"It's just your age, you gotta expect that": Older adults' experiences of ageism in healthcare

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Abstract

Ageism towards older adults in healthcare has historically been researched and understood quantitatively with specific focus on objectivity and the particular from the perspective of healthcare providers. The purpose of this study was to explore the subjective experience of ageism in this context from the accounts of older adults themselves. With Interpretative Phenomenological Analysis (IPA) as the framework for this study, three older adults were interviewed to deepen this understanding across different angles. Five themes emerged from participants' accounts. The Foundational Components of Ageism centred around participants' confidence of age as the cause of their treatment. Their confidence was influenced by their assessment of why and how often ageism occurred alongside recognition that differential treatment began in their older years. Complexity of Self-Advocacy highlighted why participants advocated for themselves and the approaches they took. This did not always have the intended outcome and support on behalf of another individual was often needed to stop discrimination. Removal From Situations described how the emotions participants experienced by not having their voices heard motivated them to step away from the situation. The Impact of Ageism delved into the varied and sometimes opposite ways participants were affected. Lastly, Non-Ageist Experiences detailed the positive encounters in healthcare. For participants, this signified what they wanted or expected to see throughout the system. This thesis is one of a small number of studies that focuses on the older adult perspective and has contributed to the study of ageism in healthcare research. By using IPA, the findings demonstrate how experiences of discrimination can share similarities while uncovering different ways to conceptualise ageism towards older adults.

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Chapter One: Introduction and Literature Review

Population Ageing

Defined as an uphill trajectory of the proportion of the population towards older adults, population ageing is occurring at a global level at an increasingly faster rate. Adults aged sixty and above accounted for 12% of the global population in 2015 which is projected to increase to 22% in 2050 at 2.1 billion people. This will have doubled from 1 billion in 2020, increasing to 1.4 billion by 2030 (World Health Organisation, 2022). For adults aged sixty-five and above, there is an estimated six percent increase from 10% in 2022 to 16% in 2050 (United Nations, 2022). Larger changes are anticipated for the eighty and above demographic with the population predicted to triple to 426 million people from 2020 to 2050 (World Health Organisation, 2022). This global shift can be attributed to lower mortality rates and advances in medical care that has increased the global life expectancy from 66.8 years in 2000 to 73.3 years in 2019 (World Health Organisation, 2022). Alongside this, decreasing fertility rates has produced a change in the direction of the age distribution between older and younger populations. It is predicted that by 2050, the global number of older people aged sixty-five and above will be double than the global number of children under five years of age and a similar number to children under twelve years of age (United Nations, 2022).

Similar patterns of population ageing are occurring in New Zealand (Ministry of Health, 2023). Older age is legally defined as sixty-five and above (Ministry of Health, 2016) and older adults will compose of more than 20% of the country's population by 2035 with 10% aged seventy-five and above, and 5% aged at least eighty-five. As with the global patterns, this can be attributed to increased life expectancy (Ministry of Health, 2023), rising from 78.6 years in 2000 to 82 years in 2019 (World Health Organisation, 2023), and decreasing fertility rates (United Nations, 2022).

Age-Related Health Characteristics

As people age there is increased use of care services, particularly in healthcare (Elbourne & le May, 2019) and the type of healthcare differs significantly. Some may require medical appointments whereas others may need long-term care (Buttigieg et al., 2018) to retain functioning and longevity (Wyman et al., 2018).

Age-related differences in the acquisition of health conditions are the result of higher susceptibility to illness and mortality for older adults (Jecker, 2020). Although health conditions vary widely, they commonly include diabetes, visual impairment, hearing loss, and back and neck pain (World Health Organisation, 2022). Alongside this, geriatric syndromes refer to states of ill health that is not situated within distinctive classifications of medical conditions and includes, falls, urinary incontinence, frailty, and delirium that can have a profound impact on one's quality of life (Inouye et al., 2007).

The prevalence of geriatric syndromes have been found to be around 70%; about 65% for adults aged between sixty-five and seventy-four and about 80% for those aged between seventy-five and eighty-four years. Over all ages, injuries resulting from falls and functional decline has a general prevalence of 20% with urinary incontinence at 25%. Among the sixty-five to seventy-four age group, injuries from falls, urinary incontinence, and cognitive impairment has a prevalence of 17.6%, 23.3%, and 52.7% respectively whereas for those aged seventy-five and above the prevalence rises to 24.5%, 32.5%, and 62.9% (Liang et al., 2018; Tkacheva et al., 2018).

In New Zealand, the presence of two health conditions is most common among older adults (31.0%) compared to three (19.7%), and at least four conditions (12.0%) and is slightly more common than having one health condition (28.5%) and substantially more than having none (8.8%) (Abey-Nesbit et al., 2023). Data on health statistics divide older adults into three age groups; sixty-five to seventy-four years, seventy-five to eighty-four years, and eighty five and above. Globally, multimorbidity, the acquisition of at least two chronic health conditions (World Health Organisation, 2022), has a general prevalence of 62.0%, 71.7%, and 78.0% respectively including conditions like hypertension (60.6%), dyslipidaemia (51.2%), and pain disorders (34.0%) (Ofori-Asenso et al., 2019) and in New Zealand, hospital discharge data for multimorbidity show a prevalence of older adults at 17.1%, 30.7%, and 43.3%. Pharmaceutical data had an overall higher rate at 55%, 71.7%, and 80.4% (Stanley et al., 2018).

Within emergency departments (ED), Lee et al. (2018) found that older adults made up 16.9% of ED data. Medical causes (such as spontaneous internal organ dysfunction) encompassed 80.6% of all ED visits at 79.5%, 81.3%, and 81.7% by age, whereas 19.4% were non-medical causes (such as general procedures) at 20.5%, 18.7%, and 18.3%. Patient transfer had a positive correlation with age (12.2%, 15.4%, 17.5%) with hospitalisation rates at 40.3% (35%, 42.8%, and 48.5%). Internal medicine had the highest admission rate at 59.5% (57.5%, 59.3%, and 64%) and discharge rates after an ED visit had a negative correlation with age (58.4%, 50.7%, and 42.6%) with similar patterns found for discharge after hospital admission (84.5%, 78.8%, and 71.5%).

Among older adults aged between eighty and ninety in New Zealand, the general practitioner (GP) and pharmacist were the most used services over a twelve month period at 98% and 87% respectively. Optometrists and practice nurses were also seen regularly at 53% and 46% (Ministry of Health, 2015).

Higher patterns of healthcare usage as a result of susceptibility to health conditions leads into differences in healthcare use, whereby older adults use a significant portion of the costs of healthcare systems (Jecker, 2020), and in New Zealand, these costs are growing faster compared to other resources. Population ageing is a direct cause of these patterns and while the proportion of older adults requiring these services is not increasing, the numbers are

(Ministry of Health, 2023), alongside a lack of recognition of the effects on the healthcare system from industry planners (Clendon & Munns, 2014). There is a concern that financial and human resources will not keep up with this change, nor with changing health needs and with the age distribution shift, there will be a reduction of the proportion of people who typically provide care for this demographic (Elbourne & le May, 2019).

Overall, as people age there is increased susceptibility to ill-health, particularly with the acquisition of multiple conditions. This is reflected within older adults' use of various healthcare services wherein they make up a significant portion of patient statistics and subsequently use a substantial amount of healthcare costs. With the increase in these costs comes concern over its impact on healthcare systems.

Ageism in Healthcare

Consequently, population ageing has economic, health, and social repercussions (Elbourne & le May, 2019). One of these social consequences is an escalation of ageism towards older patients from healthcare workers (Pritchard-Jones, 2017).

The term 'ageism' was first coined by Robert Butler in 1968 as a type of discrimination embedded in society that is ignored, manifesting through then-present laws such as mandatory retirement. Butler described ageism as prejudice against members of an age group by members of another age group, particularly the younger and middle aged, out of a dislike for the associated views of death, illness, disability, and hopelessness that is strengthened through cultural norms that isolate older adults from society (Butler, 1969). The definition of ageism has undergone many transformations since the first conceptualisation (Iversen et al., 2009) and has now been defined by Sao Jose and Amado (2017) as "negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) us on the basis of our chronological age or on the basis of a perception of us being as being 'old', 'too old', 'young', or 'too young'. Ageism can be self-directed or other-directed, implicit or explicit and can be expressed on a micro, meso, or macro-level" (p. 375). Research on the prevalence of ageism in healthcare has consistently found an average of 26% of older adults reporting at least one experience of age discrimination (Ayalon & Cohn-Schwartz, 2022; Dobrowolska et al., 2019; Shin et al., 2019; Shpakou et al., 202), increasing in frequency with age to 31% of adults aged eighty and above (Elliott et al., 2022; Shin et al., 2019).

The Ecological Systems Theory

Ageism in healthcare has been theorised within Urie Bronfenbrenner's ecological systems theory, a conceptualisation of an individual's development within proximate and broader internal and environmental levels made up by the *individual, micro-, meso-, macro-, and exosystem.* Despite being developed within child development literature, the ecological systems theory has been shown to have direct relevance to ageism in healthcare that can affect the development of older adults (McNamara & Williamson, 2019).

The Individual

At the centre of the ecological systems theory lies the biopsychological elements of the individual (Bronfenbrenner, 2000) which are characterised by developmental theories of the internalisation of age stereotypes across the lifespan (Ayalon & Tesch-Romer, 2018). Acquisition of positive and negative stereotypes of older people begins in early childhood (Nemiroff, 2022) with negative stereotypes often relating to poor physical health (e.g., disease and backache) (Flamion et al., 2020) and positive stereotypes to warmth (e.g., friendliness). However, these judgements of warmth become increasingly negative with age across children and adolescents (Vauclair et al., 2018). When one reaches older age, these stereotypes gain prominence in everyday life (Levy, 2009), affecting expectations of ageing that become unconsciously and automatically self-fulfilling. Research has shown that ageism, and the affiliated health stereotypes, has been associated with poorer self-perceptions of ageing, quality of health, preventive health behaviours such as physical activity and consumption of nutritious diets, and healthcare satisfaction. These relationships increase over age and correspond with older adults perceiving his or her age as a direct cause of ill-health (Abdou et al., 2016; Ayalon & Cohn-Schwartz, 2022; Kotter-Gruhn & Hess, 2012; Phibbs & Hooker, 2018; Stewart et al., 2011). Since ill-health is also often diagnosed as occurring from ‘old age’ it reinforces these beliefs and leads the underlying causes to remain undiagnosed and untreated (Ouchida & Lachs, 2015). Unsurprisingly, experiences of ageism have been linked to an uptake in hospital admissions, readmissions, length of stay, and a decline in mental and cognitive functioning (Nemiroff, 2022) that costs the United States healthcare system $63 billion per year (Levy et al., 2020).

The Microsystem

The microsystem is the most immediate environment to the individual and consists of processes that occur in daily settings (Bronfenbrenner, 1994). Here, the most noticeable occurrences of ageism in healthcare take place comprising the interactions between provider and patient (McNamara & Williamson, 2019). Research on ageism in healthcare largely centres around the microsystem and healthcare workers’ attitudes towards older adults which consists of three processes; stereotypes, prejudice, and discrimination (relating to cognition, affect, and behaviour respectively). Nurses are often the focus of research due to the large amount of care they provide for older adults (Clendon & Munns, 2014), and in the context of population ageing, research around healthcare workers’ attitudes to and about working with older adults is becoming more relevant (Liu et al., 2015), made more so by research demonstrating that among nurses and student nurses, these attitudes have become increasingly negative since the start of the twenty-first century (Liu et al., 2013). Compared to other disciplines, negative attitudes are particularly widespread in nursing with reported prevalence at 82.8%, 89.9%, and 100%, particularly for younger nurses, with attitudes becoming more neutral with age (Deasey et al., 2016; Lampersberger et al., 2023; Mohammed & Omar, 2019; Ozdemir & Bilgili, 2016; Podhorecka et al., 2022; Rababa et al., 2020; Rababa et al., 2021). In the literature, negative attitudes have been theorised in relation to how positive and negative stereotypes contribute to ageist care, how prejudice is influenced by three components; associations between older adults' and death and illness, knowledge of ageing, and positive and negative interactions with older patients, and how ageist behaviour is showcased through communication patterns and differing treatment recommendations between younger and older adults'.

Stereotypes. Located within social psychology theories, ageism often stems from a combination of positive and negative stereotypes (Vervaecke & Meisner, 2021). As in the individual level, while older adults are largely perceived as warm, they are also regarded as dependent and in ill-health with prevalence of these negative attributes ranging from 63.5% to 74% of studied samples (Carlson et al., 2022; Dobrowolska et al., 2019; Ozdemir & Bilgili, 2016; Sarabia-Cobo & Pfeiffer, 2015; Schroyen et al., 2016). The perceived normalcy of these conditions due to heightened exposure to ill patients (Crutzen et al., 2022; Hall & Hoy, 2012) has consequences for the quality of care as negative perceptions alongside work stress has been associated with decreased competency in nurses (Lee et al., 2023) and the combination of warmth and dependent perceptions is accompanied with an overly benevolent system of care (Vervaecke & Meisner, 2021).

Prejudice. In accordance with theories of prejudice, older adults are associated with views of death and illness and an awareness of one's mortality creates a detachment between younger and older individuals on behalf of the former age group that results in unfavourable perceptions of the latter age group (Martens et al., 2004). As with stereotypes, fears of ageing commonly relate to ill health (75.6%) and decreasing physical ability (66.0%) (Nitschke et al.,

2022) and high levels of death anxiety alongside low levels of self-esteem, interpersonal reactivity, and symbolic immortality were all associated with 58.0% of ageism scores (Rababa et al., 2023). Positive attitudes and a preference for caring for older patients are predicted by lower levels of ageing anxiety (Liu et al., 2015), however, according to Palsgaard et al. (2022) ageing anxiety is an indirect predictor of ageism, mediated through lower expectations of ageing and has a weaker relationship than knowledge and age has to ageing expectations (i.e., younger age is associated with lower knowledge of ageing which predicts lower expectations). However, when examining a direct relation between knowledge and ageism, both high and low knowledge has predicted negative attitudes, but with increased positive perceptions of caring among providers with more formal education (Holmberg et al., 2022; Rababa et al., 2021). Healthcare knowledge constitutes many areas and despite being highly knowledgeable on physical facts, expertise in older patient care is often inadequate (Mohammed & Omar, 2019; Parker et al., 2021).

As with knowledge, frequency of contact has mixed findings in the literature with higher contact correlating with more positive attitudes among dental students and physiotherapists (Nochajski et al., 2011; Podhorecka et al., 2022), but correlating with more negative attitudes among nurses (Holmberg et al., 2022; Lampersberger et al., 2023). Situated alongside theories of prejudice, Drury et al. (2017) found that positive interactions only corresponded with a slight reduction in negative attitudes, whereas negative interactions was associated with a substantial increase in negative attitudes. Although positive contact is related to decreased ageing and death anxiety, these factors, alongside a preference to work with older adults, was lower among those in good health who provided care most often (Gherman et al., 2022).

Discrimination. Ageist behaviour in healthcare occurs through two main ways; communication and treatment recommendations. Ageist communication can manifest through ‘elderspeak’ that mimics how adults talk to young children, functioning within perceptions of dependency towards both age groups, and is one example of benevolent ageism (Shaw & Gordon, 2021). Among nurses in dementia care, elderspeak was prevalent in 96.6% of patient interactions and made up 28.7% of communication. The semantic component was present at 69.3% and included childlike patterns of speaking (44.3%), ‘we’ rather than ‘you’ pronouns (42.0%), and overly endearing words (29.6%). Ninety-four percent of ageist communication was at the discourse level which mainly included lessening the harm caused by the treatment (87.5%) and laughing at or ridiculing the patient (36.4%). The final component at 73.9%, referred to higher pitch, over-pronunciation of words, and patterns of pitch change (Shaw et al., 2022). Schroyen et al. (2018) demonstrated that healthcare workers and medical students spoke fewer words, repeated what they said more often, and described side effects of breast cancer treatment less alongside ways to mitigate them for a seventy-year old patient compared to a forty-year old patient. Positive and negative views of ageing had no impact on the amount of words used or rate of speech, however, these characteristics were present more often towards both ages among those with a negative viewpoint due to a belief that youth ended earlier compared to those with a positive view of ageing. Alongside communication, ageist behaviour is showcased through different treatment recommendations for older patients, such as higher recommendations for immunotherapy and chemotherapy for patients in their thirties compared to patients in their fifties, and lowest for those in their seventies (Schroyen et al., 2016). Neal et al. (2022) observed that between breast cancer patients in their sixties and seventies there was a 3% difference in surgery recommendation (65% versus 61.86%) and a 26% difference between women in their sixties and eighties (43.33% versus 25.89%). Differential treatment, particularly for more dependent patients, is often the result of objectifying the older adult, reinforced by minimal communication, and results in similar care provision regardless of individual needs (Band-Winterstein, 2015).

The Mesosystem

The mesosystem is characterised by the interactions occurring between at least two settings within the microsystem (Bronfenbrenner, 1994). Here, ageism is largely expressed through triadic communication between patients, their healthcare providers, and their chaperones. The third party, most often a family member, plays an important part in the support system of the ill older adult (Stubbe, 2017), as evidenced by one study reporting that 86.5% of older patients specified that most of their support came from their family, compared to 9.7% reporting that it came from their healthcare providers (Repetto et al., 2009). The percentage at which family members accompany an older relative to their healthcare appointment has been reported at 31.3% and 32% and increases with age (e.g. for adults in their late seventies compared to late sixties) and with prevalence of comorbidity (Diamond et al., 2023; Wolff et al., 2013). However, despite the role family members have as a support system, the presence of them in healthcare appointments can lead to the older patient not being directly involved in their own treatment, with providers discussing medical history and treatment plans with the family members instead (Ben-Harush et al., 2017). Diamond et al. (2023) found that when an older adult had a chaperone to these appointments, the physician less frequently discussed information and questions across medical, lifestyle, and psychosocial domains compared to when the patient went by themselves. Extending from this, Repetto et al. (2009) discovered that while the majority of older patients (80%) stated that they felt providers gave an exhaustive and clear-cut description of the information, satisfaction rate decreased to 67.9% of all participants and 56.8% for those who reported not being directly informed. Similarly, 59% stated that they felt their companion did not receive more direct information, however of the patients who indicated this, most of them reported feeling informed. Likewise, the majority of older adults (84.4%) reported that the quality and quantity of received medical information greatly influenced a positive relationship with their provider, however the 25.3% of patients who were uncertain about this relationship, mostly consisted of patients who reported feeling uninformed.

This issue of triadic communication is exemplified among older adults with cognitive difficulties such as dementia, especially considering the difficulties both the patient themselves and their family members face after a diagnosis (Stubbe, 2017). In a study exploring the triadic communication within memory clinics, Karnieli-Miller et al. (2012) found that although the physician is the main contributor to the conversation, they start the appointment by limiting the discussion to the patient only, but over the course of the appointment, the physician converses mainly with the chaperone. Reasoning behind this shift included a belief that the patient only needed to understand the basics of the information provided whereas the chaperone, who was now the main caregiver, were required to deeply understand the full array of the related knowledge. This left the older patient feeling frustrated and confused as to what their role, as the one with the diagnosis, entailed.

The Exosystem

As with the mesosystem, the exosystem refers to the interactions occurring between the microlevel but with at least one setting indirectly influencing the individual (Bronfenbrenner, 1994) and although not included in the definition of ageism (Sao Jose & Amado, 2017), much research explores it in this level. As was briefly discussed in the microlevel, preference to not work with older adults is another example of ageism and one that is represented by the exosystem (Gherman et al., 2022). Despite the high amount of care provided, students' intentions to work with older adults are quite varied and although positive attitudes is a mediator of these intentions, it is not necessarily a predictor (Liu et al., 2015). Among nursing students, preference has been observed at 55%, 61.5%, and 66.3% of samples whereas for other medical students it has been as low as 36%. Common reasons for not wanting to work with older adults include preference for other areas such as paediatrics, lack of interest, less opportunities for career growth, and perceived difficulty and is often influenced by the environment created by teachers and supervisors both with regards to learning and mentorship that reinforces perceptions of illness and dependency as the norm (Ben-Harush et al., 2017; Carlson & Idvall, 2015; Dahlke et al., 2020; Dobrowolska et al., 2019; Ozdemir & Bilgili, 2016). Discrimination is also reinforced due to the minimal consequences given and the supervisory aspect of healthcare institutions that are more concerned with bureaucracy and protocol rather than the level of care provided (Band-Winterstein, 2015). Moreover, within the wider bureaucratic aspect it is quite difficult to introduce policies against the benevolent aspects of ageism present in the microsystem, such as elderspeak, due to it being understated (Swift et al., 2017).

Other well-documented areas concern exclusion in medical trials which limits the development of knowledge about safety and efficacy in treatments of the older population (Inouye, 2021). When included, older people tend to be in their sixties and early seventies, have fewer health problems, and take fewer medications. As such, they do not necessarily represent older adults who use healthcare services more often (Cherubini et al., 2010). In clinical drug trials Beers et al. (2014) found that among trials for diseases strongly connected to age, older adults aged at least sixty-five accounted for 43.1% of the participant population, dropping to 16.1% for those aged seventy-five and above. In trials for diseases that are common in older age, but not necessarily associated with age, 9% of participants were at least sixty-five years of age and 1% were above seventy-five years. The most common exclusion criteria were comorbidities (75.4%), a general state of ill-health (56.1%), and use of accompanied medications or past experience of side-effects (71.9%). In clinical trials relating to cancer, it was found that only a very small percentage (1.4%) of trials specifically focused on those sixty years and above whereas 43.8% of trials excluded older adults via upper age limits, most commonly, between sixty-six years and seventy-years of age, proceeded by seventy-six and eighty years of age. Exclusion of participants aged at least eighty years of age was present in 35.4% of all trials (Krysa et al., 2022).

The Macrosystem

Finally, the macrosystem is defined by the processes within the former levels, but further encompasses one's culture and the broader knowledge, belief systems, customs, and resources within that (Bronfenbrenner, 1994). As a result, ageist attitudes present in the microlevel are not formed in isolation but are done so and influenced by these societal patterns that correspond with the wider population (Liu et al., 2013). For example, Crutzen et al. (2022) found that negative attributions about older adults was most prevalent among both the general population (45%) and healthcare workers (46%) compared to positive (28% versus 36%) and neutral (27% and 18%) attributions. Regardless, ageism at the macrolevel is under-researched despite the pervasiveness of it (Levy, 2022). This level includes policies in healthcare favouring young people in regards to what patients to treat and what treatments to use (McNamara & Williamson, 2019). For instance, with medical treatments, the use of quality adjusted life year (QALY) measures allocates treatment based on quality of life and life expectancy. It is an inherently ageist measure as older adults are often a lower priority (Harris & Regmi, 2012). Situated alongside QALY measures is the fair innings argument, referring to instances of when there are limited resources and older and younger patients require the same resources, the allocation of these resources are biased towards younger patients (Bognar, 2015). Theories within the macrolevel suggest that people living longer and with better health has resulted in a shift of older age from the exception to the norm subsequently altering the status of older age from a privilege to a state of ill-health and dependency (Ayalon & Tesch-Romer, 2018). However, research has shown that this shift is a direct result of population ageing, rather than general patterns of increased life expectancy (Rudney & Vauclair, 2022).

Summary

This section highlights the background to ageism in healthcare. Population ageing, resulting in higher global numbers of older people, and its associated age-related health inequalities, has produced changes within the healthcare system that escalates concern over an increased propensity of ageism toward this demographic. Ageism within these systems can be explored through the ecological systems model along an individual, micro-,meso-,exo-, and macrolevel that respectively relates to an internalisation of age-related stereotypes, the interactions between provider and patient, three-way communication between provider, patient, and accompanied family members, low preference to care for the older demographic and exclusion in clinical trials, and general societal attitudes to older adults and broader structural processes that disproportionately favour younger patients. Ageism within each level does not operate separately, but converges to influence and reinforce these patterns of ageist attitudes.

The Dominance of Quantitative Research

Of the research on ageism in healthcare that was previously discussed, the majority of it aligned with the quantitative, positivistic approach that served the purpose of theoretical development in the multiple levels of the ecological systems model (Rennie, 2012). The development of the field of gerontology was, and continues to be, dominated by the biomedical model which influenced the pervasiveness of positivism across the many components associated with gerontological research (Grenier, 2023) and the commonality of this approach further reflects the synonymity of psychological science with hypothesis testing and the methodical choice of measurements and statistical analyses (Gergen et al., 2015). Subsequently, the components that make up the current definition of ageism are well reflected within traditional empirical research. This is further evident through examining these factors within the individual and microlevel by using statistical measures on the elements of ageism that older adults' and healthcare workers are familiar with and can understand, particularly when it becomes salient for the former group (Snellman, 2016; Snellman, 2018). As a result, the findings offered from this systematic type of research are integral in developing and shaping an understanding of ageism in healthcare, and the methods within quantitative research allow researchers to assess the validity of their hypotheses, for example, in relation to how the object of inquiry presents itself or how two phenomenon of interest interact with each other (Westerman, 2004), which has uncovered the diversity of how ageism operates in this context (Buttigieg et al., 2018).

Keeping in line with the positivist paradigm of causality and objectivity, studies on ageism employ large sample sizes to the benefit of data consistency and a wide array of demographic characteristics of participants that supports production of generalisable results of the prevalence of ageism and its associated characteristics among healthcare workers and older adults themselves. As such, these results have been indispensable over understanding the operation of this phenomenon (Park et al., 2020; Rennie, 2012).

Choice of a positivistic framework in ageism research is unsurprising given the nature of the studies itself. Largely concerned with examination of theories of ageism, the effects of ageism, and the associated variables, quantitative methodologies and methods are a highly practical way to gauge these effects efficiently, simply, and quickly when dealing with a large sample. However, there are limitations in the methods favoured in a quantitative approach that impacts on the type of knowledge produced (Maksimovic & Evtimov, 2023)

Limitations of Quantitative Research

Despite positivism having a firm hold in research, the characteristics that permeate it are also its inherent limitations that are underpinned by the rigid preference for objectivity, observed within the methods and what can subsequently be known. As a result, while positivism aims to advance theory, knowledge of the operation of ageism centred around theoretical frameworks within the ecological systems model has fallen short within past and current research. The rigidity of the methodological approach to positivist research means that the criteria for how much and the diversity of data that is subject to analysis is bounded by a narrow framework (Maksimovic & Evtimov, 2023). Choice of a particular research paradigm is dependent on what researchers hope to achieve (Snellman, 2016) and the deductive approach rests on presumptions of how phenomena manifest (Varpio et al., 2020). In ageism research, the components relating to it – both within healthcare providers and older adults themselves – are studied and measured systematically based on predetermined ideas of how ageism is expressed and what it means to those that are affected by it (Maksimovic & Evtimov, 2023).

The Rejection of Subjectivity. Based on the lack of distinction between natural and social sciences, the application of positivism with its objective stance is overwhelmingly employed within fields of study concerned with subjective experience (Maksimovic & Evtimov, 2023; Patnaik, 2023). Within social research, criticism of positivism centres around how well society can be understood from a purely objectivist standpoint and how practical it is to observe the varied components of social phenomena through a detached and neutral stance (Hasan, 2016). The pervasiveness of this has resulted in the social world – including experiences centred around ageing – being reduced to variables (Chen, 2010; Hasan, 2016).

The tunnel vision towards procedures and findings treats human action and experience on a one dimensional level. It reinforces the assumption that these factors can easily be explained superficially no matter the context from which it emerges across all those that experience ageism in healthcare. From here it can be observed that this type of research particularly falls short in the microlevel as these characteristics often leads to components of human behaviour, such as intentionality, being disregarded in favour of making generalised statements. Within this, the role of researcher and participant causes a lack of communication towards the latter group (Alharahsheh & Pius, 2020; Gergen et al., 2015; Hasan, 2016; Maksimovic & Evtimov, 2023; Park et al., 2020). What this results in is the failure of explicating the complex and multiple elements of subjective experiences, such as how older adults themselves experience, understand, and make sense of ageism (Patnaik, 2023).

By recognising the importance of subjectivity in research, the gaps within past and current research on ageism in healthcare become unignorable. Knowledge on ageism is unable to expand if the research within the field remains restricted in ways to conceptualise it (Snellman, 2016). Despite the necessity of the previously discussed studies, it is time for research to expand in other directions, mainly by building upon the knowledge gained from quantitative research, deepening the understanding of ageism across various elements by utilising more qualitative frameworks (Buttigieg et al., 2018).

Summary

This section delved into the dominance of quantitative, positivistic research in psychological inquiry. The methodical choice of measurements and statistical analyses in research has been integral in contributing to the understanding of the varied components of ageism in healthcare, reinforced by employing large sample sizes that allows for generalisation of results. Despite the contribution of quantitative research, the criterion of objectivity means that research is conducted based on fixed ideas of what ageism looks like in a setting focused on subjective experience. Consequently, the nuances of experience such as contextual factors and aspects of human behaviour are rejected for these objective, generalisable results.

A Move Towards Qualitative Research

The dominance and inherent limitations in the methodology and methods present in the previously synthesised quantitative literature highlights the areas that now need attention, particularly around a need for more qualitative research (Buttigieg et al., 2018). By undertaking qualitative research it opens up a different way to perceive and understand a phenomenon of interest. To reach a heightened understanding of the subject of inquiry, it is vital to incorporate and utilise the diversity of methodologies, even ones that have conflicting assumptions, as it can develop knowledge on both an interpersonal and societal level (Gergen et al., 2015). Furthermore, while theory can guide what methodological framework to use, theory development requires a range of methodological choices to be sensitive to the contextual components within the lived world. Expansion towards qualitative research will help guide the inclusion and development of other theories (Gergen et al., 2015; Grenier, 2023).

Qualitative research focuses on the aspects of phenomena that positivism completely disregards and is a way to make up for the shortcomings present in the microlevel through the key features of this paradigm mapping onto the limitations that permeates positivism in the context of social research (Hasan, 2016). Qualitative research concerns itself with the subjective meaning participants have over a specific phenomenon (Alharahsheh & Pius, 2020). Through an in-depth understanding of the interactions individuals have within society, the nuances and complexities of the social world are particularly highlighted such as experience and the intent and meanings prescribed to that, how experiences change over time, as well as the ability to explicate affective elements. The shift away from pure observable human action inevitably diversifies the understanding of phenomena (Chen, 2010; Hasan, 2016; Maksimovic & Evtimov, 2023; Varpio et al., 2020). Paying attention to and reflecting on these qualities is crucial as subjectivity is intrinsic to human experience and to understand and illuminate the varied workings of it, it is important that researchers become increasingly focused on the depth of their scope through the perspective of those who experience the phenomenon (Alharahsheh & Pius, 2020; Hasan, 2016).

Despite older adults being targets of ageism little research actually looks at this phenomenon from their perspective (Van den Hoonaard, 2018). In 1992, Jane Aronson argued for the voice of older adults to be included in gerontological research. Driven by predefined ideas of the needs of older adults, she argued that their perspective has gone overwhelmingly unnoticed (Aronson, 1992). Furthermore, within qualitative research, most of the already published studies focuses on healthcare workers and their views and experiences of ageism toward older patients. Knowledge of the perspective from the ones who experience this type of discrimination remains underdeveloped despite the potential to uncover these subjective experiences and meanings (Ayalon et al., 2023). Even research that does not explicitly focus on older adults experiences of ageism, but at self-directed ageism is under researched compared to the interactions between provider and patient due to the inherent inequality and nature of appointments that is centred around ill-health and injury (Buttigieg et al., 2018).

Qualitative research provides a different way to develop theory through the voice of older adults that provides indispensable information pertaining to their lived experiences (Warren-Findlow, 2013). Compared to quantitative research, qualitative research favours a more in-depth and intricate understanding of ageism in healthcare by placing the older adults – who are the experts of their own experiences – at the fore (Van den Hoonaard, 2018). The benefit of qualitative research within the context of ageism is that it allows for the myriad of components relating to it across social, behavioural, and psychological facets to be understood in relation to older adults' experiences of ageism (Chen, 2010). Furthermore, ageism is rooted within social practices. Older adults experience and understand these occurrences through the interactions they have with the people around them which in turn influences how older adults understand themselves (Van den Hoonaard, 2018). Through employing the older adult voice in research, not only does it shed light on the experiences of older adults *as a group,* but it is also sensitive to the *individualistic* aspect (Harbison, 2019).

Older Adults' Perspectives

Despite it being limited within the field of ageism research, a few qualitative studies on ageism in healthcare from the perspective of older adults has been done, subsequently broadening how ageism is conceptualised.

In a qualitative study by Vogt and Dahlke (2023) examining older adults experiences of ageism, a participant found that her concern over her weight was dismissed as something to not worry about by her doctor due to a perceived normalcy of having extra weight among older women. The lack of regard for the participant's wish to maintain a healthy weight suggests that this type of concern is not an important one for older adults. This characteristic of viewing the older person as part of a group, rather than as an individual was further prominent in participants' experiences in aged-care facilities. Once participants moved into these facilities they felt that healthcare workers saw them as dependent residents, rather than unique individuals. One participant in the study noted how the personalities of new residents go from being lively to subdued within a short time frame due to this nature of socialisation that results in the older adult acting in accordance with the "role" of a resident that leaves many feeling as if their rights have been taken away.

In another qualitative study by Gholamzadeh et al. (2022), participants discussed how negative assumptions of older age as a state of ill-health and older adults themselves as dependent and attention-seeking all contributed to a lack of and untimely diagnosis and care, even with acute conditions. This was especially so in instances where there was a shortage of medical equipment in which younger patients were a higher priority. Much of the care disregarded individual matters, treating older patients as a uniform group and at times, basic care requirements could not be met. In extreme cases, patients were misdiagnosed, being put through treatment that had no benefits or were subjected to needless procedures due to an assumption of a need for an abundant level of care. With communication, participants discussed how providers avoided any sort of individualised communication style that suited their specific needs and were often quite hostile and aggressive both in how they spoke and in their behaviour, particularly among nurses. While participants further highlighted the lack of communication through providers completely ignoring them, only discussing what was absolutely necessary, and disregarding their opinion, they also mentioned the lack of information regarding care after a discharge from hospital such as only being provided with a pamphlet with insufficient information on it, showcasing how experiences within a healthcare setting has consequences outside of it.

Similar findings were observed by Martinez-Angulo et al. (2023) in which participants discussed how their providers disregarded their needs by not listening to their concerns and paying little attention to the medical condition in favour of quick, routine treatments. Home caregivers also displayed similar apathetic behaviour by establishing treatment plans without consulting their patient and arriving at patient homes without informing them, and when concerns were brought up to these providers, participants were made to feel like they were engaging in attention-seeking behaviour. Furthermore, with providers taking advantage of the inherent inequality between them and their patients, participants were left feeling oppressed with a lack of regard toward their dignity and level of care. All these experiences influenced a negative self-perception of ageing, particularly with their physical health and was associated with a reduction in visits to the health clinic, opting to self-medicate instead. This pattern of avoidance was further present in a study on older adults with back pain. Participants revealed their reasons for not going to doctors’ appointments included already held views that back pain was an unfortunate consequence of ageing that became reinforced by similar statements from their health provider. Moreover, many were unsure of taking prescribed medications due to numerous other medications they already had to keep track of or a concern the medications might react negatively with each other. Providers regularly dismissed these concerns and expressed medication as the only option, even creating treatment plans without conversing with their patients. In contrast, some participants expressed that their providers insisted that surgery was the only option, and like with the prescriptions, patient concerns including fear were dismissed even in instances where some participants had previous complications from surgery. In spite of this, some participants expressed that having a good relationship with their provider was a positive influence in making and attending appointments (Makris et al., 2015).

However, obtaining these understandings depends on the older adult recognising what ageism is and when something constitutes age discrimination (Voss et al., 2018). In two similar qualitative studies by the same researcher, it was found that not all older adults believed ageism in healthcare is a matter that concerns them, having the opinion that there is not a difference in how providers treat younger and older patients, even in instances where they acknowledged how friends and family have expressed discontentment about not having their ailments taken seriously. Of those who acknowledged the existence of ageism, many held negative stereotypes about age, believing that ageism is only an issue for the "oldest" patients (i.e. patients in their eighties and nineties) due to perceived difficulties with comprehension and acquisition of multiple conditions that would require more attention. The internalisation of these stereotypes fed into their belief that ageism occurs due to a detriment in the older person. Unlike "other old people" participants discussed how they do not experience ageism due to their good health and positive personality that makes them a desirable patient compared to the "typical" cranky, complaining oldest patients. As such, many believed that ageism will only become a problem once they reach those years and in light of this, the only participants who discussed experiences of ageism were over eighty years old, manifesting through providers disregarding their conditions because of their age (MacRae 2018; MacRae, 2022).

Gaps in Current Qualitative Research. Despite the necessity of these qualitative studies and the indispensable findings they have produced, gaps remain in the literature concerning the voice of older adults within the specific context of healthcare. For example, Gholamzadeh et al. (2022) had three groups of participants; older adults, family caregivers, and healthcare workers. Despite the former group having a voice in the study, the analyses and subsequent findings were influenced by all three rather than having the findings emerge from the accounts of those that directly experience ageism. Moreover, the older adults interviewed were all patients within different departments of a hospital. While focusing the study on a specific setting is not necessarily a limitation, it does produce findings within that specific context which may disregard other forms of healthcare. In contrast to the specificity of the previous study, Vogt and Dahlke (2023) conducted their study with older adults looking at their experiences of ageism *in general* and how that influenced their self-perceptions. As a result, ageism in healthcare emerged from the findings, rather than the authors specifically examining it within that setting. Similarly, the aim of Makris et al. (2015) was to look into the interaction between older adults with back pain and their navigation of the healthcare system. As a result, experiences of ageism came forth from the data and was not an explicit focus at the fore. From here, it can be observed that Martinez-Angulo et al. (2023) was the only study that explicitly looked at the experiences of ageism in healthcare from the perspective of older adults.

Summary

In summary, the foundations underpinning qualitative, inductive, research are ones that quantitative research disregards. Through highlighting the subjective, complex, and multiple arrays of lived experience, the social world can be understood on a deeper level, particularly when it is done so through the perspective of those who experience it. Despite the limited quantity of it, qualitative research on older adults' experiences of ageism in healthcare provides researchers with the opportunity to give voice to participants in order to explore how certain experiences occur, how they are understood, and how it has been impactful. Current research demonstrates the diversity of ageism in healthcare across the homogenisation of older adults, negative assumptions impacting care, communication issues, apathetic attitudes towards care, feelings of oppression and negative self-perceptions of ageing, the impact on navigation of healthcare systems, and age as a cause of health concerns. Alongside this, it has been demonstrated that acquisition of age stereotypes influences older adults' perception of ageism. While these findings go some way into expanding the knowledge of this phenomenon, most of the qualitative research did not focus their aims specifically within the context of ageism or healthcare, meaning that the findings presented continue to be bounded by a narrow framework.

The Current Study

A large amount of research on ageism in healthcare has been examined within Bronfenbrenner's ecological systems theory comprising of the individual, micro-, meso-, macro-, and exosystem (McNamara & Williamson, 2019). Across these levels, research has focused on internalisation of age stereotypes among older adults' (Ayalon & Tesch-Romer, 2018), stereotypes, prejudice, and discrimination from healthcare workers (Clendon & Munns, 2014), triadic communication (Stubbe, 2017), intentions to provide care to older adults and exclusion in medical trials (Inouye, 2021; Liu et al., 2015), and the use of policies that places the older adult as a lower priority for medical treatment (Bognar, 2015; Harris & Regmi, 2012).

The understanding of ageism in healthcare within the ecological systems model has been largely acquired through quantitative, positivistic research. As such, the findings presented in the ecological systems model has been shaped by this approach, both in relation to the operation of ageism and how multiple concepts within this have interacted with each other, supported by the generalisable quality of quantitative research (Park et al., 2020; Westerman, 2004). However, the unwavering adherence to objectivity results in these aspects of ageism being studied based on researchers' pre-established assumptions of the phenomenon (Maksimovic & Evtimov, 2023). Within this, the subjective experience is dismissed and inevitably, the individualistic components of experience, understanding, and sense-making (Patnaik, 2023).

Qualitative paradigms will be beneficial for developing the field of ageism research, particularly within the microlevel due to the face-to-face interactions patients have with their healthcare providers. It is due to this reason that ageism is also the most discernible to older adults in terms of their direct experience in this level (McNamara & Williamson, 2019). On account of these factors, examining older adults' experiences of ageism within the microlevel will be a useful place to start. Placing experience at the fore of research is worthwhile due to the limited research that has been done (Van den Hoonaard, 2018). Healthcare providers are generally the group where ageism in healthcare is examined from and the older adult perspective goes ignored (Ayalon et al., 2023). Using qualitative research to examine older adults' experiences of ageism allows for an in-depth, examination of the subjective components such as how ageism is experienced, what is means for each individual, and how these experiences are influenced by contextual factors. Sensitivity to the varied elements of experience allows for ageism to be understood in the way that it occurs – through social processes (Alharahsheh & Pius, 2020; Van den Hoonaard, 2018).

Population ageing and its consequences provide a need for more research on ageism to be conducted within healthcare systems. With population ageing and increasing numbers of older adults' using healthcare services (Ministry of Health, 2023), ageism in healthcare is becoming a growing problem (Pritchard-Jones, 2017). With an average of 26% of older adults' experiencing this form of discrimination at least once, healthcare services are a prominent setting from which ageism takes place (Ayalon & Cohn-Schwartz, 2022; Dobrowolska et al., 2019; Shin et al., 2019; Shpakou et al., 2021). Although much research has looked at ageism in healthcare, there has been a lack of research combining older adults' perspectives specifically in the context of healthcare with both factors often emerging from the findings (Makris et al., 2015; Vogt & Dahlke, 2023).

In light of all these factors, the research question of the current study is, "What is the experience of ageism like for older adults within healthcare systems?".

Chapter Two: Methodology and Method

Methodology

The methodology section will cover the ontological and epistemological assumptions guiding this study and the relation they have to my chosen methodology. Within the methodology, what it is and its fundamental components will also be discussed. All these factors will be situated within my research aim and how they were chosen to best reach this aim.

Ontology

The ontological assumptions underpinning this thesis is relativism. Chosen for its framework of reality as subjective and diverse, relativism holds that the nature of reality is different for everyone as it is dependent on how one perceives and experiences the world (Ryan, 2018; Scotland, 2012). As a result, there is no single 'truth' waiting to be discovered; what is known depends on the context – such as language and culture – that permeates each individual and these surrounding contexts – and the associated 'truth' – are multiple and therefore, socially constructed (Baghramian & Coliva, 2019; Ryan, 2018).

Epistemology

Relativist ontology is closely associated with an interpretivist epistemology (Junjie & Yingxin, 2022) and the qualities within interpretivism reflects the qualities I believe to be important when undertaking research on individuals' experiences. Born out of criticism of positivism and similarly to relativism, knowledge within an interpretivist framework is subjective, descriptive, and contextually and historically bound, emerging from individuals' experiences and their interpretation of those experiences (Al-Ababneh, 2020; Hiller, 2016; Ryan, 2018). In research, interpretivism is concerned with the relation between phenomena and participants and the meaning, viewpoint, and feelings individuals have over an experience (Junjie & Yingxin, 2022).

Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) is an interpretative methodology focused on lived experience, and how individuals make sense of those experiences and the meaning they ascribe to it (Chamberlain, 2011), with special consideration of experiences that are of particular importance (Smith, 2011). Thus, IPA is experiential (Smith, 2011) and as with the ontological and epistemological assumptions that guide this thesis, concerned with subjectivity and the socio-cultural contexts from which lived experiences occur (Todorova, 2011). IPA situates lived experience within social, historical, and linguistic contexts through placing the participant at the fore of the research (Smith, 2011). Prioritising this point of view allows for IPA research to uncover all these components that make up lived experience by becoming as situated within it as possible. Due to IPA's focus on experiential inquiry, it is particularly useful in augmenting the results from previous quantitative research (Smith & Nizza, 2021).

IPA is made up of three theoretical components that influence how IPA research is conducted; phenomenology, hermeneutics, and idiography that all contributed to my preference for IPA (Chamberlain, 2011; Smith & Nizza, 2021).

Phenomenology. Influenced by Edmund Husserl, phenomenology is the philosophical and descriptive study of understanding lived experience (Finlay, 2011; Smith, 2011). As such, IPA's concern with experiential inquiry is directly derived from phenomenology. A tenet of phenomenology is that inquiry of experience should be approached purely through how it presents itself, rather than through predefined ideas, theory, and assumptions of the world (Smith & Nizza, 2021). Husserl's phenomenology is concerned with the immediate experiences in an individual's consciousness and how individuals can fully and accurately understand their lived experiences in order to explicate the vital makings within the phenomenon. Thus, Husserl argued that to understand consciousness is to be aware of the factors that can obstruct this (Smith et al., 2009). Phenomenology is a particularly important aspect within IPA for giving voice to participants as it is an opportunity for them to share their experiences and to make further sense of them (Finlay, 2011).

Hermeneutics. The interpretative aspect of IPA comes from hermeneutics, as influenced by Martin Heidegger and which extends beyond Husserl's descriptive phenomenology (Chamberlain, 2011), while remaining situated alongside it (Smith & Fieldsend, 2021). From Heidegger's point of view, interpretation is particularly necessary to examine experiences in-depth and find the meaning that might not be obvious on a surface level (Smith & Nizza, 2021). As such, the phenomenology is needed to interpret it and the hermeneutics is needed to understand the phenomenon (Smith & Fieldsend, 2021). The main aspect of interpretation concerns the double hermeneutic; a process by which participant and researcher display interpretative practices. The participant interprets their lived experience through the detailing of it and the researcher interprets those statements, and thus, their own understanding (Chamberlain, 2011). Due to these reasons, the sense-making of the participant is first-order whereas the researcher's is second order. Understanding operates between the part and the whole of the experience, both of which relate to one another. The whole experience is understood through examination of the parts that make up it and vice versa (Smith et al., 2009). IPA's concern with meaning making is influenced by hermeneutics (Smith & Nizza, 2021).

My choice of IPA as a research methodology, and subsequently interpretivism as an epistemology, was influenced by the double hermeneutic. As a researcher, it is not my belief that I can completely separate myself and my values from my participants and their accounts. IPA allows me to bring forth my own understanding while remaining close to the participants words.

Reflexivity. Although Husserl's phenomenology is concerned with explicating experience through the way it occurs, rather than through assumptions and theory (Smith & Nizza, 2021), a significant portion of my introduction touched on past ageism research. This has inevitably shaped my own expectations of the experiences of ageism. Due to the assumptions I have, it was important for me to reflect on my position and what I brought to the interviews and interpretation of the findings. For example, some of my questions were influenced from the past literature as two of them pertained to the impact ageism had on participants' perception of self and their health. However, this was worded in a way that did not assume there was any effect e.g., "does age-based discrimination influence…" rather than "how does age-based discrimination influence…" which implies that the participants would have been impacted in this way.

When it came to the interpretation and analysis of the interviews, I was aware that although I could not completely disregard my assumptions, I could be mindful of them and make sure to bracket them as much as I could. Rather than using the past literature as a guide, which I did for my design of the study, as seen through the interview questions, it was important to be constantly aware of and actively analysing each participants account solely within their own words, rather than trying to fit their narrative within the findings of previous literature.

Idiography. Idiography can be understood through its favouring of the particular and is the part of IPA research that is concerned with understanding specific contextually-bound experiences through the perspective of specific individuals through an in-depth analysis of these accounts (Smith et al., 2009). The influence of idiography is especially observed in the methods of IPA research (Smith & Nizza, 2021).

Based on the belief that every situation is unique to those that experience it, my choice of IPA as a research methodology within qualitative research is reflected in these characteristics. Since my research question is positioned along experiential inquiry, through the perspective of a certain demographic, IPA was deemed the most suitable methodology to explore that. Furthermore, as a young researcher, my own experiences and understanding will be fundamentally different compared to older adults'. Giving older adults voice allows them to share their experiences without my presumptions being imposed onto them.

Method

The method section will go into detail on participant recruitment, tying into the nature of the sample and participant characteristics. The interview process will then be described and finally, the procedures undertaken for data analysis.

Participant Recruitment

Participants were recruited through Age Concern Otago, an organisation I am a volunteer for and thus, quite familiar with. By asking the leaders if I could recruit participants through their organisation, they offered to place the advertisement (appendix 1) on the Age Concern Otago Facebook page. Containing my email address, willing participants contacted me and I either solicited their phone numbers or continued to email them in order to discuss the nature of the study, allow them to ask questions, ask them questions pertaining to the inclusion criteria, and when they confirmed their interest to partake, to arrange a time and place for the interview.

Purposive Sampling. Due to IPA's focus on particular lived experiences, purposive sampling was used to recruit participants that represented a homogenous sample, reflecting that particularity rather than representing a population (Smith et al., 2009). As a result, the inclusion criteria was at least sixty-five years of age and sufficient understanding of the English language.

Sample Size

Due to idiography being an integral component of IPA, sample sizes are small. A sample size of three participants was chosen for this research project as it allowed each case to be analysed in-depth – in its own right – while also allowing for analysis of convergences and divergences between participants (Smith et al., 2009). Furthermore, three participants is recommended for novice researchers, particularly for students with time constraints in order to focus on the depth of each participants' case (Smith & Eatough, 2012).

Participant Characteristics

The three participants of this study were given pseudonyms in alphabetical order of when they were interviewed.

At the time of the interview, Alice was an eighty-five year old woman who was living alone at her home. She had two main health conditions.

Beth was a seventy-three year old woman residing in a residential care home. After an accident that left her disabled, she was living with a number of health conditions. As such, Beth required assistance with daily activities and extensive physical rehabilitation.

Charlotte was an eighty-two year old woman living at her home with her husband. She suffered serious health issues.

The participants being all women, while not an inclusion criterion, supported the homogenous criteria of IPA research.

Interview Schedule

As per Smith and Nizza (2021), the interviews for each participant were semi-structured and guided by an interview schedule (appendix 2). There were ten questions within this schedule that were purposefully designed to be open and expansive through the use of words such as 'how', 'what' and 'does' so participants were not constrained in their answers, alongside to avoid assumptions about their experiences of ageism in healthcare. For each participant, a descriptive question about their usage of healthcare systems was first asked to gain a sense of what services they used. The following questions became reflective and analytical, e.g., “What do you hope…?” and evaluative e.g., “How do you feel…?” to gain a sense of their experiences from different angles. Prompts and probes e.g., “In what way…?” and “What do you mean by…?” were also asked to get more in-depth of participants’ accounts. The questions were ordered in a way that went from what I anticipated to be the least sensitive questions first towards the more anticipated sensitive ones.

With each interview, however, the participants led it and the questions I asked emerged directly from their accounts. As a result, the questions were asked in a different order from the way they appeared on the interview schedule for all participants and some questions were asked that were not anticipated, but still relevant to the topic at hand, supporting the framework of the participant as the expert (Smith et al., 2009).

Interview Procedures

All interviews were held at the participant’s place of residence. Before the interviews began, each participant was given an information sheet (appendix 3) to read detailing the nature of the study. After they all read through that, a consent form (appendix 4) was given for them to read and sign. Once each participant gave their consent and signalled they were ready to start the interview, I started audio recording from my cell phone and from here, each interview began. Each participant received a forty dollar gift card as a thank you after their interview ended.

The three interviews lasted between fifty-four minutes and one hour and ten minutes.

After the interviews were completed, each recording was then manually transcribed on a Word document and checked for accuracy in order to begin the analyses.

Data Analysis

Although IPA does not have strict guidelines on how to conduct the analyses, I, as a novice researcher, closely followed the steps presented by Smith and Nizza (2021) and Smith et al. (2021) while also remaining flexible to IPA's iterative process. In doing so, I was able to fully adhere to the change in IPA's terminology from 'initial comments', 'emergent themes', and 'superordinate themes' to 'exploratory notes', 'experiential statements', and 'personal experiential themes'.

Due to IPA's idiographic requirement, a single case analysis was performed on each transcript in order to remain solely within the participant's account. Before beginning each analysis, a read through of the transcript while simultaneously listening to the interview was done to re-familiarise myself with the structure and content of the interview. From here, the document was edited to include two columns on either side of the transcript with 'Exploratory Notes' on the right hand side and 'Experiential Statement' on the left (Smith et al., 2021; Smith & Nizza, 2021).

Each analysis began with a reading of the transcript where line by line, I wrote down my first impressions of anything deemed to be significant and of interest in the 'exploratory notes' margin. This process consisted of three levels; descriptive notes (the surface level understanding of what is being said), linguistic notes (such as particular words used, repetition, pauses, and laughter), and conceptual notes (an in-depth reflection on my and the participant's understanding of what is being said, mainly stated as a question). All three aspects converged to produce a comprehensive understanding of each experience, however, throughout this process it was vital I kept my interpretation within the context of what each participant was saying (Smith et al., 2021; Smith & Nizza, 2021).

Under the 'experiential statement' heading, these exploratory notes were then used to form experiential statements, an analytical process of understanding the meaning behind these experiences, which written down as a phrase represented both the descriptive and psychological elements. As an example of IPA's iterative approach, I was able to go back and re-analyse and write more exploratory notes to facilitate the creation of the experiential statements. Experiential statements were formed for every section that the participant spoke. Some lines within these sections required no or minimal statements and others corresponded to multiple statements. Here, my interpretative role as the researcher became especially apparent, particularly with highlighting the psychological elements as it demonstrated the level of depth and reflection required to come to these conclusions. The influence of hermeneutics is apparent in this part of the analysis; the focus on certain parts of the transcript allows for a greater understanding of the whole experience, however this understanding needs to remain in the context of the full transcript. From here, all experiential statements were typed up on a separate document, printed out, and each statement individually cut up. All statements were placed on a flat surface from where I was able to look at all of them at once and cluster together ones that were similar. Not all experiential statements were included in this grouping. Repeated statements were either excluded or combined together with other statements and ones that were not relevant to the research question and thus, did not contribute to the analyses, were taken out (Smith et al., 2021; Smith & Nizza, 2021).

Once the clustering was done and on a separate document, personal experiential themes (PETs) were created for each cluster that represented the convergence and divergence of the experiential statements. For PETs that had many statements, subthemes were created. Under the heading of each theme and subtheme, the statements were ordered in a way that made them flow from one to another, such as on a temporal dimension. Next to the PETs, in the middle margin of the document, the line and page number were listed beside each experiential statement detailing where in the transcript it came from. Also, alongside the experiential statements on the right-hand margin were extracts of the quotes that represented what each statement conveyed. Creating the table of PETs in this way not only allowed me to look back and see where in the transcript an experiential statement came from and its context, but it also represented the interpretative process that led to the creation of the PETs (Smith et al., 2021; Smith & Nizza, 2021).

Once each individual analysis was completed, a cross-case analysis was performed to create Group Experiential Themes (GETs). For ease of analysis, a broad review of all the PETs was first conducted to look for general similarities and differences. The PETs that were similar across participants were rearranged in a similar order. For example, theme one for all participants related to how their age affected their healthcare experiences, so they all remained as theme one for each participant. However, all participants had a theme relating to their response to ageism. For Alice and Beth, this was theme three whereas it was theme two for Charlotte. As a result, this became theme three to match the other two participants. After, each participant's table of PETs was printed out and displayed in a way that I could easily examine them together to look for any convergences and divergences. The full quotes were also typed up, printed out, and cut up individually to help ground myself in each participants' account. This part of the analysis began at the PET level, the highest order. However, it was not a prescriptive approach and at any point I could move beyond the PET and into the subthemes and experiential statements, particularly if there was not any obvious similarity at the PET level. During this process, clustering of the full quotes was conducted, similar to the clustering in the single case analysis. Although PETs were the highest order, during the analysis I found that quite often a subtheme or experiential statement worked best to form a new GET. This meant that some statements that were under the same PET moved to different subthemes under a GET or moved to a different GET and statements that were in different PETs came under the same GET. As with the PETs, the experiential statements under each GET and subtheme were ordered in a way that allowed the quotes to flow on from one another instead of detailing them one participant at a time. Throughout this whole process it was vital to be sensitive to IPA's idiographic approach through grounding my analysis within the individualistic context of each participant (Smith et al., 2021; Smith & Nizza, 2021).

Analysis in the Write-Up of the Findings

In IPA, the analysis of the data continues when writing up the findings, and it is a clear example of what it means when IPA analysis is described as an iterative process (Smith & Nizza, 2021). In my own experience, I found that the table of GETs I created was not the most suitable for the narrative approach that the findings section required. For example, I added another subtheme in the first GET to lay the groundwork of how the women recognised ageism, subsequently allowing the rest of their accounts to flow from that. I also removed a subtheme from the same GET and turned it into the last GET as I found that what the women said in that section followed on from everything else. Similarly, quotes were rearranged so they could expand on each other and ensure it was as narrative as possible. Lastly, some quotes that were initially disregarded due to repetition were found to be useful as it provided additional context and allowed for a fuller understanding of what was discussed.

Ethics

This section will review the ethical considerations and how these risks were mitigated.

Avoidance of Harm

Due to the nature of the study where participants discussed their experiences of age discrimination and health conditions, it was anticipated that this might be a sensitive topic. A list of three older adult and/or health support services were given in the information sheet. Participants were allowed to request for the recording to be turned off, no reason needed. If done so, any comments they made were to not be included in data collection and subsequent analysis. Participants also had the right to request for a break or to end the interview at any time. Despite these considerations, they were not necessary for any participant.

Informed Consent

An information sheet was given to each participant, detailing the nature of the study and their rights as participants and all were allowed to ask questions pertaining to it throughout the research process. Once each participant read through the information sheet and indicated their willingness to partake, a written consent form was given which they signed. Alongside this, verbal consent was obtained before each interview began. Despite written and verbal consent, participants had the right to withdraw from the study at any time. Since the study involved experiences of healthcare providers, whether it be a place or an individual, participants were requested to refrain from naming all providers by name.

Privacy and Confidentiality

To protect participants identity, pseudonyms of ‘Alice’, ‘Beth’, and ‘Charlotte’ were given. If participants discussed a health provider by name it was edited for anonymity during transcribing. This was done to protect identifying the providers who did not give consent and also to remove any identifying features of the participants. Other personal information was also anonymised.

Although the three interviews were recorded on my cell phone, all were immediately transferred to Massey OneDrive for safekeeping and subsequently deleted from my cell phone. All confidential material, including consent forms, are located where only I have access to them.

These procedures were approved by Massey University Ethics Committee (Ohu Matatika 3, Application OM3 23/41) before recruitment began.

Chapter Three: Findings

In this chapter, the five group experiential themes that emerged from the participants' accounts will be discussed. The first theme, *Foundational components of ageism,* was related to the women's, often growing, understanding of what ageism looked like for them. This theme comprised four subthemes; *Age causes discrimination, Why age influences discrimination, Starting point of ageism,* and *Frequency of ageism.* From this understanding, the second theme, *Complexity of self-advocacy,* focused on the action, or attempted action, the women took to stand up against ageism. Here, five subthemes emerged; *Issue of being ignored, Standing up for oneself, Resistance to self-advocacy, Risk of hostility,* and *Advocating for others.* With the women's self-advocacy against ageism came instances where the emotional consequences influenced their decision to stop engaging in that behaviour, as was described in *Removal from situations. The impact of ageism* goes into detail surrounding the multifaceted ways all those experiences were impactful for the women. Despite the previous four themes detailing the women's experiences of ageism, *Non-ageist experiences,* delved into the women's appreciation of the positive encounters they had.

Foundational Components of Ageism

Age Causes Discrimination

An important element of experiencing discriminatory treatment for the women was recognising and understanding what was causing those experiences. Despite their reflection, there were differences in how each participant came to their conclusion. Alice and Charlotte both referred to their age as the sole contributor. For example, Alice observed how her age affected her treatment in healthcare through her providers dismissing her concerns as age-related:

"I: Have you ever felt that your age has influenced how a healthcare provider has treated you?"

"Alice: I do because sometimes they say to you "Oh it's just your age, you gotta expect that." And that's not the answer you're looking for, is it?"

Alice's age was not just perceived to be a primary cause of her health conditions, but as the only cause. For her providers, age came with an inevitable increase in ill health that made awareness of other potential factors unnecessary. Subsequently, older age became an insufficient and unworthy reason to have a discussion surrounding her health. Being explicitly told that her age caused her ailments made Alice confident that those experiences were discriminatory.

Alice further said: *"You want answers to what you've asked and that's not an answer."* Alice, who went to healthcare appointments with a goal in mind dismissed this reasoning as unsatisfactory. To her, her age was largely irrelevant to the diagnosis. For her providers to immediately label older age as the cause, without consideration for what she thought, they purposefully ignored other, more valid reasons that would have been responsible for Alice's ill-health.

Like Alice, Charlotte noticed that her age impacted on how providers treated her. Contrary to Alice, however, she observed this through the difference in treatment between her and younger patients: *"But in the hospital it was sort of noticeable."* Here, she found that she was the lowest priority when it came to distribution of resources and treatment. The hospital provided a unique setting from which this occurrence was particularly obvious. In hospital, she was surrounded by adults of varying ages. How younger patients were treated, how she was treated, and a comparison between the two was able to be easily remarked upon. As with Alice, witnessing how her age impacted on her treatment – although not as directly obvious – was the starting point for Charlotte's understanding that this constituted ageism.

Differing from Alice and Charlotte, Beth at the beginning of her interview, was initially most unsure as to what was causing her unsavoury experiences: *"Again, I don't know whether it's, what it is that makes them decide to treat me like that."* With the possibility of multiple, diverse reasons pinpointing them was challenging: *"Yeah, I'm not sure whether it's a disability. All those instances, it's, it's either incompetence or indifference or ageism or because I'm disabled."* Unlike Alice and Charlotte, Beth was both an older adult and had disabilities. For her, she had to consider both factors as a potential reason. Being able to reflect on her experiences, allowed her perception to go from completely uncertain of the cause to deliberation over what she thought might be occurring by the mid-point of the interview. Within this, her confidence grew. The causes behind Beth's unpleasant experiences occurred in isolation from each other. Why her providers decided to treat her a certain way was not always the result of discrimination and when it was, it was due to her age *or* disability, rather than her age *and* disability.

Despite differing confidence in why they were being treated a certain way, all participants had an awareness that their age was at play. For Alice and Charlotte, this directly emerged from specific instances. For Beth, this came from a wider reflection across all of her experiences. As a result, this recognition provided the foundation for the women's understanding of what ageism is and what it looked like in the context of healthcare.

Why Age Influences Discrimination

All the women wondered what it was about their age that caused their experiences of ageism in healthcare, but this was expressed differently across the participants. Despite different reasons as to why age was a factor, two of the women concluded that as older adults, they were not important enough for their healthcare providers. For Alice, she understood her experiences of ageism through a social construction of older age, saying: *"I think it's because it's retirement age, you know, and I just think they connect it all together. Once you're not* *working, you're old and everything happens because of your age."* Here, she's referencing sixty-five as the age healthcare providers start to see someone as an older adult, purely based on laws that govern how society distinguishes age groups. When this age was reached, other causes of health conditions were disregarded in favour of locating age as the primary – and only – factor.

Despite the narrow viewpoint, Alice did not fully reject the sentiment: *"It's not that I don't believe them, I just think they haven't got the whole picture [pause] I think they don't take you seriously enough."* Compared to her healthcare providers, Alice did not see her age as the only cause of her health conditions, detailing it as one part out of multiple reasons. Healthcare providers' tunnel vision towards age as the *only* factor, rather than *a* factor is what made up the framework of her experiences of ageism. The providers' clouded judgements that resulted in a refusal and a lack of desire to take into account other concerns was due to Alice not being taken seriously. As a result of all those factors, it led to her feeling that her age made her unimportant within healthcare appointments.

Alice further echoed this sentiment in the context of a provider not listening to her concerns over a medication that she was reacting negatively to: *"I think it was because you're old, they, doesn't really matter."* Through being made to feel unimportant came the perception that Alice, as an older adult, was not entitled to have her concerns listened to, even with the potential risk keeping her on that medication could have had to her health. As such, the degree to which her health could have been impacted was irrelevant to the providers.

Charlotte also shared a similar view of feeling unimportant because of her age that directly resulted from why ageism occurred. However, her assessment of why differed from Alice's reasoning:

"I: What do you hope to get out of those appointments?"

"Charlotte: Confidence."

"I: What do you mean by confidence?"

"Charlotte: Just keeping the ability to keep mobile and uh, it's ok to do it."

"I: Do you often find that you do get that confidence from a healthcare provider?"

"Charlotte: No."

"I: Why do you think that is?"

"Charlotte: I think…I'm making judgements, but I think they look at your age and think you haven't got long, uh, long in years and it's not worth it, to be, you get the feel that y-you just don't justify it."

Charlotte pointed to the fact that her belief on the matter was her opinion. It was her assumption that had resulted from how she had felt within healthcare appointments, and she was aware it may not be what her providers were actively thinking. In contrast to Alice, Charlotte's feelings of unimportance were related to older age as an end-of-life stage. Charlotte believed that her wish to stay active was considered futile by providers due to their perception of impending death.

Although Beth initially struggled with understanding what was causing those experiences, her continued reflection on them increased her confidence at what was happening and why as she neared the end of her interview:

"People think they can get away with it or they are lazy or they're incompetent, or, I don't know. I-you can't jump to conclusions, can you? But the fact is they don't do it and I don't know why. But I reckon it's easier to get away with things when you're dealing with disabled, old people than when you deal with young, healthy people."

Although still not completely confident, Beth suggested possible, distinct reasons why, and like Charlotte, Beth was aware that those were her judgements. With healthcare providers not explicitly stating why they were engaging in a certain type of behaviour, she recognised that those were assumptions and not necessarily accurate ones. Despite this uncertainty, Beth now saw her age and disability as operating together, rather than distinctly. This duality motivated her providers' poor treatment of her due to her perception that it went unchecked more often compared to individuals who were not elderly and disabled.

Theorising reasons as to why their age impacted their treatment was apparent for all the women. It was natural for them to try and understand why they were being treated a certain way and through figuring out the motives of others, it helped them build their comprehension of what they were directly experiencing. Thus, aiding how they made sense of their own experience of ageism as a whole.

Starting Point of Ageism

Certainty in knowing when ageist experiences started was apparent for all women. However, there were differences in when and how it started. For two women, ageism became apparent at a distinct point in time. For instance, Beth's experiences began on the day she acquired her disability: *"Thirty-one July 2021 [pause] yep [pause] that's when I started getting treated differently. Yes, so it's a combination I think."* Her ability to remember the precise point is unsurprising given the salience of the event that inevitably had a huge impact on her life, and which subsequently caused dramatic increase in her use of healthcare services, creating more opportunities for exposure to discrimination. With Beth being an older adult at the time of the accident, thinking back to when her discriminatory experiences started, alongside her general reflection throughout the interview, gave her the most confidence she had in determining ageism and ableism as an intertwined source by the end of the interview. Although she speculated on other reasons, her healthcare providers seeing her as a disabled older adult became the most significant factor behind their treatment towards her.

Alice similarly shared a starting point that ageism began for her, but rather than a specific date, this was at a specific age: *"One doctor said to me when I was sixty-five and I said, he said "Oh you're getting old, you're sixty-five" and I said [pause] "Age is just a* *number", you know? He says "Do you reckon?""* Alice explicitly being told that sixty-five was the gateway to older age created her perception of healthcare providers seeing age as an arbitrary, social construction and why, compared to the other women, she was most confident in her reasoning of why ageism was occurring. Despite differing confidence, Alice and Beth were able to make sense of the *why* behind discrimination through their remembrance of when it began. Alice's rejection of the statement and the doctor's disbelieving response not only demonstrated the opposing stance, but showcased the rigidity of their beliefs, that had been highlighted in the previous subthemes.

Unsurprisingly, being seen as 'old' signified the beginning of treatment differences for Alice: *"So once you get to sixty-five, everybody's old and [pause] get treated like an old person and [pause] get your coffin ready [laugh]."* For Alice, this was not an issue that merely applied to her, but to all older adults. Providers' perception of older age as a uniform life stage impacted on treatment decisions. Once the criterion of older age was reached, preconceived ideas of how this group should be treated were applied to all, rather than accounting for individual differences and was influenced by older adults nearing their end-of-life. Rather than giving them a new lease on life, they were being prepared for death. This aspect related to how Charlotte viewed the nearing prospect of death as the main influence over why ageism occurred. Differently from Charlotte, however, was that this emerged from other reasons, i.e., as a consequence of why ageism occurred, rather than as a standalone point.

In contrast to the other women, Charlotte remembered ageist experiences starting more gradually and through comparison of past experiences in healthcare:

> *"It's bit different to when I broke my back 'cause my, about, I was in my late forties and I got real top treatment in [hospital] um, and it's just true the older you get I think the more, they probably think you've got time to wait."*

Through looking at and comparing the stark differences from when she was younger, Charlotte was able to definitely say that her age made her a lower priority in the context of what she discussed in *Age causes discriminatory experiences.* The difference here, however, is that with older age came an assumption that she had an abundance of free time and with more time she had, the longer she could wait compared to the younger patients who were assumed to not be as temporally flexible. As with Beth, Charlotte's assuredness of why her difference in treatment was happening grew when looking retrospectively.

For all of the women, their remembrance of when ageism began was intertwined with their awareness of why they were experiencing it. Thinking about and discussing when those occurrences began, aided in their confidence over why. Thus, this demonstrated how comprehension of a broader issue can be developed through breaking down and isolating certain, related components.

Frequency of Ageism

Interconnected with experiencing ageism was the frequency at which it occurred. When discussing their experiences, the participants all made comments regarding how often they had to deal with those instances. In spite of this, the frequency of ageism differed across the three women. Ageism in healthcare was a common occurrence for Charlotte: *"They don't mean to, but lots. Um, like if you're at the hospital, they'll look at you and go work with the younger ones then come back."* Healthcare providers' judgements about older adults being less important with more spare time to wait was directly related to her being chosen last for her required treatment. This was considered an implicit bias, believing that providers were not actively aware they were doing so and why they were making those decisions. Despite it not being apparent for them, it was very overt for Charlotte, as she touched on in *Age causes discriminatory experiences.*

She further expressed this sentiment: *"If they did do something first, like the guy came to take me for an X-Ray and he came straight to me and I said "Oh", you know, "Me! My turn?" Um, it's quite a surprise."* Her surprise at being picked first demonstrated the infrequency of being a high priority and the lack of expectations she had regarding it. Such a strong, emotional reaction would not occur if this happened most or some of the time.

Compared to Charlotte, Beth stressed her ageist experiences as irregular incidents both in and out of healthcare settings: *"Yeah, it happens, it happens right across the board. Most of the time, they, they are nice because of my age and disability. Sometimes, occasionally, they're not nice because of my age and disability."* Here, a dichotomous outcome was observed; both age and disability could serve to influence two opposing behaviours. In this, Beth detailed the frequency of each, emphasising the atypicality of negative experiences. Discussing the positives was as important to her as discussing the negatives:

"'Cause a lot of people are very, very, very nice, I must say. That's, that's the mes-majority of my experience. But don't ask me to give you percentages 'cause I'm, I'm not like [national insurer] I don't put everything in boxes and percentages [laugh] it's not possible."

The continuous emphasis of others good behaviour, further demonstrated through Beth's repetition of the word 'very', and reinforced by those experiences as dominant, showcased how highly she thought of people in general. In doing so, she recognised that she could not categorise human behaviour. The dynamic and variable aspect of this made doing so inappropriate.

In opposition to both Charlotte and Beth, Alice was most unsure over how often she experienced ageism due to the minimal amount of trips she took to healthcare appointments: *"Oh, I don't know 'cause I don't really go very often. Probably two ti-twice a year to the doctors. I just ring up and get my prescriptions put through 'cause I can't see the point in going."* Infrequent visits with long wait times in between made it difficult for Alice to remember the prevalence. However, her decision to remove herself from healthcare services was influenced by those ageist experiences, suggesting that it must have been frequent enough to contribute to her decision.

When ageism was experienced, there was an unavoidable consequence of the frequency at which it occurred. Despite polarising views, Charlotte and Beth were sure of how often this happened, whereas Alice had the most uncertainty. Regardless, it can be observed that for all of the women, the frequency at which ageism was experienced was a key part of their assessment of the situation or their subsequent behaviour.

Complexity of Self-Advocacy

Issue of Being Ignored

Being ignored in healthcare was a prominent way in which providers were ageist to Alice and Beth. However, between the two participants, how this occurred and why differed. Alice's frustration at being ignored stemmed from her expectations not being met:

"I expect them, yeah. I mean if I go up there and say that I've got a problem, I expect them to listen and do something about it 'cause I didn't go there for no reason. But doesn't always happen like that."

Going to a healthcare appointment was done so with an intent in mind on behalf of herself and her provider; for her to tell her providers what was concerning her and for them to listen and take action. Alice's strong expectations signified that she was not open to a dismissive response, especially with her health at play. Listening was the most basic component of an appointment. When a provider listened to Alice's concerns, it signalled to her that her health mattered and she was being taken seriously. Listening also provided the foundation to discuss and engage in diagnostic tests if need be. Action could not be taken if her providers ignored what Alice was saying. As a result, listening and proactivity were equally important. The combination of her expectations not being met and the dismissal of her concerns, both of which served to influence the other, was the sole source of frustration.

This was primarily a problem on behalf of her doctor:

"I had a sore in my head that wasn't healing and had been there for a long time and it just wasn't healing and I said to her about it and she just said "Oh, you've got a scab in your head" and that was that."

The sore was a source of concern for Alice, especially with it not healing. With a common theme among her appointments being the dismissal of her worries, it further reinforced Alice's feelings that her health did not matter, which in turn, increased her feelings of frustration. This was further expressed on another, unrelated trip to her doctor:

"And I'll say to her that, you know, um…I think I'm, um, going to be getting a scan and she said "Oh takes months to do that." I said "I've got the appointment", 'cause my specialist is very good, and "I've got the appointment for that" and she goes "Oh really?" You know? So, I don't know if she-if she would have even bothered to put me down for one if, if I hadn't had one."

Alice felt like a chore to her doctor. Despite only stating she would be getting a scan, rather than asking for one, her doctor became immediately dismissive due to the presumed long wait time. The assumption Alice would have had to wait a while for the appointment signalled to her that it was too much effort to go through with and her health was not worth that. Fortunately, the proactivity of Alice's specialist was a motivator for her doctor to take action. However, both examples demonstrated how Alice's doctor's lack of interest in her concerns spilled over into lack of treatment given.

Opposed to Alice, Beth's concern over being ignored emerged from her vulnerability and the consequential standards she applied to her own behaviour:

"But, uhh, yeah you have to be careful when you're old and disabled. You have to be careful what you say and what action you take because you're very vulnerable and people can choose to do something that's not very favourable. They can choose to ignore you, or not see to you, or to, you know, you are vulnerable. It's a worrying thing when you're vulnerable, it's a worrying thing."

The difference in authority between a provider and their patient created certain expectations over how Beth should and could handle a situation. Despite her providers' behaviour being a choice, the action they took and Beth's response to that was influenced from the intersection of her age and disability. Although ignoring and not seeing to a patient was the responsibility of the provider, Beth unwittingly bore some of that responsibility and felt she had to adjust her own behaviour to create a barrier against that. The exploitation of her vulnerability and her repetition over how worrying it was served as a source of emotional turmoil for Beth.

For both women, their issues with being ignored was situated within the expectations they had. In Alice's case, this involved her expectations for her provider whereas it emerged as self-expectations for Beth. Despite differences in how between the two women, being ignored was a source of upset. As such, the consequences were not purely physical.

Standing Up For Oneself

All of the women had been in situations where standing up for themselves was a necessity. Despite differences emerging between the participants regarding how and why this was done, all related to the need to be properly treated. Alice's discontent with her doctor's dismissive response to the sore on her head led her to seek out another doctor: *"Well I felt I wasn't listened to, so I-I'd thought I'd try someone else and see what they've got to say 'cause I wasn't happy about it."* The pattern of Alice's doctor not listening to her concerns and the frustration surrounding that, motivated her to actively find another doctor. Her doing so was a prime example of how foundational listening was for Alice and showcased how salient those experiences were.

Alice further highlighted why being proactive was important:

"I wasn't satisfied with that so I did go to, err, ring up and get a different doctor and got her to have a look at it and, um, oh she says "Come back either tomorrow or in the next day", it was within a couple of days, "And we'll do a biopsy on it". And she did."

Being proactive in standing up for her needs resulted in a new doctor who met her standards. The doctor's response to make an appointment within a short timeframe and her willingness to give Alice a procedure to determine what was wrong illustrated what Alice meant in *Issue of being ignored* where she stated her expectations over what providers should do; listen and take action. Although motivated by the initial doctor's response, Alice's need to have her sore checked out was also in response to a fear of what it could have been: *"You know, 'cause I thought with it not healing it could be cancer, but anyway it wasn't, but the other doctor did a biopsy almost immediately."* Alice's satisfaction with the change in doctor represented her further expectations beyond the initial foundational ones; to get diagnosed and treated if something was wrong, but also for a peace of mind. With the possibility of her health being at risk, she became fearful and her need to have her expectations met became heightened. Her repetition of the doctor taking action, highlighted the value she placed in it.

Similarly to Alice, Beth also took an active approach in her healthcare treatment:

"So yeah I've had a few instances and, uh, and people making decisions without telling you. That's also happens. Like, or without consulting you, like [rest home] doctor telling me that I should get a stoma, so I researched it and it said; number one, it's non-reversable, number two, you have to follow a diet that is low in fibre which is bad for your intestine, number three, umm, I'm allergic to many adhesives, so if the bag doesn't stick, you can't reverse it and then I've, you've got, we've got a real problem then."

Differently to Alice, Beth's proactivity resulted from a lack of involvement in her treatment plan, which enticed her to do her own research. Due to her disability and her numerous health conditions, Beth had to be concerned about the potential impact treatment had to her health over multiple elements. For her, it was crucial to be involved in those treatment decisions so her expertise over her own health could help guide treatment recommendations to ensure her health would not be negatively impacted. If something were to have happened, it would not have affected just her, but also the doctor who encouraged her to get the stoma in the first place.

Beth recalled another instance where she had to advocate to be included in her treatment. Here, however, she had to repeatedly stand up to her physiotherapist:

"Sometimes it takes a bit of convincing…to convince physio of my needs…and I have to say…and then I say, I've, no "Trust me I'm a physiotherapist, I've done that for many years". "Trust me I've been in this body for two years. I know exactly what my body's like and what it needs". So I just have to put my foot down, which is a bit frustrating."

Beth's need to advocate for herself demonstrated her physiotherapists refusal to include her in the treatment decisions. The physiotherapist seeing themselves as the expert due to their work experience deemed interacting and including Beth as unimportant which resulted in the inability for the physiotherapist to adapt. Beth, who was referring to when she had her accident, saw herself as the expert of her body due to her being the one to have to live in it. No one would have been as familiar with her body than her, no matter the professional expertise. For Beth, this is why consultation, and being open to consultation, were important qualities for her healthcare providers to have.

Like Beth, Charlotte also had to stand up for herself to a healthcare provider, but rather to be included in treatment decisions, a provider refused to give her the repeat prescriptions:

"I copped it at the chemist recently [pause] I…have got, had got used to the staff, but I went in and there was a stranger there and I wanted my repeats and they hadn't notified me, you know how they text your normally? And I fronted up and he, this chap came up and he looked on the computer "She can't have those!" And he gave a big sigh [imitation sigh] another one of these, you know. And, but it was enough to make people look and I said "Why not?" And I had a, um, at home we ha-I had a box saying they were viable until the twenty-third of November, and this was over a week ago."

Despite Charlotte's inquiry into why she had not been notified for her repeats being met with the chemist treating her like a nuisance, she retained her ability to continue questioning him about it. Knowing that she was in the right gave her the strength she needed to confront the chemist. The date her repeats were viable to also happened to be the date Charlotte's interview took place. This strength was maintained in spite of the embarrassment she felt at being the recipient of the chemist's harsh, attention drawing behaviour.

Standing up against discrimination was particularly important for Beth. Driven by what was right and wrong, this played a significant part in how she navigated ageist experiences:

"But I've always been "I can't". I can't let people get away with things that are drastically wrong. The little thing, ehh okay, people forget things, that's fine, you know. People have language problems, that's fine. But lying, no. Abuse, no. Forgetting my medication, to wake me up for my medication, no. Forgetting to switch on my mattress, no. Leaving me upside down in my bed for fi-more than five hours, no. "I'll come back and check in you when you've-in half an hour". Five and a half hours later, I woke up still upside down, was to encourage my, uhh, blood pressure, but of course…the next nurse on duty who didn't do this, said it could have caused, um, a stroke, yeah."

Drawing on from her previous experiences, Beth distinguished between what was acceptable and what was not. Knowing that mistakes could happen and that there could be barriers made her forgiving over certain situations. What was not acceptable for Beth were situations where there was an abuse of power and where her health could have been at serious risk. Although her healthcare providers needed to be mindful of her health, this was not a choice for Beth as any impact would have vastly affected her.

Coupled alongside her need for advocacy was the standard of behaviour she imposed on herself:

"It's important that, that people speak up and it's important to always use PR language no matter what gets thrown at you [laughs] just stay nice and patient and polite and, a-a-a-and that, yeah that's the way to, to deal with issues and to have dealt with them properly, yep."

As was mentioned in *Issue of being ignored,* Beth's own standards stemmed from the risks over how her behaviour may have been responded to. Like with her advocation, applying that behaviour was a necessity for her to obtain her goals. With the possibility of her providers taking advantage of Beth's actions, the guidelines she followed ensured her role as a 'good patient' that appealed to their interests. Since the only way to sort issues out were through her providers, the importance of adhering to those guidelines strengthened.

With the potential of their health at risk, self-advocacy was one way the women had to fight to get what they wanted from a provider. Despite different reasons why, Alice and Beth's future behaviour was in response to how their doctor handled their respective situation, whereas Beth and Charlotte detailed instances where their advocacy was in a direct response to a providers behaviour. Therefore, with self-advocacy, the participants demonstrated the power and autonomy they had at taking an unsatisfactory situation and seizing control of it.

Resistance to Self-Advocacy

Self-advocacy did not necessarily guarantee that a healthcare provider would take notice of Alice's and Beth's concerns. For both women, this came about through a provider not listening and responding to their requests. Alice's doctor's lack of interest and dismissive response to her patient was a barrier for Alice's continuous desire to get her knees treated:

"I mean my knees have been bad for years and I've mentioned that to the doctor several times and she just says "Aw" [mocking tone] and now it's got to the stage and I can't do very much because of my knees and that could have been sorted out years ago [pause] and they'd probably tell me they wouldn't do them because of my age, I would imagine."

The unavoidable consequence of her knees getting worse due to the lack of treatment was a significant source of bitterness for Alice. With what could and should have been preventable, Alice now had to live with the undesirable consequences. The influence of her age could be seen with both aspects. Starting with her doctor's response being a hinderance for the initial examination, over time her age grew to become an assumed obstacle for getting proper treatment. Since the latter stage emerged directly from the first, it demonstrated that at no point did Alice think that there would become a time her doctor did take her seriously.

As with Alice, Beth's continuous requests had also been met with an unsatisfactory response:

"But I, what I also do nowadays, I try to get everything in writing, So when I have an, an um, an issue, I write and "I-I-I look forward to your written response". And I insist and I don't always get that and then it's like "I can't find anything, emails I haven't answered. Can you please look?""

In a demonstration of Beth's persistence at advocating for herself, her new strategy of doing so also ran the risk of not having the intended consequences. In spite of this, her determination at getting them to look at issues she was concerned about remained strong and she continued to do so. Throughout this process the power dynamic between provider and patient shifted. Beth became the one in charge through trying to get her providers to do the job they should have been doing.

While Alice struggled to get her doctor to listen, in one instance, Alice's insistence was immediately met with a refusal when it concerned the same medication that was discussed in *Why age influences discrimination:*

"When I was in-I broke my pelvis and that at Christmas and I was down at the hospital and the medication they gave me, I've got a liver condition, and the medication they gave me wasn't agreeing with that and I was trying to tell them and I was saying, you know, about, about, he said "I just don't want to discuss that.""

The doctor's refusal at listening to her concerns did not make her feel valued. The continuous pattern Alice faced of her providers ignoring her concerns and the potential impact on her health signified to her that across multiple providers and across many of her health concerns, those aspects did not matter to them as a direct result of her age and that for Alice, her experiences of ageism consisted of one area of it influencing other, related areas. Alice expanded on this further:

"You know people say they, because they're too busy, but I was there. I had the doctor in front of me. It would have taken a few seconds to listen to me and make a decision and he didn't want to know about it."

Alice's rejection over a common excuse as to why providers did not show as much interest as they should have reinforced her perception that it stemmed from a place of disinterest, rather than from external factors out of their control. Intertwined with what she said in *Starting point of ageism,* Alice's reasoning as to why there was such a lack of interest was to do with the doctor's refusal to go against predefined ideas over how older adults should be treated: *"You can't get them to listen. They have a set thing that they do and it's like* *what's in the book is what goes. They don't take it as-as you're a different person, you know, someone…else, you know?"*

The doctor's stubborn and insistent response came from them viewing pre-established methods of treatment as the best and only way. Their methodical way of treating older adults ignored the individuality of each patient. When being cared for, it was important for Alice to be seen as her own person with her own needs. She further touched on this:

"You know, yo-you get rolled in and…they go "Right, we've got you an X-ray. It's this". So, they do what they do and they probably do the same to every person that's there and everybody's different and…I-I felt like I wasn't treated as a person, but as a group, you know? That this is what we do to people like you, instead of this is what happens to you."

Predefined ideas over how to treat patients resulted in a lack of communication and thus, involvement for Alice – and other older adults – in hospital. Older age being looked at as a uniform life stage contributed to the doctor's stubbornness over treatment recommendation.

With the decision to push for a two-way discussion about their health, came the risk that Alice's and Beth's requests would not be heard. For both women, the failure of their healthcare providers to take part was a source of irritation. For Beth, her annoyance came about from her decision to try a new method of advocation being met with the same response. For Alice, it was an extension of the ageism that she most experienced, now situated within her lack of desire to be treated as part of a group. For both women, however, it demonstrated their lack of power when it came to decisions about their own health.

Risk of Hostility

From the act of standing up for oneself came the chance that healthcare providers' behaviour could become antagonistic to the women. Both Charlotte and Beth experienced direct hostility, but differences emerged in how they dealt with it. For Charlotte, this occurred in her experience with the chemist:

"He said "I can give them to you, but you're gonna have to pay!" And he made me feel as if…that I was scrounging and it wasn't just one item, it was several and I said "But nobody notified me". "Well that's your fault if we haven't got your number!" But they did have."

Despite the gravity of the event and how emotionally charged it was – as evident by Charlotte's repeated imitation of the chemist – she continued to stand her ground and make known she was not at fault for the situation, partly influenced by the high cost she would have potentially had to pay. This persisted even with the chemist trying to aggressively shift the blame to her and make her feel she was doing something wrong, rather than admitting his own mistake. Charlotte, who was most familiar with her own situation there compared to the new chemist, was able to use that familiarity to retain her assuredness over who was right and wrong in the situation.

Beth echoed a similar interaction where a carer became particularly aggressive towards her:

"Right in my face, really angry and I said "You're angry", "No", "Well, you're loud", "No. This is angry" and then she "Ugh!" And the other carer and me we just looked at each other and we both thought the same, if we react it will make it worse."

With Beth's other carer as a source of support for her, Beth realised that with her standing up to the carer in telling her how she was behaving, the situation was going to escalate. Here, Beth realised she had to change her own behaviour to diffuse the situation. Once again, Beth had to hold her own behaviour to a higher standard to change the behaviour of others. As Beth had to be mindful over how her behaviour could have increased the carer's hostility, being painted as hostile herself was another reason she had clear rules over her behaviour: *"Sometimes I have to say "No, I'm not aggressive, I'm assertive. I make sure you understand what I'm saying.""* Although Beth had been in situations where she had to advocate for her advocation, she was confident in her abilities to do so and was sure of herself regarding what she was conveying to her providers. While she was fully aware of the difference in connotation with her own behaviour, she ensured others were aware too and did not let their perception influence her own. If not, she ran the risk of her behaviour being misinterpreted, unintentionally or purposefully:

"Of course I'm not allowed to get angry ever 'cause then I've done it. I have to be always patient and cooperative. Those eleven things, that's me. No matter what happens it's what I have to be, otherwise I get accused of aggression instead of…assertion. Because I'm, I'm very assertive."

Unlike her healthcare providers, Beth did not have the privilege to not be concerned over how she handled situations. With the power difference between a patient and their provider, Beth found herself following guidelines. The eleven things she mentioned referred to qualities that she valued in a healthcare appointment:

"Beth: I've got a list of qualities that, I, that I appreciate which is love and compassion [pause] and an interest [pause] respect [pause] honesty, democracy, peace, uhh, communication skills, cooperation. Have I got eleven?"

"I: Um [pause] nine."

"Beth: Ten. Nine, oh. Um…understanding…did I mention patience?"

"I:…No I don't think so."

"Beth: Well that makes eleven then…that's the lucky eleven. That's what I was, what I expect."

Although Beth valued and saw those qualities as the gold standard from a provider, she recognised that those values had to be simultaneously applied to herself. For the provider, those qualities ensured an equal and respectful environment. For Beth, they were applied so her behaviour would not be misconstrued.

With self-advocacy came the possibility of Charlotte and Beth experiencing a hostile response. In both instances, the providers' reaction influenced the women's subsequent behaviour. For Charlotte, she continued to stand up to the chemist and for Beth, she recognised that her behaviour had to change to diffuse the, and other, situations. As such, when the providers were opposed to the participants advocacy, the women had to be mindful, ready, and willing to adapt to the situation or to carry on with their original intent.

Advocating For Others

A key feature of standing up against ageism was the ability to advocate for others, but whether it was being advocated for or towards others differed among participants. For Charlotte, being advocated for helped her understand she was being treated differently because of her age in hospital:

"I suppose every time the pills were given out, or the meals, I would be the last one to get mine and I thought it was just me being sensitive and shut up about it and didn't say anything, but then the other woman started to say to whoever bought the pills in, "Go and do Charlotte first. She's been waiting."

Even though Charlotte had been the lowest priority across many facets, the subtleness of it made it difficult for her to definitively see it as ageism. Although it was noticeable, with the possibility of other reasons at play, she did not want to be or seen as overreacting to the situation. As with Beth, Charlotte struggled with immediately labelling the behaviour as ageism as it was not something their providers explicitly told her was happening because of her age. Unlike Beth, however, Charlotte did become immediately suspicious it was ageism. The other patient noticing and commenting on it aided in her understanding that she was not overreacting and made her confident that her it was not just in her head, and was in fact, due to her age.

Similarly, Alice was grateful to be advocated for by her daughter as she was concerned about what could have happened if her daughter was not there:

" Everybody's treated the same and it makes me wonder how many of these older people end up in nursing homes because of the wrong medication they're taking [pause] 'cause that's what woulda happened…to me if my daughter hadn't been there-sort of supporting me."

Healthcare providers ignoring the individual differences of older adults and their stubbornness over how to treat this demographic was the cause of Alice's worry. With the issue of her medication, Alice was concerned that her providers would respond to the negative reaction as a problem with her, rather than introspectively looking at what they may have done and how the treatment they applied was not the right decision. With the medication negatively impacting Alice's memory, this effect being labelled as a loss of cognitive function was a potential reality:

"Um, so if she wasn't there to speak up for me, knowing a lot of people go in there that don't have anyone and they just continue to keep giving me that medication, they'd had probably put me down as Alzheimer's or something like that, and [pause] not capable of living on your own, no."

Alongside the providers viewing and treating older adults as if they represented a uniform life stage, came them attempting to label Alice's response to the medication as a symptom of a disease that predominately affects older adults. All aspects of care from the assessment to treatment was done so through the viewpoint they had of older adults. Those decisions could have potentially caused unnecessary responses that impacted on her and other older adults' way of life.

As had been discussed, advocacy was important for Beth, however, rather than being advocated for, she highlighted the merit of advocating for others, especially knowing she was not the only one experiencing ageism: *"You know I can speak up 'cause if it happens to me it happens to other people."* Driven by what is right and wrong was not just applied to herself, but to other older adults as well. No matter who for, Beth placed great value in doing so. Through speaking up, Beth could draw more attention to the discriminatory practices of healthcare providers. With the possibility that those occurrences could begin to have consequences or result in more awareness of what was happening, it could help other older adults, whether inadvertently or directly. Beth recounted an instance where she drew attention to the mistreatment of another patient:

"The people with, uh, dementia they don't, you know, th-there was an arrest, was in another rest home, I was there and a man knocked on my door because my carers were there and he could se-, "Can you please check my room?" and his bed was wet with water, the floor was covered in shards of glass, and the bed, they'd thrown some sheets on top of the bed. So there he was and then the excuse was "Oh he doesn't know what's going on, he's got dementia." He knew very well what was going on otherwise he wouldn't have knocked on our door. It was me, they don't get away with that."

The providers, who saw the patient's dementia as a reason to target him due to their belief that with his cognitive impairment, his perception could not be considered reliable, assumed they would be able to get away with it. Through immediately dismissing their excuse and by giving the patient more credit than they did, Beth and her carers became a strong advocate for him. For Beth, she was as equally moved to help other older adults as she was to help herself.

The women's experiences of advocation was not always self-imposed. Charlotte and Alice were both advocated for on behalf of another individual in response to unfair treatment. For Beth, standing up for others was as important as standing up for herself. As a result, across all participants, the help from others was a principal and appreciated way to minimise and stop ageism.

Removal From Situations

With self-advocacy came instances where the effects of doing so were largely emotional. This became the primary reason why all of the women made the choice to remove themselves from the situation at hand, but how this was done differed. For Alice, not having her concerns about her knees listened to made her stop bringing it up to her doctor:

"No, we didn't talk about, I said to her about it and how bad they were and she just…really just shrugged it off. "Well what do you do?" I said I rub balm on them but it's not helping…and it's never been mentioned since. I can't see the point."

Despite Alice providing space for a discussion about her knees multiple times, her doctor ignored the seriousness of it every time and placed the responsibility to treat them on her patient. Knowing that since her doctor did not take it seriously at any point, Alice's desire to bring attention to it again dropped due to the absolute lack of confidence she had in her doctor to start behaving differently.

This was reinforced from her doctor never bringing the discussion up again: *"She's never me-neither of us have, I've just never bothered I think what's the use."* Not only did the doctor's response make Alice think her knees did not matter, but the doctor's non-response was further proof of that, reinforced by the long period of time that had transpired since Alice first told her doctor: *"Oh it's been a few years ago now since I told her [pause] and when I got that reaction I've never bothered again, I thought what's the point."* Alice continually making the point that discussing her issues with her doctor was useless reinforced her feeling undervalued in her appointments. This consequence continued to stem from a place of frustration that her expectations were not met.

Like Alice, Beth's frustration impacted her subsequent behaviour. Unlike Alice, however, this resulted from her not knowing how to handle a situation: *"Yeah I view myself…usually as an assertive, capable person. Sometimes I'm very frustrated and don't know what to do and then look for distraction and then I hope time will resolve the problem, yeah."* Despite Beth's strong sense of self, some situations could be difficult for her to manage, both strategically and emotionally. When she had no other options or did not know how to handle a situation, removing herself from it in order to distract herself became her strategy. While relying on external factors, she relinquished herself from the authoritative role she usually upheld.

In doing so, Beth employed a number of distraction techniques: *"I either look for peace and quiet like some trees and flowers and birds and sunshine and nice breeze and yeah. Some games on TV and yeah. That's, talk to my family. Distraction basically, yeah."* Through utilising different means of distraction, Beth was able to compose herself through a variety of different ways. From feeling calm to being entertained to talking with a support network, all of it were done so to keep her mind off the situation and reduce the frustration she was feeling.

Likewise, Charlotte also removed herself from a situation, yet this was a decision to leave her chemist and go elsewhere: *"I'm usually tough, I worked for [government agency] years ago and you had to be tough and I-I was in tears and I said "Well I'm finishing up, I'll, I'm not coming back here."* While up until this point, Charlotte was able to remain opposed to the chemist, the intensity of it and how emotionally impactful it became too overwhelming for her to handle. Although Charlotte saw herself as someone not easily effected by such things, her limits were tested. Because of this, and her not tolerating the chemist's behaviour, she made the immediate decision to change chemist.

Alice shared a similar situation where, although not changing providers, her doctor's behaviour was the result of her decision to drastically reduce the amount of appointments she made:

"I: So just going back to the point about having to advocate for yourself, um, how often would you say you have to do that?"

"Alice: [Pause] probably every time you go, uh-um, and I don't go very often because of it, so."

For Alice, there was no point in advocating for her worries about her health to be taken seriously. With the repeated pattern of her doctor not listening to her and her advocation being led to nothing, doing so became tiring. Without her doctor taking action for her, Alice knew that going to the doctors was pointless. Although Alice stated in *Frequency of ageism,* that she was unsure over how often she experienced ageism, this demonstrated that it was frequent in the sense it occurred in every doctor appointment she had, which eventually become the direct reason she stopped going.

When self-advocacy did not have the intended result, all three women made active decisions to remove themselves from the situation. However, this was not necessarily a decision the women made because they wanted to, but as a last resort because the emotional consequences were becoming too overwhelming and pointless. Thus, removing themselves was a coping strategy for the participants.

The Impact of Ageism

With the multiple, contextual elements of the women's experiences of ageism and the salience of those events, there were unavoidable consequences for the participants. How ageism impacted the women was diverse across the three of them. One of the repercussions it had on Alice was her frustration over all the components related to her experiences, such as the lack of change: *"Like I've wasted my time [pause] no better off when I come out than when I went in."* With no change before and after a doctor's appointment, her physical health remained the same with no attempt for treatment in sight.

While this went against Alice's wishes, it also constituted a waste of resources: *"I just think…I-it's just been a waste of time and money. Wh-why did I bother?"* Here, the impact it had on Alice concerned her navigation of healthcare systems. In making appointments, there were costs that had to be made – ones that Alice could not get back. The incorporation of this loss and lack of results was the source of the emotional consequences Alice faced: *"I think…yeah, I mean they're still [pause] being sort of kind, but, um…they dismiss a lot of things…I find I get dismissed and I come out feeling frustrated."* For Alice, the impact on one area – the waste of resources – impacted a subsequent area – her internal processes. Both of those stemmed from the aspect of ageism that predominately plagued her – her expectations in healthcare not being met.

Alice further expanded on how those two factors converged: *"Where had she discussed my knee and why she wasn't doing anything about it, or my knees, you would sort of come away thinking "Well she listened to me at least."*

As Alice had stressed throughout the interview, listening to her concerns was the most fundamental component of her healthcare appointments. Listening paved the way for discussion and involvement to open up. This was the basis for her to feel respected, even if no treatment was given. In the numerous instances where this did not happen, it contributed to the frustration Alice felt.

Alongside ageism having an emotional impact on Alice, it also had a drastic consequence on her physical health: *"And it was because my knee gave out that I fell down and broke my pelvis and had they listened to me about my knees and corrected them, that never would have happened."* While the physical injury was not needed for Alice to become frustrated, it was a major source of it in this instance due to the ease with which it should have been preventable. This was an example of how there were wider consequences to the doctor's initial response and how one instance of ageism opened the doors for other opportunities for exposure to ageism, i.e., through Alice's issues with her medication.

Charlotte also experienced an emotional effect, but this was related to how she internalised ageism: *"Low, worthless [pause] I feel like we're filling in time 'till we die and [pause] and it's very good, very hard to get self-worth [pause] you just feel, feel like a nuisance."* Charlotte's experiences of ageism negatively impacted on how she viewed herself. Without any confidence being installed in her, she felt like a burden to her healthcare providers and that her and her concerns did not matter. With providers viewing older age as the life stage closest to death, Charlotte was made to feel as if that was the only thing going for her. As a result, how she viewed herself mirrored her reasoning of why they are ageist in the first place.

In stark contrast to Charlotte, Beth found it essential to have a strong sense of self: *"I'm me. Other people don't determine who I am, I do. And that's I think, that's essential to, uh, to stay happy and functioning."*

Not allowing others to dictate or influence how to view herself, this was a prime coping strategy for retaining her psychological wellbeing. The confidence in how she identified herself was observed across many facets. Beth was sure of her capabilities in handling situations was and sure of herself as a person. The former was able to come forth from the establishment of the latter.

As another coping strategy, Beth often employed humour: *"I joke around a lot. It's the best way to deal with, that's what I do."* Making jokes about her experiences helped lessen the negative impact it had on Beth. It was one way, alongside having a strong sense of self, that Beth was able to retain and improve her psychological wellbeing.

Unlike Alice and somewhat like Beth, Charlotte's experiences of ageism had a significant impact on her subsequent behaviour, but rather as a coping strategy, she believed that because of her age, she could not do the same stuff she once did anymore: *"If you're not careful they make you start behaving frail instead of saying, the old me would have given it a go and if you hurt afterwards well bugger it, it's worth it."* Charlotte found that her behaviour became moulded into what her healthcare providers expected from an older adult. Her younger self, being more driven and confident, was quite different from how she painted her behaviour now. Despite the reasoning behind this change falling onto other individuals, Charlotte felt she bore the responsibility to be actively mindful around noticing this shift. If not, she would find herself pulling away from behaviours that were once familiar to her:

"Yeah. Um, stopped walking down steps. Um, there's a perfect answer if people can't walk down steps, you go down them backwards. It looks daft, but, um, that's the type of thing, you stop doing things and if you stop them it's hard to start again."

Due to Charlotte's bad knees, she had solutions in place to help her keep mobile. However, she found it all too easy to lose the engagement she had with those strategies. Having healthcare providers attempt to shape her behaviour a certain way, it became more difficult for Charlotte and retain her self-motivation and too easy for her to fall into patterns of certain behaviour. As with Alice, Charlotte's frustration often emerged from another factor at play. Here, it related to her change in behaviour:

"You give up, start giving up stupid little things and it escalates. Um…you don't have to do it when you're younger, but you have to start making a concentrated effort to do things. "Righto, I'm going to get down." I can't kneel, for instance, my knees have gone and I'm determined that one day I will be able to kneel down on the floor and do something. You've, you still gotta set targets."

Charlotte's frustration came from how easy it was for her to stop engaging in simple acts. It started off small, but through falling into this pattern of habit, the consequences became larger. With older age, came a much higher need to be active and motivated in retaining certain behaviours. Despite the difficulty of it, Charlotte had retained her confidence for her future self that those targets could still be reached. However, Charlotte often found that through stopping her engagement in certain behaviours, it resulted in a subsequent impact on other behaviours due to a perceived inability she could not do it:

"Yeah it's…I found myself stopping making plans ahead. Things, just things like that. Um [pause] you start to screw yourself into a corner. It's very hard and you see other people doing it and that's what troubles you out of it. Um [pause] yeah it's difficult."

Through this, Charlotte's freedom dropped. While knowing this was the result of ageism, she, again, felt responsible for the decisions she was making. Despite the difficulty of the situation, witnessing other individuals doing the same thing, became a motivator for her. Trying to understand what was happening was hard when it was done so purely through introspection. Through observing others, she was able to more clearly look at what she herself was doing. With the ability to assess her own behaviour, Charlotte was able to start engaging in behaviours she used to do again.

For all three participants, they were inevitably impacted by ageism in healthcare. For Alice, this emerged as her frustration over a lack of change and a waste of resources, as well as the physical impact. For Beth and Charlotte, despite to opposite degrees, it impacted on how they viewed themselves and their subsequent behaviour. Despite the diversity of how and what they did, if they did, to overcome it, it remained a crucial focal point over how they experienced age discrimination. As such, the impact it had provided insight into how they perceived, made sense of their experiences, as well as the salience of it.

Non-Ageist Experiences

With the women's discussion of ageism, it was important for them to highlight moments where they had been treated fairly. Although ageism was not always an issue with every healthcare provider the women came into contact with, there were differences in how this was expressed. Emphasising that ageism was an individual issue rather than a healthcare issue was particularly important for Beth: *"'Cause they can get away with it, they'll do it, some of them. Others are really good."* Beth's constant reinforcement of healthcare providers as good and her respect for them was shaped by her experiences being largely positive. Due to this she was able to provide a clear distinction between providers who delivered good care and those who did not.

This distinction was upheld even after the negative experience with her aggressive carer:

"This carer was lying about me, about her co-workers, and about her boss…I don't know if she was lying about herself I [laugh] can't check that, but um, yeah, not a very nice experience and um, the other carer said she had never experienced, she's been working for, I think twelve years in a rest home, so never experienced anything near it. Uh, yeah that was pretty bad, but it's a one off. Can't judge the rest of them."

Despite the gravity of the situation, it did not cloud her judgement of healthcare workers as a whole, further reinforced by the majority of her experiences being positive. The other carer who was a source of support for Beth during this time was one example of how, with the negative experience, Beth could rely on and have a good experience with another provider. Beth's ability to isolate negative incidents was further strengthened through the other carer acknowledging the rarity of those instances.

As with Beth, positive experiences from other healthcare workers provided a source of support for Charlotte. As she discussed in *Removal from situations,* Charlotte and her husband made the decision to change chemists. However, a future positive encounter was a barrier against that decision:

"The staff in at [chemist] umm, you have to wait a big longer, but you always get a smile and they get to know you and, we went in there and the young woman was just so pleased to see us, it made me feel, you know…I'm over this, I'll stay here. So that's what we did."

A warm, welcoming environment was an important quality for Charlotte. The environment provided a sense of belonging and installed feelings of value in her which became a key factor in her decision over what chemist to use. The positive environment was paramount for Charlotte to such a degree that it overrode other limitations in its service.

Alice expressed a similar sentiment at her relief over the appointment she made with a different doctor regarding her sore on her head:

"I think, I think, no, I think she was really, what I expect a doctor to be, to listen, an-and understand what you're saying. You know people don't spend money to go there and have a conversation. They go because they've got a problem."

Alice's appraisal of her doctor signified that her expectations over what should happen in an appointment was met. Her continuously stressing how much she appreciated a provider listening to her concerns demonstrated just how important it was for her and why she saw great value in the instances where her expectations were met. Not only did she feel respected and valued, but it also justified the costs she made to have the appointment. For Alice, the costs she had to make reflected both a want and a need for her appointments to be worthwhile.

Alice's appreciation of those factors in healthcare was further expressed: *"Well he [specialist] does listen to what you're saying and he's always, you know, "You ring me up if you've got a problem" or…you know, "Don't just sit around a-and worry about it. Get on the phone to me.""* As with her other doctor, Alice's specialist was one that took an active approach to care. Through encouraging Alice to see him as soon as she experienced a problem, both parties became proactive. The combination of being encouraged and knowing her concerns will be taken seriously was a motivator for her to attend his appointments.

Despite ageism being present in the women's navigation of healthcare, all also come into contact with providers that treated them with dignity and respect. For Beth, this was quite common, but for Alice and Charlotte those positive experiences were important for them as it signalled what they wanted and/or expected in healthcare, resulting from previous failures to meet those standards. As such, all the women recognised that through their navigation of those systems, ageism was not going to be a threat every time.

Chapter Four: Discussion

The aim of this research was to examine older adults' experiences of age discrimination in healthcare. To expand on and provide new insight into this phenomenon without basing it on prior assumptions, Interpretative Phenomenological Analysis was employed to allow the participants to be placed at the centre of the research in order to hear directly from them without any constraints in what they could say. As such, the research question was: "What is the experience of ageism like for older adults within healthcare systems?"

This chapter consists of an overview of the findings that will be related back to the past literature. The implications of the study will be subsequently discussed in terms of how the research contributed to and add to the understanding of ageism in healthcare, particularly within qualitative research. In addition, the limitations will be described, ending on recommendations for future research.

Summary and Interpretation of Findings

Understanding Ageism

For the women to label their experiences as ageism, it was necessary for them to understand what ageism is and how it can be expressed. This comprehension was shaped by them noticing when they started being treated differently. Whether it started at a specific point in time or over time, all participants were aware of a change that was different to what they were used to. The women's recognition of this was often intertwined with their understanding of why their age served as a reason for discrimination.

Withholding or delaying treatment was a common experience that was perceived to emerge from assumptions about older age that healthcare providers held. In support of past literature, stereotypes regarding age and ill-health has resulted in a lack of interest in patient concerns leaving older adults' feeling like their age makes them less worthy of treatment (Abdou et al., 2016; Ouchida & Lachs, 2015; Vogt & Dahlke, 2023). In further support of the literature, being a lower priority compared to younger patients was apparent. Both in past experiences and potential future experiences, older adults have experienced and been worried about not receiving the same attention and becoming disregarded as a result. In contrast, however, some found that it fair that younger, working adults were prioritised over those who were already retired as delayed treatment would not have impaired their daily lives to the same degree (Werntoft et al., 2005). In agreement with research regarding ageism in the macrosystem, the issue of treatment hierarchy related to how ageism can be observed in the allocation of resources to which younger adults tend to be top priority. The difference between the current findings and past research, however, is that QALY measures and the fair innings argument relate to external processes that determine the priority of patients (i.e., through measures and limited resources). Here, there were no issues regarding what demographic should get a specific treatment, but rather the order in which it was done. Since past research on this topic tends to focus exclusively on these measures, those results fit that narrative. In the current study, these findings emerged based on how participants observed the healthcare system (Bognar, 2015; Harris & Regmi, 2012).

Not feeling important enough for desired care was a common finding and related to older age being viewed as close to death. While older adults and mortality are often associated with each other, theories of prejudice suggest that it is being aware of one's own mortality that impacts on discrimination (Martens et al., 2004). Although the approach the current study took cannot lend support to whether the women's providers held this prejudice through that association, it did present findings that from older adults' perspective, the two are closely related.

Alongside age, the findings demonstrated that having a disability can be a significant reason as to why one can be treated differently in healthcare. Like ageism, ableism is also characterised by stereotypes, prejudice, and discrimination. However, this is directed towards those with a disability – hidden or visible – chronic conditions, mental disorders, or based on the perception that an individual is physically or mentally incapacitated to some degree. Past literature has gone into detail about the intersection of ageism and ableism, with some researchers postulating that ageism and the associated fears about the ageing process emerges directly from ableism. Since ableism classifies disabilities in terms of health with little regard to the social aspects, healthcare is a prominent place in which this discrimination occurs (Gendron et al., 2024; Langmann & WeBel, 2023; Rabberu & Gillis, 2021). Although this was not a focus of the current study, the intersection of ageism and ableism in the findings supported the notion of a relationship between the two.

Engaging in Self-Advocacy

As demonstrated by the findings, discriminatory treatment was not always through explicit communication. Often it resulted from a lack thereof. Older adults having their concerns ignored has been a prominent finding in past research where this ultimately had significant impacts on their treatment (Gholamzadeh et al., 2022; Makris et al., 2015). As was shown in the current findings, the two-way interaction between provider and patient was the basis for providing treatment. This sentiment was echoed in past research where having a provider listen to their concerns and communicate about it with them was a desirable quality for older adults and when this did not happen, they were left feeling like they were not important enough for their providers (Kelly et al., 2019; Williams-Roberts et al., 2018). The present findings further showed that being ignored was a potential risk resulting from the vulnerability of being an older, disabled adult. In the literature, however, this has been contextualised through ageism or ableism. Both, however, are framed in the viewpoint of vulnerability based on stereotypes that can cause patronising care due to the perception that their wellbeing is of a lower quality and that the patient has reduced capacity to be as involved, subsequently minimising their autonomy. All these factors ultimately influences how treatment is conducted. Despite the tendency for research to isolate ageism and ableism in this regard and to locate vulnerability in terms of an abundance of care rather than a lack of it, fear over how older age and a disability impacts on treatment has been found to have a strong relationship among this demographic (Gendron et al., 2024; Graff & Russell, 2023; Langmann, 2023).

Resulting from the issue of communication, self-advocacy was a prominent way the participants responded to ageism. Past research has found that engagement in self-advocacy was prevalent in 41.35% of older adults and as with the women in the current study, the decision to do so was motivated by their belief that it could result in a positive outcome for their health, despite different reasons for doing so (Novinmehr et al., 2019). The findings revealed that not being involved in one's own treatment plan and issues surrounding medication were significant reasons for this engagement. While there was no relation between self-advocacy and being made to feel like one is seeking attention, as other older adults in past research have found, the concerns presented here echoed the findings of past studies where older adults expressed how a lack of involvement in their treatment plans demonstrated that their worries were not taken into account and that being involved was a quality that mattered a lot to them. Retaining autonomy in those decisions was an especially important characteristic that had been further prevalent in previous literature. As such, conducting one's own research to help them decide the route they wanted to take for their treatment was a common method of self-advocation (Martinez-Angulo et al., 2023; Makris et al., 2015; Ruggiano et al., 2016 Van de Pol et al., 2015; Williams-Roberts et al., 2018).

Unfortunately, self-advocacy did not always have the results the participants were hoping for as many providers were not willing to respond to their patients' interests in the way they would have liked. Unsurprisingly, continuing dismissal is a common reaction to those efforts and the continuation of self-advocacy has been found to be influenced by providers' responses (Ruggiano et al., 2016). The findings here demonstrated that health issues remained due a pre-established idea over how treatment should be given. In accordance with past literature, differences in treatment to what was wanted was one form of discrimination that emerged from a lack of communication, particularly for dependent patients. In both instances, this resulted in the patients' needs being synonymous with the needs of older adults in general (Band-Winterstein, 2015; Gholamzadeh et al., 2022; Martinez-Angulo et al., 2023; Ruggiano et al., 2016; Vogt & Dahlke, 2023).

At times, providers communicating in a hostile manner was a risk that participants faced in their attempts to advocate for themselves, as reported by the current findings and past studies (Gholamzadeh et al., 2022; Kelly et al., 2019). Despite this, participants were able to retain their ability to advocate for themselves in the face of hostility due to the belief they had in themselves. As had been demonstrated, past research has found that confidence in oneself and their own ability to communicate well was an important quality with an older adults' decision to self-advocate and their continuing to do so after being dismissed (Novinmehr et al., 2019; Ruggiano et al., 2016).

While the participants were advocates for themselves, they also were advocated for or advocated on the behalf of others. For all the women, their descriptions of a third party being involved led support to ageism operating in the mesosystem. Despite the attempted self-advocation, change sometimes only occurred through another's behaviour. While past research has historically focused on how the presence of another can influence ageism regarding communication, the findings presented here highlight how it can also reduce it in the same way. As such, the current findings lend credence to the importance of others in older adults' healthcare experiences (Ben-Harush et al., 2017; Stubbe, 2017). As was previously demonstrated, the nature from which participants were able to discuss their experiences of ageism in general rather than focusing on specific aspects, allows for different ways of conceptualising this form of discrimination.

Reducing Engagement With Healthcare

Continuing to self-advocate for themselves was not something that the participants were able to consistently engage in largely due to the difficulty of the situation. As a result, the participants also made the decision to step away from the situation at hand. Often, the women were not comfortable remaining in their respective environment and as Ruggiano et al. (2016) put forward, how comfortable one is in standing up for themselves can determine whether or not to engage in this type of behaviour.

Furthermore, the findings demonstrated how ageism can lead older adults to minimise their engagement with providers or stop using certain healthcare services due to no progress being made and low expectations that their needs will be met, thus making appointments futile. The findings presented here support those by Martinez-Angulo et al. (2023) in which participants discussed how ageism resulted in fewer trips to healthcare appointments. While this decision was made in part with poorer self-perceptions of ageing, the current findings were purely related to a providers' behaviour. Although this was not touched on in the current findings, ableism itself has been found to negatively impact patients' relationship with their provider, causing reduced communication on behalf of the patient over concern of being ignored or being negatively looked at (Graff & Russell, 2023).

Ageism as Impactful

The whole experience of being discriminated against and the participants' responses impacted the women in various ways. Despite the diversity of this, the effects were largely on the participants' internal processes. As past research has similarly found, frustration was a significant consequence for older adults that left them dissatisfied with their poor care (Abdou et al., 2016).

Furthermore, the present findings also demonstrated that another's behaviour can impact on one's own. Here, ageism can be a self-fulfilling prophecy in which older adults' behaviour can change to fit alongside the providers' expectations, additionally reducing one's self-motivation. These findings lead support to past literature demonstrating how ageism led to poorer self-perceptions of ageing which in turn, was associated with stereotype confirming behaviour such as a reduction in physical activity. In contradiction, however, is that the current findings showed that the association between ageism and physical health is not always mediated through how an older adult views their own age and that worsening health can be explicitly due a lack of treatment. Despite the current findings not demonstrating this, the combination of ageism and ableism has also been shown to become internalised among older, disabled adults, typically regarding fear of declining physical and cognitive health. In spite of this, all of this demonstrates how the microlevel and the individual level of the ecological systems model can, or potentially, converge together even if the individual is impacted in different ways (Ayalon & Cohn-Schwartz; Ayalon & Tesch-Romer, 2018; Gendron et al., 2024; Martinez-Angulo et al., 2023; Phibbs & Hooker, 2018).

Positive Experiences

Though the women discussed their experiences of ageism, they also touched on moments where they felt valued and recognised that ageism was not something that they experienced in every healthcare appointment. For the participants, those healthcare providers were a source of support whether it was regarding their health or installing feelings of belonging. As such, those occasions were very important for all. This supports findings presented in past research where most older adults had positive healthcare experiences and

53% of older adults had a positive relationship with their provider and were largely pleased with their communication. Around 81% of older adults further stated that their health advocacy also came from their providers. Unsurprisingly, that advocacy and support predicted the positive view of the communication style and the positive relationship older adults' had with them (Kahana et al., 2018; Werntoft et al., 2005).

Positive experiences greatly impacted the participants' subsequent behaviour. As Makris et al. (2015) reported, a positive relationship between patient and provider was a protective barrier against completely removing oneself from healthcare systems. This supports the findings presented in the current study. Since the participants' ageist experiences was the contributor to them removing themselves from those systems, feeling valued greatly motivated them to stay and to continue making appointments with their respective provider.

Contributions to Qualitative Ageism Research

In light of the similarities and differences between the current findings and past literature, it can be observed that there are numerous ways this study has contributed to the research field of ageism towards older adults in healthcare. Looking broadly, the current findings strengthen and deepen what is already known regarding ageism in these systems and this study is one of a small number of qualitative studies that focuses on these aspects. In accordance with the aims of qualitative research, this study gave participants the opportunity to express their subjective experiences of ageist healthcare providers (Alharahsheh & Pius, 2020). Alongside this, participants' accounts gave detail to multiple diverse, contextual elements including how ageism is expressed for them, such as the social, behavioural, and psychological elements (Chen, 2010). While previous qualitative research has been beneficial in contributing to this understanding, the current research further does this through explicitly looking at ageism solely through the older adult perspective, rather than combining their perspective with another group, or finding ageism or ageism in healthcare as an emergent theme (Gholamzadeh et al., 2022; Makris et al., 2015; Vogt & Dahlke, 2023).

Regarding the similarities across the findings in qualitative studies, the current study demonstrates how ageism can share the same or similar qualities across older adults from different cultural backgrounds. In contrast and in IPA fashion, it also showcases how ageism can be unique to those that experience it. In light of the research question and the depth at which qualitative research is done, it paved the way for this to occur and the differences between the internalisation of ageism demonstrated this. For example, while one's internal processes can be become quite impacted through adhering to external expectations, some degree of self-motivation can be retained, suggesting that there can be certain degrees to how internalised ageism becomes (Smith & Nizza, 2021). Furthermore, these findings also added further commentary on the ecological systems theory where it demonstrated that certain aspects of ageism can operate at multiple levels or within one specific one based on participants' individuality. The internalisation of ageism is a further example of this. Lastly, the study also provided potential new insight into ways that ageism operates within these levels. While much of the research in those systems were quantitative, the similar findings presented here and in other qualitative research, demonstrates that one perspective, i.e., through healthcare providers is not solely needed to uncover certain results.

Limitations

Interviewing plays a large part in the type of information gathered and the quality of it (Smith & Nizza, 2021). While I familiarised myself with the interview guide and practiced conducting interviews beforehand, formally doing so for research was a novelty. Upon reflection of the transcripts I realised there were moments where certain points of interest were not followed on and when I asked non-anticipated questions, how I worded them was not always ideal, such as asking a closed question when an open one would have elicited more information. While I found that the participants' accounts gave a lot of valuable information, some may have been unintentionally left out of the discussion and subsequent analysis.

As a requirement of IPA, samples should be homogenous (Smith et al., 2009). While being an older adult was an inclusion criterion, the participants being all women and of European descent was unintentional. Nonetheless, they represented a similar group. However, while the other two participants discussed their experiences solely in terms of their age, Beth being a disabled, older adult could have drawn away from this homogenous criterion. As Beth stated, she was initially unsure over how to make sense of what form of discrimination was occurring. While she did later regard it as both ageism and ableism, the combination of the two, while it still provided valuable information, did inevitably shift the focus from looking purely at ageism.

In the same context of homogeneity, participants were able to freely discuss their experiences of ageism in healthcare in general. Given the difference in health conditions between the women and the variety of providers they used, this decision was made so participants would not feel constrained in their answers. Furthermore, given the findings from past literature, a more broad overview of ageism was a goal of this research. While there were similarities in the type of healthcare providers the participants mentioned, i.e., doctor, the ability to mention experiences of ageism across multiple healthcare settings could have continued to shift away from IPA's homogenous criterion.

Recommendations for Future Research

With the sample in the current study representing a specific group, future research could continue to look at older adults' perspectives of ageism through different populations. As was demonstrated from Beth, ageism does not always operate in isolation from other forms of discrimination, but can converge with others to impact on the type of treatment received. For ethnic minorities, racism in healthcare is often prevalent throughout one's lifespan. With more difficulty penetrating healthcare systems and race being a determinant of protocols that influences treatment decisions, there are inevitable inequities in health between Caucasian and non-Caucasian populations, including a lower life expectancy and higher rates of disease. When ageism becomes another form of discrimination individuals have to endure, then the health effects already present strengthen (Farrell et al., 2022). As with the aim of the current research, through looking at the experiences of ageism and racism in healthcare through the perspective of a particular demographic, such as Māori and Pasifika, further insight could be provided into the myriad ways discrimination operates and its associated effects. Since ageism is apparent with other forms of discrimination, it is crucial to be mindful of and include others perspectives to combat discrimination in healthcare.

Continuing from here, it would also be wise to expand on how ageism and ableism interact in healthcare. As was previously discussed, the prejudice literature regarding how ageism can be rooted in a fear of illness and reduced physical capabilities is also inherently ableist as it represents the fear of disabilities (Gendron et al., 2024; Martens et al., 2004; Nitschke et al., 2022). Of course, ageism does not always emerge from ableism as older age itself can give way to discrimination, to which Alice's and Charlotte's accounts can attest to. However, further research would be beneficial in untangling this intersection and seeing the extent to which age influences ableism and disabilities influence ageism (Van der Horst & Vickerstaff, 2022). By doing so, a more fulfilled understanding of the elements of ageism can be observed.

Since the presence of ageism in healthcare has been well established, studies should also bring its attention to identifying and researching strategies to reduce ageism and leave older patients with a good impression of their healthcare experiences (Shpakou et al., 2021).

Multiple suggestions have been put forward by researchers regarding ways to reduce ageism, including communicating without reference to age or creating multidisciplinary teams that has been posed to reduce ageism through collaboration and increasing motivation to reach a shared goal, subsequently decreasing ageist attitudes. These multidisciplinary teams can help guide decision making through use of knowledge from those that specialise in geriatrics and through the patient's and families wishes as well (Gendron et al., 2018; Inouye, 2021).

Healthcare systems need to be inclusive to older adults. The current findings go against a tenet of healthcare systems – for patients to be active in discussion about their health and treatment. Acknowledging and acting on the collaborative necessity through upholding the expertise of the older adult regarding their own health, a more equal relationship can be ensued. To do so, creating an environment where patients feel comfortable discussing health related information, being allowed to contribute to the discussion surrounding what form of treatment they want, and to inquire throughout the whole process. This autonomy needs to be present throughout the entirety of older adults' engagement in healthcare (Rabberu & Gillis, 2021). Despite not being an aim of the research, the participants touched on their expectations of healthcare and the positive experiences they had. Though it can be observed that the salience of ageism can be contextualised by it going against those expectations, this study was not able to fully explore what older adults would like to see and what they think needs to change. Conducting research on this topic can shed further light on what needs to be implemented.

Furthermore, education on and having conversations about ageism among healthcare providers can help reduce stereotypes and misinformation and can lead the way to a more considerate way of providing care and can perhaps reduce the prescription of non-suitable medications. Targeting ageism across different levels such as structural interventions and the accompanied age-related policies has been a further suggestion (Band-Winterstein, 2015;

Inouye, 2021; Mikton et al., 2021). With all these recommendations, implementing and evaluating them in research could help support the efficacy of them which could then be applied in healthcare.

Conclusion

To summarise, the women's understanding of what ageism looks like for them provided support for previous findings. This included age being a reason to withhold treatment, the commonality of being treated as part of group, differential treatment based on stereotypes and prejudice, and how different types of discrimination can intersect with each other. Many times, this resulted in the women being ignored. In further support of past research, self-advocacy largely defined the women's response to ageism. While this had the intended effects, at times it did not and continuing to be ignored or experiencing a hostile response was a common barrier. Advocacy on behalf of a third party was also prominent and was vital in reducing ageism. As many other older adults have experienced, ageism and their feelings about the situation often impacted the women's decision to distance themselves from the situation. Experiencing discrimination often has various consequences, but as has been extensively found, it can change the perception of oneself. Despite all these instances, ageism is not always a threat to older adults and providers creating a positive environment can be an important source of encouragement to engage in healthcare services. Across the findings, the differences between the current study and past research can be attributed to this study's different approach and the individualism of everyday life. As such, by taking a different approach, new information could be brought to light alongside potential new ways to conceptualise past findings. Ultimately, the type and quality of information gathered depends on the researcher's interview skills and the strength to which the study adheres to the requirements of the methodology. In light of this, conducting new research on different demographic groups, the intersection of different forms of discrimination, and how ageism can and should be reduced is a beneficial direction research should go towards.

References

Abdou, C. M., Fingerhut, A. W., Jackson, J. S., & Wheaton, F. (2016). Healthcare stereotype threat in older adults in the health and retirement study. *American Journal of Preventive Medicine, 50*(2), 191-198. https://doi.org/10.1016/j.amepre.2015.07.034

Abey-Nesbit, R., Jamieson, H. A., Bergler, H. U., Kerse, N., Pickering, J. W., & Teh, R. (2023). Chronic health conditions and mortality among older adults with complex care needs in Aotearoa New Zealand. *BMC Geriatrics, 23*(318). https://doi.org/10.1186/s12877-023-03961-8

Al-Ababneh, M. M. (2020). Linking ontology, epistemology and research methodology. *Science & Philosophy, 8*(1), 75-91. https://doi.org/10.23756/sp.v8i1.500

Alharahsheh, H. H., & Pius, A. (2020). A review of key paradigms: Positivism vs interpretivism. *Global Academic Journal of Humanities and Social Sciences, 2*(3), 39-43. https://doi.org/10.36348/gajhss.2020.v02i03.001

Aronson, J. (1992). Are we really listening? Beyond the official discourse on needs of older people. *Canadian Social Work Review, 9*(1), 73-87. https://www.jstor.org/stable/41669465

Ayalon, L., & Cohn-Schwartz, E. (2022). The relationship between perceived age discrimination in the healthcare system and health: An examination of a multi-path model in a national sample of Israelis over the age of 50. *Journal of Aging and Health, 34*(4/5), 684-692. https://doi.org/10.1177/08982643211058025

Ayalon, L., Mannheim, I., Hopf, S., Casal-Sanchez, L., & Kydd, A. (2023). Ageism: An old concept from new perspectives. *Journal of Applied Gerontology, 42*(6), 1176-1178. https://doi.org/10.1177/07334648231165352

Ayalon, L., & Tesch-Romer, C. (2018). Introduction to the section: Ageism – concept and origins. In L. Ayalon & C. Tesch-Romer (Eds.), *Contemporary perspectives on ageism* (pp. 1-10). Springer International Publishing. https://doi.org/10.1007/978-3-319-73820-8_1

Baghramian, M., & Coliva, A. (2020). *Relativism.* Routledge. https://doi.org/10.4324/9780429343308

Band-Winterstein, T. (2015). Health care provision for older persons: The interplay between ageism and elder neglect. *Journal of Applied Gerontology, 34*(3), 113-127. https://doi.org/10.1177/0733464812475308

Beers, E., Moerkerken, D. C., Leufkens, H. G., Egberts, T. C., & Jansen, P. A. (2014). Participation of older people in preauthorisation trials of recently approved medicines. *Journal of the American Geriatrics Society, 62*(10), 1883-1890. https://doi.org/10.1111/jgs.13067

Ben-Harush, A., Shiovitz-Ezra, S., Doron, I., Alon, S., Leibovitz, A., Golander, H., Haron, Y., & Ayalon, L. (2017). Ageism among physicians, nurses, and social workers: Findings from a qualitative study. *European Journal of Ageing, 14,* 39-48. https://doi.org/10.1007/s10433-016-0389-9

Bognar, G. (2015). Fair innings. *Bioethics, 29*(4), 251-261.

Bronfenbrenner, U. (1994). Ecological models of human development. In M. Gauvain & M. Cole (Eds.), *Readings on the development of children* (2nd ed., pp. 37-43). NY: Freeman. http://dx.doi.org/10.1037/10518-046

Bronfenbrenner, U. (2000). Ecological systems theory. In A. E. Kazdin (Ed.), *Encyclopedia of psychology* (3rd ed., pp. 129-133). Oxford University Press.

Butler, R. N. (1969). Age-ism: Another form of bigotry. *The Gerontologist, 9*(4), 243-246. https://doi.org/10.1093/geront/9.4_part_1.243

Buttigieg, S. C., Ilinca, S., de Sao Jose, J. M. S., & Taghizadeh-Larsson, A. (2018). Researching ageism in health-care and long term care. In L. Ayalon & C. Tesch-Romer

(Eds.), *Contemporary perspectives on ageism* (pp. 493-515). Springer International Publishing. https://doi.org/10.1007/978-3-319-73820-8_29

Carlson, E., & Idvall, E. (2015). Who wants to work with older people? Swedish student nurses' willingness to work in elderly care – A questionnaire study. *Nurse Education Today, 35*(7), 849-853. https://doi.org/10.1016/j.nedt.2015.03.002

Carlson, K. J., Black, D. R., & Coster, D. C. (2022). Perceptions of older adults? Measuring positive, negative, and physical descriptors using the stereotype content and strength survey. *Journal of Gerontological Social Work, 65*(4), 437-449. https://doi.org/10.1080/01634372.2021.1978026

Chamberlain, K. (2011). Troubling methodology. *Health Psychology Review, 5*(1), 48-54. https://doi.org/10.1080/17437199.2010.520113

Chen, S. (2010). Qualitative research and aging in context: Implications to social study in China. *Qualitative Sociology Review, 6*(1), 34-47. https://doi.org/10.18778/1733-8077.6.1.04

Cherubini, A., Del Signore, S., Ouslander, J., Semla, T., & Michel, J-P. (2010). Fighting against age discrimination in clinical trials. *Journal of the American Geriatrics Society, 58*(9), 1791-1796. https://doi.org/10.1111/j.1532-5415.2010.03032.x

Clendon, J., & Munns, A. (2014). *Community health and wellness – e-book: Primary health care in practice* (5th ed.). Elsevier Health Sciences.

Crutzen, C., Missotten, P., Adam, S., & Schroyen, S. (2022). Does caring lead to stigmatisation? The perception of older people among healthcare professionals and the general population: A cross-sectional study. *International Journal of Older People Nursing, 17*(5). https://doi.org/10.1111/opn.12457

Dahlke, S., Davidson, S., Kalogirou, M. R., Swoboda, N. L., Hunter, K. F., Fox, M. T., Pollard, C., Baumbusch, J., & Salyers, V. (2020). Nursing faculty and students' perspectives of how students learn to work with older people. *Nurse Education Today, 93,* 104537. https://doi.org/10.1016/j.nedt.2020.104537

Deasey, D., Kable, A., & Jeong, S. (2016). Emergency nurses attitudes towards older people in the emergency department: A cross-sectional study. *Contemporary Nurse, 52*(2/3), 369-380. https://doi.org/10.1080/10376178.2016.1224122

Diamond, L., Livaudais,-Toman, J., & Roter, D. (2023). Communication participation in primary care visits: The physician, patient, caregiver triad: Presenter (s): Leah Karliner, University of California San Francisco, United States. *Patient Education and Counseling, 109,* 144. https://doi.org/10.1016/j.pec.2022.10.328

Dobrowolska, B., Jędrzejkiewicz, B., Pilewska-Kozak, A., Zarzycka, D., Ślusarska, B., Deluga, A., Kosciolek, A., & Palese, A. (2019). Age discrimination in healthcare institutions perceived by seniors and students. *Nursing Ethics, 26*(2), 443-459. https://doi.org/10.1177/0969733017718392

Drury, L., Abrams, D., Swift, H. J., Lamont, R. A., & Gerocova, K. (2017). Can caring create prejudice? An investigation of positive and negative intergenerational contact in care settings and the generalisation of blatant and subtle age prejudice to other older people. *Journal of Community & Applied Social Psychology, 27*(1), 65-82. https://doi.org/10.1002/casp.2294

Elbourne, H. F., & le May, A. (2019). Thinking about the ageing population. In H. Elbourne & A. le May (Eds.), *Nursing older people: Realities of practice* (pp. 3-17). Routledge.

Elliott, M. N., Beckett, M. K., Saliba, D., Cohea, C., Russ, C., Giordano, L. A., Lehrman, W. G., Goldstein, E., & Cleary, P. D. (2022). The hospital care experiences of older patients compared to younger patients. *Journal of the American Geriatrics Society, 70*(12), 3570-3577. https://doi.org/10.1111/jgs.18003

Farrell, T. W., Hung, W. W., Unroe, K. T., Brown, T. R., Furman, C. D., Jih, J., Karani, R., Mulhausen, P., Napoles, A. M., Nnodim, J. O., Upchurch, G., Whittaker, C. F., Kim, A., Lundebjerg, N. E., & Rhodes, R. L. (2022). Exploring the intersection of structural racism and ageism in healthcare. *Journal of the American Geriatrics Society, 70*(12), 3366-3377. https://doi.org/10.1111/jgs.18105

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world.* J Wiley. https://doi.org/10.1002/9781119975144

Flamion, A., Missotten, P., Jennotte, L., Hody, N., & Adam, S. (2020). Old age-related stereotypes of preschool children. *Frontiers in Psychology, 11*. https://doi.org/10.3389/fpsyg.2020.00807

Gendron, T., Camp, A., Amateau, G., Mullen, M., Jacobs, K., Inker, J., & Marrs, S. (2024). The next critical turn for ageism research: The intersections of ageism and ableism. *The Gerontologist, 64*(2), 1-7. https://doi.org/10.1093/geront/gnad062

Gendron, T. L., Inker, J., & Welleford, E. A. (2018). A theory of relational ageism: A discourse analysis of the 2015 white house conference on aging. *Gerontologist, 58*(2), 242-250. https://doi.org/10.1093/geront/gnw155

Gergen, K. J., Josselson, R., & Freeman, M. (2015). The promises of qualitative inquiry. *American Psychologist, 70*(1), 1-9. https://dx.doi.org/10.1037/a0038597

Gherman, M., Arhiri, L., & Holman, C. (2022). Ageism, moral sensitivity and nursing students' intentions to work with older people – A cross-sectional study. *Nurse Education Today,* 113. https://doi.org/10.1016/j.nedt.2022.105372

Gholamzadeh, S., Shaygan, M., Naderi, Z., & Hosseini, F. A. (2022). Age discrimination perceived by hospitalised older patients in Iran: A qualitative study. *Health Promotion Perspectives, 12*(1), 45-55. https://doi.org/10.34172/hpp.2022.07

Graff, J. C., & Russell, J. H. (2023). Ableism in health care. *American Journal of Nursing, 123*(2), 23-24. https://doi.org/10.1097/01.NAJ.0000919712.93900.29

Grenier, A. (2023). The qualitative embedded case study method: Exploring and refining gerontological concepts via qualitative research with older people. *Journal of Aging Studies, 65*. https://doi.org/10.1016/j.jaging.2023.1011378

Hall, E. O. C., & Hoy, B. (2012). Re-establishing dignity: Nurses' experiences of caring for older hospital patients. *Scandinavian Journal of Caring Sciences, 26*(2), 287-294. https://doi.org/10.1111/j.1471-6712.2011.00931.x

Harbison, J. R. (2019). Are we really listening? Ageism, voice, and older people's diversity in Nordic societies undergoing welfare change. In P. Naskali., J. R. Harbison & S. Begum (Eds.), *New challenges to ageing in the rural north: A critical interdisciplinary perspective* (pp. 175-191). Springer. https://doi.org/10.1007/978-3-030-20603-1_11

Harris, J., & Regmi, S. (2012). Ageism and equality. *Journal of Medical Ethics, 38*(5), 263-266. https://doi.org/10.1136/medethics-2011-100417

Hasan, N. (2016). Positivism: To what extent does it aid our understanding of the contemporary social world? *Quality & Quantity: International Journal of Methodology, 50*(1), 317-325. https://doi.org/10.1007s11135-014-0150-4

Hiller, J. (2016). Epistemological foundations of objectivist and interpretivist research. In B. L. Wheeler & K. Murphy (Eds.), *Music Therapy Research* (3rd ed., pp. 99-127). Barcelona Publishers. https://ecommons.udayton.edu/books/53/

Holmberg, C., Wolf, A., Olsson, M. M., & Heckemann, B. (2022). Nurses' general attitudes and caregiving-specific perceptions toward the oldest-old: A nationwide survey. *International Journal of Nursing Studies, 136.* https://doi.org/10.1016/j.ijnurstu.2022.104379

Inouye, S. K. (2021). Creating an anti-ageist healthcare system to improve care for our current and future selves. *Nature Aging, 1*(2), 150-152. https://doi.org/10.1038/s43587-020-00004-4

Inouye, S. K., Studenski, S., Tinetti, M. E., Kuchel, G. A. (2007). Geriatric syndromes: Clinical, research and policy implications of a core geriatric concept. *Journal of the American Geriatrics Society, 55*(5), 780-791. https://doi.org/10.1111/j.1532-5415.2007.01156.x

Iversen, T. N., Larsen, L., & Solem, P. E. (2009). A conceptual analysis of ageism. *Nordic Psychology, 61*(3), 4-22. https://doi.org/10.1027/1901-2276.61.3.4

Jecker, N. S. (2020). *Ending midlife bias: New values for old age.* Oxford University Press. https://doi.org/10.1093/oso/9780190949075.003.0005

Junjie, M., & Yingxin, M. (2022). The discussions of positivism and interpretivism. *Global Academic Journal of Humanities and Social Sciences, 4*(1), 10-14. https://doi.org/10.36348/gajhss.2022.v04i01.002

Kahana, B., Yu, J., Kahana, E., & Langenderger, K. B. (2018). Whose advocacy counts in shaping elderly patients' satisfaction with physicians' care and communication? *Clinical Interventions in Aging, 13,* 1161-1168. https://dx.doi.org/10.2147/CIA.S165086

Karnieli-Miller, O., Werner, P., Neufeld-Kroszynski., & Eidelman, S. (2012). Are you talking to me?! An exploration of the triadic physician-patient-companion communication within memory clinics encounters. *Patient Education and Counseling, 88*(3), 381-390. http://dx.doi.org/10.1016/j.pec.2012.06.014

Kelly, G., Mrengqwa, L., & Geffen, L. (2019). "They don't care about us": Older people's experiences of primary healthcare in Cape Town, South Africa. *BMC Geriatrics, 19*(1), 1-14. https://doi.org/10.1186/s12877-019-1116-0

Kotter-Gruhn, D., & Hess, T. M. (2012). The impact of age stereotypes on self-perceptions of aging across the adult lifespan. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 67*(5), 563-571. https://doi.org/10.1093/geronb/gbr153

Krysa, K., Kowalczyk, E., Borysowski, J., Lachota, M., & Pasierski, T. (2022). Exclusion of older adults from clinical trials in cancer-related pain. *Frontiers in Medicine, 9.* https://doi.org/10.3389/fmed.2022.945481

Lampersberger, L. M., Schuttengruber, G., Lohrmann, C., & Grobschadl, F. (2023). Nurses' perspectives on caring for and attitudes towards adults aged eighty years and older. *Scandinavian Journal of Caring Sciences, 37*(2), 458-471. https://doi.org/10.1111/scs.13127

Langmann, E. (2023). Vulnerability, ageism, and health: Is it helpful to label older adults as a vulnerable group in health care? *Medicine, Health Care and Philosophy, 26*(1), 133-142. https://doi.org/10.1007/s11019-022-10129-5

Langmann, E., & Weßel, M. (2023). Leaving no one behind: Successful ageing at the intersection of ageism and ableism. *Philosophy, Ethics, and Humanities in Medicine, 18*(1), 22. https://doi.org/10.1186/s13010-023-00150-8

Lee, H., Gu, M., & Sok, S. (2023). The effects of nurses' perception of the older adults and work stress on nursing competency of nurses who care for older adult patients at general hospital. *International Journal of Environmental Research and Public Health, 20*(3). https://doi.org/10.3390/ijerph20032095

Lee, S. B., Oh, J. H., Park, J. H., Choi, S. P., & Wee, J. H. (2018). Differences in youngest-old, middle-old, and oldest-old patients who visit the emergency department. *Clinical and Experimental Emergency Medicine, 5*(4), 249-255. https://doi.org/10.15441/ceem.17.261

Levy, B. (2009). Stereotype embodiment: A psychosocial approach to aging. *Current Directions in Psychological Science, 18*(6), 332-336. https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/20802838/

Levy, B. R. (2022). The role of structural ageism in age beliefs and health of older persons. *JAMA Network Open, 5*(2), Article e2147802. https://doi.org/10.1001/jamanetworkopen.2021.47802

Levy, B. R., Chang, E. S., Slade, M. D., Kannoth, S., & Wang, S. Y. (2020). Ageism amplifies cost and prevalence of health conditions. *Gerontologist, 60*(1), 174-181. https://doi.org/10.1093/geront/gny131

Liang, Y., Rausch, C., Laflamme, L., & Moller, J. (2018). Prevalence, trend and contributing factors of geriatric syndromes among older Swedes: Results from the Stockholm country council public health surveys. *BMC Geriatrics, 18*(1), 1-9. https://doi.org/10.1186/s12877-018-1018-6

Liu, Y., Norman, I. J., & While, A. E. (2013). Nurses' attitudes towards older people: A systematic review. *International Journal of Nursing Studies, 50*(9), 1271-1282. https://doi.org/10.1016/j.ijnurstu.2012.11.021

Liu, Y. E., Norman, I. J., & While, A. E. (2015). Nurses' attitudes towards older people and working with older patients: An explanatory model. *Journal of Nursing Management, 23*(8), 965-973. https://doi.org/10.1111/jonm.12242

MacRae, H. (2018). 'My opinion is that doctors prefer younger people': Older women, physicians and ageism. *Ageing & Society, 38*(2), 240-266. https://doi.org/10.1017/S0144686X16001021

MacRae, H. (2022). 'I've never given it a thought': Older men's experiences with and perceptions of ageism during interactions with physicians. *Ageing & Society, 42*(6), 1318-1339. https://doi.org/10.1017/S0144686X20001476

Makris, U. E., Higashi, R. T., Marks, E. G., Fraenkel, L., Sale, J. E. M., Gill, T. M., & Reid, M. C. (2015). Ageism, negative attitudes, and competing co-morbidities - why older adults may not seek care for restricting back pain: A qualitative study. *BMC Geriatrics, 15*(1), 1-9. https://doi.org/10.1186/s12877-015-0042-z

Maksimovic, J., & Evtimov, J. (2023). Positivism and post-positivism as the basis of quantitative research in pedagogy. *Research in Pedagogy, 13*(1), 208-218. https://doi.org/10.5937/IstrPed2301208M

Martens, A., Greenberg, J., Landau, M. J., & Schimel, J. (2004). Ageism and death: Effects of mortality salience and perceived similarity to elders on reactions to elderly people. *Personality and Social Psychology Bulletin, 30*(12), 1524-1536. https://doi.org/10.1177/0146167204271185

Martinez-Angulo, P., Munoz-Mora, M., Rich-Ruiz, M., Ventura-Puertos, P. E., Canton-Habas, V., & Lopez-Quero, S. (2023). “With your age, what do you expect?”: Ageism and healthcare of older adults in Spain. *Journal of Geriatric Nursing, 51,* 84-94. https://doi.org/10.1016/j.gerinurse.2023.02.020

McNamara, T. K., & Williamson, J. B. (2019). *Ageism: Past, present, and future.* Routledge. https://doi.org/10.4324/9781315472614

Mikton, C., de la Fuente-Nunez, V., Officer, A., & Krug, E. (2021). Ageism: A social determinant of health that has come of age. *The Lancet, 397*(10282), 1333-1334. https://doi.org/10.1016/S0140-6736(21)00524-9

Ministry of Health (2016). *Healthy Ageing Strategy.* https://www.health.govt.nz/system/files/documents/publications/healthy-ageing-strategy_june_2017.pdf

Ministry of Health. (2023). *Older people's health data and stats.* https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/older-peoples-health-data-and-stats

Ministry of Health. (2015). *Primary care in advanced age: Findings from LiLACS NZ.* https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/lilacs/docs/Primary%20Care%20in%20advanced%20age%20Findings%20from%20LiLACS%20NZ.pdf

Mohammed, R. F., & Omar, A. A. A. (2019). Knowledge about elderly care and its relation to ageism attitude among undergraduate nursing students. *American Journal of Nursing Research, 7*(1), 73-78. https://doi.org/10.12691/ajnr-7-1-10

Neal, D., Morgan, J. L., Kenny, R., Ormerod, T., & Reed, W. R. (2022). Is there evidence of age bias in breast cancer health care professionals' treatment of older patients? *European Journal of Surgical Oncology, 48*(12), 2401-2407. https://doi.org/10.1016/j.ejso.2022.07.003

Nemiroff, L. (2022). We can do better: Addressing ageism against older adults in healthcare. *Healthcare Management Forum, 35*(2), 118-122. https://doi.org/10.1177/08404704221080882

Nitschke, I., Gegner, U., Hopfenmuller, W., Sobotta, B. A. J., & Jockusch, J. (2022). Student perceptions of age and ageing – An evaluation of Swiss dental students receiving education in gerodontology. *International Journal of Environmental Research and Public Health, 19*(12). https://doi.org/10.3390/ijerph19127480

Nochajski, T. H., Davis, E. L., Waldrop, D. P., Fabiano, J. A., & Goldberg, L. J. (2011). Dental students' attitudes about older adults: Do type and amount of contact make a difference? *Journal of Dental Education, 75*(10), 1329-1332. https://doi.org/10.1002/j.0022-0337.2011.75.10.tb05178.x

Novinmehr, N., Hasanpour, M., Salsali, M., Mehrdad, N., Qorbani, M., & Shamsaei, F. (2019). Older adults' self-advocacy in patient safety: A cross-sectional study. *British Journal of Nursing, 28*(16), 1076-1084. https://doi.org/10.12968/bjon.2019.28.16.1076

Ofori-Asenso, R., Chin, K. L., Curtis, A. J., Zomer, E., Zoungas, S., & Liew, D. (2019). Recent patterns of multimorbidity among older adults in high-income countries. *Population Health Management, 22*(2), 127-137. https://doi.org/10.1089/pop.2018.0069

Ouchida, K. M., & Lachs, M. S. (2015). Not for doctors only: Ageism in healthcare. *Generations: Journal of the American Society on Aging, 39*(3), 46-57. https://www.jstor.org/stable/26556135

Ozdemir, O., & Bilgili, N. (2016). Attitudes of Turkish nursing students related to ageism. *The Journal of Nursing Research, 24*(3), 211-216. https://doi.org/10.1097/jnr.0000000000000131

Palsgaard, P., Maino Vieytes, C. A., Peterson, N., Francis, S. L., Monroe-Lord, L., Sahyoun, N. R., Ventura-Marra, M., Weidauer, L., Xu, F., & Arthur, A. E. (2022). Healthcare professionals' views and perspectives towards aging. *International Journal of Environmental Research and Public Health, 19*(23), 15870. https://doi.org/10.3390/ijerph192315870

Park, Y. S., Konge, L., & Artino, A. R. (2020). The positivism paradigm of research. *Academic Medicine, 95*(5), 690-694. https://doi.org/10.1097/ACM.0000000000003093

Parker, C. N., Harvey, T., Johnston, S., & MacAndrew, M. (2021). An exploration of knowledge of students and staff at residential aged care facilities and implications for nursing education. *Nurse Education Today, 96*, 104639. https://doi.org/10.1016/j.nedt.2020.104639

Patnaik, B. (2023). Psychology: The ‘scientific’ study of subjective experience. *Psychological Studies, 69,* 24-27. https://doi.org/10.1007/s12646-023-00752-4

Phibbs, S., & Hooker, K. (2018). An exploration of factors associated with ageist stereotype threat in a medical setting. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 73*(7), 1160-1165. https://doi.org/10.1093/geronb/gbx034

Podhorecka, M., Husejko, J., Woźniewicz, A., Pyszora, A., & Kędziora-Kornatowska, K. (2022). Who will treat older patients? should medical education focus more on activities aimed at displaying positive attitudes toward older people? the prevalence of ageism among students of medical and health sciences. *Frontiers in Public Health, 10.* https://doi.org/10.3389/fpubh.2022.1032487

Podhorecka, M., Pyszora, A., Wozniewicz, A., Husejko, J., & Kedziora-Kornatowska, K. (2022). Empathy as a factor conditioning attitudes towards the elderly among physiotherapists – results from Poland. *International Journal of Environmental Research and Public Health, 19*(7), Article e3994. https://doi.org/10.3390/ijerph19073994

Pritchard-Jones, L. (2017). Ageism and autonomy in health care: Explorations through a relational lens. *Health Care Analysis, 25*(1), 72-89. https://doi.org/10.1007/s10728-014-0288-1

Rababa, M., Almomani, M. H., & Al-Dwaikat, T. (2021). Assessing knowledge and ageist attitudes and behaviors toward older adults among undergraduate nursing students. *Gerontology and Geriatrics Education, 42*(3), 347-362. https://doi.org/10.1080/02701960.2020.1827398

Rababa, M., Hammouri, A. M., Hweidi, I. M., & Ellis, J. L. (2020). Association of nurses' level of knowledge and attitudes to ageism toward older adults: Cross-sectional study. *Nursing & Health Sciences, 22*(3), 593-601. https://doi.org/10.1111/nhs.12701

Rababa, M., Masha'al, D., & Shahrour, G. (2023). Association of ageism with death anxiety, self-esteem, interpersonal reactivity, and symbolic immortality among nurses. *Journal of Death and Dying, 87*(1), 231-245. https://doi.org/10.1177/00302228211019200

Rabberu, K., & Gillis, M. (2021). Navigating the perfect storm of ageism, mentalism, and ableism: A prevention model. *The American Journal of Geriatric Society, 29*(10), 1058-1061. https://doi.org/10.1016/j.jagp.2021.06.018

Repetto, L., Piselli, P., Raffaele, M., & Locatelli, C. (2009). Communicating cancer diagnosis and prognosis: When the target is the elderly patient-a GIOGer study. *European Journal of Cancer, 45*(3), 374-383. https://doi.org/10.1016/j.ejca.2008.08.020

Rennie, D. L. (2012). Qualitative research as methodical hermeneutics. *Psychological Methods, 17*(3), 385-398. https://doi.org/10.1037/a0029250

Rudnev, M., & Vauclair, C. (2022). Revisiting Cowgill's modernisation theory: Perceived social status of older adults across 58 countries. *Ageing & Society,* 1-18. https://doi.org/10.1017/S0144686X22001192

Ruggiano, N., Whiteman, K., & Shtompel, N. (2016). "If I don't like the way I feel with a certain drug, I'll tell them.": Older adults' experiences with self-determination and health self-advocacy. *Journal of Applied Gerontology, 35*(4), 401-420. https://doi.org/10.1177/0733464814527513

Ryan, G. (2018). Introduction to positivism, interpretivism and critical theory. *Nurse Researcher, 25*(4), 41-49. https://doi.org/10.7748/nr.2018.e1466

Sao Jose, J., & Amado, C. (2017). On studying ageism in long-term care: A systematic review of the literature. *International Psychogeriatrics, 29*(3), 373-387. https://doi.org/10.1017/S1041610216001915

Sarabia-Cobo, C. M., & Pfeiffer, C. C. (2015). Changing negative stereotypes regarding aging in undergraduate nursing students. *Nurse Education Today, 35*(9), 60-64. https://doi.org/10.1016/j.nedt.2015.06.006

Schroyen, S., Adam, S., Marquet, M., Thiel, S., Giraudet, A. L., Missotten, P., & Jerusalem, G. (2018). Communication of healthcare professionals: Is there ageism? *European Journal of Cancer Care, 27*(1), 1-10. https://doi.org/10.1111/ecc.12780

Schroyen, S., Missotten, P., Jerusalem, G., Gilles, C., & Adam, S. (2016). Ageism and caring attitudes among nurses in oncology. *International Psychogeriatrics, 28*(5), 749-757. https://doi.org/10.1017/S1041610215001970

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching, 5*(9), 9-16. https://doi.org/10.5539/elt.v5n9p9

Shaw, C. A., & Gordon, J. K. (2021). Understanding elderspeak: An evolutionary concept analysis. *Innovation in Aging, 5*(3), 1-18. https://doi.org/10.1093/geroni/igab023

Shaw, C., Ward, C., Gordon, J., Williams, K., Herr, K. (2022). Characteristics of elderspeak communication in hospital dementia care: Findings from The Nurse Talk observational study. *International Journal of Nursing Studies, 132,* Article e104259. https://doi.org/10.1016/j.ijnurstu.2022.104259

Shin, D. W., Park, K., Jeong, A., Yang, H. K., Kim, S. Y., Cho, M., & Park, J. H. (2019). Experience with age discrimination and attitudes toward ageism in older patients with cancer and their caregivers: A nationwide Korean survey. *Journal of Geriatric Oncology, 10*(3), 459-464. https://doi.org/10.1016/j.jgo.2018.09.006

Shpakou, A., Klimatckaia, L., Kuzniatsou, A., Laskiene, S., & Zaitseva, O. (2021). Medical care and manifestations of ageism in healthcare institutions: Opinion of elderly people. The example of four countries. *Family Medicine & Primary Care Review, 23*(1), 69-74. https://doi.org/10.5114/fmpcr.2021.103159

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27. https://doi.org/10.1080/17437199.2010.510659

Smith, J. A. (2011). Evaluating the contribution of interpretive phenomenological analysis: A reply to the commentaries and further development of criteria. *Health Psychology Review, 5*(1), 55-61. https://doi.org/10.1080/17437199.2010.541743

Smith, J. A., & Eatough, V. (2012). Interpretative phenomenological analysis. In G. M. Breakwell, J. A. Smith & D. B. Wright (Eds.), *Research methods in psychology* (4th ed., pp. 439-459). Sage.

Smith, J. A., & Fieldsend, M. (2021). Interpretative phenomenological analysis. In P. M. Camic (Ed.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (2nd ed., pp. 147-166). American Psychological Association. https://doi.org/10.1037/0000252-008

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2021). *Interpretative Phenomenological Analysis* (2nd ed.). SAGE Publications.

Smith, J. A., & Nizza, I. E. (2021). *Essentials of Interpretative Phenomenological Analysis.* American Psychological Association.

Snellman, F. (2016). Whose ageism? The reinvigoration and definitions of an elusive concept. *Nordic Psychology, 68*(3), 148-159. http://dx.doi.org/10.1080/19012276.2015.1125301

Snellman, F. (2018). Normative, empiricist, and interpretive considerations in the ageism research process. In L. Ayalon & C. Tesch-Romer (Eds.), *Contemporary perspectives on ageism* (pp. 409-424). Springer International Publishing. https://doi.org/10.1007/978-3-319-73820-8_25

Stanley, J., Semper, K., Millar, E., & Sarfati, D. (2018). Epidemiology of multimorbidity in New Zealand: A cross-sectional study using national-level hospital and pharmaceutical data. *BMJ Open, 8*(5), Article e021689. https://doi.org/10.1136/bmjopen-2018-021698

Stewart, T. L., Chipperfield, J. G., Perry, R. P., & Weiner, B. (2011). Attributing illness to 'old age': Consequences of a self-directed stereotype for health and mortality. *Psychology & Health, 27*(8), 881-897. https://doi.org/10.1080/08870446.2011.630735

Stubbe, D. E. (2017). The health care triad: Optimizing communication in dementia care. *Focus, 15*(1), 65-67. https://doi.org/10.1176/appi.focus.20160033

Swift, H. J., Abrams, D., Lamont, R. A., & Drury, L. (2017). The risks of ageism model: How ageism and negative attitudes toward age can be a barrier to active aging. *Social Issues and Policy Review, 11*(1), 195-231. https://doi.org/10.1111/sipr.12031

Tkacheva, O. N., Runikhina, N. R., Ostapenko, V. S., Sharashkina, N. V., Mkhitaryan, E. A., Onuchina, J. S., Lysenkov, S. N., Yakhno, N. N., Press, Y. (2018). Prevalence of geriatric syndromes among people aged 65 years and older at four community clinics in Moscow. *Clinical Interventions in Aging, 13,* 251-259. https://dx.doi.org/10.2147/CIA.S153389

Todorova, I. (2011). Explorations with interpretative phenomenological analysis in different socio-cultural contexts. *Health Psychology Review, 5*(1), 34-38. https://doi.org/10.1080/17437199.2010.520115

United Nations. (2022). *World population prospects 2022: Summary of results.* https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/wpp2022_summary_of_results.pdf

Van de Pol, M. H. J., Fluit, C. R. M. G., Lagro, J., Niessen, D., Rikkert, M. G. M. O., & Largo-Janssen, A. L. M. (2015). Quality care provision for older people: An interview study with patients and primary healthcare professionals. *British Journal of General Practice, 65*(637), e500-e507. https://doi.org/10.3399/bjgp15X686065

Van den Hoonaard, D. K. (2018). Learning to be old: How qualitative research contributes to our understanding of ageism. *International Journal of Qualitative Methods, 17*(1)*,* 1-8. https://doi.org/10.1177/1609406918810556

Van der Horst, M., & Vickerstaff, S. (2022). Is part of ageism actually ableism? *Ageing & Society, 42*(9), 1979-1990. https://doi.org/10.1017/S0144686X20001890

Varpio, L., Paradis, E., Uljtdehaage, S., & Young, M. (2020). The distinctions between theory, theoretical framework, and conceptual framework. *Academic Medicine, 95*(7), 989-994. https://doi.org/10.1097/ACM.0000000000003075

Vauclair, C., Rodrigues, R. B., Marques, S., Esteves, C. S., Cunha, F., & Gerardo, F. (2018). Doddering but dear … even in the eyes of young children? Age stereotyping and prejudice in childhood and adolescence. *International Journal of Psychology, 53*(51), 63-70. https://doi.org/10.1002/ijop.12430

Vervaecke, D., & Meisner, B. A. (2021). Caremongering and assumptions of need: The spread of compassionate ageism during COVID-19. *Gerontologist, 61*(2), 159-165. https://doi.org/10.1093/geront/gnaa131

Vogt, A., & Dahlke, S. (2023). Older person's experiences of ageism: A qualitative descriptive study. *International Journal of Nursing Student Scholarship, 10,* 1-15. https://journalhosting.ucalgary.ca/index.php/ijnss/article/view/77089

Voss, P., Bodner, E., & Rothermund, K. (2018). Ageism: The relationship between age stereotypes and age discrimination. In L. Ayalon & C. Tesch-Romer (Eds.), *Contemporary perspectives on ageism* (pp. 11-31). Springer International Publishing. https://doi.org/10.1007/978-3-319-73820-8_2

Warren-Findlow, J. (2013). Qualitative research in *JG:SS* – "I'll take a side of coleslaw with that." *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 68*(3), 407-408. https://doi.org/10.1093/geronb/gbt017

Werntoft, E., Edberg, A., Rooke, L., Hermeren, G., Elmstahl, S., & Hallberg, I. R. (2005). Older people's views of prioritization in health care. The applicability of an interview study. *Journal of Clinical Nursing, 14*(8B), 64-74. https://doi.org/10.1111/j.1365-2702.2005.01278.x

Westerman, M. A. (2004). Theory and research on practices, theory and research as practices: Hermeneutics and psychological inquiry. *Journal of Theoretical and Philosophical Psychology, 24*(2), 123-156. https://doi.org/10.1037/h0091238

Williams-Roberts, H., Abonyi, S., & Kryzanowski, J. (2018). What older adults want from their health care providers. *Patient Experience Journal, 5*(3), 81-90. https://doi.org/10.35680/2372-0247.1307

Wolff, J. L., Boyd, C. M., Gitlin, L. N., Bruce, M. L., & Roter, D. L. (2013). Going it together: Persistence of older adults' accompaniment to physician visits by a family companion. *Journal of the American Geriatrics Society, 60*(1), 106-112. https://doi.org/10.1111/j.532-5415.2011.03770.x

World Health Organisation. (2022). *Ageing and health.* https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

World Health Organisation. (2022). *World Health Statistics 2022.* https://iris.who.int/bitstream/handle/10665/356584/9789240051140-eng.pdf?sequence=1

World Health Organisation. (2023). *New Zealand Data.* https://data.who.int/countries/554

Wyman, M. F., Shiovitz-Ezra, S., & Bengel, J. (2018). Ageism in the health care system: Providers, patients, and systems. In L. Ayalon & C. Tesch-Romer (Eds.), *Contemporary perspectives on ageism* (pp. 193-212). Springer International Publishing. https://doi.org/10.1007/978-3-319-73820-8_13

Appendix 1. Advertisement

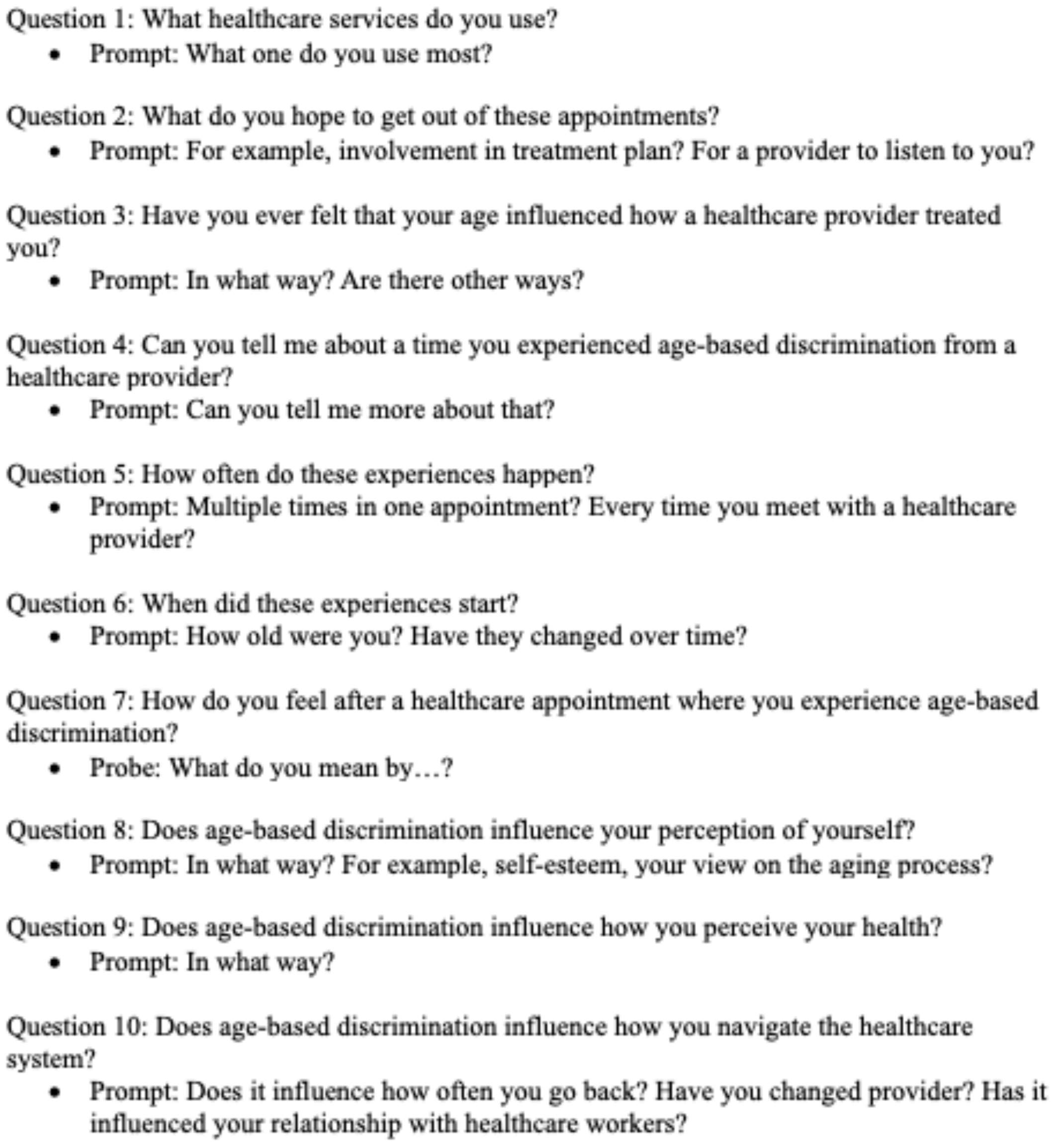
MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Are you 65 years or older?

Have you ever felt like a doctor or nurse has treated you differently because of your age?

I invite you to take part in Massey University research to explore older people's experiences of ageism from healthcare workers. If you are interested and would like to know more, please contact Nieve Sunitsch by email at [redacted]. I will phone you back to discuss the project. Thank you for your consideration.

Appendix 2. Interview Schedule



Question 1: What healthcare services do you use?
- Prompt: What one do you use most?

Question 2: What do you hope to get out of these appointments?
- Prompt: For example, involvement in treatment plan? For a provider to listen to you?

Question 3: Have you ever felt that your age influenced how a healthcare provider treated you?
- Prompt: In what way? Are there other ways?

Question 4: Can you tell me about a time you experienced age-based discrimination from a healthcare provider?
- Prompt: Can you tell me more about that?

Question 5: How often do these experiences happen?
- Prompt: Multiple times in one appointment? Every time you meet with a healthcare provider?

Question 6: When did these experiences start?
- Prompt: How old were you? Have they changed over time?

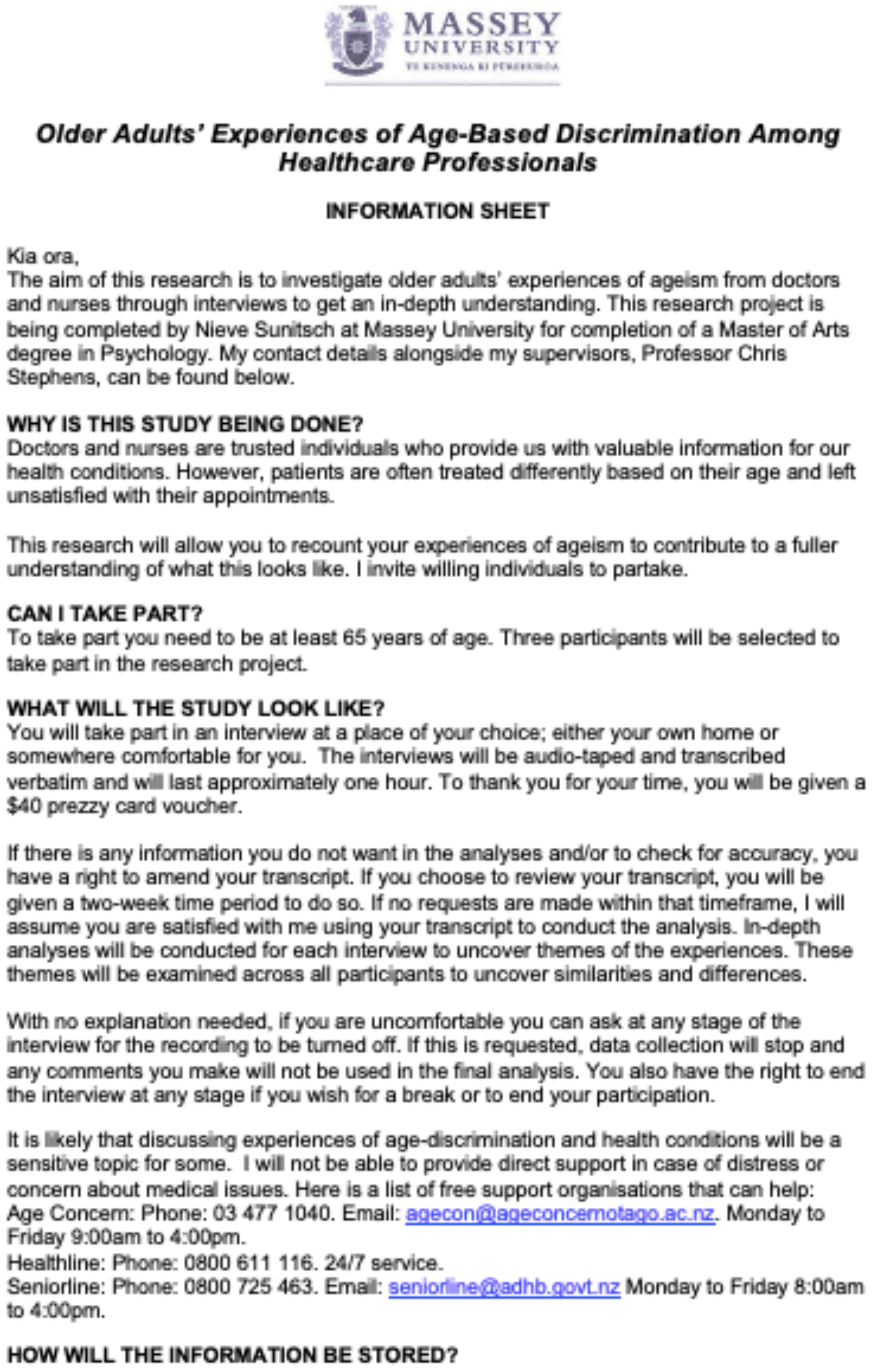
Question 7: How do you feel after a healthcare appointment where you experience age-based discrimination?
- Probe: What do you mean by…?

Question 8: Does age-based discrimination influence your perception of yourself?
- Prompt: In what way? For example, self-esteem, your view on the aging process?

Question 9: Does age-based discrimination influence how you perceive your health?
- Prompt: In what way?

Question 10: Does age-based discrimination influence how you navigate the healthcare system?
- Prompt: Does it influence how often you go back? Have you changed provider? Has it influenced your relationship with healthcare workers?

Appendix 3. Information Sheet



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA

Older Adults' Experiences of Age-Based Discrimination Among Healthcare Professionals

INFORMATION SHEET

Kia ora,
The aim of this research is to investigate older adults' experiences of ageism from doctors and nurses through interviews to get an in-depth understanding. This research project is being completed by Nieve Sunitsch at Massey University for completion of a Master of Arts degree in Psychology. My contact details alongside my supervisors, Professor Chris Stephens, can be found below.

WHY IS THIS STUDY BEING DONE?
Doctors and nurses are trusted individuals who provide us with valuable information for our health conditions. However, patients are often treated differently based on their age and left unsatisfied with their appointments.

This research will allow you to recount your experiences of ageism to contribute to a fuller understanding of what this looks like. I invite willing individuals to partake.

CAN I TAKE PART?
To take part you need to be at least 65 years of age. Three participants will be selected to take part in the research project.

WHAT WILL THE STUDY LOOK LIKE?
You will take part in an interview at a place of your choice; either your own home or somewhere comfortable for you. The interviews will be audio-taped and transcribed verbatim and will last approximately one hour. To thank you for your time, you will be given a $40 prezzy card voucher.

If there is any information you do not want in the analyses and/or to check for accuracy, you have a right to amend your transcript. If you choose to review your transcript, you will be given a two-week time period to do so. If no requests are made within that timeframe, I will assume you are satisfied with me using your transcript to conduct the analysis. In-depth analyses will be conducted for each interview to uncover themes of the experiences. These themes will be examined across all participants to uncover similarities and differences.

With no explanation needed, if you are uncomfortable you can ask at any stage of the interview for the recording to be turned off. If this is requested, data collection will stop and any comments you make will not be used in the final analysis. You also have the right to end the interview at any stage if you wish for a break or to end your participation.

It is likely that discussing experiences of age-discrimination and health conditions will be a sensitive topic for some. I will not be able to provide direct support in case of distress or concern about medical issues. Here is a list of free support organisations that can help:
Age Concern: Phone: 03 477 1040. Email: agecon@ageconcernotago.ac.nz. Monday to Friday 9:00am to 4:00pm.
Healthline: Phone: 0800 611 116. 24/7 service.
Seniorline: Phone: 0800 725 463. Email: seniorline@adhb.govt.nz Monday to Friday 8:00am to 4:00pm.

HOW WILL THE INFORMATION BE STORED?

All audio-recordings and transcripts of the interviews will be stored under password protection. You have the option to have a copy of only your transcript. All material will only be viewed by the primary researcher and the supervisor. Aligning with Massey University's data storage guidelines, all audio-recordings and transcripts will be stored for three years until 1/08/2027 which will then be subsequently destroyed by my supervisor. After completion of the thesis, a summary of the project findings will be emailed to all participants. All transcripts will be anonymised with any identifiable material removed to ensure confidentiality. This includes direct quotes used in the project findings.

YOUR RIGHTS

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study (up until 23 December 2023);
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview. In this case, data collection will end and any comments you make will be off the record and will not be included in the analyses.

RESEARCHER CONTACTS

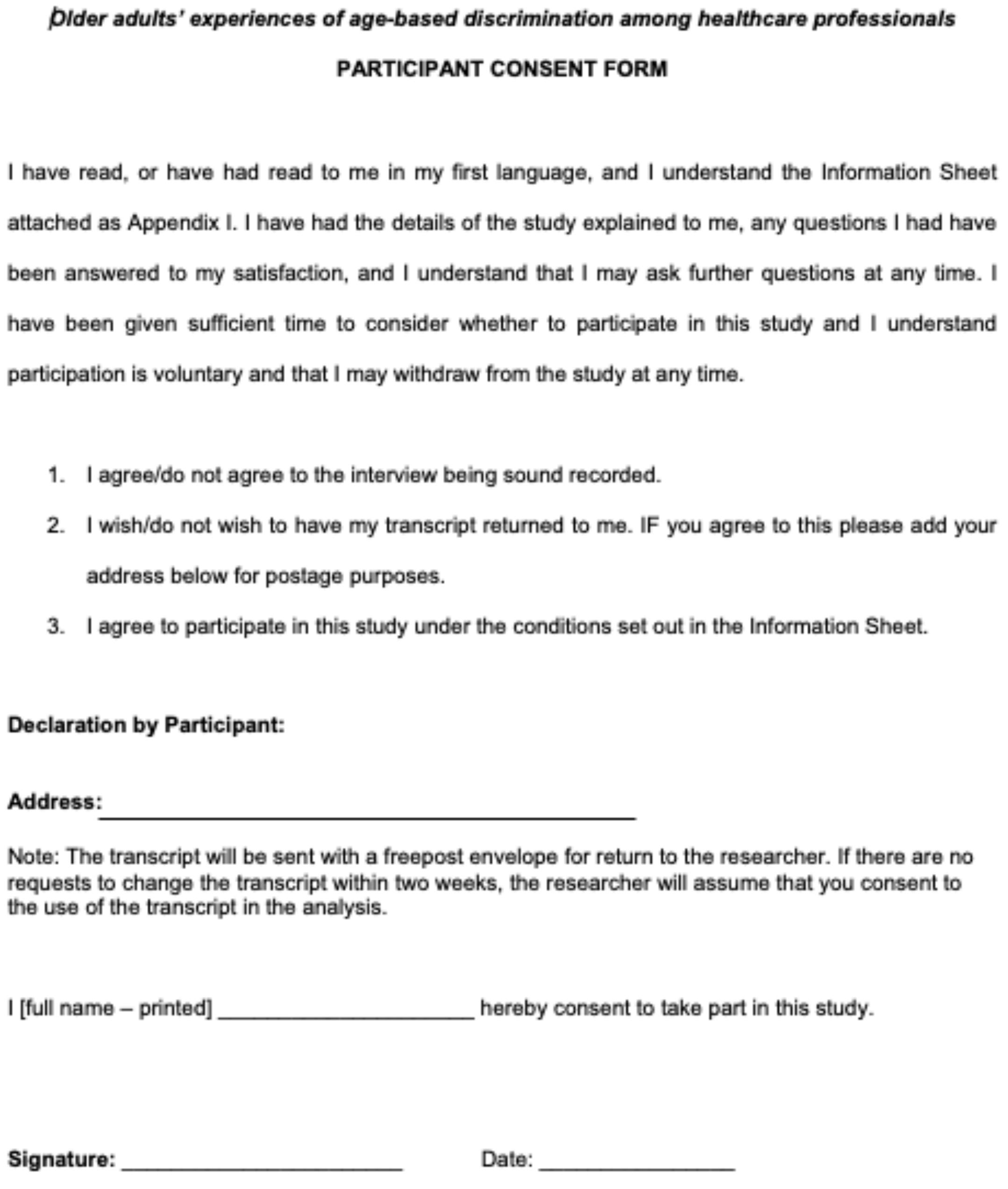
If you have any questions about the research at any stage, you are invited to contact the primary researcher Nieve Sunitsch [redacted] email: [redacted], or Professor Chris Stephens +64 69518059 email: C.V.Stephens@massey.ac.nz

1. MUHEC APPLICATIONS

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 3, Application OM3 23/41. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 3, email humanethics3@massey.ac.nz.

Appendix 4. Consent Form



Older adults' experiences of age-based discrimination among healthcare professionals

PARTICIPANT CONSENT FORM

I have read, or have had read to me in my first language, and I understand the Information Sheet attached as Appendix I. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being sound recorded.
2. I wish/do not wish to have my transcript returned to me. IF you agree to this please add your address below for postage purposes.
3. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

Address: ____

Note: The transcript will be sent with a freepost envelope for return to the researcher. If there are no requests to change the transcript within two weeks, the researcher will assume that you consent to the use of the transcript in the analysis.

I [full name – printed] ______________________ hereby consent to take part in this study.

Signature: ________________________ Date: _________________