Ageism in Healthcare

Journal Article 1: A Systematic Review of Healthcare Professionals' Attitudes Towards Older Adults

Journal Article 2: Exploring Ageism in Irish Healthcare

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Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism.

Signed  16.05.2019

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Journal Article 1 – A Systematic Review of Healthcare Professionals' Attitudes Towards Older Adults

Prepared in accordance with submission guidelines of Psychology and Aging Journal (see Appendix A)

*For the purpose of examination, figures and tables have been included in the text rather than separate file as per journal guidelines

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A Systematic Review of Healthcare Professionals' Attitudes Towards Older Adults

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Abstract

Background: Ageism was first introduced in the literature in the 1960s, gaining increasing recognition in the decades since. Ageism can impact a range of domains, including physical, emotional and mental well-being. Ageism in healthcare can influence older adults' access to screening opportunities, information sharing and treatment availability. With an increasing aging population, requiring access to a wide range of healthcare services, it is crucial to identify and understand healthcare professionals' attitudes towards older people, to ensure access to fair and impartial healthcare provision.

Methods: An electronic search of 3 databases was performed (Medline, CINAHL Plus and PsycINFO) in September 2018 for studies published between 2012-2018. The quality and overall findings of the studies were assessed.

Results: Twelve studies were included in the review. Attitudes ranged between neutral and positive, in line with previous reviews of the literature. More positive attitudes were evident in countries consistent with Westernised cultural value systems. No demographic variables were strongly related to attitudes with the exception of level of education which was demonstrated to be strongly associated to attitudes. Studies primarily focused on nursing staff and physicians with lower attitudes demonstrated in long-term care facilities.

Conclusions: This review highlights the need for methodologically robust research aimed at capturing a range of health-professional's attitudes. Efforts to increase education and training may act as a buffer in developing ageist stereotypes. Further research is required to better understand cultural influences with regard to ageism and attitudes.

Keywords: ageism, attitudes, older adults

1. Introduction

The aged population is currently at its highest level in human history. Virtually every country in the world is experiencing an increase in the number and proportion of older people in their population (United Nations, 2015). As numbers continue to grow, a greater demand on healthcare provision is likely, thereby requiring service providers to adapt to the changing needs of its aging service user population. The literature on aging indicates that older people are vulnerable to experiencing stereotyping and prejudice in the form of ageism. Ageism, first identified by Butler in 1968, refers to the systematic discrimination of people as a result of their age (Achenbaum, 2013) and can have a detrimental impact on physical, cognitive and mental well-being (Robb, Chen & Haley, 2002). Emerging literature in the area of healthcare and aging suggests that healthcare providers working with this population are not immune to deleterious age-related biases and prejudice. There is a growing body of evidence positing that older adults are susceptible to experiencing on-going ageist sentiments across the healthcare domain. For example, research conducted with both physicians and medical students found that older patients were perceived as rigid, irritable, lonely, isolated, asexual, depressed and easily confused (Reyes-Otiiz, 1997). Incidences of ageist stereotypes are becoming increasingly apparent and may act as a barrier towards healthcare professionals developing therapeutically beneficial relationships with older service users.

Ageist beliefs can adversely impact the quality and extent of care received from healthcare providers. Medical professionals' attitudes towards aging can impact treatment choices, information sharing and disease detection when managing older adults' health concerns. For example, there is evidence to suggest that older people are more likely to be incorrectly medicated and are typically not screened for issues relating to sexual health, alcohol or drug abuse (Correa-de-Araujo, 2006; Durvasula, 2014; Van Egaren, 2004).

Further, research has demonstrated that ageist attitudes can result in health professionals placing emphasis on chronological age rather than individual functioning and co-morbidity, increasing the risk of older adults being under or over-treated and at a greater risk of elder abuse (Bonnie & Wallace, 2003; Macnicol, 2006; Makris et al, 2015). Additionally, a report conducted by the Alliance for Aging Research (AAR, 2003), concluded that age-related biases in healthcare perpetuate increased levels of disability, greater loss of independence and higher rates of mortality. Such problematic consequences are further compounded by evidence to suggest that the number of medical professionals working within geriatrics specialties is falling. With an increasing aging population, there is an even greater need for healthcare professionals who value and are committed to working within the older adult community (Liu, While, Norman & Ye, 2012). Negative attitudes and beliefs have been associated with lower uptake of geriatric-related careers (Pan, Edwards & Chang, 2009) which thereby may impede the supply of qualified healthcare professionals available to meet the increasing demands of service provision.

Since its inception as a sphere of research, knowledge relating to the origins and ramifications of ageism have grown considerably. Ageism in healthcare is an area that has increasingly been garnering more attention in the evidence base. Reviews of the literature tend to focus on specific subsections within the healthcare community, most predominantly, either nursing staff or physicians (Meisner, 2012; Liu, Norman & While, 2013; Samra, Griffiths, Cox, Conroy & Knight, 2013). A systematic review of the literature by Liu and colleagues explored nurses' attitudes towards older people across a range of potentially related variables such as, age, gender and education level (Liu, Norman & While, 2013). Researchers found that attitudes were inconsistent, ranging from positive to neutral to negative across both qualified and student nurses, though attitudes appeared to be less positive since 2000. Despite a range of variables being examined, there were no consistent

predictors of attitudes towards older people identified; although increased knowledge of aging and career-related preferences for working with older adults were related to more positive attitudes. A review focusing on medical students' and doctors' attitudes also concluded that findings were inconsistent, however, the authors stated that knowledge-based interventions did not appear effective in changing attitudes (Samra et al., 2013). A more recent review exploring a similar cohort suggested that medics' attitudes were linked to the quality of previous relationships that individuals had with older people and inherent motivations to study medicine (Samra et al. 2017).

A consistent finding within the review literature is the requirement for updated studies and an emphasis on improving the quality and design of the research being conducted (Eymard & Douglas, 2012; Liu, Norman & While, 2013; Meisner, 2012; Samra et al. 2013). Another systematic review conducted by Liu and colleagues in 2012 addressed some of the methodological issues by exploring attitudes within the wider healthcare context. The researchers examined and compared the attitudes of various professionals providing healthcare to older adults. The review systematically examined the international research base from the year 2000-2012 and found that attitudes ranged from neutral to positive among health professionals, again, highlighting the need for greater numbers of well-designed studies. Researchers concluded that extant literature heavily represented the nursing and medical professions, yet data regarding other healthcare disciplines was considerably more limited. The issue of quality has also been identified in published reviews of the literature on healthcare ageism. A critical analysis found that reviews frequently fail to provide sufficient information or to reach appropriate quality standards, highlighting a need for greater care in finding and reporting on existing quality evidence (Wilson et al., 2017). In the literature at present, there has been no updated systematic review conducted of healthcare professionals and their attitudes towards older people. This study aims to synthesize and

evaluate the updated literature in relation to qualified healthcare professionals' attitudes towards working with or caring for older adults. It also aims to explore the potentially relevant and related variables which may underpin ageist attitudes.

Primary Outcomes:

1. To assess healthcare professionals' attitudes towards older adults in the updated literature.
2. To establish the potential predictors and related variables which may predicate ageist attitudes.

2. Method

It was the aim of this study to review and describe the research findings in relation to healthcare professionals' attitudes towards working with or caring for older people. This systematic review was reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) checklist (Moher, Liberati, Tetzlaff & Altman, 2009). The review questions were predetermined from the outset. The review protocol is attached in Appendix B.

2.1.Eligibility criteria

Studies were eligible for inclusion if they included 'older' or aging populations. For the purpose of the current review, only adults aged 65 years or over were included. Studies were considered relevant if they pertained to primary research with one of the overarching objectives being to explore healthcare professionals' attitudes. Therefore, papers where one of the foci of the study was not related to measuring attitudes were excluded. Studies focusing on student healthcare populations were also not included. In order to focus on the updated literature, the publication range included papers from 2012-2018. Eligibility included peer reviewed articles only and therefore grey literature and unpublished studies

were not deemed relevant in the context of this review. For the purpose of maintaining applicability to the overall research question and for comparability with previous reviews in this area qualitative studies and discursive papers were also excluded from the review.

2.2.Information Sources

In September 2018, a systematic search of the following databases was performed; Medline, CINAHL Plus and PsycINFO (EBSCOhost). The databases were selected as they provide access to publications across the biomedical, allied health, psychology and related disciplines literature. The search was restricted to peer reviewed articles published in the English language between the years 2012 and 2018. Three meetings were held with the librarians in University College Cork to ensure the most appropriate and efficient strategy and search terms were being utilised.

The most relevant subject headings were established using the MESH function in Medline, CINAHL Headings in Cinahl Plus and Thesaurus in PsycINFO. Subject headings included “Attitude of Health Personnel” OR “Allied Health Personnel” OR “Physicians” OR “Nurses AND “attitude”. The subject headings for older were; “Aged” OR “Frail Elderly”. The subject headings were combined with a number of relevant keywords and were applied in title and abstract using the Boolean Operators “OR” and “AND”. Keywords included; "health* pro* attitude*" OR "doctor* attitude*" OR "physician* attitude*" OR "nurse* attitude*" OR "attitude* toward* old* people" OR "attitude* toward* elder*" OR "attitude* toward* aged" OR ageism OR ageist OR prejudice* OR stigma OR "age* stereotyp*" OR "age* discrimination" OR “age* bias” AND aged OR "elderly person*" OR "elderly people" OR "old person*" OR "old people" Search limiters were applied in order to refine the search results to peer-reviewed, English language articles between the years 2012- 2018.

2.3.Search selection and data extraction

The search of the databases produced a cumulative total of 979 articles. Following the export of the search results into the software program Mendeley for reference management, duplicate articles were identified and removed resulting in 670 articles being identified as suitable for initial screening. Articles were then transferred to Rayyan QCRI, an online service, to facilitate screening and data extraction. Titles and abstracts were initially screened by the first author and then re-read by another researcher to determine the relevance and inclusion of the research papers. Reference lists of eligible studies were also searched for other relevant publications. Articles that both reviewers deemed suitable to meet the aim of the review were read and re-read in order to gain a thorough understanding of the paper's content and overall relevance. Following the exclusion of papers deemed as unsuitable for the purpose of this review, the full text of articles identified as potentially eligible were obtained for further screening. Full text screening of 26 papers was conducted by both reviewers independently. Two further articles were identified from reference lists of included papers bringing the total number of papers being screened to 28. Review of the full texts removed a further 16 papers due to failure to meet aspects of the eligibility criteria. Conflicts between authors arising from the screening process were resolved by discussion until consensus was achieved. The identification, screening and selection process is detailed in Figure 1. A total of 12 articles met the inclusion criteria for the present review. A summary table was used to extract the data from the selected studies (see Table 1). The data was extracted by the first author and reviewed by the second author. The following data was extracted from the 12 studies; authors(s), year of publication, location, design, sample, measure(s), raw score(s), converted percentages of scores and individual quality rating.

2.4.Quality assessment

The Quality Assessment Tool for Observational Cohort and Cross-sectional Studies developed by the National Heart, Lung and Blood Institute of the National Institute of Health (NIH) was used to appraise the methodological quality of the included studies (U.S. Department of Health & Human Services). For the pre and post study, the Quality Assessment Tool for Pre-Post Studies with no Control Group, also from the NIH, was used. The quality of the studies was evaluated as either 'Poor', 'Fair' or 'Good' based on criteria such as; study design, selection bias, defined variables, valid and reliable measures, blinding, attrition and confounders. The quality assessment of the papers was conducted by two researchers. Quality assessment tools and outcomes for all studies are included in Appendices C, D and E.

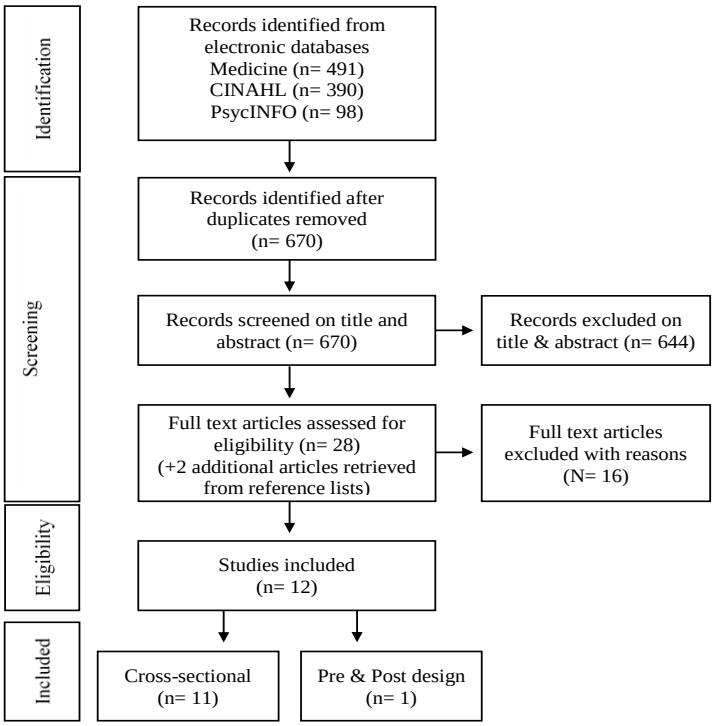

Figure 1. Flow chart diagram detailing study identification, screening and selection process.

3. Results

3.1.Quality and Design

Of the 12 studies included in the review, six papers were evaluated as having a fair rating of quality. Another five articles were categorised as poor quality, with only one of the papers rated as good quality. The majority of papers, 11 in total, implemented a cross-sectional research design. The remaining paper consisted of a pre and post design. Due to the observational nature of cross-sectional analyses, exposures and outcomes tended to be measured within the same timeframe and therefore could not provide sufficient evidence to infer causal relationships between variables. The study rated as good quality utilised a pre and post design with a sufficiently large sample size to provide confidence in the findings, appropriate blinding to the participants' intervention and less than 20% loss to follow-up at baseline. The five papers assessed as poor quality, consisting of 42% of the overall studies included in the review, were considered unsatisfactory due to a number of factors including; failure to reach a participation rate of eligible persons of at least 50%, not providing a sample size justification or power description, lack of sufficient blinding procedures and failure to adjust statistically for potential confounding variables and their impact on exposures and/or outcomes. Additionally, two studies had sample sizes of less than 100 people which may indicate a weaker ability to detect relationships.

Over a third of studies were conducted in Turkey (n = 5), with the remaining being conducted in Israel (n = 3), Belgium (n = 1), Iran (n = 1), the United States (n = 1) and one study which utilised transcontinental data. Six of the studies recruited samples from a single site, potentially selected as locations of geographical proximity and convenience, providing little in terms of clearly defined criteria or information regarding site selection. Between one and three studies were published yearly between 2012 and 2018. Three of the studies recruited populations from multiple sites, with one incorporating a worldwide sample. Two

more of the studies reported to have recruited from multiple sites but did not provide clear information regarding the number of locations.

3.2.Measures employed

Overall, papers utilised a small number of tools developed specifically to measure attitudes towards older people. The measure selected most frequently in the literature was Kogan's Attitude Towards Old People Scale (KAOPS; Kogan, 1961), employed in seven of the overall studies in the review. The measure contains 34 items, 17 positive and 17 negative statements about older adults, with a Likert scale ranging from (1) strongly disagree to (6) strongly agree. Scores range from 34 to 204 with higher scores indicating more positive attitudes. Research has reported appropriate construct and content validity for this measure as well as satisfactory internal consistency and reliability (Erdemir, Kav, Citak, & Karahan, 2011). Despite being widely used as a measure in the research, Kogan's scale has been criticised for being outdated, having been developed more than 50 years ago. Issues relating to the tone and relevance of scale items have been questioned, as well as its' ability to capture the attitudinal shifts stemming from societal changes in recent decades (Flores, 2016). Furthermore, due to flaws in the scale's structure, its psychometric utility has also been challenged (Iwasaki & Jones, 2008). Various translated versions of the KOAPS were also employed in studies in the review including; Hebrew, Iranian, Turkish, Greek, Portuguese, Italian, German and Slovenian versions. A number of the translated scales demonstrated acceptable levels of reliability and validity with the exception of the Italian, German and Slovenian versions.

The University of California at Los Angeles Geriatrics Attitude scale (UCLA-GA; Rueben et al, 1998) and the Ageism Attitude scale (AAS; Vefikulucay & Terzioglu, 2011) were the next two most commonly utilised measures, included in two papers each. The UCLA-GA is a 14-item measure with a Likert scale ranging from (1) strongly disagree to

(5) strongly agree. Scores range from 14-70 with higher scores indicating more positive attitudes. Both reliability and validity of the UCLA-GA scale has been demonstrated (Sahin, Mandiracioglu, Takin, Senusun, & Akcicek, 2012). However, there is evidence to suggest that the internal reliability of the measure has been sub-optimal in studies outside UCLA, as well as issues regarding construct validity (Stewart, Roberts, Eleazer, & Boland, 2006). The tool has also been critiqued as a more effective measure of beliefs rather than attitudes (Intrieri, Von Eye,& Kelly, 1995) Despite the highlighted shortcomings, the UCLA-GA continues to be widely used in the literature to date.

The AAS contains 23 statements regarding older people rated on a Likert five-point scale ranging from (1) strongly disagree to (5) strongly agree with higher scores demonstrating a more positive attitude. A more recently developed scale, the AAS, was designed by Vefickulucay and Terzioglu in 2011 to determine young people's perspectives towards ageism. Both reliability and validity of this scale has been established in the literature among university populations (Vefikulucay & Terzioglu, 2011) however, the scale has scarcely been used to evaluate medical professionals 'attitudes.

Lastly, the Fraboni Scale of Ageism (FSA; Fraboni, Saltstone, & Hughes, 1990) was employed in one study. The FSA is a 29-item scale evaluating attitudes towards older people and has demonstrated some evidence of reliability and validity in the literature, primarily in university student populations (Rupp, Vodanovich & Crede, 2005). Similar to the AAS, the FAS has been criticised for its paucity in assessing medical professionals' attitudes' (Rupp, Vodanovich & Crede, 2005). The study included in the current review utilised the French version of the Fraboni scale, a 14-item tool measuring on a Likert scale of (1) strongly disagree to (5) strongly agree with a high score indicating a less positive attitude to older adults. The psychometric robustness of the French version of the scale has been demonstrated in the evidence base (Boudjemadi & Gana, 2009).

The research has highlighted on-going issues in relation to the availability of robust measures, effective in assessing ageist attitudes. A recent critical review of ageism measures used in the literature concluded that there were currently no valid and reliable tools available in this area (Wilson, Kuurle & Wilson, 2018). Further research denoted that a number of existing ageism measures require considerable refinement in order to increase their psychometric properties (Iwasaki, & Jones, 2008). An example of each of the measures is included in Appendices F, G, H and I.

3.3.Attitudes towards older people

To account for the range of measures utilised and in order to draw comparisons across the studies, the raw mean scores of each scale was converted to percentages so that potential attitude scores for each measure ranged from 0% to 100%. This conversion method has been employed by previous reviewers in the area who concluded that the approach does not distort the data (Liu, Norman & While, 2013; Liu, While, Norman, & Ye, 2012). The reviewers applied a system of categorical descriptors delineating outcomes of measures, attitude scores under 40% were rated as ‘negative’, scores of between 40% and 60% were classified as ‘neutral’ and outcomes ranging over 60% were considered ‘positive’. The current review has utilised a similar categorical approach solely for the purpose of comparability between previous reviews and therefore will refer to previous descriptor methods for context only. Specific descriptor categories have therefore not been assigned formally in the table and are not used as an outcome indicator for subsequent analyses. One of the studies did not provide sufficient data to calculate a percentage from the raw mean score and so was omitted from the corresponding section of the table. The characteristics of each of the studies included in the review are presented in Table 1.

The three studies with the highest percentage of attitudinal outcomes originated from Belgium, the United States and Turkey respectively. Each of these studies ranked above Liu

and colleague's (2012) descriptor range of 60%, corresponding to 'positive' attitudes. The studies ranked at the lower end of the data table originated from Turkey and Israel with attitudinal outcomes falling within the 40th percentile. As per the categorisation criteria cited in prior reviews, no studies fell within the 'negative' attitudinal range or demonstrated raw scores accumulating to less than 40% as per Liu and colleagues' criteria (2012). When compared to previous reviews, the findings suggest there may be a slight increase in positive attitudes due to the paucity of studies falling within the 'negative' category range and the majority of studies (n = 10) falling above the 50th percentile.

Seven of the twelve studies measured nursing staff attitudes only. One study reported medical residents' attitudes, one focused on neurologists' attitudes and one pertained to both nurses' and physicians' attitudes. Two studies reported on an array of healthcare professionals' attitudes including; social workers, psychologists, medical support assistants, nurse assistants and medical technicians. Interestingly, in terms of attitudes, nurses ranked at both the top and bottom ends of the table. The highest reported positive attitude was among oncology nurses, however, the authors also reported that within the sample, nurses with greater levels of negative attitudes tended to exhibit age discrimination with regards to support for reconstructive interventions following cancer, rather than on more explicit measures of ageism (Schroyen, Missotten, Jerusalem, Gilles & Adam, 2016). Another study noted that midwives reported more positive attitudes compared to other types of nurses and clinical technician staff (Pekince, Aslan, Erci & Akturk, 2018). The studies with the least positive attitudes were reported among nurses working in long-term care facilities (Iecovich & Avivi, 2017; Natan, Ataneli, Admenko & Noy, 2013). Physicians were somewhat under-represented in the data; however, they were reported to have relatively positive attitudes towards older adults in the studies that included them (Halpin, 2015; Tufan et al., 2015).

Table 1 *Summary of characteristics of studies included in review.*

Author(s) & year	Design	Sample	Measures	Raw scores	Converted scores	Quality Rating
Adibelli & Kilic (2013) Turkey	Cross-sectional design	282 public hospital nurses	Kogan's Attitude towards Old People Scale; KAOPS (Turkish version)	*M* 98.83, *SD* 11.19 Possible range 26-156 High scores = +ve	56%	Fair
Halpin (2017) United States	Pre- post quasi experimental design	476 health staff Nurses (n = 120) Doctors (n = 30) Social workers (n = 32) Psychologists (n = 20) Nurse assistant (n = 63) Medical support assistants (n = 36) Clinical staff (n = 40) Non-clinical (n = 135)	KAOPS	Pre-test: *M* 168.76, *SD* 17.06 Post: *M* 171.41, *SD* 18.57 Possible range 34-238 High score = +ve	All Pre-test 66.1% All Post-test 67.4%	Good
Iecovich & Avivi (2017) Israel	Cross-sectional survey	154 nurses working across 17 long term care facilities	KAOPS (Hebrew version).	Long-term care nurses *M* 125.94, *SD* 16.74 Possible range 34-204 High scores = +ve	45.9%	Fair

Natan, Ataneli, Admenko & Noy (2013) Israel	Cross-sectional survey	104 nurses working in long-term care facilities	KAOPS (Hebrew version)	Long-term care nurses *M* 3.4, *SD* 0.68 Range (1-6) High scores = +ve	48%	Fair
Pekince, Aslan, Erci & Akturk (2018) Turkey	Cross-sectional survey	242 health professionals Nurses (n = 155) Midwives (n = 28) Technician staff (n= 59)	Ageism Attitude Scale (AAS) Vignettes	Healthcare professionals *M* 68.58 *SD* 5.6 Possible range 23-115 High score = +ve	50.5%	Poor
Polat, Karadag, Ulger & Demir (2014) Turkey	Cross-sectional survey	110 nurses 57 physicians	Ageism Attitude Scale (AAS)	Nurses *M* 80.02, *SD* 7.64 Physicians *M* 83.17 *SD* 9.09 Possible range 23-115. High score = +ve	Nurses: 62% Physicians 65.4%	Poor
Schroyen, Missotten, Jerusalem, Gilles & Adam (2016) Belgium	Cross-sectional survey	76 oncology nurses	Fraboni Scale of Ageism-revised (FSA-R) Fluency task Vignettes	Oncology Nurses Mean 27.83 SD 4.27 Possible Range 14-70 High scores = -ve	76.3%	Fair

Seferoglu et al., (2017) Turkey	Cross-sectional survey	100 neurologists	University of California at Los Angeles Geriatrics attitude (UCLA-GA)	Range between 14-70 High scores = +ve	Insufficient data provided	Poor
Topaz & Doran (2013) Israel	Cross-sectional survey	170 nurses	KAOPS (Hebrew version)	Mean: 3.32 out of 5, SD 0.33 Possible range (1-5) High scores = +ve	58%	Fair
Tufan et al (2015) Turkey	Cross-sectional survey	274 Internal medical residents	University of California at Los Angeles Geriatrics attitude (UCLA-GA)	Range between 14-70 High scores = +ve No ED *M* 46.1, *SD* 5.1 Geriatric course *M* 49 *SD* 5.1 Rotation *M* 47.9 *SD* 5.3 GC & GR *M* 47.9, *SD* 4.1	No education: 57.3% Geriatric course: 62.5% Geriatric rotation:60.5% GC & GR: 60.5%	Poor
Yazdanian et al., (2018) Iran	Cross-sectional survey	261 nurses	KAOPS (Iranian version)	*M* 150.2, *SD* 19.20 Range 34-238 Neutral = 102 High score = +ve	57%	Fair
Zampieron et al., (2012) Worldwide	Cross-sectional survey	1061 renal nurses	KAOPS (Worldwide)	*M* 151.50, *SD* 17.49 Range 34-238 High score = +ve	57.6%	Poor

*Note. One study failed to report sufficient raw data and was omitted from the relevant section in the table.

3.4. Variables explored in attitudes towards older adults

Forty-eight variables were identified across the 12 studies. Variables of most statistical prominence are listed in Table 2, along with their relevant statistics and corresponding effect sizes. A comprehensive list of variables included in each of the studies is in Appendix J.

3.4.1. Demographic variables.

Age, sex and marital status were the three most commonly investigated demographic variables across papers. All of the studies examined age and attitudes with nine papers reporting no evidence of a relationship. Three studies reported a link between the two variables, two concluded that younger adults had more positive attitudes, although in one of these studies, the effect of age disappeared in the multivariate regression when controlling for other factors (Pekince et al., 2018; Topaz & Doron, 2013;). One study concluded that older neurologists had fewer negative attitudes than younger ones (Seferoglu et al., 2017). No relationship was found between sex and attitudes or marital status and attitudes, with the exception of one study indicating that married females were more likely to have more positive attitudes (Pekince et al., 2018). One study looked at ethnic background, concluding it was predictive of positive attitudes with Jewish Israeli nurses scoring higher than Arab Israeli nurses. (Topaz & Doron, 2013). Religion as a variable illustrated conflicting results, one study demonstrated no association and another suggested that Protestant nurses exhibited less ageism than other religions (Iecovich & Avivi, 2017; Zampieron, Saraiva, Corso & Buja, 2012). Less commonly studied variables included; country and continent, whereby one study suggested that lower levels of ageist attitudes were present in South America, Denmark, Brazil and Portugal (Zampieron et al., 2012). Other demographic variables explored in smaller numbers were; employment status, nationality, place of residence, duration of residence in country and parental marital status. None demonstrated evidence of a relationship to attitudes towards older adults.

3.4.2. Work-related Experience.

Professional interactions and work-related experiences appeared to be largely unrelated to attitudes overall. Seven studies in total explored whether duration of professional experience influenced attitudes. Six of the papers found no relationship between the two variables, one study concluded that nurses were more likely to demonstrate positive attitudes, the longer the period of time spent working with older people (Natan et al., 2013). No evidence of a relationship was found for attitudes and length of time in current job, work setting, duration of residency for medics or number of nursing home visits completed. One study noted a significant difference in nurses' attitudes relative to their working shift, in that nurses working a morning shift reported less negatively; however, this effect disappeared when included in the final regression model (Topaz & Doron, 2013). Having previous experience of working with older people was shown to be influential in positive attitudes for both nurses and doctors when compared to professionals currently working with older adults but with no previous exposure, indicating a medium to large effect size (Polat et al., 2014). Finally, one study looking at duration of care given to older people found that professionals working for a period of 1-5 years tended to report more positive attitudes than individuals' working in the field for longer periods of time (Pekince et al., 2018).

3.4.3. Education and Training.

The most studied variable in relation to professionals learning and attitudes was education level. Eight studies explored the influence of education on attitudes towards older people revealing somewhat mixed results. Three of the seven articles yielded no evidence of a relationship between the two variables. Nevertheless, there was considerable evidence to suggest that the role of education is influential. Five studies indicated a relationship between either level of education or years of schooling and attitudes. All five studies

concluded that higher levels of education achieved were related to more positive attitudes towards older people. The only 'good' quality rated paper included in the review reported a positive relationship between educational achievement and capacity for attitude change following an aging simulation workshop with a number of differing healthcare professionals (Halpin, 2017). The study revealed post-test changes across a range of clinical staff with the exception of nurse assistants and medical support assistants, however, the size of effect was minimal, d = .014. Completion of either a geriatric course or rotation in medical school was also linked to more positive attitudes demonstrating medium to large effects sizes, r = .40 and d = .52 respectively (Seferoglu, et al., 2017; Tufan et al., 2015). Knowledge of aging was shown to be somewhat predictive of attitudes; again however, the size of effect was small. Lastly, training in older adult care and engagement in academic events relating to older adults indicated no relationship to attitudes (Polat et al., 2014).

3.4.4. Exposure to older adults.

Six studies investigated various aspects of professionals' own personal contact and exposure to older adults and attitudes. Of the six studies examining the influence of currently living or previously lived with an older adult, two studies found evidence of a relationship with attitudes. One study suggested that individuals with experience of living with an older person was related to more positive attitudes consistent with a medium to large effect, d = .66 (Pekince, Aslan, Erci & Akturk, 2018). Contrary to the previous finding, the other study demonstrated a negative relationship between the variables, suggesting that a previous history of living with an older adult is related to more negative attitudes revealing a small to medium effect size, r = .28 (Seferoglu et al., 2017). Two studies investigated whether presence of older adults in the family was an influential factor in relation to attitudes. Again, one study indicating a relationship (p <0.0001), the other one found no evidence for this

association (Seferoglu et al., 2017; Zampieron et al, 2012,). Participating in voluntary activities with older adults demonstrated no effect on attitudes (Polat et al, 2014).

3.4.5. Additional variables to note.

One study focused on ageist attitudes and the potential impact on professionals' likelihood of experiencing burnout in the workplace. Results indicated that negative attitudes towards older adults were predictive of higher levels of depersonalisation, lower levels of personal achievement and greater levels of work burnout (Iecovich & Avivi, 2017). Another study focused on the predictive value of personality upon nurses' attitudes. The research suggested that higher levels of the trait of agreeableness and lower levels of the trait neuroticism were associated with more positive attitudes (Yazdanian et al., 2018). Furthermore, a medium effect size (r = .36) was evident in the study for personality as measured by the Italian version of the Big Five Inventory (BFI; Fossati, Borroni, Marchione & Maffei, 2011) in its ability to predict nurses' attitudes. Lastly, one study found a large effect size (*r* = .80) for the predictive value of negative attitudes towards nurses' performance of a pain assessment (Natan et al., 2013). The study concluded that nurses who held more negative views of older people were less likely to perform pain assessments in clinical practice. A summary of variables studied is illustrated in Table 2. Primary outcomes of included studies is depicted in Table 3.

Table 2 – Summary of variables related to attitudes towards older people reported by included studies

Variable	Studies with significant relationships to attitudes found	Studies with no significant relationships found	Total number of studies
Demographics			
Age	2 studies indicated younger age is associated with more positive attitudes [5, 9] 1 study found older people had fewer negative attitudes [8]	9	12
Sex	1 study indicated married females display more positive attitudes [5]	8	9
Marital status	1 study (same as above)	6	7
Ethnicity	1 study indicated Jewish Israeli nurses held more positive attitudes [9]	N/A	1
Religion	1 study indicated Protestant nurses held more positive attitudes [12]	1	2
Country	1 study indicated more positive attitudes in South America, Brazil, Denmark and Portugal [12]	N/A	1

Work-related Experience			
Professional experience duration	1 study indicated more positive attitudes associated with longer time spent working with older people [4]	6	7
Previous exp of working with older adults	1 study indicated previous exp of older adults associated with more positive attitudes [6]	N/A	1
Duration of working with older adults	1 study indicated professionals working 1-5 years held more positive attitudes [5]	N/A	1
Education & Training			
Education level	5 studies indicated more positive attitudes were related to higher levels of education [2, 4, 5, 9,12]	3	8
Completion of geriatric course/rotation	2 studies indicating more positives attitudes were related to completion of geriatric training [8,10]	N/A	2
Knowledge of aging	1 study indicated greater knowledge was related to more positive attitudes [6]		

Exposure to older adults			
Currently living /previously lived with older adults	1 study indicated previously living with related to more positive attitudes [5] 1 study indicated previously living with related to less positive attitudes [8]	4	6
Presence of older adults in the family	1 study indicated presence related to more positive attitudes	1	2
Additional variables			
Burnout	1 study indicated more negative attitudes related to greater levels of work burnout	N/A	1
Personality	1 study indicated higher levels of agreeableness and lower levels of neuroticism related to more positive attitudes	N/A	1
Pain assessment	1 study indicated more negative attitudes related to reduced likelihood of performing pain assessment	N/A	1

[1]Adibelli & Kilic, 2013; [2] Halpin, 2017; [3] Iecovich & Avivi, 2017; [4] Natan, Ataneli, Admenko & Noy, 2013; [5] Pekince, Aslan, Erci & Akturk, 2018; [6] Polat, Karadag, Ulger & Demir, 2014; [7] Schroyen, Missotten, Jerusalem, Gilles & Adam, 2016; [8] Seferoglu et al., 2017; [9] Topaz & Doran, 2013; [10] Tufan et al., 2015; [11] Yazdanian et al., 2018; [12] Zampieron et al., 2012.

Table 3 – Variables of interest and primary outcomes

Author(s) & year	Main variables of interest	Analyses	Primary findings
Adibelli & Kilic (2013)	Demographics	T-test	No significant relationship to any demographic variables found.
Halpin (2017)	Change in attitude following workshop	T-test & Anova	Significant change between pre-test and post-test (p = <.001) following an aging simulation workshop however the effect size was small (d = .014). [a]
Iecovich & Avivi (2017)	Work burnout	Correlations Regression analyses	A negative correlation between positive attitudes and levels of Depersonalisation (p < .001), Personal achievement (p < .001) and Burnout (p < .001) consistent with a small to medium effect size (r =.23). [b] A small effect size (r = -.19) [b] that ageist attitudes were predictive of higher levels of Depersonalisation (p <.05). A small to medium effect size (r = -.24) [c] that higher ageist attitudes predicted lower personal achievement (p <.01). Ageist attitudes were more predictive of work Burnout (p <.05), consistent with a small effect size (r =-.18). [c.]
Natan et al.,(2013)	Demographics Intention to perform pain assessment	Bivariate correlations. Hierarchical multiple linear regression	A small - medium effect size (r =0.20) [b] for a positive correlation between duration of nursing career and positive attitudes (p < 0.05) and for a positive relationship between education level and positive attitudes (r = 0.34, [b] p = 0.01).

			A positive association (p = 0.01) between intention to perform pain assessment and positive attitudes indicating a small to medium effect size (r =0.30). [b] Ageist attitudes identified as a strong predictor of nurse's non-performance of pain assessment (p =0.001) indicating a large - very large size of effect (r = .80).[c]
Pekince, et al., (2018)	Demographics Education level Family structure Living with elderly person Length of time working with elderly people Years of study	T-test & ANOVA	A statistical difference between genders on the RL (p =0.003) and NA (p=0.0001) subscales indicating a small to medium effect size (d = .48) [a] and a medium effect size (d = .53)[a] respectively, females reporting more positive attitudes than males. A small effect (d = .22) [a] for significant differences between types of occupation and attitude with midwives indicating more positive attitudes (p = 0.033). A small effect size detected (d = .26) [a] suggesting married people had more positive attitudes (p = 0.043). A medium effect size (d = .59) [a] suggesting higher educational level associated with positive attitudes (p=0.000). Participants with extended family structures reported more positive attitudes (p =0.015) indicating a small to medium effect size (d = .33). [a] People living with elderly person reported more positive attitudes (p =0.021) consistent with a medium to large effect (d = .66) [a.] Professionals with 1-5 years' work experience had more positive attitudes than those working for longer periods of time (p =0.014) indicating a small to medium effect size(d = .36)[a]
Polat, et al., (2014)	Demographics Exposure to older adults	T-test and one-way analysis of variance	Significant difference between doctors and nurses with doctors showing fewer negative attitudes (p = 0.019) indicating a small - medium effect size (d = .37). [a] A medium- large effect size (d = .74) [a] for significant differences between nurses who have previously worked in older patient units compared to those who don't (p < 0.049) in that those with previous experience scored higher on positive attitude items.

			A small to medium effect size (d = .41) [a] for differences in attitudes of physicians who had previously worked with older people as compared to those who don't, those who had previous experience scored higher on positive attitude items (p =0.021).
Schroyen, et al., (2016)	Vision of aging Difference in support for immunotherapy, chemotherapy & breast reconstruction	Correlations One-way ANOVA	Results showed a large effect size (η^2 = 0.16) [d] for a reduced level of support of an older patient in undergoing breast reconstruction with a significant difference between groups in FSA-R scores (p =0.003).
Seferoglu et al., (2017)	Demographics Geriatrics course OA relatives Hx living with OA Hx of nursing home visits Voluntary community activity	Correlations Binary logistic regression (BLR) Multivariate linear regression	Increasing age correlated with more positive attitudes (p = 0.04) indicated a small size of effect (r = 0.2). [b] BLR showed a positive relationship with completion of a geriatrics course during medical school (p = 0.023) indicating a medium to large effect size (r = .40)[b] and a negative association with a history of living with older adults p = 0.036) indicating a small to medium effect size (r = .28).[b] The overall size of effect of the BLR model was consistent with a medium to large effect size (r = .41) [b.] MLR detected independent associations - completion of a geriatrics course in school (p = 0.004) and increased age (p = 0.006) with positive attitudes with an overall medium to large effect indicated (r = .38) [b].
Topaz & Doran (2013)	Demographics Knowledge of aging	T-test, chi square & ANOVA Multiple regression	Significant relationships between attitudes and knowledge of aging (p = 0.02) indicating a small effect (r = 0.18) [b] and ethnic background (p = 0.02) indicating a medium effect size (d = .58) [a]. Both level of knowledge of aging (p = 0.01) and ethnic background (p = 0.01) were predictive of more positive attitudes with Jewish Israeli nurses scoring higher than Arab Israeli nurses indicating a small size of effect (r = .09) [c] and a very large effect size (r = .86) [c] respectively.

Tufan et al (2015)	Demographics Geriatric course Geriatric rotation	Correlational analysis. Binary logistic regression	Completion of a geriatric rotation during internal medical residency was the only significant factor associated with positive attitudes (p = 0.028) indicating a medium effect size (d = .52) [a]
Yazdanian et al., (2018)	Dimensions of personality	Correlation co-efficient	A medium effect size (r = .36) [b] for the predictive value of the Big Five Personality Dimensions on nurses' attitudes (p = 0.001).
		Multiple Linear Regression	A small to medium effect size (r = 0.20) [c] for a trait Agreeableness in predicting attitudes (p = 0.046). A small to medium effect (r = .25) [c] for trait of Neuroticism negatively correlated with positive attitudes (p = 0.003).
Zampieron et al., (2012)	Demographics	T-test. Multiple regression	Positive attitudes were influenced by continent (p <0.0001) and country (p <0.0001), religion (p <0.0001), presence of older people in family (p <0.0001) and level of education (p <0.0001). Multiple linear regression suggested the variables most predictive of attitudes were continent, lowest value in Oceania (p < 0.03) and having older relatives in the family (p < 0.01).*

*Insufficient data provided in study to calculate reliable effect size.

[a] Effect size not reported by authors therefore categorisation was made according to Cohen's convention as small (0.2), medium (0.5), and large (0.8) (Cohen, 1988).

[b] Interpreted using Cohen's convention for r values as small (0.1), medium (0.3), and large (0.5) (Cohen, 1988).

[c] Converted Beta coefficient to correlation coefficient using formula $r = \beta + .05\lambda$ (Peterson & Brown, 2005); Cohen (1988) provides r values of .10, .30, and .50 as benchmarks for small, medium, and large effect sizes, respectively.

[d] The effect size measure was partial $\eta 2$ (interpretation: >.01 small, >.06 middle, >.14 large (Cohen, 1988; Cohen, Miles, & Shevlin, 2001)

4. Discussion

The purpose of this review of 12 studies was to systematically examine the literature on health professionals' attitudes towards older people and to explore factors relating to these attitudes. Factors that were investigated most frequently in the evidence base included; demographic, work-related, education and training variables. The findings of the current review are in line with previous research in the area which concluded that professionals' attitudes range from neutral to positive (Liu et al., 2012). The findings indicated slightly more positive attitudes compared to Liu & colleagues, however, the current review's criteria differed somewhat due to the exclusion of healthcare students. The current review differed in terms of cultural representativeness also. Almost half of the studies included in the review originated from Turkey (42%) and a further 25% originated from Israel. These figures contrast from Liu's study which primarily consisted of research authored in the United States and Western societies. The bulk of studies in the current review stem from countries consistent with Eastern value systems such as, Turkey, Israel and Iran.

The evidence base with regard to cultural differences in ageism is mixed. The more dominant narrative suggests that the majority of Eastern societies hold positive attitudes with regard to older people, with Western societies more likely to have negative attitudes (Alsenany, 2016; Prudent & Tan, 2002). Eastern cultural value systems are typically characterised by a strong emphasis on traditional family structures and respect for older people (Yilmaz & Ozkam, 2010). Western societies, on the other hand, tend to prioritise independence, personal control and innovation, aspects which are somewhat less congruent with older people, who may typically embody stability and tradition (Nelson, 2009). The findings in the current review established that the studies with the lowest calculated attitude

percentage overall, both originated from Israel, while higher scores were evident in Belgium, the United States (US) and Turkey. As a country, Turkey is located in a unique position between both Europe and the Middle East and therefore may be culturally influenced by both sets of values. Researchers in Turkey attribute a cultural ethos of respect and importance of the elderly, in line with Eastern societal values, as one of the primary factors responsible for positive attitudes towards the older population in their country (Polat et al, 2014). Israel, on the other hand, has one of the youngest populations in the world (Central Intelligence Agency, 2014). A potential explanation for the current finding of poorer attitudes may be as a result of the level of exposure and access to older people in the country. There is, however, evidence to suggest that Israel's demographic profile is changing, and the older population is beginning to increase. In recent decades, the number of people over 65 years of age in Israel grew enormously, from just over 98,000 to exceeding over 1 million (UN, 2017) therefore it is possible that perceptions towards older people are undergoing change parallel to this demographic shift.

The influence of ethnic background and culture and its role in nurses' attitudes has been highlighted in the literature (Topaz & Doron, 2013), however, further research will be required to better understand the interaction between these two variables. Only one study in the review included trans-continental data which suggested that European nurses held more positive attitudes than those in Oceania (Zampieron et al., 2012). Similarly, the present findings indicated that Westernised countries illustrated higher levels of positive attitudes. The presence of two Westernised countries at the top of the table disputes the eastern-western 'cultural hypothesis' currently proposed in the literature. This finding is line with previous research suggesting that both Eastern and Western participants report similarly positive or

mixed attitudes with regard to older adults (Lin & Bryant, 2009; Runkawatt, Gustafsson & Engstron, 2013). Future research directions may consider utilising multiple research locations in order to better understand the cultural variation in attitudes and related components across countries and/or continents.

This review examined a range of variables in relation to attitudes towards older people including demographic, work-related and educational. Of all the variables, the findings suggest that education is the most prominent in terms of its influence on attitudes. This finding is in direct contrast to a recent review relating to medical students and doctors' attitudes which found geriatric training and education did not appear to play an influential role (Samra et al., 2017). Five of the eight studies in this review that investigated education and training variables demonstrated evidence of a relationship to attitudes with medium to large sizes of effect. This result augments existing assumptions that increasing knowledge and training in the area of geriatrics is beneficial. Demographic and work-related variables did not appear to have a strong influence with regard to ageist attitudes.

Another pertinent issue highlighted in the review process related to the quality of the research being published within this domain. The overall quality of the papers included in the review were given ratings of between fair and poor quality, due to increased risks of bias and weak research designs. The majority of studies employed correlational and cross-sectional designs thereby making it difficult to infer causal relationships from the findings. In accordance with this, there was a heavy reliance on self-report measures which at times were dated or not validated. Additionally, the fallibility of self-report measures must be considered, as measuring ageist attitudes is a socially sensitive topic which could potentially increase the risk of socially desirable responding to occur (King & Brunner, 2000). The issue of quality

within this sphere of research has been highlighted previously and while efforts are being made to improve both quality and quantity, there is an on-going need for adherence to methodologically robust research protocols (Kite, Stockdale, Whitley & Johnson, 2005). The review highlighted further quality issues which may have impacted findings relating to small sample sizes (Natan et al., 2013, Schroyen et al., 2016, Seferoglu et al., 2017) and researchers utilising translated versions of measures that had not been previously validated.

The findings indicated that nurses working in long-term care facilities exhibited more negative attitudes towards older people. Older adults in long-term geriatric care facilitates are arguably some of the most vulnerable members of society and ageist attitudes have been shown to be predictive of increased levels of depersonalisation and burnout among nurses (Iecovich & Avivi, 2017). Furthermore, findings suggest that negative attitudes can influence performance of important nursing practices such as; pain assessments (Iecovich & Avivi, 2017), thereby potentially placing already vulnerable, aged adults at further risk of sub-optimal standards of care. This finding is in contrast to a narrative review of the literature involving physicians which concluded that aging attitudes do not influence medical care provided to older people (Meisner, 2012). Further research is required to understand the basis of this finding. Of the papers in the review which investigated the influence of work setting on attitudes, all three pertained to investigating varying units of the same hospital or clinic. Future research directions examining differences across settings, including both acute and longer-term care, will enable a greater insight into variations underpinning the spectrum of attitudes towards older adults.

Another key finding from this review was the paucity of papers reporting attitudes from a range of healthcare disciplines. The studies primarily consisted of nursing populations

of varying specialities i.e. renal, oncology and long-term. Only two papers investigated a range of healthcare professionals, however, one of these the papers also included non-clinical staff in their sample (Halpin, 2017). The remaining papers focused either on the nursing profession or on physicians. The over-representation of nursing and medical staff in this sphere of research has been highlighted previously (Liu et al., 2012; Pekince, et al., 2018) and the need for good quality studies investigating attitudes across a range of healthcare professions remains an on-going gap in the literature.

4.1.Limitations

The current review was limited to peer-reviewed articles in the English language which narrowed the scope of the search and may not have captured relevant findings written in other languages or those contained in unpublished or 'grey' literature. The use of only three databases may also have impeded researchers in gaining a comprehensive insight into the domain. Further, the concept of attitudes is multi-faceted therefore exclusion of qualitative data may have made it more difficult to develop insights into the mechanisms involved in ageist attitudes.

The findings of the review are in line with similar reviews conducted and suggest that attitudes to older adults are within a 'neutral to positive' range, yet the research indicates there is still much room for improvement. There remains a gap in the evidence base for good quality, methodologically sound studies investigating attitudes of varying healthcare disciplines. Professions such as psychology, physiotherapy, dentistry and many others are vastly under-represented in the literature in relation to this issue. Additionally, there is a plethora of cross-sectional research in the evidence base, therefore it is difficult to draw accurate conclusions, particularly while adherence to quality criterion remains unmet. An

emphasis on robust research designs, across a variety of settings using updated and validated measures will considerably augment the position of this sphere of research in the future. Emphasis on education and training may to help to negate age-related biases and bolster professionals in addressing and eliminating ageist attitudes within the healthcare system.

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Appendix A

Authors Guidelines

Psychology and Aging Journal - Author Guidelines

Submission

To submit to the Editorial Office of Elizabeth A. L. Stine-Morrow, please submit manuscripts electronically through the Manuscript Submission Portal in Word Document format (.doc).

SUBMIT MANUSCRIPT

Elizabeth A. L. Stine-Morrow
University of Illinois at Urbana–Champaign

In addition to addresses and phone numbers, please supply email addresses and fax numbers, if available, for potential use by the editorial office and later by the production office.

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Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6thedition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Journal Manuscript Preparation Guidelines before submitting your article. Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Length

Articles do not typically exceed 8,000 words, excluding references, tables, and figures. Shorter manuscripts are equally welcome.

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The first manuscript page is a title page, which includes a title of no more than 12 words, the author byline and institutional affiliation(s) where the work was conducted, a running head with a maximum of 50 characters (including spaces), and the author note.

Abstract and Keywords

All manuscripts must include an abstract typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

For regular articles, abstracts are no longer than 250 words; for brief reports, no longer than 100 words.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**
  Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin, 139,* 133–151. http://dx.doi.org/10.1037/a0028566
- **Authored Book:**
  Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.*Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
  Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

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Appendix B

Systematic Review Protocol

1. Proposed Systematic Review Title

A Systematic Review of Healthcare Professionals' Attitudes towards Older Adults

2. Background & Rationale

The aged population is currently at its highest level in human history. Virtually every country in the world is experiencing an increase in the number and proportion of older people in their population (United Nations;UN, 2015). During the past decades, there has been a growing body of evidence to suggest that many older adults are exposed to frequent age-based stereotyping and discrimination, often referred to in the literature as 'ageism' (Palmore, 2004; Nelson, 2005;2016, Coudin & Alexopoulos, 2010). Ageism, defined as prejudice based on one's age can include features such as discriminatory attitudes, prejudicial comments and unjust treatment of older persons (Nelson, 2005; APA, 2008).

As the age of the population continues to grow exponentially, a greater demand on healthcare provision is likely, creating a need for healthcare professionals who value and are committed to working within the older adult community (Liu, While, Norman & Ye, 2012). Unfortunately, emerging literature suggests that healthcare professionals working in this area are not immune to such biases and prejudice. In research conducted with both physicians and medical students, older patients were perceived as rigid, irritable, lonely, isolated, asexual, depressed and easily confused (Reyes-Otiiz, 1997). An Ageism Survey conducted by Palmore (2001) involving adults aged 60-93, found that 43% of participants reported that either a

doctor or nurse had attributed their health complaint to their age. Such ageist attitudes and beliefs may have a direct impact upon the quality of healthcare received by older adults. For example, there is evidence to suggest that older people are more likely to be under or over medicated and are typically not screened for issues relating to sexual health, alcohol or drug abuse (Correa-de-Araujo, 2006; Van Egaren, 2004; Durvasula, 2014). Furthermore, negative attitudes and beliefs have been associated with lower uptake of geriatric-related careers (Pan, Edwards & Chang, 2009) which thereby may impede the supply of qualified health care professionals available to meet growing demand.

Research conducted by Liu and colleagues (2012) highlighted the paucity of reviews in the literature relating to the attitudes of the professionals working and providing healthcare care to the older adult population. The researchers conducted a systematic review of the literature in this area to examine and compare the attitudes of various professionals providing healthcare to older people. The review consisting of 51 papers and included publications ranging across a 10-year period, highlighted the need for a greater number of well-designed studies of both qualified and student healthcare professionals recruiting random samples across a range of sites with the inclusion of validated instruments in order to enable comparison over time and across regions. A systematic narrative review, conducted by Meisner on physician attitudes towards older adults, indicated a need for both updated studies and wider international presence of research outside of the United States (2012). A more recent narrative review of the literature on nursing and healthcare ageism concluded a greater emphasis on balance and quality evidence is needed within the realm of this research. In the literature at present, there has been no updated systematic review conducted with regard to a variety of healthcare professionals in this area. In light of this, the proposed systematic review

is considered beneficial to synthesize and evaluate the updated literature base in relation to healthcare professionals' attitudes towards working with older adults.

3. Objective

The primary aim of the review is to synthesize and evaluate the updated literature in relation to health professionals' attitudes towards working with older people. A secondary aim of the review is to compare these attitudes across different professional groups over time.

4. Proposed Search Strategy

The following electronic databases will be systematically searched to identify potentially relevant studies: PsycINFO, MEDLINE and CINAHL. The resident University librarian will be consulted in order to ensure the most effective search strategy is being devised.

4.1. Selection Criteria

The selected studies will examine:

- Healthcare professionals' attitudes towards older people
- Older adults will be defined as aged 65 years or over

Specific inclusion criteria:

- Studies published in English from any country
- Studies published in peer reviewed journals
- Studies published between 2012 and 2018
- Studies describing original data
- Studies including adults aged 60/65 years or over as outlined above

Specific exclusion criteria:

- Studies including participants outside the age range mentioned above
- Studies whereby the focus of the paper is not relevant
- Studies in a language other than English
- Unpublished studies or 'grey literature'
- Studies published prior to 2012
- Studies including secondary analysis

4.2. Search Terms

The terms outlined below are preliminary. It is anticipated that the subject librarian will be consulted to support development of a comprehensive list of possible search terms to facilitate a systematic search protocol using the PICO framework where applicable. Search terms will include healthcare professional(s), healthcare worker(s), healthcare staff, healthcare provider(s), healthcare personnel, medical professional(s), doctors, nurses, physicians, older adult(s), older people, geriatric, elder, aged, elderly, seniors, older*, health*, attitude(s) to/toward old(er) people/elder/aged/elderly/geriatric/senior(s) ageism, stereotyping, prejudice, stigma, discrimination, bias.

5. Quality of Studies

In order to appraise the scientific quality of the studies selected for review, studies will be rated on criteria in accordance with a transparent grading system such as one developed by the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) Working Group or a similarly appropriate quality assessment tool pertaining to the design of the overall studies selected. Studies will be reviewed by at least two researchers in order to minimise the risk of bias.

Appendix C

Quality Assessment tool for observational cohort and cross-sectional studies

Criteria	Yes	No	Other (CD, NR, NA)*
1. Was the research question or objective in this paper clearly stated?			
2. Was the study population clearly specified and defined?			
3. Was the participation rate of eligible persons at least 50%?			
4. Were all the subjects selected or recruited from the same or similar populations (including the same time period)? Were inclusion and exclusion criteria for being in the study prespecified and applied uniformly to all participants?			
5. Was a sample size justification, power description, or variance and effect estimates provided?			
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?			
7. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?			

Criteria	Yes	No	Other (CD, NR, NA)*
8. For exposures that can vary in amount or level, did the study examine different levels of the exposure as related to the outcome (e.g., categories of exposure, or exposure measured as continuous variable)?			
9. Were the exposure measures (independent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?			
10. Was the exposure(s) assessed more than once over time?			
11. Were the outcome measures (dependent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?			
12. Were the outcome assessors blinded to the exposure status of participants?			
13. Was loss to follow-up after baseline 20% or less?			
14. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?			

Appendix D

Quality Assessment Tool for Pre-Post Studies with no Control Group

Criteria	Yes	No	Other (CD, NR, NA)*
1. Was the study question or objective clearly stated?			
2. Were eligibility/selection criteria for the study population prespecified and clearly described?			
3. Were the participants in the study representative of those who would be eligible for the test/service/intervention in the general or clinical population of interest?			
4. Were all eligible participants that met the prespecified entry criteria enrolled?			
5. Was the sample size sufficiently large to provide confidence in the findings?			
6. Was the test/service/intervention clearly described and delivered consistently across the study population?			
7. Were the outcome measures prespecified, clearly defined, valid, reliable, and assessed consistently across all study participants?			
8. Were the people assessing the outcomes blinded to the participants' exposures/interventions?			

Criteria	Yes	No	Other (CD, NR, NA)*
9. Was the loss to follow-up after baseline 20% or less? Were those lost to follow-up accounted for in the analysis?			
10. Did the statistical methods examine changes in outcome measures from before to after the intervention? Were statistical tests done that provided p values for the pre-to-post changes?			
11. Were outcome measures of interest taken multiple times before the intervention and multiple times after the intervention (i.e., did they use an interrupted time-series design)?			
12. If the intervention was conducted at a group level (e.g., a whole hospital, a community, etc.) did the statistical analysis take into account the use of individual-level data to determine effects at the group level?			

*CD, cannot determine; NA, not applicable; NR, not reported

Quality Rating (Good, Fair, or Poor) (see guidance)
Rater #1 Initials:
Rater #2 Initials:
Additional Comments (If POOR, please state why):

Appendix E

Individual quality assessment ratings for each study

Article	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	#	R
1.Schroyen, et al,	2016	Y	Y	NR	Y	N	N	N	Y	N	N	Y	NA	NA	N	**5**	Fair
2.Iecovich & Avivi	2017	Y	Y	N	Y	Y	N	N	Y	Y	N	Y	NA	NA	Y	**8**	Fair
3.Yazdanian, et al	2018	Y	N	NR	Y	N	N	N	NA	NA	N	Y	N	N	Y	**4**	Fair
4.Zampieron, et al	2012	Y	N	N	N	N	N	N	NA	NA	N	Y	NA	N	N	**2**	Poor
5.Adibelli & Kilic	2013	Y	Y	Y	Y	Y	N	N	NA	NA	N	Y	NA	N	N	**6**	Fair
7.Natan, et al	2013	Y	N	Y	Y	Y	N	N	NA	NA	N	Y	N	N	Y	**6**	Fair
8.Tufan et al	2015	Y	Y	N	Y	N	N	N	NA	NA	N	Y	N	N	N	**4**	Poor
9.Topaz & Doran	2013	Y	Y	N	Y	N	N	N	NA	NA	N	Y	N	N	Y	**5**	Fair
10.Polat Karadag, Ulger & Demir	2014	Y	N	N	NR	N	N	N	NA	NA	N	Y	N	N	N	**2**	Poor
11.Halpin*	2017	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N			**9**	Good
12.Seferoglu et al	2017	Y	N	N	N	N	N	NA	NA	N	N	N	N	N	Y	**2**	Poor
13.Pekince et al	2018	Y	N	Y	NR	N	N	Y	Y	N	N	N	N	N	N	**4**	Poor

*pre and post quality tool

4 and under – Poor 5-8 – Fair 9 & above – Good

Appendix F

KOGAN ATTITUDES TOWARD OLD PEOPLE SCALE

Directions: Circle the LETTER on the scale following each statement, according to the following key, that is closest to your opinion of old people.

Key:

Strongly Disagree	Slightly Disagree	Disagree	Agree	Slightly Agree	Strongly Agree
A	B	C	D	E	F

1. It would probably be better if most old people lived in residential units with people their own age.
   A.....B.....C.....D.....E.....F

2. It would probably be better if most people lived in residential units with younger people.
   A.....B.....C.....D.....E.....F

3. There is something different about most people; it's hard to find out what makes them tick.

   A.....B.....C.....D.....E.....F

4. Most old people are really no different from anybody else; they're as easy to understand as younger people.
   A.....B.....C.....D.....E.....F

5. Most old people get set in their ways and are unable to change.
   A.....B.....C.....D.....E.....F

6. Most old people are capable of new adjustments when the situation demands it.

   A.....B.....C.....D.....E.....F

7. Most old people would prefer to quit work as soon as pensions or their children can support them.
   A.....B.....C.....D.....E.....F

8. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.
   A.....B.....C.....D.....E.....F

9. Most old people tend to let their homes become shabby and unattractive.
   A.....B.....C.....D.....E.....F

10. Most old people can generally be counted on to maintain a clean, attractive home.
A.....B.....C.....D.....E.....F

11. It is foolish to claim that wisdom comes with age.
A.....B.....C.....D.....E.....F

12. People grown wiser with the coming of old age.
A.....B.....C.....D.....E.....F

13. Old people have too much power in business and politics.
A.....B.....C.....D.....E.....F

14. Old people should have power in business and politics.
A.....B.....C.....D.....E.....F

15. Most old people make one feel ill at ease.
A.....B.....C.....D.....E.....F

16. Most old people are very relaxing to be with.
A.....B.....C.....D.....E.....F

17. Most old people bore others by their insistence on talking "about the good old days".
A.....B.....C.....D.....E.....F

18. One of the most interesting and entertaining qualities of most old people is their accounts of their past experiences.
A.....B.....C.....D.....E.....F

19. Most old people spend too much time prying into the affairs of others and giving unsought advice.
A.....B.....C.....D.....E.....F

20. Most old people tend to keep to themselves and give advice only when asked.
A.....B.....C.....D.....E.....F

21. If old people expect to be liked, their first step is to try to get rid of their irritating faults.

22. When you think about it, old people have the same faults as anybody else.
A.....B.....C.....D.....E.....F

23. In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.
A.....B.....C.....D.....E.....F

24. You can count on finding a nice residential neighborhood when there is a sizeable number of old people living in it.
A.....B.....C.....D.....E.....F

25. There are a few exceptions, but in general most old people are pretty much alike.
A.....B.....C.....D.....E.....F

26. It is evident that most old people are very different from one another.
A.....B.....C.....D.....E.....F

27. Most old people should be more concerned with their personal appearance; they're too untitdy.
A.....B.....C.....D.....E.....
...F

28. Most old people seem quite clean and neat in their personal appearance.
A.....B.....C.....D.....E.....F

29. Most old people are irritable, grouchy, and unpleasant.
A.....B.....C.....D.....E.....F

30. Most old people are cheerful, agreeable, and good humored.
A.....B.....C.....D.....E.....F

31. Most old people are constantly complaining about the behavior of the younger generation.
A.....B.....C.....D.....E.....F

32. One seldom hears old people complaining about the behavior of the younger generation.
A.....B.....C.....D.....E.....F

33. Most old people make excessive demands for love and reassurance than anyone else.

Appendix G

THE UNIVERSITY OF CALIFORNIA AT LOS ANGELES GERIATRICS ATTITUDES SCALE

Directions: Please use the scale to indicate the degree to which you agree or disagree with each statement. The best response is the one that truly reflects your personal opinion. Findings of this study will be reported only on a group basis with no individual names identified.

	Strongly Disagree	**Somewhat Disagree**	**Neutral**	**Somewhat Agree**	**Strongly Agree**
1. Most old people are pleasant to be with.	1	2	3	4	5
2. The federal government should reallocate money from Medicare to research AIDS or pediatric diseases.	1	2	3	4	5
3. I would rather see younger patients than elderly ones.	1	2	3	4	5
4. It is society's responsibility to provide care for the elderly.	1	2	3	4	5
5. Medical care for old people uses up too much human and material resources.	1	2	3	4	5
6. As people grow older, they become less organized and more confused.	1	2	3	4	5
7. Elderly patients tend to be more appreciative of the medical care I provide than are younger patients.	1	2	3	4	5
8. Taking a medical history from elderly patients is frequently an ordeal.	1	2	3	4	5
9. I tend to pay more attention and have more sympathy towards my elderly patients than my younger patients.	1	2	3	4	5
10. Old people in general do not contribute much to society.	1	2	3	4	5
11. Treatment of chronically ill old patients is hopeless.	1	2	3	4	5
12. Old persons don't contribute their fair share towards paying for their health care.	1	2	3	4	5
13. In general, old people act too slow for modern society.	1	2	3	4	5
14. It is interesting listening to old people's accounts of their past experiences.	1	2	3	4	5

Appendix H

Ageism Attitude Scale

A Restricting life of elderly (eigenvalue 4.24, explained variance 18.67, Cronbach α 0.70)

A1. The external appearance of the elderly is repulsive.
A2. Care of the elderly should not be considered to be an economic burden by family members.
A3. Elderly people can't carry bags and packages without help.
A4. It is unnecessary for the elderly to buy homes, cars, possessions or clothes.
A5. The elderly should live in homes for the elderly.
A6. Lives of the elderly should be limited to their homes.
A7. Elderly people should be paid less than young people in their work lives.
A8. Preference should be given to care for young people over the elderly in the hospital.
A9. Elderly people who lose their spouses should not remarry.

B. Positive ageism (eigenvalue 4.12, explained variance 18.23, Cronbach α 0.70)

B1. Elderly people are more tolerant than young people.
B2.Elderly people are more compassionate.
B3. When decisions are made in the family the opinions of the elders should be considered.
B4. The elderly should be shown importance by the family members with whom they live.
B5. Elderly people are more patient than young people.
B6. Young people should learn from the experiences of elderly people.
B7. When the family budget is being developed the opinions of the elderly should be sought.
B8. Preference should be given to the elderly in places where waiting in line is required.

C. Negative ageism (eigenvalue 4.07, explained variance 17.14, Cronbach α 0.67)

C1. Preference should be given to young people for promotions in work.
C2. Preference should be given to young people over the elderly for jobs.
C3. Elderly people are not able to adapt to changes like young people.
C4. Elderly people are always ill.
C5. Elderly people should not go outside on their own.
C6. The basic responsibility for the elderly should be to help their children with tasks such as housework and kitchen chores and care of their grandchildren.

Appendix I

The Fraboni Scale of Ageism (FSA)

Next to each item, place the number that best describes your answer based on the following scale: 1= strongly disagree 2= disagree 3= agree 4= strongly agree * Items reverse-scored.

1. Teenage suicide is more tragic than suicide among the old.

2. There should be special clubs set aside within sports facilities so that old people can compete at their own level.

3. Many old people are stingy and hoard their money and possessions.

4. Many old people are not interested in making new friends preferring instead the circle of friends they have had for years.

5. Many old people just live in the past.

6. I sometimes avoid eye contact with old people when I see them.

7. I don't like it when old people try to make conversation with me.

8* Old people deserve the same rights and freedoms as do other members of our society.

9. Complex and interesting conversation cannot be expected from most old people.

10. Feeling depressed around old people is probably a common feeling.

11. Old people should find friends their own age.

12* Old people should feel welcome at the social gatherings of young people.

13. I would prefer not to go to an open house at a senior's club, if invited.

14* Old people can be very creative.

15. I personally would not want to spend much time with an old person.

16. Most old people should not be allowed to renew their driver's licenses.

17. Old people don't really need to use our community sports facilities.

18. Most old people should not be trusted to take care of infants.

19. Many old people are happiest when they are with people their own age.

20. It is best that old people live where they won't bother anyone.

21* The company of most old people is quite enjoyable.

22* It is sad to hear about the plight of the old in our society these days.

23* Old people should be encouraged to speak out politically.

24* Most old people are interesting, individualistic people.

25. Most old people would be considered to have poor personal hygiene.

26. I would prefer not to live with an old person.

27. Most old people can be intimidating because they tell the same stories over and over

28. Old people complain more than other people do.

29. Old people do not need much money to meet their needs.

Appendix J

Comprehensive list of variables included in all studies

Author(s) & year	Variables
Adibelli & Kilic (2013)	Age Education status Marital status Family type Place of residence Years in occupation Way of work(shift) Total duration of work Difficulties experienced in older patient care
Halpin (2017)	Change in attitude following simulation workshop
Iecovich & Avivi (2017),	Age Gender Marital Status Religion Work burnout Professional education, Length of residence in Israel Professional experience in years Length in current workplace
Natan, Ataneli, Admenko & Noy (2013)	Age Gender Type of qualification, Duration of work with older adults Duration of nursing career Years of schooling Intention to perform pain assessment
Pekince et al. (2018)	Age Gender, Occupational status Marital status

	Children Education level Family structure Living with elderly person Length of time working with elderly people Years of study
Polat, Karadag, Ulger & Demir (2014)	Age Gender Education Marital status Department of work Status of living with older people Period of work Clinic of work Satisfaction with serving older adults Training in older adults Participation in research in older adults Difficulties serving older adults
Schroyen, et al (2016)	Vision of age Difference in support for immunotherapy, chemotherapy & breast reconstruction Age Years of exp
Topaz & Doran (2013)	Age Gender Ethnic background Place of birth Education Knowledge Working shift Home-care experience with older adults Working ward
Tufan et al (2015)	Age Sex History of nursing home visits

	Duration of residency Living with elderly relatives Geriatric course taken Geriatric rotation
Seferoglu et al (2017)	Sex Age Duration of neurology expertise, Monthly number of older adults seen Marital status Children Parent marital status Geriatrics course Older adult relatives History living with OA History of nursing home visits Voluntary community activity
Yazdanian, Alavi, Irajpour & Keshvari (2018)	Age Sex Work experience Marital status Employment status Living with older Professional care given to aged
Zampieron, Saraiva, Corso & Buja (2012)	Gender Continent Country Level of education Religion Marital status Older people in the family Lived with older people Place of work Years in employment Work exp with older people

Journal Article 2 – Exploring Ageism in Irish Healthcare

Prepared in accordance with submission guidelines of Psychology and Aging Journal (see Appendix A)

*For the purpose of examination, figures and tables have been included in the text rather than separate file as per journal guidelines

Word Count including appendices:17, 312 (excluding abstract, references and tables)

Exploring Ageism in Irish Healthcare

Louise Concannon

Dr Mike Murphy

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Abstract

Background: Ageism in healthcare can result in deleterious consequences for older people. Ageist attitudes can affect healthcare quality through reduced access to information, screening and treatment options. As the population ages, it is imperative to understand Irish healthcare professionals' attitudes to ensure older people are provided with equitable, unbiased healthcare. Further, it is important to explore older peoples' perspectives of healthcare interactions, to examine whether ageism is part of the narrative, and its' potential impact on older people seeking care.

Methods: A mixed-methods research design was employed. Questionnaires sent out to 150 general practitioners with a response rate of 38%. Qualitative interviews were conducted with older adults' attending a community mental health service to explore their healthcare experiences to date.

Results: No significant differences were observed on attitudes across a wide range of demographic variables. More positive attitudes were evident in individuals' currently living with an older person. The personality traits agreeableness and extraversion were correlated with more positive attitudes. Themes suggested that older people's healthcare perceptions are influenced by previous historical perspectives, perceived patient vulnerability and patient-centred relationships.

Conclusions: The current findings corroborate previous literature with regard to the role of specific personality correlates and increased contact with more positive attitudes towards older adults. Older people are reporting negative healthcare interactions, however, tend not to interpret these experiences as ageist. Further research is required to understand the interplay between older adults' reported experiences and perceived reliance on services.

Keywords: ageism; healthcare professionals; older people

1. Introduction

The growth rate of the aging population has been increasing rapidly for decades. Recent statistics indicate that between 2015 and 2050, the proportion of the world's citizens aged above 60 years of age will rise from 12% to 22% (World Health Organisation, WHO, 2018). As the growth of the older population has become increasingly recognised, so too has interest in the ubiquity of ageism (Nelson, 2016). Ageism was first described by Butler (1969) and refers to the systematic stereotyping or discrimination against persons due to their age. Age-related discrimination can present in several ways across any number of settings and is often characterised by condescending or patronising behaviours and actions. Examples include negative communication methods such as, talking down to an older person, using baby-talk or overexaggerating the volume of ones' voice, stemming from stereotypical beliefs that older people have hearing difficulties (Kite & Wagner, 2002; Nelson, 2005). Ageist experiences may also manifest in the form of limiting older peoples' involvement in discussions and decisions relating to their own health, and welfare, and attributing less importance to older persons' opinions (Chrisler, Barney & Palatino, 2016).

Age-based discrimination is primarily derived from negative stereotypes relating to age, for example, beliefs that older people are irritable, isolated or decrepit (Kite & Johnson, 1988). Negative narratives relating to aging permeate throughout society via the mediums of language, print, television, advertising and social media, thereby condoning and reinforcing age-related stigmas. Societal emphasis on delaying natural aging processes, such as, the use of hair-dye and anti-aging products, only serve to further perpetuate age biases, which has led to ageism being labelled as the most socially acceptable type of prejudice (Nelson, 2005). Ageism is a complex concept and there are a number of theoretical explanations relating to its origins and manifestations in the literature. Two of the most

prominent theoretical approaches are Terror Management Theory (TMT, Greenberg, Solomon, & Pyszczynski, 1997) and Stereotype Embodiment Theory (SET, Levy, 2009). TMT alludes to an external form of ageism. The model posits that individuals maintain beliefs and views which provide protection from existential threat brought about by the awareness of one's own vulnerability and mortality. Older adults, by virtue of the aging process, can prompt reminders of the finite nature of life and the ultimate inevitability of death. In the TMT and ageism literature, it is proposed that younger individuals employ separation and distancing as techniques in order to alleviate the threat of mortality (Martens, Greenberg, Schimel & Landau, 2004). In turn, individuals maintain negative belief systems with regard to older people and aging to preserve their ego and sense of self-esteem. The theory has been corroborated by research identifying links between age-related prejudice and fear of death (Bodner & Cohen-Fridel, 2014).

SET, on the other hand, refers to internalised ageism. SET proposes that when older individuals are exposed to 'stereotype threat', such as negative comments about ageing, internalised self-stereotypes become activated (Levy, 2009). Once activated, the internalised stigma provokes 'embodiment' or the acting out of behaviours associated with the stereotype, serving as a self-fulfilling prophecy. The manifestations of internalised negative age stereotyping are evident in the literature, resulting in significantly deleterious physical, emotional and cognitive consequences for older people. For example, older people have exhibited poorer outcomes on handwriting and memory tasks when exposed to negative ageist stereotypes (Levy, 1996; 2000). Longitudinal research has also demonstrated that perceived age discrimination and internalised negative self-perceptions of aging are predictive of poorer health outcomes for older people (Levy, Slade & Kasl, 2002; Sargent-Cox, Anstey, & Luszcz, 2012). Age-related prejudice can also have a detrimental impact on

mental health. Research has suggested a link between perceived age discrimination, greater levels of psychological distress and lower levels of positive mental well-being (Yuan, 2007).

A third theoretical approach providing an understanding of ageism is Social Identity Theory (SIT, Tajfel & Turner, 1979). The theory highlights the uniqueness of ageism to other forms of prejudice in that, rather than being focused towards specific 'out groups', age-related stigma is targeted towards our future selves. SIT proposes that in order to cope with the fear of deterioration and death associated with aging, diverse methods are employed by younger age groups to create a distinction from 'older' groups. Strategies such as 'active aging' and assuming a younger age identity are utilised to create and maintain a positive and separate identity based on one's own age group (Lev, Wurm & Ayalon, 2018). Similar to the distancing techniques posited by TMT, older people can internalise these negative social evaluations creating a self-ageism (Tajfel & Turner, 1979). There appears to be a consensus in the ageism literature, that age-related stigma is borne out of implicit existential threat and the negative consequences associated with aging. Irrespective of the origins, the explicit manifestations and expressions of these internal threats can result in the internalisation of ageist sentiments by older people (Levy, 2009).

The prevalence of ageism in healthcare has been increasingly highlighted in the gerontological literature. Findings suggest that ageist sentiments exist among both healthcare students and professionals (Liu, While, Norman, & Ye, 2012; Liu, Norman, & While, 2013; Meisner, 2012). There is evidence proposing that age stereotyping may provide useful cognitive functions for healthcare staff, such as, maximising efficiency in clinical judgements (Snyder & Miene, 1994). Furthermore, in line with TMT, age-related stigma may serve as a protective function for health professionals due to their on-going exposure to sick and/or frail older adults in health settings. Exposure to ageism in healthcare can

significantly impact the provision of care received and older people are more likely to receive different clinical decision-making and case management than younger patients. Research has demonstrated that older persons presenting with heart issues were less likely to receive onward referral to a specialist, were less likely to be provided with further testing or to receive specific surgical intervention as compared to middle-aged patients presenting with similar complaints (Harries, Forrest, Harvey, McClelland & Bowling, 2006). Reduced access to services for older people has also been evidenced in the domains of both oncology and sexual health (Kagan, 2008; Lindau et al., 2007).

Within the sphere of mental health, there is further evidence to suggest that older patients frequently receive suboptimal care compared to their younger counterparts. For example, older people are less likely to receive onward referral for psychotherapy (Van Egeren, 2004). An Australian study involving both psychologists and counsellors, concluded that clinicians appraised therapeutic alliance building with an older person as more difficult, rated older clients as being less suitable for therapy and as having a worse prognosis than younger clients with similar presentations (Helmes & Gee, 2003). Similar biases have been illustrated in studies with psychology undergraduate students and clinical psychology trainees (Gonclaves et al., 2011; Lee, Volans & Gregory, 2003).

While considerable research has been conducted relating to health professionals' attitudes towards older people, the evidence base has yet to establish the most prominent factors involved. Demographics, education, level of exposure to older adults and knowledge about aging are some of the most commonly investigated variables indicating mixed results (Natan, Ataneli, Admenko & Noy, 2013; Seferoglu et al., 2017; Topaz & Duran, 2013). For example, with regard to demographic variables, males are frequently found to report higher levels of ageism than females (Boswell, 2012; Boudjemad & Gana, 2009). However, further

research has found no evidence of a relationship between sex and ageist attitudes (Iecovich & Avivi, 2017, Natna, Ataneli, Admenko & Noy, 2013). Similarly, level of contact with older people is another commonly studied variable in the ageism literature, with findings suggesting conflicting results. Some research has demonstrated that increased contact with older people results in more positive attitudes (Luo, Zhou, Jin, Newman & Liang, 2013), while others have indicated no evidence of a relationship (Allan & Johnson, 2009, Boswell, 2012). Further analysis has suggested that it is the quality of contact rather than the amount is the important factor (Sullivan, 2008).

The influence of level of education upon ageist attitudes also remains unclear. For example, education level has been demonstrated to be a significant predictor of healthcare professionals' attitudes, in that greater levels of educational attainment were predictive of more positive attitudes (Gallagher, Bennett & Halford, 2006). Conversely, however, there is evidence to suggest there is no relationship between ageist attitudes and education level (Buttner 2008, Hweidi & Al-Hassan, 2005). Such inconclusive findings are particularly problematic for researchers in the area with regard to designing and developing effective interventions to target ageism in healthcare. As it currently stands in the literature, the most prominent demographic variables with regard to ageism remains unclear. Therefore, due to the dearth of literature in the Irish context, a range of demographic variables were selected with a view to exploring a comprehensive list of potentially related factors to physician's attitudes. Variables selected included, age, sex, years of clinical practice, relationship status and practice type. Education level in terms of further geriatric training and exposure to older adults with regard to living situations and socialisation were also examined.

Personality characteristics are likely to influence individual's attitudes and are demonstrated to have a predictive role in nurses' attitudes (Yazdanian, Alavi, Irajpour & Keshvari, 2016). Personality attributes linked to social functioning such as, respect and courtesy are associated with more positive attitudes (Sung, Kim, & Torres-Gil, 2010). Furthermore, traits such as Openness, Conscientiousness and Agreeableness have been found to be negatively correlated with ageist attitudes (Allan, Johnson & Emerson, 2014). As general practitioners (GPs) tend to be the most commonly accessed source of health assistance for older people and are essentially gatekeepers of specialist services in terms of onward referral, exploration of attitudes in this domain is pivotal. To the best of the author's knowledge, the role of personality with regard to GPs has yet to be explored within the Irish context. In the present study, the relationship between attitudes toward older adults and personality correlates among GPs is examined, addressing a gap in the evidence base.

Several studies have explored health professionals' attitudes and ageism, however, there is a relatively short supply of research investigating experiences from the perspective of those being stigmatised. Therefore, there remains limited understanding of how older people make sense of exposure to age-related prejudice. Previous research suggests there is a mismatch between how ageism is described in the literature and older people's articulation and expression of the subject (Minichiello, Browne, Kendig, 2000). The study found that although experiences of age-related stigma were being reported, older individuals' understanding of these events related to the extent to which the experiences were internalised. More recent research focused on older people's perspectives in relation to care seeking and chronic back pain, highlighting that ageist patient-provider communication played an intrinsic role in treatment outcomes and acted as a barrier in the likelihood to seek care (Makris et al., 2015). In Ireland, the National Council on Aging and Older People

(NCAOP, 2005) undertook the first examination of age stereotyping in the Irish healthcare system. The report concluded that age discrimination is present in services, evidenced by reduced access to specialist services and poorer quality of care facilitating older peoples' needs. As it currently stands, the pervasiveness and influence of ageist attitudes and what they may mean for older people in the context of their own health remains unclear.

The paucity of research illustrates the need for greater recognition of older people's perceptions of the healthcare system, to examine whether ageism is part of the narrative and if so, exploring the interplay between how these experiences are understood and the potential impact. Moreover, there is a need to capture the current attitudes of the professionals on the front-line of older adult healthcare. The first objective of the present research is to evaluate Irish GPs attitudes towards working with older people. Secondly, the research aims to explore older peoples' experiences of the health system and healthcare professionals.

2. Method 1

2.1.Design

The study employed a mixed-methods research design using quantitative methods and analysis to evaluate health professionals' attitudes towards older adults and related variables. The second arm of the study utilised qualitative methods and analysis to explore older people's perspectives and experiences of the healthcare system.

2.2.Participants

Participants were recruited from an online HSE directory of GPs listed as working in the community in Cork city and county. In total, 150 GPs were invited to participate in the research.

2.3.Measures

Attitudes were assessed using the Cork Attitudes to Older Adults Scale questionnaire (CAOAS; Murphy & O'Sullivan Curtin, 2016). The CAOAS is a 34-item multi-dimensional scale measuring attitudes across four domains; positive, negative, engagement and decline. Higher scores indicate greater levels of attitudes on each of the four subscales. Participants are asked to what extent do they agree with particular words and phrases describing older people rating their agreement from 1 – strongly disagree to 5 – strongly agree. Validity and reliability of the scale has been demonstrated (Murphy & O'Sullivan Curtin, 2016). The internal consistency of the CAOAS was measured using Cronbach alpha co-efficient (Cronbach, 1951). The Cronbach alpha of the CAOAS was α =.77 therefore meeting appropriate levels of internal consistency (DeVellis, 2003).

The Big-Five Inventory 10 (BFI-10; Rammstedt & John, 2007) was selected to assess personality and for its brevity and utility as a measure. The ten-item questionnaire is an abbreviated version of the Big Five Inventory 44 (BFI-44, John & Srivastava, 1999) designed to measure the Big Five personality traits; extroversion, agreeableness, conscientiousness, neuroticism and openness. Participants are asked to rate on a scale of 1 – disagree strongly to 5 – agree strongly, how well a list of statements describe their personality. The BFI-10 has demonstrated adequate reliability and validity in the literature (Rammstedt & John, 2007). As the BFI-10 is a short scale with only 10 items, the mean inter-item correlation (MIIC) was considered a more appropriate measure of internal consistency (Mitchell & Jolley, 2012) with scores over .2 considered adequate (Briggs & Cheek, 1986). The MIIC scores for each of the subscales of the BFI-10 was; Extroversion (r = .54), Agreeableness (r = .32), Conscientiousness (r = .10), Neuroticism (r = .26) and Openness (r = .16). The questionnaire also included a series of demographic questions. Information pertaining to the rationale of survey methodology is in Appendix B.

2.4.Procedure

Prior to the commencement of the research, an application was submitted and approved by the Clinical Psychology Research Ethics Committee in the School of Applied Psychology, University College Cork (see Appendix C). GPs were initially contacted by post with a letter outlining the purpose of the study (Appendix D), an information sheet (Appendix E), a questionnaire (Appendix F) and a return stamped addressed envelope. Consent to participate was achieved by completion of the questionnaire and return postage. Data collection occurred between November 2018 and January 2019. Questionnaires were collated, scored and data was input into an online statistical programme for further analysis. Statistical analyses were performed using IBM SPSS version 25.

3. Results 1

3.1.Sample description

A total of 58 completed questionnaires were returned. One questionnaire was returned incomplete and was removed resulting in 57 completed questionnaires and a response rate of 38%. There were slightly more female (53%) than male (47%) respondents and the majority of GPs in the sample were married (84%). Over half of participants (58%) worked in an urban based setting. A considerable proportion of respondents conducted nursing home visits as part of their job (74%) and just over one fifth (21%) had undertaken some form of specialist geriatric training during their career. Less than half the sample (47%) reported that they were either currently living or previously had lived with an older person. The majority of GPs (61%) identified as having social relationships with an older person(s). The mean age of the respondents was 48.90 years (*SD* = 9.16). The participants reported an average of 22.93 years (*SD* = 8.22) of clinical practice in medicine.

The distributions of the data in the questionnaires were subjected to tests of normality. Kolmogorov-Smirnov scores were significant for the BFI-10 subscales; agreeableness D (57) = .24, $p < .05$), conscientiousness (D (57) = .22, $p < .05$), openness (D (57) = .13, $p < .05$), and neurotic (D (57) = .15, $p < .05$), and the CAOAS subscale decline (D (57) = .12, $p < .05$), indicating deviations from normality. Visual inspections of the distributions of scores as recommended by Tabachnick & Fidell (2007) indicated relative normality (See Appendix G) with the exception of the decline subscale which exhibited a potential outlier in the data. Further analysis of the descriptive table indicated that the trimmed mean and mean value of the decline subscale were 22.70 and 22.96 respectively. Given that the means were similar and that the value was not too different from the remaining distribution (Pallant, 2010), the case was retained in the data file.

3.2. Quantitative analysis

Independent sample t-tests were performed on a range of variables to assess for differences in attitude scores between groups. Analyses indicated there was no significant difference in attitudes scores between males (n = 27) and females (n =30) across the four attitude domains; positive t (55) = 1.81, p = .97, negative t (55) = .41, p = .25, engagement t (55) = -1.68, p = .48, or decline t (55) = 1.93, p = .67. Participants were categorised into two groups based on relationship status. No significant differences on attitude scores were observed between respondents who reported being in a relationship and those not in a relationship, positive t (55) = .09, p = .93, negative t (55) = 1.15, p = .26, engagement t (17.23) = 1.11, p = .28, or decline t (55) = -.02, p = .98. There were no significant differences found in attitude scores between urban-based practice clinics as compared to those rurally located, positive t (47) = 1.23, p = .23, negative t (47) = 1.11, p = .27, engagement t (47) = .15, p = .88, or decline t (47) = 1.03, p = .31. Respondents were categorised into two groups

based on whether or not they had undertaken specialist geriatrics training during their career. There were no significant differences observed between the two groups on the four attitude subscales, positive t (54) = .81, p = .42, negative t (54) = -.25, p = .81, engagement t (54) = 1.12, p = .23, or decline t (54) = -.13, p = .90. A one-way between-groups analysis of variance (ANOVA) was conducted to explore the impact of living or having lived with an older person(s) on attitude levels. Participants were categorised into four groups; group 1: living currently, group 2: lived previously, group 3: never lived, and group 4: occasionally lived. There was a statistically significant difference between groups at the $p < .05$ level on both the negative and decline subscale of the CAOAS F (3, 53) = 3.12, p = .03. and F (3, 53) = 2.98, p = .04 respectively. Despite reaching statistical significance however, the effect size, calculated using eta squared, was small, .15 and .14 respectively. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for Group 1 (M = 16.67, SD = 3.22) was significantly different from Group 2 (M = 29.96, SD = 5.85) and Group 3 (M = 28.63, SD = 8.19) on the negative subscale. The mean score for Group 1 (M = 16.33, SD = 6.43) was also significantly different from Group 2 (M = 23.38, SD = 3.62) and Group 3 (M = 22.74, SD = 3.85) on the decline subscale.

The relationship between personality and attitudes was explored using Pearson product-moment correlation coefficient. There was a positive correlation between scores on both extraversion and agreeableness and scores on the engagement subscale (r = .31, n =57, $p < 0.05$) and (r = .33, n = 57, p <.05) with a medium effect size. There was a negative correlation between scores on the neurotic subscale of the BFI-10 and the engagement subscale of the CAOAS (r = -.30, n = 57, $p < .05$) with a medium effect size. There was evidence of a significant negative relationship between levels of agreeableness and the negative subscale of the CAOS, with a small effect size (r = - .28, n = 57, p <.05). There

was no evidence of a relationship between age of GP or years of clinical practice and attitudes scores. The correlational analyses are presented in Table 1.

Table 1: Pearson correlations between attitude and personality

Variables	1	2	3	4	5	6	7	8	9
1. Positive	−								
2. Negative	-.271*	−							
3. Engagement	.263*	-.281*	−						
4. Decline	-0.193	.507**	-.292*	−					
5. Extrovert	0.179	-0.030	.313*	-0.065	−				
6. Agreeable	0.213	-.288*	.328*	-0.188	.280*	−			
7.Conscientious	0.202	-0.034	0.193	-0.152	0.204	.307*	−		
8. Openness	0.027	0.217	0.153	0.171	.377**	-0.072	0.011	−	
9. Neurotic	-0.223	0.237	-.305*	0.178	-.299*	-0.232	-0.194	-0.032	−

*. Correlation is significant at the 0.05 level (2-tailed).

**.Correlation is significant at the 0.01 level (2-tailed).

4. Method 2

4.1.Participants

Qualitative interviews were conducted with seven participants, three males and four females, ranging from 68-87 years of age. Participants were attending an older adult community mental health service and purposive sampling was used to recruit potential participants. Initial contact was made with potentially suitable parties by the Lead Senior Clinical Psychologist on the team. As per inclusion criteria, clients aged 65 years or over were eligible to participate. Suitability of potential candidates was established by the Senior Psychologist, based on clinical judgement of individuals' wellness, ability and willingness to contribute to the interviews. Initially, participants were provided with an information sheet (Appendix H) outlining the purpose of the study and those who expressed interest in participating were subsequently contacted by the lead researcher.

4.2. Procedure

Interested parties were invited to engage in a semi-structured interview at a suitable date and time. Interviews were conducted either in the community mental health setting or in participants' own homes. The principal researcher was accompanied by an assistant researcher when interviews were conducted outside community settings. Prior to the commencement of the interview, participants were provided with an opportunity to ask questions and discuss the study further. Participants were required to give formal written consent if they wished to proceed (Appendix I). Participants were informed that they may withdraw from the research at any point during the interview and up to 2 weeks after the interview. The interview schedule focused on open-ended questions relating to participants' perceptions and experience of healthcare professionals and provision to date (see Appendix J). Interviews lasted between 25-51 minutes with a mean duration of 33 minutes and were audio-recorded.

Analysis

Thematic analysis was employed to analyse the collated data and followed an inductive approach. The data collected from the semi-structured interviews were transcribed by the principal researcher. Efforts to maintain awareness of the researcher's own preconceptions and to minimise imposing on the data were sustained throughout the process through on-gong consultation with a second researcher. Throughout the transcription process, initial ideas and thoughts were noted, recognised as a critical component of the analysis (Riessman, 1993). Further information regarding qualitative procedures are included in Appendix K. Following transcription, the data was read and re-read extensively to ensure familiarity and 'immersion' in the data (Braun & Clark, 2006). The next step in the analysis process involved the development of initial codes. Data was coded line by line and was data driven to capture potential patterns throughout the data set (see Appendix L). The initial coding of each interview was completed by the principal researcher and an assistant researcher and compared to encourage a reflexive dialogue throughout the process. Once the transcripts were coded and collated, initial codes were analysed and combined to develop broad themes reflecting the patterns presenting in the data.

5. Results 2

The thematic analysis process elicited several key concepts from the data transcripts. Narratives revealed a number of important factors intrinsic to older people's interactions within the healthcare system and the experiences that influence their approach to managing their healthcare communication. On the whole, participants reported positive accounts of their interactions with healthcare professionals. However, the majority of the sample also had negative experiences to report which were understood and made sense of in various ways. For example, some of the participants demonstrated a reluctance to engage in negative

evaluations of services and would express concern about getting staff in trouble. The relevant quotes for each theme are presented in Table 2. An extended thematic analysis is presented in Appendix M. The themes identified are as follows;

5.1 Themes

Theme 1: Changing Times

The majority of participants anchored their current perception of health professionals against earlier experiences within their personal history. Attitudes of healthcare personnel were described as having shifted considerably from times gone by. A number of the respondents spoke about the evolution of the healthcare system over time and how dramatically it has changed since their younger years. All of the participants grew up in an era when medical assistance was not as widely available as it is today and acknowledged the advances made in terms of access to and availability of quality healthcare in recent decades.

Subtheme 1.1 Us and Them

A central aspect of this overall theme was the significance of the role of healthcare professionals previously. Historically, the doctor was an esteemed and highly respected member within the local community. Participants recalled the sense of medical authority and paternalistic attitudes that doctors maintained during those times. Societally, doctors maintained a privileged position, recognised as an expert, someone who knew best and was therefore not to be questioned or challenged. Accordingly, the inequality created the perception of a dichotomy, between ‘us’ the patients and ‘them’ the doctors. The participants acknowledged an improvement in the attitudes of health professionals and a greater sense of equality since moving on from this more archaic method of working.

Subtheme 1.2: Personal to the Professional

Another key point highlighted in the data was the changing experience of medical care over time, moving from a system which historically centred on one professional opinion (the family doctor) to a system incorporating several differing specialisms and types of professional input. A number of the participants questioned the value of such specialisms and described the current system as lacking in personalised care. For an older person, who arguably is more likely to have increased contact with the health service, the sheer volume of professionals that can be involved in one's care, along with the information accompanying their involvement, can be overwhelming. One participant recalled feeling distressed trying to remember the names of each professional and the frustration at having to retell her story repeatedly. The importance of familiarity and developing relationships was evidenced within the data and it was acknowledged how difficult this can be to achieve in the current system when being bounced between different professionals.

Theme 2: Engagement versus Efficiency

Another important feature identified in the data was the interplay between engagement and efficiency. The participants identified the development and maintenance of a positive relationship with their primary healthcare provider as a key component in seeking and receiving quality care. Although participants described negative experiences with GPs in the community, a large proportion of the less positive experiences reported occurred in inpatient or hospital settings where staff are more time constrained, it is more difficult to establish relationships and there is a greater drive towards efficiency and effective time management.

Subtheme 2.1: Importance of relationship

The importance of the patient-provider relationship was repeatedly highlighted throughout the data, in particular, the importance of the relationship with the GP. Feeling listened to and being heard, being understood, feeling at ease, being cared for and feeling safe were deemed essential attributes of positive healthcare interaction. For the majority of participants, the GP was the healthcare provider most frequently identified as possessing these qualities. The benefit of the GP interaction was described as being afforded the time and opportunity to develop a trusting relationship with a medical professional, who has a detailed knowledge of one's specific medications, allergies and medical information. There were some negatives identified regarding the familiarity of the GP relationship also, participants described spending too much time chatting during the consultation and not feeling comfortable requesting a female doctor when attending for gynaecological health issues.

Subtheme 2.2 Just a patient

All of the participants conveyed feeling a sense of vulnerability as an older adult patient in the health service, particularly in hospital inpatient settings. Participants identified feeling helplessness, powerlessness, and frustration, and described being ignored and dismissed. Systemic failings such as; long waiting lists, staff shortages and inappropriate facilities were identified as being contributing factors. Negative personnel experiences included, being ignored repeatedly by staff, privacy violations, medication side-effects, staff unavailability and lack of appropriate monitoring. Participants described feeling a reduced sense of autonomy once admitted as a patient, both in their healthcare decisions, overall well-being and in their sense of identity.

Theme 3: Ageist interactions

There were also accounts of exposure to what the literature describes as ageist behaviours (Green, Adelman, & Rizzo, 1996). One participant recalled being persistently ignored and dismissed by staff despite repeated requests to see his consultant, which was only resolved when his 40-year old daughter demanded action to be taken. Upon his daughter's request, the patient was tended to promptly. There was evidence of paternalistic interactions with GPs, examples of attributing presenting physical issues to patients' age and focusing treatment on symptom maintenance rather than preventative care. Despite these narratives, participants did not explicitly classify such events as ageist in origin. Participants described a reluctance to address such incidents, despite being dissatisfied with, and at times distressed from, the interactions; there was a preference for tolerance over challenge. Respondents were more likely to identify experiences in the wider community as explicitly ageist in nature, such as getting pushed while queuing at the supermarket and getting on buses.

Subtheme 3.1 Strategies

Lastly, there was evidence of the employment of strategies by participants developed to best serve effective navigation of the health system. Participants conveyed the necessity of maintaining a sense of autonomy and awareness as a patient where possible, which appeared to be somewhat related to the identified vulnerability felt as an older patient. As well as this, the importance of family members and visitors remaining vigilant throughout an older person's care while in the system was highlighted. Such strategies were perceived to be helpful in minimising negative healthcare experiences. Participants also identified the need to remain on favourable terms with staff in order to increase the likelihood of receiving quality care.

Table 2: Themes identified relating to older peoples' experiences in healthcare

Theme 1: Changing Times	
Subtheme: Us and Them	They didn't make you feel as comfortable. This is back along now; a doctor was someone who was a way above you. They were a little bit up there. You didn't ask them anything, you just listened to them you know, and you'd have to assume on how they behave. (Participant 1)
	Certainly, when I was younger, I can remember the attitudes of doctors then. They treated people as if they were under them and that's not the case now, it's more of a one to one now. (Participant 3)
Subtheme: Personal to the Professional	The whole system changed. For me anyway, the personal thing seems to me to have changed. You have a specialist there, and in most cases, you have 4 or 5 people hanging onto him…Now you're talking to someone who knew everything about practically nothing. That's what a specialist was to me, someone who know more and more about less and less until they know everything about nothing. (Participant 1)
	It was very stressful because I would be sitting down and I'd realise I wasn't seeing the female doctor I had thought I was seeing; I was seeing some man that I had never seen before. I had to tell them my story again. (Participant 4)
Theme 2: Engagement versus Efficiency	

Subtheme: Importance of relationship	It's a friendship that you build up and it's a comfortable feeling then, there's no feeling of nervousness or that. I think the fact that you feel comfortable is the most important thing and from there on everything develops… By being friendly, that makes all the difference. There has to be that feeling that the person is put at ease and then the best is got from that patient. That's the most important thing. ...I think there should be an aim to do that, whatever age. (Participant 3)
	We've had a GP for about 10 years now which is nice. He knows all the pills and all the medications. I see a Consultant for my Parkinson's and he was giving me a pill which was making me...crazy but my GP wouldn't do that because he knew I'm allergic to medications like that so it was nice to have someone that you trust that you've been with a long, long, time. (Participant 6)
Subtheme: Just a patient	I think once you say you're a patient, no matter how educated or intelligent you might be, they don't seem to have the capacity to respect your point of view. You' re just a patient. (Participant 5)
	I wouldn't like to be in the bed and a doctor would come in with a bunch of students hanging onto him and you feel like an object there. I would prefer if that doctor came in first and explain to you, not to come in on top of you and you don't know who in God's name is looking at you. (Participant 1)
	There was an uncertainty. When people go into hospitals, they don't feel in charge of themselves anymore. From the time they go in, then the nurse is in charge or the doctor is in charge, so they lose their own domain. (Participant 3)
Theme 3: Ageist experiences	My wife, she's slowing down a lot and she's attending a doctor and she attends a specialist twice a year. She's getting enough, she's getting enough but a lot of the year...how will I put it...alot of the attention she's getting, it's to keep you going, to keep you ticking over, not curing anything, not preventing anything just to keep you out of trouble. It's like taking an aspirin now if you have a pain in your head. You'd like something a little more thorough. (Participant 1)

	We have our own doctor, he's ok. He does say age. If I say to him 'Oh I have such a thing', he'll say 'that's age'. And I'll settle for that because he said it and he's a doctor… And I'd say sure I'm only 75, that's not very old, if I was 95 I might expect it and he'd start laughing. Then he might say I'll give you a cream so and we'll see what happens. (Participant 7)
	I wouldn't stand up for myself and say you shouldn't have said that to me. I wouldn't be that type but I was annoyed and you see, its still in my brain and I don't like that. (Participant 4)
Subtheme: Strategies	I would say that a person should be on guard themselves. In that particular case, when I sought out the consultant, that turned the screw for me, only for that I'd say I could be in trouble. In other words, if you hand everything over to the doctors and nurses you could be in trouble. You have to concentrate on yourself. You have to prompt them yourself. I think a person should become self-conscious themselves, can you help yourself rather than becoming dependent. (Participant 2)
	I like to have fun with people, I like to kid with people. You sorta think they're gonna care for you more if they like you. If you're gonna be an old grouch, they're not gonna do much for you. They don't have to. (Participant 6)

6. Discussion

The present research augments the evidence base with regard to the current picture of ageism in the Irish healthcare system. The findings did not suggest any significant differences in GPs attitude scores as measured by the CAOAS across a wide range of variables including, sex, relationship status, workplace setting and completion of specialist training. Further, there was no relationship detected between age or years of clinical practice and attitude scores. There was evidence to suggest, however, that those currently living with an older person exhibited more positive attitude scores than those who had previously lived with and do not live with an older adult. This finding has been corroborated in a previous study which indicated that the presence of an older person in the house was related to positive attitudes consistent with a medium-large size of effect, $d = .66$ (Pekince, Aslan, Erci & Akturk, 2018). Similar findings suggest that a previous history of living with an older person are associated with more negative attitudes (Seferoglu et al., 2017). This finding gives weight to the on-going debate in the literature that greater exposure to older adults, on a personal level rather than professional, is linked with more positive attitudes.

The findings also suggested that particular personality characteristics were associated with more positive attitudes. Result indicated that higher levels of the traits agreeableness and extroversion and lower levels of neuroticism were related to higher attitude scores. This finding substantiates previous findings in relation to personality and attitudes towards older people (Yazdanian, Alavi, Irajpour & Keshvari, 2018). Taken together, the outcomes give weight to previous research illustrating that demographic variables play a limited role in attitudes towards older people (Adibelli & Kilic, 2013). The findings of the current study are also in line with a recent systematic review which concluded

that demographic variables are not predominant factors in doctors' attitudes towards older people (Samra et al., 2017).

The themes identified in the data corroborate aspects of previously conducted literature on ageism while also suggesting new insights and interpretations. The findings propose that older adults' current healthcare perceptions are informed by the historical and societal context of earlier medical experiences. The prevalence of paternalism in healthcare, as highlighted in the data, was endemic and inequities in the patient-professional relationship was commonplace. Power differentials between patients and healthcare providers are well documented in the literature (Coyle, 1999). The medical authority epitomising these earlier healthcare interactions may have influenced older adults' perceptions of doctor-patient dynamics. Research has posited the importance of recognising and addressing power differentials in older adult healthcare, due to an increased rate of disadvantage relative to other healthcare consumers (Eliassen, 2016). Distorted views of appropriate patient-professional relations may lead to the inadvertent minimisation or misunderstanding of ageist interactions. Further, as proposed by SET, it is possible that older people have internalised these historical power differentials acting as a barrier to self-empowerment in managing current healthcare interactions. The current finding signifies a need for further exploration into the impact of historical and societal factors in older peoples' perceptions of the healthcare system.

Themes also illustrated the important of relationship in creating successful patient-provider experiences. Feeling listened to, understood and prioritised were highlighted as crucially important facets of the relationship. This observation was consistent with a systematic review concluding that relationship-based approaches to older adult care were related to more positive experiences (Bridges, Flatley & Meyer, 2009). Negative

experiences were reported more frequently in inpatient settings rather than community settings. Hospitalisation was associated with a sense of reduced autonomy and a loss of identity. The concept of powerlessness and threats to identity in acute care is not unique to older adults and research has described the sense of objectification and feelings of disempowerment experienced by many patients, irrespective of age (Coyle, 1999). Older people in particular however, may be at risk of 'layered' stigma, due to the on-going existing risk of age-related prejudice. Moreover, research has established that poor interactions with healthcare personnel can act as influential deterrents in seeking future care (Makris et al, 2015). Therefore, it may be likely that poor quality interactions are serving as obstacles in older people accessing more effective and comprehensive healthcare. This finding adds to the evidence-base that greater clinical guidance is required for clinicians working in older adult care directed at augmenting patient-provider communication. For example, greater emphasis on interpersonal communication and developing effective therapeutic relationships may provide a pragmatic direction for current training healthcare professionals and clinicians.

The findings suggested that older people held a relatively positive impression of healthcare professionals. Themes do indicate that negative interactions are problematic for older people, however, they are not necessarily interpreted as explicit ageism. Participants described interactions consistent with descriptions of ageism in the literature such as; attributing presenting ailments to age, over-medication and dis-regarding views relating to one's own health. Whilst acknowledged as unpleasant and negative, these situations were not generally labelled as ageism by participants and would frequently be dismissed as unimportant or trivial. There was evidence of discomfort when describing typically ageist experiences and participants were quick to provide justifications for negative interactions.

Participants frequently minimised negative comments by concluding with a positive remark, cautious not to be perceived as complaining about staff. The concept of older adults' reluctance to complain is not a new phenomenon. Although, older people are one of the largest groups of consumers of the health service, they tend to be one of the least likely groups to complain about suboptimal care. Research conducted suggests that 16% of individuals aged over 65 are unlikely to report a complaint, compared to 10% of 25-64-year olds (ICM, 2013). A report published by the UK Ombudsman found that older people are largely afraid to complain about the care they receive due to a fear of negative consequences and how it may impact future treatment (Parliamentary & Health Service, 2015). Preferred strategies include; accommodating healthcare personnel rather than using confrontation in in order to minimise the risk of jeopardizing care (Lagacé, Tanguay, Lavallée, Laplante, & Robichaud, 2012).

Health provision for older people in Ireland is under-resourced and the right to such health service is not currently defined in Irish legislation (Donnelly, O'Brien, Begley & Brennan, 2016) therefore, access is frequently discretionary, inequitable and problematic. Knowledge relating to services can be difficult to obtain and older people are often reliant on health professionals to provide accurate information and onward referrals. Thus, it is pragmatic for older people to maintain positive relationships with healthcare providers in order to enhance awareness and access to both current and future services. As older people are more likely to have on-going health needs, there may be an underlying belief that complaining about healthcare and/or healthcare staff could negatively impinge upon their current healthcare provision and anticipated health requirements in the future. The development of strategies by participants in the current study suggests an understanding of the need to protect oneself as an older healthcare consumer. Strategies employed to garner

more positive interactions from staff may be useful in serving as a buffer from potential threat considering the reduced likelihood of older people addressing or contesting negative experiences. Further research is required to better understand the relationship between older adults' experiences of healthcare interactions in light of their own perceived reliance on healthcare professionals and services. Additionally, further exploration of the specific factors related to older people's reluctance to address ageist interactions is also warranted.

A final and contrasting explanation is that participants reported negative interactions are not related to ageist sentiments. There are a range of factors which may impact upon patient-doctor relations including; demanding workload, lack of communication training and an under-resourced health-system (Na & Pei-Luen, 2017). A number of the participants identified broader issues in the system, such as understaffing, inappropriate facilities and long waiting lists. Therefore, it is possible that health professionals' attempts to navigate wider systemic factors, are in turn, impacting on the development of positive healthcare interactions and relationships with patients. Future work would be pragmatic in working towards disentangling these concepts to provide more clarity with regard to understanding the precipitating factors involved in lower quality interactions.

a. Limitations

There are a number of limitations to acknowledge with regard to the present research. Participants were recruited from a somewhat limited geographical area utilising purposive sampling techniques for the qualitative arm of the study. Taken together with the relatively small sample size this may reduce the generalisability of the study. Further, consideration must also be given to the fact that the participants were attending a community mental health service. Evidence has suggested that prejudice is multi-faceted and may be further complicated when combined with other socially stigmatized conditions (Reidpath & Chan,

2005) therefore it may be difficult to disentangle age-related stigma from mental-health stigma. Also, the participants were aware the researcher was collecting data relating to ageism and it is possible that more socially desirable responses were submitted on the questionnaire. Lastly, it must be noted that the MIIC for some of the subscales of the BFI-10 was lower than optimal levels for reliability and therefore may not provide an accurate reflection of the variables it was designed to measure.

The current study has provided further analysis on the current picture of ageism in the Irish healthcare service. The findings indicated that aspects of personality and exposure in the form of living with an older adult are related to more positive attitudes in Irish GPs in this sample. The findings identified important aspects of older adult perspectives regarding the role of historical factors. Future work may focus on unravelling the historical intricacies involved in older peoples' early healthcare experiences to explore how they may influence the ability to seek care and engage with the health service. The present research highlights the need to work towards developing a greater insight into older people's understanding of the concept of ageism and how it is perceived to manifest in healthcare settings. Further exploration is also warranted to examine the factors related to older people's perceived reliance on the healthcare system and related factors which in turn may be influencing the evaluations being reported in the literature. The research provided an initial insight into age-related prejudice towards older people at present. Future work will need to build upon these findings to provide a comprehensive account of ageism in Irish healthcare with a view to informing the literature and optimising healthcare provision for older people.

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7. Appendices

Appendix A: Psychology and Aging Author Guidelines

Appendix B: Survey Methodology

Appendix C: Ethics approval letter

Appendix D: Letter to GPs

Appendix E: Study Information sheet (quantitative)

Appendix F: GP questionnaire

Appendix G: Normality Tests

Appendix H: Study information sheet (qualitative)

Appendix I: Participant consent form

Appendix J: Interview schedule

Appendix K: Qualitative Procedures

Appendix L: Coded Transcript

Appendix M: Extended thematic analysis

Appendix A

Authors Guidelines

Psychology and Aging Journal - Author Guidelines

Submission

To submit to the Editorial Office of Elizabeth A. L. Stine-Morrow, please submit manuscripts electronically through the Manuscript Submission Portal in Word Document format (.doc).

SUBMIT MANUSCRIPT

Elizabeth A. L. Stine-Morrow
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It is the policy of *Psychology and Aging* to encourage transparency of methods and open access to data in the service of improving the reproducibility of research results. The Online Supplement for the journal and repositories are valuable resources to achieve these aims. Authors are encouraged to use our Online Supplement to augment information from the manuscript as necessary to ensure the unambiguous presentation of methodological approach (e.g., stimulus materials, protocols, detailed analysis of the sample). The Online Supplement is also useful for reporting ancillary analyses that are not central to the argument of the paper or alternative approaches to data visualization.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6thedition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Journal Manuscript Preparation Guidelines before submitting your article. Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Length

Articles

Articles do not typically exceed 8,000 words, excluding references, tables, and figures. Shorter manuscripts are equally welcome.

Articles exceeding the 8,000 word limit may be considered if they offer an especially novel theoretical framework, or complex methodology or statistical approach that requires more extensive exposition.

Title Page

The first manuscript page is a title page, which includes a title of no more than 12 words, the author byline and institutional affiliation(s) where the work was conducted, a running head with a maximum of 50 characters (including spaces), and the author note.

Abstract and Keywords

All manuscripts must include an abstract typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

For regular articles, abstracts are no longer than 250 words; for brief reports, no longer than 100 words.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**
  Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin, 139,* 133–151. http://dx.doi.org/10.1037/a0028566
- **Authored Book:**
  Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.*Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
  Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES®database. Please see Supplementing Your Article With Online Material for more details.

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See also APA Journals® Internet Posting Guidelines.

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In light of changing patterns of scientific knowledge dissemination, APA requires authors to provide information on prior dissemination of the data and narrative interpretations of the data/research appearing in the manuscript (e.g., if some or all were presented at a conference or meeting, posted on a listserv, shared on a website, including academic social networks like ResearchGate, etc.). This information (2–4 sentences) must be provided as part of the Author Note.

Authors of accepted manuscripts are required to transfer the copyright to APA.

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and

who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930).

Appendix B

Survey Methodology Rationale

From the outset of research design, a number of factors were considered with regard to selecting appropriate methodologies to best serve the objectives of the study. One of the most prominent considerations was how to capture the relevant data in a time-efficient and methodologically robust manner. Survey instruments are posited as a useful method of obtaining information from large samples of the population (Glasgow, 2005). One of the primary advantages of survey tools in research relates to the large amount of information that can be gathered in a relatively efficient manner. When surveys are well-designed, they can extract a large amount of data representative of the larger population. Written survey methodologies or questionnaires have been posited as an effective way of accessing constructs that are oftentimes difficult to evaluate observationally, such as attitudes (McIntyre, 1999).

The challenge of recruiting GPs as participants was acknowledged from the outset of the research process. The evidence-base has highlighted that a myriad of factors may impinge upon GPs likelihood to engage with research, such as on-going requests to participate in studies and time-work constraints (Barclay, Todd, Finley, Grande & Wyatt, 2002; Kaner, Haighton & McAvoy, 1998). There are several recommendations in the literature suggesting ways to maximise successful completion of survey questionnaires. For example, the length of a survey or questionnaire can impact response rate across a broad of range of cohorts including; clinical and non-clinical populations and both healthcare and non-healthcare professionals (Edwards et al., 2009). Similarly, it is recommended that researchers avoid using long-winded questions that result in participants disengaging with

the material (McIntyre, 1999). In light of the evidence-base, it was imperative that the survey instruments for the present research were concise, time-efficient and easily readable.

A survey instrument in the form of a written postal questionnaire was selected as the most appropriate method of gathering information. Postal questionnaires were deemed more suitable for the proposed study population for a number of reasons. Practically, given the time constraints within general practice in the community, an online survey could potentially be more susceptible to being missed, forgotten about or dismissed entirely. A written questionnaire however, provided a tangible reminder to participants in the event that survey completion needed to take place in more than one sitting. Questions were kept as brief and concise as possible with a view to optimising participant engagement. Similarly, validated questionnaires pertaining to the variables of interest were selected for their brevity as much as their demonstrated utility in the literature. (Murphy & O'Sullivan Curtin, 2016; Rammstedt & John, 2007). A further advantage of utilising a postal questionnaire was the lack of direct contact with the participants. Measurement errors can occur for a number of reasons during the research process, therefore, minimising exposure between the researcher and participants reduces the likelihood of such errors occurring (Salant & Dillman, 1994). Collecting data with regard to potentially stereotypical attitudes can be particularly challenging as it is a socially sensitive topic which could potentially increase the risk of socially desirable responding to occur (King & Brunner, 2000) therefore eliminating exposure between researchers and participants may reduce the likelihood of this occurring.

References

Barclay, S., Todd, C., Finley, I., Grande, G., & Wyatt, P. (2002). Not another questionnaire! Maximising the response rate, predicting non-response and assessing non-response bias in postal questionnaire studies of GPs**.** *Family Practice, 19***,** 105–11. doi:10.1093/fampra/19.1.105

Edwards, P. J., Roberts, I., Clarke, M. J., DiGuiseppi, C., Wentz, R., Kwan, I., *et al*. (2009). Methods to increase response to postal and electronic questionnaires (Review). *The Cochrane Database of Systematic Reviews*, ***3*.** doi:10.1002/14651858

Glasgow, P. A. (2005). *Fundamentals of Survey Research Methodology*. Virginia,Washington: Mitre. Retrieved from https://www.mitre.org/sites/default/files/pdf/05_0638.pdf

Kaner, E.F.S., Haighton, C.A., McAvoy, B.R, (1998). "So much post, so busy with practice - so, no time!": a telephone survey of general practitioners' reasons for not participating in postal questionnaire surveys. *British Journal of General Practice*, 48, 1067–9.

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Murphy, M. & O'Sullivan Curtin, H. (2016). Introducing CAOAS: Cork Attitudes to Older Adults Scale. Unpublished.

Salant, P., & Dillman, D. A. (1994). *How to conduct your own survey*. New York: John Wiley and Sons.

Rammstedt, B. & John, O. (2007). Measuring Personality in One Minute or Less: A 10-Item Short Version of the Big Five Inventory in English and German. *Journal of Research in Personality, 41*, 203-212. 10.1016/j.jrp.2006.02.001.

Appendix C

Ethics Approval Letter

04/12/2017

Dear Louise

Thank you for presenting your work to the D.Clin. Research Ethics committee and I am sorry for the rather tardy response. The committee is happy to approve your research study but we would like to ask that you consider the points below and make some minor amendments to your protocol. You do not need to resubmit these changes for approval but we would ask that you do send us an electronic copy of your protocol with any such changes in place.

Good luck with your research.

Sean Hammond

Please consider the following: -

- Rewrite sentence to remove "I have to." You are engaging in research the results may be published in your doctoral thesis.
- The information sheet for older participants is very wordy. Consider how it may be simplified with reference to literacy issues.
- Ensure that your wording is not leading – need to strike a balance between neutrality and transparency - "what are your experiences of ageism to date" – very leading question. Consult with supervisor on this point
- Need for more clarity on how you would mitigate if participant become distressed.
- Consider field supervision who might offer clinical field supervision if necessary?
- We would like to see you identify putative sites and list these
- Clarify the signposting and referral pathway and your confidentiality protocol.
- Need to be more explicit that this research is completely independent of treatment.
- Soften the wording about the authorities being contacted, it's currently scary.

Appendix D

Letter to GPs

Doctor of Clinical Psychology (D.Clin.Psych)

University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Dear Dr. _____,

I am in my final year of completing my Doctorate in Clinical Psychology as part of the D.Clin.Psych programme in UCC. The D.Clin.Psych is a joint enterprise between the School of Medicine and the School of Applied Psychology.

I am currently conducting research for my doctoral thesis with regards to exploring attitudes among healthcare professionals towards older adults. I would like to invite you to participate, by completing the attached questionnaire. It will take approximately 5-10 minutes to complete. There is a stamped address envelope accompanying this letter, for the survey to be returned via post once completed.

If you would be willing to take part in the research, there is an information sheet overleaf with more detailed information and my contact details if required.

Your time is very much appreciated.

Warm Regards,

_____

Louise Concannon,
Psychologist in Clinical Psychologist in Training; BA, MAAP

Appendix E

Study information sheet (quantitative)

INFORMATION SHEET

University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Purpose of the Study. As part of the requirements for the D.Clin.Psych doctoral thesis at UCC, I am conducting research concerned with exploring attitudes in Irish healthcare. The findings of the research will be published as part of my doctoral thesis.

What will the study involve? The study involves completing a brief questionnaire consisting of questions relating to attitudes, followed by a vignette describing a medical situation. The questionnaire will take approximately 10min to complete and can be returned via the stamped addressed accompanying this letter.

Why have you been asked to take part? The researchers are interested in accessing the attitudes of healthcare professionals.

Do you have to take part? No. You do not have to take part the research and participation is completely voluntary. If you do agree to take part, consent to participate will be assumed by the completion and return post of the questionnaire.

Will your participation in the study be kept confidential? Yes. No identifiable information will be collected from you.

What will happen to the information which you give? The data will be kept confidential, available only to me and my research supervisors. The results will be

securely stored on an encrypted laptop and on UCC servers which are covered by EU data protection. On completion of the project, they will be retained for minimum of ten years and then destroyed.

What will happen to the results? The results will be presented in the thesis. They will be seen by my supervisors, a second marker and the external examiner. The study may be published in a research journal. Again, there will be no identifiable information in the thesis.

What are the possible disadvantages of taking part? I don't envisage any negative consequences in taking part.

What if there is a problem? No harm is anticipated, however, listed are the contact details of some useful support services if you do feel you need to contact someone; The Samaratians 1850 609 090; www.corksamaritans.ie,

Pieta House (021) 434 1400; www.pieta.ie,

Who has reviewed this study? Approval was granted by the Social Research Ethics Committee of UCC.

Any further queries? If you would like to discuss further, you can contact me: Louise Concannon - 086-8223340 or 087-2350160. Email: 113221788@umail.ucc.ie

Alternatively, you can contact my research supervisor; Dr. Mike Murphy, 021-4904507. Email: mike.murphy@ucc.ie

Appendix F

GP Questionnaire

Demographic Form for Healthcare Professionals

Are you Female ☐ Male ☐ Other (please specify) ☐ _____

What age are you? _____ Number of years in clinical practice? _____

Are you Single (never married or never in a civil partnership) ☐ Partnered ☐ Married ☐

In a civil partnership ☐ Divorced ☐ Separated ☐ Widowed ☐

Type of practice you currently work in? Urban ☐ Semi-rural ☐ Rural ☐

If you were to complete your medical training again, on a scale of 1-5, how likely would it be that you would choose a speciality in;

General Medicine

1	2	3	4	5
Not likely	Somewhat unlikely	Neither likely nor unlikely	Somewhat likely	Very likely

Paediatric Medicine

1	2	3	4	5
Not likely	Somewhat unlikely	Neither likely nor unlikely	Somewhat likely	Very likely

Emergency Medicine

1	2	3	4	5
Not likely	Somewhat unlikely	Neither likely	Somewhat likely	Very likely

Geriatric Medicine

1	2	3	4	5
Not likely	Somewhat unlikely	Neither likely	Somewhat likely	Very likely

Psychiatry

1	2	3	4	5
Not likely	Somewhat unlikely	Neither likely nor unlikely	Somewhat likely	Very likely

Surgery

1	2	3	4	5
Not likely	Somewhat unlikely	Neither likely nor unlikely	Somewhat likely	Very likely

Did you complete a geriatrics elective as part of your training? Yes □ No □

Have you completed other specialist geriatric training Yes □ No □

If yes, please explain further _____

Do you complete nursing home visits as part of your job? Yes □ No □

Have you lived with an older adult? Yes, currently □ Yes, previously □

No □ Occasionally □

Do you engage in social relationships (i.e outside of work) with older people? Yes □ No □

Please write down the first five words that come into your head when thinking of an older person.

Vignette

Martin is 35 years old, married to Sara and has 2 children. Martin is an engineer in his professional life. He is usually healthy, is not on any medication or has any diseases. He drinks on special occasions only. He has no history of psychological treatment. For the past 2 years, Martin has been having an affair with Fiona, who he met at the gym. Fiona is 8 years younger and is an energetic and attractive woman. Martin attended his GP complaining of difficulties maintaining an erection in the last 3 months. Martin also noted he has become more irritable and moody. According to him, the loss of the erection appears only with Fiona (his lover) and not with his wife. After Fiona expressed her dissatisfaction with the situation, Martin attended his GP for help and to return to normal sexual functioning with her.

1. Please rank the likelihood that you would diagnose this case as;

(A) Erectile dysfunction

Very unlikely □Somewhat unlikely □ Neither likely or unlikely □ Somewhat likely □Very likely □

(B) Performance Anxiety

Very unlikely □ Somewhat unlikely □ Neither likely or unlikely □ Somewhat likely □Very likely □

Other _____

2. What treatment options would you be likely to recommend to Martin?

Pharmacotherapy □ Psychotherapy/counselling □

Pharmacotherapy & psychotherapy/counselling □ No treatment □

Other _____

3. How would you rate Martin's prognosis for success of treatment?

Very good □ Good □ Fair □ Poor □ Very poor□

Instructions: **How well do the following statements describe your personality?**

I see myself as someone who …	Disagree strongly	Disagree a little	Neither agree nor disagree	Agree a little	Agree strongly
1. … is reserved	(1)	(2)	(3)	(4)	(5)
2. … is generally trusting	(1)	(2)	(3)	(4)	(5)
3. … tends to be lazy	(1)	(2)	(3)	(4)	(5)
4. … is relaxed, handles stress well	(1)	(2)	(3)	(4)	(5)
5. … has few artistic interests	(1)	(2)	(3)	(4)	(5)
6. … is outgoing, sociable	(1)	(2)	(3)	(4)	(5)
7. … tends to find fault with others	(1)	(2)	(3)	(4)	(5)
8. … does a thorough job	(1)	(2)	(3)	(4)	(5)
9. … gets nervous easily	(1)	(2)	(3)	(4)	(5)
10 . … has an active imagination	(1)	(2)	(3)	(4)	(5)

To what extent do you agree that the following words or phrases describe older adults?

1 = Strongly Disagree; 2 = Disagree; 3 = Neither Agree Nor Disagree; 4 = Agree; 5 = Strongly Agree

		1	2	3	4	5
1	Wise					
2	Appreciative of people and things					
3	Contribute to family life					
4	Skilled					
5	Warm					
6	Storytellers					
7	Interesting					
8	Bossy					
9	Pessimistic					
10	Living in the past					
11	Opinionated					
12	Talk too much					

13	Suspicious					
14	Self-important					
15	Frowning on young people					
16	Set in their ways					
17	Angry					
18	Sense of entitlement					
19	Active					
20	Open to new technology					
21	Interested in social reform					
22	Adventurous					
23	Outgoing					
24	Curious					
25	Ambitious					
26	Energetic					
27	Sexual					
28	Frail					
29	Vulnerable					
30	Forgetful					
31	Wrinkled					
32	Approaching death					
33	Ill					
34	Lonely					

Thank you for your time in participating in this research today. ☺

Appendix G

Table 1: Table indicating normality checks conducted on data

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Age	.082	55	.200*	.987	55	.821
Years of clinical practice	.085	54	.200*	.971	54	.212
Extrovert total	.106	57	.175	.962	57	.072
Agreeableness total	.235	57	.000	.919	57	.001
Conscientiousness total	.216	57	.000	.889	57	.000
Openess total	.125	57	.027	.956	57	.039
Neurotic total	.149	57	.003	.956	57	.039
Positive	.098	57	.200*	.901	57	.000
Negative	.086	57	.200*	.974	57	.266
Engagement	.103	57	.200*	.970	57	.175
Decline	.117	57	.049	.941	57	.007

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Figures 1-5 – Histograms indicating distribution of data in variables indicating deviations from normality.

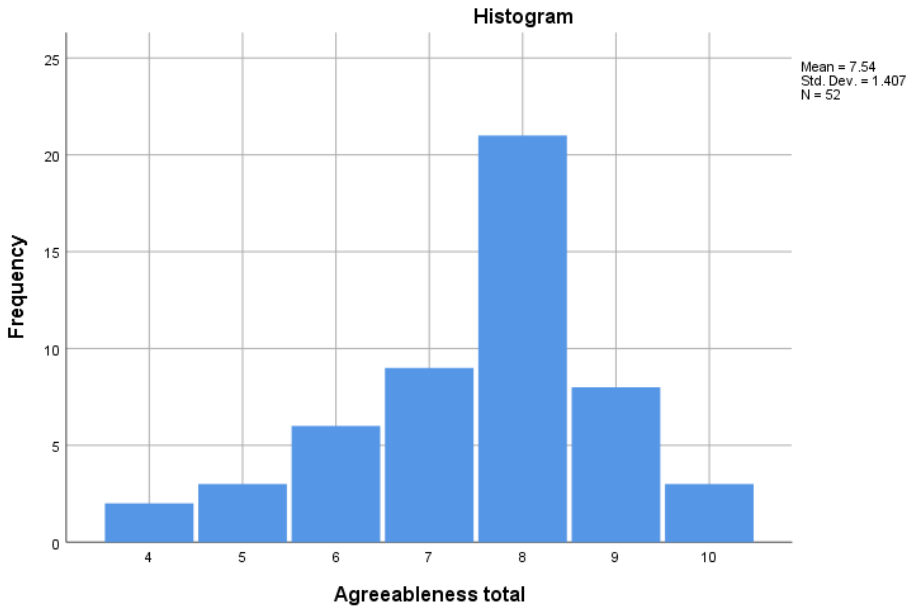


Figure 1: Agreeableness scale of BFI-10

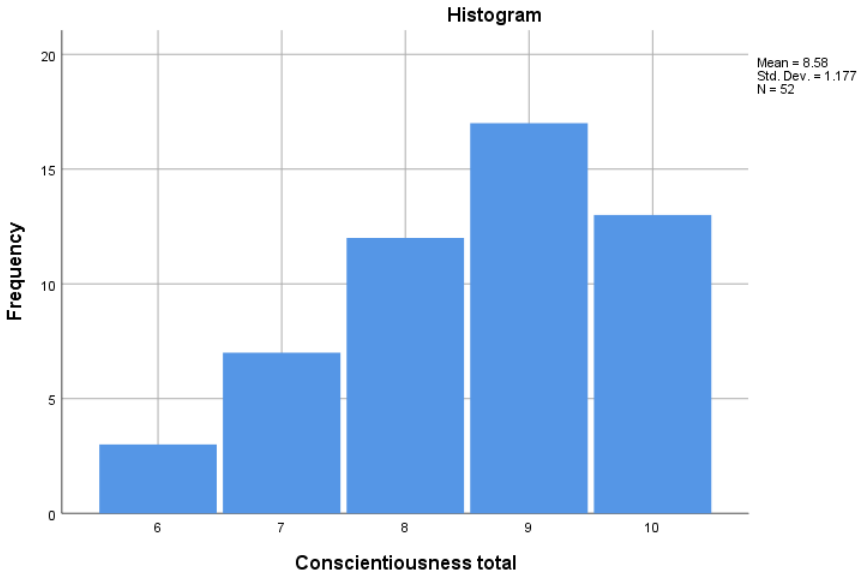


Figure 2: Conscientiousness subscale of BFI-10

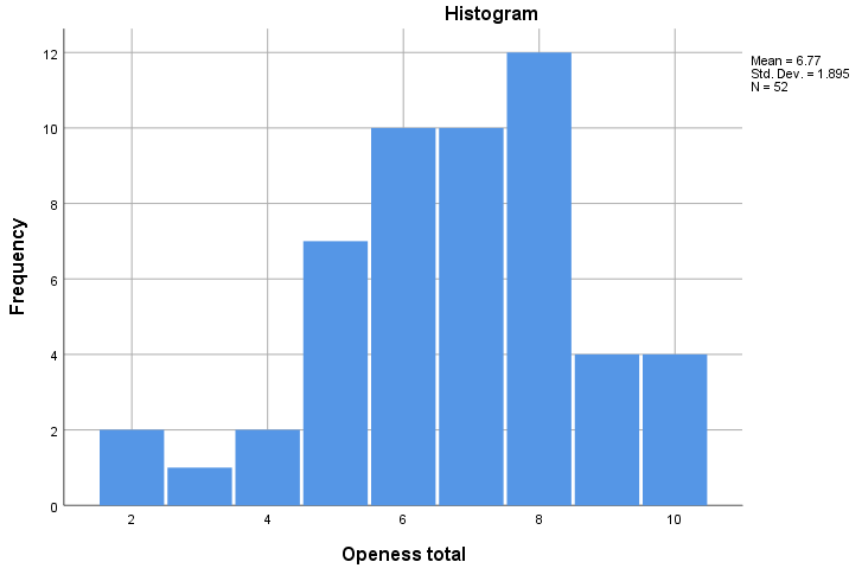


Figure 3: Openness subscale of BFI-10

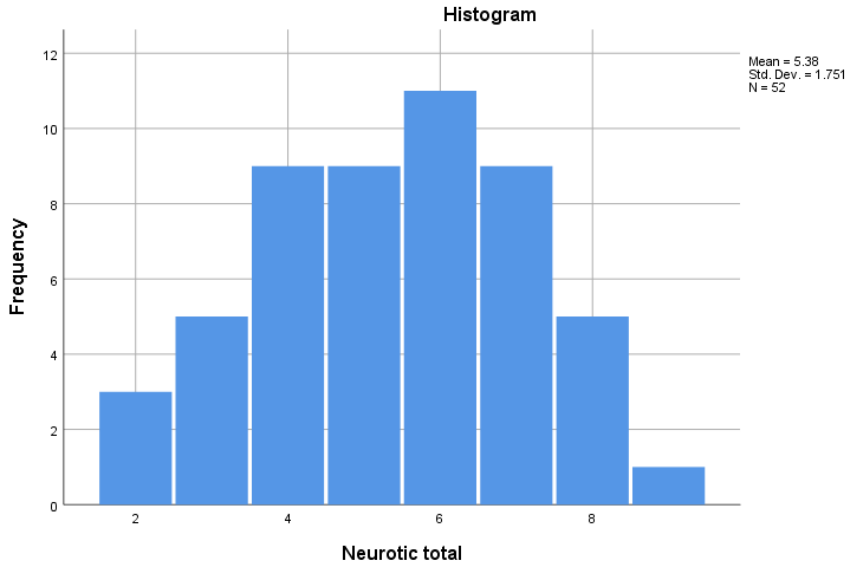


Figure 4: Neurotic subscale of CAOAS

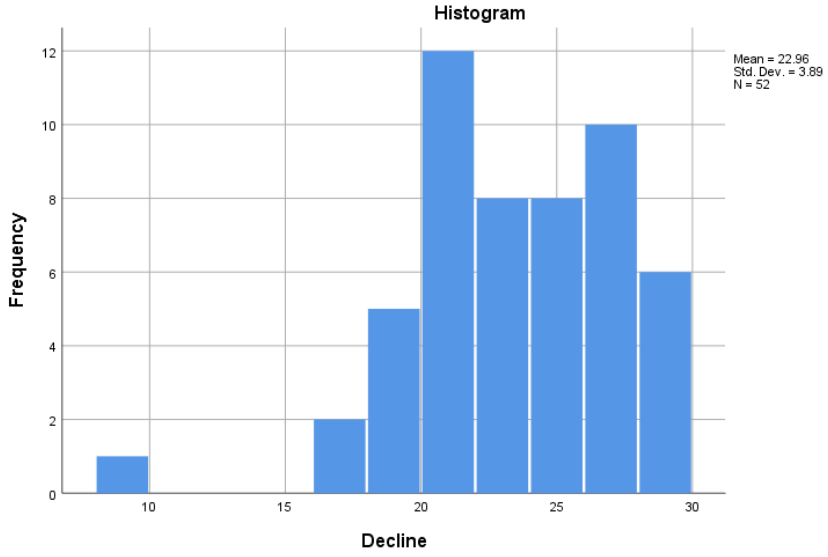
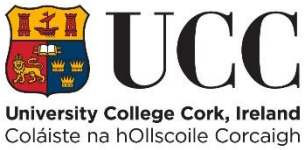


Figure 5: Decline subscale of CAOAS

Appendix H

Study information sheet (qualitative)

INFORMATION SHEET



Purpose of the Study. As part of the requirements for D.Clin.Psych doctoral thesis at UCC, I am conducting research about experiences in the Irish healthcare system. Healthcare system includes experiences of GP services, healthcare professionals in hospitals and out of hours healthcare services.

What will the study involve? The study will involve meeting me (Louise) to discuss your experiences. The meeting will last approximately 30-40 minutes. Interviews will be audio-recorded and the findings of the research written up for completion of the doctoral thesis. No identifiable information will be used in the thesis.

Why have you been asked to take part? The researchers are interested in hearing about your experiences of healthcare to date. The decision to take part in the research or not will not affect you receiving treatment and/or services in any way in the future.

Do you have to take part? No. You do not have to take part the research and participation is completely voluntary. If you do agree to take part, you will be asked to sign a consent form. You can keep a copy of this information sheet and the consent form for your own record. You may withdraw from the research at any time up and until 2 weeks after you have met with the researcher. If you do decide to withdraw from the study, any information you may have given will be destroyed.

Will your participation in the study be kept confidential? Yes. I will ensure that no clues to your identity appear in the thesis. Any quotes used in the thesis will be entirely anonymous.

In the event that a disclosure of harm or abuse is made in relation you or another person, care will be taken to handle the matter sensitively and appropriately and if required, taking steps to contact the relevant supports may occur.

What will happen to the information which you give? The data will be kept confidential, available only to me and my research supervisors. Following the interview, information will be securely stored on an encrypted laptop and deleted from the audio-recorder. The information will then be stored securely on UCC servers covered by EU data protection. On completion of the project, they will be retained for minimum of a further 10 years and then destroyed.

What will happen to the results? The findings will be presented in the thesis and will be seen by my supervisor, a second marker and the external examiner. The study may be published in a research journal. Again, there will be no identifiable information in the thesis.

What are the possible disadvantages of taking part? There are no known negative consequences from taking part in the research.

What if there is a problem? In the unlikely event something will go wrong, the interview will be stopped. If for example, in the unlikely event you become upset for any reason, a break will be given and you will have the choice whether you would like to continue with the interview or not. You are free to withdraw from the research

at this point. If you decide to continue, I will check in with you at the end and if required appropriate support contacts will be provided.

If you feel you would like some more support, the following numbers may be useful:

Researcher-Louise Concannon, contact number 086-8223340.

Email: 113221788@umail.ucc.ie

Age Action – (021) 206 7399 -www.ageaction.ie,

Aware - 1800 80 48 48 - www.aware.ie

Active Retirement Ireland - 01-8733836 - http://www.activeirl.ie

The Samaritans - 1850 609 090 - http://www.corksamaritans.ie

or alternatively you can contact your own GP.

Who has reviewed this study? Approval must be given by the Social Research Ethics Committee of UCC before studies like this can take place.

Any further queries? If you would like to discuss this further, you can contact me: Louise Concannon, contact number 086-8223340. Email: 113221788@umail.ucc.ie

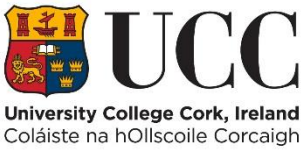
Alternatively, you can contact my research supervisor Dr. Mike Murphy, contact number 021-4904507 Email: mike.murphy@ucc.ie

If you agree to take part in the study, please sign the consent form overleaf.

Appendix I

Participant consent form

CONSENT FORM



I……agree to participate in Louise Concannon's research study.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I give permission for my interview with Louise to be audio-recorded.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box:)

I agree to quotation/publication of extracts from my interview □

I do not agree to quotation/publication of extracts from my interview □

Signed: ……. Date:

PRINT NAME: …….

Appendix J

Interview Protocol

- What has been your experience of different healthcare professionals to date?
- How have you found the attitudes of people working in healthcare?
- Have you had any positive/negative experiences?
- Have you ever felt you have been treated differently for any reason?
- How/ in what ways has this affected you?
- What has been its biggest impact?
- What makes it easier/ more difficult?
- How has this affected/ influenced your interaction with the healthcare system?
- What needs improvement/changing?
- Is there anything else you would like to say about anything we have discussed today?

Appendix K
Qualitative Procedures – Thematic Analysis

Thematic analysis is a qualitative research method to aid in identifying, organising, and analysing data found within a data set (Braun & Clark, 2006). Thematic analysis was selected for the purpose of this study for its ability to capture the richness, detail and complexity of the data (Braun & Clarke, 2006). While thematic analysis provides a certain level of thematic freedom, it is essential to engage in a research process that assures rigor and trustworthiness. The research suggests that an important step in developing coherency is by making explicit an epistemological position that can underpin the study's empirical claims (Holloway & Todres, 2003). The primary qualitative focus of the research was to capture the experiences and reality of older adults within the healthcare system, therefore, an essentialist or realist method of thematic analysis (Braun & Clarke, 2002) was employed to best serve the objective of the study. Themes and patterns were primarily identified through an inductive, data-driven approach, at a semantic level in order to develop a rich thematic description of the data overall. The process of theme development is presented in Figure 2.

Quality Assurance

Reflexivity.

From the outset of the study, a number of steps were taken throughout to ensure that the data was managed and analysed coherently and consistently. Research has highlighted the importance of an on-going reflexive dialogue (Braun & Clarke, 2006) which was achieved through a number of mechanisms. For example, throughout the research process, records of the raw data were maintained in the form of a reflexive log (Lincoln and Guba,

1985). Prior to engaging in data analysis, the primary researcher identified pre-conceived perceptions and assumptions relating to the data by documenting initial thoughts and questions. An example of items noted here was a reminder to be mindful of one's own perception of ageism and expectations of findings. Reflections relating to the interview process were noted and ideas and preliminary themes or patterns stemming from individual interviews were acknowledged. Logging the data collection experience augmented the analysis by enabling structure and organisation of the initial data particularly moving from the transcription and familiarisation stage of the analysis to the generation of codes.

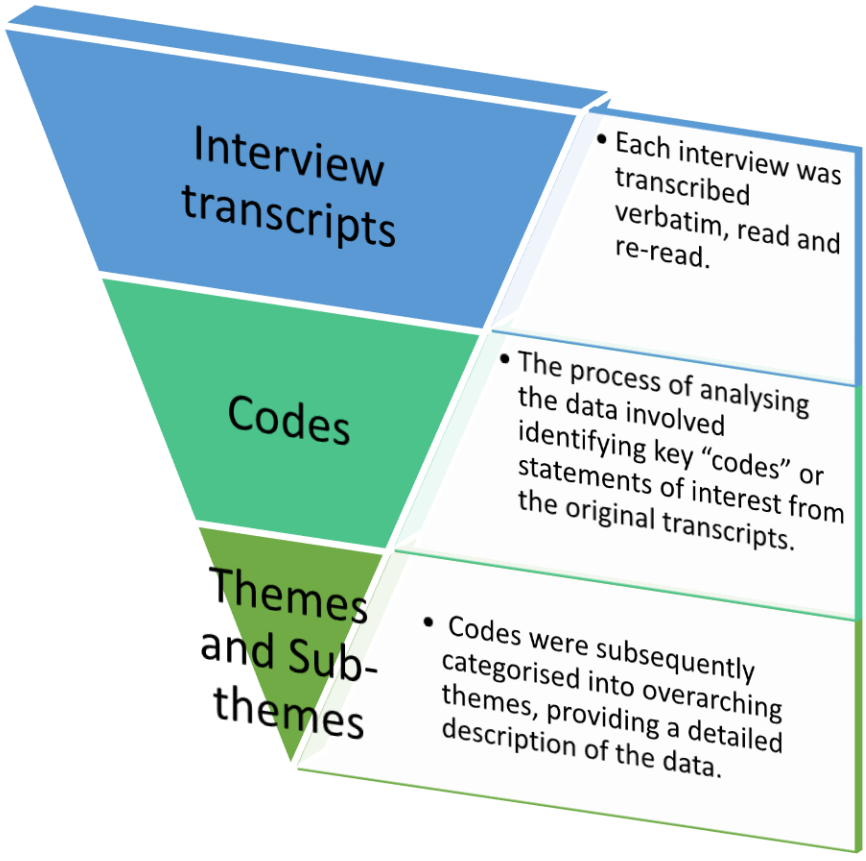


Figure 2: *A number of themes and subthemes were developed through a process of familiarisation and coding of the data.*

Triangulation.

A number of triangulation methods as outlined by Denzin (1978) and Patton (1999) were also employed during data collection and analysis. Firstly, efforts were made by the researcher to ensure triangulation of data sources to examine the consistency of the findings across different settings. Source triangulation was achieved by inviting participants to interview in a more public environment (i.e. in a private room in the hospital) or private settings (i.e. within their own home). Being flexible with regard to the interview location, enabled the researchers to compare and contrast the data collected across both settings to look for patterns or discrepancies in the data. Providing the option to interview in an environment outside of a healthcare setting where participants were likely to feel more comfortable may also have provided an opportunity to reduce the likelihood of socially desirable responding.

Additionally, to further promote reflexivity in the research design, analyst triangulation was utilised through collaboration with other researchers in the research process. The aim of this triangulation method was to highlight the potential blind spots and to offer alternative perceptions from that of the primary investigator. Each of the interviews conducted away from the main hospital site were attended by a second researcher. Debriefing took place following each interview to discuss reflections and interpretations of the interview process affording engagement with the data through a different lens. Research has highlighted that inclusion of multiple investigators can aid in promoting dialogue with regard to understanding the findings and achieving a more comprehensive insight into the data (Pandey & Patnaik, 2014).

Data Familiarisation

The primary researcher was present for all of the interviews and conducted all transcription of the data. The transcription process facilitated greater development of initial

ideas and thoughts as the data became more familiar. The data was transcribed manually and was rechecked for accuracy to ensure the interviews had been captured verbatim and was consistent with its verbal account (Poland, 2002). The data was then read and re-read several times by both the primary investigator and another researcher.

Generating Codes

The inclusion of a second researcher enabled the data set to be coded by two separate investigators, enhancing the credibility of the findings (Nowell, Norris, White & Moules, 2017). Both researchers worked separately and systematically coding the data utilising a line by line approach. Peer debriefing occurred to further discuss emerging thoughts and perceptions as this phase unfolded. Discussion related to the relevancy or redundancy of certain codes, codes that may combine to create over-arching themes and codes that may be collapsed into other codes. Once initial codes had been generated, the research supervisor was consulted to ensure further triangulation of the data.

Searching for themes

Once transcripts were coded and collated, each code was written out on individual sticky notes so they could be manually arranged and categorised as necessary. Codes were then grouped broadly, at first encapsulating general over-arching themes and subsequently rearranged and moved out into different themes or split into related subthemes. Initial groupings included themes such as, barriers and challenges to care, differing roles of healthcare professionals, patient-centred care, facilitators to successful interactions and patient rights. As per Braun & Clarke (2006) a ‘miscellaneous’ theme was created to house codes which did not fit clearly into other themes or subthemes. Codes were grouped and regrouped until a broad but coherent picture addressing the relevant phenomena was established.

Reviewing themes

This phase involved more detailed breakdown of the initial themes developed in the previous stage. As part of theme review, elements of the data that did not appear to 'fit' or contradicted other identified patterns were paid particular attention to. This approach has been recommended in the literature as a way of revising and broadening previously identified themes (Creswell, 1998). Some themes were removed due to insufficient support. Themes and subthemes were revised and discussed at research meetings during this period. At this point, the researcher re-consulted the raw data to ensure themes corresponded to and reflected the information garnered in the interviews (Nowell, Norris, White & Moules, 2017).

Defining and naming themes

Larger themes were refined by the development of subthemes to better explain each particular aspect of the overall phenomena. During this phase, themes were considered in relation to each of the other themes in terms of how they tell the story of the participants with regard to the research questions (Braun & Clarke, 2006). Research meetings discussed direct examples of each theme and subtheme and how each related to one another to ensure comprehensive representation of the data.

Producing the report

All themes and subthemes were presented in the text along with a thematic table including related quotes. Findings were discussed in relation to previous findings and implications for future research.

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Appendix L

Coded Transcript

Person	Data Item	Initial Codes
I	**What has been your experience of the healthcare system to date?**	No issues/ needs met
P	Personally, I did very well I think because I was able to get all the things I needed to get done, through the healthcare system. I had no qualm, no problem with the healthcare system. I wasn't one of those who wasn't able to get into a hospital because there was no beds available. I did get my tonsils out, that was a 3 day affair, my first in hospital. Now, there was no bad moments there, everything was grand. In our family life, we had no big problems with doctors, doctor came that time if you were sick came to the house and all the rest of it and most births were at home. As a child, I had no had experiences. I can't think from a family angle now of any bad experiences with doctors until a bit older possibly. I remember one bad experience, one bad experience in the hospital. I was 11 years old, you went up to North Infirmary for the dental mechanics, they were apprentices so to speak. In one particular case, he was cleaning out my mouth and he put a little bottle of disinfectant or something, it tilted over and spilled on the cotton wool and I saw it and he just caught it and stood it up again. But later on, he grabbed a bit of that cotton wool and put it into my mouth and it burned the whole inside of my mouth. I had that for a couple of weeks I remember it well. That was the only bad experience I remember as a child now. On a couple of occasions I'd have to go in for a fall or whatever but no real bad experience.	No problem Not like others Tonsil surgery Historical perspective Doctor house calls Medical care in the home Old times Negative experience as a child Dentist in training Burned mouth Personalised care Memories of a bad experience Isolated bad event Occasionally utilises services

	What about in terms of the healthcare professionals you were dealing with and how has that changed over time?	
I **P**	That time, the doctor knows everything, he'd always give you a prescription and he'd solve your problem but I had no bad experience with any of them until we got married. Now when you get married it's a different issue altogether because now you're concern is for yourself and your wife and if you go on to have children after that. That was before the VHI. It was the National Health then and everything was done through that. There was no problem, there was no waiting and I never remember it being a matter of money. Doctors were very good because when you selected a doctor, he was the man you went to for everything. We never had to change a doctor. The health system for me that time was grand. If I remember correctly, specialists were not really dominant at that time. Now, there were specialists obviously, the man for the ear, nose and throat was a specialist but we never looked on them, we looked on them as a doctor but he was a doctor of eyes and all the rest of it. Over the years, my family and myself had various episodes of things requiring a specialist but because of my insurance etc we never had a problem getting anything done that needed to be done. As one got older then, the system changed quite considerably.	Historical perspective Medical authority No problems Solution through prescription Extra family responsibility Medical cover Centralised systems No waiting times One doctor solved problem Stayed with one doctor All-inclusive medical care Less professional diversity Less specialists Memory of one specialism Professional status Accessing a specialist Insurance provided safety Advantages of insurance Well looked after
	In what way?	Getting older
I **P**	There was more emphasis on seeing specialists about this, that or the other thing, like do you know. In other words like, I wasn't a specialist in welding and I knew everything about welding. Now you're talking to someone who knew everything about practically nothing. That's what a specialist was to me, someone who know more and more about less and less until they know everything about nothing. And it was so specialised. So your doctor would say to you, if you come along with something wrong with your ear and he said look I'll send you to such a person...you would have thought that he would have been able to solve your problems straight away that changed dramatically. I have	Changes in healthcare system Niches developing Increase in specialists Expert by experience then not now Increased but constricted knowledge Questioning value of specialists Reduction in utility of knowledge/skills

	a condition called haemochromatosis, this requires that every so often, they take a pint of blood off me and I still attend a doctor for this. But this is where I begin to see from another angle now. When I was working and I was in the National Health that was all covered. When I went on a bit and especially when near retirement, I went on the VHI, my whole family now are on the VHI, grand, everything was covered. The whole system changed. For me anyway, the personal thing seems to me to had to change. You have a specialist there, and in most cases, you have 4 or 5 people hanging onto him, training and all the rest of it. In no time at all, they're looking after ya, he just comes in, he pokes his head in and has a good look like. I'll go up now to give a pint of blood and some mornings that's all I see of him and there's a bill gone out for that. When the bill comes in for that, you're saying, "Jaysus, sure he wasn't even near me". You get the impression like, whats all this money for here? I asked a question one day, I said "If I have a medical card..can I get him to do it?" "If he will do it they told me". They didn't want to and that's the first thing they'll ask you when you go into the hospital. So, the money thing came out very very strongly to me, very very strongly. That the doctor was putting all this fee up and he wasn't earning it at any stage.	Less direct medical care from GP Onward-referring increased Shifting perceptions about doctors Personal medical condition Different vantage point System changes in healthcare Ageing caused a shift in experiences Insurance becoming more important Age impacting experiences Reduction in personalized care More clinical Reduced value for money Reduced contact time Questioning value of new procedures Financial concerns emerging Care becomes a choice rather than a duty
I	**So there seems to be 2 changes you've noticed as you've gotten older. One, is the emphasis on the specialists and having to go see specialists and the second one is an emphasis on money.** There was no question about that. **What about the attitudes of the health professionals you were dealing with, did you notice any changes over time as you got older?** Some of the doctors were a little bit aloof, do you know what I mean.	Financial concerns are now primary focus No value for money Changes in care

	In what way?	
P	They didn't make you feel as comfortable. This is back along now, a doctor was someone who was a way above you do you know what I mean. They were a little bit up there. You didn't ask them anything, you just listened to them you know and you'd have to assume on how they behave. My wife goes to a specialist twice a year, lovely gentleman and all the rest of it but he's not a friend if you know what I mean. My family doctor I can go to him and I can say anything to him. I have no problem saying anything to him which is what a family doctor should be like. But when it comes to specialists they do tend to be a little bit aloof. You're there alright but you're a big earner for him.	Healthcare increasingly more clinical
I		Impersonal
P		Historical perspective
I		No longer at ease
P		Heightened status
		Social superiority
		Not comfortable asking questions
		Medical authority
		Specialist vs GPS
		Easier to talk to GP
	Has that been something you've felt increasingly as you've gone through the system?	Familiarity
		Expectation of role
		Different relationships with different professionals
	Ya, I did, I did feel because when I had six children, I had the whole family in VHI, Plan B with options, that was as good as you'd want like you know. That was grand, then they all got married and that and we still kept a good plan. But then it was kind of expensive, "Jesus what's all this money for?" Because when I saw the bills I was getting from the hospital for being up there for about a half an hour and every time I get in there now, it's gonna cost E100-150 to take a pint of blood off me.	Specialists less personable
		Healthcare as a financial transaction
		Questioning value of insurance
		Imbalance between care received and money paid
		Price of procedures
I		Increased communication between professionals
	You've talked about gps and specialists and doctors in hospital. I'm interested to hear about other healthcare people such as nurses or other healthcare staff that you've had, how has your interaction been with them as you've gotten older....has it changed?	
P		Historical perspective
		Medical authority
		Status is not as evident now
		Change in doctors position
		No bad experiences
	No, it has not. I would say myself possibly that the nurses are able to communicate a little bit better with the doctor. In other words, the nurses are always in attendance when you came in and the doctor was able to discuss things with her.	Differing opinions

I	They were nearly closer together I thought like. Things have changed a little bit that way. Because if I go back a far enough, the doctors were..everybody would stand to attention more or less when they came in do you know what I mean, that was the way it was. That has gone now more or less except if you go to a very high level of specialist.	
P	**And what about their interaction with you...the nurses and the other healthcare staff?** I can't say I had a bad experience, no. You have your own views on things, in hospitals and the rest of it. That's only personal opinion. There was one occasion, getting a cardioversion, they stop your heart, I was in the ward and they came in with all their apparatus and they put a little bit of paper in front of me and they said sign this here and I said whats that and they said that's in case you don't wake up, in case you don't wake up (laughs) I would have thought that was a little sudden that could give someone a heart attack to hear it, that wasn't a good way to do business like.	Memory of a bad experience Heart procedure Lack of explanation of forms Poor bed-side manner of nurse Importance in bedside manner Manner not appropriate
I	**That ties into my next question. You've talked about staff being aloof and difficult to talk to and being 'up here'...im interested in hearing what qualities make it easier or more difficult to interact with staff?**	
P	I'd like to think when you're in hospital you're as important to them as anyone else in the room. I'm a friendly person, I'd salute anyone and I'd like medical authorities to d exactly the same whether it's a nurse, an orderly or a doctor and treat you properly. Be nice to you and not come in to you as if you were an object. I like a friendly attitude. Everybody in the hospital, they're all a little worried and you must compose them, you must make them feel good. You must make them feel that you're very important to them. In the main, I can't remember any bad experience I had of	Dignity and equality is needed Importance of feeling respected Minimisation of social divides Treated as an equal Importance of attitude Vulnerability of patients Role of medical staff

I P	being treated badly like that. I wouldn't like to be in the bed now and a doctor would come in with a bunch of students hanging onto him and you feel like an object there. I would prefer if that doctor came in first and said I'm going to bring in a few people there just to show them and explain to you etc not to come in on top of you and you don't know who in Gods name is looking at you. You want to be treated with a bit of respect in the hospital. I've never had an occasion, I don't think where I've felt very very badly about that. It pains me an awful lot to think that people are in hospital and they're out in the corridor. I can't understand that mentality in this day and age. It all comes down again to bad management at the top. **You've talked about your experiences in the healthcare system as a young man, a family and an older man. Coming from the position you are now, what needs improving, what needs changing in our interactions with healthcare staff?**	Containment of worry is key Need to feel important Overall experiences fine Dislikes crowds of medical students Informed consent should be prioritised Feeling like an object Awareness of other's negative experiences Patients on trolleys Difficulty understanding why Attributes to bad management
                  I	I can only come at this from a personal angle. My wife, she's slowing down a lot and she's attending a doctor and she attends a specialist twice a year. She's getting enough, she's getting enough but a lot of the year...how will I put it...alot of the attention she's getting, it's to keep you going, to keep you ticking over, not curing anything, not preventing anything just to keep you out of trouble. It's like taking an aspirin now if you have a pain in your head. You'd like something a little more thorough. My wife, I keep getting things for her in the chemist and I said to myself surely they could do more than that like you know. Again, would that not come back to our family doctor, if she sees a thing a specialist could help more with, surely it would be her option to advise her to go to the specialist. You must have money to go to a specialist number one. Big money involved there. That's a deterrent for a lot of people, unfortunately. And I do think the specialists are after getting into the act now and they know	Personal experiences Increased medical needs with age Management rather than cure Maintenance rather then prevention Treating systems rather than causal factors Care not at an adequate standard Over-emphasis on medication Better care needed for elderly Role of the GP in recognising more care is needed

P	where they get most of the money. There are good people out there and they do a good job. I think the specialists in the most cases are overpaid for the amount of work that they do.	Role of money in getting needs met Financial concerns preventing engagement Diversity in quality of care received Money paid does not reflect care received Specialists overpaid

Appendix M

Extended Thematic Analysis

Theme one: Changing Times

The findings of the current research suggest that historical experiences of the health system play a considerable role in shaping older people's current perspectives of their healthcare interactions. The participants included in this study were born and raised in an era whereby healthcare professionals, and more specifically physicians, were revered. Participants told anecdotal stories of having to 'tip their hat' as a way of social curtesy when meeting the doctor in the street. Another participant commented that she did not call a doctor by their first name until she was in her forties. Participants tended to benchmark their current opinions off these earlier, more paternalistic, experiences. In recent decades however, there has been a shift away from this type of medical authoritarianism towards a more collaborative and shared approach between patient and professional. As healthcare consumers become increasingly more empowered through the socio-political context, the media, social media and government-led best practice initiatives, power inequalities between patient and professional have been greatly reduced. However, little attention has been focused on the residual historical effects stemming from this outmoded system and how they may be impacting on the way older people engage with and utilise the service.

Since the early 1990s, there was been an increasing strive towards patient involvement and shared decision-making in healthcare consultations (Elywn, Edwards & Kindersley, 1999) yet, people continue to experience age-biased healthcare interactions depriving them of these privileges. Previous research suggests that older people tend to be more passive in their pursuit of medical information, than their younger counterparts and therefore are heavily reliant on healthcare staff to engage in information sharing and in

making integrated care decisions (Bilodeau & Degner, 1996). Given the historical accounts in this research of the 'don't ask' mentality of the healthcare system of old, it may be possible that when met with difficult healthcare encounters older people do not feel sufficiently empowered to seek more information or to ask questions with regard to medical decisions. Thus, if medical or health professionals do not engage in effective interpersonal communication and provide appropriate advice and information, older people are likely to be at an increased risk of receiving suboptimal healthcare.

Within the theme of change, there was an acknowledgement of the overall progression in the health service as a whole. Participants provided mixed reviews on the evolution of the system, highlighting both positives and negatives. Whilst improvements in overall health personnel attitudes were noted, there was also reference to the drawbacks related to its' transformation. The increase in the number of professionals involved, particularly in acute care and the waiting periods to attend specialists were the two most frequently cited shortcomings. This data echoed similar findings in a study conducted with older people who reported that their healthcare experiences were lacking patient-centredness, were more rushed and were becoming increasingly impersonal (Kelly, Mrengqwa & Geffen, 2019). Participants' in the current study reported feeling 'like an object' or 'just a number' and described experiences of various healthcare professionals demonstrating little interest in interpersonal engagement. While arguably the subjective experiences described by participants are not wholly unique from other groups of healthcare consumers, these findings are particularly troubling in the context of older persons. Previous research has highlighted that pervasive biomedically-focused narratives tend to assimilate the process of aging with disease and decline (Phelan, 2011) thereby augmenting the

likelihood of exposure to age-related prejudices. Thus, placing older patients at increased risk of experiencing stereotyped behaviour and consequentially inadequate healthcare.

Engagement vs Efficiency

Good quality healthcare may encompass a range of features from adequate information provision to integrated decision-making. Particularly, the literature illustrates that effective communication between patient and professional is at the epicentre of optimal healthcare standards. For the participants in the current study, the most effective interpersonal communication was reported to occur with individuals' own GP. Patient-centred care refers to healthcare interactions that are mindful of patient needs, values and preferences with a view to informing and advising clinical decision-making (Institute of Medicine, 2001), a definition appearing to fit respondents' descriptions of their most highly rated healthcare experiences. Participants identified feeling "listened to" and being made a priority as primary components in successful healthcare communication. They acknowledged the importance of gradually building trust with the GP and the level of support garnered from the relationship.

The reported negative experiences frequently centred on acute healthcare settings such as hospitals and other inpatient mental-health environments. Less positive interactions were characterized by evoking feelings of helplessness and powerlessness. Some of the participants used phrases such as 'when I wasn't myself ' to refer to the period when they were hospitalised, as if to make a distinction between their own sense of self-identity and the period spent as a patient. Naturally, when a person is ill or hospitalised, ones' vulnerabilities are heightened and alleviating these stressors should be a central tenet of person-centred care (Hobbs, 2009). In the experiences described, there was a lack of recognition on the part of health professionals towards this vulnerability and potential threat

to one's identity. As a result, participants were left with an acute sense of reduced self-worth and importance. Participants tended to attribute negative experiences to factors such as; overworked and time constrained staff or inappropriate settings rather than assign blame to personnel specifically. Furthermore, previous research has illustrated that healthcare professionals hold negative attitudes towards individuals with mental health difficulties (Henderson et al., 2014) and older adults are susceptible to facing 'double stigmatisation' in the form of biases towards both age and mental health (Werner et al., 2009). Therefore, it remains somewhat difficult to disentangle whether the negative experiences described in the current study stemmed from age-stereotyped behaviours, other patient-related stigma or a combination of both. What is known however, is that the negative interactions described by the participants impact older people's ability to seek care of the health system (Makris et al., 2015), in turn, making it increasingly difficult to support the overall health and well-being of older persons.

Ageist Experiences

There were, however, examples of what the literature would describe as explicit incidences of ageism or age-related prejudice reported in the data. Ageism events can be implicit or explicit and examples of both were presented by the respondents. Ageist interactions can be nuanced and covert in nature and due to its subtlety can frequently be overlooked or go unnoticed. Direct examples, such as physicians directly attributing presenting health issues to age are easier to identify than for example, an older person being disregarded by healthcare staff. Perhaps one of the most confounding aspects of ageist communication is that it can be totally well-intentioned. (Gendron, Welleford, Inker & White, 2016). This finding is interesting, given that participants describing ageist incidents did not identify or recognise the situation as fundamentally ageist. One of the proposed

reasoning for the non-identification was attributed to the lack of available language by older people to accurately describe the experiences (Minichiello, Browne & Kendig, 2000). However, participants were able to identify experiencing physical acts of ageist behaviour in day-to-day life, such as, getting pushed by younger, more physically able people in order to skip ahead in a queue. A more likely and potentially more harmful explanation may be that ageist sentiments have become so entrenched within our society; that older people have developed a sense of internalised ageism. Internalised stigma is equally as problematic in its ramifications for older people as is externalised forms of stigma. Research illustrates that internalised ageism is linked to a range of poor health outcomes (Coudin & Alexopoulos, 2010; Levy, Slade, Kunkel & Kasl, 2002).

Notwithstanding, as previously mentioned, the utilisation of strategies by participants indicates an awareness, whether conscious or unconscious, of the need to maximise opportunities for better care. Suggested strategies included, employing humour to charm health professionals, stemming from a belief that being liked equates to better care. This particular strategy could be considered a direct example of internalised stigma given that the literature has indicated that health professionals do hold beliefs that older people are cranky, irritable, and depressed (Reyes-Ortiz, 1997). Further strategies involved maintaining a sense of personal responsibility for ones' own health during periods of hospitalisation and endeavouring to avoid being admitted to hospital entirely. One participant, having experienced a distressing incident occurring as a result of staff negligence, noted his difficulty in 'trusting the system'.

Another identified strategy for better healthcare was acquiring private health insurance. Though not questioned directly on financial or insurance-related situations, the topic of private and healthcare emerged in several of the interviews. Participants alluded to

the advantages of having private insurance and relayed more positive narratives about the health system than those who were public patients. This finding corresponds to previous research reporting that private patients receive better quality care and have higher self-report health ratings than patients in the public healthcare system (Peltzer & Phaswana-Mafuya, 2012). Given that the majority of participants were private health patients, it is possible that the current findings depict a slightly more positive portrayal of the health system than if the sample had included more public patients.

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