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QUALITATIVE PAPER

Preferences of newly qualified healthcare professionals for working with people with dementia: a qualitative study

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Abstract

Background: there is little research on preferences in students and newly qualified healthcare professionals for working with people with dementia. Understanding the development of these preferences can help inform strategies to increase workforce capacity in response to current suboptimal dementia care and the increasing numbers of people with dementia.
Objective: to explore the factors that influence career preferences in relation to working with people with dementia. Specifically, to understand how these factors relate to early career doctors' and nurses' preferences and how they influence decisions and perspectives on their careers.
Methods: qualitative in-depth interviews were conducted with 27 newly qualified doctors and nurses within 2 years of graduation. This included a subset of participants that had taken part in a dementia educational intervention during their undergraduate training. Transcripts were analysed using grounded theory methods.
Results: the results present six main categories representing complex interlinked factors influencing preferences for working with people with dementia as well as exploring the definition of a career working with people with dementia. The factors include the importance of making a difference; seeing dementia care as a different type of care; its perceived alignment with personal characteristics; perceptions of people with dementia; care environments and career characteristics.
Discussion: this is the first study to explore the factors influencing preferences for working with people with dementia in newly qualified healthcare professionals. It provides useful data to inform workforce planning, and curriculum and practice development to stimulate interest and drive improved quality of care.

Keywords: dementia, education, healthcare students, career preferences, qualitative, older people

Key Points

- Willingness to work with people with dementia is central to improving the quality and capacity of dementia services.
- There is a lack of research on preferences of working with people with dementia in early career healthcare professionals.
- This qualitative study identifies several interlinked factors that influence preferences for working with people with dementia.
- Central concepts include making a difference, a different type of care and alignment with personal characteristics.
- These findings can be used to help enhance interest in working with people with dementia.

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Background

Improving dementia care is an international priority [1–3]. The need to improve dementia care is clear from reports of inadequate care practices including poor patient outcomes [4] and stigma [2] and is intensified by the increasing numbers affected and limited specialist services. Developing the competences and capacity of the healthcare workforce is integral to improving dementia care [1, 2, 5, 6]. An important component of building capacity is to understand and increase healthcare workforce preferences for working with people with dementia. This can attract professionals to related specialities (e.g. geriatrics, old age psychiatry and older people's nursing) and enhance engagement with the needs of this group generally across specialities.

Studies have consistently found medical and nursing students have low preferences for specialities related to working with people with dementia [7–10] and older people in general [11, 12]. There is some understanding of low preferences for working with older people but little research on preferences for working with people with dementia [13][1]. Potential factors associated with preferences for working with people with dementia include positive associations with female gender; older students; positive ageism and characteristics of the work such as communication and emotional challenges [14]. Evaluations of undergraduate dementia education interventions suggest they may positively influence preferences; however, they have not explored the mechanisms behind this [15–17]. Worryingly, research suggests that undergraduate training actively diminishes preferences for working with older adults and the cognitively impaired [18–21]. Therefore understanding the role of undergraduate education is important as a first step to optimisation, especially with current drives to improve undergraduate dementia education [2, 22–25].

The objective of this study was to explore factors that influence career preferences in relation to working with people with dementia. Specifically, to understand how these factors relate to newly qualified doctors and nurses, by drawing on their experiences and preferences as students and how they influence decisions and perspectives on their careers.

Methods

Individual semi-structured interviews were conducted with doctors and nurses within two years of qualification. A qualitative grounded theory approach was chosen as career preferences for working with people with dementia has not previously been conceptualised and grounded theory allows the generation of a framework that is embedded within newly qualified healthcare professionals' views, and considers context, important for exploring the complexity of preferences.

Setting

This research was nested within the Time for Dementia (TFD) study, a dementia educational intervention for undergraduate healthcare students that aims to improve students' attitudes, compassion, empathy and knowledge of dementia [26]. The programme involves students being paired with a family affected by dementia and visiting them five times over two years. TFD has NHS Health Research Authority ethics approval (REC ref: 15/LO/0046).

Participants

Potential participants included doctors and nurses in the two years after qualification who had taken part in TFD comparison or intervention cohorts during undergraduate training and who agreed to be followed up into practice. Twenty-seven participants were interviewed.

To gain a variety of viewpoints, participant sampling was purposeful based on key points of difference during undergraduate training: university cohort, participation in TFD (yes/no) and profession (doctor/nurse). During analysis, researchers were sensitive to similarities and differences for which implications would be of interest to interdisciplinary interventions. Interviews were not conducted at set time points but sampled to include a mix of newly and later-qualified professionals within two years post-qualification (Year 1/Year 2).

Participant characteristics are presented in Table 1. Recorded career choices of preferences for working with dementia (low, high and neutral) taken in their last year of undergraduate training were also used in sampling to include perspectives from those with different preferences. The preferences for working with people with dementia presented (Table 1) are those stated at interview because, for some participants, their preferences changed and current preferences were perceived to be more important for the context of the findings. Participants were also sampled by characteristics based on emerging themes (during analysis) that needed to be explored further (i.e. theoretical sampling). This included those who indicated preferences for particular specialities such as geriatrics to explore emerging differences between factors influencing preferences towards particular specialties and working with people with dementia in general.

Data collection

Potential participants were contacted and invited to take part in an individual interview at a time of their choice. Interviews were conducted between April 2019 and March 2020. Participant information sheets and consent forms were sent in advance of interview, and informed consent was given before the interview. Interviews were conducted by telephone and

1 Given that age is the most significant risk factor for dementia, older people with dementia have been the focus of the study, with reference to the literature on working with older people. However these findings may also have relevance to those with young-onset dementia and working with them.

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Table 1. Participant characteristics

Characteristic	Median (range)/n
Age at interview	26 (23-53)
Sex	
Female	18
Male	9
Profession	
Nurse (adult or mental health)	10
Doctor	17
Dementia experience before training	
No	8
Yes	15
Ethnicity	
Missing	2
Mixed/multiple ethnic groups	1
Asian/Asian British	2
White British/European	19
Other	1
Black/African/Caribbean/Black British	2
Year post-graduation	
Year 1	16
Year 2	11
TFD participation	
No	13
Yes	14
University	
BSMS	14
UEA	3
UoB	3
UoS	7
Preference for dementia in general (i.e. clinical interest)	
High	12
Low	6
Neutral	9
Preference for dementia-related specialty (i.e. recognised specialty)	
No	22
Undecided	1
Yes	4

Note: Year 1/Year 2 = foundation years 1 and 2 for doctors. Preferences for 'dementia in general' were defined as a participant's general preference for working with people with dementia (across specialties) expressed in the interview: classed as low, neutral or high. These categorisations were checked for agreement with the second reviewer (SD). Preferences for 'dementia-related specialty' were coded as career choices that were related to dementia; in this sample, this included geriatrics, old age psychiatry and nursing of older people. BSMS, Brighton and Sussex Medical School (TFD and non-TFD cohorts); UoB, University of Brighton (non-TFD cohorts); UEA, University of East Anglia (non-TFD cohorts); UoS, University of Surrey (TFD and non-TFD cohorts).

lasted a mean 35 minutes. Interviews were audio-recorded and transcribed verbatim, anonymised and checked for accuracy. Example questions are in Supplementary Appendix S1 available in *Age and Ageing* online. Questions focused on: participants' career intentions; definitions of a career working with people with dementia; preferences of working with people with dementia and explored influences on these preferences during undergraduate training and since graduating, including experiences of dementia.

Analysis

A constructivist grounded theory approach was used for analysis [27]. Data collection and analysis were not linear, as recruitment was conducted in a continuous manner parallel to analysis, but for clarity, three key phases are described (Figure 1).

Phase 1: initial line-by-line coding of transcripts by two researchers. Phase 2: focused coding, practically a large number of open codes were aggregated into a smaller number of more conceptual focused codes. Phase 3: theoretical integration, developing and refining conceptual categories and relationships between them. Researchers remained sensitive to theoretical saturation; exploring areas where components of categories were unclear until they were fully formed. Further details of analysis and theoretical sampling are in Appendix S2 available in *Age and Ageing* online. The output was a set of core conceptual categories that were saturated (i.e. reached sufficient depth and understanding). Constant comparison was used at each stage to clarify meanings, comparing data with codes, codes with codes and between participants (including doctors and nurses). Rigour in the analysis was enhanced by the use of NVivo12 [28] to systematically manage data and record memos, and consultation

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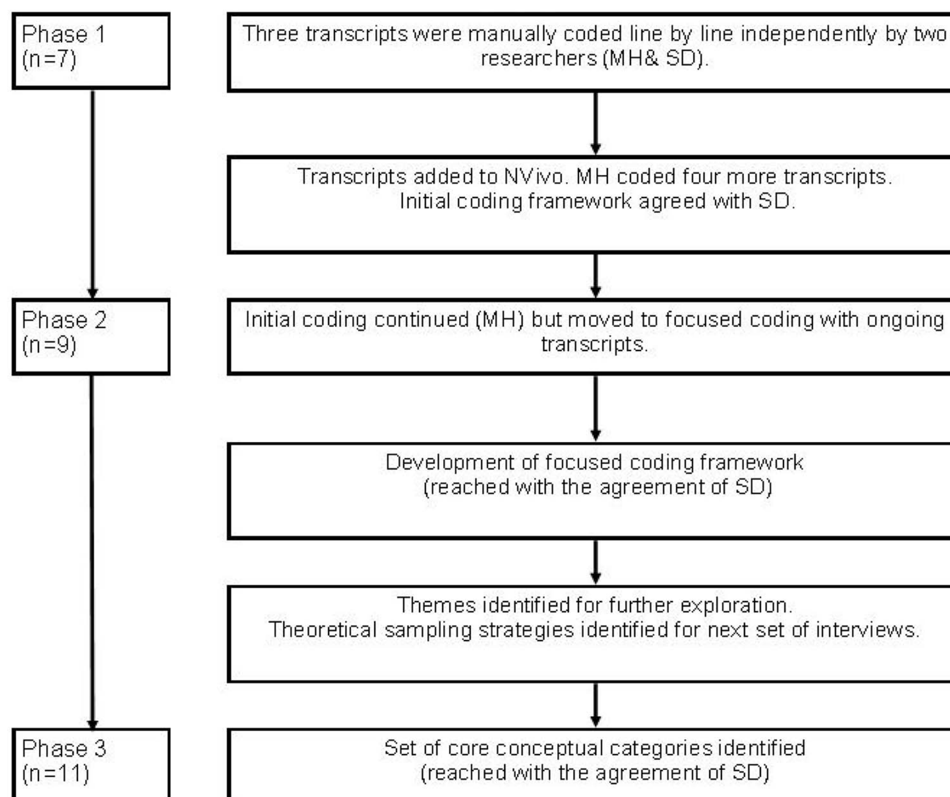

Figure 1. Analysis procedure.

with a second reviewer throughout, including agreement of initial and focused coding frameworks.

Results

There were seven categories. One on the nature of preferences, and six inter-connected factors associated with preferences for working with people with dementia. An overall core category was not developed due to the multi-dimensional conceptualisation of preferences. The main categories and subcategories are described below (N = nurse, D = doctor).

Nature of preferences

Defining a career working with people with dementia

Both doctors and nurses described working with people with dementia as inevitable, due to the prevalence of the condition. The majority were able to identify healthcare careers that specialised in or worked with large numbers of people with dementia. For doctors, this included geriatrics, old age psychiatry and general practice (GP). For nurses, this included wards with a higher proportion of older patients, community nursing, long-term care and intermediate care. Some also identified dementia specialist nurses.

Individual preferences

Preferences for working with people with dementia were split between general preferences (working with people with dementia in the context of their career in general) and those towards specialties related to dementia (recognised specialties).

In terms of general preferences for working with people with dementia, there was a range, with some participants holding higher, neutral or lower preferences (Figure 2). There were accounts of positive and negative changes in preferences, during training or practice, demonstrating that preferences are not fixed.

Nature of overall preferences

Participants identified their wider career preferences and were able to identify the most important factors influencing them. Individuals often had a different hierarchy of career preference and viewed working with people with dementia through these priorities.

Making a difference

Rewards of making a difference

Participants described one of the best aspects of working with people with dementia as their ability to make a difference. The difference was frequently described in non-medical terms, with the limitation of medical interventions noted. Social or psychological interventions were described as important, for example identifying additional support and referrals to other healthcare professionals or services; effective communication and providing comfort.

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(High preference) D6: 'In general I find it kind of be very rewarding, I find it interesting, and I like doing it as a part of medicine overall, I wouldn't want to specialise in it, and I wouldn't want all my patients or too high a proportion of them to suffer with dementia, but overall yeah, I feel fairly confident and well equipped to manage patients with dementia, and I enjoy doing it as part of my normal patient workload.'
(Low preference) D4: INTERVEIWER: 'So, within your career, so obviously you intend doing GP training, would you say that you'd prefer or not prefer to work with patients with dementia? PARTICIPANT: 'clearly it's difficult. I mean I'd say it's probably easier not to, because it's difficult, at my current stage as a junior,'
(Neutral preference) D1: 'I'm a bit ambivalent really. I'm not opposed to working with them, but I'm not, you know, I didn't really go out of my way to look after a patient with dementia, I just got on with the job.
(Neutral preference) N2: 'I'd probably just say that I... yeah, I wouldn't mind either way. Yeah, I have no problems working with people with dementia, at all.'

Figure 2. Example of general preferences for working with people with dementia.

Their ability to make a difference was described as rewarding. Making a difference to patients' lives and deriving satisfaction from this was acknowledged as an inherent goal for healthcare professionals, but those with a preference for working with people with dementia appeared to view working with people with dementia as more rewarding. This is because dementia was perceived as a complex condition that is hard to make an impact on, so making an impact was viewed as more meaningful.

> N3: 'obviously what they're going through is so difficult and so hard and so horrible, when you do something that will make that even a little bit better is amazing, and yeah, that for me is the most rewarding thing I think.'

A unique aspect for doctors was accounts of how preferences increased due to recognition of the impact they can make. This was attributed to how they felt able to make a difference in practice as doctors, compared to as students as well as gaining appreciation through educational experiences such as TFD.

> D11: 'I guess it (TFD) really highlighted to me how good medical . . . you know being a good medical practitioner can really make a difference to these families and the patients. So, yeah, I guess it did make me think "Oh yeah, actually this is much more interesting and you can make a difference".'

Reduced satisfaction in lack of impact

Participants with lower preferences linked this to their limited ability to make an impact and/or meet patient needs. Participants reported that this was often because of external restrictions such as time, lack of support from others, or it not being a core part of their role. Where participants defined impact on patients in terms of medical outcomes, the opportunity to make a difference was seen as being limited.

> N10: 'I think, for me, I struggled . . . I found it quite difficult because like they're never going to get better'

Therefore while some acknowledged that the best part of working with patients with dementia was making a difference, and this is rewarding, they reflected that in practice this is hard to achieve. The resulting view of the work when participants felt unable to make a difference was a lack of satisfaction from the work particularly in general hospitals. It was associated with emotional conflict and a feeling of unease or frustration and was 'difficult to reconcile'.

> D10: 'That's very hard when you constantly have to walk past that patient in distress and you just don't have time, there's already been so much time spent on him, and you've got all these other patients, you just don't have time. So, that's really quite difficult to come to terms with'

This dichotomous concept of making a difference suggests that preferences for working with patients with dementia depend on how students/professionals define 'impact' or 'needs' for patients with dementia and their perceived agency in being able to help to achieve this.

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Alignment with personal characteristics

Competency or confidence

There was a clear dichotomy in those who held higher or lower preferences in terms of their perceived competency or confidence in working with people with dementia.

> N10: 'I don't know whether it's because maybe I just don't have much experience of it outside the professional life and so that's kind of like me and my own confidence and lack of awareness that puts me off a bit as well.'

This was often regarded as a central factor; however, for those with an interest in a related specialty, it was one of the multiple factors drawing them to the area and they noted their relevant skillset or 'talent'. Many described how their confidence for working with people with dementia had grown and their preferences increased as a result. A key theme was increased preferences by overcoming fears of working with patients with dementia, which was one of the identified outcomes of TFD.

Personal attributes

Participants described personality traits that made them suitable for working with people with dementia such as patience, maturity and empathy.

> D12: 'I quite like sort of having those conversations and taking that time, whereas I think some personalities in medicine wouldn't enjoy that aspect of it so much'

Impact of experience

The majority explicitly identified how particular individual experiences (family, work experience and educational placements) had had a positive or negative impact on preferences via confidence or competency, recognition of rewards of making a difference and appreciation of positive interactions with people with dementia.

The experience of TFD was explored in participants that participated in the programme, and while all were positive about the experience, there were mixed opinions about its influence on preferences. Those that did not feel TFD influenced their preferences commonly said they did not think about the experience in that way or that clinical placements were more important in preference formation. For those where TFD had influenced preferences, these reflected identified mechanisms by reducing fears and increasing competence and confidence; recognising the positive impact of healthcare professionals and therefore making a difference; gaining an appreciation for working with people with dementia or developing non-discriminatory attitudes or increased interest.

The concept of alignment with personal characteristics suggests newly qualified healthcare professionals relate preferences to whether the work is suited to them and their skills. Importantly they relate their competency to their preferences.

A different type of care

Appreciating a 'different type of care'

Many attributed positive preferences to the type of healthcare in dementia care; specifically, it was perceived to be more holistically focused, with more patient contact, and less medicalised, with a focus on patient quality of life, and were drawn to the work because of this. This was repeatedly seen as a positive factor in holding a preference for geriatrics and psychiatry for doctors. Participants viewed this holistic approach as different from normal medical or nursing practice. The theme that this care was not 'standard' recurred, and participants' regard for this type of care was an influencing factor.

> D1: 'it's, you know, to be quite frank, the social care side of it, that's not the sexy part of medicine, you know, that's the . . . not why anybody who goes to medical school, but certainly for me I kind of lost of interest in that side of medicine, and I became more interest in the kind of lifestyle stuff. So, I think if a student has more of an appreciation for the social side of medicine and social care and quality of life . . . .I think that's what would drive an interest in patients with dementia.'

Preference for medical or acute care

Lower preferences for working with people with dementia were associated with a desire to work with more acute conditions, or a medical/biological (rather than psychosocial) approach to patients.

> D3: 'Because I much prefer things that I can – or not – that generally are reversible. I much prefer things where people have like a good baseline, they come in with something that's quite kind of acute but reversible, and then they go back to that good baseline'

This was cited as a reason for a lower preference towards psychiatry. For those with a preference for medical or acute care, lower preference for dementia was often directly linked to the desire to deliver medical interventions, which were felt to be limited in dementia and so associated with reduced satisfaction due to lack of impact.

> N5: 'I think people obviously for maybe the same reasons I did, tend to go for the acute medicine, I think that's the way I can think of about it, it's more kind of especially, you know, kind of excitement of you know variety of different procedures, but then there are some obviously nurses who just like elderly care, or who just like working with dementia, but at this stage of my, you know, post-qualification career, I don't.'

This suggests that participants' preferences for working with people with dementia are aligned with how they view their role as a healthcare professional and how they want to treat or care for patients, along with their role in the patient's journey.

Ambiguity or uncertainty

Participants reported finding the ambiguity of clinical decisions or care practices for patients with dementia challenging. Some reported this made them feel uncertain about their

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actions for these patients and resulted in lower preferences through reduced satisfaction due to lack of impact.

Perceptions of people with dementia

Care challenges

Participants outlined symptoms, behaviours or characteristics associated with dementia they found particularly challenging: communication difficulties; lack of patient compliance; complexity; differences between patients and aggression. These challenges were related to (or caused) other factors found to be difficult. For example, communication difficulties and heterogeneity between patients contributed to perceived ambiguity and uncertainty in practice.

> D9: 'In medicine, you want to go and ask the perfect patient, they'll give you a great history and then you'll examine them, and they'll be really compliant and then they'll be compliant for all investigations, but obviously that's like what we taught to do at medical school, and then we go into hospital and you come up to patients with advanced dementia, and they can't give you a history, and you can't examine them and they won't tolerate investigations. Obviously, that makes me feel quite under-confident in what I'm doing.'

These care challenges contributed to the perception of additional difficulties with this patient group.

Additional difficulties

Participants commonly said it was difficult to work with people with dementia, and frequently referred to the work as more difficult than with other patients. The 'additional difficulty' was attributed to the time involved, barriers in performing therapeutic tasks and the requirement to make adjustments. For some, this was a key factor in preferences against working with people with dementia.

> D4: 'So, I think it is actually quite difficult to do, . . . sort of how much time it takes to often look after them when it is challenging, especially if you're on a busy ward, which does sound quite bad'

Participants with a strong preference for working with dementia also described challenges but did not view these as barriers; instead, they saw them as positive challenges to overcome.

> N1: 'I think it really depends on the person, I just enjoy it because usually I know it can be really challenging, but usually you know that you've gone in, you've done what you need to do, they're in a better position now because you've done it'

For some, these additional difficulties were a reason why it was difficult to make a difference in dementia and related to reduced satisfaction due to lack of impact.

Positive interactions with people with dementia

Participants frequently identified positive interactions as one of the best aspects of working with people with dementia, regardless of preference. This was one of the most frequently cited positive reasons for preferences for working with people with dementia in general. It included pleasant conversations, enjoyment, disposition of the patient and inter-generational learning. Some, who identified that their preference for working with people with dementia had increased over time, attributed this to increased enjoyment of these interactions through more exposure.

> D14: 'I think the experience (during undergraduate training) has definitely helped turn from somebody who probably thought it's just sort of boring old people, to actually people that have got really rich characters and lots to offer'

Involvement of family

Participants recognised that the patient's family play a key role in dementia care and form a core part of their interactions with patients. This was seen as posing additional challenges such as the reliance on family for information, introducing extra steps or difficult conversations with families. The involvement of family contributed to the perception of working with people with dementia being 'a different type of care' that is holistically focused adding ambiguity and uncertainty by relying on others for information about their patient.

> D12: 'I mean it (dementia) adds another dimension often to a conversation or to things like capacity and deciding what the best treatment options are for people, and often it brings in the link of discussing with family and next of kin as well, which again adds another sort of issue.'

Care environment

Difficult care environments

Participants described that working with people with dementia posed additional difficulties; for some, the work was more difficult in particular settings and therefore would not prefer to work with people with dementia in those contexts.

> D4: 'it's your responsibility to sort of get stuff done practically, so it's quite easy for the consultant to go, "Well, let's just pop the catheter in, put a cannula in . . . . but in practical terms if someone's got dementia, they're disorientated, don't sort of understand what's going on or aren't particularly cooperative, that can be quite . . . well, very difficult and time-consuming to manage'

Quality of care

Participants described how they viewed certain care environments as restricting the quality of patient care they could deliver and therefore felt reduced satisfaction due to lack of impact, leading to a lower preference for working with people with dementia.

> N1: 'I would never have gone for a job on a medical ward, or orthopaedics, . . . because, yes, it's a high level of dementia, that's not the reason I wouldn't go, I would just feel that I wouldn't be able to provide the care I could (in a different role) for the patients with dementia'

A recurring theme was that of hospital versus community settings. Hospital care was often described as a difficult

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care environment and providing poorer quality of care for patients with dementia. Some participants with a preference for working with people with dementia described how they could not do this working in a hospital. Hospital wards were seen as 'no place for somebody with dementia'.

> D10: 'Community, there's more time and that's what the focus is . . . . but in the hospital, people with dementia don't get the time because it's too busy, and that's the aspect I don't find satisfying. That's the aspect that I find frustrating, hospital medicine goes too quickly for people with dementia.'

Experiencing different settings

Participants commented on how exposure to a variety of settings (hospital and community) was important to get a balanced view of working with people with dementia.

Career characteristics

These factors encompass wider aspects of a career working with people with dementia that influenced preferences.

Team environment

Positive experiences of working with people with dementia were associated with good team environments. In particular, there was a sense that those working in older people's specialties were particularly 'good teams' to work in.

Challenges due to systems

Preferences were affected by infrastructure in settings related to dementia. These issues were often described as challenges they directly experienced and included lack of funding, staffing levels and poor organisational systems. These system challenges were linked to views of care environments as they contributed to issues with performing direct care in certain settings.

Professional development

Lack of professional development was a consideration. For nurses, some identified not wishing to work with people with dementia because they felt in non-dementia areas they would 'get more skills' or 'push' themselves further.

> N4: 'I love care of the elderly. So, I would . . . I think I'll end up sort of going back there. I like where I am at the moment, but I need to sort of maybe branch out and I have thought maybe sort of a slightly more demanding ICU or A&E, for the experience'

Variety

Variety in work was a key factor in the appeal of careers overall and specifically in relation to dementia. Those who enjoyed working with people with dementia identified variety as a positive feature of work, whereas those with a lack of preference cited an absence of variety or identified dementia care and recognised specialties as monotonous. Several doctors saw a positive aspect of geriatrics was the variety of medical issues as a generalist.

> D2: 'it was a relatively . . . it wasn't particularly varied let's say, it was basically . . . even though it was old age psychiatry over 99% of the referrals were essentially progressive memory loss'

> D11: 'So, I think it's really important, again I did quite like geriatrics because it's not super-specialised'

Discussion

This data from this study contributes to our understanding of how newly qualified healthcare professionals view a career working with people with dementia, and the factors influential in forming these preferences, after qualification and while students. To our knowledge, this is the first qualitative study to explore positive and negative factors influencing preferences for working with people with dementia in newly qualified healthcare professionals.

Six main categories contributed to preferences for working with dementia. Three factors were central to preferences, and the first was **making a difference**. It implies preferences may be encouraged by helping them gain an appreciation of the difference they can make to patients, reducing barriers to making an impact by increasing competencies (e.g. through enhanced education) and providing environments conducive to meeting patients' needs. This accords with research on staff retention and job satisfaction in dementia care that suggests that intrinsic motivations, such as ability to deliver quality care, are most satisfying [7, 29].

Second was **a different type of care**. Students and newly qualified healthcare professionals need to value holistic, person-centred care highly to be attracted to working with people with dementia. Low preferences for working with older adults have been attributed to curricular focus on acute care and technical care, which students then internalise as superior. This has been referred to as the 'hidden curriculum' [30] or 'socialisation of nurses' [20, 31]. Undergraduate training needs to explicitly promote the value of holistic, person-centred care. Strategies include giving it more prominence in the curriculum in all years, a focus on person-centred care as a key concept and visible dementia care role models [32, 33].

Third was **alignment with personal characteristics**. Research suggests undergraduates do not feel adequately prepared for working with people with dementia [34, 35]. These results suggest improving confidence and competency may help cultivate more positive preferences and produce staff better able to meet patient needs. The quality of the curriculum could be improved by consistent attention to dementia educational frameworks [23, 36] and by addressing skill deficits identified such as communication and tolerance of ambiguity. Experiences that increased participant's confidence or competency, their understanding of how they can make a difference to patients and appreciation of positive interactions with people with dementia increased preferences. These add to potential mechanisms of influence. There was evidence that TFD stimulated interest, as with other dementia education [15–17]. Our data indicates

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i.	Inclusion of focused dementia education, including developing skills and confidence in managing care challenges such as difficulties in communication.
ii.	Articulating the value and importance of working with people with dementia. Challenge the view of the work as outside their normal remit, promoting a holistic focus, and enhance students' understanding and appreciation of the contribution they can make to those with dementia.
iii.	A clear definition of roles and healthcare providers responsibility for dementia care in practice facilitating students' awareness and understanding of career options that relate to dementia. Exposure to these clinical areas to evaluate fit with their values.
iv.	Ensuring access to relevant practice placements including a balanced view of working with people with dementia through working in different settings (community/hospital).
v.	Encouraging and developing 'talent' with those with aligned interests or enhanced skills in dementia care.
vi.	Targeted dementia educational programmes to meet dementia curriculum requirements in undergraduate education and increase preferences for working with people with dementia.
vii.	Continued improvement of services for people with dementia, allow healthcare professionals to work in an environment where they feel confident to be able to deliver quality dementia care.

Figure 3. Recommendations.

interventions that improve knowledge, attitudes and confidence may also influence preferences. Evaluations of dementia educational interventions should record preferences as an outcome to explore this further.

Three further categories contributed to preferences: perceptions of people with dementia, care environment and career characteristics. A finding to highlight is that dementia care in hospital was less preferred and viewed as problematic, and this is reflected in the literature on sub-optimal hospital environments for people with dementia [37]. Together these findings suggest that preferences will not be influenced by changing perceptions or increasing competency alone, but that the environment is important—healthcare professionals want to work in a healthcare environment where they can be effective and meet patient needs. Therefore service improvement work, already identified as vital to improve patient outcomes [1–3] and the motivation of current staff [29], is important in forming preferences and attracting staff.

Many factors were dichotomous, and they could affect preferences positively or negatively. A novel aspect of this study was the ability to explore positive aspects of working with people with dementia both generally and within related specialties by interviewing those with a previous preference for working with people with dementia. Consistent positive factors included the rewarding nature of the work, appreciating a different type of care, enjoying interactions with people with dementia and regard for the team environment. These findings add to the literature on the positive perceptions of working with people with dementia and what is valued. They also identify the type of students who might be drawn to this area. Those with these qualities could be encouraged in targeted education or experiences.

This study offers the first attempt at conceptualising and understanding preferences for working with people with dementia. The Bland-Meurer conceptual framework of speciality choice proposes medical students match their career

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needs to satisfy to their perceptions of specialities, both influenced by personal characteristics and experiences [38, 39]. These results viewed within this framework provide an understanding of the needs being evaluated (e.g. making a difference and type of practice) and perceptions, concerning working with people with dementia. We offer recommendations that may help to increase interest in the future workforce (Figure 3). Future research should explore how these factors predict actual specialty choices and explore ways to incorporate these findings into curriculums and practice to increase preferences for working with people with dementia.

Strengths and limitations

A strength of this study was that it was nested within the wider TFD evaluation. This meant participants could be purposively sampled based on previous preferences and included participants who had completed (or not) a dementia educational intervention. A limitation is the sampling was limited to four universities. However, in line with qualitative constructivist theory, while it is acknowledged that these findings may not be generalisable outside this sample, they provide detailed reflections that may help explain factors that could be theoretically transferable to comparable populations. Influential factors during undergraduate training were explored alongside wider factors; however, these were retrospective accounts (as participants had qualified) and accounts might have differed if participants were interviewed during undergraduate training. An advantage of this approach was being able to explore how preferences influenced decisions and changes following qualification.

The quality of this framework, as outlined by Charmaz's (2006) criteria of credibility, originality, resonance and usefulness, is increased by rich data, rigour in the analysis methods and theoretical sampling. A limitation is that we did not use member checking to further explore resonance i.e. do early career professionals relate to the generated concepts.

Conclusion

We need to increase the dementia healthcare workforce in line with need and global care quality concerns. Undergraduate training is critical in forming career preferences and educators need to consider how to stimulate interest in working with older people in general and people with dementia specifically. The factors identified here suggest strategies to help build a future workforce better equipped to meet the challenges of ageing and dementia.

Supplementary Data: Supplementary data mentioned in the text are available to subscribers in *Age and Ageing* online.

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Abbreviations: TFD: Time for Dementia.

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