The role of professional education in promoting the dignity of older people

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ABSTRACT

This paper considers the education of social and health care professionals who work with and care for older people. It asks whether education can promote the dignity of older people, how this may be done, what factors may ease or impede the promotion of dignity within professional education, and what part education plays alongside other influences on care practices.

Beginning with consideration of research on the nature of professional education, the paper reviews principles of professional education, cultures and methods of teaching and learning and processes of practical apprenticeship. The paper argues that there are a number of challenges to the promotion of dignity within professional education, for example, inconsistencies in development of professional values, curriculum contradictions such as those between education for management and for direct care of older people, the balance between theory and practice and education for practice under changing real-world conditions.

KEY WORDS

professional education  dignity  older people

teaching methods  professional practice

INTRODUCTION

Almost all societies are ageist; ours is no exception. Negative stereotypes of older people and discriminatory practice abound both in health care and elsewhere (Lothian & Philip, 2001; Roberts et al., 2002). However, a good deal of attention has recently been paid to improving the way that older people are treated. Government policy has been active in
this respect – for example the Service Framework for Older People emphasises person-centred care and the rooting out of age-discrimination. It is now much more widely understood that old age does not necessarily mean decrepitude and disability, that the older population is hugely heterogeneous, and that most older people are fit and active and fulfil important roles in the labour market, or for example as carers, consumers or community activists. Nonetheless, older people often feel humiliated and belittled in many areas of their lives: seen as a burden on the working population, viewed as ugly or incapable, treated in impatient or patronising ways.

Extrapolating from the findings of this European project one can identify four major aspects of dignity which are challenging for professional practice:

- promoting (and assisting older people to control) their personal appearance and presentation of self as suits their preferences and sense of self-respect (the challenge here is that professional practice may both aid the older person to retain this type of dignity and explicitly violate it)
- promoting the person’s privacy and personal space (a challenge in that social and health professionals often have to breach that space)
- enabling an older person’s involvement in and control over choices and decisions about his or her life (a challenge when a person may have difficulty in making choices or when it seems easier to the professionals to make them themselves)
- advancing older people’s ability to challenge the environments and structures that accord them lack of dignity (an issue for professionals who may or may not see it as part of their role to help people develop these abilities and who may also have an interest in preserving the status quo).

Since ‘dignity’ features so prominently in professional codes and standards, we might assume that it features in professionals’ education. For example, the code of practice for social care workers in the UK has as one of its standards ‘respecting and maintaining the dignity and privacy of service users’. The GMC’s code of practice, Good Medical Practice, says much the same, that doctors must ‘respect patients’ dignity and privacy’. Tomorrow’s Doctors, the GMC’s recommendations on medical education, states that the principles (such as the one about dignity) should be ‘at the centre of undergraduate education’ and that students and doctors must respect patients. It says that students must develop the right attitudes as well as the right behaviour, skills and knowledge. They must be given opportunities to practise the necessary patient-centred skills such as communicating with vulnerable patients, as well as to develop understanding of topics such as the psychology and sociology of ‘growing old’.

Although the topic is relevant to several professions this paper focuses on the education of health and social care professionals because promotion of dignity is so central to their work with older people. The promotion of dignity is a complex subject for education, as the four elements described above indicate; however its complexity is not addressed in Tomorrow’s Doctors, where dignity is mainly linked to privacy and where the challenges of ‘respecting’ it are not delineated. However, extrapolating from the four elements one can see that learning to maintain or promote dignity of older service users will involve:

- learning about older people, what they are likely to prefer and how to elicit their preferences
- learning an attitude set which makes it likely that dignity will be respected
- learning how to practise in such a way that dignity is not breached, or if it is, that it is done in such a way that the service user can accept it
- learning how to involve users in decisions and to respect their preferences, and especially how to do that when the older person may have difficulty in decision-making, or when environmental or resource constraints obstruct it
- learning to what extent the role of the professional may involve trying to change aspects of the environment which threaten older people’s dignity or to help them to challenge such threats.

**Enhancing Dignity through Education**

Thus education for dignity involves:
• learning knowledge. Learning more about old age and older people from a multi-disciplinary perspective, and how they compare with younger people as well as with older people in former times or other cultures, will help students to appreciate their preferences and points of view; their experience and capabilities, their roles and contributions. We know from research that nursing, medical and social work students’ knowledge about ageing is limited and variable (Beall et al., 1992; Reed et al., 1992). Multi-disciplinary Masters programmes in Gerontology are an ideal vehicle for educating health and social care professionals, through study of the sociology, psychology, economics, social policy, health care, biology and demography of ageing and later life. However, whilst there is little doubt of the need and demand for professionals educated in gerontology at postgraduate level, such courses are few in number in the United Kingdom and lack of the resources to study frequently deters applications and suppresses demand. Unlike some areas of study a masters in gerontology does not generally feed into a well-funded, high prestige private sector of the economy well able to give financial support. For gerontology, such support only comes from sustained pressure by the academic and professional community on potential employers and governments to convince them of the benefits of fostering these degrees (Askham et al., 2005). Teaching and learning knowledge about ageing is complicated by the fact that (i) such knowledge is seen very much as a background to the competencies or skills which professionals need in order to do their jobs and is thus likely to receive less attention and time in a curriculum than it needs (Reed et al., 1992), and (ii) that a good deal of the curricula of social or health care students is not about how to work with people but how to manage work, or how to categorise clinical or care situations. Such topics will not help students to see their patients or clients as individuals.

• learning attitudes. Attitudes towards older people will have been formed already even before people become students (though they can change), evidence showing that the greater the contact with older people, such as a close relationship with a grandparent, the more positive and the less stereotyped the views (Deary et al., 1993; Haight et al., 1994). Increasing knowledge and contact with older people can improve attitudes (Hope, 1994; Skog et al., 1999) but there are also some more practical learning tools. For example there have been a number of innovatory educational schemes designed to inculcate dignity-promoting attitudes. In the field of dementia care, where the challenges are perhaps greatest, the work of Kitwood (1997; Kitwood & Bredin, 1992) and his dementia care mapping, with its identification of principles and practice, was pioneering in encouraging person-centred care. However, as Nolan et al. (2004) state, ‘some have begun to doubt if person-centred care can actually be achieved, and to question whether it is simply an evangelical idea’ (Packer, 2000). And as Nolan et al. (2004) also say ‘the most commonly adopted ‘models’ of nursing provide little or no guidance about how to work positively with older people.’ Their own ‘senses framework’ is an approach which enables the subjective experience of ageing to be taken into account in the caring process and involves a set of postulates for caring relationships, which include the goal of maintaining the dignity of older people and enabling them to exercise choice (Nolan et al., 2001). This model, however, is still in its formative stages with no clear guidance yet on how it can be taught. Somewhat similar is the model proposed by Hart et al. (2003) which sets out a framework for helping health and social care professionals to develop an ‘inequalities imagination’ to sensitise practitioners to promote the dignity of disadvantaged groups of service users (though not designed specifically with older people in mind).

• learning practice. The importance of practical or clinical experience during students’ training has been strongly emphasised. But again evidence suggests that learning practice for promoting dignity often comes up against obstacles. For nurse students, for example, the educational experience has been found to have a negative effect on their attitudes and motivations, where they have also picked up negative messages not only about
gerontological work but also about older people themselves (Nolan et al., 2004). As one study in England showed, students may be taught how to do something – such as handling patients in a way that preserves their dignity – but on the ward they do not practise in that way, either because they do not want to lose face among the trained staff who practise in a different way, or for lack of time or equipment (Swain et al., 2003). Again one can find a number of practical proposals or initiatives, some of which appear to be implemented, but little evidence about ease or difficulty of implementation and very little indeed on their benefits or effectiveness (McCormack, 2004). These include training in how to elicit older people’s goals and preferences so that these can direct their care (Clarke, 2000; Packer, 2003), and how to foster a positive, companionate relationship between professional and older person (Johns, 1994; McCormack, 2001; Titchen, 2000).

Whilst medical, nursing and social care all appear to have developed ideas about how to work with real older people in dignity-promoting ways, they have also moved in a somewhat different direction, with simulated patients (dummies, actors, computer-simulated patients) and students simulating patients and written hypothetical cases being used to help students learn how to practise. While this is seen to hold promise as an educational tool for helping medical students learn how to involve patients in their care (Edwards & Elwyn, 2001), some aspects warrant further scrutiny. For example, do problem-based hypothetical cases really help students to understand real people? A recent textual analysis of a sample of such cases revealed that they were mainly written in the passive voice, with little sense of agency, and that ‘there was almost no sense of the presence of the patient as person’ (Kenny & Beagan, 2004) and the authors concluded that such cases may actually encourage the detachment of students from ‘the messiness of real patients’ lives and emotions’. This may be even more likely to happen with computer-generated ‘standardised patients’, where even though the learning objective may be technical proficiency rather than patient-centredness, they may nonetheless affect students’ views of what patients are like (Backstein & Reznick, 2003). Conversations with real people, whether they be patients or other professionals look likely to have more positive outcomes. For example, patient-focussed inter-professional workshops appear to have some benefits, such as in improving communication skills with patients, despite some problems of attempting to work across professions differing in status (Kilminster et al., 2004) and introducing groups of elders as student advisers also appears to hold the promise of enhancing practice (Katz et al., 2000).

CONCLUSIONS: CHALLENGES TO PROGRESS VIA PROFESSIONAL EDUCATION

There are many challenges to the promotion of dignity through professional education, partly arising from the characteristics of old age (where some of the age-related illnesses and disabilities, such as dementia, incontinence or severe arthritis, make it harder for older people to retain dignity by their own efforts), but more to do with the nature of education and the environment and structures within which education takes place.

As far as the educational process and provision is concerned seven challenges can be highlighted, all of which are relevant to dignity promotion among older people, but many of which are of more general relevance.

- There are inconsistencies in educational goals and values such as those between education for management and education for practice. The former distances the professional from patients or service users, seeing them as inputs or as statistical aggregates.
- There is a theory–practice gap, whereby what students learn in the classroom has to be applied in real world situations where organisational structures and resources, and the attitudes of other professionals will intervene.
- There are difficulties in learning with real people. How can one learn how to treat people with dignity if one is practising on a
dummy or other simulated scenario? Yet, to what extent does it jeopardise the dignity of real people to allow students to practise with them?

- There is growing emphasis on learning competencies. But unless the training in competencies also includes knowledge and attitudes that are essential to learning dignity promotion they will not affect practice. Competencies for promoting dignity of older people cannot be seen as a simple bolt-on – like learning how to set up a drip or operate a hoist. And superficial competencies such as how to address an older person may mask continuation of indignity at a deeper level.

- The educational process and student culture affect trainees in ways that are not conducive to enhancing older people’s dignity. Although the evidence is mixed, throughout their training negative dispositions appear to be heightened among nurses and social workers (Reed et al., 1992). The same seems to be true of medical students whose ability to communicate with patients (even though this may be a transitory phenomenon) has been found to deteriorate ‘as they proceed through medical school’ (Towl & Godolphin, 2001).

- More fundamentally, it has even been asked whether, because of its complexity, promoting the dignity of older people can be taught at all, especially when much of the way professionals behave towards older people is acquired before their professional education. For example, Caris-Verhallen et al. (1999) found that the factor relating most strongly to the way nurses communicate with elderly patients was their former educational level.

- Finally, there is the challenge of inadequate provision of training. There is a lack of specialist courses in gerontology in the United Kingdom, and within programmes of study insufficient time devoted to the study of ageing and dignity promoting care such as communication skills (Elwyn et al., 1999).

As for the wider environment within which education occurs, the following challenges can be picked out:

- Societal values and attitudes, enshrined in structures and fabrics as well as within organisations underpin the low status of work with older people. Perhaps not unexpectedly work with older people is seen as of low esteem, boring and unrewarding among a wide range of health and social care students (Standing Nurse Midwifery Advisory Committee, 2001; Happell, 2002; Mackinlay & Cowan, 2003, Lee et al., 2003; Nolan et al., 2002). If professionals view their work with older people as of low status, and their own motivation is low, they will not be in the best position to accord dignity or to teach others to accord it.

- Resources may militate against the kind of practices (and education for practice) which would most achieve dignity for older people, eg, time for communication and funding for choices to be realised. The stresses of work in health and social care are also part of this problem.

- The fact that professionals will generally only see those who are in need of care and treatment, and have insufficient acquaintance with normal ageing, will lead almost inevitably to them holding a medical model of ageing and therefore negative stereotypes of later life.

- There is inadequate conceptualisation of, and research on, the topic. For example some argue that patient-centred care is an over-individualised concept and a product of an individualistic and consumer-orientated society. It therefore does not promote dignity, which requires more attention to the person in his/her social context and to the relationship between older person and professional (Nolan et al., 2001). Also, as there has been insufficient research on dignity-enhancing practice, even though there are some encouraging ideas and new practices we still do not know what works, nor therefore how to teach it in educational context.

References


