the biographies.

C: C’s academic achievements are Diploma in Nursing, Douglas College (1977); Bachelor of Science in Nursing, University of Victoria; Master of Science in Nursing, University of British Columbia. C has worked in many nursing positions, including staff nurse, Director of Clinical Services at an intermediate care facility and Accreditation Coordinator for private intermediate facilities. She has been active in the Gerontological Nurses Group of British Columbia and the Canadian Gerontological Nurses Association. She has served on numerous educational and professional committees. At the time of the interview she had seventeen years of gerontological nursing experience and held a faculty position in a baccalaureate nursing program in British Columbia.

Anne Earthy: Anne Earthy’s educational achievements include: a Diploma in Nursing, Toronto General Hospital (1967); Bachelor of Nursing, McGill University; Master of Arts (Adult Education), University of British Columbia, Gerontological Nurse, Certification. Earthy has held many nursing positions in several provinces in Canada including instructor at BCIT and Douglas College. She has been involved in developing
clinical practice guidelines on various gerontological topics such as: wound care, responding to excessive behaviours, pain and falls. She has been involved in various research projects and was the 2003 recipient of the Registered Nurses Association of BC Distinction in Nursing Award. At the time of the interview, she was a clinical nurse specialist in gerontology and an affiliate faculty member at the University of British Columbia and had twenty-two years of experience in gerontological nursing.

Elaine Gallagher: Elaine Gallagher’s academic achievements include: Diploma in Nursing Grey Nuns Hospital School of Nursing (1964), Bachelor of Science (Nursing) University of Windsor, Master of Science (Nursing), Duke University; PhD (Gerontology), Simon Fraser University. Dr. Gallagher has worked as a staff nurse and has held a number of positions in academia. Among her numerous memberships and offices held are: the Advisory Committee of New Horizons-Partners in Aging Advisory Coalition, Health Canada, Chair of the Educational Division of the Canadian Association on Gerontology, and Divisional Chair of Biological and Health Sciences, Canadian Association on Gerontology. She has published and presented extensively and has been the Assistant to the Editor of the Canadian Journal on Aging. At the time of the interview she was Professor, University of Victoria School of Nursing and Director, Centre on Aging, University of Victoria, BC.

Bett Lauridsen: Among Bett Lauridsen’s numerous qualifications are: Diploma in Nursing, Winnipeg General Hospital (1951); Certified Nurse Practitioner, Certificate in Health Care Management, Certificate in Healing Touch, Certificate in Integrative Energy Healing, Langara College, Vancouver. Lauridsen has a long history of working with older adults. She worked with the Victorian Order of Nurses for eighteen years in Winnipeg and
Vancouver and helped to develop the hospice program in Vancouver. She has been an instructor in nursing continuing education at the University of British Columbia, and a therapist at the Vancouver General Hospital Healing Centre. Lauridsen has published articles in the Canadian Nurse magazine and presented at many national conferences on aging. She was the manager of the Short Term Assessment and Treatment Centre (a gerontological nursing unit) at Vancouver General Hospital from 1980-1995. At the time of the interview, she was the Transportation Manager at Vancouver General Hospital and regularly gave workshops in healing touch and therapeutic touch. She had thirty-seven years of experience in gerontological nursing.

Jessie Mantle: Jessie Mantle earned a Diploma in Nursing in 1956 from Royal Jubilee Hospital School of Nursing, Victoria, BC (1953), Bachelor of Nursing, McGill University; Master of Nursing, University of California, San Francisco; Diploma in Gerontology, University of Washington. Mantle worked as a staff nurse in medical surgical and gynaecology nursing units in Vancouver and on Vancouver Island before taking up a teaching position University of Western Ontario. For 16 years, Mantle held a joint appointment as Professor at the University of Victoria School of Nursing and Clinical Nurse Specialist at Juan de Fuca Hospitals, in Victoria, BC. She was the first president of the Canadian Gerontological Nurses Association of which she is an honorary life member, and has given many conference presentations and written numerous articles. At the time of the interview she was Professor Emeritus at University of Victoria School of Nursing and still active in promoting gerontological nursing.
Nan Martin: Nan Martin received her Diploma in Nursing from Glasgow Royal Infirmary, Glasgow (1959) and took a Nursing Refresher course at the British Columbia Institute of Technology. She has worked in a variety of staff nurse positions throughout Canada including several extended care and nursing homes. Martin was the head nurse of an extended care unit in Shaugnessy Hospital in Vancouver, BC for 5 years and also worked at a geriatric assessment unit and extended care unit. She was involved in the early stages of the Gerontological Nurses Group of BC as treasurer and editor of their newsletter and later as their president. She has published some articles in the Canadian Nurse and has presented at nursing conferences. At the time of the interview, Martin was retired from nursing and was taking courses toward her Bachelor of General Studies. Although she is retired from nursing work, she continues with an active interest in gerontological nursing including attending and presenting at professional nursing conferences.

Vera McIver: Diploma of Nursing, Grey Nuns Hospital School of Nursing (1941). McIver worked as a private duty nurse for about twenty-five years before becoming Director of Care at St. Mary’s Priory a residential care facility near Victoria, BC. She transformed the way care was given at the facility and her work became an inspiration for many of the broader changes that followed. Her work there will be discussed in more detail later in this paper. McIver has received several awards for her work, most notably the Registered Nurses Association of British Columbia Members Award, the Order of Canada and the Queen’s Jubilee Medal. McIver published several articles, presented frequently at professional conferences around North America, and has given interviews for newspapers. Her work has been recorded in a book called the Forgotten Revolution: the Priory Method a restorative
care model for older adults (Mantle & Funke-Furber, 2003). At the time of the interview she was ninety two years old, retired from nursing and recently retired from her voluntary position as archivist for the Roman Catholic Diocese of Victoria.

Ethical Considerations for the Study

Informants in oral history studies should be informed of the purposes and procedures of the study and of oral history in general and any anticipated or potential uses of the findings of the study (OHA, 2002). Informants should also be informed of their rights during various stages of the process, the expectations and nature of their participation, and the confidentiality of the interviews until the informants have released their consents (OHA). As this study was conducted as part of the educational requirements for graduation from a graduate level program, ethical approval was obtained from the Behavioural Research Ethics Board of the University of British Columbia. A copy of the approval form is included in Appendix A. Participants were given written information about the purposes of the study, the potential uses of the information, such as the potential for publication of the findings, their right to withdraw from the study at any point, and that the information would remain confidential. A copy of the consent form used for this study is included in Appendix B.

Data Collection and Analysis

The interviews took place between March 2007 and August 2007. They were conducted in pre-arranged appointments at a time and in an environment of each informant’s choosing. I interviewed six of the informants once. I interviewed one of the informants twice because of a malfunction in my recording equipment. Two of the interviews were conducted in the informant’s own homes with no interruptions. Two informants were interviewed in
their own offices. In one of these office interviews, which took place in mid-afternoon, not only were there frequent interruptions, but also the informant hadn't eaten and ate her lunch during the interview. One interview took place in an unused room at the informant's workplace and there were no interruptions. One informant chose to be interviewed in an unused, private room in the school of nursing at my university. One informant was interviewed in a hotel room prior to her speaking at a conference. The interviews varied in length from forty-five minutes to two hours.

Oral history interviewers do need some prepared questions to guide the narrators to the topic they are interested in, but they should be few and based on a clear idea of what each informant might tell (Thompson, 1988). I used a set of questions to guide the discussion, but I kept them few in number. Portelli (1998) emphasizes that, although the control of the historical discourse lies in the hands of the researcher, priority must be given to what the informant wishes to tell rather than what the researcher wants to hear. Unanswered questions must be saved for later or for another interview. This reflects an important characteristic of qualitative studies: that data collection and data analysis are interrelated processes with analysis of early data influencing data collection in later stages (Speziale & Carpenter, 2003). The questions that I used to guide my interviews are listed in Appendix C.

Immediately following the interviews, I made field notes regarding my feelings, perceptions and any situational aspects that might have affected analysis or interpretation of the data. The field notes helped me to remember incidental things such as gestures and other aspects of the informants' stories that would not be apparent from listening to the recording of the transcribed interviews. For example, some of the informants made comments after the
tape was turned off. These comments helped me to understand their stories a bit more or to look at the transcripts in a different way than I might have without the notes. A transcriptionist then transcribed the interviews. Analysis on each data set was started as soon after each interview as possible using the framework discussed earlier in this chapter.

**Credibility and Reliability of Findings**

Portelli (1998) suggests that the final result of the interview is a product of both the narrator and the researcher. He explains that when the researcher’s voice is not evident in the interview, the impression can be that the narrator will always say the same things. In fact, he warns, oral testimony is never the same twice. His statement leads to the question of rigour in an oral history study. If participant’s stories are changeable and result from the interaction of both interviewer and narrator, are they credible and reliable? Portelli insists they are credible, explaining that the importance of oral histories is not whether they are factual, but that they reflect an active process of creating meaning. For Portelli, the value of oral history lies in how narrators’ memories reveal their efforts to make sense of the past and set their narratives in their historical context. Thompson (1988) agrees and suggests that in oral history research, what people imagined having happened may be as crucial as what actually happened. He explains that it is the symbolic truth that life stories convey, which matters most. The stories the narrators of my study chose to tell me reflected what they felt was important to be told. The specific events in the stories might not have been accurate in every detail: memories seldom are. But the stories the narrators were telling provide valuable insights into the meaning that the narrators gave in retrospect to the events that they were recounting.
In discussing reliability, Thompson (1988) emphasizes the importance of using the same checks that are used with other historical sources, such as: searching for internal consistency, cross-checking details from other sources, and taking historical context into account. I used his guidelines for reliability in my analysis of the data, but also kept in mind the possible meaning of any discrepancies that came up. As my study used the perspectives of educators and their stories of their experiences to understand the grassroots development of gerontology, the strict criteria for reliability was not always achievable for all the data. However, I cross-referenced historical events or systems or policies whenever possible and compared them to secondary sources such as published records, government documents, and policies. When I found discrepancies with other recorded events, the data were not necessarily disregarded, but were analysed with respect to how they fit into the study’s framework and how they might be part of the educator’s way of giving meaning to past events.
Chapter II: Humanizing Care

The stories of the educators I interviewed were rich and varied and contained many themes. Two of the significant overall themes related to trends in the development of gerontological knowledge in British Columbia in two time periods: the mid 1960’s to the mid 1970’s and the early to mid 1980’s. In this chapter I will discuss the trend toward humanizing care that began to emerge during the period from the mid 1960’s to the mid 1970’s.

In order to discuss the changes that began to occur in the mid 1960’s it is necessary to understand what gerontological nursing was like before that period. As I discussed in chapter one, a beginning recognition of gerontological nursing as a distinct area of specialised knowledge began in the mid 1960’s in the USA, but had not yet developed in Canada. However, around that time, some nurses in Canada began to use a holistic model of care in which the whole older adult was cared for, not just their physical body. A movement to individualize care for older adults began, involving several key players in BC and beyond. The history of the system of residential care that I briefly described in chapter one, provides a good basis for understanding the humanizing trend in gerontological nursing that began around the mid 1960’s.

History of Residential Care

The system of residential care for older adults in BC contributed to the conditions that led to the movement toward humanizing care for older adults. In his book *Warehouses for death: The nursing home industry,* Baum (1977) describes Canadian residential care facilities:
People are there to die. Once they walk through the nursing home door and take their rooms, they will not walk out again. They are stripped of their assets, given a small personal allowance, promised minimal nursing care, regulated severely in their routine and medicated to institutional compliance. In a very real sense, they are encapsulated and warehoused for death. They are removed from the community, and the community accordingly does not have to see either old age or death (p.3).

Bett Lauridsen describes her early memories of residential care, which convey a similar context:

Lauridsen: I can remember in the ’70’s, going into a senior’s residence and there’s the whole line-up of old people sitting there in front of the TV. The TV was flickering away, and everyone’s sitting there; nobody thought about activities at all; at least the ones I saw. There were no activity programs in those places (Interview #5, B.L., p.17)

C confirms this view of residential care:
C: And it was really custodial care. It wasn’t considered where they lived, it wasn’t their home. You were just looking after people and doing for them. There was none of those concepts of recreation that was meaningful, none of that stuff. It was all custodial care. (Interview #6, C, p.7)

These comments reflect the low social value accorded to institutional care for older adults. According to historian Megan Davies (2003), this low social value stems from the origins of the residential care system. Davies explains that for many people, the system of residential care that existed until the 1950’s in British Columbia evoked the poorhouse system that had been imported from Britain. According to Davies, the poorhouse system began with the Poor Law, enacted in 1601 in Britain in response to growing numbers of indigent citizens. The Poor Law essentially involved a special tax being levied to support the poor, which was then distributed by an overseer to those who needed it, including aged, sick
and poor people. Eventually in the nineteenth century, the law was modified and a system of 
poor houses was established. This system was punitive and demeaning in nature as it was 
meant to discourage people from seeking state assistance for as long as possible. Older adults 
who had no family support and who could no longer care for themselves were sent to the 
poor house, where they were required to work for their food and shelter (Davies). Davies 
suggests “the poor law was – and to a degree still is – a strong presence in B.C.’s old age 
homes” (p. 6). Although residential care facilities of the early part of the twentieth century 
were not as punitive and the residents were not required to work for their keep, nevertheless, 
Davies believes that the ethos around these institutions existed in relation to homes for the 
aged as they were called at the time. She claims that she evokes the poor law as a way to help 
her readers “appreciate the profound judgement and power imbalance implicit in the culture 
of old age home and present in many practices common to these facilities” (p.7). Snell 
(1996), a Canadian social historian, maintains that the residential facilities established for 
older adults were expressions of new twentieth century views of older adults as less than full 
citizens.

Vera McIver, one of my study participants, describes the conditions that existed in 
many long-term care facilities in the mid-1960’s and the effects that those conditions had on 
the residents. Her description suggests that another reason for the dismal conditions was the 
training and approach of the staff who were used to working in impersonal medicalized acute 
care settings.

McIver: When long-term care facilities began operating sometime in the early ‘40’s, 
nurses and doctors had no model upon which to build a suitable program. So they 
introduced what they knew best, the acute care hospital model. It took some years 
before this detrimental folly could show itself in mental and physical deterioration of
patients. The reason the acute care model created such drastic effects was because care was incomplete. The emphasis was placed on the body; the psychosocial aspects, as referred to in education, were not really grasped and therefore were never put into practice.... As in acute care hospitals, patients admitted were stripped of their clothing and dressed in the hated hospital nightie, with their backsides exposed. The family was told to take home all the belongings as a patient would not need them, a dressing gown would be okay. Also, the visiting hours were from 2:00 to 4:00. These policies have a deleterious effect and would help to turn the person into a bed-ridden patient. The use of tranquilizers would hasten it as well.

Interviewer: Were tranquilizers used often?
Vera: Oh, my god! They were the chemical restraint. If it didn’t work, they upped the dose. The atmosphere which added to the hospital environment was staff dressed in white uniforms. The hated bedpans were offered and meals were served on trays at the bedside. Exactly like an acute care hospital. There was no space for personal mementos or belongings. Flowers would be seen as a nuisance due to the lack of space for them. Don’t you remember that in your training? ‘Where would you put those damn flowers?’ (Interview #7, V.M., p.2-4)

McIver goes on to explain what nursing training was like for her in the late 1930’s and maintains that the way nurses were trained contributed to the bleak conditions in residential care facilities. She recalls that nurses were taught to remain impersonal and reserved toward the patient. The prime focus of care was the diagnosis and its management. Sometimes, the patient might even be referred to by their diagnosis, rather than by their name. McIver also suggested that the traditional hierarchical nature of the nurse/physician relationship prevented many nurses from offering suggestions or opinions to the physicians. (Interview # 7, V.M., pp.3 & 5). This type of training and approach to nursing practice appears not to have been unusual. Henderson (1966), another visionary nurse, confirms that she had a similar kind of training. She states that in the general hospital where she trained technical competence, speed and an impersonal manner were emphasized and an authoritarian type of medicine was practised.
New Approaches to Care

Against the historical background of nursing care described above a new group of leaders in gerontological nursing emerged in the 1970's, advocating change. Dr. Elaine Gallagher, herself a pioneer in gerontological nursing, describes some leaders that influenced her.

Gallagher: There were a few leaders of people whose work actually has stood the test of time. Irene Burnside was one of the early writers who really influenced a lot of my thinking about what could be done in gerontological nursing. She was taking students through experiential learning opportunities to help encourage them to think what it would be like to be a patient in a nursing home and into aging. She had these different experiences...she had a whole textbook of learning activities. She was way ahead of her time: really influenced me tremendously. I choose to go to Duke University in 1975 because of a woman named Stone, Virginia Stone, and she was going around the world and was quite influential in Canada in terms of talking about personalizing care; giving people autonomy; treating them like people, like human beings as opposed to cases or patients or whatever. And was really optimistic about the fact that, you know, if you developed a really individualized care plan for someone, and encouraged them to get active and to get involved that you could actually reverse some of what people thought were some of the negative changes of aging. And she was very adamant about that and it was because of her teachings that I chose to go to Duke University and study with her. (Interview #4, E.G., p.3)

From Gallagher’s experience, it is evident that there were influential nurses writing and speaking about improving and humanizing care for older adults. This was a major shift during the 1970’s. Interestingly, as Gallagher mentions, Virginia Stone and Irene Burnside were already exploring different ideas related to care of older adults. While these influential nurses came from the United States, many of their ideas could be applicable to the Canadian system. For example, Stone (1971) suggested that physicians no longer should be the gatekeepers for the health care system and for older adults’ access to care. Instead, she proposed that other health care workers such as nurse practitioners or other specially trained
workers could undertake many of the assessment, prevention, health promotion and educational activities older adults required to maintain optimal health. Gallagher’s own contribution to gerontological nursing will be explored in the next chapter.

In the passage above, Gallagher mentions that she was influenced by the writings of Irene Burnside. In 1973, Burnside edited a book called *Psychosocial care of the aged* (Burnside, 1973). It had four main sections, titled: communicating with the aged patient, the aged patient in the institution, the aged individual in the community, and, the hospitalized aged in the group [setting]. In the preface to the book, Burnside explained that these topics are only a few of the many significant topics related to care of the aged. She stated:

Subjects which are not covered include: (1) disengagement as it applies to the nursing care of aged patients, (2) crisis intervention, (3) multiple losses in the aged, (4) emotional problems of the aged, especially confusion, (5) coping with social behaviour problems in the elderly, (6) interpersonal relationships within the geriatric nursing unit itself, (7) the “normal healthy” aged, and (8) research on the aged clientele. The omission of so many significant topics in no way implies these are unimportant areas, but rather indicates the limitation of this volume (p.xi)

Burnside’s list of topics that still needed to be addressed is interesting and significant in the context of available information for gerontological nurses. The awareness that older adults had special and different needs from other adults that were not being met was a new idea in the 1970’s. Burnside addressed the omissions she described above in 1976 when she edited *Nursing and the aged*, a comprehensive text in which all the topics Burnside had
previously omitted were discussed and which also included an instructor’s manual (Burnside, 1976)

Not only American nurses were influential in gerontological nursing in the mid 1960’s to mid 1970’s. Canadian nurse leader Vera McIver was another ‘nurse pioneer’ in that period. Gallagher describes the influence that McIver’s ideas had at the time.

Gallagher: The nurse that set up the Priory in Victoria, for example, in the mid-70’s, you know she was a real pioneer in her day and she did something different. She treated people individually and it was one of the reasons that I actually came to Victoria because Virginia Stone had come here and had met her and had seen some of the pioneering work that was being done here and had said, ‘You know, if you want to go somewhere where there’s something really worthwhile happening in gerontological nursing, you should go to Victoria.’ She told me that in the mid-70. So...clearly, you know, the ‘Priory method’ if you will, which was really just a very intuitively driven person oriented individualized care planning model, had made itself known around the world...around North America anyway...in nursing circles and I think wound up really actually making a difference in terms of how care was envisioned and planned (Interview #4, E.G., p.5).

McIver’s work was an inspiration for Gallagher and was an example of real changes happening in gerontological nursing care. McIver’s work was being developed in the 1970’s in Victoria, British Columbia and McIver published many articles in journals. The next section will discuss her work and her role in moving forward the new ideas about humanizing care for older adults.

**Humanizing Care: a New Way Forward in Gerontological Nursing**

**The history of St. Mary’s Priory**

Vera McIver’s pioneering work began at St Mary’s Priory, a nursing home (as they were referred to in those days) in Victoria, British Columbia. She began her work there in 1967. To understand the context in which McIver’s changes were made, it is important to
look at the history of St Mary’s Priory. Mantle and Funke-Ferber (2003) give a brief history of the Priory, as it was commonly known, in their book *The forgotten revolution: The Priory method, a restorative care model for older adults*. Here are the highlights of the history Mantle and Funke-Ferber describe. The Priory began as a smaller facility, named the Priory Convalescent Home, which had been started by the Sisters of the Love of Jesus in 1951. Initially it housed 48 severely mentally handicapped elderly patients. However over time it went through a number of changes including the addition of a wing called the House of Peace, which housed over 100 people, somewhat over its official capacity of 91. By the mid 1960’s, the operation had gone into debt and an advisory board was set up to assist the sisters in managing their facility. The British Columbia Hospital Insurance System eventually agreed to provide the necessary renovations and operating expenses for the provision of extended care services for 95 older adults. Upon the recommendation of the advisory board, an administrator and a nursing director were hired. The nursing director was Vera McIver.

McIver describes her first impressions of the care given at the priory when she arrived.

McIver: I was no stranger to the Priory as I had frequently visited my sister, Sister Mary Elizabeth who was a nurse in charge of the House of Peace. I had observed the patients in a cursory manner and understood care to be inadequate. However, care here was par for the course as the term ‘warehousing’ of the old was a familiar description used throughout Canada and the U.S. (Interview #7, V.M., p.1)

Some of McIver’s other first impressions of the nursing home have been mentioned previously. For example, the ‘cold and detached atmosphere’ of the nursing home that was run on an acute care model with the older adults dressed in hospital gowns and subjected to restrictions on visitors from outside. McIver’s use of the term warehousing and her portrayal
of the use of tranquilizers for restraint of older adults in the nursing homes of the time fit with
the description of nursing homes given by Baum. McIver describes some of the other
institutional approaches that contributed to the conditions she observed when she began
working at the Priory.

McIver: The prime focus of care was a diagnosis and how to manage it. The kardex was very important and was used to note all the necessary information . . . the name, the room number, the diagnosis and orders . . . In the main, the diagnosis was senility and orders were drugs. The nurse thought she was caring for the whole person, but it was merely the whole body. The yardstick she used to measure care was absence of bedsores. She did not realize she and the doctor were contributing to ‘warehousing’ conditions. (Interview #7, V.M., pp.3&5)

McIver’s point about senility being the main diagnosis for older adults in care is supported by Virginia Stone: “It is still not unusual for old age to be equated with senility- and senility to be considered irreversible. Nor is it unusual to equate confusion with senility” (Stone, 1972, p.33). McIver’s story shows that she really was a pioneer in her day, with a perspective on the residents in her care that was different from the mainstream.

The Restorative Care model: a humanistic approach

McIver explains how her understanding of the needs of the residents of the Priory differed from common practices and how this different understanding influenced the care she gave and the environment she promoted.

McIver: The Webster’s Dictionary describes humanistic medicine as follows: ‘it respects and incorporates the concept that the patient is more than his or her disease. The professional is more than a scientifically trained mind using technical skills.’ I thought that might help to understand why the acute care philosophy wasn’t working. Besides the disease and care, a person has the following basic needs: biological, psychological, social and spiritual which have to be fulfilled during his lifetime. An elderly person does not necessarily have a disease but has a frailty, which cannot be allowed to deteriorate because of neglect in fulfilling the appropriate needs. You
know, they used to just come in with frailty and then they were immediately put into a patient role. (Interview #7, V.M., pp.5-6)

This excerpt shows that McIver considers her approach to be a humanistic one. She also ties the humanistic approach in with holistic approach. Around the same time, another visionary nurse in the USA, Virginia Henderson, was promoting the holistic approach to patient care. Henderson was a faculty member at Columbia University and at Yale University whose extensive work has had a profound effect on nursing and the provision of patient care. Henderson defined nursing as assisting the individual to gain independence in the performance of activities contributing to health or its recovery that he or she would normally be able to perform independently if he was knowledgeable or strong enough (Henderson, 1966).

Vera McIver’s understanding of the needs of older adults fit with the ideas that Virginia Henderson was promoting. McIver saw the common practices around diagnosis and treatment of older adults as part of the acute care approach that she believed was not useful or relevant for nursing care of frail older adults. It was this perspective on the needs and concerns of older adults that influenced how she envisioned care and how she began to change the methods and surroundings at the Priory.

McIver’s ideas eventually developed into an approach she called Restorative Care. The philosophy of this approach is as follows:

We believe in the dignity and worth of all human beings. In order to make this a viable fact, within a total community, all staff with the resident and his family, develop a restorative programme. Together, we are given the opportunity to reach and
attain our maximum potential in the pursuit of growth and development. With the freedom of expression, encouragement and positive expectations, all strive toward a continuum of care, which encompasses prevention and maintains, improves, or restores bio-psycho-social health (Document provided by McIver during interview, no date, no page).

McIver uses the symbol of a tree to illustrate her model (Mantle & Funke-Furber, 2003). She suggests that the roots of the tree represented the basic needs of the older adult, which includes physiological, psychological and spiritual needs. Independence and identity are the fruits of the tree, which will not flourish if the roots are not adequately nourished (Mantle & Funke-Furber, 2003).

Vera McIver describes some of the changes in practices that she implemented soon after beginning her role as director of the Priory.

McIver: Many patients were now no longer able to walk, so exercises in bed were begun. Those that could were walked with help. Parallel bars were used to a great advantage. Since residents now had bathroom privileges, they were walked to the toilet as well as to the dining room. Those that couldn’t walk at this time were given wheelchairs so they could participate. Nurse and residents were taught the art of safe transferring from chair to bedside, and so on. We had the physiotherapist teach transferring. Daily playful exercises were introduced with arts and crafts to keep them busy. As soon as the ladies were able, we took them to functions in the community. Walkers and wheelchairs went with them when necessary. All this was accomplished with the help of volunteers. Some soon discovered, for themselves, that they could walk. They were truly motivated. One lady came in her wheelchair and she saw she had to walk: she just got up and grabbed the railing and off she went. (Light laughter) You know, that’s what motivation is. But if you don’t ever expect anything, you won’t get anything... And there was the psychological care. I’d say this one was done instinctively. The first thing [was] to bring back the pride and self-esteem and, you know. No one should be allowed to live their lives in a nightie, before their time. We began by attempting to restore pride in self with ego-enhancing experiences. A hair salon was set up which provided perms and sets. Purses with some money were
returned. The ladies now were expecting to pay for these services and decision-making came into play in their daily lives. (Interview #7, V.M., pp.6-7)

Virginia Stone reminds her readers of A.F. Wessen’s suggestion that we need to change the way we look at older adults so that instead of talking about infirmity and helplessness, we talk about “maximization of the patient’s remaining functional potential [and] minimization of further deterioration” (Wesson, A.F. cited in Stone, 1975, p. 8). This is the kind of activity that McIver’s story illustrates.

**Individualizing care**

As Vera McIver’s philosophy shows, she believes in seeing each of the residents as individuals. When she was Director of Care at the Priory, she adapted a nursing history form that was being used in the United States to the needs of the Priory in order to get an idea of the individuality of the residents.

McIver: And then all a sudden they would be taking histories. ‘Oh, did you know that Mrs. Johnson was a pianist?’ Or ‘So and So was an artist?’

Interviewer: And that was something they hadn’t done before? That wasn’t normal in long-term care?

Vera: No...they didn’t even know that they had an artist or a pianist. They only looked in the Kardex and [saw] ‘she’s there for senility’. And it was dropped, right there. So when you’re preparing a person’s file and you find out she’s a pianist, well naturally you’ll take her to the piano, and she would be as happy as could be. She’s back doing something. Give her paints or whatever. Get her back to doing what she knew best. (Interview # 7, V.M., pp.14 – 15)

The preceding passage illustrates the difference in McIver’s approach from previous approaches. McIver insisted on seeing each person as an individual. She saw nursing care as going beyond physical care. She understood the need for each person to continue to live their life and be the unique person that they were before admission to the care facility. McIver
indicates that individualizing care was not usual at the time. Davies (2003) agrees and states that older adults were "seen and judged within the professional paradigm of 'aged', reducing the potential for them to be viewed as individuals".

McIver also believed that part of continuing to feel like an individual was maintaining existing ties and relationships that were important to each person and being part of a larger community. Vera describes the things she implemented to encourage maintenance of ties to each resident’s friends and family.

McIver: First of all, visiting hours were eliminated and families and friends could drop in at any time. Can you imagine why they couldn’t? 2:00 to 4:00 was the visiting hours.
Interviewer: For working families, that’s working time.
Vera: Yeah. In the past the nurse always knew best and felt she didn’t need the help of families, in fact their participation wasn’t always encouraged. We offered coffee for the families and they had a private area so they could visit and the families knew they could come and help themselves. We also provided meals, like for a spouse who would come from a long distance or a birthday or something. He could have dinner with his wife. We installed a telephone at wheelchair height so wheelchair residents could phone friends and relatives. We were trying to bring them out, you know. (Interview #7, V.M., pp.16 -17 & 21)

Davies (2003) explains that by the 1950’s old age homes became institutions for the infirm aged and places which were separate from the rest of the community and which shut residents out from all former connections and lives. This was indeed the situation Vera McIver found when she started at the Priory, which she soon changed with her new approach.

Davies (2003) explains that in the past, when the residents of nursing homes were relatively healthy, they moved freely between the nursing home and the community, and were often visible and active in the broader community. Gradually the institutions became more closed and inward looking and the residents become more isolated from the rest of the
McIver saw this and knew that part of humanizing care for older adults included creating community and maintaining ties with the larger community. She describes some of the ways in which residents were able to feel part of their own community as well as continuing to be part of the larger community outside of the facility.

McIver: I knew that we needed a community, and the hospital to become a part of a greater community of the district. Staff began bringing their children who enjoyed playing nurse and pushing wheelchairs. And school children were invited and held their Home Economics classes at the Priory. In turn the ladies sometimes went to the school, the better ladies. Sometimes the ladies would plan to have Kentucky Fried Chicken. So they became young again, they did things. We also became part of the district community. The Lions Club adopted us and poured cement outdoor bowling alley which created a great deal of interest, especially when the residents formed teams. Residents’ families became involved in supervising barbecues and picnics. The children of the community held a dog show and the residents were the judges and they participated in the prizes. Every dog got something. Then the Riding Club put the horses through their various feats of dressage and jumping. Residents could really identify with this. On the first of July the Priory entered a float and it was a beautiful float; they got a first prize. Woodward’s provided a shopping night for the disabled at Christmas and so each one of the ladies had a volunteer and they went [shopping].

(Interview #7, V.M., pp. 15 & 22-23)

McIver’s approach ensured strong and continued ties with the larger community both by encouraging residents to go out and participate and by bringing the community into the nursing home. Her approach was a marked change from the past decade and an attempt to restore meaning in the lives of the residents of the Priory.

Conclusion

The early history of gerontological nursing in British Columbia was part of a larger movement toward humanistic and holistic care of older adults. One nursing leader, Vera McIver, played a significant role in promoting this new perspective in British Columbia. McIver’s focus on individualizing care and creating community was innovative and
visionary. The shift toward humanizing care for older adults laid the groundwork for recognition of gerontological nursing as an area of specialized knowledge. The next chapter will look at the development and advancement of gerontological nursing knowledge and education in British Columbia that was achieved through the promotion of science and professionalism.
Chapter 3: Science and Professionalism

By the 1980’s, the innovations and ideas of gerontological nursing pioneers such as Vera McIver, Irene Burnside and Virginia Stone were beginning to be known all over the world. McIver had published a number of papers including: *Freedom to be: A new approach to quality care for the aged* (McIver, 1978). In her article, she used a case study as an example of what life in a traditional nursing home was like to illustrate her model of a more caring, humanistic and restorative way of nursing frail older adults. McIver’s article added to the rapidly expanding knowledge base of gerontological nursing. As mentioned in chapter 1, the development of gerontological nursing education programs began earlier in the United States than in Canada. Ebersole and Touhy (2006) explain that with the increasing number of master’s and doctorate level nursing graduates in gerontology in the late 1970’s in the United States, there was a concomitant increase in quality and quantity of gerontological nursing research. They recount that by 1980 there were 13 textbooks on gerontological nursing, and the *Journal of Gerontological Nursing* was 5 years old.

The increase in scientific gerontological nursing knowledge seemed to go hand in hand with the improved recognition and professionalization of the specialty of gerontological nursing. In 1984, the National Gerontological Nurses Association was established in the U.S.A. (Ebersole and Touhy, 2006). Ebersole and Touhy (2006) contend that, in the U.S.A., by 1985: “With a developing scientific base, advanced nursing practice education programs, and strong leaders, the specialty of geriatric nursing had come of age” (p.21). At the same time, Canadian gerontological nurses were to follow the American lead, establishing the Canadian Gerontological Nurses Association in 1985.
The recognition of gerontological nursing as a specialty and the establishment of the professional association were important milestones in the development of the field of gerontological nursing in Canada. As the biographies of the study participants show, all of the nurse educators I interviewed contributed to the developing knowledge base and education in gerontological nursing. Two of them, Jessie Mantle and Elaine Gallagher, played key roles in establishing the Canadian Gerontological Nurses Association, thereby elevating the professional status of gerontological nursing in British Columbia and Canada. To provide a context to their stories I will discuss some key highlights of the history of care of older adults in Canada from the mid 1970’s to the mid 1980’s.

**Growing Awareness of Nursing Home Conditions**

In the period from the mid 1970’s to the mid 1980’s, the conditions and standards inside nursing homes were beginning to get public attention all over North America and critique on those conditions arose. According to Ebersole and Touhy (2006), there was concern over the quality of nursing care and the conditions in nursing homes in the United States from the mid 1960’s through to the 1980’s. In Canada, concern over the rapid proliferation of nursing homes and the lack of future planning prompted Health and Welfare Canada to publish *Nursing home care in Canada: A review* (Clark & Collishaw, 1975). The purpose of the paper was to examine the status of nursing home care in Canada at the time. In their review, Clark and Collishaw state:

The major problem in Canada is that we simply do not have a generally accepted and rationally based public philosophy and policy relating to the care of the aged in our society. To a large extent the care and treatment of senior citizens with limited or
only partial disabilities relies heavily, with the exception of the province of Quebec, on the old English Poor Law philosophy of 'less eligibility'. It is in response to the lack of a clear formulation of a public philosophy relating to the care of the aged that we have witnessed in the last decade the unprecedented burgeoning of private enterprise in the field. (p.iii)

Davies (2003) supports the idea that care of older adults with limited abilities connected to the English Poor Law. She contends that the Poor Law that was instituted in England in the nineteenth century has cast a "long historical shadow" over residential care facilities for older adults in British Columbia (Davies, 2003, p.4). Davies explains that the key principle of the Poor Law was 'less eligibility'. This principle essentially meant that state assistance was made to be as unattractive and minimal as possible so that people would seek employment or assistance from families or friends before requesting help from the state. According to Davies, under this new system older adults were treated in the same punitive way as beggars and migrants. "Poorhouses, into which the aged were compelled to enter and were unlikely to be able to leave, were designed to be profoundly disempowering and humiliating" (Davies, p.5). As Davies points out, although there were no poorhouses in British Columbia, memories of the Poor Law maintained a strong presence in residential care facilities in British Columbia in the first half of the twentieth century. In Davies’ opinion, the administrative practices and cultural nuances found in many old age homes were derived from the workhouses of earlier times. This situation might explain both the nursing home conditions that were drawing criticism and the lack of public policy regarding the care of frail older adults that Clark and Collishaw commented on.
Clark and Collishaw (1975) mentioned that, at the time of writing their report, there was a lack of sufficient, reliable, and comprehensive data on the issues surrounding nursing homes and their proliferation. They found that, although there were over 2000 nursing homes with over 113,000 beds for older adults in Canada at the time, it was unknown what the physical and mental conditions of institutionalised older adults were, how many people were employed in the care of the elderly, or even the costs of providing care. Clark and Collishaw remarked that older adults in institutions existed in a “nether world where the principle concern seems to be ‘out of sight, out of mind’. They are truly Canada’s ‘forgotten people’” (p.1).

The invisibility of older adults in the mid 1970’s was mentioned by C., one of the participants in my study.

C: Even in ’77, when I was first working on that med/surg. mixed unit, not many of them got very old. Old people didn’t have a priority stage in the community. Somebody you knew may have had a grandmother living with them but other than that they went to old people’s homes. They didn’t have a high profile in the community, much the same as people with disabilities. I did not see that sidewalks were not level, people couldn’t get out of the house, and nothing was made amenable to them. And those kinds of recognitions were not there in 1977. I think [professionals] were starting to become aware but there was no action done to respond to the need (Interview #6, C, p.5-6)

C makes an interesting comparison here between attitudes towards older adults and attitudes towards people with disabilities in the mid 1970’s. She remembers both groups of people as being ‘invisible’ populations. What is striking about her story is the lack of response of health professionals who were aware of the needs of older adults. Some possible reasons for this lack of response will be explored in the next chapter.
Legislation, Regulations and Standards for Nursing Homes in British Columbia

In their review of Canadian nursing home care, Clark and Collishaw (1975) pointed out that in 1975 some legislation and minimal standards and regulations for nursing homes had only recently been introduced in the provinces. In British Columbia, there were several sets of standards and regulations referring to care of older adults in extended care hospitals, as care facilities were then called. A brief summary of these standards and regulations follows.

Revised Standards for Licensed Private Hospitals giving Nursing Care had been published in 1969 (British Columbia Hospital Insurance Service, 1969). A note in the front of the document states “The Minister of Health Services and Hospital Insurance has, pursuant to Section 11 (1) of the Hospital Act, specified that every licensed hospital shall be operated and managed in accordance with these standards” (BC Hospital Insurance Services, 1969, no page number). The document contains standards related to administration, including qualifications of staff, medical and nursing care, food services, patient records, staffing of patient areas, personnel policies, general provisions, fire precautions, and ownership and shareholdings of the private facilities. Under the nursing care section, specific criteria were to be used to determine if patients (as they were referred to then) were receiving adequate nursing care. Some of the criteria were related to the adequacy of personal hygiene and nutritional intake, prevention of bedsores, cleanliness and condition of environment and equipment, and evidence of activity programs (BCHIS, 1969). The use of the term ‘patients’ to describe older adults in residential care underscores Vera McIver’s observation noted earlier in this paper that older adults in care were thought of from a medical, acute care point
of view. As well, the document’s criteria for determining adequate care used basic physical indicators and did not include any psychological, social or spiritual components, although “evidence of activity programs” was a start. These were the same elements of care that Vera McIver noticed were missing in the Priory when she started there.

In 1970, the Canadian Council on Hospital Accreditation published the first accreditation guide for extended care centres (Canadian Council on Hospital Accreditation, 1970). The stated aim of the accreditation program was to assist extended care facilities “in improving the quality of care and of services offered” (Canadian Council on Hospital Accreditation, p.B-1). The guide gave 26 standards for accreditation and detailed interpretation of the standards which included everything from physical plant requirements to professional services to programs. Following these standards was not required by law, as the accreditation process was voluntary (Canadian Council on Hospital Accreditation), so not all institutionalized older adults necessarily benefited from the application of these standards. The standards, like the criteria of the Revised Standards that had been published a year earlier used a narrow medical perspective to discuss care for older adults.

In 1971, the government of British Columbia published *Hospitals for Extended Care: Guide for Operation of Extended Care Programs* (British Columbia Hospital Insurance Service, 1971). This document did not have the legal force of the standards, but rather its goal was to “give guidance to Hospital Boards and staff and those organizations who are planning to provide hospital facilities for this class of care” (BCHIS, 1971, p.ii). The document described the guidelines as suggestions or recommendations rather than requirements or regulations (BCHIS, 1971). Design guidelines for planning the physical
space for extended care facilities were published in 1969 and revised in 1984 (Province of British Columbia, Ministry of Health 1984). The foreword to the guidelines states that these suggestions were neither regulations nor building code, but rather design aids for planners (Province of BC, 1984).

As the summary of the relevant standards and guidelines shows, while there were documents addressing care of older adults at the time of Clark and Collishaw’s (1975) report, few of them had legal force. Rather, several contained guidelines or suggestions for providing quality care for residents of extended care hospitals, which were mostly, though not exclusively older adults. These documents may have been in response to the concerns and critiques about nursing home care mentioned above. Since even official documents providing care standards for older adults in residential care had a narrow medical perspective, it is not surprising that care facilities had the kinds of conditions Vera McIver described. This was the context in which the ideas about holistic and humanistic individualized care arose.

Development of gerontological knowledge in British Columbia

Early inclusion of gerontology in nursing education

In the mid 1970’s, there was an attempt to provide gerontology-focused education to nursing students in British Columbia. According to University of Victoria archivist L. Wilson, the University of Victoria (UVic.) School of Nursing was established in 1974/75 (L. Wilson, personal communication, November 23, 2007). One of my study participants, Dr. Elaine Gallagher, has been a faculty member at the School of Nursing since 1980. From the start of her appointment, she took leadership and made significant contributions to the
development of gerontological nursing in British Columbia. She is a professor at the University of Victoria, School of Nursing, the Director of the Centre on Aging at the university, has won numerous awards and honours for her research, and has written many articles on gerontological topics. She explains that the focus of the nursing program at the University of Victoria had initially been gerontological nursing but that focus was soon changed.

Gallagher: U of Vic had actually started as a gerontological nursing program, and that was really the focus of the entire curriculum when it first started. Isabel Dawson was the first director, not the Isabel Dawson who's there now, but another Isabel Dawson, which is kind of interesting. And she started that in the mid-70's. The rationale for it was around the need for gerontological nursing. Much of the program was devoted towards that and what happened was that the students actually had a revolt and you know, they petitioned the dean, at the time, to broaden the program, to make sure it was more encompassing of people who's interests included care of children and care of women [ie] maternity child, and mental health and med/surg, in general. And so then, a major curriculum revision was undertaken just before I arrived and when I got here it was to find that the gerontological nursing focus had been significantly watered down but was still a strong emphasis. (Interview #4, E.G., p.6-7).

Gallagher’s memories of the curriculum revisions of the late 1970’s are particularly interesting in light of the discussions and debates around gerontology in nursing curricula that were happening at the time. There had been an article in the nursing literature advocating inclusion of geriatrics in the baccalaureate curriculum as early as 1969 (Moses, 1969, cited in Mahoney, 1993). Davis (1971) called for the inclusion of gerontological knowledge in basic nursing programs. She wrote:

The student’s exposure to the care of the aged will be most advantageous if it occurs within her basic program as an integral part of her preparation for nursing practice.
This is not just a block of time designated as geriatric care, but it needs to be a significant part of whatever the student learns. (p.11)

Although Davis was writing about American nursing programs, her argument could be applied to Canadian schools given the similar demographic trends in Canada and the U.S.A. Gress (1979) was also concerned about the slow development of gerontological programs in schools of nursing. She discussed the factors that contributed to the lack of nurses prepared in gerontological nursing and the lack of opportunity for nursing students to adequately prepare for looking after older adults. She stated that there was “a dearth of educational programs in gerontological nursing” (Gress, 1979, p. 46). She advocated for increasing the gerontological content of nursing programs as a way to “fully discharge [their] responsibility and accountability to the society that sustains them” (p. 48). Given the increasingly frequent and strong calls for improving gerontological content in nursing programs and the specific attention to geriatrics by the American Nurses Association in the 1960’s, as previously mentioned, it is interesting that the gerontological content of the baccalaureate program at the University of Victoria’s School of Nursing was changed from its original focus on gerontology. As Gallagher explains, the focus of the program was broadened to encompass other specialties, though gerontology still had a strong emphasis.

Elaine Gallagher was not deterred by the changes made to the nursing curriculum at the University of Victoria. In fact, those changes spurred her to find innovative ways to promote gerontological nursing knowledge in British Columbia.

Gallagher: So, Lyn Jackson and I got our heads together and decided to do two things to try and keep the gerontological nursing emphasis alive. One was a six-part update in gerontological nursing, which we developed for the Knowledge Network; it was the first distance education course that was taught at U of Vic. and it was a six-part
series called ‘An Update in Gerontological Nursing.’ We divvied them up and each took on three of the programs. (Interview #4, E.G., p.7.)

Clearly, Gallagher was a pioneer and innovator in her field: not only was she determined to promote the advancement of gerontological knowledge for nurses, but she used what was, for the time, a new and innovative learning modality, televised distance education. Gallagher and her University of Victoria colleague Marilyn (Lyn) Jackson used the most up to date and modern technology to respond to what they perceived as the need for gerontological nursing knowledge for practicing nurses.

Moving beyond nursing education: the bigger picture

Gallagher and her colleague Lyn Jackson’s vision to “keep the gerontological nursing emphasis alive” went beyond simply teaching and promoting gerontology to nursing students. They went on to organize the first national conference on gerontological nursing, which was held in June of 1983. Ultimately, their vision helped to establish gerontological nursing in British Columbia and Canada as a specialty field.

Gallagher: We then talked about the need for having a national conference to bring nurses across the country together. It was a bit of chance; we had no idea how successful that would be and how many people would come. We knew there was a need and that people were feeling kind of isolated and distanced from the research that was going on in the field and without opportunities for workshops and learning about new techniques and strategies, so we decided to just take a leap of faith. We applied for funding and got funding from, I think, five major Canadian foundations that put money into it so that we weren’t taking a huge financial risk and we were able to run it reasonably and economically so that a working nurse could afford to come and 400 nurses came from across Canada. It was just incredibly successful. And people just told us they were hungry, you know, for that kind of opportunity to hear what was going on, what were the latest developments, what can we learn about caring for people, what were the latest care approaches, etc. (Interview #4, E.G., pp. 7-8)
Gallagher’s mention of nurses’ hunger for new gerontological knowledge suggests that new gerontological knowledge was unavailable to many nurses. Although there were journals such as the Journal of Gerontology, in general, nurses didn’t have access to current gerontological literature. One of my study participants, Anne Earthy, tells of the difficulty she experienced in finding gerontological information.

Earthy: There weren’t any nursing textbooks in gerontology. I think the Journal of Gerontological Nursing and Geriatric Nursing might have been in [their] beginning phases, but other than that there was not very much specialized information. [We got our information from] medical textbooks. [You had to] pull [information] out and make conclusions yourself [as to] how it would affect the functioning of the individual. [My role was] to bring that information out and to make it meaningful to front line nurses. (Interview #2, A.E., pp.5 & 6)

Earthy’s memory of having to use information from medical sources to extract and develop gerontological knowledge that would be useful to nurses gives us a glimpse of the ways nurses worked to develop gerontological knowledge by integrating any sources they could. Her memory underscores Gallagher’s description of nurses being hungry for new knowledge. Gallagher also revealed that nurses were also eager to share knowledge and network among themselves at the conference.

Gallagher: [Nurses valued] just getting together and finding out, you know. ‘I’m doing this and it seems to be working,’ and having the opportunity to informally share those kinds of things, so that was the reason for having that conference. (Interview #4, E.G., pp.7-8.)

The importance of networking and sharing knowledge between gerontological nurses at the conference fits with the tradition of knowledge development through grassroots mentoring that had been the primary method of educating gerontological nurses up to that point. Gallagher’s anecdote shows that the nurses at the conference valued both traditional,
informal methods of transmitting gerontological knowledge as well as newer, formal methods. They also were able to accept both kinds of knowledge as equally valuable for sharing and improving nursing care.

Gallagher’s telling of the story of organizing the conference is somewhat modest. Jessie Mantle, a nurse clinician, university faculty member and herself an important influence in gerontological nursing in British Columbia and Canada, described the contribution of Elaine Gallagher and Marilyn Jackson in her address summarizing the conference proceedings:

The conference resulted from the vision of two of my colleagues at the University of Victoria, Elaine Gallagher and Lyn Jackson. How daring to believe, two years ago, that it was possible to alert nurses from across Canada, the USA, and beyond, that it would be worthwhile to travel to the furthermost western corner of our land to discuss gerontological nursing. Persistence of action in attention to the multiplicity of details by the small community planning group is consistent with the history of nurses in this specialty. Clearly the potential list of deterrents either were ignored or, in the case of seeking funding which they received to the tune of $14,000, were changed to strengths (Mantle, 1983, p.2).

Mantle’s comments highlight the magnitude of the undertaking of planning a national conference in a time before the popularity and proliferation of electronic communication. She illustrates the risk that Elaine Gallagher and Lyn Jackson were taking in planning an unprecedented event and the vision and commitment it took to make the event successful. The event was indeed successful; more than 400 nurses from all parts of Canada, the USA,
Great Britain, and Australia attended (Gallagher, Jackson, & Zilm, 1983). This first national conference on gerontological nursing was a very important and significant contribution to the development of gerontological nursing in Canada. There was a wide range of topics of discussion and many nurses gained a sense of self worth about their specialty (Gallagher et al., 1983). Elaine Gallagher and Lyn Jackson had clearly understood the need for sharing knowledge amongst gerontological nurses.

Mantle (1983) points out another way that Gallagher and Jackson, through their organization of the conference, contributed to the advancement of gerontological nursing knowledge. She notes: “The decision to publish the proceedings will make a major contribution to the written records describing the activities and perceptions of Canadian nurses about their practice. These proceedings will move us beyond the oral tradition” (p.3). Mantle’s point is important as it highlights the shift from traditional oral methods of knowledge transmission (through grassroots mentoring) which, by their nature tend to be geographically limited, to methods that facilitate the rapid and prolific dissemination of gerontological nursing knowledge in more formal and structured ways, facilitated by a context of professional leadership. This change in the way gerontological nursing knowledge was transmitted in British Columbia, and ultimately the rest of Canada, was a significant stage in the development of gerontological nursing knowledge and both Elaine Gallagher and Jessie Mantle were major players in that change.

Professionalization of gerontological nursing

The first conference on gerontological nursing was the impetus for the beginning development of the Canadian Gerontological Nursing Association (CGNA). The idea for
establishing a national organization for gerontological nursing was hatched at that conference and a committee was established to examine the feasibility of such an organization (Gallagher et al., 1983). Gallagher et al (1983) explain the purpose that was envisioned for the proposed organisation. Conference participants felt that such an organization:

"Would provide a mechanism for mutual support and decrease the sense of isolation that bothers some who are involved in the care of the elderly. As well, a national network would provide a mechanism that would allow nurses to influence the direction of care through united political advocacy for the elderly" (Gallagher et al, p.iii).

Considering the inadequate conditions of residential care, the invisibility of older adults in society and the difficulty gerontological nurses experienced in finding and creating useful gerontological knowledge, it is not surprising that the conference attendees would be determined to create a mechanism for support and advocacy for older adults and for the specialty of gerontological nursing. The time was right for the establishment of a professional organization of gerontological nurses developed from the grassroots.

A second national conference was held in Winnipeg in 1984. It was attended by 800 people and culminated in the beginning steps towards the creation of the CGNA (Mitchell-Pedersen, 1984). An executive was established and given the task of creating a newsletter and drafting by-laws to be discussed at a third national conference, to be held in Hamilton, Ontario, in June 1985 (Mitchell-Pedersen). At that third national conference the bylaws were ratified and Canadian Gerontological Nursing Association (CGNA) officially came into being. (CGNA, 2008). The first president of the CGNA was Jessie Mantle (Ebersole &
Touhy, 2006). Through the establishment of the national association, the specialty of gerontological nursing obtained an organized form and attained a professional status for the specialty. The dual purposes of professional support and advocacy that were important to the gerontological nurses of the time remain to this day the central purposes of the Canadian Gerontological Nursing Association (CGNA, 2008).

Further innovations in gerontological nursing education

As mentioned previously, Jessie Mantle, another of my study participants, also played a key role in the development of gerontological nursing knowledge in British Columbia in the 1980's. At the time she held an adjunct appointment with the University of Victoria as a professor and she also was a clinical nurse specialist at the Juan de Fuca Hospital, an extended care hospital in Victoria. (Interview #4, E.G. p.22). Elaine Gallagher names Jessie Mantle as an influential leader in gerontological nursing:

Gallagher: I do think that some of the key leaders have been extremely influential, Jessie Mantle being one, and I really want to go on record having said that because Jessie came and, as a clinical specialist, did the first joint appointment at the university between the university and Juan de Fuca hospitals and really, I think, role-modeled a different way of teaching and a different way of questioning clinical practice... I think it had a really profound effect on clinical practice through some very non-threatening forms of clinical research that you just can’t do as an outsider but when you’re there and you’re in the system, people aren’t threatened by that. (Interview #4, E.G., p.22)

In describing Jessie Mantle’s contribution to nursing education, Gallagher makes some interesting points about the relationship between academia and clinical nursing practice. She suggests that nurses in the clinical settings of the time (early 1980’s) were not always accepting of outsiders who questioned their practice. This attitude may have influenced the acceptance by practicing nurses of new gerontological knowledge that was published in
journals as opposed to knowledge that was passed on orally. Gallagher also suggests that

Jessie Mantle’s innovation was that she combined the traditional way of sharing

gerontological nursing knowledge through mentoring, with the developing scientifically
based way of understanding nursing practice that was based on research and dissemination of
findings through professional journals.

Mantle describes her experience of making scientific knowledge accessible and
acceptable to nurses practicing in clinical settings.

Mantle: Because of my practice background, they would say things, ‘you know, for
years we’ve been treating bedsores with mashed-up garlic and I suppose you’re going
to stop all that, are you?’ And I said, ‘No, tell me about it. How did you do it?
What, how many times did you do it? We’ll have to test this and see how it works.’
So they said ‘Oh! Really.’ I said, ‘Well, if you say it’s as good as it is, we ought to
be able to set up a little trial here and I’ll run that and you’ll do it and you’ll tell me
how the procedure goes’... And then the pharmacist and the Docs wanted to impose
this rule about how to do bowel care and I said, ‘Would you mind if I took this over
as a project?’ Then they began to see, ‘Hey, there are lots of ways of practicing;
some of what we’ve been doing is being honoured but there are some new things we
could learn.’ Now remember, 50% of my time is at the university at which I was
teaching a generalist course and what the students would tell me is ‘you don’t talk
like a professor.’ Well, I didn’t, I talked like a clinician and [I chose] to teach the
research and to do all the things as a good academic I knew to do but with a clinical
focus. (Interview #2, J.M., p.22-23).

Mantle’s approach was to work with a traditional, clinically-based mentoring process
of sharing knowledge that nurses were accustomed to while introducing the scientific method
of testing approaches through research. In doing this, she gained acceptance of research
methods from the frontline nurses who were fearful of research and academic approaches.
Mantle also suggests a reason for the nurses’ fear: they perceived that research-based
knowledge came from non-clinical sources and that its introduction in the clinical setting
meant that their work was not being respected and honoured. Mantle’s story shows that
having the frontline, clinical caregivers involved in the research helped with buy-in from that same staff. Mantle’s final sentence in this excerpt, “I talked like a clinician” is telling. Like her colleague Elaine Gallagher, she used an innovative way of teaching gerontological nursing and by doing so contributed to the development of gerontological nursing knowledge and its acceptance among clinical nurses. Interestingly, the lack of acceptance of a scientific approach was not limited to gerontological nurses but was part of a larger phenomenon in nursing. Moloney (1993) contends that many nurses in the 1990’s did not understand or appreciate the value of research or a strong theoretical body of knowledge for practice.

Gerontological Nursing as Specialized Knowledge

The changes and innovations in gerontological nursing education and the move to create a national association for gerontological nurses were signs of a beginning recognition of gerontological nursing as a specialized body of knowledge. However, while some nurses working with older adults recognized that they were practicing in a new nursing specialty, there was still a need to increase awareness of gerontological nursing as a specialized body of knowledge. Anne Earthy, describes the focus of the first educational sessions she developed for nurses in the clinical setting. The invisibility of older adults in society prompted Anne to focus her initial education sessions on making older adults more visible and human to nurses.

Earthly: I can remember the first educational sessions. There was a lot of emphasis at the time on trying to get individuals to understand what it felt like to be an older person, so a lot of education on poor eyesight and hearing and sessions on getting them to experience that and to begin to have better empathy and understanding of where the elderly were coming from. (Interview #3, A.E., pp. 3-4)

By focussing on empathy and understanding of older adults, Earthy’s approach encouraged the recognition of some of the unique challenges and experiences of older adults,
which had a psychological as well as a physiological basis. Earthy assisted nurses to understand that older adults had different health care needs from the rest of the population and that therefore nurses needed specialized knowledge to care for them. In this way, Earthy promoted gerontological nursing as an area of specialized nursing knowledge.

Although there were some nurses advocating for standards of care for older adults, Earthy found that health care team members were not always aware that older adults had different care needs and often presented with a different clinical picture from younger adults. Much of Earthy’s initial work as an educator was influencing the people around her to see their practice and their patients from a different perspective and looking at standards for care of older adults.

Earthy: A lot of it was just raising the awareness of a lot of people around you. I remember [talking to people] at the lab, questioning the lab values and that sort of thing. Developing a diabetic self-learning module and working really hard with the diabetic resource person, in that there were differences in the elderly and what were some of the standards in and around the elderly care, what kind of things we were looking at. So, it was certainly a lot of work just trying to raise various specialties’ awareness and [helping them] look at things differently. (Interview #3, A.E., pp. 5-6)

Developing empathy and awareness of differences in the needs of older adults was the initial focus of the educational sessions Earthy provided to practising nurses. However, she soon found that there had been a change in thinking about gerontological education.

Earthy: [There] was a big swing of thinking during that time because initially there was a lot of emphasis on ‘oh, we have to keep people in empathy with the elderly,’ whereas the big change was that if they have the knowledge base and know how the aging process effects these people differently, then if you can do a proper assessment of them and where they are in their life phase, socially, physically and all these other ways, then the nurse feels much more empowered. So, finally it wasn’t just recognizing how you feel about it but it was also providing them with knowledge to be able to make that changeover. (Interview #3, A.E., p 7-8)
The change in focus of education of frontline staff reflected the increasing recognition among educators of the specialized knowledge that was involved in providing nursing care for older adults, such as knowledge of the aging process and its effects on various aspects of care. In the early 1980’s in the USA, the John Hartford Foundation recognized the need for specialized knowledge about aging. The John Hartford Foundation was founded in 1929 to provide funding for medical research that could not obtain support from other sources. By the 1980’s the Foundation, recognizing the rapid growth in the population of older adults and the needs for health services that growth would require, began to focus exclusively on research on aging (John Hartford Foundation, n.d.). One of the topics on which very little research had been done, involved studying the barriers to optimal medication use by older adults, such as the differences in the ways older adults metabolized drugs and the risks of drug interactions from polypharmacy (John Hartford Foundation). In response, over several years the John Hartford Foundation gave seventeen grants for research addressing geriatric drug safety issues (John Hartford Foundation).

The stories of the study participants suggest that the growth in professionalization in gerontological nursing was related to the expansion of a scientific knowledge base. This idea was not limited to gerontological nursing. In discussing the relationship between scientific knowledge and professionalism of nursing in general, Moloney (1992) maintains that recognition of nursing as a professional discipline requires a commitment to the development of scientifically based theory. Moloney states “nursing will be greatly influenced in its progress toward professionalism over the next decade by nurse theorists who are accepting
the challenge of developing nursing as a scientific discipline” (p.53). Moloney sees development of scientific knowledge as important to professionalization.

In discussing the value of knowledge based nursing care, Earthy made the following comment.

Earthy: [Nurses] want to learn but they won’t feel good about the care they can provide, unless they have the knowledge base. We’ve seen that from time to time, the more you encourage them and they learn and they get involved then they’ll take off. (Interview # 3, A.E., p. 10)

Earthy emphasizes the positive effect on nursing practice and on nurses’ satisfaction with their work that can come from having good relevant knowledge on which to base their nursing practice. Not only did the development and advancement of specialised gerontological nursing knowledge help them to focus their care, but it helped them to develop and advance their nursing practice and their careers.

Conclusion

Gerontological nursing educators in British Columbia in the mid 1970’s to the mid 1980’s were building on the holistic, interdisciplinary model of caring for older adults that was begun in the previous decade. They continued to work toward developing the specialized knowledge necessary for providing nursing care to older adults. At the same time, they were advancing the professional status of gerontological nursing through innovative educational approaches, professional conferences and a newly formed professional association. However, these gains did not change the status of gerontological nursing overnight. As I will show in the next chapter, there were still many barriers for gerontological nurse educators to overcome in order to have specialized gerontological nursing knowledge accepted and implemented in the health care system. Some of those barriers remain today.
Chapter IV: The Road Less Travelled

In the previous chapters I highlighted some of the ways in which the educators in my study contributed to the development of gerontological nursing through new ways of approaching their practice. The innovations they developed came about as a response to the situations they found themselves in. What was notable about the gains in professional status and recognition of the specialty of gerontological nursing that the educators achieved was not only their innovation, but also that those gains were achieved despite social ambivalence towards gerontological nursing which the educators encountered in their practice. The social ambivalence was manifested in attitudes that devalued gerontological nursing and older adults both in society in general and more specifically in nursing culture. In choosing the socially unpopular area of gerontological nursing as an area of practice, the educators were challenging that ambivalence and championing the cause of excellent nursing care for older adults. Part of the challenge the educators faced in choosing the ‘road less travelled’ was to overcome both societal values regarding gerontological nursing and specific barriers and constraints to the development of knowledge in gerontological nursing. One of the ways that the nurses sought to overcome some of those barriers was through advocacy and influence on policy.

Some of the barriers that the educators overcame have already been mentioned. For example, Elaine Gallagher and her colleague overcame the potential barrier of financial and practical feasibility to organize the first gerontological conference. Jessie Mantle used innovative clinical education approaches to gain the support of clinical nurses to include research and academic approaches in their practice. Vera McIver’s humanistic perspective
changed the way care of older adults was understood by overturning the barriers to meaningful individualised care that were part of the acute care model, such as a focus on the physical condition and diagnosis of the older adult and the impersonal environment. The educators in my study experienced other barriers and constraints to their practice, but, as I shall discuss in this chapter, they found innovative ways around those challenges ultimately resulting in improvements in nursing practice and advances in gerontological nursing knowledge.

All the educators in my study talked about the way that societal ambivalence about older adults created barriers to the provision of good nursing practice. Many of the barriers were a reflection of negative attitudes toward aging and older adults that were pervasive in both general society in British Columbia and nursing culture. This chapter will explore those cultural, political, and economic influences that affected the social acceptability of the gerontological practice of nurses who were working to develop the evolving field of gerontology. It will also look at the ways the educators developed and advanced knowledge in an area of nursing that was not necessarily valued in a similar way to other specialties.

**Cultural influences on gerontological nursing**

**Cultural attitudes towards older adults**

In the mid 1970’s, Irene Burnside, a gerontological nurse leader who wrote two of the early textbooks on gerontological nursing, commented on societal attitudes toward aging that influenced peoples attitudes toward older adults. In the foreword to her first textbook *Psychosocial nursing care of the aged*, Burnside pointed out that: “In our youth oriented culture, growing old tends to be viewed as highly undesirable and elderly citizens for the
most part command little respect or admiration” (Burnside 1973, p.ix). Later in her other seminal gerontological nursing text she commented on “the pervasive negative attitude in our society about the aged. Nurses are not immune to this attitude. Mass media bombard our youth with images of the beautiful young people.” (Burnside, 1976, p. 11). Burnside was clearly concerned with the way that cultural values about aging and older adults influenced nurses. She reminded readers that nurses, as part of society, can be influenced by powerful societal values and beliefs regarding older adults.

Burnside was not alone in commenting on the pervasive negative attitudes toward older adults. In 1969, Robert Butler, a physician and university faculty member in Washington, DC, had written about the cultural phenomenon of prejudice against older adults:

Prejudice of the middle aged against the old... is a serious national problem. Age-ism reflects a deep seated uneasiness on the part of the young and middle-aged – a personal revulsion to and distaste for growing old, disease disability and fear of powerlessness, ‘uselessness’, and death. Cultural attitudes in our society reinforce these feelings. (Butler, 1969, p.243-244)

Although Burnside’s and Butler’s comments addressed American society and cultural values, their observations can be useful in understanding attitudes toward older adults in all western countries, including Canada. The youthful images in the mass media to which Burnside refers are equally available and accessible to Canadians as to Americans and can account for some of the continuation of negative attitudes toward older adults.
Invisibility of older adults

Butler’s and Burnside’s comments about cultural attitudes toward aging and older adults might help to explain the invisibility of older adults and their needs that was mentioned in the previous chapter. The comments of Clark and Collishaw (1975) regarding institutionalized older adults being Canada’s forgotten people can be understood more clearly in context of the pervasive cultural ideas about aging and older adults. Similarly, the previously mentioned lack of response to the needs of older adults by health professionals might be explained by Burnside’s reminder that nurses are not immune to cultural influences. Davies (2003) confirms the idea of the invisibility of older adults: “It is not so much that we see old people as deviant as that we do not see them at all” (p.9).

Davies’ statement is echoed in the experiences of Nan Martin, one of the educators in my study. Martin trained as a nurse in the 1950’s in Scotland; she encountered attitudes toward older adults at the time that suggested the invisibility of older adults.

Nan: Before I started my actual training in Glasgow, I worked in a little convalescent nursing home just for a short time and we were allowed to practice giving injections on the old people. That’s how we practiced our injections because they’d had their lives and then if we made a terrible mistake or anything it wouldn’t be so bad. That was the attitude there then. (Interview #1, N.M., p.2).

In Martin’s experience, older adults were invisible in the sense that they were not seen in the same light as other patients who deserved to be kept free from harm. Older adults were expendable. Experiences such as Martin’s help to explain the nursing home conditions that Vera McIver encountered when she began her work at the Priory and the reason for Anne Earthy’s need to focus early education on developing empathy for older adults.
Another nurse, Bett Lauridsen, also encountered negative images of older adults during her nursing practice. She described the common practice of labelling seniors who were in acute care beds as “bed blockers”.

Lauridsen: That’s [something] I hate about hospitals: they call seniors ‘bed blockers’. That gall-darn degrading term. Like: ‘that old hunk is lying there in bed, useless, totally not contributing anything to society and here we’ve got her blocking our $2,000 a day bed.’ Why would you bring up that term if you didn’t feel some sort of derision for that ‘old hunk lying there’? Or apathy, even worse. (Interview #5, B.L., p.31-32).

In this vivid example, prejudice against older adults and the invisibility of older adults are demonstrated in the use of language that ignores the humanity of older adults. Even the term ‘patient’, although somewhat general and impersonal, would at least denote a human being in need of nursing care.

**Attitudes toward gerontological nursing**

The stories of the educators I interviewed illustrated that the general societal and health care system indifference toward older adults was reflected in attitudes toward nurses who chose to work with older adults. Gerontological nurses found they had to overcome prejudice toward gerontological nursing itself. After her training, Martin worked in Canada as a nurse for a short time before she took time off to raise a family. After about 16 years out of nursing she took a refresher course in nursing and became a registered nurse again. She described her experience looking for employment as a nurse.

Martin: I took a refresher course in 1978 at BCIT and when I looked for employment after that they suggested, well you’ve been out for a while, you know, you’ll do less harm if you go into gerontology because they’re old and they’re going to die anyway, they’ve had their lives. (Interview #1, N.M., p.1)
Clearly, twenty years after Martin’s original experience in Glasgow, attitudes toward older adults were largely unchanged. Older adults remained invisible and expendable. Gerontological nurses were believed to be less capable than other nurses.

In the 1970’s, the idea that nurses who worked with older adults were not as qualified or capable as those working in other areas was common. Burnside (1976) commented, “the myth that it does not take much skill or expertise to take care of old people unfortunately still prevails” (p.17). In her interview, Elaine Gallagher recounted a story that illustrated that even some university nursing faculty held this view.

Gallagher: In 1972, I can remember one of the professors counselling a student (we shared an office), and I remember her saying to this student, ‘you know, you really haven’t had very strong grades. You’re going to pass this year, but I’m going to suggest that you are probably best suited to doing something fairly low key and not particularly worthwhile;’ she didn’t use the term ‘worthwhile’ but basically ‘I suggest you just go and care for the elderly.’... This was quite a well-respected person, and I remember sitting there thinking, ‘Caring for old people is one of the most complex things that you can do.’ But it wasn’t talked about in those terms at that time and there was overwhelmingly this impression that if you couldn’t ‘cut it,’ then there were outs in nursing; you could always go and work in a nursing home and just care for old people. (Interview #4, E.G., p.18)

The attitude of the professor in Gallagher’s story may seem surprising from a twenty-first century perspective. One might reasonably expect that a university faculty member would have graduate level education which would encourage a broad perspective including an understanding and acceptance of older adults. However, as Mussallem (1965) had pointed out seven years earlier, only 58 percent of full time faculty in schools of nursing held baccalaureate degrees and 38 percent held graduate degrees. In addition, King (1970) maintained that there was a lack of understanding of the function of university education; many people believed at the time that university preparation was only required for nurses
who wished to be head nurses or administrators. Although one cannot know the individual professor’s understanding of the role university prepared nurses, this perspective can shed light on a possible reason for directing a borderline student away from a potential supervisory or administrative role. As well, the faculty member in Elaine’s story clearly subscribed to the myth about gerontological nursing that Burnside (1976) described.

Prejudice and negative stereotypes about nurses working in gerontological settings were still evident in the 1990’s, despite the advances made in the 1980’s in promoting the specialty. Small (1993) remarked that nursing education frequently reflected societal values around aging and as a result, nursing educators had not given gerontology the emphasis that the demographics of the practice setting demanded. C, one of the nurse educators in my study recounted a similar attitude in the 1990’s toward gerontological nursing as easy.

C: There was also the image that the only people that worked [in extended care] were people that couldn’t ‘cut it’ anymore. That was a very clear message. I actually worked with somebody who said she’d had enough of acute care; she was going to go to extended care to take a rest. So I went over to visit her on her evening shift. Well, she didn’t look like she was resting! She didn’t have time to talk to me ... Somehow people didn’t understanding the reality of caring for older people. Everybody had this idea that it was easy. (Interview #6, C, p.4-6)

C’s story further underscores the strong, pervasive, and overwhelming power of cultural values about older adults and gerontological nursing. These cultural values were clearly still widely held in the 1990’s and undoubtedly had both direct and indirect influence on the development of gerontological nursing and its acceptance as a nursing specialty. The influence of broader cultural values around aging and older adults was not limited to the image of gerontological nursing. Those values often interacted with other values within
nursing and health care culture to influence the provision of nursing care, the allocation of nursing resources, and the planning and implementation of nursing education.

**Influence of societal and nursing cultural values on nursing care**

The educators’ stories reveal some values and norms within nursing and health care culture that interact with societal values around aging and older adults to effect nursing care. Many of the norms and values changed as gerontological knowledge and acceptance developed. One of the educator’s stories illustrates the changes in the cultural norm of restraint that advances in knowledge brought. C relates that in 1977 restraint of older adults having hip surgery was a common practice that was less acceptable in 1990.

C: [In 1977] they’d go to the OR and [they would be given] anaesthetics and they returned from the OR and we’d give them some more drugs and within 24 hours they were pretty much picking stuff out of the air and saying things that were inappropriate and seeing things that weren’t really there. And so, the response to that by nursing and by physicians was: we tied them up to restrain them from pulling out their IV’s. It was common practice so, we actually didn’t discontinue that practice; it just sort of was done... By [1990] I had learned that we [had been] putting people into delirium and we were tying them up, which made me feel quite uncomfortable with my own actions of restraint (Interview #6, C, p.1-3)

In this situation, the lack of knowledge regarding the effects of drugs and surgery on older adults combined with an acceptance of the way things were always done, resulted in frequent restraint of older adults. At the time there was little knowledge about the causes of delirium. Burnside’s (1976) text, for example, does not mention it. According to Strumpf and Tomes (1993), although there was beginning knowledge of the negative effects of physically restraining patients in the 1970’s, confused older adults who were medical or surgical patients were considered a problem warranting the use of physical restraints for their own protection. In fact, restraint of medical patients was still a practice at the Hospital of the
University of Pennsylvania in 1989 (Strumpf and Tomes). Strumpf and Tomes describe a Philadelphia newspaper article reporting the restraint of a patient to prevent the pulling out of IV’s and monitor leads. Strumpf and Tomes maintain that ideas about the necessity of restraint had been entrenched in the practices of nurses and physicians who operated under a long-standing model of care that emphasized management and control of behaviour to meet institutional and care provider needs. They explain that although, there had been an effort to draw attention to the use of physical restraints as a regular method of behavioural management in hospitals and nursing homes, such devices were still in use in some facilities at the time of their article and there continued to be people who doubted whether physical restraint use could be entirely eliminated.

In her role as a clinical educator of nursing students C, found that not all culturally accepted practices had been changed by the advancement of gerontological knowledge. She recounts an example of language that disrespected older adults but that was accepted within nursing culture.

C: I tell my students, when you have an older person who’s having problems with continence, you don’t put diapers on them; that is disrespectful, they are not infants. But you go to the hospital and the students say, ‘It says diapers on that garbage can.’ [I tell them] ‘Not diapers, they’re continence products and I don’t want you to say diapers’. But they’re hearing it. Do you think their language will change? Do you think they’ll change other people’s language or will they be changed by the language of the unit? [Nurses talk that way] because we have some sense of entitlement, like we’re ‘allowed’ to say that about people because it’s supported within the culture. I absolutely believe that. (Interview #6, C, p.22)

C reminds us of the power of language and how difficult it can be to change language that has been entrenched by frequent use and cultural acceptance. Nevertheless, C continuously reinforced the use of appropriate language with her students and encouraged them to
understand the way in which entrenched cultural values affected nursing language and practice.

Nan Martin recalls an experience in dealing with continence in older adults that occurred a decade before C's story. While working in an extended care unit in the mid 1980's, she noticed that even though there were products that could improve the comfort of the residents and prevent complications, they were not used. Martin did not find this situation acceptable and took the initiative to try to change the system. However, she encountered resistance to her attempts to implement a proper incontinence system.

Martin: There were seventy-five beds and they did not have a [proper] incontinence system. It was an awful incontinent system that they had. They were just wrapping them in pads. [Incontinence products] existed but they didn't use them. It was bad because they sit in their wheelchair and you have a puddle and their skin breaks down. And you had to go around at night drawing off these bundles of wet linen. I remember I mentioned it to the director but [the response was] 'that was just the system, that's what they did'. So I personally invited a representative [of a disposable incontinence product company] to my home and we talked about it. She said 'They just won't let me in there.' (Interview #1, N.M., p.23 &24)

Here again we see another example of entrenched cultural values influencing nursing practice. The response of the director reflects acceptance within nursing culture of societal values about aging.

Educators' Responses to Negative Cultural Attitudes

The barrier to change that Martin encountered is an illustration of the devaluing and invisibility of older adults influencing the decisions of a large bureaucracy of health care. The general public and the governmental representatives were not yet widely aware or accepting of specialized gerontological knowledge. However, Martin worked to overcome that resistance by networking with other gerontological nurses.
Martin: It started with just several nurses getting together and recognizing that there was this second class image that we have to change and we have to look at education and then network together and try to improve the standards of care. Standards of care were extremely low in some areas where older people were being cared for. And so that was really what it was, it was an overall [goal] of trying to improve...I attended the Canadian Gerontological Nursing Association’s meetings and got more and more involved and then gradually we [began to] develop standards of care. Then I was involved in trying to develop them in B.C. for RNABC I wasn’t on the committee [for developing the standards] but I was invited for input. (Interview #1, N.M., pp. 15 & 17)

The choice of networking as a means to develop the field of gerontological nursing and to advocate for older adults fits well with the tradition of mentoring that had been the primary method of sharing gerontological knowledge. This example shows while academics such as Jessie Mantle and Elaine Gallagher were working to advance gerontological nursing knowledge, at a grassroots level nurses (who were ‘into helping people at the bedside’ as Martin puts it) also played an important role in the development of gerontological nursing knowledge and education. Nurses like Martin provided frontline leadership by advocating for improved care for older adults. Although Martin did not see herself as an educator, the fact that she participated in this advocacy and worked for the development of standards of practice shows that she was in fact a leader in the ongoing education of nurses working with older adults. By working to change the landscape of gerontological nursing from the grassroots she helped to ensure that older adults in the health care system were no longer invisible.

As discussed in previous chapters, nurses often had difficulty finding and using gerontological knowledge and the educators in my study responded in diverse ways to promote that knowledge among nurses. Bett Lauridsen realized that nurses were not the only
people needing updated gerontological knowledge. She saw a need for older adults to have access to information as well.

Lauridsen: We also wanted to teach seniors to look after themselves, as well as teach other people. So I developed and wrote 20 pamphlets on aging, ranging from things like falls, constipation, incontinence, [many different] aspects of life and couching them in such a way that people could see how they could prevent some of them. How you can prevent constipation or falling... Along the same time I was doing the pamphlets, there were five newspapers around the province so we had a column in the newspapers on aging as well. We had a column on aging in a [monthly] paper called The Seniors’ Review. The Seniors’ Review gave articles to five other newspapers, some smaller ones around the province. And basically it was information like the pamphlets: talking about aging, changes in aging as you get older, how you can prevent some of the disabilities of aging, that sort of thing. So we did as best we could to promote the knowledge of healthy aging in the province. (Interview #5, B.L., p.4 & pp.42-43)

Lauridsen’s reaching out to older adults in this way was an innovative response to lack of good information on aging, and a powerful way to acknowledge the concerns of older adults to the general public. Lauridsen brought gerontological knowledge out of the professional and academic realms and made it accessible to the general public. This was an important contribution to the development of gerontological nursing knowledge in British Columbia.

Political and Economic Forces Influencing Gerontological Nursing

Prejudice and negative attitudes toward older adults were not the only forces impacting on the development of gerontological nursing in British Columbia. The stories of the study informants reveal how political and fiscal factors also played a role in nurses’ ability to advance the specialty of gerontological nursing. In order to form a basis for discussion of their experiences, I will briefly review some key policy changes and trends in health care during the 1980’s and 1990’s.
In 1986, Jake Epp, the federal Minister of National Health and Welfare acknowledged that Canada was experiencing what he termed an ‘age boom’ and predicted that the number of older adults in Canada would more than double within the next thirty-five years (Epp, 1986). Epp recognized that chronic conditions and mental health problems would predominate in the future particularly for older Canadians. He advocated a health promotion approach to meet the challenge of improving the health of Canadians of all ages. The framework Epp proposed included fostering public participation, strengthening community health services, and coordinating all public policies that had a direct bearing on health.

In British Columbia, a similar approach was advocated by the British Columbia Royal Commission on Health Care and Costs in 1991. Although the commission’s report dealt with health care for all British Columbians, in a section called ‘Seniors and the health care system’ the report stated that “the need to move medical services closer to home and the need to involve the community in its own health are particularly important issues for seniors” (British Columbia Royal Commission, 1991, p.8). The commission in British Columbia, noted in its report that the sustained rapid economic growth of the 1960’s and 1970’s had slowed in the 1980’s by a recession from which the recovery had been slow and weak. The commission predicted a continued slow recovery in the first years of the 1990’s. As well, the federal Government Expenditure Restraint Act of 1990 would reduce the level of transfer payments for health and education from the federal government to the provincial governments (British Columbia Royal Commission, 1991). The commission concluded that the predicted weak economic growth combined with the reduction of transfer payments
meant that the existing resources would have to be used more effectively and shifted to programs and services that had been identified as having the highest priority.

In the years that followed the commissions' report, the health care system of British Columbia underwent restructuring and decentralization of the health authorities to allow for flexibility to meet local health care needs and to facilitate service integration (BC Ministry of Health, 1994). By this time, the Ministry of Health had changed its name to the Ministry of Health and the Ministry Responsible for Seniors, which indicated some movement toward recognizing older adults in British Columbia.

Although the changes in the health care system in British Columbia resulted in recognition of the special health needs of older adults, the educators in my study continued to come up against political forces that may have been influenced by cultural attitudes regarding older adults. Anne Earthy tells of the difficulties encountered when advocating for funding for services and programs for older adults.

Earthy: One of my examples was at VGH. We had a really good functioning family practice unit. It was just good staff, good team, providing really good care. It was really neat and it was an old, old building, a floor in Heather [pavilion] and wasn’t good [for older adults]. We put in proposals, proposals, proposals galore because basically there was only one bathroom in the hall. We tried to maintain continence in all these folks who were mobile or somewhat mobile and to get them there [in order] to maintain it. Often there was quite a line-up. Anyway we couldn’t get a bathroom but the next thing you knew they were putting in a cardiac step down unit [with] individualized rooms where each [patient] had their own bathroom. And we were closed down. And a cardiac step down is usually a younger population. (Interview # 2, A.E., p.56-57)

Earthy’s example illustrates the political and fiscal barriers she encountered when advocating for improved facilities for older patients. The decisions were made at the health authority level and undoubtedly considered many factors that may not have been apparent at
the time. However, as Earthy describes in this story, senior’s care in a hospital setting may not have been the priority for the health authority. Although closing hospital units may have reflected the British Columbia Royal Commission’s (1991) recommendation to shift services from acute care hospitals to the community, there was concern that services in the community were not implemented. The educators in my study seem to confirm that community resources did not emerge at the level expected or needed. Bett Lauridsen tells of her experience regarding funding for community services.

Lauridsen: When they closed so many of the beds at VGH they said they were going to increase the money to the community, but they never did. So they were sending people home early but there was nothing for them to go home to because there was no help or almost no help. (Interview # 5, B.L., p.31)

Pal (2001) warns that even a well-designed policy can fail if it is poorly implemented. It seems that one of the barriers that Bett encountered was poor implementation of the provincial government’s new ‘closer to home’ health care policies combined with significant decreases in funding. Pal maintains that the new theories of public management dominating public policy making in the 1990’s included reorganization of major agencies and programs often accompanied by deep cuts in expenditures particularly in provincial education and health care sectors.

Conclusion

Long-standing cultural attitudes and prejudices toward aging and older adults had a profound effect on the practice of nursing and on nursing education. By choosing the road less travelled for their careers, the nurses in my study challenged some of the prevailing attitudes and ideas about older adults and gerontological nursing. The educators in my study
all influenced the development and advancement of gerontological nursing by advocating for
older adults and by providing leadership in policy development, professional, educational
and practice settings. Their actions were responses to interacting political and cultural forces
that influenced the social devaluing of older adults and of nurses who chose to work with
them, forces that often created challenges to change. Many of the attitudes and barriers that
the educators faced are still present in contemporary society and nursing culture. Their work
reflects the way that the development of gerontological nursing knowledge not only provided
much needed support for clinical practice, but also played an important role in giving
gerontological nurses a voice in decision-making at a political level and as well as
empowering older adults to find their own political voice. They have provided a strong
foundation on which current and future gerontological nurse educators can build.
Chapter V: Study Findings

Summary of Study Findings

In the first chapter of this thesis, I discussed oral history as a story or narrative account that can provide a new dimension to known history. Kirby (1997) maintains that oral history, rather than being simply a story of the subjective world of the informants is instead “concerned with gathering information about historical and social structures” (no page number). The stories of the educators in my study were rich and vivid in description and meaning. They add a new layer of data to the history of the development of gerontological nursing in British Columbia. The educators provided perspectives that would not necessarily be formally recorded, but which gave some insight into some of the challenges that gerontological nurses faced from the mid-1970’s to the mid-1990’s. These challenges were created by interacting forces of societal and cultural values about aging and older adults that were influenced to some extent by ethos of the Poor Law of the nineteenth century. The invisibility of older adults in the society and the societal ambivalence towards nurses who chose to care for older adults also contributed to the challenges that the nurses faced.

The research question for this study asked how the development of gerontological nursing knowledge and gerontological nursing education were related. From the educators’ stories I found that the development of knowledge and gerontological nursing education were intertwined. Each was a response to the need for information and change, improved practice standards, and advocacy. My study revealed that in the mid 1960’s there was little awareness that older adults had different needs than younger adults. Older adults, particularly those in residential care, were essentially invisible in society. Conditions in old age homes were
impersonal and care was custodial. One gerontological nursing pioneer that strongly influenced care at the time was Vera McIver whose visionary ideas about humanizing and restorative care changed the way older adults were cared for and understood. She used education to develop and advance her ideas, for example, she changed the way her staff and the families of her residents understood their care. By maintaining the connection of the residents in her care to the wider community she promoted education and understanding of her perspective on care of older adults to the general public as well. She also published and spoke often about her approach, both to professionals and lay people. Although her approach was innovative and caught the attention of many people, it did not become the norm for older adult care in BC. Forces such as social ambivalence toward older adults, low valuing of nurses caring for older adults, and political and economic reforms influenced the importance placed on the care of older adults.

In response to some of those challenges, nurses at the grassroots level and in academia realized the need for the advancement and development of the specialty to professional status by use of science and education. The organization of the first conferences and the establishment of the national professional organization enabled gerontological nurses to advocate for standards of practice, provide gerontological education for practicing nurses and to promote gerontological education in nursing curricula.

What stood out in all the nurses’ stories was their response to meeting the challenges they encountered. The key features of their approach involved three elements: new ways of thinking, innovation, and advocacy. All the gerontological nurse educators in my study promoted the development and enhancement of gerontological nursing knowledge through
their leadership, whether it was through formal educational processes or through less formal but equally effective methods. An important finding from my study was that the development of gerontological nursing knowledge has been closely tied to education and advocacy. The traditional grassroots mentoring through sharing and networking was useful for a long time. However, concerned gerontological nurses, such as the educators in my study, realized that the conditions that existed around the care of older adults needed to change and they began to seek out, develop, and promote new knowledge and new ways of understanding and sharing gerontological nursing. They advocated for older adults and their care by finding innovative ways to overcome the barriers of societal prejudice and making older adults and their health concerns visible in society. The educators I interviewed used a diverse range of methods to reach both nurses and older adults. These methods included: newspaper and journal articles, distance education through TV programs, joint clinical and faculty appointments, networking, conference planning, participation in the development of standards, challenging language used in nursing culture, and promoting understanding of the needs of older adults. For these educators, professionalization and advocacy work were closely connected to education.

Clarke (2003) states that enhanced skills and knowledge as well as networking and consultation can increase nurses' ability to influence policy. Education, for these nurse educators, had a broader goal than simply improving practice. The new knowledge and understanding of gerontological nursing gave them a stronger voice to participate in decision and policy making and enhanced their ability to advocate for older adults. The educators
were all visionaries who met the challenges and forces that perpetuated the ambivalence toward gerontological nursing with innovation and collaboration.

Clarke (2003) describes what she sees as necessary for effecting change in the face of challenges.

What is often thought of as a challenge frequently takes on the characteristics of an opportunity requiring particular strategies. Changing one’s perspective from challenge to opportunity requires a vision and a belief in one’s self and the nursing profession (p.78).

All of the educators in my study demonstrated the vision and belief to see the challenges they faced in their nursing practice as opportunities to further develop the specialty field of gerontology and to have a voice in policy and decision-making. These pioneering nurses made significant contributions to gerontological nursing that are not celebrated the way some newer, flashier accomplishments of other specialties can be, however they are no less important.

The corollary question for my study was: how has the way nurses have been prepared to care for older adults influenced current gerontological nursing education? I gained a beginning answer to this question from my study. It was clear that cultural values regarding care of older adults and the status and importance of nurses who cared for them had a strong influence on the educational experiences provided for at least one of my study participants when she was a student. Although she had trained in Scotland rather than Canada, her experience was probably similar to that of other nurses, given the societal ambivalence toward older adults that was experienced by all the nurse educators. Even two decades later,
another participant heard a comment from one of her Canadian faculty colleagues to a failing student which revealed that the cultural devaluing of caring for older adults had an influence on student placement decisions. As a result of their own experiences relating to preparation of students to care for older adults, several of the educators in my study worked toward creating a positive influence on formal university education and research in gerontological nursing.

**Importance and usefulness of the study findings**

The findings of this study are important because they provide a basis to understand the context in which the development of the field of gerontological nursing in British Columbia occurred. Understanding the context in which some of the pioneers of gerontological nursing worked to develop the specialty as well as the challenges they faced and the strategies they used to meet them can help to give a clearer picture of where gerontological nursing is positioned today. Lewenson and Herrmann (2008) explain the importance of understanding history from the perspective of the knowledge and involvement of everyday people.

That understanding of history provides us with a way of knowing what happened before, a way of understanding current issues, and offers a way to glean insight of the future. History teaches us who we are. We, as a profession, need to understand this as history offers us an identity that we can use to help us grow and evolve (p.1-2).

Given the historical role of grassroots involvement in the development of nursing knowledge and in challenging cultural forces that placed barriers in the way of that development, gerontological nurses might find that maintaining and strengthening
collaborative connections between academia and frontline nursing can be useful in promoting gerontological nursing education. Ageism and negative cultural attitudes toward older adults and nurses who have chosen to work with them still exist today in our language, in popular media, and in the cultural devaluing of gerontological nursing. The findings of my study can bring to light some of the attitudes and values that can often be hidden and are so pervasive and tacitly accepted in our culture that they may not be visible to everyone. Understanding the experiences of the nurses who found ways to challenge those values and advocate for change can help current nurses to continue to have a voice in policy making and advocate for further changes.

Knowledge of the perceptions and experiences of the gerontological nurse educators can also direct the efforts of current educators in promoting gerontological nursing education. For example, the data of this study could inform discussions about the powerful interaction of societal and cultural values on practicing nurses, students, and faculty. Perhaps educators will be inspired by the stories of my study participants and look to their example to find innovate and creative ways to bring the importance of gerontological nursing to the fore. In doing this educators would promote excellence in gerontological education for nursing students and nurses at all levels of practice and all stages of their careers.

Areas for future research

One area for future research could involve oral history interviews of older adults and their experiences of nursing care. The data from such a study could be used to determine whether older adults’ experiences in the health care system differ from that of the educators.
Such a study could also enable their stories to be heard and could help to promote gerontological nursing as an important area of specialized knowledge.

The findings from my study might also provide a foundation for research into the development of gerontological nursing in other provinces. Comparison between how gerontological nursing developed in other provinces with the findings of this study could give a richer picture of the history of gerontological nursing development in Canada. Another area for further research might involve an in depth analysis of provincial and health authority policies around care of older adults and the advocacy role played by gerontological nurses in influencing those policies. Also research in the area of nursing education, with a more in depth look at the history of inclusion of gerontology in nursing curricula in Canada, might be helpful in understanding ways to further adapt and modify curricula to ensure that newly graduating nurses have the knowledge to safely and adequately care for older adults.

Conclusion

In spite of the invisibility of older adults in society and the devaluing of nursing care of older adults, gerontological nursing in British Columbia has come a long way. There is still much work to be done to promote a positive understanding of older adults and gerontological nursing within broader society, nursing culture and academia. The findings from this study can be used to assist in this work. With increased understanding of ‘who we are’ as Lewenson and Herrmann (2008) put it, perhaps one day gerontological nurses will not have to fight for inclusion of gerontology in nursing curricula or defend the reasons for choosing their career path because gerontological nursing will no longer be the road less travelled.
References


Interview # 1, Interview with Nan Martin. Erica Roberts. March 26, 2007.


Interview # 3, Interview with Anne Earthy. Erica Roberts. April 4, 2007.


McIver, V. (no date) Philosophy. Unpublished manuscript.


Certificate of Approval

**Principal Investigator:** Boschma, G.  
**Department:** Nursing  
**Number:** B06-906

**Institution(s) Where Research Will Be Carried Out:** UBC Campus

**Co-investigators:** Roberts, Erica, Nursing

**Sponsoring Agencies:**

**Title:** Oral History Study of Nursing Educators' Experiences in Developing Gerontological Nursing

**Approval Date:** Nov. 23 2006  
**Term (Years):** 1  
**Documents Included in This Approval:** Nov. 20, 2006, Consent form / Contact letter

**Certification:**

The application for ethical review of the above-named project has been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approved on behalf of the Behavioural Research Ethics Board by one of the following:

Dr. Peter Suedfeld, Chair,  
Dr. Jim Rupert, Associate Chair  
Dr. Arminee Kazanjian, Associate Chair  
Dr. M. Judith Lynam, Associate Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.
Consent Form

Oral history study of nurse educators’ experiences in developing gerontological nursing

Principal investigator: Dr. Geertje Boschma, UBC School of Nursing 604-822-7457
Co-investigator: Erica Roberts, MSN student, UBC School of Nursing

This study is being conducted for a Master’s thesis.

Purpose:
The purpose of this study is to examine the grassroots development of gerontological nursing from the perspective of gerontological nurses who have been involved in the development of gerontological nursing anytime over the last 50 to 60 years. I am especially interested in learning about the relationship between preparation and education for gerontological nursing practice and the development of gerontological nursing knowledge.

Study Procedures:
The researcher will conduct one or possibly two interviews with you of about one hour each but no longer than 1.5 hours. The researcher will tape record the interviews. The information from the tapes will be typed. The interview can be conducted at a location of your choice. The information you share with the researcher may be used in this research study. It may be published.

The information you share will contribute to a better understanding of the historical and cultural influences that have shaped the way nurses care for older adults. The knowledge gained from this study could be used to contribute to the future development of gerontological nursing knowledge and practice and to a better understanding of the development of the field of gerontological nursing. The study has no direct benefit to you; however, you may enjoy sharing valuable information and contributing to historical knowledge.

There is a small risk that you may feel uncomfortable when sharing personal memories or become tired. You may change the topic, stop the interview or decline to answer any question at any time. If you become especially uncomfortable, the researcher will stop the interview. If you wish the researcher will suggest a person or agency that you can contact for help, normally your regular health care provider, should you experience undue emotional stress. There are no other expected risks or discomforts.
Confidentiality:
Your personal information (address and phone number) will be kept private. It will be available only to the researchers. Confidential information will not be collected by e-mail.

You will be acknowledged for any information used in the study. The results of the study will be included in a graduate thesis and may be published. You may choose not to have your name identified. If you choose not to be identified, every effort will be made to keep your personal, identifiable information confidential. However, there is a slight chance that readers will still recognise you through the information that you may share, for example about a specific role you had in a specific public event or position. Therefore, anonymity is not guaranteed entirely. The information you share will stored in a secure, locked location for five years upon completion of the study. Because the information you provide is of historical value, you can agree in the consent form that after those five years, information you provided will be deposited in a public archive, such as the BC Provincial Archives, or the archive of the British Columbia History of Nursing Group. The information may be used by future researchers according to established archival guidelines. If you do not agree to have the information deposited into an archive, the tapes and manuscripts will be destroyed at that time.

Remuneration/ Compensation:
You will not be paid for participating in the research. If you have costs for parking or bus fare for attending the interview, those costs will be reimbursed.

Contact for information about the study:
If you have any questions or desire further information with respect to the study, you may contact Dr. Geertje Boschma at 604-822-7457 at UBC.

Contact for concerns about the rights of research subjects:
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.

Consent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time.

1. Do you agree to have your name identified in the study?
   Yes ___ No ___

2. If you answered no, do you understand that every effort will be made to keep your information confidential but that anonymity might not be entirely guaranteed?
   Yes ___ No ___
3. Do you agree to have your tapes and transcripts forwarded to an archive, such as the BC Provincial Archives or the archive of the British Columbia History of Nursing Group, after five years?
   Yes ___    No ___

Your signature below indicates that you have received a copy of this consent form for your records.
Your signature indicates that you consent to participate in this study.

Printed Name of Participant    Signature    Date

If you would like to receive a summary of the research findings upon the completion of the study, please provide your mailing address below. Mailing address:
Appendix C: Interview Guiding Questions

The interviews were left fairly open to allow the informants to tell the stories they wanted to tell. However, I also had things I wanted to know. These were the questions that guided my interview. Often the informants answered them without my having to ask.

1. How did you become involved in gerontological nursing?
2. How did you learn gerontology?
3. Did you see gerontology as a specialty area?