MANAGING PERSONAL INTEGRITY: A GROUNDED THEORY OF
ELDERLY PEOPLE SURVIVING HOSPITALIZATION

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CHAPTER I

THE RESEARCH OBJECTIVE

Introduction

Admission to the hospital is a common experience for elderly people in the United States. Each year, there are three hospital admissions for every ten people 65 years or older. For people 75 years or older, there are more than four hospital admissions for every ten people (Graves & Kozak, 1998). The oldest old, those 75 years of age and older are at greatest risk to be hospitalized, stay in the hospital longest, and are most likely to be adversely affected by being in the hospital.

The elderly portion of our population is rapidly increasing. In 1987, 30 million people, 12% of the United States population, were at least 65 years of age (Siegal, 1993); currently there are 33.9 million people over 65, 13% of the population, (US Bureau of Census, 1990). Over the next two decades substantial increases in both the actual number and proportion of elderly are expected.

In addition to increasing numbers in the general population, elders occupy a disproportionately large number of hospital beds and remain in the hospital longer than younger people. At least 40% of all hospital beds are occupied by elders (Graves & Kozak, 1998). Currently, 48% of all days of hospital care are used by those 65 and over (Graves & Kozak, 1998). The average length of stay is
five days for people 45 to 64 years old, six days for seniors 65 to 74, and almost seven days for those over 75 (Graves & Kozak, 1998). Finally, those people who are admitted to the hospital and are at least 75 years old are much less likely to survive the hospital experience. For every 100 hospital discharges, more than six people over 75 years old die, as opposed to four for people 65-74 years of age; two die per 100 discharges for those people 45-64 years of age (Graves & Kozak, 1998).

Although hospitalization of older adults is common, the literature does not provide insight into their experiences of being hospitalized in the current health care environment or of the social processes they engage in while in the hospital. These social processes and the experience of hospitalization may have an effect on the outcome of the hospitalization as well as an effect on the person’s life following the experience.

Purpose

The focus of this investigation was the patterns of behavior (social processes) in which selected elderly people engaged while they were in the hospital. The purpose of this study was to develop a substantive theory of hospitalization of the elderly grounded in their experience.

An experience is like a stained glass window, composed of many parts and subtle shadings. In creating the window, the artist combines individual pieces of glass to create a picture of richness and depth. In the present study, the researcher used the perspectives of the elderly persons in the hospital, their family members,
and nurses to develop an in-depth understanding of the experience and social processes of the hospitalized elder. Each of these sources provided unique perspectives on the experience of the hospitalized elder. The totality of the individuals' perspectives was gathered into a composite of the hospitalization of the elderly. The complexity of the experience unfolded through the many dimensions considered and included in the study.

The perspective of family members was sought to provide a view of the hospitalized elderly person that was unique and long term. Family members had experience with the elderly individual both in the hospital and before the elder was hospitalized. Because, elderly individuals and their families engaged in many interactions over time, it was thought that family members would have insights into the elderly person's actions within the context of their history.

Nurses were singled out from the many health care workers as a data source for two reasons. First, nurses provide 24 hour care for hospitalized individuals. Physicians may guide the overall process, but it is nurses who are guiding the direct care of the elderly person during hospitalization. Second, the need for nursing care is often the defining factor for a person to be hospitalized. Almost all services provided in hospitals can be obtained on an outpatient basis except for the intense nursing care offered in inpatient settings.

Investigating the experience of elders' hospitalization was approached from a qualitative perspective. "The strength of qualitative research lies in the richness of its data and its decided attention to complexity, process, and meaning" (Sankar & Gubrium, 1994). The aim of the study was to illuminate the experience
and actions of a select number of hospitalized elderly persons, to discover the meaning of that experience for those involved, and to develop a substantive theory explaining the social processes in which they engaged. Social process is the continuous process of individuals making meaning for themselves out of the interactions of themselves and others and formulating and implementing actions based upon those meanings.

The Research Question

The major question of this study was: What are the social processes elderly people engage in during hospitalization? Areas investigated included:

1. The perceptions, experience, and actions of hospitalized elders as described by the elderly persons themselves.
2. The perception of the experience and patterns of behavior of the hospitalized elder as described by family members.
3. The perception of the experience and patterns of behavior of the hospitalized elder as described by nurses.
4. The recorded experience and patterns of behavior of the hospitalized elder as documented in the medical record.

Definitions

*Hospitalized Elderly Person:* was a person at least 75 years old who has been admitted to an acute care hospital for non-surgical reasons. Minimum age of 75 was selected because of the significantly higher average length of stay and the
potential impact of hospitalization on individuals in this age group. Elderly people who were admitted for surgery were excluded because of the potential for post-anesthesia changes in orientation often present in the elderly. On the advice of the New York University Committee on Activities Involving Human Subjects, no individuals in extreme pain were included. Participants were admitted through the emergency room, as were the majority of patients at this hospital. Only elderly people who were able to give informed consent to participate in the study, spoke English, and had a family member as defined below were included.

*Nurses:* Registered Nurses who worked with the hospitalized elderly person.

*Family Member:* Someone identified by the hospitalized elderly person as being emotionally connected to that person and who visited the hospitalized person. The family member was either a spouse, an adult child, or a sibling.

**Researcher Stance**

My interest in the hospitalization of elders began in my earliest nursing experiences where, as a nurses' aide, I was involved in promoting functional independence of elderly people in nursing homes. Later, when I completed my basic nursing education, I worked in long term care and physical rehabilitation settings with elderly people who needed assistance in meeting their health needs. When I became a Rehabilitation Clinical Nurse Specialist, I became interested in the hospital experience of elders and the outcomes of that experience.

Following is a list of my assumptions about elderly people in the hospital.
1) Hospitalization has changed the lives of many elderly people I have worked with over the course of my career. Many, such as a client I worked with who had had bilateral hip replacement surgery, have benefited from hospitalization. In her case, the experience of hospitalization was quite positive and improved the quality of her life. In the cases of others, the complications arising from prolonged hospitalization contributed to debilitation, decreased function, and chronic pain. Some individuals seem to adjust to the hospital stay with little stress, while others are anxious and fearful regardless of actions taken by the staff to allay the client’s fears.

2) Elderly people in the hospital want to be engaged in decision making about their health and hospital stay. They want to be informed about their physical condition, and act to maintain independence while they are in the hospital. Many times elderly persons have ideas about what actions taken by themselves, their families, and the staff will make a difference in their health. These ideas are not always congruent with the plans of the family or staff. Elderly people are sensitive to the way they are treated by others and interact with people based upon their perceptions of that treatment.

3) Autonomy, independence and interdependence are important achievements for all individuals. Elderly persons are challenged by their diminished resources to maintain autonomy. When in the hospital, the elderly person’s resources are particularly compromised, and the staff and family are in an optimum position to assist the person to maintain autonomy.
4) Nurses have a key role in the experience of the hospitalized elder. In many instances, the nurse’s perception of the hospitalized individual’s situation is instrumental in decisions regarding care. Also the nurses’ ability to provide care required by the hospitalized individual is crucial to the experience of that individual. Increased understanding of the experience by the nurse may improve the quality of the experience for the individual and improve the outcome of hospitalization.

5) Family members also have an important role in the hospitalization of loved ones. Many times, a family member is expected to provide not only emotional support for the hospitalized individual but physical assistance upon discharge. Helping family members to understand the experience of the elderly person in the hospital may help the hospitalized individual and their family members to realistically plan for hospitalization and beyond.

My interest in the experience of hospitalization of elders stems from my desire to help elderly individuals maintain their independence. Understanding the experience may help affect the experience of hospitalization and may help elderly people have a voice in their own experience. An in-depth understanding of the experience of hospitalization of elders may have implications for education of nurses with respect to working with elderly people. In-depth understanding of the experience of elderly people in the hospital may also inform discussions of healthcare policy.

Increased understanding of the experience of hospitalization also may have economic implications for clients as well as health care providers.
Understanding the experience of hospitalized elders may contribute to finding strategies to promote independence and thereby decrease the need for after hospital care. If elderly individuals about to be hospitalized have a better understanding of what to expect, it may have an effect on their experience and help identify ways to maximize the effectiveness of the hospitalization process, thereby reducing costs.

Overview of the Method

The Grounded Theory approach developed by Glaser & Strauss (1967) was chosen to uncover the nature of the experience of hospitalization of the elderly and to develop a substantive theory explaining elderly peoples’ engagement in social processes. “The grounded theory approach is a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon” (Strauss & Corbin, 1990). It was a useful technique for this investigation for several reasons. First, little research has been published which describes the processes in which hospitalized elders engage to survive the experience. Second, the experience of hospitalization is multifaceted and developing a composite picture of the whole process is best accomplished by qualitative methods. Third, quantitative methods require apriori assumptions upon which to derive hypotheses, while the theory in this qualitative method arises from the experience of the phenomena. Finally, the grounded theory approach led to a substantive theory about the experience of hospitalization.
of elderly people which may be useful to nurses and other healthcare workers who provide and direct care.

The grounded theory approach arises from the framework of Symbolic Interaction (Bowers, 1988). There are three basic premises of this framework: 1) Human beings act toward objects and events on the basis of the meaning that those objects and events have for them, 2) these meanings are part of social interaction in human society, and 3) these meanings are modified and handled through an interpretive process that is used by each individual in dealing with the things he or she encounters (Blumer, 1969). "The meaning people give to their experience and their process of interpretation are essential and constitutive, not accidental or secondary to what the experience is" (Bogdan & Bilkin, 1992). Grounded theory is a research method that is useful to inductively describe meanings in such a way as to aid in the understanding of a phenomenon.

In the current research, multiple data sources were used to "maximize the range of data that might contribute to a more complete understanding of the topic" (Knafl & Breitmayer, 1991). Data was collected through participant observation, interviews of participants, and review of the medical record.

Participant observation is a data collection technique in which the researcher "enters the world of the people he or she plans to study, gets to know them and earns their trust, and systematically keeps a detailed record what is heard and observed" (Bogden & Bilken, 1998, p. 3). The researcher engaged in participant observation for several hours each day while each elderly person was in the hospital.
Interviews with family members and nurses complemented the interviews of the elderly people and contributed to the researcher's understanding of the social processes involved in the experience of the hospitalized elderly people. The research of Cremin (1992) and Congdon (1994) illustrates the effectiveness of the use of multiple data sources in studies about aging (Cremin) and discharge planning (Congdon).

Cremin (1992) interviewed elderly people, their adult children, and the staff at a geriatric assessment clinic to explore the experience of the aging person through each of their unique perspectives. The participants (elder, family, and clinic staff) had widely divergent views as to what constituted the elderly person's symptoms of old age. In Cremin's study, the elderly people made a distinction between being old and feeling old. None of the elderly participants (ages 69-86) identified themselves as being old, although they all admitted to "feeling old" in relation to specific problems which were troublesome to them. In contrast, most of the participating family members identified their parents as "being old" (pg. 1308). While the experiences of the family members and their elderly relatives were highly idiosyncratic, the clinic staff had a uniform perspective across all participants. The clinic staff viewed the elderly person who came to the clinic as old and as having problems in relation to aging; otherwise, the elderly person would not have come to the clinic. Because the clinic was a geriatric assessment clinic, all people who were assessed at the clinic were 65 or over and were having problems in relation to aging (p. 1311).
Congdon (1994) interviewed elderly patients (n=8) 75 to 95 years old, their family members, and primary nurses to describe the elderly person's discharge experience. As did Cremin (1992), Congdon found the elderly person, the family member, and the nurse held widely divergent views. Patients thought they were ready for discharge, family members did not think the patient was ready, and nurses were uncertain (p. 127).

McCauley, Lowery and Jacobsen (1994) and Reiley et al. (1996) investigated congruence in perceptions of hospitalized individuals and nurses. The hospitalized individuals in both of these studies included hospitalized adults of all ages. The researchers found little congruence between the hospitalized individual's reported experience and the nurses' perception of the patients' experience. McCauley et al. found discrepancies between hospitalized individuals' perception of their current status, ability to cope after discharge, and beliefs about recovery, with nurses' perceptions of each individual's status. Reiley found discrepancies between nurses and hospitalized individuals' perceptions of the individuals' preparation for discharge.

In the present study the perspectives of the elderly person, the family, and the staff added depth to the description of the experience of hospitalization. The elderly person and the family held distinct viewpoints on the experience of the hospitalized elder just as they did in Cremin's (1992) study on the meaning of aging. The meaning each person ascribed to the events occurring in the hospitalization was based on his or her previous experiences with the elder, the healthcare system, personal health, and general life experience. The staff had yet
another perception of the elder's experience, related to their exposure to many hospitalized elders and the meanings that the staff ascribed to the event of hospitalization.

The behavior of the staff and the family member is based upon the meaning (Blumer, 1969) each ascribes to his or her perception of the elder's experience. The family members' and staff's behavior toward the elder was an integral part of the elder's experience while in the hospital. The elder ascribed meanings to the behavior of the staff and the family, and in the hospital, acted in part based upon their interpretations.

Significance of the Study

Although hospitalization of the elderly has been investigated from several perspectives, research describing the experience of hospitalization from the perspective of the elderly person is limited. Characteristics of the elderly person in the hospital (Buckle, Horn, Oates & Abbey, 1992; Kahn et al., 1994; Naylor et al., 1994; Pearson et al., 1992), predictors of outcomes of hospitalization (Borkan & Quirk, 1992; Dunlop, Rosenblood, Lawrason, Birdshall & Rusnak, 1993), and the elder's perspective on quality of care and the nurse's role have been studied (Boutil et al., 1993; Cohen, Hausner & Johnson, 1994, Drew, 1986; Minnick, Roberts, Young, Kleinpelt & Micek, 1995b; Minnick, Young & Roberts, 1995a). Only two studies, one completed in the United Kingdom (Koch, 1994; Koch, Webb & Williams, 1995) and one completed in the United States in the 1980's (Huckstadt, 1990), address the individual's experience of hospitalization.
The applicability to the current research of the research of Koch (1994) and Huckstadt (1990) is questionable. The current healthcare and hospital environment in the United Kingdom is quite different from the environment in the United States, so that Koch's research does not shed light on experience in this country. The study by Huckstadt was completed more than ten years ago. Over the last decade, length of hospital stay has declined, and the advent of the federal prospective payment system has had a tremendous effect on hospitalization of the elderly. More than half of the people in the hospital are elderly, and they are in the hospital longer than their younger counterparts. The experience of elders' hospitalization in the current healthcare environment must be documented to provide a basis for identifying changes needed in the delivery of healthcare to the elderly.

Many experts in the field of gerontology have focused their research on the effectiveness of new models of care delivery (Borok et al., 1994; Covinsky et al., 1998a; Fillit, 1994; Fulmer, 1991a; Fulmer, 1991b; Fulmer & Mezey, 1994; Hamilton & Lyon, 1995; Inouye et al., 1993a & b; Kresevic et al., 1998; Naylor et al., 1994; Naylor et al., 1999; Palmer, Counsell, & Landefeld, 1998; Palmer, Landefeld, Kresevic & Kowal, 1994). Fillit (1994), Hamilton & Lyon (1995), and Palmer et al. (1994; Palmer et al., 1998; Covinsky et al., 1998a; Kresevic et al, 1998) have designed special units within acute care facilities to meet the specialized needs of the elderly. The size of these units range between six and sixteen beds. Fillit reported decreased length of stay of elderly people on the specialty unit, and Hamilton and Lyon reported increased functional ability of
elderly patients. Palmer et al. reported improved health care provider satisfaction with caring for elderly individuals (Palmer, Counsell & Landefield, 1998,) and improved functional outcomes for elderly patients at discharge (Covinsky et al., 1998)

Borok et al. (1994), Inouye et al. (1993), Fulmer (1991a, 1991b), Fulmer and Mezey (1994), and Francis, Fletcher, and Simon (1998) approached the need for specialized services for the elderly from a different perspective. These authors discuss hospital-wide interventions. Borok et al. described an interdisciplinary geriatric consultation service while Inouye et al., Fulmer, and Francis described models of acute-care nursing in which nurse experts act as resource people to assist staff nurses and thus reduce the complications developed by hospitalized elderly. In either approach to care of the elderly, there seems to be a paucity of research actually outlining the status of the elderly client in these facilities prior to initiation of the research intervention. This study might fill that gap in the literature.

Summary

As the elderly portion of the population continues to increase, greater demands will be placed on the health care system. Exploring the processes engaged in by elderly people in the hospital established a theoretical baseline that described the life-worlds of elderly patients, their families, and the nursing staff who worked with them. Describing the experience in a theoretical way may assist elderly people to anticipate the experiences of hospitalization and to effectively
plan strategies to handle being in the hospital. Using the theory derived from this investigation, families may develop a clear understanding of what their elderly family member is experiencing while hospitalized. The knowledge gained from the study may assist nurses and other health care providers to plan and implement effective strategies of care for individuals and groups of elderly people, to promote independence and minimize the possible negative effects of hospitalization. Finally, the theory derived from this investigation provides a perspective of hospitalization in which the elderly person has an active voice and an active role in the process of hospitalization.
CHAPTER II
REVIEW OF LITERATURE

Many facets of the experience of hospitalization of the elderly have been investigated by healthcare providers. Studies pertaining to the hospitalized elder, the hospital environment, the health care provider, and the experiences of families are included here to provide insight into the breadth of research as well as highlight areas where research is lacking. Research pertaining to the hospitalized elderly person will be presented first. The review of literature has focused on studies published in the 1990's except in cases where a seminal article written before that time added depth to the discussion. Research conducted outside of North America was not included in the review of literature unless it was directly related to the design of the current research.

The Elderly Person in the Hospital

Elderly people use approximately 48% of inpatient hospital care provided in this country (Graves & Kozak, 1998). The hospitalized elderly person has been studied from many perspectives. Areas of investigation have included gender, race, and income level of elderly people admitted or readmitted to the hospital
Hospital Use and Gender, Race, and Income Status

Researchers investigating the quality of hospital care for Medicare patients before and after implementation of the prospective payment system analyzed relationships between gender (Pearson et al., 1992), race and socioeconomic status (Kahn et al., 1994b) and the care received. Data were collected using retrospective chart audit. Subjects were over 64 years of age (male n= 5354, female n= 5888, total n= 11242), and had a major diagnosis of congestive heart failure, acute myocardial infarction, pneumonia, or cerebro-vascular accident. There were five dependent variables: sickness at admission, process of care, length of stay, discharge destination, and post-discharge mortality rates. Sickness at admission was operationalized as probability of death within 30 and 180 days.
Process of care which was operationalized as care needed which was actually provided. Process of care was determined by five Likert-like scales: physician cognitive performance, nurse cognitive performance, technical diagnostic process, technical therapeutic process, and monitoring with intensive care and telemetry. Discharge status and outcomes were operationalized as length of stay, discharge destination, and 30 and 180 day post-discharge mortality rates.

Findings indicated that at admission males were more than two years younger than women on average (p<.001) and less likely to be admitted from a nursing home (p<.001). Gender differences in sickness at admission varied according to disease (Pearson et al., 1992, p. 1883). Process of care, operationalized as the subject receiving a service which the record indicated was needed, differed by gender. Women’s overall process of care score was lower than the men’s (0.04 SD lower, p<.05). The difference was very small but could indicate women were less likely than men to receive care they required. There was no difference between men and women in either physical instability at discharge or use of services.

Using the sample described above (Pearson et al., 1992), Kahn et al. (1994) sorted subjects by postal ZIP code to investigate the effects of race and socio-economic status on sickness at admission, process of care and outcome measures (length of stay, discharge location) of hospitalization. Poverty was determined by neighborhood using 1980 US census data. There were no differences in sickness at admission. Process of care varied by race and economic status (0.11 SD lower, p<.01). Blacks and people from poor neighborhoods were
more likely to be discharged in an unstable condition (p<.001). The type of hospital delivering care proved to be a confounding variable. Blacks and poor subjects were more likely to receive care in urban teaching hospitals which were shown to provide better quality of care overall (p<.001).

Buckle et al. (1992) also investigated severity of illness and resource use among black and white elderly. A chart audit was conducted of records of selected inpatients ≥ 59 years old (range 59 - 102, mean= 72) at two urban teaching hospitals (n= 1184, black n=462, white n=722). The Computerized Severity Index (CSI) (Iezzoni, 1992), a diagnosis sensitive illness severity matrix, was computed for all subjects at admission, maximum severity of illness, and at discharge. Elderly black patients arrived at the hospital more severely ill (z= -3.95, p<.0001), had higher maximum CSI scores (z= -3.47, p= .0006), stayed less time (F= 82.65, p<.0001) and used fewer resources (F=28.70, p<.0001) than white elderly patients in two urban hospitals. There was no statistical difference in CSI at discharge.

C. Boult et al. (1993) and L. Boult et al. (1994) investigated risk factors for admission to the hospital in a large prospective cohort study (n= 5876) conducted during the 1980’s. The factors which indicated repeated admissions to the hospital were: older age, male gender, poor self-rated general health, diabetes, availability of an informal caregiver, having ever had coronary artery disease, hospital admission during the previous year, or more than six doctor visits during the previous year.
Hennen et al. (1995) used data from Health Care Financing Administration (HCFA) inpatient billing claims during a three year period to investigate readmission rates for 30 and 365 days and death following hospitalization for elderly people admitted to Connecticut hospitals with one of the 20 most frequent diagnostic related group (DRG) diagnoses. Independent variables were gender and age group. The sample was composed of 184,490 discharges from 112,302 elderly individuals. The overall readmission rate within one year was 46.9%.

The overall 30 day readmission rate was 15.6%. At 30 days, women were less likely to be readmitted than men (15.1% versus 17.8%). The readmission rate for individuals 65-74 years old was 16.5%, age 75-84 years was 16.8% and for individuals over 85 was 14.6%. Five DRGs (cancer, congestive heart failure, acute myocardial infarction, cardiovascular accident, and pneumonia) accounted for 65% of the re-admissions, within 30 days. The findings from this descriptive study using a large database agreed with Pearson et al. (1992) in that women on average were more than 2 years older than men in the sample.

Hospital use was the dependent variable for all of the studies presented above. Using retrospective and prospective designs characteristics of hospitalized elderly people, people at risk for hospitalization or readmission to the hospital, and use of services while hospitalized were investigated. Males were more likely to be hospitalized and readmitted at a younger age than women. Poor and black individuals were more likely to be treated at urban teaching center hospitals. There is disagreement among studies as to differences in illness at admission.
between black and whites. Almost half of elderly individuals admitted to the hospital are likely to be readmitted within one year.

**Characteristics of Hospitalized Elderly People and Outcomes of Hospitalization**

Using qualitative interviews and multiple choice questions two days following surgery for hip fracture, Borkan and Quirk (1992; Borkon, Quirk, & Sullivan, 1991) investigated the relationship between the expectations of independent elderly (≥ 65 years of age) patient (n=80) expectations of future ability and actual ability to ambulate following hip fracture. Follow-up interviews of similar structure were conducted three months after fracture. Findings indicated "...a significant relationship (F=3.43, p=.04) between expectations for recovery and change in ambulation from pre-fracture to three months post fracture" (Borkon & Quirk, 1992, p. 344). Participants who did not know what to expect did not recover as well as those who expected to recover fully or partially.

Effects of age and severity of illness on outcomes and length of stay in consecutively admitted elderly surgical patients (≥ 65 years of age) were investigated by Dunlop, Rosenblood, Lawrason, Birdsall, and Rusnak (1993). Using MedisGroups (Iezzoni & Moskowitz, 1988) for assessing the severity of illness on admission and in-hospital morbidity, the sample patient records were analyzed retrospectively to test the hypothesis that severity of illness was more important than age in predicting postoperative morbidity and mortality rates.
Using correlation and multiple regression analysis, the hypothesis was supported, severity of illness was a much stronger predictor of outcome than age (p<.001).

Covinsky et al. (1999) investigated the relationship between nutritional status on admission to the hospital and subsequent mortality, functional dependence, and nursing home placement (n=369, age ≥ 70 years old). Using the Subjective Global Assessment (SGA) (p. 533), those participants who were identified as malnourished (n=60, 13.3%) had greater mortality, delayed functional recovery, and higher likelihood of discharge to nursing home than better nourished participants.

Hirsch et al. (1990) investigated changes in the functional status of hospitalized elderly people. Using a prospective cohort design, the researchers tested 71 patients (age ≥ 74 years old), who were admitted to the medical service at Stanford University Hospital during 1987. The findings indicated that functional status was lowest immediately following admission and, although the patients improved slowly, they remained significantly impaired after discharge. Findings also indicated that recovery of functional ability took longer than the recovery from the acute illness.

Covinsky et al. (1997) investigated functional ability to determine if elderly patients' admission ADL function provided information for determining prognosis and case mix. ADL score was determined by the elderly person's primary nurse, APACHE II score was determined by chart audit. Dependent measures included mortality in the hospital and 1-year post discharge, nursing home use within 90 days post discharge, and cost of hospitalization.
Hospital mortality was rated from 0.9% in patients with no deficits in ADL to 17.4% in patients dependent in all ADLs. Mortality within one year of discharge was 17.5% for subjects who had no dependencies on admission to 54.9% for subjects with six dependencies. The rate of nursing home use ranged from 2.8% to 32.9%, and hospital costs were 53% higher for patients dependent in six ADLs than subjects who were not dependent. Covinsky et al. (1997) demonstrated that admission ADL was a predictor of hospital outcome and cost.

In a prospective cohort pretest/posttest study, Dunham and Sager (1994) assessed the relationship between symptoms of depression at admission and post-discharge medical outcomes for a cohort of 247 (age ≥ 70 years old) cognitively intact community dwelling elderly people who were not terminally ill and were admitted to one community hospital for at least 48 hours. Dunham and Sager administered the Geriatric Depression Scale (GDS) (Koenig, Meador, Cohen & Blazer, 1988), the Katz Activities of Daily Living (ADL) (Katz, Ford, Moskowitz, Jackson & Jaffe, 1963) and Instrumental Activities of Daily Living (IADL) (Lawton & Brody, 1969) scales based upon their function two weeks prior to the current hospital admission.

At one month after admission follow-up data were collected for a 197 participants. After comparing admission data from participants who agreed to participate in the post test and those that did not, the researchers found that those individuals who declined to participate in the post test were more likely to have been depressed on admission (p < .05). Dunham and Sager (1994) found that 23.9% of participants had GDS scores ≥ 11 at admission. Older participants (age
≥ 75 years old) were more likely to be depressed (26% vs 18.8%). Of all participants, 19.8% had deficits in ADLs and 70% were found to have deficits in at least one IADL. The correlation between pre-admission functional status and depression was found to be significant (ADL ≥ .05, IADL ≥ .01). The conclusion reached by Dunham and Sager (1994) was that there was a relationship between depression and physical function in elderly individuals. Participants with pre-hospital deficits in ADLs were more than twice as likely to have high score on the GDS. These two factors were found to be independently related to and additive in their effects on lower functioning at one month post discharge.

In a similar study, Covinsky et al. (1997, 1999) used the GDS, Katz ADL and IADL scales to investigate depression and health outcomes. In a prospective cohort study of 572 medical patients older than 70 years old, Covinsky at al. measured symptoms of depression, health status and severity of illness at admission. The dependent variable was dependence in ADL at discharge, and IADL 30 and 90 days after discharge (Covinsky et al., 1997) and death within three years of hospitalization (1999). The objective of the investigation was to determine "whether symptoms of depression predict worse health status outcomes in acutely ill, older medical patients, independent of health status and severity of illness at admission (Covinsky et al., 1997, p. 417).

Using odds ratios, Covinsky et al. (1997, 1999) determined that participants with admission GDS scores greater than six were more likely than participants with admission GDS scores of zero to two to be dependent at
discharge, one month and three month follow up, and had higher morbidity at three years after discharge.

Rudberg, Sager, and Zhang (1996) investigated risk factors for nursing home admission following acute hospitalization. Using an existing data base of 1265 subjects whose data had been prospectively collected in 5 acute care hospitals, Rudberg et al. employed logistic regression to determine the effect of age, gender, race, mental status, pre-admission living arrangements, IADL and ADL two weeks prior to admission on nursing home use at discharge and 3 months following discharge. Only 11% of the total number of subjects went to nursing homes at discharge or three month follow-up. The subjects who were admitted to nursing homes at discharge were older, predominately white, living alone, had lower pre-hospital ADL sums, increased hospital length of stay, and had decline in ADLs during hospitalization. Likelihood of discharge to a nursing home was highest in areas where nursing home beds were available.

Sager et al. (1996a, 1996b) investigated the relationship between hospitalization and decline in function in hospitalized elderly subjects. The investigation focused on discharge and three month post-discharge functional outcomes for elderly individuals hospitalized for medical care; the extent to which subjects were able to regain their pre-admission level of function after discharge; and identify patient factors associated with decreased function following discharge. Using logistic regression with decline in ADL as the dependent variable, Sager et al. (1996b) developed and tested the Hospital Admission Risk Profile (HARP). Items included in the profile were increasing age, decreased
IADL prior to admission, and lower mental status scores. Individuals who were at least 85 years old, scored 14 or less on the Mini Mental Status Exam (Folstein et al., 1975), and were dependent in at least five IADLs prior to admission had the greatest likelihood of decline in ADL function at discharge.

Sager et al. (1996a, 1996b) and Rudberg et al. (1996) both used Hospital Outcomes Project for the Elderly (HOPE) database. HOPE (Margitic et al., 1993) is a prospective multi-center pooled analysis of related clinical trials designed to improve the functional outcomes of acute hospitalization in older persons.

Signs and symptoms of disease presentation and process of care in relation to adverse hospital outcomes (death, nursing home admission, prolonged hospital stay, and failure to regain pre-hospital functional status) in a cohort of hospitalized elderly people were investigated in Nova Scotia by Jarrett et al. (1995). Participants were classified as well (n=76) or frail (n=117) by Barthel Index (BI) score (Mahoney & Barthel, 1965). Individuals coded as well had BI scores of at least 95. Subjects with score lower than 95 were coded as frail. The most frequent atypical presentation for individuals classified as well were falls, delirium was the most frequent atypical disease presentation for previously frail individuals. Pre-morbid functional dependency, atypical disease presentation, and functional decline on admission have independent effects on adverse hospital outcomes.

Borkon and Quirk (1991, 1992) and Dunlop et al. (1993) studied hospitalized elderly people who had had surgery to determine the effect of patient expectation of function and the importance of severity of illness over age. Those
individuals in Borkon and Quirk's study who had more positive expectations of outcomes after hip fracture and surgery had better post hospital function than those with lower expectations. Dunlop et al. found severity of illness to be more important than age as a predictor of length of stay and function after surgery.

Sager et al. (1996a, 1996b), and Rudberg et al. (1996) investigated functional ability in relation to acute care admissions. Their findings indicate that increasing age, lower mental status scores, and altered functional ability at admission were strong predictors of increased dependence at discharge, of nursing home admission, and of hospital costs. Hirsch et al (1990) found that functional ability was lowest immediately following admission and remained significantly impaired after discharge and Jarrett et al. (1995) found that pre-morbid function, atypical disease presentation, decline in function during admission had independent effects on hospital outcome. Covinsky (1999) added malnutrition, to the profile of the hospitalized person at risk for negative outcomes of hospitalization.

Finally, Dunham and Sager (1994) and Covinsky et al. (1997, 1999) found depressive symptoms at admission to be a significant independent factor in predicting decreased function at and after discharge as well as higher mortality for elderly individuals admitted to the hospital with medical problems.

Complications of Hospitalization of Elderly People

Jacelon (1999, pp. 28-30) reviewed several research studies that investigated the incidence of iatrogenic disorders. Iatrogenic disorders are
complications of the plan of care that are directly related to the treatment received by the patient or negligence of the healthcare team (Brennan et al., 1991).

The Harvard Medical Practice Study (Brennan et al., 1991; Leape et al., 1991), an interdisciplinary retrospective study of medical injury and medical malpractice, sought to determine the incidence of adverse events occurring to hospitalized patients. Two studies in this sample focused on different aspects of iatrogenic complications occurring in a specific elderly population (Lefevere et al., 1992; Potts, Fienglass, Kadah, Branson & Webster, 1993). Jahnigen et al. (1982) prospectively compared a group of patients less than 65 years old with a group 65 or older to investigate the incidence of iatrogenic events.

The Harvard Medical Practice Study was designed to investigate the incidence of "adverse events" (Brennan et al., 1991) occurring during hospitalization. The goal of the study was to develop current, reliable estimates of adverse events and negligence in the treatment of hospitalized patients. An adverse event was operationally defined as "an injury that was caused by medical management (rather than the underlying disease) and that prolonged hospitalization, produced disability at the time of discharge, or both" (p. 370). Negligence was defined as "care that fell below the standard expected of physicians in their community" (p. 370). The investigators found that the incidence of adverse events increased with age and those individuals older than 64 years old were more likely to have adverse events associated with physician negligence. The researchers suggest that this finding indicates that "care for the elderly less frequently meets the standard expected of reasonable medical
practitioners” (p. 373-4).

The Harvard Medical Practice Study was published as several different articles, two of which are presented here (Brennan et al., 1991; Leape et al., 1991). The methods for chart review and sampling strategy are presented in an article by Hiatt et. al. (1989). Initially a “weighted” sample of records were randomly selected from 2.67 million records of hospitalizations at 51 participating hospitals (Brennan et al., 1991). The article by Leape et al. presented analysis of the cases positive for adverse events.

In the study reported by Brennan et al. (1991), 31,429 medical records were initially selected, 30,195 were actually reviewed. Of the total records reviewed, physicians identified 1278 adverse events and 306 adverse events due to negligence. The incidence rates reported in the article are based upon 1133 adverse events and 280 adverse events related to negligence.

Adverse events occurred in 3.7% (95% confidence interval, 3.2 to 4.2) of all cases and were correlated with degree of impairment, duration of disability, and death. The incidence of negligence was found to be greater in patients who had more severe adverse events. Adverse events were also reviewed with respect to age. Patients over 65 had more than double the risk of adverse events when compared to patients 16 to 44 years old. The likelihood of an adverse event as a result of negligence was also highest in those people over 65. Brennan et al. (1991) estimated that patients incurred 98,609 iatrogenic events in hospitals in New York State during 1984. Many of these were minor in nature, but 13, 451 may have led to death. The researchers estimated that 27, 179 iatrogenic events...
may have occurred from negligence of the health care provider.

The article written by Leape et al. (1991) is focused on the 1133 cases in Brennan et al. (1991) in which adverse events were identified. The goals of the study were to categorize the adverse events by type, to identify those events most likely to result in serious disability, as well as the types of events most likely to be caused by negligence, to assess the effects of risk factors, and to identify management errors. The authors categorized the adverse events by type of injury based on the physician review. The results showed that the cause of adverse events were attributable to negligence in 28% of the cases, that 70% of people recovered from the resulting disability within six months, that although only 27% of the population was over 64 years old they incurred 48% of the adverse events, and that 48% of the adverse events occurred in the operating room, while 27% occurred in the patient’s room.

Neither of these studies identified the nursing care as either contributing to or preventing the adverse events. The studies focused on medical care in relation to malpractice litigation, which was somewhat limiting in that it was assumed the original adverse event occurred as a result of the physician.

Although the study of cascade iatrogenesis is thought to be somewhat spotty (Brennan et al., 1991), the history is long. In 1982, Jahnigen, Hannon, Laxson, and LaForce conducted a study to see if veterans over 65 were at greater risk for developing iatrogenic disease than younger veterans. In this sample 45% of elderly patients as compared to only 29% of younger patients (p.<0.05) had untoward complications. In both groups, individuals who incurred complications
were likely to be in the hospital twice as long as those patients who did not experience complications.

Two articles in this review report on different aspects of another large study (Potts et al., 1993). The retrospective study was conducted at a large midwestern hospital and examined elderly (>65 years of age) patients who had a length of stay greater 14 days, and had a primary diagnosis of congestive heart failure, acute myocardial infarction, or pneumonia. The authors found that the rate of iatrogenic complications was 40%. The high rate is to be expected as the subjects all had been in the hospital for more than 15 days.

Lefevere et al. (1992) used the same population as Potts et al. (1993). This study focused on patients from the medical service. The purpose of the study was to identify areas of potential for improving quality of care. The authors found that “more than half of all documented iatrogenic complications [in this study] were potentially preventable, and that worse care was associated with more complications” (p. 2078). The conclusion of the study was that iatrogenic complications are common in high risk elderly patients, and that quality improvement efforts should focus on the process of care, particularly with patients with poor functional status.

The literature on iatrogenesis has several themes. First, the elderly are at greater risk than other hospitalized people for experiencing complications (Leape et al., 1991; Jahnigen, Hannon, Laxson, & La Force, 1982). The longer the hospital stay, the more likely an untoward event will occur (Potts et al., 1993). Hospitalization may have a negative impact on functional ability (Hirsch,
Sommer, Olsen, Mullen & Winograd, 1990). Finally many adverse events during hospitalization may be preventable (Brennan et al., 1991; Jahnigen, Hannon, Laxson & LaForce, 1982; Leape et al., 1991; Lefevere et al., 1992; Potts et al., 1993).

**Experience of Hospitalization**

The experience of elders in the hospital in the United Kingdom (Koch, 1994; Koch, 1998; Koch & Webb, 1996; Koch, Webb & Williams, 1995), Sweden (Ekman, Lundman & Norberg, 1999), and in the United States (Huckstadt, 1990) have been investigated by three researchers.

Koch (Koch, 1994; Koch et al., 1995) conducted a qualitative study to identify the concerns and experiences of older patients admitted to two elderly care wards in a National Health Service hospital in the United Kingdom. Average age of patients was 70 years for women and 78 years for men; average length of stay was 50 days. A description of the setting, as recorded in the researcher's log, indicated a stark setting in which physical and staff resources were lacking.

During interviews, Koch (1994) found the patients reluctant to talk about their experiences. The patients were cautious in their conversations and felt vulnerable (p. 982). Patients initially agreed to participate and subsequently changed their minds. One patient stated he was “not comfortable with ‘exposing’ some of the bad practice while he was still a patient” (p.983). Fourteen patients were interviewed either at the bedside or at home following discharge from the units on which the study was focused. The themes which emerged from the interviews were “routine geriatric style of care, depersonalization, care
deprivation, and geriatric segregation” (p. 976). Care was not individualized, needed care was not always provided, and elderly people were segregated on wards apart from the rest of the hospital.

Koch (1994) had difficulty achieving a balance between participation and observation in her study of the experience of elderly people who were inpatients on Nightingale Wards in a hospital in England. Early in the research process, the researcher’s time was consumed with participating in the environment by providing care to patients (p. 981). Little time was left for observations or uninterrupted interviewing of patients. The research design evolved so Koch could become less involved in direct care and spend more time in observation and interview. Initially, Koch focused on the activity occurring on the entire unit, then later focused on the hospitalized individuals by conducting interviews after discharge.

The study was described in two articles. One article focused on the research process (Koch, 1994) and the other on findings (Koch et al, 1995). The themes arising out of the data were discussed using exemplars from actual interviews. The findings were discussed within the historical context of care of the elderly in Britain, ageism, and ethical considerations. Measures initiated by Koch to remediate the conditions of the study wards were stated.

This is one of the few studies in which the experience of the hospitalized elderly person was described. The study is focused on the care received and the care giver, not the meaning of the experience to the elderly person. The participants in this study had a different experience than those who participated in
the current study. The healthcare environment and particularly the hospital is different here than in the United Kingdom. The majority of hospital rooms in this country are semi-private, not the open Nightingale Wards described by Koch. Semi-private bathrooms and central heat are the norm in hospitals in this country, they were not the norm in Koch’s study. In addition, the average length of stay reported by Koch was 50 days, the average length of stay for elderly people in the US at present is less than four days.

Ekman, Lundman, and Norberg (1999) investigated the meaning of illness and caring to elderly people with chronic congestive heart failure (CHF) in a phenomenologic hermeneutic qualitative research study. Elderly people who were at least 65 years old, had been hospitalized at least twice with moderate to severe CHF, and had difficulty with communication were invited to be interviewed. All but one participant was interviewed in his or her home. One participant was interviewed at the hospital. Data from 12 interviews were used to answer the research question.

Five woman and seven men aged 76-94 years old agreed to be interviewed. All participants lived in their own homes with varying degrees of support, all but two were unable to leave their homes without assistance. The participants were asked to narrate their experiences of hospital care and their outlook on and their experiences of illness (p. 204). Interviews were audio taped and transcribed verbatim.

Analysis was guided by Ricoeur’s phenomenologic hermeneutics. From this perspective, “all understanding must be mediated by explanation. The living
concreteness of a person … can only be grasped through the signs, symbols, and
the interpretation of texts” (Ekman et al., 1999, p. 204). Analysis proceeded in
three steps. First a “naïve” reading of the transcript was done to obtain a sense of
the whole and formulate guesses about the meanings in the text. The next phase
was structural analysis; the text was broken down by meanings and restructured to
combine phrases with like meanings. This reformulation led to the development
of subthemes, themes and critically examined the guesses from phase one. The
second part of structural analysis was critical analysis of the subthemes and
themes. The third phase of data analysis was an interpretation of the results to
develop a “comprehensive understanding”. All authors participated in all phases
of analysis.

Findings were that the participants found care “unpredictable” and either
as “confident but incomprehensible” or “nonconfident but incomprehensible”
(Ekman et al., 1999, p. 205-206). The participants did not understand
(incomprehensible) the care they received and were unable to predict the course
of their care. The participants described caregivers as knowledgeable (confident)
or not knowledgeable about the care required for the individual. Participants were
conceived of as being in a liminal (transitional) state. In this research, the patient
was seen as passive, humble and adaptive, and not understanding the language of
the caregivers (p. 206). The findings were discussed in relation to findings from
other studies, most notably grounded theory about chronic illness by Strauss, et al
(1984). The article did not discuss trustworthiness of the research although they
did address transferability versus generalizability.
This research is germane to the present research. Ekman et al. (1999) used a phenomenologic approach to understand and interpret the meaning of CHF and hospital care to a group of chronically ill elderly people. The aim of the current research is to develop a grounded theory about the experience of and the processes elderly people engage in while hospitalized.

Huckstadt (1990) conducted a qualitative investigation of the experience of hospitalization in the elderly using grounded theory methodology. The unpublished dissertation was completed in February of 1990. The research goal of the study was “...to explore the hospitalization process as perceived by elderly patients, family members and nurses caring for these patients.” (p. 3). Specific aims included describing the process of hospitalization as perceived by the informants, identifying problems that relate to the process, and to propose substantive theory grounded in the data that could provide a framework for formal theory.

Informants included elderly patients, nurses, family members, and a patient care representative. The research was conducted in a 300-bed acute care hospital in a large western metropolitan area (Huckstadt, 1990, p. 49). There were eight elderly participants. Data were collected through tape recorded “ethnographic interviews” (p. 55) lasting from 20 to 75 minutes. Each informant was interviewed once. All participants were 65 or older (66-83), white, middle-class, and already in the hospital at the time of data collection. Length of time in the hospital at interview varied (1-33 days). Participant observation was also identified as a method of data collection, but there is no evidence that field notes...
from participant observation were used in the generation of theory. It is not clear from the dissertation why family members and a patient representative were included as participants.

Interviews of nurses began with the question "...Tell me what it is like to care for an elderly patient (or this specific elderly patient)..." (Huckstadt, 1990, p. 56). The nurses did not necessarily respond to interview questions based upon their knowledge of the patient informants, but on their general experience of hospitalized elderly patients. The constant comparative method of data analysis was used.

Six constructs and one core concept were identified from the data. The core concept is "enduring" (Huckstadt, 1990, p. 125). The constructs are:
1) Accepting assistance, 2) Believing it will be OK, 3) Playing the game,
4) Protecting, 5) Remembering and, 6) Worrying (p. 127). Enduring was defined as "to continue in the same state;... to remain firm under suffering or misfortune without yielding..." (p. 125). Huckstadt stated that patients, as well as nurses and family members endured (p. 126).

Following explication, the model of Enduring is compared to models of stress and coping and found congruent. "The Enduring process...is thought to be a coping activity the hospitalized elderly patients and their families engaged in..." (Huckstadt, 1990, p. 148). Huckstadt linked the theory of Enduring to the physiological concepts of the early research on stress, the cognitive-behavioral appraisal and response model of more modern frameworks and most closely with a phenomenological approach to stress and coping.
Unlike the current investigation, data collection in Huckstadt's (1990) investigation occurred at one point in time during the hospitalization. Each informant was interviewed once for approximately one hour. Nurses and family members were asked about their experiences, not how they perceived the experience of the elderly person. In the current research, serial interviews and participant observation allowed the researcher to become immersed in the life-world of the elderly participants thereby gathering rich, thick data.

Koch (1994; 1998; Koch & Webb, 1996; Koch, Webb, & Williams, 1995), Ekman (1999), and Huckstadt (1990) all used qualitative methods to investigate the meanings of illness and hospitalization for hospitalized elderly people. Themes that emerged were “routine geriatric care, care deprivation, depersonalization, geriatric segregation” (Koch) “unpredictable, incomprehensible, confident or non-confident care” (Ekman, Lundman, & Norberg), and “the process of enduring” (Huckstadt).

**Elder’s Perspective of Quality of Care and the Nurse’s Role**

Research addressing patient satisfaction with nursing care (Gerteis et al., 1991; Mahon, 1996; Minnick, Roberts, Young, Kleinpell & Micek, 1995b; Minnick, Young & Roberts, 1995a), congruence between perceptions of caregivers and patients (Cohen, Hausner & Johnson, 1994; Congdon, 1994), patients’ experiences with feeling confirmed or excluded by caregivers (Drew, 1986), patients’ expectations of nurses (Santo-Novak, 1997), and the relationship
between health and satisfaction in older people (Covinsky et al., 1998b) will be presented below.

Patient satisfaction has become an established indicator of the quality of healthcare (Mahon, 1996, p. 1241). Early work in patient satisfaction was conducted by Gerteis et al. (1991) where, through the use of focus groups composed of patients and family members, the Picker/Commonwealth Program for Patient-Centered Care explored patients’ needs and concerns (Gerteis et al., 1991, p. 3). They identified seven broad dimensions of care which concerned patients: 1) respect for patients’ values, preferences, and expressed needs, 2) coordination of care and integration of services within the institutional setting, 3) Communication between patient and providers, 4) physical care, 5) Emotional support, 6) involvement of family and friends, and 7) transition to the community.

From the results of these focus groups, a questionnaire was developed to measure patient satisfaction with the identified dimensions of care. The questionnaire was administered to more than 6000 recently hospitalized patients randomly selected from 62 hospitals nation wide. The questionnaire was also administered to 2000 family members and friends of the patients’ surveyed. Although the authors report a high degree of overall satisfaction (80%) individuals’ experiences varied widely. The area identified as most problematic was transition to the community. Patients’ felt unprepared to care for themselves after discharge and hospital staff’s view of the process was more focused on discharge from the hospital than continuing care in another setting.
The second finding was that individuals who identified their overall health as fair or poor experienced more problems with every dimension investigated than did those patients who identified their health as excellent or good. Fifteen per cent of respondents reported that there seemed to be "no particular doctor" (Gerteis et al., 1991, p. 5) in charge of their care. The percentage was higher in teaching hospitals (20%).

The survey identified that the most important issues surrounding hospitalization for patients of all ages was "the sense of vulnerability and helplessness that illness and hospitalization created and the dependency on others, even, at times, for the most routine activities of daily living." (Gerteis et al., 1991, p. 5).

In order to determine patient satisfaction with services, Minnik et al., (1995a;1995b) conducted a survey using a stratified random sample of adult patients discharged from several different hospitals. The goals of the study were to: 1) describe the differences between patients' reports and ratings of care, 2) determine the influence of service on patients' recommendations of a hospital to family and friends, and 3) suggest constructive managerial responses to current patient satisfaction monitoring activities (Minnik, Young et al., 1995, p. 25). Thirty-seven per cent of subjects were 61 years of age or older. Willingness to participate was established prior to discharge and the interview was conducted by a telephone interview firm, within 26 days of discharge. Of the 2,595 patients agreeing to participate, 2,051 (79%) completed the survey.
The results of the study were presented within the context of the quality of the care provided, not the patient’s experience. The services investigated were physical care, pain management, emotional support, and receiving information. All results were reported in percentages of people who reported to need a specific service. The service reported to be needed most often was participation in decision making about their care. Patients were most likely to report a failure of service in the areas of emotional support and physical care.

Individualization of information was a problem for 59% of respondents. Pain management was a problem for 51% or the respondents who reported having pain. The discussion and recommendations section of the article focused on improving services and retooling existing patient satisfaction measures to focus on “perceived needs”.

A study of patient satisfaction in Canada employed a telephone survey to interview 4599 patients from 57 hospitals (Charles et al., 1994). The areas investigated were provider-patient communication, provider’s respect for patient preferences, attentiveness to physical care needs, patient education about medications and tests, quality of the relationship between the patient and the physician in charge, communication with family members, pain management, and discharge planning. The findings of Charles et al. were similar to other studies in this section. They identified hospital routines, medication management, diagnostic tests, pain management, and discharge planning as areas of care in need of improvement.
Cohen, et al (1994) conducted a phenomenological study exploring the experiences of 24 patients having surgery (age range 24-71 years, mean 52.8) and 24 nurses' understanding of their experiences. Participant nurses were identified by their superiors and the nurses in turn identified patients to participate. The interviews took place two days following the patients' discharge from the hospital. The patient reflected upon the role of the nurse in their hospitalization. The nurse reflected upon the patients' experience. Knowledge and presence were the themes identified by both nurses and patients. Patients emphasized receiving teaching and individualized knowledge from the nurse. The nurses emphasized lacking knowledge, using professional knowledge, teaching and leadership. With respect to presence nurses talked most about structural barriers to being present such as work schedules and work load. Patients commented on the presence or lack of nurses' attentive attitude. Cohen et al. focused on the experience of the client with relation to the behavior of the nurse. The discussion was focused on care provided (or not provided) by the staff as perceived by the patient, not the experience of the patient.

In a grounded theory investigation, Congdon (1994) studied elderly peoples' experience of discharge. Congdon interviewed elderly patients (n=8), their family members (n=8) and primary nurses (n=8) about the elderly person's preparedness for discharge. Major themes identified were "readiness for discharge" (p. 127), "family support for patients" (p. 127), "decision making in the discharge process" (p. 128), and "multidisciplinary approach to care" (p. 129). Patients identified themselves as ready for discharge, families felt the patient was
not ready for discharge, and caregivers were uncertain about the patients’ readiness. The author used quotes from transcripts as examples of participant responses. The uncertainty of the nurses arose from not being familiar with the elderly individual.

Family support was important in determining the discharge destination of the elderly person. In this investigation, only elderly participants who had a family member to act as a care giver were able to return home. Others were discharged to nursing homes. The families provided support for the elderly patients, but did not feel supported by the health care team (p. 127). Patients tended to be insensitive to the needs of family members, and nurses demonstrated a lack of awareness about the needs of family members and did not consider addressing family issues as part of their role.

The patient and family were not generally included in decision making and found the multidisciplinary team confusing. The team met and discussed patient goals and outcomes on a routine basis but rarely included the patient.

The study by Congdon (1994) has an interesting design in that the researcher used multiple data sources. It provided one model for the current research. However, the reported theory lacks cohesion. The researcher identified the core concept of “managing the incongruities of the discharge process” (p.127). However the four themes identified were not linked into a cohesive theory. Much more work seems to be needed to explicate the relationships between themes as well as the antecedents and consequences of the theory.
Drew (1986) examined the confirming and depersonalizing experiences of 35 adult patients on a surgical unit. Thirteen men and 22 women 20 to 79 years of age participated in the study. The actual ages of participants or the mean was not available. In taped semi-structured interviews, Drew asked the question “Can you describe one positive and one negative experience with a caregiver?” (pg. 40). Other questions were designed to gain information about the patients' feelings and responses to the identified situations.

A three-step process of feeling excluded or confirmed was identified by Drew (1986): behaviors of the caregiver, caregivers' behavior as an indication of regard for the patient, and the patients' cognitive and emotional response were integral to the process. Patients described caregivers which made them feel excluded as ‘lacking personal warmth’ and generally not caring about the patient (p. 41). Feelings of exclusion arose when the patient was not able to cope with the negative behavior of the staff. Interviewed patients felt confirmed by staff who conveyed the impression of expending energy on the patients' behalf. Confirming caregivers were perceived as not being in a hurry, liking their work, and having a genuine interest in the patient.

A combination of semi-structured interviews, Q-sort, and focus group techniques was used by Santo-Novak (1997) to determine the expectations of elderly people (n=28) regarding the role of nurses. Three themes were identified from the data. Elderly individuals (age 58-92) expected nurses to be attentive, responsive, and efficient, subjects expected the nurse to exhibit caring behaviors, and they expected the nurse to be knowledgeable about the interviewee's health.
needs. Q-sort was used to rank previously identified categories. A focus group of 5 participants was used for participant checking, Santo-Novak used a variety of methodologies with different philosophical underpinnings to complete this investigation.

Covinsky et al. (1998b) investigated the relationship between changes in health status experienced by elderly individuals between admission and discharge and satisfaction with care received. Using a prospective cohort design, 445 medical patients at least 70 years old (68% female, 66% black) were interviewed at admission and discharge to obtain measures of global health and function in five areas of activities of daily living (ADL) (bathing, dressing, toileting, transfer, and eating). At discharge, patients also completed a five item patient satisfaction questionnaire (technical care provided and attentiveness and kindness of physicians, technical care provided and attentiveness and kindness of nurses, and overall satisfaction).

The research question answered was “[Do] patients of similar health status at discharge vary in patient satisfaction according to whether their discharge health status represents a decline or improvement in health status?” (Covinsky et al., 1998b, p. 225). Using linear regression the researchers found that better health status at admission as well as better health status at discharge were associated with greater satisfaction with care. Differences in satisfaction between patients with better or poorer health status were greater at discharge than admission (p. 226). Whether the variable was global health or independence in ADLs, those patients who entered the hospital with high scores or whose scores improved
during hospitalization had greater satisfaction at discharge than those individuals whose health or independence in ADLs remained poor or decreased over the course of hospitalization. These findings suggest that changes in patient satisfaction and global health status measure different domains of hospital outcomes and quality (p. 228).

Through the use of patient/family discussion groups composed of newly discharged patients and their families, Reiley, et al (1996) asked about the patients’ preparation for discharge and their suggestions to improve the process (p. 312). First, patients and families were asked specific questions about their preparation for discharge (p. 314), then there was a brainstorming session. Identified themes were: 1) The need for more family involvement in the preparation for discharge, 2) It is very frightening for patients to go from the ‘intensiveness’ of hospital care to the home, where there are no supports, 3) Patients and families want more follow-up after hospitalization, 4) Information provided by staff should be as concrete as possible and should be in writing, 5) There is a need for the discharge day to be less rushed, 6) Patients and families felt that more education on what could and could not be done following discharge would have been helpful, 7) There is a need to pay more attention to symptom management in the post discharge period, 8) Billing and financial issues were troublesome (p. 314 - 316). The study by Reiley, et al (1996) was the first step in improving patient satisfaction. The research team developed and implemented interventions to remediate the identified problems.
Patient satisfaction is widely accepted as an indicator of quality of health care. In order to improve quality of care, healthcare facilities routinely survey their patients to obtain information about satisfaction. In the studies above several areas of care were identified as potential problem areas. Issues surrounding discharge (Charles et al., 1994; Gerteis et al., 1991; Reiley et al., 1996), failure of service in the areas of emotional support, physical care, and thoroughness and timeliness (Gerteis, 1991; Minnick, Young et al., 1995), patients receiving individualized information (Minnik, Young et al., 1995; Cohen, Hausner, & Roberts, 1994; Charles, 1994), and nurse attentiveness (Drew, 1989; Santo-Novak, 1997) were identified as important aspects of care received in the hospital. Global health and independence in ADLs were not found to be predictors of patient satisfaction with care at discharge (Covinsky et al., 1998b).

The literature above is a representative sample of the research conducted by health care professionals in an attempt to explain characteristics of the hospitalized elderly person, the outcomes of being hospitalized, the perceived needs of hospitalized individuals, and the lived experience of people in the hospital. As the current investigation focuses on the processes engaged in by hospitalized elderly individuals, the findings of these studies on patient satisfaction provide clues as to areas the investigator needed to be aware of in her observations and questioning.
The Hospital

The hospital is the context for the current research. As the number and age of elderly people in the hospital has increased, strategies to enhance the outcomes for these individuals have been developed. Since 1991, the Nurses Improving Care to the Hospitalized Elderly (NICHE) project (Foreman et al., 1994) has studied several models of care for the elderly to determine the most effective interventions.

Traditional Models of Hospital Care

Nursing care is administered via several models. Two systems of delivering nursing care were compared by Carruth et al. (1999) to determine if the delivery system had an impact on cancer patients’ and their families’ perceptions of caring behaviors. The research questions were “Do patients and family members differ in their perceptions of nurse caring behavior? Are perceptions of nurse caring behaviors different as a function of a primary or modular nursing care delivery system? Which delivery system variables and patient demographics data are significant in explaining patients’ and family members’ perceptions of caring?” (p. 96)

Forty-two patients age 31 to 83 years old and 27 family members rated their nurses’ caring behaviors using the Caring Perception Index (CPI). The CPI is a 10 item scale with six items measuring “caring about” and four items measuring “caring for” (Carruth et al., 1999, p. 97). Data were collected two months prior to a planned change in the nursing care delivery system from

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primary nursing to modular nursing and four months after the model change. Primary nursing was defined as a delivery system where an “RN or LPN was assigned to six or seven patients with support provided by nursing assistants” (p. 96). Modular nursing was defined as a “team consisting of an RN, an LPN, and a nurse extender” (p. 95) to care for 10 to 14 patients.

Mean caring scores did not differ significantly by nursing model (primary nursing: $X = 35.9$, $SD = 5.4$; modular nursing: $X = 36.2$, $SD = 5.3$) The only variable found to have a significant effect on patients’ perceptions of caring was length of stay. Patients’ who were in the hospital more than four days rated nurses higher on caring than patients in the hospital two to four days ($F = 4.1$, $p = 0.02$).

Models of Care for Hospitalized Elderly People

Research pertaining to two innovative models of care will be presented here. First is the expert resource model. The Geriatric Resource Nurse (GRN) is a very well documented clinical intervention project began in 1988 (Francis, Fletcher & Simon, 1998; Fulmer, 1991a; Fulmer, 1991b; Inouye et al., 1993a). The second innovative hospital model, the Acute Care of Elderly (ACE) Unit (Palmer, Landefeld, Kresvic & Kowal, 1994) approaches the challenge of hospital care for the elderly from a different prospective. The ACE model creates a hospital unit specifically designed for elderly individuals.

Both models, were originally tested in the “Hospital Outcomes Project for the Elderly (HOPE) (Margitic et al., 1993). Six hospitals from across the United States, with the goal of improving outcomes for elderly patients pooled their data.
Much of the research presented in this review of literature stems for data included in the HOPE project (Sager, Rudberg et al. 1996a; Sager, Franke et al., 1996b; Rudberg et al., 1996). Below, research pertaining to the elderly in hospitals who use the GRN model, or have an ACE unit will be presented. Post-hospital models of care will also be presented.

Expert Resource Model of Care

Several expert resource models of hospital care for the elderly exist. They include an interdisciplinary team as a resource (Inouye et al., 1993), gerontological nurses as resources (Francis et al., 1998), and geriatric physician resource models (Borok et al., 1994; Reuben et al., 1995; Winograd, Grety & Lai, 1993).

In the early 1990's researchers (Inouye et al., 1993a; Inouye et al., 1993b) at Yale New Haven Hospital developed and tested a resource model of geriatric care which was client centered and focused on the delivery of nursing care. The geriatric resource team consisted of the geriatric resource nurse (GRN), a geriatric nurse specialist, and a geriatric physician. The role of the nurse specialist and geriatric physician was to provide support and consultation for the GRN. The GRN either acted as the primary nurse for frail elderly patients or acted as a resource to other primary nurses. The team met biweekly to discuss frail patients.

The Geriatric Resource Nurse (GRN) model of delivery of care for hospitalized elderly individuals as described above, was first documented in the early 1990's (Fulmer, 1991a; Fulmer, 1991b). The GRN model with the support
of the NICHE faculty has been implemented in several hospitals (Francis et al., 1998). Evaluation studies are being conducted in hospitals using the GRN model. Francis et al. (1998) cite a “profound lack of interest in geriatrics that continues to exist both on a societal level and in the healthcare arena in general” (p. 493) as a challenge to development of expert care for hospitalized elderly people.

In the original Hospitalized Older Persons Evaluation (HOPE) project (Margitic et al., 1993, Winograd et al., 1993), Borok et al. (1994) implemented a comprehensive geriatric assessment (CGA) consultation program. In this model, the resource team was composed of a geriatrician, nurse practitioner, and social worker. Ruben et al (1995) discussed results of the intervention trial designed by Borok et al. and found no substantial differences between assessment and control groups in functional status at 3 months and 12 months or in 1-year survival (p. 1348). One possible explanation is that this model of geriatric assessment and intervention, unlike the model tested above by Innouye (1993), did not include the staff nurses.

The expert resource model provides expert consultation to health care personnel working with elderly patients. The GRN model is relatively low cost to the institution as it uses existing staff nurses and has demonstrated effectiveness in improving outcomes for hospitalized elderly people. The major costs come in staff education and commitment from staff and administration (Inouye et al., 1993a). The physician resource model (Borok et al, 1994; Reuben et al., 1995) did not demonstrate significant improvement in functional outcomes.
Specialized Units for Hospital Care of the Elderly

Another approach to care of elderly people in the hospital is the Acute Care geriatric (ACE) Unit. In this model, elderly individuals are admitted to a unit designed to promote functional ability and specialized care. The hallmarks of an ACE unit are environmental design and interdisciplinary care (Palmer et al., 1994). Since 1994, much research has been conducted on the ACE units at the University Hospitals of Cleveland (Covinsky et al., 1997a; Covinsky, Justice, Rosenthal, Palmer & Landefeld, 1997b; Covinsky et al., 1999a; Covinsky et al., 1997c; Covinsky et al., 1999b; Covinsky et al., 1998a; Covinsky et al., 1998b; Kresevic et al., 1998; Palmer, Counsell & Landefield, 1998; Palmer, 1995; Palmer & Bolla, 1997; Palmer et al., 1994).

All of these studies, many discussed elsewhere in this review, have demonstrated the effectiveness of the ACE unit in improving outcomes for hospitalized elderly individuals. The ACE unit has been a rich site for studying the effects of various conditions such as depression and poor nutrition on outcomes for elderly individuals. (Covinsky et al., 1997a; Covinsky et al., 1999a; Covinsky et al., 1999b).

Landefeld et al. (1995) demonstrated the improved functional ability and the minimized risk of nursing home placement for ACE patients after acute hospitalization. At discharge, 21% of patients on the ACE unit as compared with 13% of the usual care group had “much better” (p. 1340) function in basic activities of daily living. Fewer patients from the ACE unit were discharged to long term care facilities (14% vs 22%, p= 0.01).
Cost effectiveness of the ACE unit was measured by Covinsky et al. (1997). In a randomized controlled study a total of 650 patients were assigned to the ACE unit or another hospital unit (Covinsky et al., 1997). The total hospital cost was the outcome measure evaluated. Being assigned to the ACE unit costs increased the per bed day cost of hospitalization ($876 vs $847), however, the average length of stay on the ACE unit was shorter (7.4 days vs 8.4 days, p= .449), so that overall per patient cost was less on the ACE unit than on the standard units ($6608 vs $7240). Differences in cost did not reach statistical significance related to sample size.

The ACE unit in Cleveland is not the only geriatric assessment unit. Fillit (1994; Fillit & Miller, 1993) has documented the effectiveness of a similar unit at another facility in the United States, and Hamilton and Lyon (1995) have documented the success of a dedicated geriatric unit in Toronto, Canada. It is clear from these studies that the environment of care plays a significant role in the outcomes of hospitalization of elderly people.

**Post-hospital Care for Elderly People**

Discharge planning and post-hospital nursing intervention has been studied by Naylor and colleagues (Naylor, Brooten, Jones, et al., 1994; Naylor, Brooten, Campbell, et al., 1999). Using a discharge planning protocol for elderly patients which was implemented by nurse specialists, Naylor et al. demonstrated significant improvements in outcomes following hospitalization. By six weeks after discharge from the hospital, the intervention group had fewer readmissions,
shorter readmissions, lower post hospital charges. Naylor’s work demonstrates the need for comprehensive care post hospital but is outside the scope of the current research.

The Healthcare Provider

Health care workers have engaged in self-appraising research for many years. The research presented here is focused on the relationship between patients and health care providers. Research on attitudes of health care providers toward elderly clients and comparisons of perceptions of patients and nurses.

Attitudes of Health Care Workers Toward the Elderly

Attitudes of health care workers toward the elderly have been investigated in four studies (Intrieri, Kelly, Brown & Castilla, 1993; Jones, 1993; Pursey & Luker, 1995; Salmon, 1993). Jones used a pretest/posttest design to measure the effect of a short course in nursing elderly people on the attitudes of professional care givers. Attitudes were defined as “concerned with values and beliefs” (Jones, 1993, p. 55). Attitudes were measured using “Palmore’s Facts on Aging Quiz” (Palmore, 1977). Sample size or levels of significance were not reported. The course was said to be effective in altering attitudes. There was no comparison between attitude and practice.

Intrieri et al. (1993) investigated the effectiveness of a six week training program on the attitudes and behaviors of third year medical students toward elderly patients. The design was pretest/posttest with experimental (n=45) and
control (n=51) groups. The dependent measures were the “Facts on Aging Quiz-Revised (FAQ-R) (Miller & Dodder, 1980), the Aging Semantic Differential (ASD) (Rosencranz & McNevin, 1966), and observation of clinical interviews conducted at the end of the session. Course content focused on knowledge, attitudes, and interview skills. The testing results indicated the course had significant effects on interview criteria ($F(7, 76) =2.46, p<.02$), and for repeated measures on the ASD ($F(1, 94) =9.42, p=.0028$). There was no difference between experimental and control groups on change in FAQ-R score.

Salmon (1993), in a study conducted in England, did not find addressing staff attitudes to be effective in altering practice. Using a time-sample procedure, staff were observed in interactions with clients. A total of 1540 systematic observations were made of staff interactions with elderly patients during routine care and during reality orientation sessions. The staff then completed questionnaires based upon attitudes and treatment philosophy. The number of positive interactions between staff and elderly patients was highest during periods of formal reality orientation ($F(1, 24)=4.63, p<.05$). Salmon found a relationship between staff rank and attitudes, the higher the rank (i.e. qualified [professional] nurses vs. nursing assistants), the better the attitude toward the elderly ($F(2.24)=3.87, p<.05$). There was “virtually no relationship” (p.18) between nurse’s attitudes and behavior.

Pursey and Luker (1995) investigated the relationship between healthcare workers’ attitudes toward the elderly collectively and their attitudes toward the elderly individuals they worked with. Participants (n=136) from four institutions
in the north west of England which provide a variety of services to the elderly were selected by convenience. The participants completed a questionnaire developed for this study which requested demographic information as well as including forced choice and open ended questions regarding attitudes toward working with the elderly. The participant was also asked to write about two experiences they had had with elderly patients. One experience was to be one in which the responder felt ‘effective’ and the other ‘ineffective’. In addition, in-depth interviews were completed with 25 of the participants. The participants in this portion were selected by evaluating the responses to the questionnaires. The authors indicate the method was consistent with theoretical sampling as the respondents were invited to participate based upon their experience in working with older adults (p. 550). Results were discussed in terms of “themes” which emerged from the incidents. Themes included problems with structural features (the routine) of working with elderly people, establishing relationships with elderly people, ambivalence about working with the elderly. Many of the negative experiences these nurses reported were related to the frustrations of working with the elderly within the context of the health system, not the elders themselves. The article effectively used quotes from subjects to illustrate important findings.

Attitudes of health care providers toward working with the elderly have been measured although the relationship between attitudes and performance has not been made clear.
Comparisons of Perceptions of Patients and Nurses of Patient’s Needs

McCauley, Lowery, and Jacobsen (1994) investigated the relationship between nurses’ and patients’ perceptions of patients’ status. The sample consisted of 50 registered nurse/patient pairs. The patients were diagnosed with first time myocardial infarctions, mean age was 59.6 years (SD = 10.7).

Patients were asked to rate how well they were currently doing on a five point scale (1 = not at all well, 5 = extremely well), their expectations for coping with the future on a 16 item scale (Axelrad, 1981), and their overall, global belief about whether or not they would recover or not. This last measure was completed using a four point scale (1 = never, 2 = perhaps, 3 = yes, in the distant future, 4 = yes, in the near future (McCauley et al., 1992, p. 150). Nurses were asked to complete similar ratings.

Results were evaluated using t-tests for mean differences between patients and nurses, discrepancies were examined, relationships between pairs were examined by correlation coefficients. There was no statistical difference between nurses and patients’ evaluations of current status (paired \( t = 0.38 \), one tailed \( p = 0.35 \), 17 cases the perceptions were the same, 17 cases the patients rated recovery higher than the nurse, and in 16 pairs, the reverse was true.

Patients’ ratings were more optimistic than nurses’ on the future coping scale (Axelrad, 1981) (paired \( t = 1.73 \), one tailed \( p = 0.045 \)) as well as the belief about future recovery scale (paired \( t = 3.09 \), one tailed \( p = 0.002 \)). Discrepancies for the future coping scale included 2 cases in which the patient and nurse were in
agreement, 28 pairs in which the patient had higher expectations than the nurse, and 20 cases in which the nurse had higher expectations than the patient. The question regarding belief about future recovery was rated the same by 18 pairs, the patient had higher expectations than the nurse in 18 cases and the nurse had higher expectations than the patient in 8 cases. There was a significantly positive weak correlation between nurses and patients' future expectations (Pearson $r = 0.26$, one tailed $p = 0.33$) explaining about 7% of the variance (McCauley, 1992, p. 151). Although the aggregate data were inconclusive for data about current recovery, 64% of pairs did not agree. In the case of future coping, 96% of pairs did not agree, and in future recovery 52% or pairs did not agree. Although the results were inconclusive regarding the nurses' outlook being more negative than the patients', this study indicates a difference in perception between nurse and patient about status and recovery.

In a similar study, Reiley et al. (1996) compared nurses' ability to predict functional status of patients two months after discharge with patients' reports of function and nurses' estimation of patients knowledge about post-hospital care with patients' reports of knowledge. Patients (mean age 63.7, SD 16.0) were interviewed at admission, two weeks after hospital discharge, and two months after hospital discharge. The initial interview provided information about demographics, functioning, health perceptions, and patient needs (p. 144). The two week post discharge interview provided information about the hospitalization experience using the Picker/Commonwealth instrument (Cleary et al., 1991). The interview at two months post discharge used the Health Status Questionnaire

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(Stewart, Hayes & Ware, 1988), to elicit information about functional status. The primary nurse was contacted as soon as possible after the patient was discharged from the hospital and asked to participate in the study. A telephone interview schedule which paralleled the patients' instruments was developed and used to gather information from the participating nurses.

Data were collected for four interviews (3 patient, 1 nurse) for 97 nurse/patient pairs. Considerable disagreement was found between the nurses' predictions and the patients' reports of function at two months. Nurses were most likely to overestimate the patients' functional disability. Nurses who provided care on the day of discharge were more accurate in their predictions than nurses who provided care for the patient earlier during the hospitalization.

Agreement was present between nurses' perceptions of patients' understanding of medication regimen and patients' reported understanding. Ninety-three percent of patients' reported understanding their medication regimen and 99% of nurses' responded that patients' understood. However, there was a high level of disagreement ($p = .0001$) between nurses' estimations and patient reports of understanding medication side effects. Nurses' overestimated the patients' understanding of side effects 38% of the time. In response to when the patient could resume normal activities, 98% of nurses predicted their patients knew when to resume activities while only 50% of patients reported that they knew when they could resume activities.

In a study comparing elders' and nurses' priorities, Hudson and Sexton (1996) investigated which care giving activities were perceived as most important.
or least important by elders and nurses. Data were collected using four research instruments, two for elders and two for nurses: 1) Patient Activities Survey, 2) Nurse Activities Survey, 3) Patient Biographic Data Form, 4) Nurse Biographic Data Form. Elders (n=22) who had been in the hospital during the previous six months were recruited from a senior citizens complex. Acute care medical surgical nurses (n=45) were recruited from two community hospitals.

Elderly participants were predominantly female (73%), white (90%), widowed (68.2%), and had been hospitalized an average of 21.5 days (r=4 to 105; SD 27.27). Many participants had cardiovascular problems (91%) or hip fractures and replacements (27.3%). Nurses were predominantly white (93.3%) female (95.6%) average 31 (r=22-54; SD =7.31).

The Patient Activities Survey and Nurse Activities Survey are different versions of the same questionnaire. Participants scored each of 50 care activities on a scale of one to four, four being most important. All responses from elders for each item were averaged. The same was done for nurses. The elders’ and nurses’ scores for each of the 50 care activities were then ranked and compared.

Elders rated “see that the bed pan or urinal are provided when needed” as the top priority care activity. Nurses ranked the same activity as 11. Nurses rated “Notice change in patients’ condition and report it” as top priority, elders rated that activity as 12th in importance. Elders and nurses agreed that medication for pain management ranked third in importance. Overall, there was little agreement between nurses’ and elders’ rankings of care activities. Elders rated items related
to physical comfort and communication higher than did nurses, while nurses rated activities related to discharge planning higher than elders.

In a similar study Lauri, Lepisto, and Kappeli (1997) interviewed 92 medical and surgical patients (age 18-65) and 69 nurses in Finland. The research questions are: 1) What are the needs of patients on medical and surgical wards according to the patients? 2) What are the patient needs according to the nurses? 3) Are the needs of medical patients different than surgical patients? And 4) Do the patients' and nurses' views differ?

A questionnaire designed for this research focused on vital functions (circulation, respiration, body temperature regulation), functional health status (sleep, rest, nutrition, elimination swallowing, mobility, sexuality, senses, pain, cognitive processes and communication), reactions to functional health status (feelings, emotions, belief system, etc), and the hospital environment (information and hospital processes). The index consists of 154 items. Patients completed the questionnaire after the fourth day of hospitalization, seal the envelope and return it to the ward office. The nurse assigned to a participating patient completed the questionnaire with regards to the patient and delivered it in a sealed envelope to the ward office. The patients' and nurses' instruments were matched by similar numbers.

Patients' and nurses' perceptions of patient needs did not agree. Statistically significant differences (p<.05; p<.01; or p<.001) were present for 38% of all defined needs. Patients felt they had most needs in the areas of vital
functions and functional health status. Nurses thought patients had most needs with respect to the environment of the hospital.

The most recent investigation of congruence between patients' and nurses' ideas about patient needs and nursing care was conducted by Lynn and McMillen (1999). Using a different instrument but similar design as the studies described above, Lynn and McMillen (1999) administered the “Patient's Perception of Quality Scale – Acute Version” (PPQS-ACV) (p. 87) to 448 patients (≥ 18 years old) and 350 nurses at seven hospitals in the southeastern United States. The PPQS-ACV is a 90-item instrument developed as a result of 29 qualitative interviews. Each item is listed on a 3 x 5 inch index card. The patient completing the instrument rated each item on a six-point scale, six being the highest degree of importance to good nursing care, by sorting the cards. The nurse followed the same procedure, but was directed to rate the item as he or she thought the patient would rate the item. When the sorting was completed, the researcher marked the back of the card with the received rank. The cards were shuffled and then used for another participant.

Mann-Whitney U tests were used to compare patients' and nurses' ratings of each of the items. Patients rated 46 of the items significantly (<0.05) higher than nurses while nurses ranked five items higher than patients. These findings suggest that nurses may underrate aspects of care that are very important to patients. Nurses rated intrinsic characteristics such as trust, empathy, competence, their examination of patients, and explanations of care more as more important than did patients. The items rated higher by patients fell into three categories: 1)
the physical environment (14 items), 2) psychological aspects of care (16 items), and 3) the professionalism of the nurses (16 items). While there were differences in specific items, the overall agreement between nurse and patient rankings was 0.82, indicating that patients and nurses were largely in agreement as to the relative importance of the items with respect to good nursing care (Lynn & McMillen, p. 71), although nurses tended to underestimate the importance of many items.

In every study listed above there were discrepancies between the perceptions of patients and nurses. Nurses do not seem to be aware of the value patients place on various aspects of care.

The Families of Elderly People Needing Healthcare

Investigations of families of hospitalized elderly people included here have two major themes. First, needs of elderly people in the hospital from the perspective of the family (Tappan & Beckman, 1992), then research investigating the needs of family members for information (Bowman, Rose & Kresevic, 1998; Johnson et al., 1998; Leske, 1996; Peirce, Wright & Fulmer, 1992) will be presented.

The Hospitalized Elderly Person from the Perspective of the Family

Tappan and Beckerman (1992) employed a case study approach to investigate the experiences of five frail older persons, as described by close
family members. Each patient was hospitalized for an extended period. The unique perspective of the family member is highlighted. Cases were selected through the family member's expression of distress over the care the elder was receiving. All patients were over 65, had been in the hospital for at least two weeks, and all had multiple diagnoses. No patient was critically ill at the time of admission. The article uses quotes to address the following areas of neglect: adequate food and fluids, maintenance of circulation, potential safety problems, personal privacy and dignity, failure to individualize care and failure to see any improvement. The organizing theme in the cases described was failure of the hospital staff to meet basic human needs of the hospitalized elderly client.

The perspective of the family is unique in that the family members know the client prior to hospitalization but may or may not be able to accurately interpret the experience of illness or hospitalization.

**Needs of Family Members**

In a review of the literature (Peirce, Wright & Fulmer, 1992) addressing the needs of the families of patients in intensive care units revealed two most important items: "to have questions answered honestly", and "to know specific facts regarding what is wrong with the patient and the patients' progress" (p. 599). Peirce et al. also discussed the family's need to participate in care, visit the patient frequently, and need for comprehensive discharge planning. They conclude their review by noting "Although the nursing literature provides a baseline about
family needs in general, little is known about what specific needs elderly patients and their families may have” (p. 604).

Leske (1996) used a four-group quasi-experimental posttest design to investigate the effectiveness of inter-operative progress reports to family members on reducing their anxieties. Anxiety, the dependent variable, was operationalized as state anxiety scores on the State-Trait Anxiety Inventory Form (STAI), heart rate, and mean arterial pressure (MAP) calculated manually after intervention or halfway through their family member’s surgery. Group one (control group) received the standard treatment which did not include inter-operative reports, group two received in-person protocol driven inter-operative reports from peri-operative nurses about their family members, group three received a verbal checklist about hospital routines, and group four received telephone reports about their family members’ surgery.

Adult family members of all patients having elective surgery at one hospital during a six month period were eligible to participate. Participants were sequentially assigned to groups. The first 50 participants were assigned to group one, the next group two, and so forth. Family members in the intraoperative report group reported lower anxiety scores (F [3,196] = 16.46, P< .001) as well as lower MAPs (F [3,196] = 8.60, P<.001).

In a descriptive survey of the ability of intensive care unit (ICU) personnel to meet the needs of family members of ICU patients conducted in Saskatoon, Canada, Johnson et al. (1998) identified consistency of caregiver as important in meeting family members needs.
The FNA, Society of Critical Care Medicine's Family Needs Assessment (FNA), was the dependent variable. The FNA is a 14 item self-administered scale designed to assess provision of information, empathy, attitude, access to caregivers, technical competence, and convenience of the environment (Johnson et al., 1998, p. 268). Factor analysis demonstrated four unique factors in the family member questionnaire which contributed to the family feelings of having their needs met. One factor was attitude which explored provider behavior. Another factor was communication. The third factor was comforting skill, and the fourth had to do with isolation. The results indicated that there was greater family dissatisfaction if the ICU patient had more than two attending physicians (p = 0.048) and if the same nurse was not present on two consecutive days (p = 0.044). Family members were found to be more satisfied if the family member was female (p = 0.006), if the ICU patients’ APACHE II score was higher (p = 0.007) or if the family member was a sibling (p = 0.012) (Johnson et al., 1998, p. 267).

As part of a larger randomized clinical study investigating various aspects of hospitalized people in the hospital, Bowman et al. (1998) employed a qualitative approach to interview 74 family members of cognitively intact hospitalized elderly people within two days of admission and 50 of those family members again within two days of discharge of the elderly person. The family members were asked five open ended questions. Three questions were about the elderly person’s condition, needs to maintain health, and self care. Two questions focused on the caregivers’ needs related to care giving. The questions on caregiver needs were the focus of this analysis. The questions analyzed were
"What do you (does the caregiver) need to help take care of the patient" and
"What problems do you think might prevent you (the caregiver) from taking care
of the patient" (p. 11). Nurses providing care for the elderly person were also
interviewed at admission and discharge. The questions asked to nurses and
caregivers were identical. A complete set of interviews were obtained and
analyzed for 37 cases.

At admission, almost one third of family members and nurses indicated
there were no caregiver needs (family 29.7%, nurses 35.1%, agreement 55%). For
those who identified needs, home health assistance (family 37.8 %, nurses 21.6%,
agreement 29%) was the most frequently identified by family members and the
only identified need to show agreement between family members and nurses.
Other needs reported by family members in order of importance were the need for
information (family 16.2%, nurses 8.1%), emotional and social support (family
8.1%, nurses 2.7%), resources (time, money, patience, transportation) (family
2.7%, 16.2%), 24-hour supervision (family 2.7%, nurses 5.4%), and medical
supplies (family 2.7%, nurses 10.8%). Nurses identified family caregivers needs
for resources, 24-hour supervision, and medical supplies more frequently than did
the family members.

At discharge, more nurses (35.1%) than caregivers (29.7%) identified care
giver needs at discharge. Thirty-six percent (36%) of family caregivers and their
nurses were in agreement in not identifying caregiver needs at discharge. Home
health assistance was again noted as the most pressing need for family caregivers
(family 24.3%, nurses 27%, agreement 22%), followed by need for information
(family 16.2%, nurses 5.4%), 24-hour supervision (family 10.8%, nurses 2.7%),
medical supplies (family 10.8%, nurses 18.9%) increased resources (family 5.4%,
nurses 5.4%), and emotional and social support (family 2.7%, nurses 5.4%).

This investigation demonstrates a lack of agreement between family
caregivers and nurses understanding of family members needs when providing
care for their elderly family members. In most cases in this research, the
admission and discharge nurses were not the same person. The researchers note
this fact as a problem in continuity of care (Bowman et al., 1998, p. 14).

All of the studies in this section highlighted the need for communication
between healthcare providers and family members. Effective communication was
found to be important for families of critically ill patients (Peirce et al., 1992),
reduce family members’ anxiety during surgery (Leske, 1996), improve family
members’ satisfaction with ICU care (Johnson et al., 1998), and be identified as
important to family members of hospitalized elderly people (Bowman et al.,
1998).

Summary

The review of literature presented research on the hospitalized elder, the
hospital, the healthcare worker, and the family. The hospitalized elder was
investigated by retrospective chart audit (Buckle et al., 1992; Dunlop et al., 1993;
Kahn et al., 1994b; Pearson et al., 1992). These studies provide quantitative
information about services used by individuals. Characteristics of hospitalized
elderly people were compared with the services, treatments, procedures provided

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during the hospitalization, and hospitalization use. The investigators quantified the experience of hospitalization by identifying demographic data, counting number of procedures, length of stay, and outcome at discharge and readmission in order to explain the process. These studies yield information regarding what services were provided to whom, but they do not provide information about the hospitalized elderly person’s experience of receiving the service, or the meaning of that experience.

Dunlop et al. (1993) conducted a retrospective chart audit to determine predictors of outcome. Severity of illness was found to be a much stronger predictor of outcome following surgery than age. Borkon and Quirk (1992) and Borkon et al. (1991) used a prospective design to determine the relationship between patients’ attitudes and function after hip fracture. Individual’s who anticipated a high degree of recovery did recover more function than those with lesser expectations.

Nutritional (Covinsky et al., 1999) and functional (Hirsch et al., 1990; Covinsky et al. 1997) status and symptoms of depression (Dunham & Sager, 1994; Covinsky et al; 1997, 1999) were investigated in relation to outcomes of hospitalization. Individuals with better nutritional status, more independence, and less depression had better outcomes of hospitalization. Functional status was a variable in several studies (Hirsch et al., 1990; Rudberg, et al., 1996; Sager et al., 1996a, 1996b).

Complications of hospitalization were investigated from the perspective of physician and hospital liability (Brennan et al., 1991, Leape, et al., 1991), patient
risk for complications (Lefevere et al., 1992; Potts et al., 1993). The research
demonstrates that elderly people are more likely than other hospitalized
individuals to experience iatrogenic complications.

Qualitative studies designed to investigate the experience of the elder were
of two categories. In the first category, Koch (1994; Koch et al., 1995), Ekman et
al. (1999), and Huckstadt (1990) focused on the experience of hospitalization and
the meaning of being in the hospital. Koch was unsuccessful using participant
observation to investigate the experience of hospitalized elderly people in the
United Kingdom. Koch found her research time as participant observer was spent
participating rather than observing. In addition, the people she interviewed were
reluctant to discuss their experiences while they were still on the wards. Koch
modified her methodology to rely on interviews post discharge.

Ekman at al. (1999) found that elderly individuals who had been
hospitalized with congestive heart failure found care either confident or
nonconfident, but always unpredictable and incomprehensible.

Huckstadt used ethnographic interviews to develop the grounded theory of
"Enduring". The concept of enduring is a passive concept. No mention is made of
the patient’s participation in the experience, rather the patient’s energy is said to
be focused on getting through it. This is contrary to the notion that people
participate in their reality and their health care. The study lacks discussion of the
meaning of the experience of hospitalization. This was not one of the questions
identified on the interview schedule.
Hospitalization is viewed as a problem in this work. Little mention was made of the prosthetic qualities of the experience. The introduction identified the experience as a problem, the review of literature focused on complications and untoward effects of the experience. The substantive theory was one of enduring “...to hold out against; sustain without impairment or yielding” (Random House, 1992).

Several studies in this sample focused on quality of care. Minnick et al. (1995a; 1995b), used a large randomized sample of recently hospitalized adults to evaluate the quality of care and services provided by the hospitals. The focus of the study was quality improvement. Reiley (1996) used focus groups to improve the process of discharge at a large urban hospital. Again, the hospitalized person was used to evaluate how to improve services, not for the purpose of identifying the experience of the hospitalized person.

Drew (1986), Cohen et al. (1994), and Congdon (1994) focused on the relationship between the hospitalized person and the care giver. In these qualitative studies the researcher used semi-structured interviews of either the hospitalized person or the person and the caregiver. The focus of these studies was to identify patterns of care giving that were or were not perceived as positive by the person.

Research investigating the hospital as the environment of care was presented in this review. There are two models of innovative geriatric care. The geriatric resource model (Innouye et al., 1993; Francis et al., 1998; Borok et al., 1994) and the geriatric hospital unit (Palmer et al., 1994). Each model has
positive and negative aspects and have been a very fertile area for research of the hospitalized elderly person.

Studies of the staff investigated attitudes toward elderly patients and ability of staff to provide adequate care (Pursey, 1995, Intrieri, 1993, Jones, 1993, Salmon, 1993). Studies of staff perceptions of patient status indicated that the nurse was frequently incorrect in judging both patients preparation for discharge and functional ability following discharge. Nurses provide care for patients based upon their perception of patient status. If the nurse ascribes different meanings to patient behavior than does the patient, care may be directed at issues the patient does not perceive as important. The patient may not respond to interventions in a way anticipated by the nurse. These studies lend support to the design of the proposed study, seeking information about what the nurse perceives the hospitalized person to be experiencing.

McCauley et al. (1994), Reiley et al. (1996), Hudson and Sexton (1996), Lauri, Lepisto, and Kappeli (1997) all compared patients’ perceptions with nurses’ perceptions of care. In general, patients and nurses did not agree about the needs and expectations of patients.

Tappen and Beckerman (1992) studied the perceptions of families of elderly people in the hospital. This is a very interesting study in relation to the study proposed here. The researchers highlighted the unique perspective of the family member as he or she made sense of the hospitalized person’s experience. There was no reported attempt to gain additional data from the hospitalized person or the staff.
Finally, Pierce et al. (1992), Leske (1996), Johnson et al. (1998) investigated the needs of family members of hospitalized people. These studies are useful to the current endeavor to demonstrate the family members’ desire to participate in their significant others’ experience of hospitalization. Communication between the staff and family members was very important to the families of hospitalized elderly people. In the last study in this sample, Bowman et al. (1998) compared family members and nurses perceptions of families needs, assistance at home and need for information were rated most highly by the family members.

As the elderly portion of the population continues to increase greater demands will be placed on the health care system. The body of research presented here provides much information about characteristics of the elderly person, quality, process, complications, and outcomes of care. Models of hospital care, interactions between staff, families, and elderly people have all been well investigated.

The current research will contribute to filling three gaps in the body of knowledge. First, research investigating the active participation of the elderly people in the hospitalization process. The current research is designed to illuminate the meaning-making process engaged in by the hospitalized person and to identify the actions of the person based upon the meanings. Second, the role of the staff and family as supportive of the elderly person during the hospital experience. Lastly, the hospital as an institution and the context of the elderly persons’ experience. Thus far, research focused on the hospital has been focused
on outcomes of care, not the process of the elderly person being in a hospital. Exploring the experience of hospitalized elderly people will establish a theoretical baseline that will describe the life-worlds of elderly patients, their families, and the nursing staff who work with them.

The Theoretical Framework: Symbolic Interactionism

The theoretical perspective of Symbolic Interactionism will guide research questions, interview questions, data collection strategies, and data analysis in the proposed research (Hutchinson, 1993, p. 181). Symbolic Interactionism is theoretically focused on the acting individual rather than on the social system (Bowers, 1988). The rationale for investigating the lived experience of hospitalized elders stems from the belief that “The meaning people give to their experience and interpretation are essential and constitutive, not accidental or secondary to what the experience is” (Bogdan & Bilkin, 1992, p. 36). There are three basic premises of the framework: 1) Human beings act toward things on the basis of the meaning that things have for them, 2) these meanings are part of social interaction in human society, and 3) these meanings are modified and handled through an interpretive process that is used by each individual in dealing with the things encountered (Blumer, 1969, pg. 2; Meltzer, Petras, & Reynolds 1975).

The central concepts of the theory are the self, the world, and social action. According to Hutchinson (1993), “The self and the world are socially constructed... they are ever changing through processes of social interaction” (p.
The self is composed of the I and the Me. The Me is that part of the self that can be identified and described, Me as the rehabilitation nurse, Me as the researcher, Me as the mother. The I is the "active, interactive, dynamic, interpreting component of the self (Bowers, 1988).

The world is the "object" world in which we live (Blumer, 1969, p. 10; Meltzer et al., 1975). It is a social world. An object is anything that has a meaning ascribed to it such as a chair, love, or an icon on a computer screen. Objects have no inherent meaning; meaning is derived from how people act toward them (Bowers, 1988). The meaning of an object may change over time. The change will be reflected in how people act toward the object.

The process of social interaction occurs through the use of symbols. Symbols are used for communication and can be verbal or nonverbal. Language provides a set of verbal symbols to which groups of people ascribe approximately the same meaning. Symbolic interaction is the process by which individuals are continuously ascribing meaning to themselves and the object world (Bowers, 1988). Symbolic Interactionism is the philosophical basis for the proposed study investigating the meaning of the experience of hospitalized elders and the object worlds in which they live. It is through the process of making meaning that elderly people, their family members, and the nurses relate to each other and act in ways consistent with the meaning they ascribe to objects.

The grounded theory approach arises from the framework of Symbolic Interaction (Bowers, 1988). The goal of the method is to accurately perceive and present another's world (Hutchinson, 1993). Hospitalized elders have spent a
lifetime in symbolic interaction. Their histories will contribute to their making sense of the experience of hospitalization. Because each person has a different history, for each elderly person will be different.
CHAPTER III

METHOD

Grounded Theory

Grounded theory is a qualitative research methodology in which substantive theory is inductively derived from data. Glaser and Strauss (1967) described grounded theory as the “discovery of theory from data [that is] systematically obtained and analyzed...” (p. 1). Strauss and Corbin (1998) elaborated by adding “...data collection, analysis, and theory stand in close relationship to each other...one begins with an area of study and what is relevant to that area is allowed to emerge” (p. 12). The process of conducting grounded theory research stems from the theoretical framework of symbolic interactionism (Blumer, 1969; Bowers, 1988).

The goal of the developed theory is to illustrate the basic social processes engaged in by the participants in a particular setting. “People sharing common circumstances... experience shared meanings and behaviors that constitute the substance of grounded theory” (Hutchinson, 1993, p. 185). Strauss and Corbin (1998) comment that “grounded theories... are likely to offer insight, enhance understanding, and provide a meaningful guide to action.” The researcher enters the field “steeped in the literature that deals with both the variables and their
associated general ideas" (Glaser, 1978), with a very general focus of inquiry. The emergence of themes and a sharper focus occur over time as the participants identify their experiences to the researchers (Stern, 1994). The resulting theory "emerges as an entirely new way of understanding the observations from which it is generated. It is this understanding that permits the development of relevant interventions in the social environment under consideration" (Hutchinson, 1993, p. 182).

Theory developed through the grounded theory method should fit the data (Glaser & Strauss, 1967, p. 238). The theory must closely correspond to the data if it is to be applied to every day situations. Data from the research should fit cleanly into developed categories. Evidence of researcher bias in the propositions of the theory would indicate a poor fit of the theory to the data. (Glaser & Strauss, 1967).

The researcher "tries to make the theory flexible enough to make a wide variety of changing situations understandable...[and] general enough to be applicable to the whole picture" (Glaser & Strauss, 1967, p. 242). The researcher's goal is to inductively develop an "... inclusive, general theory through the analysis of specific social phenomenon" (Hutchinson, 1993, p. 183).

A grounded theory must be accessible and understandable to the people working in the area of the research. For example, the nursing staff working with elderly people may use the theory developed in this study to redesign, plan and implement care for hospitalized elderly people. The elderly person should also be able to understand the theory so that they may be better able to understand the

A well developed grounded theory can be used to assist the user to “understand and analyze ongoing situational realities, to produce and predict change in them, and predict and control consequences both for the object of change and for other parts of the total situation that will be affected” (Glaser & Strauss, 1967, p. 245). The theory should help the user to predict changes in the area of interest based upon the propositions of the theory.

Grounded theory methodology has been selected for the proposed study in order to develop inductively derived theory which may be useful to elderly people anticipating hospitalization, their families, and the nurses who work with them. A basic assumption of this research is that elderly individuals will interpret the events of their hospitalization based upon their past experiences with hospitalization and illness, and the elderly person will interact with family members and hospital staff based upon their interpretations. The process of conducting the research and theory is described in detail below. The process must be explicitly stated so that the reader may evaluate the appropriateness of the process and the accuracy of the theory (Strauss & Corbin, 1990, p. 249).

Role of the Researcher

The qualitative researcher employs a wide range of interconnected interpretive methods in the attempt to find ways to make the worlds of experiences that have been studied understandable (Denzin & Lincoln, 1998, p.
24). In a grounded theory research study, the researcher intentionally immerses him or herself in the world of the participants (Bowers, 1988, p. 43). The researcher seeks to understand the world of the participants from their point of view.

While trying to become immersed in the world of the participants, the researcher simultaneously attempts to maintain a position of questioning those things that the participants take for granted (Bowers, 1988, p. 43). The balance the researcher strives to achieve is to view the participants world both as an insider and outsider. The researcher tries to blend his or her observations with the observations provided by participants (Denzin & Lincoln, 1998, p. 23).

In the current research, the researcher sought to immerse herself in the world of the participant. It was the hope of the researcher that by being present in the hospital with the elder for long periods of time the researcher could become so much a part of the routine as to begin to see what the experience of the elder was like. This was a successful tactic. The nursing staff ceased to take more than casual notice when the researcher was present.

The elderly participants often wanted to chat with the researcher either to pass the time or to entertain the researcher. The researcher developed a strategy of having some “work” to do while in the elderly person’s hospital room. The “work” in question was usually some light reading or writing such things as note cards which did not take a high degree of concentration. If the researcher appeared to be involved in some activity, the elderly person did not seem to need
to entertain the researcher. At other times, the elderly person and the researcher engaged in conversation about a wide range of topics.

**Steps in the Grounded Theory Method**

It is important to note that the steps of grounded theory do not occur in a linear fashion, but overlap, are recursive in nature, and often occur simultaneously (Bowers, 1988, p. 45). The steps are separated here in order to explain the process.

**Constant Comparative Method**

The constant comparative method was originally developed by Glaser and Strauss (1967). It is a method for research which involves multiple data sources in which data analysis begins soon after data collection begins and occurs in tandem with the data collection (Bogdan & Biklen, 1998, p. 66). Hutchinson (1983) described the constant comparative method as “the fundamental method of data analysis in grounded theory generation” (p. 200). As new data are collected they are compared to already existing data in order to determine patterns, similarities and differences. The goal of this method of data analysis is to develop a theory that encompasses as much behavioral variation as possible (p. 200).

**Coding**

In qualitative research, coding is a research activity used to organize data (Coffey & Atkinson, 1996, p. 27). Coding in grounded theory research is the analytic processes through which “data are fractured, conceptualized, and
integrated to form a theory” (Strauss & Corbin, 1998, p. 3). In grounded theory, coding proceeds in stages. First the researcher engages in open coding. “Open coding is the process of breaking down, examining, comparing, conceptualizing, and categorizing data” (Strauss & Corbin, 1990, p. 61). It is the initial stage in coding “through which concepts are identified and their properties and dimensions are discovered in the data” (Strauss & Corbin, 1998).

Another type of coding is axial coding, a process where the researcher recombines data by connecting codes into categories of like codes. It is referred to as axial coding because “coding occurs around an axis of a category” (Strauss & Corbin, 1998, p. 123). Axial coding in this research followed the coding paradigm identified by Strauss and Corbin in 1990. The paradigm divides data into conditions, context, strategies, and consequences. This paradigm was useful to organize the data and examine change in processes over the course of the research.

Using axial coding, the researcher begins to recombine the data and organize categories of data to illuminate the relationships between codes. During this process the researcher records his or her ideas about codes and discusses the relationships between codes in memos about the data.

The third kind of coding process is selective coding. It is “the process of selecting the core category, [and] systematically relating it to other categories” (Strauss & Corbin, 1990, p. 116). Selective coding also includes “the process of integrating and refining the emerging theory” (Strauss & Corbin, 1998, p. 142). It
is to be noted that the steps in coding do not outline a linear process, but the researcher moves back and forth between steps.

During the process of selective coding, the researcher makes decisions about the central ideas of the research and begins to organize other codes in relation to the central ideas. At this phase in the process the researcher may use memos and diagrams as well as sorting previously written memos and writing early drafts of the story of the theory (Strauss & Corbin, 1998, p. 116).

The three kinds of coding differ in level of abstraction, open coding being the most concrete and closest to the data, selective coding being the most abstract. The researcher moves back and forth between kinds of coding to group categories around the core category.

Memoing

Ely, Anzul, Friedman, and Gardner (1991) described analytic memos as "a conversation with oneself about what has occurred in the research process, what has been learned, the insights this provides, and the leads these suggest for future action" (p. 80). Strauss and Corbin (1990) state "memoing and diagramming begin at the inception of a research project and continue until the final writing" (p. 198-199). In addition to coding, the researcher recorded analytic memos on the process of data collection and analysis. The process of data analysis is documented through memos which demonstrate the evolution of the thinking of the researcher from the onset of data collection through the conclusion of the study.
Identifying the Core Category (Variable) or Basic Social Process (BSP) and Unarticulated Problem.

Strauss and Corbin (1990) defined the core category as "the central phenomenon around which all the other categories are integrated" (p. 116). Hutchinson (1993) used the term "basic social process" to describe a core variable that illustrates social processes as they continue over time" (p. 193). In this research, the core category emerged as the concept, Personal Integrity, and the BSP emerged as the process of Managing Personal Integrity.

The participants in a grounded theory research study are thought to share a specific social psychological problem which has not been previously identified. Solving this problem is the focus of the BSP. (Hutchinson, 1993, p. 186). Surviving hospitalization was the unarticulated problem in the current study.

Data Saturation

In a grounded theory study data collection proceeds until categories are saturated, that is to say no new codes arise from successive sampling and further data collection seems counterproductive (Strauss & Corbin, 1998, p. 136).

In the current research codes identified in the first case were labeled with a code name. During coding of the second case, new codes were given the prefix "B" to identify them as having been developed after the "A" case had been coded. After coding the "B" case, the "A" case was searched for evidence of the "B" codes. If data relating to the code were discovered, the prefix was removed from
the code. The process was repeated for case “C”, with subsequent searching of the “A” and “B” cases, and so forth. A minimal number of new codes were identified for case “D” most of which could be identified in previous cases upon searching. The “E” case was held in reserve until the theory had been developed. When the “E” case was coded using the theoretical categories no new codes were identified which indicated that saturation had been achieved.

Design of Study and Data Collection

The research design was to use multiple methods of data collection to gather rich data about elderly people in the hospital so as to apply grounded theory techniques to develop a substantive theory about the processes elderly individuals engage in while hospitalized.

Protection of Human Subjects

All participants were assured of confidentiality. All participants were given pseudonyms which were used for all transcriptions of interviews and field notes, and for identifying audio tapes. All audio tapes and consent forms are kept in a locked file cabinet in the researcher’s home office. Audio tapes will be destroyed when the study is complete. Participants had the option of listening to their audio tape and erasing any part if they so requested. No participant chose to exercise this option. Any participant could have withdrawn from the study at any time without consequences. No participants elected to withdraw from the study.
Interviews were audio tape recorded and transcribed verbatim by the researcher and a paid transcriptionist. Pseudonyms were used during dictation of all participant observation notes. Issues of privacy and the need for confidentiality were discussed with the transcriptionist in relation to interviews. The transcribed materials were delivered to the researcher on computer disc and any participant names that had not already been changed to pseudonyms were changed on the disc prior to printing a paper copy or saving on a permanent computer file.

In addition to the researcher and the transcriptionist, samples of data and researcher memos with pseudonyms were read by the peer research support group and the Chairperson of the researcher’s dissertation committee.

Gaining Access

The research was conducted at a major medical center in rural New England. The research proposal was submitted to and approved by the New York University Committee on Activities Involving Human Subjects. Approval was obtained on July 23, 1997 (Appendix A).

Gaining Access to the Hospital

Initial contact with the medical center was made via telephone to a nurse who is a Clinical Educator and a member of the Institutional Human Subjects Review Board (IRB) at the medical center. This contact was followed by a letter to the Chairperson of the IRB briefly explaining the proposal. A letter explaining the proposal was also sent to the Vice President for Nursing Services.
The researcher met with the IRB and explained the purpose of qualitative research and the aims of this study. The IRB did not have experience with qualitative methods. This research was the first nurse-designed research to be conducted at the medical center. IRB approval was obtained on June 19, 1997 (Appendix B).

**Gatekeepers**

Once IRB approval was obtained, I met with a representative from the admitting office to discuss the study and how prospective participants were to be contacted. The admitting clerks acted as gatekeepers, and were responsible for the initial contact with prospective participants.

**The Research Setting**

The research was conducted at a medium sized teaching hospital in rural New England. The hospital is a Level II trauma center offering comprehensive services 24 hours each day. Nurses at the hospital work 8 hour shifts, either 7AM – 3PM, 3PM-11PM, or 11PM- 7AM. Nurses are usually assigned to one shift, and work either 3 or 4 days per week. Nurses do not rotate shifts and are assigned to specific units in the hospital.

The hospital has many types of health care worker students in clinical rotations in all areas of the hospital. These include, but are not limited to, medical residents and students, nursing students, physical therapy and occupational therapy students.

The hospital did not have any special programs for elderly patients; patients were assigned to units by diagnosis or bed availability. For example, the participant with
pneumonia was assigned to a medical surgical unit. If that unit had been full, she might have been assigned to a cardiac floor.

Although shift and unit assignments were consistent for nurses, they did not routinely work with the same patients on a daily basis. Assignment of staff to individual patients was inconsistent and did not seem to follow any pattern. At any given point, the care needs for the entire unit took priority over consistent assignments.

Participant Cases

Each case consisted of three interviews of a hospitalized elderly person at least 75 years old admitted to the hospital for non-surgical reasons, an interview of a family member, an interview of a registered nurse, extensive participant observation, and review of the medical record. Non-random purposive sampling was used to select participants. Elderly individuals from a variety of backgrounds and experiences were sought to provide a diversity of perspectives, on the experience of hospitalization (Brink, 1991; Hutchinson, 1993).

The sample size was not predetermined in this qualitative study, but was anticipated to be small. Sampling continued until coding revealed that all categories of data were saturated and redundancy occurred. Five elderly individuals eventually participated. Categories of data were thought to be saturated after the fourth participant; the fifth participant was used as a check that redundancy indeed had occurred.
Interviews of the elderly individuals, family members, and nurses were analyzed individually. All interviews were confidential, content was not shared between participants in a case. When participant checking occurred, references to previous participants were anonymous.

Hospitalized Elderly People

All names of individuals, businesses, and the names of places were changed to protect the confidentiality of the participants. Each case was identified by letter. Names were determined alphabetically, the participant from the first case being “Amy”, second “Bob”, third “Carl”, et cetera. All of the people associated with Amy’s case; such as the physician, family member, physicians, and nurses; were also named with names beginning with “A”. Names of places were generalized. Fictitious place names were substituted for real place names or the names were generalized. For example, the name of a particular city may have been changed to “a city in the North East” or “a community in the south”. The pseudonyms were selected according to the way that the elderly person introduced him or herself to me. Amy, Bob, Carl, and Evy introduced themselves by first name, Mrs. D. introduced herself as Mrs. _____.

The elderly individuals who participated in this research ranged in age from 77-84 years old. Three were female, two male (Table 1). One elderly male participant was married, one woman divorced, the other three participants were widows or widowers. All participants lived in the community before and after his or her hospital stay. One man lived with his wife, the other lived in his own home.
with his adult daughter. The three women lived alone, two in senior citizen complexes and one in her own home. All participants were admitted to the hospital for medical conditions, two had chest pain, one atrial fibrillation, one pneumonia, one deep vein thrombosis with a history of diabetes and emphysema. Minimum length of stay for participants in the study was 48 hours, maximum stay was 26 days. Four of the five participants were in the hospital four days or fewer.

All elderly participants were admitted through the emergency room. In the hospital where the research was conducted, virtually all admissions occur through the emergency room. Prospective participants were approached about participation by the admitting clerk during their admitting interview. Only elderly individuals who were able to communicate fluently in English were included. The hospitalized elderly person had to be able to give informed consent, had to be willing to talk about their experiences to the researcher, and had to be willing to have the researcher present at various times every day throughout their hospitalization. The elderly person also had to have a family member who might be willing to participate.

The plan for recruiting participants was as follows. The prospective participant was given a brief statement describing the research (Appendix C) by the admitting person. This information was provided at the same time as the usual admitting information. The information sheet had a section at the bottom where the prospective participant was to indicate their interest in participating and include their name. After reading the information sheet the potential subject
## Table 1

**Participants and Data Collection**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Amy</th>
<th>Bob</th>
<th>Carl</th>
<th>Mrs. D.</th>
<th>Evy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>77</td>
<td>82</td>
<td>78</td>
<td>84</td>
<td>79</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Male</td>
<td>Male</td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>Diagnoses</td>
<td>Chest pain</td>
<td>Chest pain</td>
<td>Atrial fibrillation</td>
<td>Pneumonia</td>
<td>Deep vein thrombosis</td>
</tr>
<tr>
<td>Hospital length of stay</td>
<td>4 nights</td>
<td>2 nights</td>
<td>2 nights</td>
<td>25 nights</td>
<td>5 nights</td>
</tr>
<tr>
<td>Marital status</td>
<td>Divorced</td>
<td>Married</td>
<td>Widower &lt;1 year</td>
<td>Widow many years</td>
<td>Widow many years</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td>Alone</td>
<td>With wife</td>
<td>With daughter</td>
<td>Alone</td>
<td>Alone</td>
</tr>
<tr>
<td>Type of Housing</td>
<td>Own home</td>
<td>Own home</td>
<td>Own Home</td>
<td>Senior citizen high-rise housing apartment</td>
<td>Senior citizen housing garden apartment</td>
</tr>
<tr>
<td>Interviews</td>
<td>Complete</td>
<td>Complete</td>
<td>Complete</td>
<td>Complete</td>
<td>Complete</td>
</tr>
<tr>
<td>Admit Discharge Follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Interview</td>
<td>Sister</td>
<td>Wife</td>
<td>Son</td>
<td>Refused</td>
<td>Daughter</td>
</tr>
<tr>
<td>Nurse Interview</td>
<td>3-11 nurse</td>
<td>7-3 nurse</td>
<td>Senior nursing student</td>
<td>3-11 nurse and charge nurse SNF</td>
<td>3-11 nurse</td>
</tr>
</tbody>
</table>
indicated interest or no interest in participating in the research. The elderly person then placed the information sheet into an envelope which was addressed to the researcher. The admissions clerk paged the researcher to notify her that an elderly person had been admitted and there was an envelope at the admitting office.

The researcher retrieved the envelopes from the admissions office and visited those people who indicated interest. An unknown number of elderly people declined to participate without signing the information sheet or were admitted to the hospital without being invited to participate in the research by the admitting clerk. If the elderly person declined, the admitting clerk did not insist that the person sign the interest form, nor did they report the refusal to the researcher. Four elderly people indicated interest on the information sheet and agreed to participate. In the fifth case, the elderly person's daughter indicated initial interest in the study. Upon discussion, the elderly person agreed to participate. One additional elderly person signed and returned the information sheet and declined participation in the research.

The researcher retrieved the envelopes from the admitting office and she visited the elderly people who indicated interest in participating the research. When the researcher visited those elderly people she explained the study and obtained informed consent (Appendix D) from the elderly person. Throughout the research, the researcher reminded the elderly person that at any time he or she decided not to participate, he or she could withdraw from the study with no detrimental effects to them.
Initial participants were recruited smoothly according to the plan outlined above. One participant was recruited in September of 1997 and one in October 1997. One participant per month allowed time to transcribe the audio tapes and begin data analysis. Following the second participant there was a long gap in data collection. Despite my frequent visits to the admitting office, the clerks did not recruit or notify me of any further participants for three months.

At the suggestion of my research group, I provided an incentive to the admitting office. I purchased a large supply of candy, decorated the candy bag with ribbons and a note. The note read,

Thanks to your efforts, I have successfully completed half of my research on hospitalization of elderly people

This note is attached to a little something to show my appreciation for your efforts on my behalf, and to urge you on to the end Data collection will be completed after only another two or three people (although I know that you have to ask many people before two or three will say yes)

So the next time you admit a person 75 years old or older who isn’t having surgery, please think of me,

Thank you,

This tactic was very successful. Within a week, during the first week of February, 1998, three more elderly people agreed to participate. Data collection proceeded simultaneously for Carl, Mrs. D., and Evy.

Family Members

One family member for each hospitalized elderly person was invited to participate by being interviewed. Family members of four elderly participants
agreed to be interviewed, one sister, one wife, one son, and one daughter. The son of one elderly participant declined the opportunity to be interviewed. The reason for refusal was that he was so busy being supportive of the elderly person that he felt he did not have time to be interviewed. Data collection and analysis proceeded with interviews of four family members for the five participants.

In the present study the purpose of including family members’ and nurses’ perspectives was to provide depth and fullness to the description of the experience of the hospitalized elder. As noted earlier, Cremin, (1992), provided an example of how the experience of one person is interpreted in varying ways depending on the perspective of the observer. Cremin found that the elderly person, their family member, and the staff at a geriatric assessment clinic had very different perspectives on the problems the elderly person was experiencing. In the current research, these different perspectives on the experience of the hospitalized elderly person provided shadings and depth which enhanced the researcher’s understanding of the experience.

Tappen and Beckerman (1992) described patients’ experiences through the eyes of family members noting, “the family member’s perspective is unique in health care settings...focusing entirely on the care given to a single person...[it] is subjective, but...based on previous knowledge of the person...” (p. 149). This unique perspective on the hospitalized individual, having knowledge of that person prior to hospitalization and being present with the person in the hospital added unique shadings to the data.
After the elderly person had agreed to participate, the researcher contacted family members, usually when they were visiting the elderly person in the hospital. The researcher explained the study to the family member and provided them with a written explanation of the study (Appendix E). An appointment for an interview was arranged for a convenient time during the hospital stay of the elderly person. At the time of the interview, the family member was asked to sign a consent form (Appendix F).

Nurses

Reiley et al. (1996), and McCauley, Lowery, and Jacobsen (1992) compared nurses’ perceptions of patients’ status and the patients’ self report of status. In both studies there existed considerable discrepancy between the nurses’ perceptions of patients’ status and the elderly person’s status from his or her perspective. Nurses are responsible for the day to day care of hospitalized individuals. According to Blumer (1969) individuals (nurses) act in situations based upon the meaning the individual (nurse) ascribes to the situation. Therefore, nurses perceptions of patients’ experiences shaped that experience through the actions of the nurse.

Upon approval of the hospital IRB, a notice explaining the research was prominently posted on each nursing unit of the hospital to which an elderly person participating in the study may have been admitted (Appendix G). At the time the announcement was posted, I received a telephone call from a nurse manager telling me that the nurses on her units would not be likely to have an hour to be interviewed during their shift. I assured the nurse manager that I understood the
rigors of the nurses' schedule and I would make sure the research process would not interfere with the nurses' responsibilities. Coincidentally, no elderly person who participated in the study was admitted to the units supervised by this nurse manager.

When an elderly person who was participating was admitted to a particular nursing unit, the researcher introduced herself to the nursing staff and explained the role of researcher for this study. I explained that I would be asking nurses to volunteer to be interviewed about the experience of specific elderly people participating in the study. The nurse was asked to sign a consent form prior to being interviewed (Appendix H). A total of five registered nurses and one senior nursing student were interviewed for the study. A nurse or nursing student was interviewed for each elderly participant, two nurses were interviewed for the elderly participant who was in the hospital for 26 days because the elderly person was transferred from an acute care unit to a skilled care unit after six days, and the researcher thought that the charge nurse of the skilled unit might have a perspective that was different from the nurses who worked in acute care. The registered nurse from the skilled care unit did have a different perspective of the client, mostly related to having more opportunity to become familiar with the elderly individual.

Six staff people agreed to be interviewed for this research. Five were registered nurses on either the day or evening shifts and one was a senior nursing student two months from graduation. The senior student was interviewed rather than a registered nurse because the nurse was unavailable for interview and the
senior nursing student had worked closely with Carl, the third elderly person to participate in the research. Because Mrs. D. was in the hospital for 25 days on two hospital units, a registered nurse from each unit was interviewed.

Methods for Data Collection

Diversity of data "facilitates the development of a theory with both a sufficient number of general concepts relevant to most situations and plausible relations among these categories to account for much everyday behavior in the situation" (Glaser & Strauss, 1967, p. 242).

Participant Observation

Participant observation is a data collection technique in which the researcher strives to "observe, participate in, and ask questions about those observations" (Bowers, 1988). Bowers identified participant observation as the ideal method for data gathering in grounded theory. As a participant observer, the researcher attempts to discover what the world of the participant is like, how it is constructed, and how it is experienced. The researcher accomplishes this by purposefully placing herself inside the object worlds of the participants (p. 43).

The researcher must achieve a balance between detached observation and complete participation (Spradley, 1980). Spradley described the researcher engaged in participant observation as having a dual purpose for acting in the research. The first purpose is to engage in activities appropriate to the situation.
The second is to observe the activities, people, and physical aspects of the situation (p. 54). The researcher strives to increase his or her level of awareness so as to “tune in things usually tuned out” (p. 56).

As participant observer in the present study, the researcher attempted to enter the world of the elderly participant. The researcher did not act in the role of a nurse while engaging in participant observation. The researcher accompanied the client to various departments of the hospital, but did not take responsibility for the elderly person’s transport or return. When, during periods of participant observation the elderly person needed to engage in personal hygiene tasks, the researcher left the individual’s room and refocused the participant observation on other activities occurring in the patient area. When an elderly person admitted to the hospital agreed to participate in the research, the researcher visited that person in his or her room as soon as possible after admission.

The researcher met the elderly person at the hospital on the day of admission and spent two hours engaged in participant observation with him or her. The researcher engaged in periods of participant observation that were at least two hours in duration on a staggered basis to ensure observation time spent at all hours of the day and night. Periodically throughout each period of participant observation the researcher would retire to a secluded spot to dictate notes into a hand held tape recorder. During the research, participant observation took place on the patient units at all times of the day and night, in the x-ray department, and in the patient gym.
Data gathered through participant observation was recorded by use of audio taped descriptive field notes. (Bogdan & Bilkin, 1992). All audio tapes were transcribed and elaborated on following the participant observation. Field notes have a reflective component as well as a component of gathered data (Bogdan & Bilkin, 1992). The researcher’s reflections on the research process, as well as observer comments were kept in a separate section of the log as described in the section on bracketing.

**Interviews**

Interviews were used in the current research to “gather descriptive data in the participants’ own words so that the researcher could develop insights on how the participants interpreted aspects of their world” (Bogdan & Biklen, 1998, p. 94). Formal, semi-structured interviews using open ended questions were conducted with the hospitalized elderly person following admission and at discharge, and two to four weeks after discharge. The admission interview was conducted as close to admission as possible, in all cases the interview was conducted within 24 hours, four of the five participants were interviewed within 6 hours of admission. Interview schedules were used to guide the interviews (Appendices I, J, K).

The elderly participants were interviewed near their discharge from the hospital. Two participants were interviewed prior to leaving the hospital on the day of discharge, the participant who was in the hospital for 26 days was interviewed the day before discharge, and two elderly participants were
interviewed at home immediately following their discharge. Admission and discharge interviews ranged in duration from approximately 30-45 minutes.

A final interview was conducted two to four weeks post discharge. Four of the follow-up interviews took place in the elderly participants' home, one interview took place in a conference room at the hospital when the elderly participant was at the hospital for a cardiac rehabilitation session. Follow-up interviews tended to be longer than interviews conducted in the hospital, averaging approximately one hour in length. The purpose of multiple interviews was to capture changes in meanings of experiences which occurred over time. The elderly person had a different perspective on the experience of hospitalization at admission than he or she had at discharge or after the hospitalization. During the time following discharge the elderly person reflected on the experience of being in the hospital and identified ways in which the hospitalization affected their lives since they returned home.

Informal interviews were conducted during periods of participant observation. The focus of these "guided conversations" (Bogdan & Biklen, 1998, p. 95) was to clarify information the researcher had obtained previously or for the elderly person to tell me about events that had happened while the researcher was not present.

The participating family member was interviewed formally once. Interviews occurred away from the elderly person's room in a private place on the patient unit, usually the patient classroom. The interviews took place while the family member was visiting the elderly person. Two interviews occurred when the
family member had arrived to take their family member home, one occurred on the day of admission when the family member was visiting, one family member refused, and the other interview was conducted half way through the elderly person’s hospital stay. Family interviews ranged in duration from approximately one half hour to approximately one hour. The client was not present at the family member’s or the nurses’ interviews and all data were kept confidential. The family interviews ranged in length from 30 to 40 minutes. Informed consent was obtained from the nurse and the family member at the time of the interviews (Appendices H & I).

One interview with a Registered Nurse or senior nursing student (RN) working with the elderly participant was scheduled while the elderly person was in the hospital as well. Some RNs were from the day shift, some evening shift. All nurses who were interviewed worked with the elderly person within 24 hours of the interview. RN interviews tended to be about one half hour in length.

Other Sources of Data

Hospital records were also used as a source of data. The medical record was useful as a source of information about the hospital personnel’s perceptions of the health status of the hospitalized elderly person, but was not a rich source of data about the social processes engaged in by the elderly people nor their understandings of their experience.
Duration of the Research Study

The research proposal for this research was submitted and successfully defended in June of 1997. The summer of 1997 was spent obtaining approval of the hospital Institutional Review Board and the New York University Committee on Activities Involving Human Subjects, and developing the procedures for participant recruitment with the gatekeepers at the hospital. Data collection began in September of 1997 and was completed in March 1998. Transcription of audio taped researcher logs and interviews began in September 1997 and was completed in June 1998. Data analysis began with collection of the initial data in September 1997 and continued through December 1999. The major breakthrough with respect to theory development occurred in the fall of 1998 when in discussion with the peer research support group the researcher identified the core category of personal integrity. Between fall of 1998 and February 1999 the researcher was engaged in developing the theory through continued comparative analysis and memoing, library research, and writing the report. The research process spanned more than 3 years (Appendix L).

Data Management and Analysis

Data gathering and analysis occurred simultaneously in the present study. Data for the study included participant observation, interviews, and review of hospital records. This was in accordance with the constant comparative method developed by Glaser and Strauss (1967) and described by Hutchinson (1993). Hutchinson described the method as "the generation of theoretical constructs that,
along with substantive codes and categories and their properties, form a theory that encompasses as much behavioral variation as possible" (p.201). It is a process of making comparisons between the experiences of one participant and another to identify similarities and differences. Coding began as soon as the audio tapes of field logs and interviews were transcribed. Analytic memos were written after each interview and at the conclusion of each client’s hospitalization. Memoing occurred as dictated by the experiences of the participants and the researcher.

**Research Logs**

The researcher’s log is the repository for all data and analysis for the research study. The entire log was maintained on the researcher’s computer. Although much of the data and analysis was duplicated in hard copy, the primary record keeping and access to materials was through the computer files. Macintosh Computers use the metaphor of an office to organize computer files. While word processing or engaging in other work at the computer the metaphor is that you are working on the “desk top”. Individual files are organized in “folders”. Because the researcher’s log was a virtual log, different sections of the log were kept in different “folders” within the computer. The entire project was stored in a folder entitled “dissertation” and numerous folders were organized within it. Types of logs included data logs for interviews and participant observation, reflective logs for researcher’s notes and impressions, an activity log, methods log, and a log for memos. The files were protected by daily backups via tape drive as well as periodic backup via zip disc.
Each log entry was made as a separate computer file labeled as to type of file, participant observation, interview, memo, et cetera, and the date of creation. Transcripts of participant observation sessions were labeled by the first letter of the case name followed by “po” for participant observation and the date. (apo 9/18/97). Interview transcripts were labeled by the first letter of the case name and the first letter of each of the following words, ie. bfi (Bob family interview), cirm (Carl interview registered nurse), dia (Mrs. D. interview admit), eidc (Evy interview discharge), and aifu (Amy interview follow-up). The researcher’s reflections on the research process were entered by case letter and the letters “rl” for reflective log (brl). Researcher’s notes on methods were entered into the log under case letter and “ml” for methods log. Transcripts of the medical record were entered into the log by case letter and the initials “mr”. Each example of data used in the text also has a line number attached (Table 2).

In addition to the types of log entries noted above, all activities conducted in relation to the research were entered sequentially into a log. Entries included data collection, contact with advisors, the peer researchers support group, hospital personnel, and participants (Appendix L).

Participants were enrolled as the admissions clerks were able to recruit. Two participants were enrolled in the fall of 1997, one in September and one in October. Subsequent participants were all recruited during February 1998. During that period the hospital stays of three elderly participants overlapped.

Participant observation was engaged in by the researcher for each participant separately, and data were filed separately for each participant. As
Table 2

Log Entry Labels

<table>
<thead>
<tr>
<th>Type of Log</th>
<th>Label</th>
<th>Example of text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit Interview</td>
<td>ia</td>
<td>aia, 14-20</td>
</tr>
<tr>
<td>Discharge Interview</td>
<td>di</td>
<td>bia, 8-10</td>
</tr>
<tr>
<td>Follow-up Interview</td>
<td>ifu</td>
<td>cifu, 57</td>
</tr>
<tr>
<td>Family Interview</td>
<td>fi</td>
<td>dfi, 77-79</td>
</tr>
<tr>
<td>Reg. Nurse Interview</td>
<td>irn</td>
<td>eirn</td>
</tr>
<tr>
<td>Participant Observation</td>
<td>po</td>
<td>apo 9/13/97, 80-82</td>
</tr>
<tr>
<td>Reflective logs</td>
<td>rl</td>
<td>brl 10/8/97, 10-30</td>
</tr>
<tr>
<td>Methods logs</td>
<td>ml</td>
<td>cml, 2/21/98</td>
</tr>
<tr>
<td>Medical record</td>
<td>mr</td>
<td>emr</td>
</tr>
<tr>
<td>Participant Check</td>
<td>pc</td>
<td>dpc</td>
</tr>
</tbody>
</table>

* With case and line references

mentioned above, data saturation occurred at four participants, the data from the fifth participant not analyzed until after the theory had been proposed. No new
categories of data were generated by analyzing the fifth case, all data fit cleanly into the proposed theory.

Mariano (1995) noted that qualitative samples “emphasize depth and not breadth” (p. 468). The data from the present research reflect that philosophy. The researcher strove to gather deep rich data from each participant.

Data Analysis

Following transcription, hard copies of all files were printed. The process of coding began by the researcher reading the hard copy of the first case and coding line by line manually. After the transcripts were coded manually, the computer version of the transcript was imported into the qualitative data analysis software (QDAS) chosen for this study. (See below). The coding initially done by hand was then replicated in the data base.

For the second and successive cases, the transcripts were both printed and transferred into the QDAS. The researcher read the hard copy text while simultaneously using the QDAS to code data. When individual codes were being analyzed to determine variations within the code, data from that code were printed, cut into discreet quotes, and sorted manually.

Computer Assisted Qualitative Research

Computers are an integral part of the research process. All computer programs are tools which facilitate the processes in which the researcher engages. Several computer programs were used to facilitate this research. Microsoft Word

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98 for Macintosh computers (Microsoft, 1998) was used to write the proposal and final report, as well as transcribe all field notes and interviews in this project. Endnote (Niles, 1998), a reference manager was used to manage references. Endnote is a database program designed to make managing a large body of references easier. ClarisWorks (Hearn & Holdway, 1996) was used to create diagrams to explain the theory. While it is routine for the researcher to use all of these computer programs, computer assisted data analysis for qualitative research is a new technique and warrants discussion.

**Computer assisted data analysis for qualitative research.** Analysis of qualitative data often involves cutting up transcripts with scissors to separate chunks of data into codes and then storing strips of transcripts in envelopes or folders. The benefit of using a textual analysis software package is to “ease the researcher’s workload, save time, and generally enhance the power of qualitative analysis” (Buston, 1997, p. 2). Tak, Nield, and Becker (1999) describe a benefit of QDAS as “dramatically reducing the amount of time spent in the endless cutting, pasting, copying, and filing that is required to maintain (Qualitative Solutions and Research Pty. LtD, 1996) data in an adequately organized way” (p. 112).

The process of coding data was assisted by the computer software package Q.S. R. NUD*IST 4 (Qualitative Solutions and Research Non numerical Unstructured Data: Indexing Searching and Theory-building, version 4) (Sage, 1996). NUD*IST is a computer program designed to assist with managing qualitative research data for analysis “by supporting processes of coding data in...”
an index system, searching text or searching patterns of coding, and theorizing about the data” (Qualitative Solutions and Research Pty, Ltd., 1996, p. 2). It is to be noted that NUD*IST is not an analytical tool, it is a very sophisticated database software that can be used by the researcher to effectively manage large amounts of data easily. NUD*IST is actually two interlocked databases. One database holds the documents (transcripts); the other contains an index system which is created by the researcher as coding proceeds (Tak et al., 1999, p. 113). The document database allows for searching documents by key word or phrase. The index database is designed to store chunks of data by code, maintain references as to the source document of the data, and easily organize the codes conceptually as the grounded theory develops.

NUD*IST has functions which allow the researcher to manipulate the data in such a way as to identify codes, fracture the data and store bits of data by code, and organize the codes into a structure reflective of the researcher’s thinking and the emerging theory. NUD*IST also has a function which allows the researcher to create memos attached to particular codes in the data structure. This function was used infrequently, memos were usually written using Word 98, a word processing package the researcher is comfortable using. The memo function in NUD*IST was used mainly for the function of an audit trail. The program automatically generates a memo when codes are moved from one location in the data structure to another, or combined with other codes.

NUD*IST has the capacity to assist the researcher in searching the data to find occurrences of a particular word or idea. These searches can then be
incorporated into the data base for subsequent analysis. All data retain
information that allows easy identification as to the source of the data. The
software is flexible enough to allow the researcher to view the data surrounding
the coded selection in the original document.

In the current research, transcribed interviews and researcher notes were imported
into the NUD*IST computer software program. Each transcript was read line by
line, open codes were identified and data were sorted using the NUD*IST
software program to manage the data. As the list of codes grew, the process of
axial coding developed quite naturally from the open codes. Like codes were
organized under a more conceptual heading, and finally, the codes were organized
in the data base according to the emerging theory.

Coffey and Atkinson (1996) described the design of computer software to
“parallel and complement” the researcher’s non-computer strategies for analysis.
They emphasized that no computer program will perform automatic data analysis
(p. 187). The uniqueness of qualitative research is the role of the researcher as the
instrument of data collection and as the instrument of data analysis.

NUD*IST served a function in this research similar to systems of manual
qualitative data management. Because NUD*IST is designed to manage data
easily, the open coding process may have been more detailed than it would have
been had the researcher not used a computer program. Data analysis may have
been more complete because of the ease with which the researcher could use
NUD*IST to search the data.
Developing the Theory

During the process of open and axial coding, the researcher wrote memos about the data, the codes, and the processes which the participants seemed to be engaged in. After all data for four of the elderly participants had been transcribed, open coded and axial coded, intense memoing about the process of hospitalization began. During this phase of data analysis three events happened that were pivotal.

First was an idea that evolved from a meeting of the peer research support group. I had asked the members of the group to read and comment on interview transcripts that had been restructured and edited to only contain answers to the questions asked. The reasoning behind this was so that the researcher could examine answers from each participant simultaneously. All like interviews were combined to help the researcher understand the total response to a question. For example, the admission interviews for all participants were combined into one document (Appendix M). For this exercise only, all conversation that was not directly related to the interview questions was removed. This activity left a document that had four separate answers for each question asked by the researcher. These memos were contemplated by the researcher and discussed with the research group. This was done for each set of interviews. This was a very fruitful experience and eventually led to the beginning of a theory about the processes elderly people engage during hospitalization.

The conversation with the research group led to the identification of the core category, below is the memo that I wrote about that conversation.
Just goes to show what having someone else look at your data can do for you. Both members of my research group had interesting ideas about my interview summaries. One of them may have hit on something really important. Control. How do the participants engage in taking control over their lives/hospitalizations? Who does take control? Who lets who take control? Control is not quite the right word, but I'm looking for a better one. Look at Mrs. D.'s statement about how it was decided that she come to the hospital. She said 'They told me I was going so I decided to go.' (Methods memo, 'Control', 9/8/98)

During this period of intense analysis and memoing, each aspect of the experience of the elderly person was analyzed in depth. The hospital as the context for the experience, the role of family and staff, as well as the feeling of the elderly individuals were analyzed. The core concept personal integrity was developed from this process.

The second event occurred after continued analysis. My advisor challenged me to think about the color and pattern of personal integrity. The purpose of this exercise was to stimulate my thinking in unusual ways. This discussion led me to design and produce a quilted wall hanging to try to understand the meanings of hospitalization. After constructing the quilt, I sat with the quilt and laptop computer and wrote about why the quilt was constructed the way it was. The meaning of each aspect of the quilt to the researcher was discussed.

Hospitalization for the elderly person is not just one color, or one texture or one shape. I decided that I could not think about color without thinking about texture. I went to the fabric store and tried to select fabrics to represent facets in creating a quilt of the experience, similar to the stained glass window I spoke about in the introduction.
The background of the quilt is roughly rectangular, long side goes left to right. The reason is that the process is unidirectional, the experience is cumulative. The background color is dark, indigo or navy, the texture is rough although regular. This is the context, the background upon which the individual's experience occurs is vaguely prosthetic. The purpose of the hospital is to improve the health of the ill individual, so the color is close to that of intact personal integrity, although the color of the background lacks the intensity and the texture lacks the richness of personal integrity. The background is relatively neutral.

The experience is layered on the background. The first layer is glittery orange lame'. This represents the danger. Danger of death, danger of loss of personal integrity. The danger of the experience underlies everything.

The next layer is worry (Gray, irregular texture). Worry about everything. Worry about health, functional ability, the house…. Worry permeates the experience.

Next is the families (Green and blue stripes). Families generally supported and directed the experience. From taking care of things like the dog to determining the start and finish of hospitalization and activities after discharge.

Fabric stripes indicate facilitating and obstructing the process. The family have a central role in the experience. Hence the fabric through the center of the quilt. The danger and the worry swirl around under and over the relationships with the family.

Now I am to the issues about personal integrity. Personal integrity is very complicated it is more than the person, it is not just the soul or the body, it is the synergistic relationship between all of the dimensions of the person. On the quilt, it is represented by the multi-stranded braid. It is billows, it swells and contracts. The hospital can enhance or diminish it. (memo: color, texture, and shape of hospitalization 11/17/98)

My thinking continued to evolve after designing the quilt, but the activity helped me move my thinking in a way that I would not have been able to without the exercise. Through this process, after more memoing and analysis, finally, the core category of personal integrity was identified, the data were reorganized according to Strauss and Corbin's Paradigm Model (1990, p. 99-107) including
causal conditions, phenomenon, context, intervening conditions (modifiers of the experience), strategies, and consequences. (See Chapter 5)

After identifying the core category, and organizing all data in relation to that category, the data were re-analyzed for evidence of process during hospitalization. As the theory developed, the researcher returned to texts on grounded theory and memoing to evolve thinking to a higher conceptual level. Hutchinson’s (1993) strategies for identifying the unarticulated problem and the basic social process for the hospitalized elders in this research added depth to the theory. These strategies are described below.

**Identifying the Basic Social Process**

The third pivotal point in data analysis came in June of 1999 when further dialogue with the data and my dissertation committee, and references on grounded theory method led to identifying the basic social process and movement in my thinking to a more conceptual level. I sat with the data and Hutchinson’s (1993) chapter on grounded theory. As I read each paragraph of the chapter I applied the information to the data. This further clarified the concepts and process in the theory derived from the data and enhanced the conceptual level of the theory.

Excerpts from the memo are included below.

**Unarticulated Problem:** Surviving hospitalization  
**Basic Social Process:** Managing personal integrity  
**Definition of BSP:** An active process in which the elderly person creates meaning out of social interactions occurring within the context of hospitalization and acts to enhance the chances of survival.
Consequences: If the elderly person cannot successfully manage personal integrity their post-illness status is significantly different than their former (pre illness) status. There is a synergy between the three properties (health, dignity, autonomy) of personal integrity in that improvement or decline in one attribute effects enhancement or decline in the others. (Positive relationship)... (memo: managing personal integrity, 6/4/99)

Process

Process is the change in the core category over time. Once the core category of personal integrity had been identified, changes in personal integrity needed to be identified. These changes were identified by a process of sorting data by day of hospitalization. Through this process it became clear that the behavior of the hospitalized elderly person changed over time. I began to think about the changes in personal integrity as a journey and the elderly person as the manager of the journey. In further discussions with my advisor the idea of jeopardy was introduced and resonated with the data.

Quotes from the elderly participants became the focus for each phase of managing personal integrity. Phase I became associated with the phrase “The best place to be”, the middle phase with the phrase “I might as well stay” and the last phase “It’s time to go”. Throughout this process axial and theoretical coding continued. Strategies that had previously been listed as individual codes were now grouped into more conceptual categories.

Trustworthiness

Trustworthiness in the outcome of a qualitative research study is established through ensuring rigor in the process of data collection and analysis.
The following techniques were used to improve the trustworthiness of the current research.

**Bracketing**

Bracketing is the process of the researcher becoming self aware and reflecting on the research process and her own assumptions. In order for the researcher to become immersed in the experience of the participants, it is vital that she become aware of her own preconceptions, values, and beliefs, temporarily relinquishing her own perspective so as to enter the participant’s world (Bowers, 1988; Hutchinson, 1993). “It is necessary to state clearly our conscious assumptions about that which we are investigating” (Swanson-Kaufman & Schonwald, 1988).

Bracketing was achieved by listing the researchers assumptions about elderly people in the hospital prior to beginning the research (see Chapter 1) and through the reflective portion of field notes. Lincoln and Guba (1985) described the reflective log as a “journal in which the investigator on a daily basis... records a variety of information about self and method” (p. 327). The reflexive journal provides data about the human instrument. Mariano (1995) stated the researcher must do four things in relation to assumptions, 1) assume assumptions about the area of interest exist, 2) draw the assumptions out, 3) examine values and judgments, and 4) have the work critically evaluated by someone else (p. 467). Lincoln and Guba (1985) suggested the reflective log have at least three components. First is a section on the daily schedule and logistics of the study; second is a section set aside for the researcher to reflect on the days events,
provide an opportunity for catharsis, to discuss one's own values and insights and to speculate about growing insights (p. 327). The third portion of the reflective log according to Lincoln and Guba is the methodological log in which methodological decisions and rationales are recorded. These aspects of the log were recorded as such and labeled according to the system outlined above.

The purpose of bracketing is to avoid the possibility that the data and the data analysis simply become a reflection of the researchers preconceived ideas and values (Mariano, 1995). For the present study, data logs and the reflective log were reviewed by peer support group members to address this possibility. To increase dependability of the study, all data logs were subjected to the audit process described below.

Credibility

Establishing credibility is a two-fold task (Lincoln & Guba, 1985). First the research must be conducted in such a way that “the probability that the findings are credible is enhanced” (p. 296). This is accomplished though the use of a clear decision trail and careful documentation of the process of conducting the research. Second, the participants must provide feedback to the researcher as to the accuracy of the portrayal of their experience. Methods for data collection are described above. Strategies for participant checking are described below. In addition to those techniques described, the researcher dated each piece of data and memo so that the decision making process over time could be determined. Lincoln and Guba (1985) suggested three strategies for improving credibility,
prolonged engagement, persistent observation, and multiple data sources (triangulation).

**Prolonged Engagement**

Prolonged and persistent observation (Ely et al., 1991) contributed to the credibility of this research. The purpose of prolonged engagement was to provide scope to the study (Lincoln & Guba, 1985, p. 304). According to Blumer (1969) meanings of experiences (objects) are in a continuous process of "being created, affirmed, transformed, and cast aside" (p.12).

Contact with participants began shortly after admission to the hospital and continued until after discharge. One participant was transferred from one inpatient setting to another within the hospital. The researcher followed the elderly person to the new setting. In addition to contact over time, participant observation for at least two hour blocks at various times of day and night assisted the researcher in becoming immersed in the world of the participant. The range of time in hours spent with elderly participants in participant observation and interviewing varied from approximately four hours with Carl whose length of stay was approximately 2 days, to more than 48 hours with Mrs. D. who was in the hospital 26 days.

As a nurse the researcher has considerable experience with being in hospitals and therefore, as the researcher, already has considerable knowledge of the context with in which this study occurred.
Persistent Observation

"The purpose of persistent observation is to identify those characteristics and elements in the setting that are most relevant to the object being studied and focusing on them in detail (Lincoln & Guba, 1985, p. 304). The design of the study included observation over time. Through the process of constant comparative data analysis the most relevant characteristics and elements of the situation emerged and guided selection of further data gathering. For example, two behaviors of the early participants, being nice to the nurses and worrying, eventually became strategies as I observed how successive participants engaged in these activities. As prolonged engagement provided scope, persistent observation provided depth to the study (Lincoln & Guba, 1985, p. 304).

Multiple Data Sources

The purpose of using multiple data sources is to maximize the range of data that might contribute to the researcher’s understanding of the participant’s experience (Knafl & Breitmayer, 1991). For the current research, data sources included the researcher’s log, transcriptions of audio taped interviews, and hospital records pertaining to the individual. Interviews of a family member, a nurse and the client over time added fullness to the description of the experience. The plan was not to verify information of one person or from one interview with another, but to add depth and richness to the emerging theory.
Participant Checking

Participant checking is a process of seeking feedback from the participants of the study. It is a method of checking the accuracy of the researcher’s interpretations of the experience of the participant. It is part of the process of establishing credibility (Ely et al., 1991).

Participant checking was a continuous process which occurred as data analysis proceeded through both formal and informal interviews. During interviews and periods of participant observation the researcher asked questions such as “At admission you told me____ can you tell me more?” or “other participants have told me that ________ have you experienced similar things?” During interviews the researcher asked the participants about themes and hunches. At later interviews with the elderly participants the researcher asked for clarification of comments made at earlier interviews.

When the theory was near completion, an appointment was made with Mrs. D., the participant who was in the hospital longest for a session of participant checking. The interview was audio taped and transcribed. Mrs. D.’s comments were used to verify the accuracy of the theory. A written summary of the theory was given to Mrs. D. (Appendix N ) and I explained the theory.

Mrs. D. agreed with the findings. She had been in the hospital again within a month of the session of participant checking. Mrs. D. was able to reflect on the hospitalization during which she participated in this research as well as her recent hospitalization. Her comment was , “I think it [being in the hospital] was pretty much like that, this time too.” (dpc, 12/7/99).
Peer Researcher Support Group

A peer support group was a valuable strategy for enhancing the quality of this research. The group provided emotional support for the researcher as well as feedback on the research process. At various times during the research process, support group members reviewed and commented on transcripts of participant observation and interviews, discussed memos written by the researcher, and provided a forum for discussion of the researcher's ideas.

Peer checking was another purpose of the group. During peer checking, the researcher shared portions of her field log, and asked group members to individually create categories and themes, and then compare with the researcher's categories (Ely et al., 1991).

The peer researcher support group was composed of four doctoral candidates from the School of Education at New York University. One student withdrew from the group after approximately two years of regular meetings, when she moved too far away from New York to be able to participate in meetings. The group has agreed to meet on an average of every three weeks to discuss the research of each of the group participants. Each meeting is two to three hours long. The group has met on a regular basis depending on the needs and the stage of the group members research. The group will continue to meet on a regular basis until the last doctoral candidate has finished her research.
Transferability, Dependability, and Confirmability

The researcher's responsibility toward transferability of the results of a qualitative research study lies in the provision of a detailed data base which includes rich description so that another may be able to comprehend the researcher's conclusions (Mariano, 1995). The data base for this research contains transcripts of a total of 25 interviews (5 admission, 5 discharge, 5 follow-up, 4 family members, 6 RN), approximately 40 participant observation logs, five medical record transcriptions, and numerous reflective and methodological logs regarding the process of data collection. In addition there is an extensive collection of dated memos on development of the theory.

Dependability enables someone other than the researcher to logically follow the process and procedures used by the researcher (Mariano, 1995). The researcher addressed the requirements of dependability through careful description of the process of data analysis. An audit was conducted to address confirmability of the findings. The raw data as well as preliminary coding and other data analysis was available for audit. The auditor was Dr. Veronica Rempusheski, a nurse researcher selected for her expertise in gerontological nursing and grounded theory methodology. Correspondence pertaining to the audit can be found in Appendix O. All written and taped records of the study will be kept as described above until the conclusion of the study.
I first met Amy in the late afternoon of the day on which she had been admitted to the hospital. In her hospital room, Amy was lying on the bed by the window wearing a thin hospital gown. The gown was tied loosely, deeply scooped at the neck. I could see a well healed scar from cardiac surgery on her upper chest. She was then 77 years old, short and stocky with bright blue eyes; her hair was salt and pepper. Her eyesight was diminished, she moved her head in a way as to suggest her vision was very poor.

When I first met Amy, she was wearing a nasal cannula for oxygen. The plastic tubing was attached to a nozzle on the wall behind the head of the bed. A bag of intravenous (IV) fluid was lying on top of the suction canister behind the head of the bed, connected to Amy’s left wrist by a length of tubing. The fluid was not infusing. The head of the bed was elevated at about 30 degrees. There was a yellow coverlet drawn up about Amy’s shoulders, and a second yellow coverlet was folded lengthwise and placed on top of the first, over the length of the bed. The side rails on the top of the bed were up; those on the lower bed were down. She was wearing a medic alert bracelet on her left wrist.
When Amy spoke, she was articulate and expansive. Her voice was loud and coarse with a bit of a New York accent. She had a long history of smoking that made her voice rough. Amy said that she has word finding problems from a stroke she had a few years ago; these are quite mild. As she told the story of her admission she punctuated her narrative with facial expressions and hand gestures. The red nail polish on Amy’s long fingernails drew attention to her hands.

Amy’s Attitude

Amy talked a lot. She told stories, and jokes and made lots of somewhat sexual comments. She often commented about how handsome or cute and attractive the doctors were. Amy was worldly; she was not naïve; she was rather streetwise; she could be brassy, and coarse. I felt her bravado was covering up some acute anxiety about her condition. Amy said, “Pretty soon you’ll know that I’m a clown. I clown around to cover up how I really feel” (apo 9/13/97, 80-82).

Amy seemed to like to have a circus going on and to perform in it. She related experiences using hyperbole. Amy used phrases like “... if the nurse does that, I’ll kill her” or “if my sister does that, I’ll kill her” or “my sister will be furious if that happens”.

One night, Amy had one sister visiting with her, another sister on the telephone, and a nurse in the room. Amy and her sisters were throwing comments
back and forth in rapid fire, playing off each other on the nurse. It was very jovial and very light, as Amy kept things.

Amy had a stage persona that she put forth for anyone who was watching. Because she kept everything with a note of humor in it, it was hard to tell what was really on her mind. Her attitude seemed very matter of fact and she communicated with very quick-witted banter.

**Amy in the Hospital**

Until a few months before Amy came to the hospital, she owned a restaurant and bar at which she played music and sang. The restaurant was just a few miles from her house.

She continued to visit nightclubs on a regular basis. The night before Amy’s admission to the hospital, she and her sister had been out at the nightclub, returning home at 2AM. They had a large snack before retiring. Amy woke up about an hour later with chest pain, which she and her sister tried to deal with at home, and then by going to the hospital.

Amy had been in several different hospitals several times during the last three years; she had been in this hospital several times recently. When I visited them, Amy’s sister was sitting in a chair at the foot of the bed while Amy related the following story about getting to the hospital. “Well, this time I went in [to the hospital] because I had such a horrible pain... and I wasn’t sure. They had given me instructions in Boston on how to do this. They said you wait 5 minutes if you have a severe pain.’
“When I have a good heavy pain, I call up the ambulance, (laughed) that’s if it doesn’t go away in 15 minutes. I have that down pat. Every five minutes take a pill (nitroglycerin).’

“I thought it was indigestion so I took two pills for that. I figured ‘Oh well, that ought to straighten me out.’ And I went back to bed. I get back into bed and the pain was ferocious.’

“So I said ‘OK, so I’ll take a nitroglycerin’. So I took a nitroglycerin and I timed myself. In five minutes it had gotten no better, it was worse. So I took another nitroglycerin and I called my sister, she was sleeping on the couch. I said ‘you better get in here’. So, she got up, so she comes into the bedroom and I explained what happened. I said ‘time me, ‘cause in another five minutes I have to take another nitro.’

Amy’s sister interjected, “So she took the second nitro, it was more than five minutes, more like ten minutes.”

Amy continued, “So we timed it and five minutes more went by, and still a hard pain. This pain was like a ball in the middle of my chest, hard.

Amy’s sister continued the story, “She was going to take a third one, and I says ‘it’s better if you don’t take a third one, you should go to the hospital, because once you have three, well that’s it.’”

Amy took up the tale, “I says ‘well, call 911. It’s the only thing to do’. ‘Cause they had told me, ‘don’t take a ride in a private car’.
“So OK, we call 911, the ambulance comes, it takes me to town. It (the ambulance ride) was wonderful. All those young guys telling me to roll this way, roll that way, it was fine.

“I get into town, they examine me, give me an EKG and put me in the hospital. (Laughs) That wasn’t funny! ‘Cause I didn’t know whether it was a heart attack or if it was an angina attack.”(aia)

On the day that Amy was admitted, she was happy about being in the hospital. She was quite dynamic. She explained being in the hospital this way. “To come to the hospital, as I say, is nothing, cause you know you’re going to be looked after. Whatever reason. Just like myself at home, you know, if I don’t like what’s happening then I’ll go (to the hospital). I am delighted to be here. I expect it to be excellent. Who can complain? I’m gonna get three meals a day served to me in bed. I don’t have to get up for anything.”(aia)

During Amy’s hospital stay, a series of small physical events occurred. Once she had a reaction to an injection, once the tape of her IV site caused a reaction, another time there was pain when the nurse irrigated the IV. On one occasion, Amy reported to the Medical resident that she was getting a kidney infection because her urine smelled strong. Although Amy did not seem to be demanding on the nursing staff, she seemed to like the attention and security of having a staff person in the room, and her physical concerns may have been attention-seeking behavior. Although she did not ask for help and seemed to be fairly self-sufficient caring for herself, she usually called the nurse for a physical problem.
At the time of this study, she was as healthy as she ever gets, by discharge, she was not having any chest pain and was not on oxygen, although she did get short of breath on exertion.

**Amy’s Family**

Amy had two sisters; one lived in the sun belt, one in a large city a few hours away. When I met Amy, one of her sisters was with her in her hospital room. They described the third sister as the one who worries. The interactions between Amy and her sister were all very light banter. Even when discussing serious things, they teased each other and kept the tone of all their conversations light.

The sisters had had a lot of experience with the healthcare system. Amy had a lengthy cardiac history and her sister was visiting while recovering from a second mastectomy.

Angie, Amy’s sister, appeared to be in her late sixties or early seventies. She was wearing a blue shirt and pants, covered by a western-style fringed red flannel shirt with silver and turquoise collar points. She was wearing silver dream-catcher pierced earrings and large glasses with turquoise insets on the outer aspects of each rim.

Amy described her sisters this way, “My sister, Angie, the one that you saw, that I keep teasing, fatty and all this stuff. She had just come from a breast operation. That was the second breast removed. And she took it like a real trooper, no problem at all. She doesn’t mind if you talk about her boobs. She says
'Oh, now I can go on the beach without anything on. I can be just like the guys, no chest.' She can tease about it, it doesn't bother her.'(apo)

"Angie was here, visiting. Of course she had to visit with me. At my house, it's down on one floor. In her son's house she'd have to go up stairs. And she wasn't in the mood to run up and down stairs. So she stayed with me."

"As for my other little sister, that's my pet. I love her dearly. And she is such a little mother hen, you have no idea. (Laughed) She watches everything I eat, everything I do, and if I'm doing something wrong, boy do I know about it."

Amy readily spoke about her mother and father, sisters, nephews, and mentioned her daughter who lives out of state. She only mentioned her ex-husband once, in a way that suggested that she did not hold him in high regard. She did not say how long she had been married or divorced, or what happened to Mr. A. When Amy was at home, her daughter telephoned every other night. Amy explained, "If everything's fine that's fine. If everything's not fine then we talk."

Amy's two nephews, lived near by, and she relied on them if she needed anything when she was at home. When Amy was discharged from the hospital, she stayed with one of them for a short time, but it didn't work out very well. Amy didn't like being at her nephew's; she wanted to be in her own place. When I interviewed Amy at her follow-up interview, Amy said, "They wanted me to go up to their house, but I don't want to go anyplace, I want to stay here [at home]. If something happens, I got the phone right next to the bed, and I can call... but... you don't know what to do" (Chuckled).
In addition to family, Amy had a very active network of friends. The friends' activities with and without Amy punctuated her conversations. It was a friend who took Amy home from the hospital when she was discharged.

**Amy at Home**

Since Amy did not drive, I asked her how she was going to get home from the hospital when she was discharged. She said she had a friend who would come and get her or that her nephews would come if she asked them. “Or, if nobody can come, I’ll take a cab home. I don’t miss them.”

When I visited Amy at her home, Amy had her hair combed neatly; it looked as if it had been set recently. Amy was wearing a little bit of lipstick. The nail polish on her fingernails was pretty worn, and I wondered if perhaps Amy thought she had removed the nail polish, but did not remove all of it because she could not see very well. She was wearing a thermal jacket and long underwear as well as slacks and a sweater. She said she was often cold.

Amy’s home was very isolated, several miles outside a very small town and it would be easy for her to get snowed in. She had a big wood stove in her kitchen that she lighted with a match. A neighbor delivered and stacked wood for the stove. She had electric heat as a back-up to the wood stove.

Amy was quite independent and fairly self sufficient at home, although she required many support services and had very poor vision. She spent most of her day at home in her kitchen, preparing meals, cleaning, and trying to maintain her independence. For company, the television played loudly from morning until
night. Amy went out a lot in the evening, particularly Wednesday and Friday nights.

Amy said she tries to remember to take her pills. The VNA nurse came every other week to fill her medication pill boxes. However, when I visited, in addition to two filled pill boxes where the pills were sorted into boxes by day and time, Amy had several bottles of medicine without the lids just sitting on the table.

Amy will not spend the winter alone. At Thanksgiving she will go to her sister’s house a few hours away, to stay until Christmas. At Christmas, she will go to her daughter’s house out of state and stay there until May, when she will return home.

Bob: Trying to Be in Control

First Impressions

Bob was 82. He was a tall man, quite a bit taller than his wife. He had shaggy white hair and short, neatly trimmed white whiskers. He usually dressed in khaki pants, khaki turtleneck, khaki jacket, and khaki baseball cap.

He had a Hemingwayish appearance. Bob was a novelist who has published several books. The galley proofs of his memoir were nearly ready and he wanted to see it published before he died, so he was very concerned about surviving for the next few months.

When I met Bob, he was lying on his hospital bed, filling out his menu. He was wearing a hospital gown with a pouch on the front to hold the heart monitor
to which he was attached, and he was receiving oxygen through a nasal cannula. He also had a patch containing heart medicine applied to his chest, visible above the neck of the hospital gown. When Bob finished the menu, he lay on his side, very quiet, thoughtful and withdrawn.

Bob’s hospital room was very noisy and busy. During one half hour on the first evening Bob was in the hospital, seven people entered and left the room for one reason or another. Bob’s roommate was a young man who had been admitted for a drug overdose. While Bob and I were visiting, a medical student was behind the curtain room divider interviewing the roommate in excruciating detail about his drug history. The curtain provided the illusion of privacy to the roommate and the medical student, but Bob and I could clearly hear every word.

**Bob’s Attitude**

“Now I wish that doctor had never said anything about the small arteries. I didn’t need to know that, sometimes they tell you too much. I’ve been worrying about those arteries ever since. I am so tired of it all. I have to wonder if it’s all worth it? Because, I mean, this is hardly a life. Every time you’re worrying you begin to get a pain, you begin to worry about it.

“I’m concerned about the fact that this might go on and on and on and on. You know, if I have to keep going to the emergency room and getting plugged in and all that, is it worth it? I begin to think in terms of ‘it’s better to be dead’. Sometimes I think that I should just go to Holland where I could just take a pill and end it all. I worry about having to come to the emergency room again and
again. I think I've been here seven times in the last two years. So that's what I worry about most, can't they do something to give me a couple of years without any problems?

"At any rate, I left the hospital near our other house pain-free but once I was home it began all over again. The chest pain has been coming and going for a couple of weeks. I kept thinking, well, it will go away, and then finally I saw my doctor.

My doctor told me, 'At the slightest hint of any pain, you just go to the emergency room. Don't worry about feeling foolish or anything like that, you just go'. Even though that was in the back of my mind, I hesitated when I began to have these back pains and chest pains. My wife and I had a date to leave tomorrow to go to our vacation home for a couple of weeks, I was hoping that if anything was going to happen with my health that it wouldn't happen until I came back. My wife encouraged me to go to the emergency room, to put my mind at ease.

"So I had to come into the hospital. That was so exasperating. A very unhappy thing. I arrived at around 9:00 this morning. My wife was with me. Since then it's just been a series of doctors. I'm going to have a nuclear stress test tomorrow morning. If everything turns out OK, we still might go to the house in the afternoon. I guess I'll have to come back for tests as an outpatient."
Bob in the Hospital

On the day of admission, Bob told the story of this illness this way: "Well, so far, this illness has really been an exasperation from beginning to end. First of all, I, they, couldn't figure out what the problem was. This incident began a couple of weeks ago while we were at our vacation home. I had to go, I went to the hospital there because I was having chest pain. The doctor thought it could be the heart or perhaps the esophagus. She assumed that it was sort of an anginal attack. She said something about the small arteries in my heart that were never taken care of when I had my bypass. I began to worry about the small arteries. Her diagnosis was very disappointing because I thought I was pretty angina-free, what with all my medications and stuff like that.

In the evening of the day of admission, Bob had another episode of chest pain. It was very severe and lasted about a half-hour. Although Bob had been having pains for a couple of weeks, he was surprised and concerned about this episode. After the pain had subsided he said, "I didn't think I'd be hit like that. It makes me reassess my situation and decreases my hopes for recovery. I didn't feel as if my condition was terminal, now I'm not so sure. I thought I would be discharged tomorrow so we could go away, now I don't think I'll be going anywhere. The last time I did this I went home and I was back a couple of days later because I still had pain."

A foreign, female medical resident visited Bob. The resident introduced herself to Bob and said, "The nurse reported to me that you had some chest pain earlier. There weren't any changes in your EKG."
Bob replied, "I don't believe in EKGs any more. There are never any changes in the EKG."

The medical resident said, "Is the chest pain all gone now?"

Bob said, "Mostly all gone".

The medical resident, "All gone, or mostly all gone?"

Bob, "Mostly, I still have some pain in my shoulder blades."

The medical resident had Bob sit up in bed. The medical resident used the stethoscope to listen to Bob's back and then to his chest. She said, "I changed some of your medications around. They will be giving you a little bit more nitro paste and that might help the chest pain a little." The resident was very polite, and very communicative.

After the episode of chest pain that first evening, and after the unit had begun to quiet down a bit, Bob began to talk about what it was like to be in the hospital. "My wife left late this afternoon. Since then, I can't even get a paper to read in this place, that's one thing that bothers me. I asked for some reading matter. I thought sure I'd pick up a magazine or a newspaper or something, but I haven't. So it's been a little difficult, here I am just lying here staring into space. That's not the healthiest thing when you are worrying about your health. I have a lot of time to think. Time moves very slowly, it passes by the second.

"I'm a little worried. I don't feel that what I have now is fatal. My doctor said that everything I have is reparable. But that doesn't mean that you can't croak in an hour. So you think about it.
“I tell people not to visit while I’m here, I don’t like to be disturbed while I’m here. I’m not a television watcher; most of the stuff on television is not worth watching. I’m not allowed to go for a walk, I’m on bed rest. Earlier today I asked for a paper or something to read, I’m still waiting.

“Being in the hospital is wearing. There’s nothing to do, but you don’t really feel like doing too much. In the morning, I feel pretty good, by afternoon, I’m usually feeling pretty dragged out, tired, and stressed.”

Bob was worried about his heart, about dying before he’s ready. He said “I have things I have to finish up, I’m not ready to die yet, I have unfinished business.” He was worried because he felt no one was giving him information about his health so he suspected bad news. He said he understood that no one is telling him anything because they have nothing to tell at this point, but he identified the difference between knowing something and worrying about it. “You know you worry, I’m anxious, I’m concerned about what they’re going to find out about my health.”

There were two times during his hospital stay that Bob took control of the situation. The first was when he demanded information from the hospital staff. Bob felt that he wasn’t getting information. “The worst part of waiting is waiting for information. You go downstairs for a test and then you wait. The medical residents have to follow some sort of hierarchy protocol where they have to leave good or bad news to the primary physician. The longer I have to wait the more I worry that the news will be bad. I feel like I don’t know what the hell is going on.
"It is frustrating not to know what the results of the tests are. This morning they did a stress test and then they were going to do an ultrasound. Then the doctors decided not to do the ultrasound but perform a MRI instead. I don’t know why they decided to do one test over another. They weren’t offering any information about how or why these decisions were being made. All the doctor said was ‘Well if you do the MRI, then you won’t need to do the ultrasound, but if the MRI doesn’t work, then we’ll do the ultrasound too’.

“While the physicians were trying to figure out what in the world was causing the pain, I was trying to get information. I had had a bunch of tests and another severe episode of chest pain. It wasn’t until I started to complain about not knowing what was going on that one of my doctor’s charges (residents) came and talked to me for a while. Then, finally last night when they told me they knew what it was now it was a release. It felt very good. And I felt very good until they bothered me about having that test done this morning.”

The second time Bob took control was on the morning of discharge. He was waiting to be discharged when a transport aide came into the room.

The transport aide said “I’m ready to take you downstairs for your test.”

Bob looked at him at said “I’m not going for any test, I’m being discharged”.

The transport aide very politely said, “OK, well I’ll go get the nurse and she can straighten this out.”

The aide and the nurse returned quite promptly. The nurse said to Bob “They want you to go back down and finish the test you started yesterday.”
Bob said, “They decided yesterday that they weren’t going to finish that
test, that it didn’t need to be finished today.”

The nurse said, “Well, the doctor did order today that the test be finished.
The aide is here to get you, why don’t you go down and have it done.”

Bob went down to have the test done. When he arrived at the X-ray
department, he and Betty, the technician, chatted while Betty prepared and
injected a radioactive substance into Bob’s IV. There was no explanation of what
she was doing, just conversational banter. There was also a male technician in the
room. He sporadically entered the conversation as he moved about the room.

When Bob moved to the X-ray table, he was positioned on the narrow
plinth, with one arm extended over his head. As Betty positioned the arm, Bob
grumbled about an old shoulder injury and how uncomfortable the position was.
When Betty told him he would have to stay on the table for 22 minutes, Bob
stopped trying to be agreeable, and said, “I’m not staying in this position for 22
minutes. Get me out of this machine, I’m not having this test done, I’m sorry, I
don’t mean to be disagreeable but I’m going upstairs, NOW.”

Betty helped Bob get back in his wheelchair. She was very cordial, “I
understand how you feel, it’s very unfortunate, we’re only doing what we’re told”
etc. She really tried to smooth things over and make Bob feel better.

The male technician said to Bob “Well, I wish you had refused to do this
test before we gave you that radioactive injection”.

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Bob apologized profusely to Betty, saying, “I don’t mean to be difficult, but I just can’t stay in that position; it’s really uncomfortable. You know I was really uncomfortable in that position yesterday.”

Bob said to me, “Now, I’m angry with myself because I didn’t finish the god damned test. But only because it was proforma, and ah, of course, I’m mad because it was proforma. I didn’t think it was necessary.

“That’s why I mean I hate to displease Betty down, down in that room (X-ray) because she’s so darn nice. I know the test is supposed to be for my good, but like, I felt in that particular situation that they just wanted to finish a job. And that the patient there really didn’t matter. So I just didn’t feel compelled. Also, I think not having been told before to... first having been told I was going to be leaving. And then being told I have to go and finish a test, that ah, that’s very, well to me a torture. You know it upset me. And I just wasn’t compelled to lie under that darn thing for 22 minutes. So you know I would say they really should not do that. They should have let me know ‘You have to go down for this test’ and prepare me for it. I wasn’t prepared at all.

“I was upset because they told me that the nuclear scan from yesterday was very good so that the second one probably wouldn’t be necessary. So then all of a sudden they come in and tell me that it is necessary, maybe something wasn’t clear. But I really didn’t care any more I just didn’t want to do it, I just didn’t want to go through the pain.

“So I’m much happier (laughed) now than I was a couple of hours ago. And the doctors come in ‘you didn’t want to finish the test?’ ‘No, I didn’t want to
finish the test.’ I guess they feel that you have to finish the test. You just have to finish it because that’s what they’re supposed to do.

“I think that’s generally, they try to make the patient comfortable. But I don’t see why they can’t give me a shot in my shoulder and numb it a little bit so I don’t feel the pain. But I suppose they have their reasons, you know, that it affects what is taking place in the body. I think when they design these things [machines] they ought to think more along those lines. I don’t know why they’re not made with the idea of being comfortable. I mean that narrow thing like that. I t ’ unbelievable. You know it’s for a little kid. So that’s very annoying, that’s very annoying. So I’m glad to go home.”

Bob’s Family

Bob was married and had grown children who live less than an hour’s drive from Bob and his wife. His wife and one of his children had doctoral degrees. Bob was not very forthcoming about his family; it was Bob’s wife who provided the details.

Bob was very private about his illness, he asked his wife not to tell the children that he was in the hospital until there was some concrete news about his health. He said “I don’t like to be disturbed when I’m in the hospital by phone calls and all that. I tell the kids generally not to call me unless they’re, unless they’re too upset, and want to hear my voice”.

Bob’s wife was a small dynamic woman in good health. Bob said his wife has been doing a good job taking care of him. Bob said she worries when he is
having these episodes, but he tries to reassure her that he’s “not gonna croak yet”.

Bob’s wife described her role in his illness this way, “When I come to visit at the hospital he’s very happy to see me, and at the same time worried that I’ll be bored and upset and sad being here. He worries too much about what I’m reacting to.

“Bob’s very happy to have me here. Bob would just as soon be sleeping and know that I’m sitting here and be very content. He’s basically a kind of shy person, although he hides that from most people. He gets tired of people. He often says the best thing in the world is to just be alone with me, or with the children. When he’s in the hospital Bob doesn’t want people to call, he didn’t even want the children to know about his illness until he knew what was going on. So I didn’t even tell the children until last night when we knew everything was all right.”

At the follow-up interview, Bob described himself; “I’m a worrier. I was brought up in a home where my mother had five cancer operations, but she survived them all. She lived on until her 80’s. She was always worrying about her children having cancer. So I begin to worry. As soon as I get a bad bellyache, right away I begin to worry that I have cancer. That’s always been a problem with me.

“When I have a pain, like the other night I was having terrible cramps, I began to think ‘oh, they’re not telling me the truth, they’re concealing it from me, I’ve really got cancer, I’m going to die soon’ and all that sort of stuff. I’m mostly concerned about dying before my book comes out. I want to make sure I live to see my book come out, then we’ll worry about the dying part.
“My wife always tells me, don’t worry until you find out for sure. Which is, if I could only be that way, it would be great (smiling).”

Bob’s wife picked up the story; “I think he thought he was going to die. You know, heart attacks, anything to do with the heart is very frightening, and so he was concerned about what they [the pains] were signs of. As soon as they told him it wasn’t the heart or they didn’t think it was the heart, he always has a worry about cancer. Several people besides Bob’s mother have also had cancer. Bob often worries about all kinds of illnesses, and I’m the one who tries to reassure him (laughs) and tell him he is going overboard with it.”

Bob’s wife continued, “I’m worried that he won’t be able to relax and get back into his life, now he knows that this pain is from his esophagus and not his heart. I’d like him to stop worrying so much about his health. He’s 82 and I can understand that, you know, he also worries about how is he going to die, is it going to be a lingering illness, is he going to have to go to the nursing home which we’ve discussed. He’s worried about me, leaving me, if he should die soon. I’m always trying to reassure him. He knows that I’ll be very sad, but that I’ll manage.”

Bob at Home

At the follow-up interview, Bob described the above incident this way, “Well, it was sort of a confusing stay with all the different tests I took. Though I haven’t had a problem with the symptoms that I came into the hospital with, I’ve
had this other problem with my stomach. It began with the medication I took to solve the first problem.

"I don’t think too much about the hospital stay, except I did take those tests which I hated. Otherwise, I’m just trying to get back to normal, that’s the best I can say.

"The hospital, well, it’s a good hospital; the nurses are marvelous and decent. The day I came home I wouldn’t have minded if they had kept me another day. But that’s the way this hospital is, it’s sort of homey.

"I felt terrible about refusing that test, because I felt I was insulting the technicians. The fact is I did go back a week later to beg their pardon. They were only doing what they were supposed to do.

"But I was a little annoyed with the doctors. They should be able to give you a shot. So it does, it does lessen the effects of the test a little bit. It does make you, it does give you a little comfort so you can go through with the darn thing. They (the doctors) never think of the patient, never. They don’t give a damn if he’s uncomfortable or in pain or whatever. They just ignore it. Now it was Betty, who was the nuclear technician. She said they’re not allowed to do anything down there. The physician has to do it, he has to decide. And ah, so, of course she said she (laughed) said she wasn’t offended, she understood very well, because she has a rotator cuff problem too. So she understands. I felt a little bit abashed. I felt as if I had affronted them.”
Carl: I Want To Go Home

First Impressions

Carl was 78; soon to be 79. He was tall and thin, and drove for the local senior services, providing transportation to and from physician appointments and the hospital for elderly people who do not drive.

I met Carl on the evening of his admission to the hospital. Carl had been admitted to the same room that Bob had been in a few months earlier. He was in bed, wearing a hospital gown and his glasses. Carl’s son, daughter, and a family friend were visiting.

During the winter when his activities are restricted because of the weather, he watched television, drove for the senior services, and went to church on Sunday. In warm weather, Carl had a lawnmower repair business. Carl said that when his daughter was not at home he went outside and burned the trash as well as taking short walks. In conversation, Carl tended to repeat himself. He told me the following story about the doctor’s lawn mower several times. He was very proud of his mechanical abilities.

“As I say, Coombs is my primary physician. And I used to have to go to him when I renewed my pilot’s license. Cause he had the FAA status to renew the pilot’s license. And so that’s how I knew him. And today, when he visited me at the hospital, he [the doctor] looked good. He’s right from jogging and everything. So I asked him if he was still jogging, he said yeah, but not so much. He’s getting old too.
"As I say, I fixed him up a lawn mower one time. He called down and wanted to know if I had any used mowers around so I fixed up one and took it up and put it in his hallway under his office. And he took it down to his son. And he was kind of disgusted. He said his son wouldn't even be bothered to push it around. It was motorized, you know, but it wasn't self-propelled. You know, like that."

**Carl's Attitude**

Carl’s daughter exercised a lot of responsibility for Carl’s health. When I asked him why he came to the hospital he explained it this way.

"My daughter brought me to the hospital today. I came in at about 7:30 this morning. My daughter there saw blood in the toilet. Well, I don't know where it came from, 'cause I wasn’t in pain, but it got there anyways, and I don’t even recall. The only thing I can think is from blowin’ my nose--my nose bled a little bit and I just threw the paper towel in the toilet."

"So anyways, my daughter's a great one for this emergency room. She says, 'Dad, we're out to the emergency room'. She says, 'I called down and told 'em I wouldn't be into work today'. So down to the emergency room we come. So she insisted, she's a great one for that. 'You're getting out to the emergency room'. So twice now, as time went on, she has forced me to go out. And that's what happened this time. She was on to my tail to get going to go out there."
"'We'll take both cars I said, and if we're only there a while, I can drive back'. 'No,' she says. She figured we be longer there than I did. So we went in her car then, the little car in the driveway. And like that...

"Once I got to the emergency room, well, they wheeled me into a room, there on a stretcher and started checkin' my blood pressure and pulse and all that stuff, ya know. And ah regular, routine more or less examination to see what they would come up with next and stuff like that. But ah...Well, as I say, well, that's life anyways.

"And after we went through all the procedure down there, then I ended up comin' upstairs here—the 4th floor. It's a great place--great place--it is wonderful. It's all the wonderful people that are around. It's great. Yup. You'll have to ask my daughter what all they [the staff] did; she talked to them more than I did."

**Carl in the Hospital**

Carl had been willing to spend one night in the hospital, but then wanted to be discharged. When I arrived early on Saturday morning, Carl was sitting on the edge of the bed eating a big breakfast. He had already finished off two bowls of cereal and was working on eggs. The first thing he said was “I didn’t sleep a wink all night. I want to get out of here this morning”. The story of why he stayed in the hospital another day is written below.

The medical record indicated that Carl was admitted with atrial flutter after having fallen twice yesterday and having hit his head. Carl’s son related the history of this present illness:
“Well, he fell twice yesterday or the day before, whenever it was. He hit head once and he fell another time. It’s like it seems like he’s falling an awful lot. And he fell one other time he said too that I didn’t know about. And then I knew about a time he fell in the driveway because they all told me they were gonna call 911 and everything because he was having a hard time getting up. He’s falling too much and I think maybe this narrowing of the aortic valve there is not making all the blood flow go there that should be.

“So they just put him on the medication, and that seemed to get his heart rate down. It was up to 150 when he came in. So now it’s down to normal and I think they still would rather have him stay this extra day just to make sure everything’s gonna be fine when he does go home.

“He [Carl] feels it’s unnecessary for him to be in the hospital. But, on the other hand, if my sister didn’t bring him in, he might not’ve been here. He might’ve been down on the ground. All Dad can think about is getting out of here, which is probably natural.”

Carl had major vascular surgery a week or ten days prior to this hospital admission. Carl told the story this way.

“Well, I was only in a week. Yup, it was a week. Course, they got me taped up and everything then I went back home. So I did have a mini stroke months ago, and I could get around good and everything, but they knew there was somethin’ wrong and they had to find out. So they run me through that machine [MRI] downstairs there. Well, I call it a barrel anyways; that’s what it felt like. They put earphones on my head for music.

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"They found a blot clot, 90 per cent clogged in here [indicated right side of neck]. But uh I if I’d had a major stroke from the... what they operated on--90% had clogged. Well, I might not have been here today. And uh, anyways, right in the nick of time, It saved my neck.... Well, gee, I don't remember how I got in then, probably through my daughter forcin' me."

**Carl’s Family**

Carl’s daughter managed his health. Carl didn’t really know the doctors who admitted him. He really did not have a clear sense of why he was in the hospital. He came to the hospital because his daughter wanted him to. The daughter took Carl to the doctor when she thought he needed to see a doctor. She knew what medications he was taking and which activities he should engage in. For the most part, Carl lived within her direction in relation to his health.

Carl’s daughter made the decision for him to go to the hospital and she signed the consents. When I entered the room Carl’s daughter was sitting on a commode; the lid was down and she was using it as a chair. It was the most obvious chair the way the room was set up.

At Carl’s discharge interview, he explained the role of his daughter this way. “Now yesterday, when I wanted to go home, there was no great problem. I wanted to go home, my daughter wanted me to stay like the doctor said. I said ‘No, I want to go home’ get in my own bed to sleep and everything. And my daughter said, ‘No, Dad you better stay. You’re going to stay one more day.’ So there I was until today.
"I was a little upset 'cause I wanted to get out of there. It's a good place and they do a lot of good things but I still wanted out."

Carl was a widower, who missed his wife— "that little blonde girl." They had been married for 57 years. Mrs. Carl died about eight months prior to this study at a nursing home one day after being discharged from the hospital where Carl was now a patient.

He told me the story of his wife's death soon after our initial meeting, and at least once more during the two days he was hospitalized. Once, when I visited Carl in his hospital room, I found him lying on the bed, gazing at the ceiling. He had taken the oxygen cannula from his nose, but was still wearing his glasses. The lighting in the room was dim. He told me the following story.

"Like I say, I enjoyed my years of bein' in the factory, and I just wish my wife would've lived a few more years, ya know. Well, to start with, I brought her out to the new building over there, the office building near the hospital. She had an appointment in the medical lab. And I told her, I says, 'You wait by the door while I go and park the car.' So I went and parked the car and I come back and she wasn't there. So I went in and here she is in the wheelchair. She had tripped and fell and broke her right hip. That was the beginning and she went down we all come down on like everything.

" Yup. They even changed her blood. They had sent her over to the new medical center in the City; she was over there for a week. They changed her blood over there and did somethin' with her, and you know and like that. But she come back--she was in this place 11 weeks, and the ah...June 13th of this year, they sent
her to a nursing home and the 14th she passed away there. Yup. So... Anyways, we would’ve been married 57 years.

"Yah, as I say since the wife died. Yup. Yup. But, I sure miss that blonde girl; I’ll tell ya. I had her so many years. Yah. She’s a beautiful Christian lady. Long-time Grange member. She loved the Grange. And stuff like that. And she would go out to the Christian Center with people, ya know, be involved like that."

Carl at Home

When I visited Carl in his home, he was wearing a blue cardigan sweater, checked shirt buttoned all the way to the neck, light green work pants, and large heavy black shoes. Carl was well kept- with a neat white crew cut. He wore black- rimmed glasses. Carl was especially proud of his flying and airplanes. When I visited him at his home, he told me about his flying.

"I’m sure glad my airplane pictures are all enclosed there on the shelf. I’m proud of them, the fact that I built something and stuff like that. And if I were five years younger I’d build another one. Yeah, I’m crazy, I’m crazy."

"I was gonna say I wish you were around years ago and coulda gone up in my fool airplane, and I learned to fly originally in four hours. Yup. With my friend, he worked at the same place my father did. And he had an old J2 Cub--40 horsepower Cub. And uh first thing I know I’m flyin’ the thing all by myself. He climbed down over the airport, and I was on my way. (laughed)"

"Yup. Yup. So I’ve had lots of fun over the years. I don’t regret any of them. Only that when another buddy said he wanted to fly with me, he owned half
my Stenson (airplane). ‘Pull the flap panel up’— I asked him to pull one notch of flap panel up, he pulled the handle all the way up and I came down in a field across from where the car wash is now. There was no houses in there then. And I ended up bein’ upside down there and broke my nose. And today that poor fellow, well, he didn’t make it; he’s dead too but not from that. Yup. So it’s one of those things.

“I never did it for a living or anything, just for fun because did I say as long as I got somebody to go half way with me to help me build and new things like that, why that way I can afford to do it.”

“Now I’m home, I’m glad to be out of there, a beautiful place, they do beautiful work, I met a lot of people. But, here my daughter is in a 10-room house by herself. As I say, I’d rather be here too. Because, you know why I was so afraid, as time goes on if people find out there’s nobody around, you’re liable to have things happen. You know, maybe you bum a hut down or somethin’.

“So other than that, life has been pretty decent most of the time. Yup, yup, I like it here better than anyplace. For some reason. And ah, or else sometimes I say we got one, two, three, four, five six, bedrooms in this house. And sometimes I wish that more of my relations were in here too or somethin’ you know. As I say my daughter, today and tomorrow, she’ll be here and she’ll go to church tomorrow. And like that you know.”

Carl lived in a house he had owned for many years. His daughter lived with him. It is a very large house, and Carl loved the house dearly.
Carl had a fairly set routine at home. Carl’s son explained how Carl behaved when he returned home from the hospital after his last admission. “When he came home from the hospital last time, he had to take it easy. They told him to take it easy, but he was out shoveling a little snow right after he came home, and I said, ‘You’re not shovelin’ too hard are you?’ and he said, ‘Oh no. I’m taking it easy.’ Ya know, it’s just an eye browning concern because even my mother-in-law said, ‘You gotta watch him. You gotta keep an eye on him.”

Mrs. D.: Please Treat Me With Respect

First Impressions

I met Mrs. D. around 8:00 PM on the day she was admitted to the hospital. She was 84 years old. She was sitting upright in her hospital bed with two pillows behind her. She was wearing a hospital gown; she had an IV flowing into in her right forearm, and an oxygen cannula in her nose. She was covered by a sheet; there was a yellow blanket next to her, which she had moved so it was not on top of her. Between spasms of a very wet sounding cough, Mrs. D. was trying to eat some of her dinner. The tray had been brought from the kitchen two hours earlier and was now cold. There were two televisions suspended from the ceiling at the foot of each bed, one for each patient. Both were turned on to the same channel, with the volume turned up loudly. Although Mrs. D. was quite short of breath and looked tired, she continued to talk with me throughout the time I spent with her that evening.
Mrs. D had short gray hair. Her reading glasses and several boxes of tissues were on her overbed table, and a small garbage bag was taped to the end of the table. Mrs. D.'s black leather pocketbook and a packet of admitting information lay haphazardly on the windowsill. The blinds on the window were closed. Her cane was standing in the corner next to a chair with a shopping bag on it. In the bag were the clothes Mrs. D. had been wearing when she had arrived at the hospital. The curtains between the beds were open and Mrs. D. glanced over at the roommate often.

The room to which Mrs. D. was assigned was directly across from the nurse’s station but, Mrs. D. and her roommate were protected from direct view by the placement of the door. Mrs. D did not have a direct view of the station either, but could often hear the commotion and general bustle of the nurse’s station. From Mrs. D.’s bed by the window, the noise sounded rather far away. During the evening, the room felt secluded from the bustle of the work going on outside.

The roommate was elderly and appeared to be quite ill. She had a lot of edema throughout her body she was wearing an oxygen mask and she moaned continuously. Occasionally she cried out.

Mrs. D.'s Attitude

Mrs. D. had very definite ideas about how hospital personnel should treat patients. She also had ideas about how patients should respond to staff members. Mrs. D said that the patient’s attitudes toward the staff were very important. Attitude made a big difference with respect to how the staff treated you. Mrs. D.
was quite sure that you needed to have a positive attitude towards the staff so that the staff would treat you positively as well.

In general, that was exactly what Mrs. D. tried to do. Watching her, I could see her affect change depending on which staff member came into the room. Mrs. D. said “The nurses here have all been very nice, but there’s one guy who’s kind of gruff with her [the first roommate], and he’s not very sociable.” With this nurse, Mrs. D’s affect was very light. She would try to kid with him and tease him, trying to get along with this nurse whom she did not care for.

There was a nurse’s aide on the skilled unit that Mrs. D. particularly did not care for. She described his behavior this way: “He comes in and shouts at me. I'm not deaf. And he comes in and tries to give my glasses. I have almost 20/20 vision. I don't need to have my glasses on for breakfast. He’s always pushing everyone to get done. See, he just wants to get finished so that he can hang out with the girls down at the desk.” It is the impression that he gave that he had other things to do, than attend to the immediate client that contributed to Mrs. D's dislike of him. This particular aide called Mrs. D. by her first name.

Most of the staff, both nurses as well as other staff, called Mrs. D. “Mrs. D.” They tended to call most patients especially on the Skilled Unit by first names, but Mrs. D. seemed to expect the formality of a title.

The staff members that Mrs. D. thought the most of were those staff members who conveyed genuine caring. The individuals who conveyed that they were interested in Mrs. D. were those that she liked best. One such staff member was the medical resident who admitted Mrs. D. He took extra time with Mrs. D.
and went out of his way to arrange for her dog to come and visit Mrs. D. Another
was a respiratory therapist who conveyed an aura of calm and competence. Mrs.
D. liked several of the nurses. They were usually the older ones; she thought they
had more compassion.

Mrs. D. in the Hospital

Mrs. D has had problems with asthma for many years. In addition to her
breathing, during the past year she had had a couple of falls, one in which she
broke her ankle, and another where she needed stitches in the bridge of her nose.
Approximately three months ago, Mrs. D was awoken from a sound sleep by a
severe nosebleed. She was transported to the hospital by ambulance and admitted.
She apparently lost a significant amount of blood during the ambulance ride. She
had been in this same hospital several times during the last three years.

In addition to the breathing problems, Mrs. D had had a stroke in 1979
resulting in mild weakness on her left side. Mrs. D used a cane when she walked
long distances or went outside. In her apartment, Mrs. D generally relied on the
furniture for support.

Mrs. D called her physician because she was having trouble breathing. It
seems she had become a little disoriented and called the physician's office quite
late in the evening. The next morning, the office nurse called Mrs. D. and told her
to come to the doctor's office. Mrs. D's son took her to the office and waited in
the waiting area while Mrs. D. was examined by the physician. She explained the
experience this way.
“Well, I’ll tell ya. I must have been in a bad way…So my Don came and got me over [to the doctor’s office] within about 20 minutes. He [the doctor] examined me – he could hear the pneumonia. The doctor said ‘I’m gonna take you to the hospital’. Well, I gave some arguments but he didn’t pay much attention to me. The doctor went out in the hall and talked to my Don. Then the doctor came back to me and said, ‘Have you decided?’ I said ‘Decided what?’ he said ‘That you will go to the hospital’. I said ‘I knew that before you went out’.

“I got word from the doctor’s office at about five after nine, and I was in the hospital, I think, by quarter of ten. I’ve been here all day. I was in the emergency room all that time. I was kind of disgusted. He [the doctor] handed me a slip of paper. My son had the paper and it said go straight to emergency and go right up [to the floor]…. So I didn’t have to sit and watch all that, but somebody didn’t read the symbol on the paper right…. 

“…Well, to tell you the truth, I didn’t feel too good about coming to the hospital, but I couldn’t think of anything [to keep me from coming]. I just wanted to get here and have him (doctor) tell me to go back home. I didn’t want to leave them at home, and I didn’t think I needed to come to the hospital. Dr. Daniels thought different. So anyhow, I know that this is the best place.”

Mrs. D was in the hospital for a total of 26 days. The first six days were on a medical/surgical acute care unit. Mrs. D was then transferred to a Skilled Nursing facility located within the same hospital. She was not happy with the move or the way it was handled. Mrs. D. felt that she had been hurried into...
moving and misled about the unit she was being transferred to. Mrs. D. described
the experience this way:

"Well, first, they told me or they told Don that we had about a half hour to
get my stuff together to come down [to the skilled unit].

"Wasn't even ten minutes. Then they [the staff] came in with these two
paper bags. It was terrible. I have a new coat that I like. They took my coat and
my boots and just rolled 'em up and shoved them in the bags. Just like you
were... I mean I don't understand that. They were so disrespectful of my things

"It happened much faster than I thought it was going to. In the first place,
they could have had Don take my clothes home. I wouldn't have my boots all
rolled in my coat. I just think that wasn't very nice.

"And tellin' me how wonderful it was gonna be down here. Ya know that
just wasn't very nice. See I had two bad roommates and they pretended that's
why they were moving me.

"Which wasn't. They wanted the bed. Because they said, 'You won't have
any of that [bad roommates] down there.' So, I came down to this. So you could
imagine when they were wheeling me in, I couldn't get in. She [the roommate]
had me blocked. I was way over in the corner with no room most of the time.

"So that--number one--was a lie that they said. Well, I don't think that's
necessary to tell stories to people. Tell 'em the truth. Right? They could have said
how there was a two-bed room and there's a heavy-set lady who's bad gonna be
down there. She cries out at night."
“It keeps me awake all night. She keeps me awake all night, but it don't bother me because I know that she is sick. I think they could've been more honest with us.”

Mrs. D. developed iatrogenic complications while in the hospital (health problems that were directly related to the treatment she received in the hospital). At least one of these problems had not resolved by the time Mrs. D was discharged.

When Mrs. D. was admitted to the hospital, she had been quite dehydrated. At admission, the physician ordered 500cc of normal saline bolus to be followed by continuous IV set at the rate of 100cc per hour. During the first 24 hours of being in the hospital, Mrs. D. received almost 3000cc of fluid. By the third day, Mrs. D. was having significant problems with stress incontinence. She explained it this way: “You know about the problem I’m having with all this fluid. I’m so well hydrated that every time I cough I wet the bed. I’m not used to having all of this fluid.”

Seventy-two hours after admission the IV fluids were discontinued and the stress incontinence gradually resolved. By that time, Mrs. D had taken to sitting on the commode all of the time she was out of bed so as not to urinate on herself and her clothing. In bed she was using waterproof pads and changing them independently when the pads became wet. She was dropping the wet pads on the floor. Her perception was that the nurses were not interested in her incontinence, she said “I just threw one of those things (incontinence pads) under the bed, they (the staff) don’t care.” Mrs. D. was considering having her grandson purchase
incontinence briefs for her. Mrs. D said that she was having a hard time getting the staff to respond to her needs for dryness.

The second and third problems were related to the same medical intervention. Mrs. D. had been given a significant dose of steroids to reduce the inflammation in her lungs and improve her breathing. The medication had the side effect of suppressing Mrs. D.'s immune system and leaving her susceptible to opportunistic organisms. First Mrs. D. developed a severe case of thrush (candida) in her mouth. The thrush persisted throughout the entire hospitalization. Mrs. D experienced severe mouth pain that inhibited her ability to eat. During week two, the infection spread to Mrs. D.'s eyes, causing severe pain, swelling, and itching. When I visited Mrs. D. for our follow-up interview about a month after discharge, she was still complaining of and treating the eye infection.

The third complication of steroid therapy was the development of a very large cold sore (aphthous ulcer), which was very painful. Mrs. D. was particularly conscious of the ulcer. She said "I'm 84 years old and I've never had any blemishes on my face until now, it looks terrible." The ulcer was a problem throughout the month that Mrs. D. was in the hospital; it began to resolve shortly before discharge. When I met her for the follow-up interview, the ulcer had completely resolved leaving some faint scarring.
Mrs. D.'s Family

Mrs. D. lived alone on the fourth floor of an apartment building for senior citizens in a small town. She engaged in an active family life with her son and grandson and their families, but her closest companion is her dog, Dotty.

Mrs. D. was very attached to Dotty, the current dog in a long succession. She was a very small dog who had been Mrs. D.'s constant companion for the last two years. During the time Mrs. D. was in the hospital, Dotty stayed alone in their apartment. Mrs. D.'s son stopped by the apartment twice a day and walked the dog and played with her. Dotty came to visit Mrs. D. at the hospital every other day while she was a patient.

Mrs. D. had moved from the Sunbelt to western New England four years ago. She had been living independently far away from her only son and decided to move closer. Don found an apartment that would allow her to bring her dog and she moved into. It was walking distance from stores and church.

Mrs. D seemed to be a resourceful and independent person. When at home, she spent most of her time in her own apartment. When her great-granddaughter came to visit, they usually went down to the activity room of the apartment complex, as Mrs. D.'s apartment was very small and the child was 2 1/2 years old and rambunctious. Mrs. D said she did not socialize with her neighbors very often, although she did occasionally go down to the activity room for coffee and sometimes went out to eat with her neighbors.

Although Mrs. D. now lived near her son Don and her grandson Donny, she had maintained her independence. Up until this illness, she managed all of her
own household tasks. Mrs. D and her family had had a regular schedule of when they visited; for example, Mrs. D had dinner with her grandson and his family every Wednesday night. She was in communication with her son or grandson almost every day.

Mrs. D was quite close to Don, her only child. Don was a teacher and actor with quite a sense of humor. He teased his mother often. During Mrs. D’s hospital stay Don visited at least every other day, ran errands for his mother and took care of the dog. He spoke with Mrs. D on the phone frequently and telephoned the nurse’s station to advocate for his mother and get information. Don’s wife was not as involved in supporting Mrs. D. She was Don’s second wife and she did not seem to be that close to her mother-in-law. She did visit Mrs. D in the hospital occasionally with Don.

Donny, Mrs. D’s grandson, visited as often as his father. They usually tried to stagger their visits so that Mrs. D had company often but not too much at any one time. The grandson was married and had a small child. Mrs. D’s granddaughter-in-law was as attentive as her husband. She visited often and brought the baby to visit her great grandmother. Although Mrs. D had other grandchildren and great grandchildren that she was very fond of, they do not live near her. She did communicate with them by telephone. She also communicated with her sister and a niece.

As Mrs. D was approaching discharge, she was quite apprehensive about going home. Mrs. D said that she felt afraid about going home. She said, “I don’t
know why I feel afraid this time. I've gone home from the hospital before." She said, "But I do. I feel afraid."

Mrs. D said that she could not tell Don and Donny that she was scared to go home. She said, "They're doin' so much, I just can't tell them, stuff like this, I don't want to worry them any more than they're already worried." So, in addition to being afraid of how she would manage at home, she was worried about adding additional burdens to her family.

Mrs. D at Home

When she was discharged from the hospital this time, her family provided more support than they had ever needed to before. Mrs. D.'s granddaughter-in-law began doing her laundry. Until Mrs. D regained some strength, Don handled banking and business chores. When Mrs. D returned from the hospital, her children helped organize her apartment, set up her telephone answering machine message to protect her from unwanted phone calls, and put a sign on the door to limit visitors. In addition, there was a calendar hung in a conspicuous place in the apartment which indicated who would be visiting each day. At the time of our follow-up interview, which was about a month after her discharge, Mrs. D. was continuing to need a lot of support from her family. One of the family members visited daily to make sure Mrs. D. had everything she needed.
Evy: Keeping On Schedule

First Impressions

When I first met Evy she had already been in the hospital for 24 hours on bed rest. Evy was a very social person. She was quite willing to talk with me. Evy was 79 years old. Even though Evy has serious health problems including diabetes and emphysema, this was the first time she had been in the hospital in more than 25 years. She was a heavy-set woman with thick white hair, cut short in a boyish fashion, with bangs down over her forehead. She had rather heavy facial features and wore glasses with heavy bifocals. After many years of having diabetes, Evy was quite pleased that the quality of her vision was as good as it was. As a person with insulin dependent diabetes, Evy was used to a very regimented schedule at home, and was concerned about how variable her schedule was in the hospital.

Evy was wearing a blue hospital gown which, even though tied at the neck, kept falling off her shoulder. She was wearing hospital socks on her feet. Her right leg was swollen from a deep vein thrombosis, elevated on pillows, and wrapped in a heating pad. She had an audible wheeze from emphysema. Evy did have some shortness of breath, but it was not severe enough to inhibit her talking. Evy was sitting up in bed, with the television on. Evy had certain television shows she watched every day at the same time. An intravenous infusion of Heparin, an anti-coagulant, was infusing into Evy’s right arm, and an IV saline well was in her left arm. Periodically the nurse came in to obtain a blood sample from the saline well site.
Evy's Attitude

Evy was concerned about giving up her independence. She had led a very independent life, and did not wish to be a burden on her daughter. For that reason, when Evy first began to have trouble with her leg, she did not mention it to anyone. Her leg began to swell on Saturday, but she did not mention it to anyone until her daughter telephoned her on Monday. This is the story Evy's daughter told me about how Evy entered the health care system.

"I (daughter) called her on the phone on Monday, I don't call every day, only periodically, and said to her, 'So how ya doin'?"

"My mother said, 'Fine, no I'm not fine. To tell you the truth, I'm not doin' very well.' Then the story about her leg being swollen came out.

"I (daughter) said, "Well, did you call the doctor?"

"Evy, 'No, I got laundry in.'

And I says, 'Your laundry can wait. I can do your laundry. You gonna call Dr. Eckles?'

Evy, 'No.'

I said, 'I'll call her.'

Evy, 'Well, why don't you. I can't drive over there myself anyway.'"

Evy's daughter took Evy right to the doctor's office. The doctor looked at her leg and said, 'You need to go to the hospital.' She came over to the emergency room, and they didn't have a bed for her when she got here.
Evy waited downstairs in the emergency room for quite a long time. During the wait for a bed, the admitting clerk took Evy and her daughter into the admitting office to complete the forms that are usually completed after the patient is settled in a room upstairs on a unit.

At about 1:30 PM, Evy's daughter said, "My mother is a diabetic and she hasn't had anything to eat yet so she really needs to eat." The staff gave Evy a credit slip for the cafeteria to have some lunch, and Evy and her daughter went down to the cafeteria. When they returned to the emergency department there was a room ready for her and they got her into bed.

**Evy in the Hospital**

Evy was in the hospital for five days, four nights. She felt that that was quite long enough. At one point she said maybe she'll get out of here some day and she can't wait and she's not coming back. She really began to seem to have a hard time with being in the hospital. Evy's main concern with coming to the hospital was that they fix the health problem—care of the leg so she wouldn't lose her independence, which was a vital concern.

Evy told me that she was concerned about her blood sugar. She had had diabetes for about 15 years, and was very careful with her diet and her insulin. She'd kept a daily record of her blood sugar values until coming to the hospital. While Evy was in the hospital, her blood sugar has been as high as 300. At home, Evy managed her blood sugar in the range of 100 to 140. Evy tried to understand why her blood sugar was fluctuating and was concerned that the diet being
provided for her in the hospital did not contain the right foods. Evy had asked for a consultation with a dietician. Evy’s life at home was very regular and her life in the hospital was not regular at all. At home, Evy followed a very strict diet, eating almost the same thing at the same time every day. In the hospital, her diet was much more varied and her blood sugar fluctuated widely.

When Evy and I conversed about her health and medications, Evy knew her medication regimen precisely—exactly what she was on. She pointed out the punched out star on her hospital identification bracelet. She said that she was no code status. Dr. Eckles had the discussion with her about her being a no code status. She said Dr. Eckles said, “I don’t think anything is going to happen while you are here, but it’s always better to know what that status is than not to have had the discussion.” Evy had great faith in her physician’s skills.

Evy’s biggest problem with being in the hospital was with the hospital routine. Evy lived according to the clock. She maintained a precise schedule that included all of her daily activities. When she came to the hospital, she had to adjust to the hospital schedule.

**Evy’s Family**

Evy said that when her leg started swelling, she wasn’t going to tell anybody about it, until her daughter happened to phone. Evy had one daughter, an only child. She lived in the same town as Evy and was quite supportive. Evy said that when she told her daughter about her leg, the daughter took right over, that the daughter could do things to her and for her. She could take charge and get her
mother the help she needed and that it would be satisfying for her to do something in return for her mother.

Evy's daughter said, "Mom, you've babysat for so many years, now if I can baby sit for you a little bit, that'll be good."

Evy also had four grandchildren, and one pair of twin great grandchildren. The grandchildren are all in their 20's and 30's. Evy also had a younger sister who lived nearby, she walked with a cane and was quite heavy. She was six years younger than Evy, and had a history of heart disease.

Evy told me about a conversation she had had with her sister. Evy said to her sister, "You are the last one. Who's going to bury you?" And the sister looked at her and said, "You're the one that's going to bury me."

Evy had a brother who had had diabetes. Evy felt that her brother had died of complications of diabetes because he did not regulate his life well enough. Evy said, "My brother said to me, 'You don't have to watch your diet. You can eat whatever you want, and then a week or two before you go to the doctor, then you eat right'.”

Evy said, "But he paid for that." He went blind. The diabetes really got him in the end." Evy was very careful with her lifestyle and kept herself in very good control.
Evy at Home

Evy was a very social person. She was happy to talk with me. Evy lived in the same small town for 52 years. Prior to that she was born in and lived in an even smaller town near by.

When I visited her at her home for her follow-up interview, she was feeling well and had almost returned to her pre-hospital vitality. While we spoke, Evy was a little short of breath and used pursed lip breathing quite a bit.

When I arrived at the senior citizen garden apartment complex where Evy lived, she was outside sitting on a bench near the entrance waiting for me. We walked at a regular rate of speed down to her apartment where we conducted the interview.

Evy’s apartment was very orderly and very well-kept, although quite small and had many things in it. The apartment was two small rooms connected by a hallway with a bathroom off to the side. The front door opened onto a courtyard.

On the walls Evy had some oil paintings and embroidered pictures which she had painted. She had made both the ceramic lamp on the table and the patchwork quilt on her bed. Evy has had a very active life.

Evy showed me around her apartment with pride. She was very happy to have me visit. Evy offered to show me around the complex into the day room, which I asked to see, so she took me into the meeting space and showed me the laundry room and the kitchen and said that there is a supper there once a week and coffee hour on Wednesdays.
When I visited Evy, she was wearing slacks and a top with a sweater over it. Evy was wearing a support hose on her right leg only. After two weeks, Evy had nearly returned to her normal activities including going out of the apartment complex and driving the car.
CHAPTER V

THE THEORY: MANAGING PERSONAL INTEGRITY IN THE HOSPITAL

Endangered Personal Integrity

This study was an investigation of the processes five elderly people engaged in immediately prior to, during, and following being in the hospital for a potentially fatal illness. Within the context of Symbolic Interaction, it became clear that the elderly individual was interpreting his or her experiences, engaging in the process of making meaning of those experiences, and constructing and guiding his or her actions based upon the attributed meanings.

The theory that the researcher has derived from this experience is as follows: Elderly individuals survive hospitalization by managing their Personal Integrity. Personal integrity is a dynamic intrinsic quality of individuals composed of three properties: health, dignity, and autonomy. Each property has physical and psychological attributes. There is a positive synergy between the properties of personal integrity in that improvement or decline in one property effects improvement or decline in the others.

In this research, personal integrity was jeopardized both by the initial insult to health and by being in the hospital. Throughout hospitalization, in the face of many insults such as poor health, thwarted dignity, and altered autonomy,
elderly individuals managed their personal integrity by using introspective, interactive, and active strategies to enhance some properties while maintaining others. Their goal was to survive hospitalization. The hospital episode was divided into four pre-hospital stages, three phases of being in the hospital, and three stages following hospitalization. Strategies varied by the stage or phase of hospitalization.

The outcome of successfully managing personal integrity during a serious alteration in health requiring hospitalization was to survive the hospital stay and to return home in a condition that approximated pre-hospital abilities and health (the evolved usual way of being). The consequences of failing to successfully manage personal integrity were increased dependency, diminished dignity and despair, or inability to resolve illness or dying. The elderly individuals were afraid of “not being like I used to be,” dying, or having to live in a nursing home. For example, Bob commented, “I didn’t think I’d be hit like that [with chest pain], makes me reassess my situation. It decreases my hopes for recovery.” (bpo 10/7/97 : 180 – 182). He expressed concern about dying, “I’m mostly concerned about dying before my book comes out. I want to make sure I live to see my book come out” (bifu 11/6/97, 245). Mrs. D. explained her fears about how she might change after being in the hospital.

I hope I’ll be able to be that way [having a good sense of humor] again when I get home. Ya know, in living in this place [a senior citizen’s apartment building] for four years, I’ve seen the change in people. They go off to a hospital and when they come back they’re not the same, and I don’t want to be like that. I wanna be back to normal; I wanna be myself. (dpo 2/24, 64-68)
The nurse who worked with Mrs. D. talked about her perceptions of what it was like for Mrs. D. to be in the hospital.

I think she is scared. I think she is afraid of dying. She asked me if her roommate, in the bed next to her, died. Mrs. D. said "she has been gone for a long time." She says, "You can tell me the truth. Did she die next to me?...I Don't know... She was concerned that she would die. ...But I think she is scared. She is very eager to go home. (dirn1, 6-12)

All of the elderly participants in this research survived hospitalization and returned home. At their follow-up interviews all participants reported that their activity had improved since discharge, but not all had returned to pre-hospital status.

The Concept of Personal Integrity

*Personal Integrity* is a dynamic, intrinsic quality of the self that has properties composed of physical and psychological attributes (Figure 1). In this research an unbearable health problem led to an imbalance in the properties and the elderly individual experiencing the problem initiated action to restore balance. Throughout hospitalization the elderly individual engaged in strategies to maintain and enhance personal integrity.

*Health* is defined in this theory as a property of Personal Integrity which encompasses the individual's experience of the body. Health has both physical and psychological attributes. The attributes of health identified during this research were pain, wellness/illness, energy level (as evidenced by how the

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individual was feeling and energy for physical activity), and sleep patterns and feeling rested.

*Dignity* is the elderly individual’s dynamic sense of worth. A person’s dignity is strong when their behavior, sense of their own value, and other people’s actions conveying their worthiness are in agreement. An individual’s current

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**Figure 1.** The concept of Personal Integrity with properties and attributes.
dignity is based upon an internal definition developed over time through past experience. The attributes are self-dignity and interpersonal dignity.

*Autonomy* has both physical and psychological attributes. It is the elderly person’s freedom and ability to act on his or her own behalf. Autonomy consists of two attributes: independence and control. Independence is the ability to act in a situation. Control is a measure of the elderly person’s perceived power in a given situation.

Each property of personal integrity will be discussed in a separate chapter. Changes in the property and the strategies used by elderly individuals in relation to each property will be presented in relation to phases of hospitalization. Below is an introduction to the categories of strategies.

**Strategies**

Personal integrity was endangered by being in the hospital. In the process of maintaining personal integrity the elderly individual acted as a manager and used strategies to reduce the jeopardy to personal integrity. These strategies are actions deliberately initiated by the elderly individual in the hospital in an attempt to enhance or maintain personal integrity. This is accomplished by enhancing one or more of the properties and attributes of personal integrity while preventing decline in the others. Strategies are not inherently positive or negative, they are context driven and depend on the meaning the elderly individual ascribes to the situation.
Throughout the hospitalization, the elderly person worked to manage the properties of personal integrity (dignity, autonomy, and health). Individuals managed the risks to survival by using strategies to improve the possibility of returning home to their pre-hospital usual way of being. Strategies can be grouped into three types: introspective, interactive, and active (Table 3).

*Introspective strategies* rely on the individual's perceptions of current events in the light of the meaning of past social interactions. Individuals used introspective strategies to reinforce their self-concept and prepare themselves for the rigors of being in the hospital.

While introspective strategies were aimed at making a difference in the elderly person's self-management of personal integrity *interactive strategies* were designed to affect personal integrity through the interactions between the elderly participants and hospital staff, family, and roommates. Hospitalized individuals sought to create meaning out of interactions with other people and to influence the

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<tr>
<th>Introspective Strategies</th>
<th>Interactive Strategies</th>
<th>Active Strategies</th>
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<tr>
<td>Life Reviewing</td>
<td>Managing Information</td>
<td>Maintaining Health</td>
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<td>Magical Thinking</td>
<td>Managing Image</td>
<td>Taking Responsibility</td>
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<td>Worrying</td>
<td>Reciprocating in</td>
<td>Taking Action</td>
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<td>Adjusting Attitude</td>
<td>Relationships</td>
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<td>Relying on Authority</td>
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meaning-making of others. An elderly person's ability to influence the meaning-making of other people stemmed from his or her decisions about how he or she interacts with others. The elderly individual used interactive strategies to purposefully interact with others making decisions about communicating, managing information, and negotiating activities so as to influence the outcomes and enhance personal integrity.

Hospitalized elderly individuals also used active strategies in order to improve the outcome of hospitalization. Decisions about which actions to engage in were derived through the process of making meaning of a situation and then taking action in light of the interpretation. Specific strategies will be discussed with respect to the properties for which they are implemented.

The Model of Hospitalization

Hospitalization is conceived of as a multi-stage process incorporating four stages of pre-hospital activity, three phases of activity in the hospital, and three stages after discharge. In each stage or phase, the elderly individual uses strategies to enhance or maintain personal integrity. The word phases is used to describe the facets of being in the hospital to highlight the non-linear nature of the process of managing personal integrity while in the hospital. The phases of managing personal integrity in the hospital are a dynamic and evolutionary process rather than the linear pre- and post-hospital stages. Table 4 demonstrates the relationships between individual strategies; phase of managing personal integrity; and properties of personal integrity.
Table 4

**Strategies by Phase of Hospitalization and Property of Personal Integrity**

<table>
<thead>
<tr>
<th>Properties of Personal Integrity</th>
<th>Pre-Hospital Stages (Usual way of being, Identifying, Confirming, Transition)</th>
<th>Hospital Phase Stabilizing</th>
<th>Hospital Phase Repairing</th>
<th>Hospital Phase Reintegrating</th>
<th>Post-Hospital Stages (Returning home, Adjusting, Evolved usual way of being)</th>
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<td>Health</td>
<td>Magical Thinking</td>
<td>Magical Thinking</td>
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Prior to the onset of the health problem which led to admission, the individual was functioning at home in his or her usual way of being. The *Usual way of being* is defined as the dynamic physical, social, and psychological
condition that the elderly person is in immediately prior to the health problem that led to admission. In their usual way of being, all elderly participants had health problems that they were managing. While at home, the elderly person developed either a new health problem or an exacerbation of an existing problem. When the alteration in health became unbearable, the elderly person took action.

The four stages of pre-hospital activity were: 1) the usual way of being, 2) identifying the health problem, 3) confirming the health problem, and 4) transition, treating the health problem in the emergency department. The serious nature of the health problem precipitates the need for hospitalization, results in diminished personal integrity, and places the elderly individual in jeopardy of dying.

As the context of managing personal integrity changes from home to hospital, the nature of the management changes. At home, the process proceeds in stages where each stage builds on a previous stage. Once the health problem is confirmed and the person is admitted to the hospital, the phases of managing personal integrity in the hospital begin.

There are three phases of managing personal integrity in the hospital: 1) Stabilizing, 2) Repairing, 3) Reintegrating. During each phase, one of the attributes of personal integrity, health, dignity, or autonomy, was the primary focus for the elderly individual. During the stabilizing phase, health was of primary importance; during the repairing phase, dignity was the primary focus of managing personal integrity; and in the reintegrating phase, autonomy became the focus as the elderly person prepared for discharge. If at any time during the
hospitalization there was a change in the status of one of the attributes of health, dignity, or autonomy, the individual moved to the phase where that attribute was the focus.

After discharge from the hospital, the process continued in three more stages. There was a period of returning home, a period of adjusting, and then the evolved usual way of being. At this point the elderly person had survived the episode of endangered personal integrity. The evolved usual way of being became the current usual way of being until the process began again with a new health problem. Figure 2 illustrates the entire process of hospitalization.

The elderly person’s success in managing the threat to personal integrity is mediated by the people with whom they interact. These people include hospital staff, family members, friends, and hospital roommates. Each of the individuals in these groups understands the experience of the hospitalized elderly person in a unique way. Their actions, based upon their understandings, either enhance or diminish the elderly person’s ability to maintain personal integrity.

**Antecedents To Hospitalization:**  
**Pre-hospital Stages of Managing Personal Integrity**

Prior to being admitted to the hospital, the elderly individual experienced an unbearable health problem. Amy’s story of what happened prior to her admission illustrates the pre-hospital stages of managing personal integrity.
Figure 2: The process of Managing Personal Integrity during an episode of altered health requiring hospitalization.
Amy was in her usual way of being, and had been at a night club until late in the evening. When she came home, she and her sister went to bed. A little while later Amy awoke with epigastric/chest pain which could be an exacerbation of her existing cardiac problems. She then went through a period of identification. She took some medicine for indigestion to rule out causes of pain not related to her heart. When the medicine for indigestion did not relieve the pain, Amy began taking nitroglycerin for chest pain. When the nitroglycerin did not work, her health problem became unbearable; she first sought confirmation from her sister, and then called the ambulance to transport her to the emergency department. From the emergency department, the diagnosis of chest pain was confirmed and Amy was admitted to the hospital (aidc, 8-41).

In four of the five cases, the elderly individual went through a similar process of identifying the problem, seeking confirmation, and then coming to the hospital. In the fifth case, Carl, his daughter acted as his surrogate during the pre-hospital stages. Figure 3 illustrates the pre-hospital stages of managing personal integrity. At every stage, the elderly person might have decided that the alteration in health did not warrant further action and returned to their usual way of being.

**Usual Way of Being**

Prior to hospitalization elderly individuals were in their usual way of being in their usual environment. *Usual way of being* is defined as the conditions
Figure 3. Pre-hospital Stages of Managing Personal Integrity. The bold line indicates the Managing of Personal Integrity. At every stage there is an alternative outcome or opportunity to return to the usual way of being.
of the individual's personal integrity prior to the onset of the current alteration in health. Personal integrity is in balance, health is stable and individuals are autonomous and having their usual degree of dignity. The word 'usual' is used here to indicate that each individual has a unique way of being specific to his or her own abilities and resources. For the theory, 'usual way of being' cannot be made more specific, because each of the elderly participants lived in different circumstances and managed their lives in unique ways. There were similarities among the elderly individual's situations in their usual way of being. All of the elderly participants in the current research lived independently in the community. Amy lived alone in the house she had lived in for 35 years. Mrs. D. and Evy lived in senior citizen apartment complexes. Bob and Carl both lived in their own homes, Bob with his wife and Carl with his daughter. All of the participants led active lives prior to the current health problem. All had chronic health problems which they had been managing for several years.

The onset of the alteration in health that began the chain of events which led to hospitalization varied amongst participants. Unlike Amy's story above, the transition from the usual way of being to an alteration in health was gradual for Mrs. D. Initially she did not identify the symptoms of declining health as requiring intervention from healthcare providers.

Mrs. D. was telling me that she went for a walk two days before she came into the hospital. It was a nice day without any wind. Mrs. D. said she doesn't go outside when there is a wind because she's not strong enough to do that. She took Dotty, the dog, out to
the block where she always walks. Mrs. D and Dotty walked down one side of the block and across the street to the other side of the block. As she was coming back up the block, she said, "I really had a hard time. I really had to sit down. I didn't think I was gonna be able to make it back." Mrs. D. didn't relate her weakness to the fact that she had pneumonia. She said, "I was really tired." She saw that as an overall weakening in her condition.

Mrs. D. said that at home, the last couple nights before she came into the hospital that she was feeling really weak. She felt she was having a hard time getting around and that she needed to watch herself. (eia, 201)

As mentioned above, each elderly participant had a history of chronic health problems. Amy had extremely poor vision and a chronic heart condition, Bob had a history of cardiac problems, Carl had had major vascular surgery within a week of the hospitalization which is the focus of this research, Mrs. D. and Evy both had chronic respiratory problems, and Evy had diabetes. All of the participants were living with these health problems when an acute problem arose.

Identifying an Alteration in Health

In every case, the event precipitating hospitalization was an alteration in health which had the potential to be life-threatening. An alteration in health led to an imbalance in personal integrity by disturbing the individual's usual way of being and altering the dynamics among the properties of personal integrity.

The elderly individuals perceived the alteration in health as having the potential to permanently alter their usual way of being. They feared the illness as life-threatening (as in the case of chest pain) or as having the potential to permanently, significantly decrease their personal integrity by altering one or
more of the properties of personal integrity. Bob spoke about his symptoms this way

   Well, I'm most concerned about the fact that this [the alteration in health] might go on and on and on and on. I begin to think in terms of 'it's better to be dead.' Because, I mean, this is hardly a life. Every time you're worrying you begin to get a pain, you begin to worry about it.... (bia10/7/97. 61-72)

Carl was an exception to the elderly individual's identifying the health problem. In Carl's case his daughter identified his illness and acted on his behalf. Carl's daughter sought confirmation in the second stage (cia, 19-25) as well. The role of family members will be discussed in more depth when the modifiers of the process of managing personal integrity is discussed.

The period of identifying the health problem was characterized by a decrease in physical function and an increase in symptoms of altered health. The duration of this phase varied from minutes to a few days. The elderly person engaged in both introspective and active strategies to improve health. During an initial period, the individual used the introspective strategies of worrying and magical thinking. Evy used magical thinking when she thought that if she just continued her usual routine the health problem would resolve. At the same time, she and all other participants worried that the health problem was serious. This period was followed by taking action. Some individuals self-medicated while others moved directly to seeking confirmation.

   When the symptoms of the alteration in health became unbearable the elderly person sought confirmation of the problem and admission to the hospital.
Once their initial strategies failed, all the participants sought assistance from family and healthcare personal.

**Confirming an Alteration in Health**

When symptoms of an alteration in health persisted, the elderly individuals used interactive and active strategies to confirm their need for professional intervention. They consulted with a family member (strategy of managing information) about the need for medical intervention. The family member confirmed the need to seek medical attention and facilitated the process by making phone calls or providing transportation.

Evy and her daughter negotiated about who was going to contact the physician and then the daughter drove Evy to the physician’s office. Evy’s daughter relates the experience

... when I called on Monday to see how she [Evy] was doing... and said, ‘How ya doin’? How are ya?’

She [Evy] says, ‘Fine... No, I’m not fine.’ (laughed) So then it came out [that she was not well].

And, ya know, that was the progression of... I said, ‘Well, did you call the doctor?’

[Evy said] ‘No, I got laundry in.’

And I says, ‘Your laundry can wait. (laughed) I can do your laundry. You gonna call Dr. Eckles?’

[Evy said] ‘No.’

I said, ‘I’ll call her.’

[Evy said] ‘Well, why don’t you, I can’t drive over there myself anyway.’(eif, 38-47)

Once contact had been made with a healthcare provider, the elderly individual or the family member interacted with the physician in one of three ways: by visiting the doctor’s office, by consulting with the physician by phone,
or by calling the ambulance based on physician-prescribed actions. Bob’s wife explained her role in confirming Bob’s need to seek medical attention:

Oh, I drove him here, when he was at home wondering what to do and being hesitant, I said ‘do you think we should go to the hospital?’ At that point he said, ‘yeah, I think we’d better go’. So I think he needs to have me approving of it. (bif, 42-52)

Amy had been to the hospital by ambulance before. She described her strategy for taking action in coming to the hospital.

...you stick around until you get a good heavy pain and then that’s another story. [Then] I call up the ambulance and they take me into town [to the hospital] (laughed) That’s if it doesn’t go away in 15 minutes. I have that down pat. Every five minutes, take a pill. Until the last one and then scream. And I had said ‘Oh, I can go to the hospital in my neighbor’s car’, and they [physicians] said ‘Never’ don’t go in a car, get the ambulance. OK, so I’ll call the ambulance. (aifu, 390-403)

The physician (healthcare provider) confirmed the need for hospitalization and the elderly person departed for the emergency room. Being sent to the hospital confirmed the severity of the illness for the elderly individual.

Transition to the Hospital.

Each elderly person arrived at the hospital either by ambulance or car. In every case in this research, he or she was accompanied by a family member. In the hospital where this research was conducted, all admissions occurred through the emergency department. The elderly people entered the hospital with their personal integrity diminished by the alteration in health. Immediately upon admission, personal integrity was further compromised by the decontextualization
which occurred. Phase I of being in the hospital began when the elderly person was admitted to a room in the hospital. Up until that moment, the course for an inpatient stay had not been set. At any point during the process described above the elderly individual or the healthcare provider could have decided that hospitalization was not indicated.

Managing Personal Integrity in the Hospital

In the hospital, elderly people engaged in strategies to manage personal integrity. The goal of managing was to enhance their personal integrity, thereby improving their chances for surviving the hospitalization. The risk of ineffective management was to "not be like I was before" (dpo 2/24, 64) or to die (bia, 165; bif, 60; didc, 647-678). The elderly people sought to build or increase their personal integrity through improving their health, maintaining their dignity, and increasing their autonomy.

In the present research, three phases of hospitalization were identified. There are a triad of properties which combine in the core concept of Personal Integrity. In each phase of hospitalization, a different property was the focus of the phase for the elderly person. At every phase, the staff was primarily concerned with the elderly person's health and the elderly person's ability to manage his or her health after returning home. In the stabilizing phase, health is of over-riding concern for both the elderly person and staff. During the repairing phase of being in the hospital, the elderly person focused on dignity, and during the reintegrating phase he or she was primarily concerned with autonomy. In the figure below
(Figure 4), the property which was the focus of the phase for the elderly person is in bold at the top of the figure. In the drawing, the object personal integrity rotates as each property comes into primary focus, thereby having the core concept evolve (in this case to the right of the page), toward discharge in a spiral fashion.

**Figure 4.** Properties of Personal Integrity by phase of hospitalization.

The process of hospitalization does not always proceed smoothly. In some cases elderly people had exacerbations of the health problem that
initiated the hospitalization, in others individuals developed iatrogenic illnesses. Any exacerbation of health problems during hospitalization caused the elderly individual to refocus their attention on their health and use strategies similar to those used during the stabilizing phase of hospitalization. For example, after conclusion of the stabilizing phase, both Amy and Bob had episodes of chest pain. Amy’s actions following the episode of pain demonstrate an example of an elderly participant returning to an earlier phase of hospitalization following an exacerbation of symptoms.

This morning I said to Amy, “You don’t seem to feel so well this morning”.

Amy replied “No, you’re right I don’t feel so well. How do you know?”

I replied, “Well, yesterday you were talking about how you wanted to go home, et cetera. Today you weren’t saying those things. It made me think that maybe today you didn’t think that you were quite ready to go home.”

Amy said “yeah, you’re right”. (ar9/13/97, 17-42)

Likewise, those people who had progressed to the reintegrating phase of hospitalization and had experiences which they felt compromised their dignity used the strategies including keeping a positive attitude, developing reciprocity in relationships with staff, image management and life review, that were effective during the repairing phase to enhance their dignity. Figure 5 demonstrates the possible negative outcomes of the phases of hospital occurring in the hospital.

Iatrogenesis refers to health complications that the elderly person developed while in the hospital as a result of a diagnostic, prophylactic, or...
therapeutic intervention; an error of omission by the hospital staff; or an accidental injury occurring in the hospital setting. While in the hospital, several of the participants developed iatrogenic illness. Amy was in the hospital for four days. During that time she developed allergic reactions to a medication and adhesive tape, strong smelling urine indicating a possible infection, and pain in her hand during an IV administration (ar9/13/97). All of

Figure 5. Negative outcomes of Managing Personal Integrity in the hospital.
these problems were directly related to being in the hospital or the treatment she received.

Mrs. D. also developed several iatrogenic problems while in the hospital. Mrs. D.’s problems were more serious and longer in duration. Early in her admission, to remediate Mrs. D.’s severe dehydration, she was given intravenous fluids. She became over-hydrated and began to experience iatrogenic urinary incontinence. Once the administration of fluids was decreased, the incontinence resolved.

As part of the treatment for her pneumonia, Mrs. D. was administered steroids. These steroids suppressed Mrs. D.’s immune responses and increased her susceptibility to opportunistic viruses such as herpes and diseases such as thrush. By the time she was ready for discharge, many of the problems had resolved, although some, like an eye infection, were not adequately addressed until after discharge.

Exacerbations of illness, whether related to the cause of admission or iatrogenic, had the effect of refocusing the elderly person’s attention on his or her health and moving them back to the stabilizing phase of being in the hospital. The gravity of the health problem determined whether or not the individual could move from the stabilizing phase toward discharge. If the health problems were deemed to be not serious, as in the case of Mrs. D.’s eyes, the person could move
toward discharge. If the nature of the problem was serious as in the cases of Amy and Bob's chest pain, the individual remained focused on the health problem.

Although one property is of primary concern of the elderly person during each phase, the elderly individual uses introspective, interactive, and active strategies to maintain or enhance all properties while in the hospital. Figure 6 demonstrates the relationship between categories of strategies and properties of personal integrity by phase of being in the hospital.

Phase I: The Process of Stabilizing Personal Integrity

The process of stabilizing personal integrity is conceptualized as the elderly person using introspective, interactive, and active strategies to enhance health and maintain dignity and autonomy within the context of the hospital. In the first phase of managing personal integrity in the hospital, the elderly person was relieved to be in the care of experts. Mrs. D. said that being in the hospital was "the best place to be" when she was admitted.

Well, to tell the truth, I didn't feel too good about comin' to the hospital, but I couldn't think of anything [to keep me from coming]. I just want to get here and him [Dr. Daniels] tell me to get back home.

I didn't want to leave [my home], and I didn't think I needed to come to the hospital. And Dr. Daniels thought different. So anyhow, I know that this is the best place [to be], ya know. (dia, 128-135)
Phase 1: Stabilizing Personal Integrity

Phase 2: Repairing Personal Integrity

Phase 3: Re-integrating Personal Integrity

Figure 6. Properties of Personal Integrity and strategies used to increase Personal Integrity by phase of hospitalization.
All participants made comments about the hospital being “a wonderful place”. Carl said:

... So down to the emergency room we come. And after we went through all the procedure down there [emergency department], then I ended up comin' upstairs here--the 4th floor. It's a great place--great place--it is wonderful. It's all the wonderful people that are around. It's great. Yup. (ciu, 24-28)

Amy described the hospital this way

“You know, you need a hospital when you’re sick. It’s the best place in the whole world...” (apo9/12/97, 85-90)

During this phase, the hospital workers are focused on stabilizing the health problem that brought the elderly person to the hospital. The elderly individuals and their families regard the staff as the experts in the situation. The staff respond to the critical nature of the elderly person’s illness. This focus on illness management is reflected in entries into the elderly person’s medical record. The entries were focused on physical and health status.

Admitted to the telemetry unit at 3:25 PM. Admission Note as follows: Yesterday she had no chest pain or shortness of breath. She has crackles in her lungs, she's foxing (Finger oximetry) at 99% on 3 liters (of oxygen via nasal cannula). (amr)

Elderly individuals are also focused on their health during this phase. The first phase begins when the individuals place themselves in the hands of the healthcare professionals. This is accomplished by an active strategy to improve health, “taking action”. Although the individuals have concerns about their health and about entering the hospital as a strange and somewhat scary place,
they are relieved to be in the hand of experts. They engage in the interactive strategy "relying on authority". The hospital feels like a safe haven, now that they are in the hospital they will be better.

When the elderly people entered the hospital, they were afraid because each had an illness that was potentially life threatening. "Magical thinking" was a strategy that individuals used to reassure themselves about their ability to survive hospitalization. For example, Bob was sure that his chest pain would resolve upon admission to the hospital.

The elderly people's perception of the hospital was 'it is the place where the experts can take care of me, where they can find out what is wrong, where I'll be OK'. It seemed like a safe, supportive place. Initially it was nice to have people bring them their meals and wait on them and be concerned about them. Amy explained the hospital this way, "This is a great place [the hospital], they take care of you, they serve you three meals a day, life is wonderful, life is wonderful..." (ar 11/29/97, 10-15).

Evidence of a successful outcome of the stabilizing phase of hospitalization is the elderly individual moving into the repairing phase of hospitalization. The elderly individual feels as if the right decisions were made, the person really did need to be in the hospital, and that the healthcare team could resolve the health problem. In each case, the elderly individual thought the hospital stay would be short, health would improve, and a return home would follow. In his admission interview Bob told me he would be in the hospital for just one night. He stayed two. "I don't know, well, first thing tomorrow morning
I'm going to have a nuclear stress test, I expect to be released in the afternoon. And, ah.. then come back again for other tests” (bia 10/7/97, 39-46). During her admission interview, Amy said,

Well, ... I'd like to go home, quickly, instead of staying in the hospital...

Well really it's [being in the hospital] just for observation,... Well, that's all they can do, they can't open up your chest again, at least I hope not. (aia, 79-99)

Carl, during his discharge interview, explained how he felt about being in the hospital for more than one night said,

Well there was no great problem yesterday when I wanted to leave, I said 'No, I want to go home' get in my own bed to sleep and everything.

And my daughter said, 'No, Dad you better stay. You're going to stay one more day.' So there I was until today.

I was a little upset 'cause I wanted to get out of there. It's a good place and they do a lot of good things but I still wanted out.(cid, 174-214)

Mrs. D. realized that she needed to be in the hospital for her health, but felt some urgency over leaving her dog home alone.

... But that's why I wanna, I gotta go home.... No. I'm not happy; I'd rather go home and see my dog. I just have my faith in my doctor. Ya know, and this is... this is gonna help me. And (uhhh) I want to go home, of course, but I think he's gonna find out what I got wrong with me....Yah, but I'm gonna go home fairly soon. So I'm lookin' forward to that doctor walking in here. (dia,17-31, 174-214, 472-486)

In each case the first stage came to a close at the point where the individual found that he or she would have to be in the hospital for longer than they expected. On the second day of Bob's hospitalization, as he entered the
reparative phase, Bob said, "Yeah, I knew when I woke up this morning that I wasn't going home today. I anticipate leaving the hospital pain free, and ahh, the last time I did this [was in the hospital for chest pain] I went home and I was back a couple of days later, I still had pain." (bpo 10/8/97, 163-168)

As elderly individuals' health became more stable, the elderly individuals began to notice the effect that being in the hospital had on other aspects of their personal integrity. As the acute illness began to repair, they focused their returning energies on maintaining and building their personal integrity by enhancing their dignity. This change in the elderly individuals' focus signaled the beginning of the second phase of hospitalization.

**Phase II: The Process of Repairing Personal Integrity**

The process of repairing personal integrity is conceptualized as the middle period of hospitalization where the elderly person used introspective, interactive, and active strategies to enhance dignity, maintain autonomy, and continue to restore health within the context of the hospital. During the second phase of hospitalization, the health problem had been stabilized and the emergency was resolving. Hospitalization was still required while the elderly individual's body repaired and responded to health care. The staff continued to be focused on the health problems of the patient, but the elderly individuals began to expand their focus beyond the acute health problem. The phrase that summarized the elderly person's feelings about being in this phase of hospitalization is "I might as well stay". 

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Mrs. D. said there were three doctors who visited her today. Mrs. D. said she did not ask about when she could go home, she asked yesterday and the doctor said several days. Mrs. D. said to me, "You know, there's really no reason I can't stay here, so I might as well just be here and not bug them." (dpo 2/6, etc. 162)

The feelings of relief described in the stabilizing phase are soon replaced by annoyance or resignation at having to live by the hospital rules. Elderly individuals longed to do things their own way. One day when I visited Mrs. D. on the skilled unit she was particularly frustrated by her schedule of activities. When I came in she said,

I'm not gonna fight em' anymore.... I'm gonna go down there [to the dining room]. I'll stay out of bed if they want; I'll just do whatever they want. I'm just gonna let them do what they want with me... If they want me to be up, I'll be up. I'll do whatever they want. (dpo 2/15/98, 87-90, dpo 2/17, 4)

The elderly individual began to realize that although their health may not be better yet, it had begun to improve. The elderly individual had become familiar with the routine of the hospital, perhaps a little resigned to being there and a bit weary of the changes required by being away from home. When at home, Evy kept a very rigid schedule. She was frustrated by the hospital schedule or lack thereof...

...it still does my diabetes good to stay right on the strict schedule with meals, go-to-bed time, get-up time.

I get up at 5:30. First I go to the bathroom. If I have to take a blood test, it's done then. By the meantime, my coffee's ready. I have a cup of coffee. Then I go get showered, dressed, washed up and everything. Coffee wake me up to get... Then I have breakfast. [By now, it's] Quarter after six, 6:30 (laughed).

Then I have lunch at 11. My dinner is usually 4, 4:30. Then I go to bed at 9. It's an early day, but it's... And I find that by
getting my meals every day at the same time and things, I have no problems with sugar.

[Here in the hospital it's] 8:30 for breakfast. What was it? 12:30 for lunch. And what was it, 5:30 for supper? It was quarter after 5 last night. But it's uh... But, I've always had a bedtime snack, which I didn't get here... (laughed)

There doesn't seem to be a bed time here. I go to bed— I try to— say 10 o'clock. [the staff is] Hopin' they'll get everything done before the night crew comes on. And then what happens? What is it 12:30 or 1 o'clock they come in for temps?

They were comin' in for a blood test, what time? I almost think it was 3 o'clock in the morning... Had to be done on each shift. (eidec, 81-115)

The elderly individuals again engaged in strategies to build personal integrity. The dynamics of the repairing phase of hospitalization are less complicated than during the stabilizing phase; elderly individuals focused on improving their dignity so as to restore balance to their personal integrity and survive being in the hospital. Prevalent strategies during this phase included introspective and interactive strategies such as life reviewing, adjusting attitude, reciprocating in relationships, and managing image.

The elderly individuals engaged in life reviewing to remind themselves of their value as a person in other settings. Life reviewing is a strategy in which elderly persons reminisce on times in their lives where they felt that they had stronger dignity. The outcome of using life review is to enhance the elderly individuals' current dignity by improving his or her self-concept.

For example, Mrs. D. told me a story about experiences she had when she was a gray lady on a medical/psychiatric hospital during World War II. It was a time when she was making a contribution to society and gained experience in a role similar to that of the healthcare providers that she worked with now (dpo 2/6,
etc. 72). By telling me that story she reminded herself and me of her value as a person. This particular story had the benefit of reminding Mrs. D. that she had experience like the health care providers thereby equalizing the relationship in Mrs. D.'s mind and justifying her feelings of being disrespected by the staff.

Mrs. D. engaged in adjusting attitude when she was moved from the acute care part of the hospital to the skilled nursing facility within the hospital. The outcome of attitude adjusting was to change the meaning of the current situation to make it more tolerable. Initially when Mrs. D. was moved, she was very unhappy about her room. Given a day or two to adjust, she changed her attitude from negative to positive.

[In the beginning, I liked my room upstairs better than this one]
Not now; I have gotten used to this one, and I like the fact that there's that little shelf over there for my tissues and those things. There's the radiator under the window that provides an excellent place to put stuff. (dpo 2/24, 42)

During the second phase, the hospitalized elderly people sought ways to establish reciprocity in relationships with staff. Bob made a point of complimenting a nurses' aide about her uniform (bpo 10/8/97, 183 - 192). This was an attempt on Bob's part to give something to the staff person, to equalize the relationship between them. The goal of equalizing the relationship was to improve the status of the elderly person in the eyes of the staff thereby improving the treatment the elderly person received.

The hospitalized elderly people managed their image during the second phase of hospitalization by "not bothering the nurses" and "being polite". Amy
and Bob made a point of trying not to summon the nurses too often (brl 10/7/97, 64-69). Mrs. D. did not ask the medical resident when she might be discharged because she thought it would “bug” him (dpo 2/6, etc. 162). Evy didn’t complain about her roommate being up all night (efi, 227-240). Mrs. D. also made a point to be polite to the researcher and staff members (dpo 2/6/99, 167). The goal of managing image was to act in ways that the staff would like thereby improving the likelihood that the staff would provide good care for the elderly person.

Successful outcome of this phase of being in the hospital was transition to the re-integrating phase. At the close of the repairing phase, the elderly people had concerns about self and their ability to be autonomous and negative feelings about being in the hospital. During the second phase, they tried to justify the need to stay in the hospital, and initiated the strategies described above to marshal their resources against diminishing personal integrity.

**Phase III: The Process of Reintegrating Personal Integrity**

The reintegrating phase of managing personal integrity is conceptualized as the final phase of hospitalization where the elderly individual used introspective and active strategies to improve autonomy, introspective strategies to increase dignity, and introspective and interactive strategies to improve health in preparation for discharge from the hospital. The focus of this phase is autonomy. The elderly individuals were engaged in learning how to use active strategies to maintain their personal integrity after discharge. The elderly individuals were tired of being away from home in the hospital, worried about
their health, worried about what it will be like when they were discharged, and anxious to return to their own environment. The phrase that expresses the elderly person’s feelings about this phase is “time to go home” (bid).

During the reintegrating phase, both the staff and the elderly person were focused on preparation for discharge. Mrs. D.’s comment below demonstrates that although the goal for both parties is discharge, there may not be agreement about when that goal may be met.

When the doctor came to visit Mrs. D. yesterday he said, “So when do you want to go home?”

Mrs. D. replied, “How about Sunday?!”
The physician said, “How about Tuesday?!”
Mrs. D. laughed and said, “I’m making all the decisions as long as they’re what he wants”. (dpo 2/28, 42)

The staff during this phase was focused on preparing the elderly person for discharge. They were engaged in medication teaching and arranging follow-up services. The nurse working with Bob explained her concerns about Bob at discharge.

My concern about Bob is that, he’s on a lot of medications. When I tried to go over his list of medications he put me off saying ‘I’ve been on all of those for a long time, I know them all ready, just tell me about my two new medications’

And I’m afraid that he doesn’t, he may know when he’s supposed to take them, but I don’t know because I didn’t talk to him that much, or he wouldn’t let me talk to him, whether he knew what the real reasonings for all his medicines were. Especially with adding two new ones.

We seem always to be doing that to these elderly patients. They come, we put them on new medicines, we send them home without telling them about the old ones. (bim, 35-45)

Although the staff and the elderly people have synchronous goals, the way that the staff and patients met those goals may not have been synchronous.
Several participants had very strong negative things to say about being in the hospital. The quote below is a marked change from Amy’s earlier feelings:

“I hate it. I really do. I don’t appreciate being in the hospital. As I said before, if you’re gonna die, you’re gonna die. If you’re not, damn it. I hate these little attacks. (chuckled) And so that’s what I think.

The hospital’s nice, nice that you have the doctor come in every day, nice that you have the nurses, nice that you get fed three meals a day. (sing song) I don’t want three meals a day! If you know what I mean, they have so much. (aifu, 75-83)

The elderly participants anticipated no longer having to endure the hospital routine and saw it as a barrier to independence and strong personal integrity. Although the elderly individuals were ready to separate from the protective environment, they were anxious that they were not well enough to be discharged. The elderly people made many statements about how difficult it was to be in the hospital. Perhaps this behavior made it easy to separate from what was previously seen as a protective environment. Carl described the hospital on the day of his discharge:

“Well, I felt, to me it was a very dreary place. Even though there were so many pleasant ladies and doctors around. The building as far as being in the building was concerned, to me it was very dreary. It seemed that way. Because if you had pictures on the walls and everything it would have been nicer. And that’s somethin’ to think about and like that. (cid, 25-30)

Carl’s desire to be home was so strong that he perceived the hospital was a dreary place. He did not notice that the walls were painted a cheery color and there were prints mounted on the walls.
Although the elderly individuals were eager to be discharged, some were concerned about their ability to function at home. The elderly people used the strategies of taking action and worrying to enhance their autonomy during this final phase of being in the hospital. The quote below demonstrates Mrs. D.'s taking action and worrying to gain control over her discharge. Mrs. D. was orchestrating her situation so as to not have to leave the hospital until she felt ready. The registered nurse working with Mrs. D. on the skilled nursing unit told me the following:

Umm, well she said to me last week, 'You're not gonna send me home, you're not gonna make me go home. You're gonna make sure I'm well.'

I said, 'No. We won't make you go home until you're well.'

And then today she said, 'You believe me don't you? You believe that I'm really sick. You believe that I'm not faking, and I think sometimes they believe I'm faking.' It seems... She is very needy. She seems very needy. She seems to need you there. She seems to need a lot of reassurance.

And she has had a hard time. So I just think she's just afraid to go home and have it start all over again... It's my understanding that she's been hospitalized quite a bit in the past couple of years, and uhh she's quite happy in this setting. (dim2, 12-20)

For these participants, the family also organized for discharge. They planned transportation home for the elderly person, planned who would stay with the person or whose home the elderly person might go to after discharge, planned for health-care services at home. The families arranged to be available to facilitate discharge. Carl's son talked about his ideas about Carl's needs at discharge and immediately following.
Well, on the day that he comes home from the hospital, there's got to be somebody there if he’s going to go home. Well just gettin' out of the hospital—No, I don't wanna take that chance.

The day after, ya know... Once he's there for a day, that's one thing. Well, like I said, maybe tomorrow or the day after will be fine. The next day, ya know, as long as we're checking on him, ya know, I'll give him or call or stop in or somethin' to make sure that everything is all right. (cfi, 50, 80-103)

Successful consequences of this phase of being in the hospital were being discharged to the elderly persons' previous living situation, negative feelings about being in the hospital, and predominately positive feelings about being discharged with some worry about returning home. The feelings about being in the hospital had been quite positive on admission but had now become negative.

Mrs. D. said,

"Well, I can't begin to tell you how terrible it's been. Ohhhh, ohh. Like that... I guess the first day I just kept gettin' worse. And I couldn't even tell like when I wet myself and all that kind of stuff. It was... Well, I mean I was always wettin' myself I was a mess. Nobody seemed to be helpin' me. (didec, 15-27)

Mrs. D. expressed concerns about being discharged that the other elderly participant did not share. Mrs. D. said that she felt afraid about going home. "I don't know why I feel afraid this time. I've gone home from the hospital before. But I do. I feel afraid." (dposnf, 52)

Successful outcome of the reintegrating phase of managing personal integrity is discharge home. The elderly individuals were eager to leave the hospital although somewhat worried about how they would be once they had returned home.
Post-hospital Stages of Managing Personal Integrity

All of the participants in this research returned home to their former living situations. Some participants resumed their pre-hospital life style, some needed more support from family and the healthcare system, and some enhanced their health maintenance activities and needed fewer supports than prior to this episode of hospitalization. During the post-hospital stages the elderly individuals engaged in the active strategies of taking responsibility and maintaining health. The goals of these strategies were to facilitate improving health and autonomy after they were discharged.

Figure 7 illustrates the post-hospital stages of managing personal integrity. The bold arrows indicate the path of the desired outcome of Managing Personal Integrity, but at any point along the path an alternative, less desirable outcomes are possible.

Returning Home

The day of discharge was a hallmark day. From the perspective of managing personal integrity, discharge from the hospital provided a change of context from hospital to home. The elderly participants were no longer bound by the hospital routine. Their health had been stable in the hospital while the hospital staff was acting to maintain the individual’s health, but now that they were home they had to take responsibility for maintaining health with less assistance. Active strategies were used by the elderly individuals to maintain their health and obtain supplies for being at home.
All patients were ready to leave the hospital substantially in advance of when their transportation arrived to take them home. The elderly people were uniformly anxious about getting home and getting settled. There were prescriptions to be filled and home care services to be organized. Mrs. D. spoke about leaving the hospital:

Well, I'm scared for one thing. Guess I'm scared 'cause one says I don't need oxygen and the other guy says I need oxygen. And that kind of worries ya...
Well, I can't say that I'm not worried about bein' alone for awhile.... I'm afraid about the first night. I'm afraid that I'm not gonna be like I was before. (didc, 132-165)

Amy was the participant who took her discharge plans most casually. Although Amy was ready to leave the hospital early on the appointed day, she was not concerned about transportation home. She told me:

Yeah, well my girlfriend called and that settled that [needing transportation home from the hospital] immediately. If it wasn't her it would have been another girlfriend that would, you know, had called me and said 'if you need a ride, I'm out of work early, just give me a call.' So I didn't have too much concern over that. (aidc, 99-105)

Very soon, the hustle and bustle surrounding discharge settled down and the elderly individuals began the process of getting their lives back in order. Once the elderly person was home a new routine had to be established. He or she was not the same person who had entered the hospital, he or she had evolved and had different needs and abilities.

Adjusting to Being at Home

After the elderly person returned home he or she went through a process of adjusting to his or her new way of being. At his follow-up interview, Bob spoke about getting back to normal. “I'm just trying to get back to normal, that's the best I can say…” (bifu 11/6/97, 96-104).

The elderly people no longer felt decontextualized by being in the hospital, but they experienced a different decontextualization. They were home, but most participants were not able to step back into their old lives. They needed new ways
of doing things. Several had new medications, needed more rest than previously, required treatment that the had not needed previously.

By the time the follow-up interview happened, the individual had regained a strong sense of personal integrity and was no longer threatened by the decontextualization that occurred in the hospital and were beginning to feel like themselves at home.

I don’t know, I don’t think too much of the hospital stay, except I did take those tests which I hated... And ah, the hospital, well, it’s a good hospital, the nurses are marvelous and decent.... [It was a good place] to be ‘waited upon and served’... (smile in his voice) (bifu, 96-108)

Part of adjusting to being home was finding meaning in the experience of being in the hospital. This was accomplished in part through remembering and thinking about being in the hospital. Evy’s daughter told me that her mother hadn’t said too much about being in the hospital yet, but probably would after she had been home for a while.

I'm thinking when I get her home, she'll probably talk to me more about what it was like [being in the hospital] than actually being here. I think she might, ya know, sit and think about the days that she had up here and the good days and the bad days... and the good things and the bad things...(efi. 412-430)

The stages of returning home and adjusting were very stressful for all participants. Evy explained that the first week she was home she didn’t feel like herself, but by two weeks she was back to normal.

The first week [I was home] was kind a--I wasn't with it. Let's just say, I mean uh, my foot was still up [swollen]. I still had to set right. I set in there with that thing up, ya know all the... And I didn't have any ambition to do anything. I don't know why.
Yah, it was just sort of—I don't know what you call it. I could sit here and do nothin', which is unusual for me. It took about... I'll tell you what was uh umm—what was it, just last Wednesday afternoon?—I sat here, and all of a sudden, I felt wonderful. [Then I felt like I was back to normal] (eifu, 5-20)

By the time the elderly individuals were interviewed for their follow-up interviews, between two and four weeks after discharge, all participants said they were getting back to normal. Their health had continued to improve; restored to their own surroundings their dignity was enhanced; and having to rely on themselves more than when they were in the hospital improved their autonomy.

**Evolved Usual Way of Being**

The evolved usual way of being was the post-hospital condition of the person. The individuals did not return to the pre-hospital usual way of being, but to an evolved way of being. The evolved usual way of being was different than the pre-hospital usual way of being because the individual had been changed by meanings he or she had derived from the experience of being in the hospital. The person's personal integrity, the balance between health, dignity, and autonomy, had been disrupted by the process of hospitalization and a new balance had been achieved. By the time the follow-up interview was conducted all of the participants had gotten organized at home and were approaching their evolved usual way of being.

The acute alteration in health that precipitated the hospitalization had resolved and the individual was again managing chronic health problems. The
evolved health problems required new treatments to be administered by the elderly person. For example, prior to being hospitalized Mrs. D. had not needed supplemental oxygen. At her follow-up interview she told me she was getting used to being on oxygen at home. She had even left the house with the portable oxygen once or twice.

The elderly persons gained dignity by being in their own surroundings and their own clothing. They were again able to rely on their status in the community to help maintain dignity. The quote from Mrs. D. below indicates the importance of being in her own home.

In order to support Mrs. D.'s autonomy, her family had developed a schedule of visits and the neighbors were visiting but not tiring Mrs. D. out as they did when she first came home. Mrs. D. told me what it was like for her to be at home in her evolved usual way of being.

It's good to be home. The bed felt real good. (laughed) Oh yah, life has changed. Now I feel like somebody's lookin' over my shoulder all the time, ya know.

The oxygen is new. It's gettin' so that I... When I eat, I notice that I need the oxygen. They tell you about oxygen: Eat slow because when you chew fast, you don't get your breath at the same time. And then you get kinda... (She breathes loudly.) And then when I put the oxygen on, I can feel a big difference, and when I don't, I don't get so short of breath. I've got that [oxygen] in the other room, too. Uh but I can't tell ya... It's just good to be home, that's all.

There was a little bit of time there in the hospital where I thought I might not be able to come home... but, unless I have somethin' ... like dyin' of cancer where I needed somebody to... Well, with Hospice and that, there's no reason I can't stay in my own apartment. If I got that, I'd just sit inside and die. If Hospice comes in and takes care of ya, then there's no reason why I can't stay in my apartment. I don't have to go to a nursing home. (difu, 1020-1074)
At this point, after the elderly individual has been home from the hospital two to four weeks, their personal integrity has stabilized at an evolved level. This is not the same condition in which the elderly person's personal integrity was prior to the hospitalization, but is an evolved condition, a new level of dynamic balance between the properties. The meanings derived from the experience of being ill and being hospitalized have been incorporated into the elderly individual’s repertoire of experiences, and all future experiences which effect personal integrity will be interpreted based in part on the meanings derived from this experience. This new state developed as a result of the insults incurred to health, dignity, and autonomy, and the strategies implemented by the elderly individual to enhance the properties while hospitalized. The evolved usual way of being becomes the new baseline, and the person develops new ways of living. If a subsequent hospitalization occurs, the entire process begins again.

The Meaning of Hospitalization for Elderly People

There is both safety and danger in being admitted to the hospital. The safety arises from the action of placing oneself in the hands of the experts. The danger comes from being decontextualized, isolated from one's life-world, and placed in a situation where one voluntarily sacrifices autonomy and dignity in order to increase health. To put oneself in the hospital means acting to surrender
one's self into the hands of experts to improve health. Bob's wife described how

Bob felt being in the hospital

I think it’s [being in the hospital] very disappointing and stressful, at the same time it’s very comforting because he feels taken care of and if there’s a life-threatening problem, he believes this is the best place to be. (bif 10/9/97, 6-10)

In some cases, being admitted to the hospital represented failure of the elderly person to maintain adequate health Bob explained his feelings about the events which led to hospitalization this way:

I must say I’ve been in despair all day. About being in the hospital again. It’s a, (pause) I don’t know what to call it. It’s a plague. This time I’m pretty damn sad about it most of the time I go in with the idea, ‘well, they’ll take care of me, I’ll get, feel better, I’ll go home, I’ll be better, I won’t have a, it won’t be a problem, be troubled anymore for a while.’

I’m in despair that here I am again. I mean I thought I was doing pretty well, and ah... and to find now there are more problems, is despairing. When you get to be 82, 83 years old you know, you want a little peace. And there seems to be no peace................ (bia 10/7/99, 146-164)

A note from a researcher’s log summarizes the meaning of hospitalization for the elderly people in this research.

The experience of hospitalization seems like a time out of people’s lives. Amy was in and out of the hospital often. She had been in and out of several hospitals. So for Amy, being in the hospital was sort of part of living. Sometimes she was in the hospital and sometimes she was not in the hospital, and her life, although adjusted depending on where she was living at the time, it was seamless in the sense that she saw being in the hospital, I think, as part of living-it's just part of living.

Bob, Mrs. D., and Evy all took time out of their lives to be in the hospital. Bob decided he needed to check himself into the hospital for testing because his chest pain was interfering with his life. He came in and he was anxious to be gone back to his life.
Evy took time out of everything because she needed to go on bed rest. She put it off as long as possible, but then she needed to leave her home and independence. Mrs. D. also put off going to the hospital. Mrs. D. and Evy put off admitting they were sick until they were both really ill.

Carl saw being in the hospital as being away, but in Carl's circumstance, he had really delegated all of his health care behaviors to his children, particularly his daughter. So being in the hospital was, I think, an extension of doing what his daughter told him to do. But he definitely felt that he wanted to get back to his house and get back to normal. (dpo-pd/c, 20)

The Hospital: Context Of Managing Personal Integrity

The elderly individuals in this research managed personal integrity within the context of the hospital. A hospital is a residential institution in which a particular set of conditions exist (context), within which interaction occurs between the people who are either in the role of "living-in" the institution or in the role of workers at the institution. Examples of residential institutions are prisons, boarding schools, and residential camps such as elder hostel. In each case in these settings it is the role of the workers to be responsible for the people who "live-in". People who "live in" are dependent on the workers for services and expertise. In this research, the people who are living-in are the elderly individuals. The workers in this research are the health care workers. The workers are responsible for maintaining the integrity of the institution and carrying out activities in order to meet the goals of admission of those that live-in.

The attributes of the hospital as the context for managing personal integrity will be discussed below.
Attributes of Hospitals

The purpose of hospitals is to provide expert healthcare for individuals who require 24 hour management of their health problems. The goal of admission is to stabilize the person’s health and discharge them to a safe setting in a timely manner. Bob described his confidence in the hospital and hospital workers’ ability to provide expert healthcare.

Well I looked to the hospital, I'm not adverse to coming here when I think it’s necessary. It's a place where one comes when to be helped, and so far, I've had good luck.

And ah so, a lot of people say 'oh, going to the hospital, that's dreadful'. I don't find going to the hospital dreadful. I mean ah, ... as soon as you are there, you feel as if you are in competent hands. The nurses are, you find them very competent and you feel relieved, you feel, you know, that you will be helped. And you feel comfortable.

And I've always felt that way about this hospital. And I've been here so much, I can't count them anymore, and each time I've been treated so well, and I feel so comfortable, that I don't look upon it as a problem....

And certainly the way I've been treated in recent years, I mean, for years and years there was nothing wrong. And then all of a sudden, I started being hit with these different things. But ah, well maybe because I have that attitude I recovered quicker. It's possible. I probably, I mean ah, I always manage to recover pretty quickly. And ah, that's the way I feel about it. (bifu, 255-282)

Reason for Admission, Source of Initial Contact and Referral, and Voluntariness of Admission

In hospitals, admission is driven by the need of those that desire to live-in (the elderly individuals) for the services offered by the workers of the institution. As hospitals are a moderately restrictive residential institution, the reasons for admission are narrowly defined. The person who desires to live-in initiates the
contact by approaching the workers of the institution for admission. It may be at
their own discretion or through a referral for the unique services offered by the
workers of a particular institution. For example, Amy, Bob, and Carl initiated
services by coming to the emergency department. Mrs. D. and Evy went to the
physician’s office who referred them to the hospital. The referral for admission
always comes from a person whose skills are similar to the institutional workers.
As the institution increases in restrictiveness, the authority of the referral source
increases. In the case of Mrs. D. below, the physician made the referral to the
hospital. In some cases it is the physician in the emergency department who
orders the patient to be admitted.

In the hospital, the admission process is semi-voluntary. The initial health
problem experienced by the elderly individual led them to contact the institution
or healthcare worker for services. It was then determined by the healthcare worker
that the elderly individual should be admitted, and the elderly person submitted to
be hospitalized. Mrs. D. described what happened when she went to the
physician’s office prior to her admission.

He [physician] said I’m gonna take you, send you to the hospital. Well, I gave some arguments, ya know.... So he didn't
pay much attention to me, went out in the hall and talked to my Dan. And he came back and said, "Alright, have you decided?" I
said, "What?—Decided what?" "That you will go to the hospital." I said, "I knew that before you went out." (laughed)(dia, 4-35)

Mrs. D. voluntarily gave up her autonomy to rely on the authority of the
physician.
Restrictiveness, Access by Visitors, Control by Workers, Directedness, Structure/Schedule

The hospital is a moderately restrictive setting. In residential institutions, the workers have control over the live-ins. The hospital staff directs the activities of those people living there. Their direction includes implementing health practices such as medications and treatments, hours for sleeping, activity level, and access by other people.

In the hospital, there is an expectation of "usual behavior" of the people who are "living in" and negative consequences for people who do not conform to the usual behavior. The usual behavior arises from the meaning making of many people over time. There is flexibility in the usual behavior to allow for variations in behavior among people, but there is an expected range of behaviors. Those people who live-in in residential institutions behave in the usual ways based upon their earlier contact with the institution. Bob felt his refusal of a test was outside of the normally accepted behavior, but that the hospital had placed an unreasonable expectation on him. By refusing, he was exercising his autonomy and had increased his personal integrity by increasing his control over the situation. At the same time, he had decreased the amount of inter-personal dignity he could anticipate receiving by behaving outside the norm. The increase in autonomy outweighed the anticipated decrease in dignity led to action.

I hate to displease Betty down, down in that room (x-ray) because she’s so darn nice. And I know it’s supposed to be for my good, but like, I felt in that particular situation that they just wanted to finish a job. And that the patient there really didn’t matter…………..Ah……….
...You know, it upset me. And I just wasn't compelled to lay under that darn thing for 22 minutes. So you know I would say they really should not do that. They should have let me know 'you have to go down for this test' and prepare me for it. I wasn't prepared at all. (bidc, 68-79)

I felt terrible about that because I felt I was insulting the technicians. The fact is I did go back a week later to beg their pardon... (bifu, 135)

Visitors are somewhat restricted in the hospital. The more ill the patient is, the more restricted is access. In intensive care units, visits are typically restricted to family for five minutes out of every hour. On regular units in the hospital, visiting is usually restricted to the hours between 10AM and 8PM. Part of the process of decontextualization for the live-ins is to have access to visitors restricted.

As discussed above, the elderly person in the hospital has little control over their schedule in the hospital. A hallmark of the residential institution is structure and schedule. The structure exists both for live-ins and workers, but is designed to control the behaviors of the live-ins and facilitate the functions of the workers. The following excerpt is from a participant observation log from an early morning visit.

It is 6:15 AM over the last 15 minutes it has begun to get a little noisier. One of the day nurses has already arrived. There was just a conversation between two nurses directly outside Bob's room. The conversation was about IV tubing. The level of overall noise is beginning to increase.

6:30 AM a nurse entered Bob's room and turned on the light over the roommate's bed. the nurse prepared to hang an IV for the roommate, in preparation for the client to have a cardiac catherization. The nurse and the roommate were chatting, the nurse was saying that she had never seen a cardiac catherization and that she would like to go see one at some point. (bpo 10/9/97, 27-43)

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Bob said grumpily at one point, “What do they do out there, out in the hall?”
I said, “Well, there is sort of a desk out there.”
Bob said, “Who gathers there? Nurses, doctors?”
I said “all of the above”
Bob said “Boy, they make a lot of noise. Well, it wasn’t nearly as noisy last night as it was the night before.” (bpo 10/9/97, 64-73)

Another example of the hospital schedule being for the convenience of the workers is cited below.

Amy’s roommate has become increasingly agitated. She is putting the call light on frequently she’s making faces and grimacing, she’s sitting up, she’s lying down.
I suggested she might take a walk in the hall. She said “NO, I don’t want to do that, I’m waiting for someone.”
A few minutes later she put on the call light and asked the nurses aide if she could go for a walk in the hall. The nurses aide said “It’s ten minutes to three, you’ll need to wait a few minutes until the next shift comes on” (apo 9/14/97, 99-114)

Privacy

Privacy has been discussed as an attribute of dignity. It is also a consideration in residential institutions. The amount of privacy for those people who live-in varies with the restrictiveness of an institution. The more restrictive the environment, the less privacy live-ins have. In the hospital, live-ins have little privacy. The doors of patient rooms are routinely left open, and workers enter the patients’ rooms with little or no announcement of their intentions. Curtains around the beds can be placed so as to provide visual privacy, but there is little actual privacy as any conversation a live-in has can easily be heard by the roommate and any staff who happen to be in the room. During the first evening Bob was in the
hospital, in approximately 35 minutes, seven staff people entered the room for some purpose and left again. Most of the people entered the room to interact with the roommate rather than Bob, but had to pass by the foot of Bob's bed to get to the roommate's bed (bpo 10/7/97, 64-66).

Decontextualization

Decontextualization is a hallmark of residential institutions. The more restrictive the setting the more decontectualized the live-ins. For example, nursing homes are typically less restrictive than acute hospitals. In nursing homes it is usual practice for the staff to encourage patients to personalize their surrounding with articles from home; in the hospital patients are frequently encouraged to send their personal belongings home. Most participants in this research wore hospital gowns from the time they changed out of their own clothes in the Emergency department until they got dressed for discharge. The exception to this was Mrs. D. Toward the end of Mrs. D.'s stay in the Skilled Nursing Facility, she began to wear her own clothing in preparation for discharge.

The staff knew little about the elderly individual's life outside the hospital. This contributed to making all hospitalized elderly people "patients" and treated as such. As patients, the elderly people were equalized in their standing and were treated uniformly. This differed from the elderly people's experience outside of the hospital, where their status was based upon their standing in the community.
Achievement of Goals

The primary goal of admission to a hospital is to stabilize the health problem which incited action on the part of the live-in to seek admission to the hospital. Upon achievement of the goals of admission, the person who lives-in leaves the institution. Evaluation of goal achievement is evaluated primarily by the workers. Discharge is usually determined by the workers or collaboratively. For elderly people in the hospital, a combination of people are involved in the decision making. As demonstrated by the participant observation note below, the responsibility rests heavily with the healthcare workers, mainly the physician. Carl thought he was well enough to leave the hospital on Saturday, meanwhile the physician strongly recommended he stay until Sunday (dpo 2/6/98, 39).

Hospitals provide a fairly restrictive environment which is highly focused on stabilizing and repairing the health of individuals who seek the services of the expert workers at the hospital. As a restrictive institution, the workers have a large amount of control over the activities of those who live-in, people who come to the institution for services. In the current research, the hospital was the context within which the elderly person used strategies to improve their personal integrity and their chances for surviving the hospitalization.

Summary

Personal Integrity is a dynamic, intrinsic quality of the self which has properties composed of physical and psychological attributes. The three properties of personal integrity are: health, dignity, and autonomy. There is a dynamic
balance between properties. Increase in one property of personal integrity can have the effect of compensating for decreases in other properties. Strategies are used by elderly people to maintain a balance in overall personal integrity, attempting to enhance some properties while experiencing uncontrolled alterations in others. Through use of introspective, interactive, and active strategies, elderly individuals manage their personal integrity with the goal of maintaining or enhancing their overall personal integrity and surviving hospitalization. Managing personal integrity in this research is conducted within the context of the hospital, a fairly restrictive residential institution.

The process of managing personal integrity is a dynamic process in which the elderly individual uses strategies to enhance his or her personal integrity in order to improve the chances of surviving hospitalization. The process begins when the elderly individual identifies an alteration in health. From the beginning he or she engages in introspective, interactive, and active strategies to improve personal integrity. Throughout the time that the person is in the hospital, the focus of the strategies changes according to the phase of hospitalization. Early in the hospitalization, during the phase of stabilizing personal integrity the elderly individual is focused on his or her health. During the middle phase of hospitalization, the phase of repairing personal integrity, the individual is focused on dignity. In the last phase of hospitalization, the reintegrating phase, the elderly individual is focused on regaining autonomy.
CHAPTER VI
HEALTH: A PROPERTY OF PERSONAL INTEGRITY

Health is the property of Personal Integrity which encompasses the individual's experience of the body. Health has both physical and psychological attributes. The components of health identified in this research were pain, illness, energy level (as evidenced by how the individual was feeling and energy for physical activity), and sleep patterns and feeling rested. When health is good, personal integrity is enhanced. When health is poor, particularly life-threatening, health thwarts strong personal integrity.

As a consequence of the unbearable health problem that precipitated admission to the hospital, health was poor for all participants during the early part of hospitalization. Individuals were uncomfortable or in pain, felt sick, had low energy, low activity levels, impaired physical function, and were not sleeping well. As the hospitalization continued, health improved, although the course of improvement was not always smooth. Episodes of improvement of health alternated with episodes of exacerbation of symptoms. New health problems sometimes occurred as a result of treatments for the primary problem. The general sequence of events during the hospitalization was that pain diminished first, individuals moved toward improved wellness, activity increased, energy
improved, and they felt better. Alterations in sleep patterns continued throughout
the hospitalization, although the reasons for the alterations changed from internal
causes such as discomfort to external causes such as environmental noise and then
to anticipating discharge.

The elderly individuals actively participated in managing their health by
making meaning out of their condition and their interactions with the staff. They
acted on those meanings by using strategies, such as magical thinking and
worrying, relying on authority, and engaging in health maintenance activities.
These strategies will be discussed in depth below.

Attributes of Health

Pain as an Attribute of Health

The elderly individuals in this study entered the health care system when
they had an alteration in health that became unbearable. For two of the
participants, pain was the critical factor in their admission. Bob described an
exacerbation in his recurrent chest pain as the reason he came to the hospital:

Well, I’ve been having them [chest pains] on and off for a couple
of weeks now. And, ah, I did go to my physician last week and he
thought perhaps it was esophagitis from which I suffer. For a while
it was getting better, then this morning when I woke up it was
painful. It wouldn’t go away after I took nitro a couple of times. So
my wife drove me to the hospital, and here I am... (bia)

Amy described the chest pain she experienced prior to coming to the
hospital this way:
Well, this time I went in because I had such a horrible pain... and I wasn’t sure.. but they had given me instructions in Boston how to do this...So they said you wait 5 minutes, you know, if you have a severe pain. But, I thought it was indigestion so I come out here [to the kitchen] and I took two indigestion pills. I figured ‘Oh well, this ought to straighten me out.’ And I went back to bed.

I get back into bed and, the pain was ferocious....and this pain was like a ball in the middle of my chest, hard. (aidc)

For other elderly participants, pain was not a major factor during the initial stages of managing personal integrity, but developed while the elderly person was in the hospital as a result of iatrogenic illness. Mrs. D. developed thrush, a painful yeast infection, in her mouth, throat, and eyes; and a viral infection on her lip. All were as a consequence of the steroids she received to treat her pneumonia and her generally debilitated physical condition.

Mrs. D. at our follow-up interview said “My mouth is better. It had been swollen, but it’s a lot better. I’ll tell you that [thrush] was the most painful thing I ever had in my life. And look, I still got these fever sores. But uh, that hurt. Oh man, I was so hungry, and I’d take the food and put it in my mouth and then I had to spit out everything. Ya know, I never had anything hurt me as bad as that. (difu, 612-623)

In the first two cases, pain was perceived to be a hallmark of a life threatening event. The pain in the third example was interpreted by the elderly person as an indication of how sick the person was. In each case, when the pain subsided, the person felt relieved, and thought it was an indication of improvement in health; and an exacerbation of the pain indicated either poor health or a decline in health.
After Bob had an episode of chest pain [on the evening of admission], he no longer wanted the newspaper, he seemed to be preoccupied and worried.... Initially, Bob said he didn't feel as if his condition was terminal, but later in the evening after he had the pain, Bob seemed to think his condition might be more severe than he initially thought. (brl 10/7/97, 94-104)

Mrs. D. knew that her health was improving but the pain in her mouth kept her from feeling as if she were getting better. At one point about two and one half weeks after admission, I asked Mrs. D. how she thought she was doing, she said "I know I’m getting better, but I don't feel better. I'm tired and my mouth hurts". (dpo 2/17/98, etc., 42)

Pain was most significant prior to admission and in the early phases of being in the hospital. The meaning that the elderly person ascribed to pain was that pain was a measure of how serious their illness was, and how fast their health was improving. The more significant the pain, the more out of balance was the individual’s personal integrity. When elderly individuals were experiencing severe pain, the strategies they engaged in were focused on pain resolution. First they engaged in the strategy of magical thinking in the hope that the pain would resolve simply by being in the hospital. Then the elderly individuals took action to resolve the pain. They either initiated contact with the health care system, or if they were already in the system, they contacted the health care staff for assistance.
Illness as an Attribute of Health

The elderly participants viewed illness in many ways. Illness was perceived to be a threat to their autonomy, their way of living, and as a threat to their survival. Family members were in agreement with the elderly participants' perceptions. Evy’s daughter thought Evy’s health had deteriorated over the last year. She explained that she thought that this decline in health was the beginning of an overall decline in function and a threat to Evy’s way of living. She viewed the illness which led to her mother’s hospitalization as evidence of her decline.

I’ve kind of seen a slow deterioration over the last year in her health. Her [Evy] not being herself. Umm, especially in the last six months.... I think that just over the last few months, I can see she's beginning to show her age basically.... I don’t think it's anything dramatic but just a slow [decline]... (eif, 101-132)

According to his wife, Bob felt betrayed by the illness in his body. Bob viewed illness as a sign that the actions of his body could not keep pace with the actions of his mind.

... he’s very angry with his body for constantly causing him to have to be here. You know, he’s conflicted about it. He doesn’t hesitate to come to the emergency room, when he feels chest pains...[he is] Very, very relieved. Yeah, but um, of course he’s very impatient and ah distressed and wishes he didn’t have to be here [in the hospital]. (bif 10/9/97, 10-44)

Some of the elderly participants were disappointed that their health was interfering with plans they had made prior to being admitted to the hospital.

Carl was anxiously awaiting the physician [with hopes of being discharged]... The physician said what he would like to do is get Carl off some medications and get him walking around a little bit on the unit. If Carl is doing OK, then he can go home tomorrow. Carl said he really wanted to go home today. He said his son and
daughter were singing in church tomorrow; and he really wanted to be in church....(cpo2/6/55, 39)

Bob’s health also affected both his short term and long term plans:

Bob’s wife explained, “Even though we had plans to go back to the vacation house, we had to cancel. I know that he felt that I was very disappointed and he was sorry to see that he couldn’t do what I wanted to do”. (bif, 10/9/97, 40-50)

Bob had business that would not be concluded for a few months. He said, ‘I have things I have to finish up. I’m not ready to die yet, I have unfinished business’. (brl 10/8/97, 13-23)

The elderly individuals did not necessarily comprehend the severity of the illness that led them to be admitted to the hospital. In his admission interview, Carl said he was feeling OK, but the physicians thought there was a health problem because they admitted Carl in spite of the way he subjectively felt (cia). During the initial period of illness and admission to the hospital Mrs. D. did not appreciate the severity of her illness. She was reluctant to come to the hospital because she was not aware that her illness was so severe. At her follow-up interview she said:

... a couple times in the hospital, and I didn't realize I had a temperature. No, I don't realize how sick I was [in the hospital] because everything seemed to be all right. I mean, except... [for the cough] (difu, 566-583)

In most cases, treatment for the initial health problem brought on other health problems. Four of the five participants developed some iatrogenic complication from the prescribed treatment or from being in the hospital. Amy had a reaction to medication she was receiving, Bob developed uncomfortable
side effects from a medication, Mrs. D. developed temporary urinary incontinence and two iatrogenic infections, and Evy's blood sugar fluctuated widely during her hospitalization.

Energy Level as an Attribute of Health

Energy level was composed of the subjective aspects of feeling well and feeling like one had energy and the physical component of having energy to carry out activities.

The way Amy felt had a lot to do with how dynamic she acted as shown in this excerpt from a researcher log:

Amy was really quite dynamic yesterday. Today, Amy does not seem to be feeling quite as well. I said to her, "You don't feel so well this morning".

Amy replied "No, you're right I don't feel so well. How do you know?"

I said, "Well, yesterday you were talking about how you wanted to go home. Today you weren't saying those things. It made me think that maybe today you didn't think that you were quite ready to go home."

Amy said "Yeah, you're right". (ar9/13/94, 24-34)

Sleep Patterns as an Attribute of Health

Sleep was a major problem for all participants for the duration of being in the hospital. For some it was the bed, for some the roommate kept them awake, and for others it was worry over their health or the illness itself.

I asked Amy how she slept last night. Amy said she slept fine after the sleeping pill. Amy said she would need another pill this evening. The mattress was not that comfortable. The bed was really hard. It was not like her bed at home. When she lay down at home, her shoulders and hips didn't ache. (apo9/12/97, 61-69)
Sleep for the elderly participants was often disturbed by their roommates or by the hospital staff. Bob commented on how noisy it was in the hall outside his room during the night. Mrs. D. also had trouble sleeping because of the noise and activity occurring inside her room.

Mrs. D. said every time she got to sleep last night her roommate “started hollerin' and that the nurses were in and out all night”. It was unusual for her not to sleep well and therefore, she said if she missed her sleep she really felt it.

The next night Mrs. D. said the night nurse was again in and out of the room for the roommate all night long. This time the nurse and the roommate were giggling. (dpo 2/6, etc, 58, 64, 107)

For some, worry about their illness kept them awake.

...So I ah, I'm just here contemplating going to sleep, hopefully, that I'll sleep, and get through the night and get my test tomorrow morning... I'm feeling relatively decent, I mean there's no pain, I'm just worried (bia 10/7/97, 93-109)

Anticipation of discharge kept some participants awake.

Well, Dad, ya know, he can't be in here [the hospital]. Ya know, it's like, he thought he was gettin' out today...and he couldn't sleep. He probably had that on his mind all night long and he couldn't sleep...He's too concerned, ya know, and I think that's what his case was today. He was too excited about goin' home and after we said, "You might as well stay today," he relaxed. He fell off to sleep... Now he knows he's not goin' home today, might as well get some rest. (cfi, 10-13, 66-71)

The inability of hospitalized elderly participants to sleep and feel rested contributed to their diminished health. Lack of rest diminished their ability to effectively engage in all strategies to improve their health and personal integrity.
Inability to follow their usual sleep patterns was a problem that persisted throughout hospitalization for all participants.

**Relationships Among Attributes of Health**

The attributes of health interact with each other. Pain and illness have negative effects on energy and sleep: the more pain, the less energy and sleep. Pain and illness had positive effects on each other: the more pain, the more illness and vice versa. As pain and illness diminished, energy levels and sleep patterns improved. Although pain diminished as illness improved, sometimes there was a delay in the reduction of pain, as in the case of the pain in Mrs. D.’s mouth.

Energy level and sleep had a positive effect on each other. As energy levels and sleep improved, pain and illness diminished. Energy level had a negative effect on illness, the more energy the individual had, the better they felt (less illness). Energy level had a positive effect on sleep: the more energy, the better the sleep patterns. Individuals who did not feel rested did not feel as well and were less able to tolerate pain.

An alteration in health affected the overall balance of personal integrity by diminishing the elderly persons’ effectiveness. When health is diminished, the individuals ability to participate in their life world is decreased.
Health and the Process of Hospitalization

Health and Pre-Hospital Stages of Managing Personal Integrity

Health and the Usual Way of Being

All five elderly individuals who participated in the research had chronic health problems. In the usual way-of-being stage of the model, the elderly individual was able to maintain their health in dynamic balance through the use of the strategy maintaining health. For example, while at home, Evy kept close watch over her blood sugars. She had 15 years of meticulous records. While Evy was in the hospital, the nurses were monitoring her blood sugar and she was worried about the fluctuations she had experienced. Evy associated the fluctuation in blood sugar with variation in her diet while hospitalized and the casual adherence to schedule she experienced. (eia, eidc, eifu).

Bob also worked at maintaining health while in his usual way of being. He spoke about his usual patterns for maintaining health:

Well we’ve had, I’ve had this problem now for quite a number of years. We first diagnosed it about ‘92. I had to come in for what they called a Cabbage, ‘cause I had terrible angina pain. Then, a couple of years later, I had a heart attack. Then I was OK, I was going to the gym, doing exercise, watching my diet, ex cetera, ex cetera. And then I got hit with this two weeks ago... (bia)

Health and Identifying an Alteration in Health

The problem that led to the elderly individuals being hospitalized was an alteration in health. For Amy and Bob, it was an exacerbation of an existing problem. Carl and Evy developed new health problems, not directly related to
their existing conditions. Mrs. D. developed an infection in her already compromised lungs.

Mrs. D. explained what actions she took the night prior to her admission to the hospital

Well, I'll tell ya I must have been in a bad way. I go to the doctor—you know, I'm under the doctor's care with my... lungs and that...and I knew I had to get in touch with Dr. Daniels. So I called..... you know, and it was dark like this and when she [the answering service] answered, I said, 'It's dark outside. Ya know, what time is it?'

She says, 'It's 10 o'clock, Mrs. D.'
I said '10 o'clock in the morning and it's this dark?'
She says 'No, It's ten o'clock at night.'
I don't I don't realize I did that or said that. But, anyway, I got a call real early this morning. And then he [Dr. Daniels] wanted me to get over there right away.... (dia, 4-8)

The elderly individuals used both active and introspective strategies during the stage of identifying the problem. They made decisions about the seriousness of their illness based upon their prior experience with illness and their knowledge of their symptoms. Amy used the active strategy 'taking action' to self-treat her symptoms prior to having her assessment confirmed. She made the decision to treat the lesser possibility, indigestion, prior to treating the more serious possibility, angina. She then self-treated the possible angina. Mrs. D. also initiated action as soon as she identified she had a problem. She increased the number of times a day she took her medication for a couple of days prior to seeking confirmation. (dpo2/6, 84). Later both Amy and Mrs. D. thought that their initial responses to their illness may have exacerbated the problem (aia, 48-54; dpo2/6, 84).

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Evy used the introspective strategy ‘magical thinking’ after identifying a health problem. She thought that by ignoring it, the health problem might resolve spontaneously. She postponed telling anyone about the inflammation in her leg, hoping it would go away. Evy’s daughter, described the events.

Yeah, and I don’t think she... I think she may be expected there might have been some phlebitis because I think she’s familiar with all this kind of stuff. I think she’s been putting it off...sort of hoping it would go away. Because when she told me she didn’t realize that her whole leg was swollen, and (laughed) when I saw it in the doctor’s office, I said how could she avoid not seeing it when she got dressed? But I think, ya know, I have a state of denial. (laughed) (ef,67-80)

Health and Confirming an Alteration in Health

The elderly individuals sought confirmation of their need to take action with relation to their health. This was accomplished through the interactive strategies of managing information and relying on authority. They managed information by making decisions about when and how much information to share with family members and health workers. They relied on authority by going to entering the health care system and acting on the advice of the health care providers. During this stage, the elderly individual prepared to enter the health care system.

Health and Transition to the Hospital

In the emergency department, the elderly individual’s health was the primary focus. The emergency department staff and physicians focused their resources on identifying the cause and the severity of the alteration in health and
determining whether or not to admit the elderly person to the hospital. The elderly person managed information by answering questions, and relied on the healthcare worker's authority and knowledge.

The elderly participants managed information by making decisions about which information about their health status they would share with the healthcare team. Amy's sister told me about information she and Amy withheld when Amy was being interviewed during her admission process. Amy had had some sandwiches shortly prior to the episode of chest pain that led to admission. There was some question about whether it was chest pain or indigestion.

Amy doesn't want me to say [to the doctor] she ate the sandwiches, or you know, I see her, that she's not supposed to do a lot of things. Either am I with my diabetes, you know? We all know what we're doing. She knows she should get up and walk and do things, we all know what we're doing. We do it to ourselves, and when she gets hungry, she eats.

I haven't said anything about this sandwich. Loaded with mayonnaise! And when she puts butter on something, she lays it on. If she hears me say that, she'll kill me.

But ahhh.. so you know, in one way, I'm not only speaking about her, I'm speaking about old people in general, myself included. You say 'what the hell, I want to enjoy myself' (aif, 148-164)

In this case, the goal of managing information was to effect the perception of the health care provider of the elderly person. In the case above, Amy sought to hide the fact that she was not following her diet and may have contributed her current exacerbation of health so as not to diminish her status as a good patient in the eyes of the health care provider.
Health and Managing Personal Integrity in the Hospital

Health the Focus of Stabilizing Personal Integrity

During the initial phase of hospitalization, health is unstable and poor. The elderly participants were worried about their health status and were relieved to be in the hospital. During her admission interview, Evy explained her relief at being at the hospital so that someone else could worry about her health problems.

Oh dear. I almost think it's a relief...to have things taken care of for me [in the hospital]. Ya know what I mean? But it's in somebody else's hands now—my health.... Let 'em do it [worry]. I am being taken care of.... (eia, 69-84)

The elderly people in this study engaged in active, interactive, and introspective strategies to improve their health during the stabilizing phase. The elderly people engaged in active strategies such as ‘taking action’ and ‘taking responsibility’ for their health status. For example, after being taught how to do it by the respiratory therapist (relying on authority), Mrs. D. took responsibility techniques to improve her breathing and explained to her son why she needed to do it.

When Mrs. D. was talking with Don on the phone, she told Don all about the pursed lip breathing [she had been taught]. When she would use it, how she would do it and how the pursed lip breathing would help her reduce shortness of breath. (dpo2/6, etc. 132, 183)

Evy was taking action by actively problem-solving about the management of her blood sugar while in the hospital. Evy’s daughter describes the situation

So I think, ya know, she's just basically concerned in getting things under control, and she has enough knowledge of what's going on... She is concerned about her [blood] sugar for one thing because she couldn't keep it regulated [in the hospital].
After umm... I don't remember the sequence, but they changed her insulin dosage... she said she heard her sugar was up over two hundred, which was a little bit unusual. I think... She's gets a high reading, but I don't' think she ever got the over 200... (efi, 30-40)

Amy, in discussing her desire for an early discharge, recognized her responsibility for staying in the hospital until the physician felt she was ready to be discharged. “If you don’t stay [until the physician says you can go] and something happens it’s your fault. [Your insurance won’t cover it.]” (aia, 85).

For Bob and Amy, pain was a major factor in deciding to come to the hospital. Although the chest pain that brought Bob to the hospital resolved soon after arrival at the emergency department, later on the day of admission he had another episode of pain and commented, “I didn’t think I’d be hit like that, makes me reassess my situation. It decreases my hopes for recovery” (bpo 10/7/97, 180-189). Bob had believed that his pain would be relieved by being in the hospital. This is an example of the introspective strategy of ‘magical thinking’. The goal of magical thinking is for the elderly persons to reassure themselves that their health would be improved as soon as they were at the hospital.

By coming to the emergency department and consenting to be admitted to the hospital, the participants had placed themselves in the hands of the healthcare staff and engaged in the interactive strategy ‘relying on authority’. The outcome or meaning of relying on authority was to apply the knowledge of the health care providers to improve the elderly individuals’ health.
Another strategy they employed was to try to conform to the system by 'adjusting attitude'. The nurse who worked with Evy spoke about Evy's positive attitude, an introspective strategy, during the early part of her time in the hospital.

[We've had] Very warm interactions. A lot of it was started out by her attitude towards the hospital and other personnel. I got a feeling right away that she felt that we were all very competent. That she seemed to have a liking for the doctors and all the nurses. And just felt that we all could kinda do our thing. So she was very amiable to any suggestions that I made or anything like that, .... (ein, 208-218)

The goal of adjusting attitude was for the elderly person to mentally put themselves in the best position to survive the hospitalization.

Finally, in communicating with the hospital staff, the elderly participants engaged in managing information. Strategies used were giving, withholding, seeking, and receiving information. The goal of managing information in this context was to control the flow of information between the elderly person and the health care provider. Below is an example of Mrs. D. managing information with the goal of facilitating her plan of health.

Mrs. D. kept a list of medications she took at home. On the first evening she was in the hospital, the nurse asked to see the list to confirm the dosage of one of her medications.

Mrs. D. said to the male nurse, "I want that purple happy pill."
He said, "Happy pill?"
The nurse left Mrs. D.'s room to go to the medical record to see which medicine Mrs. D. was referring to.
When he returned to Mrs. D.'s room, he asked if she still had her medication list with her. Mrs. D. retrieved her medication list from her pocketbook.
The nurse gave Mrs. D. 25 mgs. of Amitriptoline and said that he was going to check the physician's order because it looked
like Mrs. D. had been taking 75 milligrams at home.... (dpo2/6, etc., 14-23, 32)

Elderly participants were selective about the information they shared with the hospital staff. In Amy’s case during the admission process, there was a question of secrecy and of not telling the doctor things that would help with her diagnosis.

Mrs. D. said that her roommate also was not completely honest with the physicians. She said:

And I could tell she wasn't doin' what... [she was supposed to] The doctors would say when they came in [to the room], "I only want you to do a little more of this." And she [roommate] would tell them "yes I did." I never said anything, but she always did tell the truth to me [and she hadn’t done what she was supposed to do]. (difu, 203-208)

During this phase, the elderly participants thought of themselves as sick. Bob’s comment above on the meaning of pain is a reflection of how ill he perceived himself to be. Several participants made similar comments.

The clients were debilitated during the stabilizing phase of being in the hospital. The participants were exhausted by the pain, the illness, the admission, and the experience in the emergency room. For some, any attempt at the slightest physical activity was taxing. For others, they felt exhausted even if physically they were able to be active. The following description of Mrs. D. illustrates her exhaustion.

Mrs. D. was lying in bed, the television was on, the curtain was closed. They room was very very warm. She was wearing oxygen, coughing a very moist, non-productive cough. Her voice was squeaky and frail, she looked very distressed... her lungs were very congested to auscultation. Mrs. D. didn’t feel well and seemed very
close to tears. In addition to everything else, she did not like the nurse who was taking care of her that evening. (dpo 2/6, etc., 196-197)

Sleep patterns were altered from the very first night the participants were in the hospital. During the initial phase of hospitalization, the participants did not strategize to improve their opportunities for sleep. Evy describes the first day or two that she was in the hospital.

Oh, boy. So the first few days [in the hospital] were kind of rough. [The nights were very noisy with the roommate’s visitors] Then I couldn’t stay awake all day. (laughed) That’s all right. I got my rest... (eidc, 109-131)

During the first phase of hospitalization the elderly people engaged in strategies to improve their chances of surviving the alteration in health that was the reason for hospitalization. The strategies were focused on the illness and pain relief those aspects of health they felt were most important at the onset of hospitalization. Activity level and sleep patterns become more important as the hospitalization proceeds. Successful outcome of the first phase of hospitalization was to survive and to proceed to the next phase.

Health During the Repairing of Personal Integrity

Illness had stabilized during this phase. The person was beginning to recover from the illness that was the reason for admission to the hospital, the body was beginning to repair. The improvement or stabilization of the elderly individual’s health had the effect of improving personal integrity, but this improvement may have been overbalanced by the elderly individual’s diminished
dignity and autonomy. However, if an exacerbation of the illness occurred, as was the case with Amy and Bob’s re-occurrence of chest pain after admission, the elderly individual again slipped into the behaviors of the stabilizing phase where health again became the primary focus.

Pain was mild or absent during this phase. For those elderly individuals who were admitted for chest pain, the initial attack was over and any recurrence of acute pain immediately moved the person back into phase one behavior of relying on staff. If the elderly individual requested something such as medication for pain relief from the staff, the length of time it took for the staff to respond to the request for assistance was perceived as a sign of how much respect, or how important the elderly person was in the eyes of the staff.

During the second phase of hospitalization, the initial acute medical problems were resolved or resolving. In some cases the individuals developed iatrogenic problems such as urinary problems (Amy and Mrs. D.) and viral infections (Mrs. D.) which contributed to their not feeling well, but the point of danger with life-threatening consequences was receding.

The individual’s physical function gradually improved, but never reached pre-hospital levels. Even though all elderly participants had physician’s orders directing the staff to help the person get out of bed several times a day, they did not necessarily get up. In some cases the elderly person refused the encouragement of the staff, and in other cases the staff did not initiate the physician’s orders. The staff would help the person get up if the elderly individual asked to get out of bed or go for a walk, but the staff rarely initiated the activity.
The elderly person's energy levels began to increase, and continually increased over the duration of the hospital stay. Sleep patterns were altered throughout the hospital stay. They continued to be affected by the roommate's behaviors and needs, the activity of the staff, and the worries associated with being in a compromised state.

During the second phase of managing personal integrity, the elderly individuals did not initiate any new strategies for managing health. They continued to rely on authority and participate in their health care plan as directed by the health care providers.

**Health During the Reintegrating of Personal Integrity**

Health continues to stabilize or improve during the last phase of hospitalization. If exacerbation of illness occurs, the individual may move to an earlier phase of the process. The elderly individuals were not in acute physical pain during this phase. There might have been some chronic discomfort, but the pain experienced upon admission had resolved.

At this point, not only had the threat of the acute illness diminished, but any iatrogenic illness had improved or resolved. The elderly person developed active strategies to maintain health at home. Bob and Carl made plans to stop at a pharmacy to purchase medicine on the way home from the hospital so they would be prepared to manage their health at home. (bpoa 10/17/97, 17-18; cid, 216-230). In the hospital, Mrs. D. learned exercises to be done after she returned home.
Evy had learned about her health while she was in the hospital and was eager to return home to try some new things.

I think I'm gonna change my diet somewhat [when I get home]. I have found that eating here has given me ideas. ‘Cause I always had prune juice in the morning, and a banana at noon and apples and things. But now with the... They thought I had to have a juice, which I find I might have with every meal. I used to figure I could only have so much. Evidently, there's no such thing, because I had salad plate with tomatoes and cucumbers and lettuce and that stuff and food on the tray...

So I'm going to make a few changes. Gonna do away with that peanut butter, banana sandwich I think... (eidc, 232-261)

Physical function had improved markedly by this time in the process of hospitalization. Energy level had also improved. As evidence of this, the elderly individuals took walks around the hospital unit, were able to use the bathroom instead of bedpans, urinals, or commodes. Several participants no longer needed any assistance to complete these activities. The elderly people began to return to pre-hospital energy and activity levels. Mrs. D. went from not having the strength to sit up in bed without support to routinely walking 150 to 200 feet in the hall outside her room. (dirm2: 222)

Sleep patterns continued to be disturbed, but seem to be less of a problem than they were earlier in the hospitalization. As discharge approached, the elderly people thought about and anticipated what it would be like after they were discharged. This thinking often occurred at night when they were not engaged in other activities.

Mrs. D. described her difficulty getting to sleep a few nights before her discharge. She told me, “I had a terrible night last night, I just couldn’t get to
sleep... I don’t feel worried or anything. I just couldn’t get to sleep. (dpo2/26: 98-100)

The consequences of successfully managing health during the third phase of hospitalization are improved health which indicates improvement in this aspect of personal integrity, discharge from the hospital to home, and resolution of this episode of the unbearable health problem.

Health and Post-Hospital Stages of Managing Personal Integrity

When the elderly people were discharged, they continued to take action to maintain their health. There were medications to purchase, organize, and self-administer; follow-up appointments with health care workers; and an increase in activity for all participants.

Health and Returning Home

When the elderly people were discharged, they took action to maintain their newly improved health. Carl stopped at the local grocery store on the way home to have his prescriptions filled. Carl explained his medication regimen

I have some new medications and I had, we had some here and I didn’t know we did. And, ah, we had to take one of the pills in the morning on an empty stomach. And one at supper, before supper. Then I found that I had no more so I had my son take me down to the store.

Well, I got only 30 pills. $55 dollars and 99 cents.... The new pill’s to keep my heart rate down low and not have it raise up. Yeah, they think if your heart rate gets too fast, boy that’s when you have problems. So I figured I’d take 30 pills, that’d be 15 days, anyway, before I go scratch up another $55 bucks for some more. (cid, 15 – 235)
When Mrs. D. was discharged from the hospital she had some difficulty getting organized at home. Getting the proper equipment installed in her home was a major task of the getting home stage of hospitalization.

Ohhh... Ohhh, that was terrible. When I left the hospital, in a bag they had a Puffer and a little bot—see the little tiny bottle there for my eye?

One of those bottles. And that's what they had in the bag. The head nurse gave that to me. She brought me home. I got home and they didn't have the oxygen set up. We just came up [home].

And uh, I'm tryin' to think, I'm tryin' to think back. So the [visiting] nurse came... She had to sit down, and I think I had about 15 prescriptions that she had to write. And she had to call the doctor, and the doctor had to call her back to get all the medicine before they let me out with just that little... And I'm not even using the Puffer. I didn't even use it. (difu, 10-35)

Amy also planned to have the visiting nurse come to her house to make sure all of her medications were in order.

They [the physicians] gave me, they gave me a whole bunch of prescriptions to get filled...

They gave me back my nurse's book with my list of pills that I take. Ah... I have to see the nurse (visiting nurse) because I screwed up the pills last week, I think I dropped them. Then I couldn't make out what the hell I was having. And this is empty (referring to weekly pill box on table). This one's OK (indicating the other pill box), but I dropped the pills and I don't remember which one I dropped the pills and I don't remember which one I dropped.

So, anyway, I got a call from the [visiting] nurse [after I got home] and she said "You got to have your water pill tonight." And I thought, Yeah, lots of luck, cause they're mixed up, I can't tell the difference, see. So I'll maybe have my niece take a look and give me a pill from over there from the bottle itself. And that's it. (aidc: 305-330)
During the stage of returning home, the elderly individuals employed the strategy of taking action to organize their home for their current health status. Once in their homes the responsibility of maintaining their newly stabilized health fell to the elderly individuals. The meaning of being home was that the elderly person had survived being in the hospital and now had to adjust to new health status. The elderly people implemented the directions they had received from the hospital and set about maintaining their health.

Health and Adjusting to Being at Home

During the first two to four weeks following being discharged from the hospital, the elderly individuals began to develop routines to maintain their health at home. Evy was still treating the edema in her leg, but was not wearing support hose as much of the time as she was in the hospital.

No I only... Don't have to wear that one anymore [support stocking] and I take this one off when I go to bed. It's [my leg] still a little bit bigger. [There is] no pain. Matter of fact, I think that it [the health problem] was coming on for a long time. I had that little pain in there that I thought was just a charlie-horse, but it wouldn't go away. She's [the physician] checked it all out since I've been home. (eifu, 224-236)

During the period of adjusting to being at home, the elderly person engaged in maintaining health. They incorporated new behaviors into their repertoire of behaviors for maintaining health. For example, Mrs. D. began to get used to wearing oxygen tubing while she walked around the house. Bob re-initiated health promotion activities such as attending cardiac rehabilitation.
Health and the Evolved Usual Way of Being

Within two to four weeks after discharge the elderly individuals had adjusted to being home after hospitalization. In order to improve and maintain health, the elderly participants engaged in activities that promoted health. For example, as a person with diabetes, Evy knew that her health was best when she maintained a rigid schedule for her daily activities. After discharge from the hospital Evy re-organized her schedule incorporating the things she learned in the hospital.

[I’m back to my schedule] ... I’m taking it [medication] now at 5:30 [AM] with my first cup of coffee so that I... Then I take it at 11. I got a new prescription. I got ‘em in there... And it’s gonna be two puffs [of respiratory medicine] every four hours, which is a little different than this. This seems to work off at four hours. Where I don't get it quite--it’s about four and a half/five hours between doses.

Yah, so first thing in the morning I’m...[ready for a dose] Yah. Probably if I have that other stuff, I’ll take a dose when I get up to go to the bathroom at about 4 o’clock. (laughed) I’m taking Coumadin, yah. Two milligrams every day. I was on one and a half and it wasn’t enough. She [the physician] got me up to two, and she’s got it where she wants it, and we’ll see what it is... (elfu, 242-323)

Other participants were not quite so structured in their adherence to schedules, but all knew which medication they took and when they were scheduled. The elderly participants actively engaged in health restoration and health management activities, and they also engaged in activities to prevent illness. Bob worked out in the Cardiac Rehabilitation Gym three times a week, Carl walked around his neighborhood, Mrs. D. took the dog for a walk, and Evy
managed her diet. These elderly people were actively engaged in enhancing personal integrity while they were in the hospital and beyond.

The Meaning of an Alteration in Health Requiring Hospitalization

The elderly people in this study worried about surviving. An alteration in health that was serious enough to require hospitalization meant that the person’s life could be in jeopardy. Bob’s wife described Bob’s fears about the chest pain that led him to be admitted to the hospital.

Well I thought, I think he thought he was going to die. You know, heart attacks, anything to do with the heart is very frightening, and so he was concerned about what they [the pains] were signs of. (bif, 10/9/97, 56-65)

Mrs. D. also thought about her illness in terms of dying:

Like I said I always felt good, but when you are in the hospital and you’re so sick and you can’t make things..., ya know... You wonder if this is it. I wonder.

My granddaughter called me from California, because her Dad had told her that I asked him if I was gonna die. She was very worried.

But you think of those things. I thought about dyin’. I don’t care if I die. I don’t care if I die. There was a patient in here, I heard them (the staff) talking. She was gonna be able to go home the next day and she died. I said to ’em, ‘I wish that was me.’ (didc, 644-662)

Although all individuals did not appreciate the gravity of their situation when admitted to the hospital, by the end of the Stabilizing Phase of Hospitalization four of the five participants recognized the seriousness of their situation. All were prepared to follow the directions of the healthcare workers as

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well as employ strategies independently to improve personal integrity and his or her chances of surviving hospitalization.

Intervening Conditions for Health Management

The ability or willingness of the elderly individual to participate in managing his or her health is an intervening condition in the management of personal integrity. Some participants preferred to let others manage their health while some participants wanted to be involved at every point in the process of their hospitalization. Carl’s story about coming to the hospital, related in the previous chapter, is an example of an elderly individual whose participation in the process of managing his health was superceded by the actions of his children. When Carl was asked about the reasons he came into the hospital and what had happened in the emergency department, he deferred to his daughter (cia). Carl came to the hospital at his daughter’s insistence, and in the emergency department the daughter interacted with the physicians more than did Carl.

Bob chose to be actively involved in all decisions about his care and health.

Yes, I saw my doctor this morning, and when I had the stress test done the cardiologist was there too. Earlier this afternoon I started to complain about not knowing what was going on and one of my doctor’s charges [medical residents] came and talked to me for a while. (bpo 10/8/97, 27-37)

Bob’s desire to be informed and engaged in the process of managing his health is an example of an individual who wants to be actively engaged in all
aspects of his health management in order to effectively manage his personal integrity. Evy also desired to be informed about all aspects of health management. Amy and Mrs. D. represented the middle of the continuum between Carl and Bob.

Summary

Health is a property of personal integrity composed of the physiologic and psychologic attributes: pain, illness, energy level, and sleep patterns. Changes in one attribute of health leads to changes in the other attributes of health. Increased illness and pain lead to decreased sleep patterns and energy levels. There is a positive relationship between illness and pain, increased pain leads to increased illness and vice versa. There are positive relationships between sleep patterns and energy levels improvement in one leads to improvement in the other.

An alteration in health is the precipitating factor leading to admission to the hospital. The elderly individual identified the health problem as an alteration in their usual way of being. Using introspective, interactive, and active strategies the elderly individuals managed their health with the goal of improving health and therefore personal integrity in order to survive the illness and hospitalization.

Health is the focus of the Stabilizing phase of being in the hospital. The hospitalized elderly people and the healthcare workers were all focused on health during the first phase of hospitalization. During subsequent phases of hospitalization the elderly individuals’ focus moved from health to other attributes of personal integrity. Health care workers continues to be focused on health throughout the elderly individuals’ hospital experience. Following discharge from
the hospital, the elderly individuals continues to manage their health as they entered into an evolved usual way of being.
CHAPTER VII

DIGNITY: A PROPERTY OF PERSONAL INTEGRITY

Dignity, the second property of personal integrity, is the elderly individual’s dynamic sense of worth. A person’s dignity is strong when their behavior, sense of their own value, and other people’s actions conveying their worthiness are in agreement. An individual’s dignity is based upon internal definition of dignified behavior developed over time through past experience. A person’s current sense of dignity is the congruence between the internal definition and their own behavior as well as the behavior of others toward that individual. Insults to an elderly person’s dignity can be absorbed until the accumulated insults exceed the individual’s dignity threshold, at which time the individual feels disrespected and denied worth. The result of insults to dignity exceeding the threshold is decreased dignity, leading to diminished personal integrity.

In this investigation, the attributes of dignity were identified as self-dignity and interpersonal dignity. The elderly individuals entered the hospital with a cache of inherent dignity. The supply of dignity had accumulated over a lifetime of interactions with other people, and through meanings they attributed to their own actions, observations of other people’s behavior, and experiences in which they felt dignified or respected by themselves and others. Their dignity helped the elderly persons sustain personal integrity during the pre-hospital stages.
of managing personal integrity, transition to the hospital, and through the first
phase of hospitalization when their health was at its worst. By the second phase of
hospitalization, the elderly individuals' dignity had been diminished by the
accumulated insults to dignity incurred during the hospitalization. During the
second phase of hospitalization, the elderly individuals engaged in strategies to
enhance their dignity. The phases as well as strategies are discussed below.

In the present research, dignity was enhanced when the elderly person's
internal definition of dignity was congruent with his or her behaviors and the
behaviors of others in relation to them. In the hospital, dignity was enhanced by
interactions with staff who demonstrated respect for the elderly person. In cases
where the way that the elders were treated was not congruent with their view of
themselves, dignity was diminished.

Attributes of Dignity

**Self-dignity as an Attribute of Dignity**

Self-dignity is the individual’s sense of self worth. Self-dignity is built
over time and is resilient in nature. It is evidenced by an individual’s behavior. An
internal image of dignity guides people’s actions and provides a measure by
which to evaluate their behavior and the behavior of others toward them. The
researcher identified self-dignity through the way individuals spoke about
themselves. The discussion of self-dignity will begin with a discussion of self-
concept and then move to a discussion of privacy. Privacy was a component of
dignity that was part of the interface between self-dignity and interpersonal
dignity.

**Self-concept**

Self-concept is all of the ideas one has about one’s self. It is the way one makes meaning of one’s self in the world. Individuals derive their value based upon interactions with other people and through past experiences. The derived value is incorporated into the elderly individual’s self-concept. Self-concept is built over time and is based in part on context.

While being in the hospital, the elderly people expressed their self-concept in many ways. One way was by the way they introduced themselves. Amy, Carl, Bob, and Evy all introduced themselves by first name. Mrs. D. introduced herself as Mrs. D. The name was evidence of their habit of introduction as well as the amount of respect they expected. Usually someone using a title and last name is afforded more respect by others than a person using a first name only.

The stories told by the hospitalized elderly people when they were engaged in life reviewing were another way of gaining evidence of their self-concept. Individuals told stories of times when they did something that was extraordinary, this had the effect of demonstrating to others the elderly person’s uniqueness. Additional evidence of uniqueness was in the individual’s dress prior to and after being hospitalized. As Mrs. D. began to feel better during the reintegrating phase of hospitalization, she began to wear earrings with her hospital gown.
“I said to Mrs. D., "You're all dressed up today. You're wearing earrings."

She said, "Yes, Don brought them. I never go without earrings. I always had earrings in my ears and so I've been missing them, so Don brought them and I put them in." (dpo 2/24, 10)

When I met Bob for his follow-up interview, he was dressed in a very distinctive manner, which expressed Bob's personality

I saw Bob today he was wearing khaki. Khaki pants, turtleneck, and jacket, and a blue baseball cap. The baseball cap had the name of Bob's vacation place and some dates written on it. He was wearing glasses. Bob's hair was a little shaggy; his beard was neatly trimmed. (bpo 1/6/97, 2-8)

In both of these examples the elderly person dressed in a manner which was consistent with their self-concept. While in the hospital, this outward expression of self was removed.

Being in the hospital allows time for reflection on one's self-concept.

Evidence of Bob's self-concept and how it was weakened by his being in the hospital was found in the following passage from an interview with Bob's wife:

"I think it [being in the hospital] makes him review his life. And Bob generally, when he reviews his life, has more of a negative feeling about his life than I think he should... he tends to put himself down.

"So when his body betrays him again, once again it's all tied in with his own, his whole feeling about his self and his life. And having so much time to just lie in bed and think about it. As he told me yesterday, my whole life is spreading out in front of me." (bif 144-152)

Being in the hospital challenged an individual's self-concept and therefore self-dignity. The challenge came from being in a situation where an individual is
out of context and in an environment where activities are largely directed by the hospital staff. In this situation, the individual may lose some of their sense of self.

Impaired health can also affect self dignity. Mrs. D.'s comments about her appearance while she was in the hospital were evidence of how her health affected her self-concept. The comments were recorded in a participant observation log. I was noting the fever sore on Mrs. D.'s lip. The sore was the result of a viral infection Mrs. D. developed while in the hospital as a consequence of a medication she had been taking.

The fever sore on her lip has spread. It is now a thick scab that sticks out almost a half an inch from her bottom lip. It extends below her lip on the chin and also between her upper lip and her nose there is a line of dark scab.

Mrs. D. said, 'I'm 85 years old; I've never had a blemish on my face. I'm so embarrassed'. (dpo 2/17 etc. 152).

Self-dignity was based in part on the elderly individual's self-concept. Individuals with a strong sense of self-dignity were better equipped to survive hospitalization than those individuals who had less positive concepts of self.

Privacy

An important issue contributing to individuals' sense of dignity was privacy. Issues of privacy were pervasive in the hospital. Privacy affected self-dignity, and was a reflection of the amount of worth the elderly individuals felt was attributed to them by other people. Privacy was minimal from the moment the elderly individuals entered the Emergency Department and continued to be compromised through discharge from the hospital and beyond. Privacy continues
to be compromised while adjusting to being home. Specific examples will be presented under each phase of the process of hospitalization.

It is to be noted that privacy is not the same as isolation. Elderly individuals felt respected when staff maintained privacy for procedures by closing the bed curtains, but if the staff then neglected to open the curtains after completion of the procedure, the elderly individual felt isolated.

**Interpersonal Dignity as an Attribute of Dignity**

Interpersonal dignity is the dignity that is achieved in the eyes of others, as perceived by the individual who is the object of the other's attention. An elderly individual identifies interpersonal dignity ascribed to them by making judgements about the amount of respect with which another person treats him or her.

**Respect**

The hospital staff engaged in social interactions with elderly persons. During these interactions, elderly individuals interpreted the actions and words of the staff as respectful or not. From this process, elderly persons felt respected or not respected. Mrs. D. described a medical resident who treated her with respect:

He was just special. He had the nicest hands. When he touched ya, ya know, it was a nice hand. I was on my back in the emergency [room] and he had a hold of my big toe. (laughs) And the whole time he was talkin' to ya he'd be wiggin' my big toe. He had such a nice... Like I was his grandmother maybe. He did kinda take to me. I was flip and he said [to another staff member], 'Well, she's got the answers. Don't try to get ahead of her'. (laughs) He was just a nice young man. And then when he left [changed rotations],
I told ya he came bargin' in (smiles) and reached over to shake my hand [and say goodbye]. (difu 484-502)

The above interaction demonstrates the effect of interpersonal dignity on an elderly person's dignity and personal integrity. Mrs. D. felt cared for and respected by the medical resident. The positive regard she felt from the medical resident was consistent with the internal picture Mrs. D. had that identified how she should be treated by the resident. This interaction had the effect of enhancing her dignity.

In another situation, Mrs. D. commented on the behavior of a therapist she was working with. In this situation, Mrs. D. did not feel respected by the person. There was no personal connection between Mrs. D. and the therapist as there was between Mrs. D and the medical resident she described above. "I like her least of any of the people from the gym. The way she talks to ya is like...she talks to you like you're a child and that laugh drives me crazy" (dpo2/26, 60-62).

Additional examples will be given during the discussion of the stages and phases of managing personal integrity in the hospital. Health providers who conveyed respect for an elderly person enhanced the elderly person's dignity. People who did not treat the elderly person with respect affected the individual's dignity, and over time could have the effect of diminishing the elderly person's dignity and thereby the individual's overall personal integrity.
Relationships Among Attributes of Dignity

As in the property of health, the attributes of dignity are connected. Self-dignity and interpersonal dignity are positively related. The individual’s self-dignity can be enhanced or diminished by how others treat that person. If others convey lack of respect to the individual, it conveys lack of interpersonal dignity and the effect is to diminish self-dignity. Respect, a quality of interpersonal dignity, has a positive effect on both self-concept and interpersonal dignity. Privacy conveys respect to an individual. Self-concept affects self-dignity positively. The store of self-dignity the individual has accrued over time is enhanced or diminished by their self-concept.

Dignity and the Process of Hospitalization

Dignity and the Pre-Hospital Stages of Managing Personal Integrity

Dignity and the Usual Way of Being

Prior to coming to the hospital, elderly individuals were at home in their usual way of being. They had an image of themselves as people who should behave in a particular way and be treated by others in certain ways. This was their internal definition of dignity. Their behavior and the respect received from others guided their activities and contributed to maintaining their personal integrity.

Individuals routinely adjusted their behavior to match their internal definition of dignity. For example, upon reflection while in the hospital, Mrs. D. decided that some of her behavior prior to coming to the hospital was inconsistent with her sense of dignity. The excerpt from a participation log below
demonstrates the effect of an individual's behavior being inconsistent with their sense of dignity.

Mrs. D. spoke about how she's going to change her life when she returns home. She was not going to dine out with the women from the apartment building. When she was in the south, she had a good life. She had her church and she was in with a good crowd, but when she came up here, she got in with a bad crowd. She said she's been spending time with the people in the apartment building and they are really catty. All they ever do is talk about each other. "If you're not there, you're the one they talk about." She would go out to dinner with them and she'd be sitting in the back seat of the car and then they would start talking about somebody and she wouldn't get into it, but she'd say, "So what am I sittin' here for?" (eia, 163)

Mrs. D. resolved to change her behavior when she returned home from the hospital. The effect of the behavior change was to be to improve congruence between Mrs. D.'s actual behavior and the standard she had set for behavior.

Bob suffered from a reduced cache of dignity in relation to self prior to being in the hospital. He had had previous experience with illness personally and within his family. The meanings derived from these past experiences contributed negatively to the meanings Bob derived from the current episode of illness. While he was in the hospital he had episodes of despair related to the effect of being decontextualized (removed from his or her usual context). Bob's wife described how she thought Bob felt and how those feelings contributed to Bob's diminished dignity.

Well, I think because there is a history of illness in his family, and because of his early childhood... it makes him very depressed and very sad to be away from me and to be cut off from his life [while he is in the hospital]. (bif 141-144)
Each elderly individual had an amount of dignity in their usual way of being. The process elderly individuals engaged in over time was to organize their behavior to reflect their internal definition of dignity.

Dignity and Transition to the Hospital

As soon as elderly persons entered the Emergency Department (ED), their dignity began to be challenged. Both the privacy of their personal space and bodies were compromised. The elderly individuals submitted to a process of decontextualization in the hospital where many of the outward signs of dignity such as clothing were stripped away. They were placed in an unfamiliar environment, dressed in hospital gowns and placed on stretchers in a cubicle or ward in the ED. There the elderly individuals submitted to a lengthy process of assessment which invaded their privacy and their physical person. Carl described his examination in the emergency room.

Well, they wheeled me into a room in there on a stretcher and started checkin' my blood pressure and pulse and all that stuff, ya know. They've run everything today [tests]. They checked my blood vessels and everything, down in my hips and my legs. And ah, regular, routine more or less examination to see what they would come up with next and stuff like that. (cia)

In the ED the stretchers were arranged in long open rooms with space for several patients at a time. Each patient area could be separated from the others by curtains, which gave visual privacy, but one could still hear the conversation.
clearly from outside the curtain. This was the beginning of the changes in privacy related to personal space and interactions with other people.

Often the elderly person spent several hours in the ED. This was interpreted by the elderly person as evidence of his or her low value in the eyes of the health care workers. Prompt service or attention by the health care provider was evidence of high value, being kept waiting was evidence of the opposite. Mrs. D. explained her time in the emergency department this way:

I got word from the doctors' at like five after nine [AM], and I was in the hospital, I think, by quarter of ten [AM]. I've been here [in the hospital] all day. Yah. I was in the emergency room, I came up here about five [PM]. I was in the emergency room all that time.

Yah, I was kinda disgusted. He [the doctor] told me, gave me a slip of paper. And Dan [my son] had the paper and it said go straight to emergency and go right up [to the in-patient unit]. So I didn't have to sit and watch all that, but somebody didn't read that symbol right.

They were nice to me down there though, but it was really hard—layin' on all those beds and cold, but that was fine—everybody was nice. They were all nice, ya know. And it was fine.

Well, Dan brought me, and they told me--when I went in, ya know--what they were going to do because I had pneumonia... and they were gonna treat me for that and also they were gonna take all these different samples of blood...

I've had so many pokes. Oh yah. Well, they told me what everything was for, ya know... (dia)

The individual's personal history such as profession, community prominence and relationships, and at times medical history were disregarded.

(Three of the nurses interviewed from the acute care unit the elderly persons were sent to from the ED, were not aware of the elderly person's primary reason for admission, although they were the nurses providing care for the person at the time)
they were interviewed). Elderly individuals relied on their cache of dignity to see them through this period of transition into the hospital. Following the time spent in the emergency department, the elderly people were brought to an inpatient unit and admitted to a semi-private room where they shared their space with a stranger (roommate). After the transition, the elderly peoples’ dignity was managed by a combination of strategies discussed below.

Dignity and Managing Personal Integrity in the Hospital

Dignity During the Stabilizing Phase

The hospitalized elderly people came to the hospital with a supply of dignity. They had made the decision to come to the hospital and had brought with them dignity based upon their identity in the world outside the hospital. As noted above, immediately upon entering the healthcare system, the individual’s dignity was jeopardized, and began to diminish.

At admission, the elderly persons' overriding concerns about health and the relief felt by being in a place perceived as “safe” diminished the initial impact of the threats to their dignity. It was not until the health crisis was resolving that the threats to personal integrity were noticed. During the stabilizing phase the elderly people engaged in the introspective strategies of adjusting attitude and image management, and the interactive strategy of managing image to maintain their dignity.

Elderly people consciously adjusted their attitude toward the hospital staff. By deliberately making their attitudes about their health, the staff, and the
situation of being in the hospital more positive, the participants believed they could positively affect their personal integrity. Mrs. D. explained the importance of a positive attitude: “Your attitude [the patient’s attitude] toward the staff makes a big difference in, with respect to, the way the staff treats you. You need to have a positive attitude towards the staff so that they treat you positively as well” (dpo, 2/6, etc., 7).

The elderly people also engaged in managing their image. They did this by working hard not to “bother the nurses” or, if they needed some attention, made sure that they asked for some legitimate reason such as a health problem. Each person in the study was very careful not to bother nurses whom they perceived as very busy. Bob talked about his observations of the nurses on the day he was admitted. “They’re very busy... I leave them alone as much as possible. I don’t press that button (the call bell)....” (bia10/7/97, 95-105).

Once admitted to the hospital and brought to the room for his or her stay, new issues around privacy arose for the elderly person. First, all individuals were placed in semi-private rooms that they shared with a stranger. All of the elderly participants lived in their own homes and apartments in the community and were not used to sharing their space with a stranger. Participants had many concerns around having roommates. Those issues will be discussed in length in the chapter about modifiers of the experience of hospitalization. The issues presented here have to do with space and privacy.

Bed curtains provided visual privacy, although they did not give actual privacy. Patients who were engaged in activities behind drawn curtains acted as if
they had complete privacy, when only illusion of privacy actually existed. The
perceived barrier was useful to the people being protected by the curtain but was
generally not recognized as a barrier to those outside the curtain.

While I was attempting to interview Bob on the day he was admitted his
roommate was being interviewed by a medical student on the other side of the
dividing curtain. Below is an excerpt of a participant observation log that
demonstrates how the illusion of privacy provided by the bed curtains fails in
actual situations.

The curtain was pulled. The medical student was asking questions
like, 'which drugs had been taken?, what's your cocaine history,
what's your marijuana history, do you drink too?, how long have
you been doing drugs?, what other times have you been in the
hospital, how much coke did you do? On and on about these
incredibly intimate details of the roommate's drug history.

It was impossible to screen out the conversation on Bob's
side of the room. The medical student and the roommate were not
speaking quietly, and Bob and I both found ourselves drawn to
listening to this fascinating tale. The roommate would break down
into tears at intervals. The whole experience was like
eavesdropping. It was impossible not to overhear the entire
conversation. (dpo10/7/97 318-338)

In another situation in Bob's room, with a subsequent roommate,

A physician was discussing a cardiac catherization with a new
roommate. The physician was speaking very loudly. There was no
way to avoid hearing everything the physician said, and you could
not have a conversation on Bob's side of the curtain because of the
volume of the physician's voice.

When the nurse went in to have the consent form signed for
the roommate's cardiac catherization, Bob was again exposed to all
of the roommate's history and concerns. Those times that a
conversation went on behind a curtain with a roommate that Bob
never met or had a conversation with were very present in Bob's
experience. (brl10/9/97 41-66)
Staff used the curtains to maintain privacy and promote dignity of clients.

The data contained many situations where a staff member drew the curtains around a patient to provide privacy and demonstrate respect for the patient.

The nurse had pulled the curtain when she examined Amy's belly, and made sure her groin was covered with a bath blanket. To protect Amy's privacy, only the area examined was exposed. (apo9/13/97 7-12)

... As the transport person helped Mrs. D. stand to put her bathrobe on she pulled the curtain to shield Mrs. D. from the hallway. She pulled it just enough to provide privacy and then after Mrs. D. was dressed and in the chair, she pushed the curtain back. (dpo 2/24 84)

When they [staff] went to help the roommate, they pulled the curtain around the bed. When the staff returned, the roommate got off the bedpan and left the room. Later a staff person came in and said, "Do you want this curtain [between the beds] closed?" Mrs. D. said no so they opened it, and the aide that had come in said, "It feels a little bit like a prison in there with that closed, like a cage in there with that closed doesn't it?" Mrs. D. said, "Oh yeah, I hate to have it closed." (dpo2/24 31-40)

When the staff forgot to open the curtains after they had purposefully screened a patient, the participants became distressed over their isolation. When the curtains were drawn without their wanting them drawn, or left drawn after the reason for visual screening was resolved, individuals felt isolated.

The roommate's doctor came in, and pulled the curtains around the bed to examine the roommate. Mrs. D. said, "I hate having those curtains closed. It really upsets me, we get along well enough."

When the doctor left, the doctor pulled half of the curtain back but left the curtain between the two beds extended. I went to pull it back, and I said to the roommate, "I'm gonna pull this back now ok?" And she said, "Oh yes." Mrs. D. said, "Oh yes, we both like it back. It's much nicer in here with the curtain open." (dpo2/17,etc. 55)
The goal for managing dignity during the phase of stabilizing was to maintain the elderly individual’s dignity at the level that it was prior to coming to the hospital. In order to do this the elderly individuals employed introspective strategies of adjusting attitude and managing image and the interactive strategy of managing information.

**Dignity the Focus of the Repairing Phase**

Dignity, conceptualized as the elderly person’s dynamic sense of worth, is the primary focus of the second phase of being in the hospital for the hospitalized elderly person. Health and autonomy remain important properties, but dignity is in the forefront. The staff continues to focus on their job of improving the individual’s health. This dis-synchrony in focus creates tension in the relationship between the elderly person and the staff.

During this phase, the elderly individual begins to feel disrespected by the staff, and out of context. All of the individuals had their own space at home, most lived alone. As the acuteness of the illness began to resolve, the lack of dignity inherent in the hospital began to wear on them. Carl spoke about feeling decontextualized.

I didn't sleep a wink all night. I wanna get out of here, this morning. I don't like being in the hospital. Well, I mean it's a wonderful place, but I would rather be home where my roots are so to speak. And uh, unless they found that I was gonna croak or somethin' with a heart attack, which I hadn't had, [I don't want to be here]... (cpo2/6/98, 33; cia, 313-323)
After the elderly individuals were somewhat settled in the hospital and their health had stabilized, the individuals became aware of treatment by the staff. They used strategies to increase the respect that they received. In some cases, the children of an elderly person were well known in the community and the elderly person received respect not on his or her own behalf but by being someone’s parent. Mrs. D. felt the respect she received improved because someone on the staff recognized her last name. Her son had been a teacher locally for many years. Because she was related to somebody, she received better treatment (dpo 2/17, 38). Mrs. D. also thought she received better treatment from the staff than some other patients because the staff knew that Mrs. D.’s son and grandson were concerned about her welfare. (dpo 2/17, 38,95)

The individual continues to be decontextualized, but begins to engage in activities to enhance his or her self-concept. The strategy used by the hospitalized elderly person is telling stories about times in their lives where they made a difference in the health of another (Amy & Mrs. D.). As an introspective strategy, life reviewing has the effect of reminding elderly people of their worth in a time when they may be feeling of small value.

Amy told me a story about meeting a mother and her deaf child in a doctor’s office. Amy told the mother that she should take the child to the school for the deaf in the city because “it’s the best one in the world”. About eight months later, Amy saw the mother. The mother said to her “Oh, thank you, for recommending that I did take my son there. We have much better communication now.”

Amy said that she felt good that she had done somebody some good. Amy said “You think that when you’re old you become a real busy body. You don’t keep your mouth shut about anything” (apo 9/14/97, 134-140)
Another type of story told by the elderly individuals was of occasions in
the elderly individual’s past when they accomplished something special or daring.
Carl told stories about his experiences as a pilot. Amy told similar stories about
her life. Below is an example of a flying story from Carl.

... But ah...Well, as I say, well, that's life anyways. I was gonna
say I wish you were around years ago and coulda gone up in my
fool airplane, and I learned to fly originally in four hours. Yup.
With my friend, he worked for the oil company, and my father did
too. And he had an ole J2 Cub--40 horse-power Cub. I flew just
for fun because, did I say as long as I got somebody to go half
way with me to help me build and new things like that, why that
way I can afford to do it. And the mill wasn't the highest paying
company in the world, but they were good people. (cia2/6/98, 70-
80, 96-100)

Finally, there were stories about recognition by others. Carl had been
given a tour of the mill he used to work in and was very, very pleased that the mill
owner knew who he was and arranged for him to visit the high security areas of
the mill.

I was boss maintenance man in Valley Mill. And Michael Mill...
In fact, one day last week, he let me go into a mill--that's where
they make the high security goods. And it's not just anybody that
can go in there.

   But, ah, I told Mike, I said, 'You never let me get in the
fool place and I spent 30 years in there'.
   'Well,' he says, 'I'll get a hold of your son and have them
come out to the gatehouse to meet ya.' So that way my son took
me in. (cia 2/6/98 : 101-119)

The outcome of life-review strategies was twofold. First, it reminded the
elderly persons of their worth, dignity and success at managing outside the

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hospital; and second, it was hoped that it had the added effect of enhancing the respect they received from the staff.

The elderly individuals engaged in interactive strategies for managing image and establishing reciprocity in relationships. During this phase, an elderly individual actively makes decisions about how to approach different members of the staff. For example, Mrs. D. had told me that she did not like a particular nurse, but her behavior toward the nurse was such that the nurse was unaware of Mrs. D.'s true feelings. When I interviewed the nurse, she characterized the relationship between her and Mrs. D. as warm and friendly (dpo 2/9-10/98, 2-5).

The elderly person engaged in conversations with the staff about the staff person’s life and children, and complimented the staff on their dress. This strategy was designed to establish reciprocity in relationships. The elderly person tried to engage the staff in conversations that were outside the boundaries of the usual healthcare provider/patient relationship. Establishing reciprocity had the effect of enhancing dignity by minimizing the differences between the healthcare provider and the hospitalized person.

When I asked Amy about her relationship with the nurses, she gave the following response

They [the nurses] were as sweet as sugar. Nice and concerned and interesting. Just as sweet as could be.

There’s one there, that ah, has a little three year old. She’s a young girl, and she said she trained her baby to use the potty by giving him marshmallows every time he went to the potty. And he said he had to have three because he was three years old. I thought that was cute.

She says “I trained my dogs like that. When they went out, I gave them a little doggy bone. When they came back, I gave
them a little doggy bone’ And I figured ‘My god, I used to blow a whistle for mine, no wonder he didn’t want to come back.’

(laughed)

That was a clever way for this young girl to train her puppies and to train that baby. So, I loved her, she was just as sweet, nice, oh what a nice girl, concerned, and lovely, and willing to do anything you wanted, if you wanted anything done. Which you can’t have too much done while you’re in the hospital. so there you go, that’s my story on the young girls. (aidc, 180-200)

Bob made a point of commenting on the staff’s dress.

It was the same nurses aide assigned to Bob tonight as last night. The nurses aide came into the room and Bob said ‘Oh, look at that bright jacket’.

The aide said ‘Yes, when I saw the jacket, I just loved the color.’ She was wearing a bright cranberry and blue print vest and maroon scrub pants. (bpo 10/8/97, 183-192)

During the second phase, lack of privacy became a major issue. Privacy has both visual and auditory components. Healthcare workers routinely entered the elderly person’s room and bed area with little or no warning, and although bed curtains provided visual privacy, auditory privacy was virtually non-existent in the hospital.

For each elderly person, the roommate, sometimes several roommates, were a source of irritation. Several participants expressed concern over the poor health status of their roommates, but also complained about the disruption the roommates caused. In each case, the elderly individual did not complain to the roommate, or most times to the staff. Evy’s daughter described the relationship between Evy and her roommate.

... I think her bed partner wasn’t, ya know, she was on kind of a day/night
schedule with her. (laughed) I really think that her [roommate]...
She slept all day and was up all night. But Mom didn't complain.

Mom said, 'I'm not gonna put up a fuss, I'm not gonna be
here that long.' (laughed) 'I'm not gonna complain.' I don't know
if that was good or bad for her. (efi, 227-240)

While in the hospital, the elderly people participating in this investigation
found themselves engaged in conversation while performing intimate hygiene
tasks. These activities challenged their dignity by devaluing their personal
activities in their eyes and the eyes of others. These behaviors were unique to the
hospital experience; they were not activities in which elderly persons would
engage in front of strangers or family at home. The strategy they employed was
attitude adjustment. The elderly people temporarily adjusted their need for
privacy during these intimate procedures. The goal of this adjustment was to
allow the elderly individuals to engage in undignified behavior while trying to
protect themselves from an overall decline in dignity. Below are examples of
alterations in privacy which could affect dignity.

Amy is sitting up in the chair next to her bed with a basin of water
in front of her. She was washing with relish. Amy was chatting
with the nurses' aide about how often she (Amy) took a shower,
etc. Amy was scrubbing herself; there was no evidence of
shortness of breath. The curtain was drawn almost to the foot of
the bed.... (apo9/14/97, 18-39)

Mrs. D. is sitting on the commode next to her bed, swinging her
feet. She is sitting on the commode because she's worried about
stress incontinence.... As she is sitting on the commode eating her
dinner. Mrs. D.'s grandson is sitting on the bed next to her. The
grandson is lounging on the bed and keeping Mrs. D. company
while she eats [and sits on the commode]. (eia, 163; dpo2/6,etc.,
208)
One of Mrs. D's physician's associates came in to see her this morning and she was sitting on the toilet in the bathroom. He said, 'Well, can I talk to you?' She said, 'Yah, you can talk to me.' He said, 'Should I talk to you through the door?' She said, 'No, if you don't mind, you can come in.' So he went into the bathroom and sat down on one of the chairs in there while she sat on the toilet... (dposnf, 18)

In many cases, the elderly person was present for the personal functions of the roommate. They again used the strategy of adjusting attitude. The elderly individuals ignored the intrusions of their roommates as much as possible. Ignoring things is part of attitude adjustment. Evy was shocked by the behavior of her roommate, and Mrs. D. was routinely subjected to the bathroom noises of other patients.

'Course that lady that was with me through the last day drove me up a wall. (laughed) I went to the bathroom, come back, and she's standin' in the middle of the floor and no curtain drawn or anything--stripped! (laughed) Anybody walkin' up the hall could have seen her.

But as I said the first one, strictly alone, the curtain drawn, never hardly had a conversation with her, but this one here, she had the curtain open all the time. She walked stark naked! (laughed) She was a little bit off I think.... (eifu, 358-390)

The bathroom is between two rooms, it's shared by four people, and the door was open. One of the women from the other side came in. Although she was walking with a walker, she shut the bathroom door on her side. She said, "Oh, I can't shut that door." [the door on Mrs. D.'s side] She left the bathroom door open. The woman was using the toilet in the bathroom with the door open just a few feet from Mrs. D.'s bed. You couldn't see the woman in the bathroom, but you could definitely hear her using the toilet. (dpo2/17, etc. 154)
Some of the elderly participants felt that visitors were an invasion of their privacy when they were feeling ill. Bob described how he felt about visitors in the hospital:

I told her [my wife] to keep it [my being in the hospital] quiet this time. ... I don't like to be disturbed when I'm in the hospital, by phone calls and all that. I tell them [my children] generally not to call me unless they're, unless they're too upset, and want to hear my voice. (BIA10/7/97, 97-134)

Its... When you're ill, you're uncomfortable, you're unhappy, you don't want ah, people trying to cheer you up while you're worrying is really what, and you have to put on a good face [for visitors].... You know, you have to keep, they come here and you have to keep them entertained. You don't feel like doing that. (bidc, 117-126)

Physical space was another issue related to privacy and dignity. If an elderly person had less than half of the room, it was thought to be an indication of lack of respect.

Well, and I thought... When I saw, first of all, I bumped her gettin' in the room. I mean she was... Well ya know, my bed was all shoved... it was always shoved all way over there [against the wall]. That was one of the things I hated about that. But anyway, I bumped into... They bumped me into her... (laughed) It was a mess...

Anyhow, all I did was I looked at that room and I said to myself and I think I said it out loud, "Well I know that I would never have put my mother in this room before I looked at it. And I wouldn't have. I would of looked the room over before my mother... But I would ask. Ya know, if they had takin' me to that room and said this is going to be your mother's room, I would have raised hell. Because this woman had the whole possession of the room. (difu, 409-431)

In the current research, between-bed curtain placement was related to privacy, or the illusion of privacy and dignity. Amy used the curtain to separate
herself from a roommate she found tiresome. Curtain use is discussed in the excerpts from participation logs below:

When I first went in, the curtain between the beds was open, but by the time I left, the curtain was pulled. Amy was shielding herself from the roommate. Amy looked at me and made a face and smiled at me like "oh brother" in respect to the roommate's restlessness (apo9/14/97 160-170)

During the conversation Amy and I were having, the roommate's gentleman friend was in the room. He and the roommate were talking to each other on one side of the curtain, Amy and I were in another conversation on our side. It was quite loud, Amy and the gentleman were literally sitting next to each other with the curtain between them. They were almost elbow to elbow, Amy was looking in my direction, sort of across the bed, and the guest was looking in the opposite direction. It was quite difficult to have a conversation that way. (apo9/14/97 225-235)

During the phase of repairing personal integrity, the strategies employed during the stabilizing phase of hospitalization continue, but over time, as energy increases and illness decreases, the emphasis of the strategies of the elderly person shift. The elderly person expends more energy in maintaining and enhancing dignity than in previous stages and phases.

During the stabilizing phase of being in the hospital, the elderly individuals focus their use of strategies on their health. As their health stabilizes and they move into the repairing phase of hospitalization, the focus of strategies becomes enhancing dignity.

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Dignity During the Reintegrating Phase

During the reintegrating phase dignity has improved. As people have increased their autonomy and begin to focus on discharge, their store of dignity is enhanced by thoughts of returning home, improved health, and increased autonomy. The hospitalized elderly people continued with strategies used in the past to maintain or increase the respect given them by the staff.

The strategies used to promote self-dignity during the last phase of hospitalization included the introspective strategy of life reviewing. The elderly people thought about times in their life where they survived difficult situations. They person used these memories to help strategize for the future. They began to make plans for the future both immediate and more remote.

The lack of privacy in the hospital continued to be an issue for the elderly person, but now may act as incentive to hasten discharge rather than an irritation to be endured.

Dignity and the Post-Hospital Stages of Managing Personal Integrity

Once the elderly person returned home from the hospital the nature of threats to dignity changed and diminished. While hospitalized, dignity was at risk from the nature of the experience of being in the hospital. Upon returning home, the elderly individual no longer experienced decontextualization. There was some residual threat to dignity in that the elderly individual must adjust to their evolved abilities in the evolved usual way of being.
At home dignity was threatened by the elderly individuals' altered physical status. Alteration in overall ability led to alteration in the elderly individuals' expected behavior. The change in expected behaviors led to a struggle to maintain dignity in the post hospital phases. Mrs. D. did not feel that wearing her oxygen was congruent with her image of herself. She again engaged in attitude adjusting to reconcile her current need for oxygen and her image of her former self.

The Meaning of Diminished Dignity While Managing Personal Integrity During Hospitalization

Having dignity is a dynamic state that is related to the individual's health and autonomy. Based upon individual supply, strong dignity can help maintain elderly persons through the challenges presented by hospitalization. Mrs. D. described the lack of respect and consequent loss of dignity she felt while hospitalized:

I can't even explain what I mean by bein'... It just seemed like, that I wasn't... They [the staff] took away everything. It was just like you were at everybody's mercy, and you didn't count, you weren't... like I tell ya, I can't even explain it to ya.

Uh, when I was good and sick it didn't matter I guess. Their word was law; you did... whatever you said didn’t amount... that they didn’t pay any attention to ya. (difu 215-220)

Over time in the hospital insults to dignity accumulated and may have contributed to an overwhelming decrease in personal integrity. Mrs. D. came to a point during her hospitalization where the combination of poor health, lack of autonomy, and lack of respect from a staff person was more than she could bear.
This morning as I [the researcher] sat in the room ... Mrs. D. just looked disgusted. She looked frail, she looked old, she looked disgusted, she looked a little shaky, and she looked uncomfortable. She was quite distressed for awhile.

She was very upset and said, "Do you think I'm a baby?" ... She said "he [the orderly] comes in and shouts at me. I'm not deaf. And he comes in and tries to give my glasses. I have almost 20/20 vision. I don't need to have my glasses on for breakfast. [He just doesn't treat me right]" (dpo 2/17:170-176)

In this situation, the behavior of the staff person together with all of the other stressors of hospitalization tipped the balance of personal integrity, and Mrs. D.'s dignity was so diminished she slipped over the threshold into despair, feeling that she had little value. Mrs. D.'s ideas about how she should be treated were not consistent with the treatment she received from a staff person. She interpreted his behavior as disrespectful and treating her like a child, telling her what to do.

Summary

Elderly persons have an internal definition of dignity. They make meaning out of their behavior and the behavior of others toward them by comparing said behavior to the existing definition of dignity. Throughout the hospital stay, dignity is continuously threatened. Both decontextualization and the lack of privacy they experienced had a negative effect on their dignity.

In the early stages of hospitalization, the threats to health are greater than threats to dignity. The elderly individual endured the threats to dignity in favor of treating the health problem. In later phases of managing personal integrity, the elderly individuals engaged in strategies to enhance dignity whenever their
current behavior or treatment received was not consistent with the existing
definition. Failure to successfully maintain dignity can lead to despair.

Behavior of the staff had a strong effect on the elderly individual’s sense
of dignity. Client-centered staff behaviors enhanced dignity, staff-centered
behaviors diminished elder’s dignity. Support from family and friends bolstered
an elder’s dignity. The role of staff, family and friends will be discussed in the
chapter addressing objects modifying the elderly person’s management of
personal integrity.
CHAPTER VIII

AUTONOMY: A PROPERTY OF PERSONAL INTEGRITY

Autonomy, the third property of personal integrity, has both physical and psychological attributes. It is conceptualized as the elderly person's freedom and ability to act on his or her own behalf. Autonomy consists of two attributes: independence and control. Independence is the ability to act in a situation. Control is a measure of the elderly person's perceived power in a given situation.

In the hospital, several things combined to diminish elders' autonomy. First, elderly individuals may have been too ill to act independently or to exert control over their situations. Second, their autonomy was diminished both voluntarily (giving consent to treatment), and by the healthcare workers, who made decisions and acted on those decisions based upon their expertise and the immediate health needs of the elderly people. Third, the elder was in a new context and did not know the rules of behavior. There was little flexibility in the hospital routine for allowing people to create their own order thereby exerting control over their situation. Together, these things diminished elders' ability to effectively control their schedules or activities. Finally, the staff was comfortable with the environment and acted in a routine manner often demonstrating a lack of sensitivity to an elderly person's routine or individuality.
Attributes of Autonomy

Independence as an Attribute of Autonomy

People in the hospital were independent when they could meet their own physical needs, and made decisions about the physical activities that other people did for them. Some of the staff's expectations for independence in the elderly were minimal. The nurse working with Mrs. D. considered an 84 year old woman to be fairly independent if she could feed herself. (dim1, 32). This standard called for considerably less independence than any of the elderly participants had while living at home, or expected in setting their standard for performance in the hospital.

Maintaining independence was of paramount importance to Evy. When questioned about her concerns in coming to the hospital, there were two things that were important. First was that the healthcare providers take care of her health problem, the blood clot in her leg, and second, that she did not lose her independence. (eia 18)

Several of the elderly participants in this study were too ill to get out of bed so they were dependent on the staff to help with all activities. Some were ordered to bed by the physician, and some did not have sufficient energy to get out of bed. The following description of Mrs. D. is an example of the dependent state some individuals were in when admitted.

When Mrs. D. first came to the hospital she was very weak. The slightest physical effort was very taxing.
Mrs. D. had been filling out her menus. It was clearly a strain as she is sitting there in the bed. She is so weak that she is trembling all over, particularly from any exertion. She looks exhausted. She's red faced. I can hear her wheezing. She is short of breath. Her voice is very weak. She can hardly speak at all. She truly is exhausted. She's in bed. [sitting up, resting back on pillows] (dpo 2/6, etc: 70,78)

The environment of the hospital created a state in which elderly persons lost some independence. This stemmed from their need to adhere to the hospital schedule and routine. They were restricted in their mobility either by ability or convention. Patients were usually discouraged from leaving the hospital unit to which they are assigned. Some participants accepted this lack of independence as a temporary situation. A nurse explained Amy’s management of her independence this way:

I think she is very independent and is willing to let someone else take control for the present but is going to go and get right back to her same routine, where some of the other clients have a harder time. They let somebody take control and they give up, and I don’t think she’ll do that, I think she’ll go right back to what she was doing previously. (aim,74-87)

Amy’s comments about being in the hospital agreed with the nurse’s assessment of Amy’s attitude.

Ahh, you know I’m a clown, so it [being in the hospital] doesn’t bother me either way, I’ve been in the hospital too long to let it bother me. Ahh, I don’t like it because you’re confined and I don’t like to be confined..... (aidc, 46-93).

Mrs. D. was very conscious of the lack of independence she experienced while she was hospitalized. Initially, she was too ill to engage in any activity. As
her health improved, Mrs. D. began to gain independence in personal care. The measure of being independent in the hospital was being able to take care of one's personal needs. This was a dramatically different level of ability than the elderly individuals engaged in prior to this hospitalization. This lack of independence was interpreted as inconsistent with Mrs. D.'s image of her abilities. Being able to meet one's personal needs was an indication of being a patient that did not need much attention from the staff. Meeting self care needs improved one's status in the eyes of the staff. For Mrs. D. the reputation of being able to meet her own needs partially compensated for the overwhelming lack of control she felt. Meeting her own personal needs was a way of managing her image as well as validating her worth.

...I always did do my own bath and everything. That's what they said upstairs before they took me downstairs. 'You won't have any bother with her. She does everything herself.'

And I made up my mind if I ever go back in the hospital I can do everything for myself. (difu, 628-632)

When individuals are dependent, they feel that they have to rely on someone else to meet needs that they were previously able to meet independently. The elderly people in this investigation were independent prior to coming to the hospital. Decrease in their ability at self-care was inconsistent with their idea of themselves. The effect of having to rely on someone else is to diminish autonomy and thereby personal integrity. Mrs. D.'s nurse explained her thoughts about independence below. It is to be noted that her words are not congruent with Mrs. D’s perceptions above.
Maybe... Maybe here [in the hospital] she [Mrs. D.] has lost some of her independence. Maybe at home she'd have to deal more. Here she doesn't have to. She can just pass it right on to us and we're supposed...and we take care of it. And at home, she's got to deal...(dim2, 62-68)

In reflecting on the meaning of dependence for elderly patients, the same RN made the following statements.

It must be awful to lose your independence. It must be awful to all of a sudden be dependent, and even to suddenly wanna be dependent.

It's gotta be awful to lose your independence and be afraid that you'll never ever get it back. I can't imagine ever being dependent on someone like that.

That's a hard one.
I just can't imagine.
It's got to be awful to lose your...
I mean especially somebody their whole life...
She's [Mrs. D.] probably never been sickly and then all of a sudden she has all this going on, and it just must be hard to spend so much time in the hospital and you never know if you're gonna make it out. (dim2, 208)

The threat of being in the hospital was that the elderly person will lose independence and not have sufficient independence to return home.

Control as an Attribute of Autonomy

A person was in control when they feel they could exert their will over a given situation. Control is a mental process while independence is a physical attribute. The senior nursing student who worked with Carl explained her ideas about the importance of control for the elderly people she worked with.

Well, they [elderly patients] need to feel like they're safe. And umm, that they still do have some control. And when they know what's going on, they are able, they understand that they can ask.
And maybe it helps them feel a little bit better, mentally maybe, if not physically. But knowing that they're in good hands, and that I as a nurse will respect him and his privacy. (cin, 34-37)

This student nurse suggested that the staff had a role to implement in relation to the elderly individual's sense of control. The role of the staff will be discussed later.

The hospital had a routine that was alien to the individual. The elderly persons' ability to control their activities was curtailed by their health status and by the structure of the hospital. Elderly individuals had little control over their day. Diminished control was evident in the individual's inability to schedule their activities while in the hospital. Evy expressed her lack of control over her schedule in the hospital.

They [the staff] come around at 1 o'clock [in the morning] for temps, which I couldn't see. I go to sleep at night, and they come around for my blood sugar at 10 o'clock [PM]. Everything had to be done on schedule... but their schedule, and not my schedule. Because they get pills at 10 o'clock in the morning, where I get mine at 7:30 [AM].... But it still does my diabetes good to stay right on the strict schedule with meals, go-to-bed time, get-up time. (eifu, 87-106; eidc, 83)

In addition to patient's schedules being out of their control, the schedules were unpredictable. Often patients were told that a particular activity would happen at a certain time so they would prepare to be ready at the appointed time, only to be kept waiting or have the activity happen before they expected it.

... you wash yourself up. Yah, ya know, before you had your breakfast. So you get in there, get everything in your bucket, and go into the bathroom because somethin' was going to happen, maybe like in another hour and a half. No sooner ya get in there, and bang, they were there to take you upstairs.
They say you're gonna do that at 11 o'clock. Well, [then they come and say] I can take you in at 9 o'clock. Well, then you do it.

You just get settled and then they take you down for X-rays and do somethin'... Whenever they were ready, you had to be ready. I asked 'em a couple of times about that. Ya know, how come they didn't have things... I just thought that it wasn't managed very well.(difu, 624-667)

There were other occasions where the elderly person was scheduled for something that they were not aware of. This contributed to the elderly person's feelings of lack of control.

While we were sitting in Bob's room waiting for the physician to come back [to discharge Bob], a transport person came into the room with a wheelchair and said "I'm ready to take you downstairs for your test."

Bob looked at him and said "I'm not going for any test, I'm being discharged".(bpo 10/9/97, 122-126)

In addition to an inability to control their schedule in the hospital, some of the elderly individuals had difficulty getting accurate and timely information about their care. This lack of information led them to feel like they had no control over their situation and their health. Bob explained his feelings about his inability to obtain information:

[Yesterday], I was angry that they didn't come and tell me what was happening with each test. And so that, I was, until finally my primary physician came in and told me. I guess, maybe they were waiting for him to do it.

But I mean, up to that point I was worried because they didn't tell me, I thought that maybe something, something really bad was wrong with me.

Oh course, as soon as he walked in, he said 'it's good news' From that point on, I've felt much better. I can assure you.

But I really was mad. I really think that, maybe they were following some sort of protocol, hierarchy protocol, where you
have to leave the good news or the bad news to the primary physician.

But, the fact is that thinking about that made me think it was going to be bad news. Otherwise, they [the medical residents] didn’t want to do it, they wanted to leave it up to him [primary physician] to do it. I didn’t know what the hell was going on. (bidc, 10-28)

Independence, the physical ability to provide self-care, and control, the ability to make decisions about one’s situation were jeopardized by illness and hospitalization.

**Relationships Among the Attributes of Autonomy**

Control and independence are in positive mutual relationship. An increase in an elderly person’s ability to complete functional activities has the effect of improving their control. A decline in physical ability requires an increase in the amount of assistance an individual requires thereby reducing the ability to control the situation.

An increase in the amount of control an elderly individual has over their situation does not necessarily improve their physical ability, but it does improve the individual’s options in terms of problem solving about functional activities. Situations which improve one attribute make deficits in the other attribute easier for the elderly individual to bear.
Autonomy and the Process Hospitalization

Autonomy and Pre-Hospital Stages of Managing Personal Integrity

All elderly individuals were autonomous in their usual way of being. Their independence varied according to their abilities, but they were all living independently and making decisions about their daily lives. Amy had help from a visiting nurse, Bob and his wife collaborated in decision making, Carl lived with his daughter and she made many health decisions for him. Mrs. D. and Evy lived alone and were in regular contact with their children. With the exception of Carl, they exercised their autonomy by taking actions which led to their admission to the hospital. Carl’s daughter acted on his behalf and Carl concurred.

Upon entry into the healthcare system during the transition stage of managing personal integrity, the elderly people willingly suspended their autonomy by relying on the authority of the health care workers to treat their illness.

Autonomy and Managing Personal Integrity in the Hospital

Autonomy During the Stabilizing Phase

As noted above, during the initial stages of managing personal integrity, the elderly person, usually with the help of a family member, made the conscious decision to ‘take action’ by coming to the hospital. The individual willingly placed him or herself in the hands of the healthcare workers to be taken care of. The staff acted by providing “expert” care. Individuals recognized that they “needed that help” (aifu, 404-420) and are therefore willing to ‘rely on authority’.
At the initial phase of being in the hospital, people were willing to give up control for the security of being in ‘the best place to be’ (dia, 130-138).

In terms of independence at admission, people were often too ill to want or be able to exert much independence. Several participants were critically ill and not able to participate independently in meeting their own physical needs. Also, the hospital routine placed restrictions on the hospitalized elderly individuals. The nurse working with Amy described the restrictions placed on the elderly individual in the hospital.

...And I think one of the major, umm... problems that they have is that all of their, all of their, their routine that they’re used to doing is taken away from them. We’re telling them when they can go to the bathroom, they have to go to the bathroom in this hat. Take your medications now, a lot of them are used to taking their medications on their own schedule at home and we’re telling them, ‘no you have to take your medicines on an every twelve hour basis’. I think it’s frightening, I think it’s frustrating, umm... I think every patient does [feels this] on some level. I think it’s more overwhelming for some of them, but I think on some level they all do. I mean even that they have to ask for a drink. (aimn, 7-8)

The strategy used by hospitalized elderly people in relation to autonomy during the stabilizing phase of managing personal integrity is to rely on the authority of the health care workers. This has the effect of diminishing their autonomy, but is necessary in order for health to benefit. The properties are in dynamic balance. At this stage, the perceived loss of autonomy is outweighed by the anticipated improvement in health.
Autonomy During the Repairing Phase

Worrying is the predominant strategy for improving autonomy during the repairing phase of hospitalization. Worrying is an introspective process that individuals used to attempt to improve their personal integrity by improving their autonomy. People worry when they experience a lack of control over a particular situation, in this case their health, and are trying to find a way to improve their control. Worrying had both positive and negative effects. Some individuals tried it to improve his or her sense of control over their situations, but worrying had a negative effect on sleep patterns. Worry in the positive sense served the purpose of “doing something” when there was no action individuals could take to enhance their control. Bob’s worry about his health problems is an example of the lack of control the elderly participants felt over his or her situation.

... And ah, so that’s what I worry most. It’s how long I’ll... you know, can’t they do something to give me a couple of years without any problems?
... I was hoping that if anything was going to happen [to my health] that it wouldn’t happen until I came back from the vacation house.
... I mean here I am just lying here, staring into space. And that’s not the healthiest thing when you’re worrying about your health. (bia107/97, 61-109)

The longer Bob waited to find a diagnosis, the more he worried as an attempt to gain control; as he felt he had less and less control over his situation, his worrying increased in an unsuccessful attempt to find a way to increase his control.

Well, firstly, it was worrisome...................... In spite of the, ah .................. kind help you get around here, you worry more about
your illness, then you worry about that [being in the hospital]. And, the worry just increased as they, you know, until they found what they were looking for. Some answers to the question. That’s about all I can really say about it. I’ve just been sitting here worrying all the time. (bidc, 5-11)

Throughout their entire hospitalization, elderly individuals worried. The focus of the worry changed with the phase of the hospitalization. During the initial stage, the worry was focused primarily on health/illness. In the second phase, worry about being in the hospital was added to the health concerns. In the third phase another dimension of worry was added: how will I manage when I go home? This conceptualization of worry as a strategy to improve an individual's autonomy is a somewhat unique view. Individuals used worry as a way to help prepare themselves for the next event in their lives.

During the reparative phase of being in the hospital, elderly individuals began to feel well enough to start to initiate strategies to increase their autonomy, but it is not until the third phase that control becomes the focus. Elderly individuals were feeling better and were beginning to want to reassert their control over their life. There was increased insistence on participation in decision making and increasing participation in the plan of care. This was accomplished through active strategies such as maintaining health and taking action. The elderly people began to assert control by questioning the nurses about which medications they received, and managed which medications they took.

Amy made decisions about taking medication to help her sleep. The first night she was in the hospital she did not request a sleeping pill. After having
trouble falling asleep, the nurse offered Amy a sleeping pill. Amy told me that she slept fine after the sleeping pill. She made the decision about sleeping medication on subsequent nights in advance (apo 9/12/97, 57-67). Mrs. D. routinely examined each of her medications when they were brought to her by the nurse and questioned the nurse about any medications she thought the nurse had missed.

"I know everything that I am takin'. I never take anything unless I'm sure it's the right stuff, and I always ask [the nurse] what needs to be done—what needs to be taken or if there is something missing or if something doesn't look right to me.(dpo, 64)

In the quote below, Bob was angry that he had not been told he needed to go to x-ray for a test. He took action by refusing the test in part because he was not aware it was scheduled and in part because he thought it unnecessary.

They should have let me know "you have to go down for this test’ and prepare me for it. I wasn’t prepared at all... [Yesterday] At least they explained why we were going to MR instead of the ITT or whatever it was called. At least it was explained to me before hand. And so I went for one test or another. At least I was expecting some test. But I certainly wasn’t... Also I mean it was a little upsetting because they told me that the nuclear was very good and ah, so that probably the second one wouldn’t be necessary. That was one of the things. So then all of a sudden they come in and tell me that it is necessary, and ah, maybe something wasn’t clear. But ah, I really didn’t care any more I just didn’t want to do it, I just didn’t want to go through the pain. (bide, 68-99)

During the repairing phase independence began to improve. The elderly person could generally meet their needs for personal care. Personal care may have taken longer than usual, be modified in some way, or the individual may still have needed some assistance. As the ability to be independent progressed, there were increasing attempts to “do it my own way”.

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Mrs. D. said that this morning she got up and went into the bathroom and took a really good bath and then came out and cleaned up the place. She was doing a little house maintenance, folding things up, getting rid of garbage--that sort of thing. (dpo 2/17, etc., 16-29)

The repairing phase of managing personal integrity came to a close when discharge from the hospital was scheduled. Health continued to improve throughout the repairing phase, and the elderly participant was well enough to get ready to go home.

Autonomy the Focus of the Reintegrating Phase

The reintegrating phase of hospitalization was the time during which the elderly individuals began to feel more autonomous. The crisis that brought them to the hospital was resolving or has been resolved. This did not mean that the underlying cause of the health crisis had been resolved, but that the exacerbation of the condition was improving. The elderly individual began to take more responsibility for self-care and decision making. The elderly individual continued to worry, but the focus of worrying moved from the current situation to what would happen upon return home.

Then she was quiet for awhile after that. She said again, "I wonder how I'm gonna be when I get home. I wonder how I'm gonna do everything when I get home." And I said, "Do everything?" "Well, yeah, like cook my meals and clean my house and all that stuff. I guess they'll arrange for the visiting nurse to come in and check my breathing and stuff. But I wonder how I'm gonna do anything. I wonder what I'm gonna be like." is what she said. (dpo2/26, 72)
As the elderly individuals' health improved, they gained more control over their situation. During this phase, there was heightened participation in the plan of care, and increased use of active strategies such as "taking action" on the part of the elderly person. The goal of this increase was preparing to resume independent functioning after being discharged home. Amy had a plan to take action to get home from the hospital.

I asked Amy how she was going to get home from the hospital when she was discharged. She said she had a friend who would come and get her. or, Amy said her nephews would come if she asked them. "Or, if nobody can come, I'll take a cab home. I don't miss them."

Amy is quite independent and fairly self sufficient even though Amy has a lot of support services. (apo 9/14/97, 275-280)

Independence continued to improve. The elderly person was now not only taking more responsibility for their personal needs, but was taking responsibility for their health maintenance.

Dr. Eckles had my medications all written out yesterday when she came in. Yah, no there... Then she went over with me, the nurse went over with me again. I s'pose she'll go over [them] again before I go home. Yah so... (eidc, 455)

The nurse who worked with Amy felt that patient education was very important in preparing an elderly person to go home and manage their health.

Well, hopefully, the education that we did will have a positive effect, she'll be more aware. Ummm, of contributing factors. ................................. And hopefully she won't come back. Not want to come back. (airn, 58-65)
The strategies that the elderly participants engaged in to increase their independence and feelings of control while they were in the hospital included worrying, maintaining health, taking action, and taking responsibility.

**Autonomy and Post-Hospital Stages of Managing Personal Integrity**

At home the elderly people increased their responsibility for the health. They took action to make sure their supplies were available and then implemented the health care practices that they had been taught to maintain health. Their autonomy increased as their health continued to improve. Actions to maintain health reinforced the elderly persons independence and control. Families took a bigger role in supporting the elderly individuals than they had prior to this hospitalization. This was particularly true during the phase of adjustment, but continued into the ‘evolved usual way of being’.

**The Meaning of Altered Autonomy While Managing Personal Integrity During Hospitalization**

The elderly participants perceived being in the hospital as representing a loss of autonomy. Initially, they made decisions about voluntarily giving up autonomy for the sake of health improvement.

In general, reduced autonomy is common to the hospital experience and may herald change in an elderly person’s ability to be autonomous upon returning home. Evy was the most articulate elderly participant in relation to the threat that hospitalization represented to her autonomy.
In everything that Evy does, she talks about being independent [autonomous] and what it means....

She wants to be independent [autonomous]. Anything that is a threat to her independence is very scary. She said being in the hospital was somewhat of a relief, but that it also raised many other issues about her ability to take care of herself. (eia, 18, 197)

The nurse who worked with Bob explained the stress of being in the hospital with respect to an elderly individual's autonomy.

Hmm, I think he was very anxious about being here... I think when, for some elderly patients it is very difficult for them to come in here. They lose their independence, we do things terribly different than what they're used to doing for years and years at home. And I think he was one of those. (birn, 6-11)

The nurse from the skilled unit spoke about the effect of being in the hospital on elderly people's autonomy and the difficulty returning home after a lengthy hospitalization.

Well, she's gotta get over that she's dependent now. And she's gonna have to get over that, and I think it's gonna be a little tough probably more so on her son than her... because he's gonna have to take over where we were-where we are now-to make, ya know, to try and show her that she can do this again. And she is independent. Just mentally, I don't think she feels independent. (dim2, 114-128)

Evy's daughter identified independence as the most important concern for her mother at discharge.

Being able to resume independence [is her biggest concern]. She hasn't said anything, and I can just tell in her manner that she wants to be very independent, but she's also going to be dependent on me, knowing that I will be there. We [my husband and I] both would do anything for her that we can. Coming into the hospital has been pretty scary for her in terms of this independence issue. She's never said anything, but I just kinda sense a little bit of it, ya know?(efi, 241-269)
Mrs. D. spoke about how she felt when she had been in the hospital for several days. The combination of poor health, diminished dignity, and lack of control brought Mrs. D. to a low point:

Ya know, I saw the difference in that woman [who lived in my apartment house] between when she was 84 and 85 [years old]. And I thought, geez, I wonder if when I turn 85, I'll be like that too. Well, I didn't change. Ya know, I had a birthday and things were the same. I didn't change, but now [since I've been in the hospital] I can see a difference in myself. Now I feel weak and old, and I don't feel in control. (dpo2/15/98, 16)

Mrs. D.'s comment sums up the meaning of being in the hospital with respect to autonomy. The experience of hospitalization has the potential to permanently diminish the autonomy of elderly people.

Summary

Hospitalization was a significant threat to elderly people's autonomy. During the pre-hospital stages elderly individuals made autonomous decisions to seek health care for their impaired health. During the transition to being in the hospital, the elderly individuals willingly gave up control in order to improve their health. Often at this stage and during the stabilizing phase, the elderly individual was too ill and weak to engage in independent self-care. As hospitalization progressed toward discharge, the elderly individuals began to initiate strategies to improve their autonomy. This continued during the reintegrating phase of hospitalization when increasing autonomy was important in preparation for discharge. After discharge, the elderly individuals' autonomy continued to increase, stabilizing during the evolved usual way of being.
CHAPTER IX

MEDIATORS OF MANAGING PERSONAL INTEGRITY
IN THE HOSPITAL

The elderly individual’s experience of hospitalization was affected by interpersonal factors that modified the elderly individual’s way of managing personal integrity. These factors included relationships with the hospital staff, family, and roommates. Through interactions with other people, the elderly individual made meaning out of their experiences. Below is a discussion of behaviors of the hospital staff, family members, and roommates that influenced the elderly individual’s ability to enhance personal integrity and survive hospitalization.

Hospital Staff

The behavior of the hospital staff affected the balance of personal integrity and strategies used by the hospitalized elderly people. Staff included physicians, nurses, nurses aides, and all other professional and assistive personnel employed by the hospital. In the discussion below, the staff will first be discussed as an aggregate, followed by discussion of the roles of nurses and physicians.

In general, the hospitalized elderly people had very favorable opinions of the hospital and the staff. At his follow-up interview, Carl said:
Well, I just remember mostly there were so many good people that come to take care of you. They were so good, they come in and want to know if you were all right, you know stuff like that. So it's very good anyways. And then they bring me urinals, stuff like that, real good people. (cifu (44-52).

The elderly participants had generally favorable impressions of the quality of the care at the hospital. This was true even if the elderly individuals had negative experiences while in the hospital. At the follow up interview all had positive things to say except for Mrs. D. At her follow-up interview, Amy said she was very pleased with the care she received while in the hospital. She said, "I thought I got lovely care". (aifu, 166-168)

During interviews, the elderly participants spoke about the work behavior of the hospital staff and how they interacted with the elderly participants. For example, on the day of admission, Bob told me how busy the nurses were and what strategy he used for interacting with them.

They [the nurses] will do what they have to do [with me], they will give me my medications, get my vital signs every couple of hours, keep me more or less clean, I guess. I can’t expect anything more from them. They’re very busy.

It’s a very busy hospital today with the, it’s been absolutely murder around here (laughed). They’ve been running their asses off. I can hear them, running from one room to the next.

And you know, I sort of sympathize very much with them. I leave them alone as much as possible. I don’t press that button (the call bell). (bia, 93-109)

The hospital is the usual working environment for the staff, so the staff was subject to all the effects of the workplace. For example, the staff were very sensitive and at times verbal about the number of staff scheduled to work at any given time. The participation log below outlines a conversation which occurred at the nurse’s station outside of Mrs. D.’s room.

Out at the nurse’s station the nurses were talking about the poor staffing they were experiencing and the amount of overtime the hospital was paying for the existing staff working through supper and leaving their shift late as a consequence. The consensus of opinion was that the hospital could have afforded to place an
additional nurses aide on the unit to help with the high number of difficult patients on the unit, it would have saved the hospital some of the overtime paid. (dpo2/6/98, 124).

This quote reflects the need for the hospital staff to have what they perceive to be good working conditions in order for them to do their jobs. In this instance, promoting the health of the patients was a secondary consideration to the hospital staff’s ability to get the job done. Their job in this context was the care of those people who were hospitalized on the hospital floor to which the staff was assigned during their assigned shift.

The primary purpose of the hospital staff is to improve the health of the hospitalized elderly individuals throughout their hospital stay. Unlike the strategies used by elderly individuals, the staff’s behavior did not change by phase of hospitalization. The staff’s behavior can be divided into two categories: attitude and management of care.

Attitude: Staff Behaviors Affecting the Elderly Person’s Dignity and Autonomy

In this research, attitude was defined as the staff’s general behavior toward hospitalized elderly people. The hospital staff’s interactions with the hospitalized elderly people ranged along a continuum between behaviors that were patient centered, focused on the elderly individual, and enhanced personal integrity; and staff centered behaviors, that met the needs of the staff and had a neutral or negative effect on the elderly individual’s personal integrity (Table 5). Although each
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The property of personal integrity affects the other properties, behaviors discussed with respect to staff attitude were predominately related to the personal integrity.
properties of dignity and autonomy. These behaviors indirectly affected health by enhancing or diminishing the elderly person's personal integrity as a whole.

Staff Behaviors Affecting the Elderly Person's Dignity

The behaviors coded as attitude were behaviors which enhanced or diminished the hospitalized elderly person's dignity. These included behaviors such as attentiveness, connectedness, friendliness, helpfulness, obtrusiveness, and respectfulness.

Attentiveness. Staff interactions with the hospitalized elderly individuals varied in the degree of attentiveness to the elderly persons' comments about their health. When Bob had an episode of chest pain on the night of admission, a medical resident questioned Bob about the pain in a way that demonstrated a high degree of attentiveness.

The resident introduced herself to Bob and said “The nurse reported to me that you had some chest pain earlier. There weren't any changes in your EKG.'

Bob replied, “I don't believe in EKGs any more. There are never any changes in the EKG.’

The resident said, ‘Is the chest pain all gone now?’

Bob said, ‘Mostly all gone.’

The resident, ‘All gone, or mostly all gone?’

Bob, ‘Mostly, I still have some pain in my shoulder blades.’

The resident said ‘I changed some of your medications around. They will be giving you a little bit more nitro paste and that might help the chest pain a little.’ (dpo 10/7/97, 186-209)

As a result of the resident's interaction with Bob, Bob felt that the resident was interested in Bob's experience and was organizing his treatment based upon Bob's report of his experience in spite of the fact that the objective information reported by EKG did not agree with Bob's subjective experience. Bob's dignity was enhanced by the feeling that his reporting of his chest pain was interpreted by the physician as being important.
In other interactions hospitalized elderly persons felt that the staff paid little or no attention to their comments. Mrs. D. described some interactions with the staff where she felt the staff was inattentive to her comments and needs.

Mrs. D. had been complaining to several staff members for several days about the pain and itching she was experiencing in her eyes. A treatment had been ordered and administered, but the treatment was not resolving the problem. On the day before she was discharged, she was anxious to see her physician to discuss the problem. She was distressed to find out that her primary physician was away for two weeks and his associate was visiting patients. This participant observation note tells the story.

Mrs. D. was quite angry when I saw her today. Dr. Daniel's associate, who visited her yesterday, visited again.

Mrs. D. said to the doctor, 'My eyes are killing me.'
He said, 'Well, what's the matter with your eyes?'
She replied, 'You ought ta know, you've been lookin' at them every day for two weeks.' (dirn2, 243)

Mrs. D. felt that the physician did not pay attention to her concerns and did not remember her problems from one day to the next. Because he did not explain his rationale for not changing the existing treatment, Mrs. D. interpreted the physician's actions as not valuing her experience and complaints. These events had a negative effect on Mrs. D.'s dignity.

Connectedness. Staff behaviors that were sensitive to the elderly person as an individual were labeled connectedness. There were several examples of staff members connecting with the hospitalized elderly people.

The evening nurse sat down on Amy’s bed... She and Amy had a lengthy conversation which included the chest pain Amy had experienced earlier that day and more generally how Amy was faring. The nurse told Amy she would look at Amy’s medical record to see if there was any mention of when Amy would be discharged. (apo, 9/14/97, 168-204)

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On many occasions staff made an effort to connect with the elderly person to improve his or her comfort. There were instances where hospital staff of varied educational levels engaged in activities to connect with or provide comfort to the hospitalized person. For example, one evening a nurse’s aide helped Bob get more comfortable by giving him a back rub (bpo 10/7/97, 318-320); in another example, a Licensed Practical Nurse (LPN) helped Mrs. D’s roommate get positioned in bed to be more comfortable (dpo 2/6/98, 66). In cases where a procedure was uncomfortable for the elderly person, such as when a nurse was irrigating the intravenous needle in Amy’s arm, the staff person was often apologetic for causing discomfort (apo9/13/99, 108-112). Bob was offered pillows for his head and behind his knees while on a procedure table to increase his comfort (bpo 10/9/97, 165-169). All of these interactions between staff and the elderly person contributed to the elderly person’s feeling of value, thereby enhancing dignity and personal integrity as a whole.

Although not as frequent as the interactions demonstrating connecting, there were occasions when the staff seemed to make no attempt to connect with elderly persons. During these incidents the staff spoke harshly to the elderly person or physically handled him or her roughly. These experiences diminished the elderly individual’s feelings of self worth and dignity. Amy told me that on her last night in the hospital, the behavior of the staff made her angry because she thought she should be treated better. The incident challenged Amy’s dignity by diminishing her sense of worth.

... But, the last night at the hospital. Now, I don’t know if you know this, but the nurses were lovely. We had beautiful nurses all around the clock. Except the last night.

The last night. Those nurses that were on duty were the worst that I have ever imagined. I wouldn’t think that there’d be nurses like that in a prison camp.

Well, the old lady [roommate], would go to sleep. She’d fall asleep and you’d hear her breathing hard. All of a sudden she
would, now, she was a whiner, which is all right, you know, what the hell she’s eighty—what?, eighty-five, eighty-six?
I don’t care how much of a whiner she is, she’s got a right. She’d wake up out of a deep sleep 'I can’t breathe, I can’t breathe, I can’t breathe.'

Now, you don’t wake up and say ‘I can’t breathe, I can’t breathe’ if you’re breathing, right?’

Well, we called for the nurse. Number one, we waited two hours before they showed up. Number two, when they did, they were as nasty as could be. And I mean nasty. Telling you off, that they were busy, that there was only three girls on duty (raising her voice) and that we shouldn’t bother them!
I’m telling you, if that’s a heart ward and you speak like that to a patient that has heart trouble, you’re liable to throw them into another heart attack.

I don’t like that sort of thing, you should check those nurses. Because they certainly were not nice.
Then, in the daytime, nurses come and they’re sweethearts.
Last night was the only night like that. Yeah, I don’t know where those girls came from, but yaaaaaa.. make your teeth rattle. (laugh) Really. (aidc, 58-97)

Friendliness. The staff usually approached the hospitalized elderly person in a friendly and helpful manner. During his admission interview, Bob generalized the friendliness of the hospital by saying

I’ve always found this hospital a very amiable, I’ll use that word, where I find, I find that the staff is very proficient and ah... I mean, ... I find it very, everybody’s pretty friendly. (bia, 47-58)

Mrs. D. spoke about how nice and how friendly staff members were to her.

Another nice thing was the lady that did my hair. She was so kind so nice. So that was real nice. She came down and got me, done my hair.

Then the girls who worked in the breathing business [respiratory therapists]. They were really nice. We got to be good friends. They’d tell me their problems, stop some place and sit and talk. I like those girls—were really nice women.
Well, one nice thing when I came back to my room one day, there was a package of gum by my stand. And this girl, I know she had bought it for me. When she came, 'course I thanked her. Now that was nice, ya know. (difu, 463-473)

Often while performing procedures, the staff person and the elderly person engaged in casual conversation, often about the staff person’s children or life activities outside of the hospital. One of the strategies engaged in by the elderly
person was reciprocity in relationships. The staff responded to that strategy by reciprocating and engaging in personal conversations with the hospitalized elderly person.

This behavior was most apparent when the staff person was engaging in some procedure for the elderly person which required time. For example, a nurse was visiting with Bob while trying to get the intravenous fluid flowing through the needle in Bob’s arm. The nurse sat down on the bed next to Bob and engaged in a casual conversation while she was working (bpo 10/7/97, 312-320). At another time, an LPN came into Mrs. D.’s room to inspect the administration of an intravenous medication, and as the medication was finishing the LPN said to Mrs. D. “Good to the last drop.” (dpo 2/6/98, 68)

On occasions where the staff was overly cheery, it was not interpreted by the elderly people as friendly, but as false and demeaning. Mrs. D. complained about the behavior of a male nurses’ aide and about a physical therapy assistant both who did not seem genuine in their friendliness.

Helpfulness. The staff routinely engaged in helpful behaviors, with variable commitment. In the data, there are several examples of helpful behavior by the staff. Amy needed help with her menu because of her poor vision. I made the following participant observation note:

The nurses’ aide was sitting on the side of the bed next to Amy reading the menu to Amy and helping her fill it out. The aide was asking Amy what she would like to eat. (apo 9/12/97, 101-103.)

The staff sometimes made promises that they did not keep. A staff member promised to put something in the refrigerator for an elderly person (Amy); return to an elderly person’s room to perform some task and then never return to it (Mrs. D.). This forgetful behavior was interpreted by the elderly person as indicating that the elderly person’s needs were of low value or less important than some other

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activity in the staff person's work day. The elderly people who participated in this research cited several examples of the staff being forgetful or unreliable.

But, uh ya know, Daryl, would give ya [only] so much attention. Then he'd go out and he'd forget all about what he was doin' – what he said he was gonna do, you know (difu, 258)

Although in general the elderly people saw the staff as pleasant and helpful, there were several examples of the hospitalized elderly people having to wait for what seemed to them to be a long period for attention. Early in her hospitalization, Mrs. D. experienced incontinence related to the quantity of fluids that she was receiving. She felt the staff was slow to respond to her needs. She said, “It was... Well, I mean I was always wettin' myself. I was a mess. Nobody seemed to be helpin' me... I just can't tell you how awful it was” (didc, 25-33).

Later in her hospital stay, Mrs. D. commented on the length of time it took for the staff to answer her call bell (didc, 702-208). Mrs. D. suspected that the staff did not respond when they knew it was Mrs. D. who was needing assistance.

“...For instance, I turn on my light (call bell). I don't get answers until she (roommate) turns on hers. They can tell whose light's on out there.” (didc, 709-714).

Obtrusiveness. Obtrusiveness of the staff's behavior into the world of the elderly person varied along a continuum between being unobtrusive and being very obtrusive, noisy and seemingly unaware of the elderly individual's needs. At times, staff members made a point of not interrupting or disturbing an elderly person engaged in an activity. At other times, the staff seemed to disregard the elderly person's needs.

An example of several staff members being very unobtrusive happened at midmorning during Amy’s third day of being in the hospital.
While I was sitting in the room the housekeeper came in with the dust mop and dusted the floor, dusted under Amy’s bed while Amy was sleeping without disturbing her.

The nurses aide came in to make the roommate’s bed but decided that she would wait to make the bed until the roommate left the room to go get a chest Xray. The nurse aide peeked around the curtain to see if Amy was asleep. The aide decided Amy was sleeping, and that she would make the bed later.

The nurse returned to attempt to draw the blood again and woke Amy up. The nurse was very gentle. She woke Amy up by calling her by name in a quiet voice, explained that she was there to draw the blood again.... (apo, 9/13/99, 143-173)

While the staff was providing care to patients, they often engaged in conversation with the patient and with any staff members they were working with. Mrs. D. reported getting very little rest during her first few nights in the hospital because her roommate needed a lot of attention from staff. When the staff responded to the roommates needs, they talked, they put lights on, and at times even laughed, all this activity compromised Mrs. D.’s ability to sleep.

Mrs. D. said she didn’t sleep all night because every time she tried to sleep the staff came in to do something to the roommate, on the second night the roommate and the staff were giggling. (dpo 2/6/98, 54; drl2/8/99, 28)

At times the staff behaved in a way labeled “being at work”. During these times, the staff was not usually in the patient’s rooms, but in the halls and at the nurses station. At those times, the staff did not try to be unobtrusive, but engaged in usual work activities. One morning while engaging in participant observation with Bob, I observed the staff begin the activities of the day at 6:15AM. “(bpo 10/9/97, 27-110). There was no indication that the staff was aware of the patients trying to rest.

Respectfulness. The staff engaged in a range of behaviors which demonstrated degrees of respectfulness. Staff was usually polite when addressing patients which was seen as respectful. Staff routinely introduced themselves when
first meeting elderly patients. An example of routine politeness was when a male transport person came into Bob's room on the day he was to be discharged.

There was a knock at the door, a male attendant entered and said “Good morning, how are you sir? It's nice to see you, but I'm sorry to see you here [in the hospital].” (bidc, 48-52)

Mrs. D. had an experience where a male nurses aide treated her in a way the Mrs. D thought was disrespectful. This interaction was followed immediately by another staff person who was very respectful, helpful, and courteous.

Ya know, I just didn’t think it was necessary [to treat me like that]. He’d throw my breakfast down and then expect me to eat it with all that stuff [mucus] in my mouth.

This one nurse, the one that gave me the medicine, she brought me cotton balls and then she said, ‘I’ll bring you hot water.’ She wiped my eyes off... She brought me in a glass of warm water and she said, ‘before you eat, rinse your mouth out.’ Well, things were a little better after that.

The staff often acted to protect the privacy of hospitalized individuals, which demonstrated respect. Privacy, as discussed was relative, usually visual not auditory; and privacy was not always protected. One evening while I was sitting in Bob's room, his space was continuously invaded by people entering the room to visit the roommate. In a period of about 35 minutes, seven people entered the room for some purpose and left again (bpo 10/7/97, 51-66). Bob's was continually being exposed to people walking through his space as if it were a hallway, which diminished his dignity.

At her follow-up interview, Mrs. D.'s described how she felt marginalized and disrespected by the way the staff treated her while she was in the hospital. When Mrs. D. was transferred from the acute care unit to the skilled care facility on a different floor in the same hospital, she felt that the staff was very disrespectful of her and her property.

And they came in and they told Don they were takin’ me down –I don’t know down or up, wherever they took me, [they said] it would be much nicer, better off, nicer room. And they took all my
clothes. I told ya that. And instead of... They were my belongings. [They] just opened the door to the closet and threw all my clothes in a bag.

Uh, then when I got downstairs, they started tearin’ my stuff... just puttin’ here and puttin’ there. And I said “Would you please leave that alone? I’ll put it away myself.” (difu, 381-406)

Staff Behaviors Affecting the Elderly Person’s Autonomy

Most of the staff behaviors relating to attitude affected the elderly person’s dignity, but some had an effect on the elderly individual’s autonomy. Bob’s experience with refusing an X-ray procedure provided examples of positive and negative staff behaviors. When Bob refused a test because of the pain in his shoulder that was caused by the position he had to be in to complete the test, the X-ray technician was very gracious and said, “I understand how you feel, it’s very unfortunate, we’re only doing what we’re told”, “it’s not anyone’s fault... these things happen” (bpo 10/9/97). The other technician in the room scolded Bob for refusing the test. He said “Well, I wish you had refused to do this test before we gave you that radioactive injection.” (bpo 10/9/97). The male technician created a situation in which Bob’s control over the situation was diminished whereas the female technician supported Bob’s ability to make decisions about his comfort and exert control over the situation.

There were occasions where the staff doubted the statements of the elderly person. In Bob’s episode of chest pain described above, the medical resident initially challenged his perception of chest pain by saying, “...The nurse reported to me that you had some chest pain earlier. There weren’t any changes in your EKG” (bpo 10/7/99, 190). The implication was that Bob might have misinterpreted his symptoms. However, she ultimately affirmed Bob’s feelings of chest pain by adjusting his medications,
In another example of the staff doubting the veracity of the elderly people, one of the nurses interviewed about Mrs. D.’s experiences suggested that Mrs. D. might be inventing an episode of loose stools because she was afraid of being discharged.

This morning [Mrs. D. called for me]. Uhh, she is saying that she has diarrhea now, and she's getting nervous 'cause she's supposed to go home either tomorrow or the next day, and she has diarrhea. This is what she says: She wants something for the diarrhea and she wants to be sure that we're not gonna make her go home with diarrhea.

We have yet to see it [the diarrhea]. I asked her to save me a specimen [which she has not done] and we'll see from there. She is kind of anxious right now, and that just might be 'cause she's probably not sure she is ready to go yet.

...I think it's mostly anxiety... Every time you talk discharge she just gets anxious and something else happens.

... She is so anxious that I think she might sabotage her own efforts [to be at home].... (dim2, 38-64)

Although this episode did not affect Mrs. D. directly, the overall attitude that had an indirect effect on Mrs. D. In interactions with the staff that day Mrs. D. felt that they didn’t believe her when she reported symptoms. These feelings had the effect of diminishing Mrs. D.’s control over her situation.

Supportiveness of scheduling needs. Scheduling of procedures and activities was another area where the staff’s behavior had an effect on the elderly person’s autonomy. The elderly person’s autonomy was enhanced when the staff included the elderly person in decision-making about activities, even though this inclusion often merely consisted of the staff informing the elderly individual in advance of an impending activity. Notification helped elderly individuals to feel they had time to prepare themselves for the procedure, but notification was helpful only when the activity happened the way it was planned. Mrs. D. related this story

First of all, they told Don it wouldn’t be for another half hour or 45 minutes, ya know. But instead of that within 15 minutes I guess, I was out of there, with my boots in that bag, and my pants rolled up and my coat... They rolled my good coat up over my boots. I just
didn’t think that was... they didn’t treat you with any dignity. That’s what I’m tryin’ to say. (difu)

Mrs. D. had other experiences where the timing of her care did not coincide with what she felt she needed or expected. One particular day she did not get washed up as she felt she should. Then, the respiratory therapist arrived to provide a treatment just as lunch arrived. Mrs. D. said they could put her lunch in the refrigerator until after the treatment. When Mrs. D. did get her lunch at around 2:30PM she found it wilted and warm. Although the staff person who brought the lunch assured Mrs. D. that the lunch had been refrigerated, a nurse later agreed with Mrs. D. that the lunch had not been in the refrigerator. Mrs. D. felt unhappy about a staff person being dishonest with her (dpo, 2/6/98, etc., 110). The overwhelming outcome of these many complex interactions was to contribute to Mrs. D.’s diminished personal integrity.

Physical care. Providing physical care with the appropriate level of assistance required by the elderly person was another way in which the staff promoted the elderly person’s autonomy through promoting independence. Elderly people generally wanted to be independent in bathing and grooming activities. However, if they were too sick to get up or to wash themselves, they expected to have the staff provide that care. The staff’s assistance as needed promoted feelings of independence and control.

One day early in Mrs. D.’s hospital stay, while she was too ill to engage in any activity, she did not get bathed. No one explained to her why she did not get the attention she needed. She felt she was being neglected by the staff (dpo 2/6/98, etc., 110), and thereby de-valued. This decreased her feelings of control and independence. The actual reason for the staff not attending to Mrs. D.’s bath had little to do with Mrs. D., but arose from the staff’s need to prioritize the tasks they
were to accomplish during their time at work. Those tasks that were less important in achieving staff goals for the day did not get done. Unfortunately for Mrs. D., her bathing had a lower priority for the staff than other tasks and simply did not get accomplished.

Many of the behaviors and activities above, such as the lack of a bath, were examples of unintentional behaviors of the staff that were interpreted by the elderly person to be directed toward the elderly person purposefully. Other behaviors such as the medical resident questioning Bob’s symptoms, were intentional but had unintended interpretations and consequences.

Management of Care: Staff Behaviors Affecting the Elderly Person’s Health

Management of care was the second dimension of staff behavior identified in this research. This aspect of the staff’s role was directly related to why the elderly person was in the hospital and was focused on the staff’s management of the episode of altered health. The effectiveness of activities directed toward managing care ranged from effective to ineffective. Effective management enhanced the elderly individual’s health state and enhanced personal integrity by improving health and supporting dignity and autonomy. Ineffective management did not enhance health and did not promote dignity or autonomy. Staff actions addressed at managing care were usually deliberate, but sometimes had unintended consequences. The behaviors presented below had the effect of enhancing or diminishing the elderly individual’s health and thereby altering personal integrity. Staff behaviors relating to managing the care of the hospitalized elderly person are presented in Table 6.

The staff, as workers in the context of the hospital, acted according to the meaning they derived from every day work situations. The unbearable, life-
threatening illnesses experienced by the elderly participants were everyday occurrences for the staff. The staff made judgements and planned interventions for the elderly individuals based on their knowledge and experience with people who had been hospitalized with problems similar to those of the elderly individuals in this research. The nurse who worked with Evy discussed her assessment of Evy’s response to her health problems.

So I think Evy’s pretty much the exception to the rule when you’re talking about the emphysema people. Usually they do get more anxious at night. And maybe she’s got her illness under control and she’s still at that early-enough stage. I didn’t get to ask if she has 02 at home. I know she was at the point... I know she has all the treatments she does herself...

And I know that’s kinda the next step so maybe she’s still removed enough from it so right at this admission, maybe she’s still handling everything pretty darn well...

... [When I worked with her last night] There didn’t seem to be one main thing on her mind. She seemed to be dealing with everything pretty much. (eirn, 64-90)

When being interviewed for this research, the nurses talked about their work routines and how they worked with elderly people who were ill. The nurse

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<td>Information provider</td>
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Table 6

Management of Care for Health
who worked with Mrs. D. in the acute care setting explained how she managed Mrs. D.'s health.

I wanna help her [Mrs. D.] to get better. (laughed). I really do. It's like all my patients, ya know... that's because I'm a caretaker. But I feel like I have to do something to help them because I hate seeing people not being able to breathe and being in pain.

[For Mrs. D.] Umm. Ya know, I'm going to try and reposition her. Apparently, she's improving. Since today I know that she is not in such distress, I think, where I need to put a call in (to the MD). Umm, I know... Ya know respiratory [therapy] has been coming in. They just keep coming in, and right now I just want to watch her. (dirml, 78-92)

Management of care was a function of the hospital staff that was integral to the reasons for the elderly person to be hospitalized. Behaviors associated with management of care which affected the elderly person’s personal integrity were the coordination of care, the communication style, and the truthfulness of the staff.

Coordination of Care

Coordinating care was a very important aspect of the staff’s work in the hospital. There were instances of effective coordination of care and poor coordination of care throughout the hospital stay of all of the elderly participants. Much of the coordination of care focused on discharge planning. The nursing student interviewed with relation to Carl explained her role in the good coordination of care this way:

Yesterday, I helped his nurse make arrangements for him to go home. And [coordinated] with the doctor to make sure Carl knew what to do when he went home. And that was probably followed up on today when he went home. (cin, 15-21).

In Mrs. D.'s case there was little coordination between the various care givers with respect to her health care needs at home. Mrs. D. felt that the staff was having difficulty deciding what her need would be for oxygen at home. During an
episode of participant observation near her discharge, Mrs. D. related the following story

...The respiratory people think that I need oxygen when I go out for a walk or when I take a bath. Not all the time, just when I get short of breath. The physician has not yet ordered oxygen for at home.

Some people say I need it, some people say I don't need it. I want this decided before I go, and I want it set up. (dim2, 244-246)

Elderly individuals who felt their care was effectively managed felt the hospital staff to be knowledgeable and supportive of the elderly person. Amy explained how she felt about the care she received:

I thought I got lovely care. Ahhh, the doctors are wonderful. What the hell more do you need, you have first class care. If you know what I mean. They really did their best. They can't make you feel better if you're sick. I think they try, but you know... I think it's wonderful. (aifu, 165-168)

I've been in some not so good places. The respiratory therapist here taught me how to use my puffer [inhaler] the best. I really appreciated that. (apo 9/11/97, 107-111)

Those individuals who felt their care was not well coordinated were less satisfied with the care they received and did not have as positive hospital experiences. Although in all cases in this research, the elderly people recovered and returned home to their previous living arrangements, their personal integrity was not always effectively enhanced.

Communication

The ways in which the staff communicated with the elderly person had an effect on the elderly person's ability to make decisions about which strategies to engage in with respect to management of their health. Some hospital staff recognized their role in creating an environment where communication can be effective. Carl's nurse thought it was very important for the patients to feel comfortable in seeking information and asking questions about their care
Hopefully [my personal practice makes a difference] it's my talking to him and getting him to share maybe some of his feelings he's having. Some misgivings, so I can clear them up. Developing that relationship so he can ask those questions, and feel like he's safe in asking those questions. And that I won't think they're stupid questions. (cin, 38-44)

There were many examples of hospital staff members giving information to the hospitalized elderly person. Information about medications was often shared.

The nurse entered the room with Amy's medication. The nurse told Amy that she had divided the pills between 8 AM and 10 AM dose so that Amy would not have to take so many pills at a time. The nurse carefully pointed out what each pill was and what it was for. (apo 9/13/97, 104-118)

Evy saw interacting with staff as an opportunity to gain information about her health status. She was eager to know what each medication was for and why it was given at a particular time of day.

It's been an education to be in the hospital. So like, I mean if I go to do things and can't do things. But uh, I can take medicine home. Take it, ya know, like she says 4 o'clock or somethin', I gotta know the reason why. But I gotta a prescription that don't tell me the reason why. So they tell me, it's the questions I have. [The nurses give me answers] (eidc, 67-84)

In many instances, the elderly participant and the staff exchanged information. The participant observation note below describes a therapeutic interaction between Mrs. D. and a respiratory therapist.

The respiratory therapist helped Mrs. D. get positioned on her side, and then performed chest physical therapy on Mrs. D.'s left side. All the time the respiratory therapist was with Mrs. D., she was instructing Mrs. D. in pursed lip breathing. The whole conversation was very therapeutic. The respiratory therapist was talking about using pursed lip breathing when Mrs. D. was angry or short of breath and how good it was to help calm yourself down. The respiratory therapist did a very nice job of just continuing to talk the whole time she was doing the chest physical therapy and helping Mrs. D. get positioned. The whole conversation was really instructive, supportive and very pleasant. An excellent example of creating a therapeutic environment. (dpo2/6, etc., 132)
On some occasions, the nurse wanted to give information that the elderly person was not interested in receiving. The nurse who worked with Bob explained her teaching and communication and Bob’s unwillingness to engage in the conversation.

Today, my relationship [with him] was just getting him ready to go home. That’s what we focused on was his discharge teaching and his new medications and that type of thing.

His primary concern before leaving is hoping that the new medicine we sent him home on was going to relieve his pain and that that wouldn’t be coming back. Only because that’s what he dwelled on when we were doing his discharge teaching, about his medications and things like that.

...When I tried to go over his list of medications he put me off saying ‘I’ve been on all of those for a long time, I know them already, just tell me about my 2 new medications’.... (bim, 24–45)

Staff routinely explained their actions when performing treatments or procedures to the elderly person. For example, while having a test performed in the X-ray department, the technician would say something like, “It will be about four minutes now... now it will be eight minutes, now just a few more minutes...” (bpo 10/7/97, 71).

Mrs. D. had a similar experience in the emergency department when she was admitted. Mrs. D. said the staff drew a lot of blood and said “they told me what everything was for, ya know.” (dia, 250)

Physicians spoke to the elderly person but were likely to include a family member in the discussion, whether or not the elderly individual had actually consented to having the family involved. When Carl and his physician were discussing his discharge Carl’s son entered the room. The physician simply broadened the conversation to include the son (see quote below, dpo 2/6/98, 39). In one case however, the family member sought out the MD for information without the elderly person being present. The physician told Mrs. D.’s grandson that it was inappropriate for him to be seeking information without including his grandmother.
Donny called the doctor the other day. He got told off. They [Don and Donny] haven’t been satisfied with what I told ‘em. He won’t call the doctor again, but I think Dr. Daniels told him it was not the right thing (didc, 564-637)

This enhanced Mrs. D.’s personal integrity by demonstrating to her that her physician recognized that Mrs. D. was in charge of her own health.

There were few examples of poor communication in relation to procedures. There was only one observed instance where the elderly person was given an injection of radioactive isotopes for an X-ray procedure without the staff person explaining what she was doing. (bpo 10/9/97, 151-156)

While staff was managing care, they frequently fell into modes of speech or action were very directive or dictatorial in style. For example, both Bob and Mrs. D. had the experience of being awakened roughly by a staff member because the hospital schedule dictated that it was time for them to be awake. This style of waking the patients was in contrast to the situation where the nurse very gently awakened Amy by calling her name in a quiet voice. (apo 9/13/97, 143-173)

There were occasions when the staff person and the hospitalized elderly patient unsuccessfully attempted to communicate. At times, when an elderly individual tried to give information about something (usually a health problem), the staff person did not receive the information being offered. For example, Bob, after having had an episode of chest pain discussed the episode with a medical resident. Bob seemed to be trying to answer the doctor’s questions, but he was answering different questions than the doctor was asking.

The medical resident’s questions were very directed, leading down a specific path. For example, when Bob said his pain was almost gone, the resident caught it immediately and questioned further.

“Is it gone, or almost gone?”

There were other answers that Bob gave that the resident didn’t seem to listen to or clarify. At times it was difficult to understand which pain she was asking about – was it the pain that led to admission or the pain Bob just had.
The resident referred to “chest pain earlier this afternoon”, Bob answered as if she was talking about the chest pain he had at admission. It seemed to me that she was asking about one thing and Bob was answering something else. (brl10/7/97, 95-100, 105-117)

Because of miscommunication between Bob and the medical resident, the resident did not have accurate information upon which to make clinical decisions. Bob’s health was at increased risk because the medical resident might adjust treatment incorrectly.

While managing care, the staff sometimes engaged in coercive behaviors. This behavior was usually an attempt to get an elderly person to engage in some activity that the staff thought would be good for the patient but with which the elderly person disagreed. When the transport aide arrived to take Bob to the X-ray department for a test he wasn’t expecting Bob questioned why he needed to have the test. The aide politely deferred to the greater authority of the nurse and the nurse came to speak with Bob.

Bob said, ‘They [the physician] decided yesterday that they weren’t going to finish that test, that it didn’t need to be finished today.’ The nurse said, ‘Well, the doctor did order today that the test finished. The aide is here to get you, why don’t you go down and have it done.’ (bpo 10/9/97, 133-137)

The nurse used her authority and the fact that the transport aide was already there to coerce Bob into going to the X-ray department for a test he didn’t think was necessary.

As another example of coercive behavior, the attending physician disagreed with Carl about his discharge. Carl wanted to be discharged on Saturday so he could go to church on Sunday morning to see his children sing. Their performance was very important to Carl, as it was in honor of Carl’s deceased wife’s birthday, the first one since her death. The physician thought Carl should stay in the hospital until Sunday afternoon. The physician said:
Well, you can do what you want; I can only tell you what I recommend, and I recommend that you stay here until tomorrow. You wouldn't like being in church and passing out or something from this new medication we put you on. So we want you to walk around a little bit and make sure that you're OK. (dpo, 2/6/98, 39)

The coercive behavior described above diminished the personal integrity of the elderly individuals by decreasing their autonomy and denying them responsibility for actions surrounding their health.

In summary, communication between the staff and hospitalized elderly people was generally good, particularly with regard to procedures. The staff could be coercive at times, the goal of coercive behavior being to improve the individuals' health at the expense of autonomy and dignity.

The behaviors that the staff engaged in while managing the care of the elderly individuals had an effect on their surviving the hospitalization and managing personal integrity. It was through these interactions that the elderly person made meaning out of their experiences and initiated strategies to enhance their personal integrity.

**Categories of Staff Members**

**Nurses**

In the original design of this research, individual nurses were conceived of as being a highly significant health care providers in the care of hospitalized elderly people. The data did not support this notion. As it turned out, the individual nurse was not significant. The elderly people had a difficult time identifying nurses from unlicensed staff. At his follow-up interview, when asked what he remembered most about being in the hospital, Carl explained, “No, I really can't say that I do [remember anyone in particular]. Because there were so many people around, and like that. So I just couldn't remember them, yeah”. (cifu, 30-52)
Not only did the elderly people have a difficult time identifying individual nurses, but the nurses had a difficult time identifying their own significance in answer to the question; “What effect does your being (elderly participant’s name) nurse have on their experience of hospitalization?” The answers reflected a range between nurses who were very clear about their unique role in the health care of the hospitalized elderly individuals and those who did not. The nurse who was most articulate about the uniqueness of her role was the nursing student who was interviewed in relation to Carl. Her answer was followed by the nurses who worked with Amy, and the first nurse who worked with Mrs. D. The nurse who worked with Amy thought it was her ability to actively listen to her clients that contributed to her unique nursing practice. The first nurse who worked with Mrs. D. felt her compassion was the unique factor in her practice. Bob’s nurse thought that her ability to listen might be her strength as well. The nurse who worked with Evy relied on her personal experience with Evy’s diagnosis to aid her in making a difference in Evy’s care. The second nurse interviewed in connection with Mrs. D. could not identify anything unique about her practice. The answers to the question are listed below in the order that they are discussed in this paragraph.

Carl’s nurse: ‘Hopefully it’s my talking to him and getting him to share maybe some of his feelings he’s having. Some misgivings, so I can clear them up.

Developing that relationship so he can ask those questions, and feel like he’s safe in asking those questions. And that I won’t think they’re stupid questions or .... Ah... (cim, 38-44)

Amy’s nurse: ‘I think... that I just kind of sit and listen to people maybe a little more so than other nurses. Maybe a little more patience. Umm so I think that helps the client to really vent his feelings, and to instill confidence, express concerns, questions, (airn, 65-73)

Mrs. D.’s nurse 1: I think I have a genuine concern for her and what happens to her [Mrs. D.] I think I’m compassionate and I think I make my patients feel comfortable. I can smile and so (laughed), I Don’t think there are too many people who actually say that. ‘Oh,
you always have a smile on your face.' And I think that makes the difference. (diml, 152-164)

Bob’s nurse said, ‘(laughed) hmmmm, I don’t know, I never thought of myself as special.... ummm.....I guess it’s, hmm, I never really thought about that... But I love listening to them, and I think, I love listening to all their stories. I don’t know, maybe just because I will sit there and listen to them as they ramble on and on. I don’t know, I’ve never really thought about it, until just now. (birm,53-63)

Evy’s nurse: I don’t know what you’re looking for here. Having background with a person in the family [with emphysema] to see what they go through... Um, I know when... to speak up for these patients... to help them breathe... It’s like somebody understands what they’re going through... but because I had watched my mother go through this. I think um that’s one reason I can key into assessment so thoroughly with emphysema because I’ve had that background... And that [working with patients with other diagnoses] has been a learning experience for me so it’s really what do you feel comfortable with as far as some of these diagnoses go. (eirm, 220-238)

Mrs. D.’s RN2: [What is it that] makes my role special? I don’t think my role is special. I’d like to think that it would umm alleviate her anxiety if I was able to meet whatever needs she had, but I don’t know about making it special. I’m not here to be special; I’m here because she has a need.

What’s unique about me? What’s unique about me. Oh God, that’s a hard one! I don’t know what’s unique about me. Umm. I can’t answer that... I don’t know what makes me different than anybody else.

[Mrs. D.’s care]... is a team effort. It isn’t just me. I guess umm. She needs to umm... It needs to be a team effort. She needs to work with therapy, she needs to feel comfortable, like on a nursing perspective, comfortable with whatever is going on with her so that she knows how to deal with it at home.

I don’t know. I guess it’s just knowing everything’s in place- knowing that therapy taught her what they can, respiratory’s [respiratory therapy] givin’ her what they can, social service sets up what they need.

See, it’s hard. Over here it’s different than over there because it involves the whole team. It doesn’t involve one person. You’re just one little part of everything. (dimns,166-204)

The characteristics of practice identified by the nurses were very subtle. The elderly person identified the primary activities of the nurses as physical activities such as administering medications and providing physical care. The nurses
identified more subtle behaviors such as providing education about the elderly person’s illness. This could be why individual nurses were so difficult for the elderly people to identify. When asked the question “What role will the nurses play in your hospitalization?” The hospitalized elderly person expected the nurse to “do everything” (eia). Bob explained the role of the nurse this way: “They will give me my medications, get my vital signs every couple of hours, keep me more or less clean, I guess. I can’t expect anything more from them” (bia, 93-99).

Another issue that contributed to the elderly people’s not being able to identify individual nurses was the staffing patterns used at the hospital where the research occurred. Nurses rarely worked with the same patients from day to day. The nurses were assigned to specific shifts and units, but their patient assignments were not consistent from day to day. In a reflective log, I related my observations about staffing.

Perhaps the reason the nurses have so much difficulty describing their relationships with these clients is because they don’t have relationships with the clients. It is frustrating to me because on the cardiac unit at least they are only taking care of the client for one day... When the nurse walked in the room today, Mrs. D. said ‘That one’s never been in here before’. Every shift it’s someone new with little relationship to previous shifts. (drl 2/6/98, 50)

The result of this staffing pattern was that the elderly people were constantly meeting new people, and were trying to make meaning of the interactions with nurses who might only be in their lives for an eight hour shift. The nurses who were memorable tended to be those like the night nurses Amy described above, those who were unpleasant to deal with.

Although individual nurses did not stand out, the nursing staff overall had an effect on the elderly person in the hospital. Nurses who acted as described below enhanced the elderly individual’s personal integrity. A student nurse who worked with Carl described her behavior to support his efforts to enhance personal integrity...
I tried to make it seem like I wasn't invading his privacy so much, tried to knock on the door when I came in, and to tell him what I was doing... When I take care of patients that's one thing I really try to do for them. Maintain their dignity....Well, they need to feel like they're safe. And, umm, that they still do have some control. And, when they know what's going on, they are able, they understand that they can ask. And maybe it helps them feel a little bit better, mentally maybe, if not physically. But knowing that they're in good hands, and that I as a nurse will respect him and his privacy. (cin)

The nurse who worked with Amy described some of the activities she thought were important in the role of a nurse

As a nurse overall I think, umm within the first day that they're in obviously helping them with their symptoms and helping them and alleviating any physical problems that they have. And as their stay gets a little bit longer more of an education, teaching as far as..... [their health is concerned] (airn, 27-30)

Physicians

To the elderly person, the physician was the most important member of the health care team. The perceived competence of the physician colored the perception of the entire experience of hospitalization. Amy equated the quality of the care she received in the hospital with the physicians. At her follow-up interview, Amy said. “Ahhh, the doctors are wonderful... you have first class care... I think it's wonderful.” (aifu, 165-168). Carl described the physicians with whom he interacted as “… a fine bunch of people” (cid, 163).

Each elderly participant could identify by name or description several different physicians, medical residents, and medical students. In one conversation, Amy told me that several physicians had been to see her. She could name each attending physician, and could identify the medical residents by sight (apo 9/14/97, 56-64).

As the hospital where the research was conducted was a teaching hospital, the hospitalized elderly people were exposed to several medical residents and
medical students as well as their attending physicians. Bob explained his attitude about his own physician and the numerous medical residents he interacted with while he was in the hospital.

...I'm always glad to see my own doctor when he comes in. I have great faith in him. And ah, to me he's reassuring. The other guys (medical residents), well that's, they're learning. This is an education [for them]. They don't care if they bother the hell out of you, but you have to accept it. It's part of hospital life. So you accept it, some are more pleasant than others... (bidc, 127-162)

For the most part, the medical staff reinforced their individual identities and their importance as leaders of the health care team by routinely introducing themselves to the elderly person as Doctor _____ and telling the person what role he or she had in relation to that elderly person. The medical resident on the cardiac service would identify him or herself as the medical resident working with Dr. So-and-so, the cardiologist. Non-medical staff members, such as the nurses, technicians, and respiratory therapists usually introduced themselves in a more casual manner by first names.

Personal relationships between the physicians and the elderly participants were important to the elderly person's perception of the care received. Mrs. D.'s attending physician would visit her and sit down on the corner of the bed to talk about Mrs. D.'s health (didc, 632-637) Mrs. D.'s opinion of her physician's partner changed over time. She based her opinion of the man on the sincerity she perceived him to have.

Well, at first I had one doctor and I didn't like him very well. Then I changed my mind about him. He was alright... I thought he was too young. I don't like young doctors. The older I got, the less I liked young doctors.

I don't know what changed my mind, he seemed so sincere. And really, I can read in his eyes when I hurt so bad and he couldn't figure out what... I just felt he felt like I did, ya know. Outside of that, I don't know what to say bout him, I just think he's OK. (didc, 608- 625)
The elderly participants and their families went directly to the physician to get information about the elderly person’s health. As noted above, the nurses identified themselves as the professional on the health care team who taught the elderly person about their health, but the elderly person directed their information seeking to the physician. Bob’s opinion of who had the information and who could give him information was reinforced by who came to speak with him when he wanted to discuss his condition.

I was angry [yesterday] that they didn’t come and tell me what was happening with each test... and so that, I was, until finally my primary physician came in and told me.

I guess, maybe they [medical residents] were waiting for him to do it. But I mean, up to that point I was worried because they didn’t tell me. I thought that maybe something, something really bad was wrong with me.

Of course, as soon as he walked in, he said ‘it’s good news’. From that point on, I’ve felt much better. I can assure you.

But I was really mad. I really think that, maybe they were following some sort of protocol, hierarchy protocol, where you have to leave the good news or the bad news to the primary physician. (bide, 12-28)

During periods of participant observation I observed several instances of the physician as the giver of information about the elderly individual’s health.

A medical resident and two medical students entered Bob’s room... the resident was explaining Bob’s new medication regimen. The resident said Bob could go home today. The physician had changed Bob’s cardiac medications. The physician wanted Bob to walk around while he was in the hospital to make sure he wasn’t going to have any problem with dizziness. (bpo 10/9/97, 88-108)

The student nurse I interviewed in conjunction with Carl explained how Carl received information about his health condition.

I think [that Carl understood his condition] once the doctors came in and did their rounds, they came in and told him.

But maybe it wasn’t as quick as he had hoped... like maybe he wanted to know at the time [of admission] what was going on, and sometimes that just can’t happen ...

Because the doctors don’t know all the time either. It takes a while to figure it [the health problem] out. So hopefully when the doctors found out [what the problem was] they would tell Carl, and I think they did. (cim, 46-50)
In an interview with Bob's wife, she demonstrated her bias for seeking information from the physician. She told me the following:

Well, I'm sure that he's always going to be worried about his heart. And I think he's going to be confused about the esophagus [pain] because it echoes, mimics, the heart pain. I think that's, I mean I've been thinking about that. Wondering how will he ever know? Is he always going to be rushing to the hospital for EKGs and the whole thing? And he's so tired of being given those tests and being plugged in and all that. But, I mean I guess I'll have to talk to the doctor about that, figure out if there is any way to know... (bfi)

The nursing student who worked with Carl reinforced the idea of the physician as director of care to me when we spoke about the effect of hospitalization on Carl.

...Hopefully, he will take what the doctor said and his suggestions for, maybe diet changes or ways to change his environment or habits so he won't end up here [in the hospital] again... (cim, 26-29)

The role of the physician as giver of information was reinforced by the medical residents' withholding information from Bob until his attending physician could speak with him, and by the nurses' attitude toward the physician coordinating care.

Physicians have a major role as giver of pain relief. It is the physician who writes the orders and directions for pain management. During his discharge interview, Bob spoke in general about physicians who did not have the foresight to anticipate Bob's discomfort while undergoing a procedure.

But I was a little annoyed with the doctors. They should be able to give you a shot [to reduce the pain associated with the physical position required for a test]. So [what if] it does, it does lessen the effects of the test a little bit. It does make you; it does give you a little comfort so you can go through with the darn thing. They (the doctors) never think of the patient, never. They don't give a damn if he's uncomfortable or in pain or whatever. They just ignore it. (bifu 11/6/97, 130-149)
An important role of the physician in relation to the elderly person in the hospital was as controller of discharge. In Carl’s case, his primary physician deferred to the specialists about when Carl could go home. Carl’s son explained how the decision for Carl to stay another day was made.

And so when Dr. Coombs came in he said, ‘Well, there’s probably no reason why you couldn’t leave as long as the others said it was all right’. Dr. Carter and Dr. Cameron both agreed my Dad should stay here, get up and walk around and then get his bearings… (cfi, 14)

For Mrs. D., the negotiations around discharge began prior to her admission to the hospital. The physician made it clear that he had the final say regarding how long Mrs. D. would be in the hospital.

While I was getting my coat and that on, ‘ya know, I said I wouldn’t go [to the hospital]. Dr. Daniels said it’ll be just a day or two. And then Daniels went down in the waiting room, out to talk to Don.

So when I got out there [to the waiting room] I said to Dan, ‘Well if it’s not too bad, I’ll only have to stay a day.’

Dr. Daniels said, well, wait a minute. What did I tell ya?’ I said, ‘A day or two.’ (laughed).

Anyway that’s why I decided… ‘Well, I’s gonna get here anyhow whether I ’cide to go or not.’(dia, 261)

Physicians modified the elderly individual’s ability to survive hospitalization and manage personal integrity by being the director of care and the giver of information. Elderly patients viewed the physician as the person who made decisions about admission, treatment, and discharge, as well as the person who could provide the answers they needed as to what was happening while they were in the hospital.

Family

In the current research, a family member was any person identified as such by the hospitalized elderly person. Included in the following discussion are children (Carl, Mrs. D., Evy), grandchildren (Mrs. D.), spouse (Bob), sibling (Amy, Evy),
and nephews (Amy) of the elderly person. Bob and Amy also had children, but they were not directly involved in the hospitalization discussed here.

Families acted as modifiers of the elderly person’s hospitalization in several ways that will be discussed along a continuum ranging from directive behaviors to passively supportive behaviors (Table 7). Although each family member may have exhibited the range of behaviors discussed here, each family had a predominant style of interacting with the elderly person in the hospital.

Table 7

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**Directive Behavior of Families of Hospitalized Elderly People**

Family members engaged in three types of directive behaviors: acting in place of the elderly person, acting as advisor to the elderly person, and not acting. Through various degrees of being directive, the family helped the elderly person make decisions about his or her health care.
Acting in Place of the Elderly Person

Family members who acted in place of the elderly person made decisions for the elderly person without consulting him or her. Carl’s children were very directive in their participation in Carl’s hospitalization. Particularly, Carl’s daughter engaged in active decision-making in place of Carl. It was Carl’s daughter that made the decision for Carl to come to the hospital, and it was the daughter who did most of the interaction with physicians during the admission process. When questioned about his admission process, Carl said, “Well, you’ll have to ask my daughter that; she talked to them [physicians] more than I did.” (crl 2/6:5)

Carl’s children not only made decisions surrounding Carl’s coming to the hospital, his children also made the decision that Carl needed to stay in the hospital. The family acted in what the family members felt was the best interest of the elderly person, but in direct opposition to the elderly person’s wishes. For example, Carl’s son and daughter felt Carl should stay in the hospital longer than their father wanted to. Carl’s son explained his strategy this way:

And it’s like... All he [Dad] can think about is getting out here... He [the doctor] says, ‘Unless you can get out of that window with a parachute, you’re grounded for the day.’ So I figured, ya know--I was tellin’ him [Dad], ya know, look, ‘I’m not gonna take ya home’. (cfi)

After Carl returned home, his daughter continued to closely supervise Carl’s health-related activities. Carl’s daughter managed his health, while Carl took less responsibility for his health. She made decisions about Carl’s needing to see his physician, managed his medication, and supervised his activities. Carl lived within her direction (cpo 2/7/98: 53). During Carl’s follow-up interview, Carl’s daughter entered into the conversation when Carl was confused about the sequence of events or needed to confirm information.
Well, my daughter here now, she does most of the organizing and like that. She has made me an appointment with the doctor on Monday. Let's see, it was 4 o'clock Monday wasn't it?

DAUGHTER Yes, this Monday

CARL Dr. Coombs?

DAUGHTER Dr. Carver, the heart doctor (cifu, 65-85)

Carl's daughter took up the story of Carl's health since he had been discharged from the hospital two weeks before. Her comments reflect the role she had as director of Carl's health care.

I took him [Carl] to his own doctor last Saturday because I thought he might have pneumonia or bronchitis... He was coughing and coughing.... He had a sinus infection.... So he [physician] put him on Amoxicillin.

CARL Yeah, he gave me some new pills and ah...

DAUGHTER So he takes heart medication, Amoxicillin, coated aspirin,

CARL Aspirin, yeah

DAUGHTER I think the heart medication is beginning to even out. I mean his body is adjusting to it.

CARL Well, I'm taking them aspirin three times a day?

DAUGHTER Yep, you're supposed to be.

CARL Well, Let's see, yesterday I took them only twice. So now I have, before, on an empty stomach I had taken that heart pill, it makes your heart go slower, I guess they figure mine was too fast. I could run up the road and back down again, and stuff like that.

DAUGHTER But he was sleeping all day, all day. Going to bed at 5, 6:00 at night and that was due to those, his body trying to adjust to the heart medications. I think he's much better now, he's much more like himself. (cifu: 180-218)

In order for a family member to act in place of the elderly person, the elderly person and healthcare personnel must participate in the behavior. Carl participated by directing me to get information from his daughter when I asked him questions he couldn't answer. The physicians who were working with Carl were willing to discuss Carl's health with his daughter.

Evy directed her physician to answer any questions Evy's daughter had about Evy's health. Evy said, "My doctor, Dr. Eckles, is my daughter's doctor. And I think they talk about me an awful lot too. I told Dr. Eckles, I says, 'Answer any questions my daughter wants.' I told her she can answer any questions she..."
wanted to about me."(eifu). Evy was willing to share information with her daughter while managing her daily health status.

This was not so with the physician who worked with Mrs. D. Mrs. D. had not given the physician permission to discuss her health with her family members. Donny, Mrs. D.'s grandson, who was very involved and supportive of Mrs. D. tried to act in place of Mrs. D. by seeking information directly from the physician about Mrs. D.'s health. The physician refused to discuss the case and directed Donny back to Mrs. D. Family members kept in close touch with the physician and continued to intercede on what they perceived as the behalf of the elderly person.

They've [Don and Donny] done everything. Donny called the doctor the other day. He got told off. They [Don and Donny] haven't been satisfied with what I told 'em. He won't call the doctor again, but I think Dr. Daniels told him it was not the right thing... (didc, 564-580)

In this research, family members who acted in place of their elderly hospitalized family member did so with the knowledge and consent of the elderly person. In cases where the elderly person had not either passively agreed or given actual consent to the physician, the physician did not engage in health discussions with family members without including the elderly person.

**Acting as Advisor to the Elderly Person**

Family members also acted as advisors to the hospitalized elderly person. The elderly person reported health progress a family member and in return received advice. In Evy’s case, when she told her daughter about the swelling in her leg, the daughter advised Evy to call the doctor. Evy told the daughter to make the calls. The daughter was directive, but unlike Carl’s daughter, Evy’s daughter acted in collaboration with Evy, discussing decisions before action was taken. Evy's
daughter explained why she contacted the physician after a conversation with her mother.

... and when I called my mother on Monday to see how she was doing... She says, ‘Fine, No I’m not fine.’ (laughed) So then it came out [about the swelling in her leg].

I said, ‘Well, did you call the doctor?’

She said , ‘No, why don’t you call her. I can’t drive over there myself anyway.’

I said, "I'll call her [the physician]." (efi: 39-47)

Bob consulted with his wife prior to making decisions about his health. According to Bob’s wife, Bob consulted with her prior to making the decision to come to the hospital. Bob’s wife said, “...when he was at home wondering what to do and being hesitant, I said ‘Do you think we should go to the hospital?’ At that point he said, ‘Yeah, I think we’d better go’. So I think he needs to have me approving of it” (bif, 49-52).

On occasion, elderly people sought to protect their families from information. Mrs. D. withheld information from her family so that they wouldn’t worry about her. Mrs. D. was afraid to leave the hospital after having been there for almost a month, but she withheld the information from her family because she didn’t want them to worry.

Mrs. D. said that she couldn’t tell Don and Donnie that she was scared to go home. She said, ‘They’re doin’ so much, I just can’t tell them,’ stuff like this, I don’t want to worry them any more than they’re already worried.” (dposnf, 72)

Throughout the hospital stay, hospitalized elderly people discussed their health status with family members and accepted advice or action from the family.

Not Acting

Some families did not act in relation to decision making for the elderly person. Amy’s sister acted as an advisor while she was visiting with Amy, but once Amy’s sister returned to the sun belt, Amy’s family was not involved with making
decisions about her care. They were available if Amy contacted them, but did not become involved with decision making.

I have two nephews that live nearby, they came to visit me while I was in the hospital, but now Hello, Good-bye, Life goes back to ... Normal. If I want something I call them up and they'll get it for me. If I call one of them for a bit of help to get something, they'll be glad to if they're doing that or going that way or what have you. (aidc: 242-243, 252-272)

Amy made decisions about her health independent of family members. She spoke with her daughter and sisters frequently by telephone, but she had minimal local support from family.

Supportive Behaviors of Families of Hospitalized Elderly People

All of the participants were either accompanied to the hospital by a family member or the family member met them at the hospital. In each case, the family member was a support for the elderly individual. Carl was the most dramatic example, in his case the family actually signed consents, made decisions, and discussed Carl's health with the doctors. This was also true to a lesser extent for Mrs. D. and Evy. Bob had a more collaborative relationship with his family members and jointly engaged in decision making, and Amy relied on her sister for consultation but was independent in decision making.

The families of the hospitalized elderly people in this research acted to support the elderly person throughout the hospital stay. The degree of support varied among families. Family support activities can be divided into two types: activities aimed at keeping the elderly person going, and activities aimed at keeping the elderly person's life going. In addition to these behaviors, there were some families who stayed in the background and were not directly involved in supporting the elderly person while he or she was in the hospital.
Keeping the Elderly Person Going

Activities directed at keeping the elderly person going included emotional support such as visiting and sitting with the hospitalized person. Behaviors that kept the elderly person going included bringing things from home such as clothing, toiletries and other supplies, and food items. Amy's sister explained the effect of her visit on Amy, "When I’m here, you know, then she feels that I have concern for her, love for her (aif:126).

Mrs. D.’s son visited just about every day during her long hospital stay. He often brought items in from home. Early in Mrs. D.’s hospital stay her son visited and brought necessities with him. “The first thing that the son did was pitch a few balls of underwear at his mother, and said hello. He was being silly and lighthearted. He brought her glasses too” (dpo 2/6, etc. 88). At discharge, Mrs. D. spoke about the support she had received from her family during the time she had been in the hospital,

They've brought things from home. One or the other of them has been here every day... Don's been here every day, Not for long, but I mean.... Don's been bringin' Dotty in--the dog in--every other day. I didn't realize it, he didn't tell somebody [he was bringing her]. He's fearless. He didn't want her [the dog] to lose connection with me. Ya couldn't ask for two better kids as far as that goes. (idc, 580-600)

Mrs. D.'s dog was very important to her. A continual concern for her during the time she was in the hospital was how the dog was doing home alone. Don brought the dog into the hospital to visit Mrs. D. often. The visits did much to improve Mrs. D.’s mood and remind her of her life outside of the hospital.

Don visited and brought the dog. Mrs. D. was clearly happy to see the dog, and she immediately asked how the dog was eating and how the dog's bowels were. Bob took the questions very seriously and said, "Well, she's a little constipated. I gave her a bone; I thought that might help a little. As I left, the dog was
drinking out of a paper cup that Mrs. D. was holding for her.
(dpo 2/26: 106)

While at home, several of the elderly participants lived alone. They spoke
with their families on the telephone or visited with their children frequently but not
usually daily. While in the hospital, the frequency of contact increased to at least
daily, sometimes several times a day. Evy spoke about the increase in contact with
her daughter and her grandchildren.

If she [my daughter] doesn't come in, she calls. Do I need anything
or want anything?
Since I've been in the hospital, Uh, I have had two or three
calls, but mostly... Course she goes to volunteer... Her and her
husband were both here yesterday. Thursday, she had to go
volunteer again, so she showed up here at 11. So she's managed a
daily visit. (eidc, 385-401)

Evy also had visits from her grandchildren whom she did not see often
while at home.

I've had a lot of company since I've been in the hospital. See, the
first one was my grandson, outside of my daughter and her
husband—my grandson, the paramedic. I looked up and there he
stood. He brought somebody into the emergency, and he snuck up
to see me.

Then there was another day here I stood and looked there's
the other two grandsons. Well, I have my young, middle grandson,
him and his wife and their child. That was the first day I was here...
(eidc: 148-165)

The contact Mrs. D. had with all of her family members increased
while she was in the hospital too. Family members who could not visit
telephoned. Mrs. D. kept track of who phoned and visited. One evening, as
she hung up the telephone, she said, "Well that will be the last call tonight,
everyone has checked in."(dpo 2/6, etc.: 173).

The meaning of the increased attention received from family
members for the elderly person was two fold. First, the attention was an
indication of how the serious nature of his or her illness. Mrs. D. told me
her granddaughter telephoned her from the west coast because Mrs. D.'s
son had told the granddaughter that Mrs. D. was very ill (didc:655). Bob commented that he preferred his children did not visit or telephone unless they were too upset about his condition and needed to hear his voice (bia: 131-146). The children's need to speak with Bob validated the seriousness of his condition, they needed to assure themselves that Bob was all right.

The second meaning for the hospitalized elderly person of the increased attention was an indication of his or her place in the family. The visits and support from family helped to remind the elderly person of his or her life outside the hospital. The visits helped to minimize the decontextualization experienced by the elderly person while hospitalized and demonstrated the families' regard for the hospitalized elderly person, thereby increasing dignity.

Keeping the Elderly Person's Life Going

Activities aimed at keeping the elderly person's life outside of the hospital going included behind the scenes support such as running errands and maintaining the elderly person's household.

At times, the family members acted on behalf of the elderly person in ways that they would not when the elderly person was in his or her usual state. For example, while she was in the hospital, her son visited her apartment several times every day to care for Mrs. D's dog. Bob's wife kept him abreast of news from their local community, and Carl's son kept an eye on Carl's house.

The meaning of these activities to the elderly people was that the family's activities removed one category of things for the elderly person to worry about. The elderly person was assured by the family members actions that things that they
would have been attending to had they been at home were being taken care of. The activities of family members to keep the elderly person’s life outside of the hospital going also made it possible for the elderly person to return to that life when they were able.

**Staying in the Background**

As noted above, Amy’s family was the least participatory in her life while she was hospitalized. Her nephews were available if Amy telephoned them, but they did not actively intervene in her life. They visited Amy once while she was in the hospital and then invited her to their house upon discharge, but waited for her to initiate contact.

The relationship between Amy and her family while Amy was in the hospital was similar to the relationship they had when Amy was at home. Amy had organized her life so that she could manage it from the hospital. Amy maintained active relationships with several friends while in the hospital. She was not concerned about the safety of her house while she was not at home, and had no pets which required attention. Some elderly people needed their family to provide continuity in their life-world while others did not require family support in that way.

**Changes in Family Dynamics in Relation to the Elderly Person Being in the Hospital**

Being in the hospital changed the relationships in the families of some of the hospitalized elderly people. Whereas Mrs. D. and Evy had not seen their children daily before hospitalization, the children visited daily during hospitalization and continued to provide increased support to the elderly person during the immediate post hospital period. During her discharge interview, Evy explained how often she
had had contact with her daughter before she was hospitalized, and how often she expected to see her daughter after she was discharged.

My daughter has always... I think she tries to at least call me every day, and (HAHA) I always get a kick out of this because they have gone on vacation and things—they go for a couple of weeks at a time—[and then she doesn’t call]. But if her husband goes away for three/four days she is calling me at least four or five times a day. Then in the kitchen, you can hear what’s she’s doin’. I think she never got into the dishpan without calling me. She has the phone on her shoulder, does her dishes. Yeah, she’s always kept track of me....

When I go home, I expect her to walk in my house three/four times a day to see how I’m doing. [That will be a lot more than before]. (eidec, 367-401).

Mrs. D. also experienced more frequent contact with her son and grandson after coming home from the hospital. Housekeeping activities she had managed independently prior to being hospitalized were now being taken care of by her granddaughter. “My granddaughter made me promise that she could do my laundry. I’m gonna let her do the laundry. It’s not very much, but it is somethin’” (dposnf: 24). The increased attention continued for Mrs. D. at least until her follow-up interview which was almost six weeks after she was discharged.

... And last night my son called me. He’s got a new job today. Ya know, he was anxious. He says, ‘I’ll talk to ya tomorrow.’ And I says, ‘No, you don’t have to worry about callin’ me tomorrow.’ ‘Yes, mother, I will call ya.’ So he’ll call me tonight sometime before he goes to bed.

But see, I didn’t want that. I didn’t want them to think that they had... And this is what I tell ’em. I didn’t want them to think that they had to check on me every day like they’re doin’ now, before I came up here. Now I want them to check on me because I think that they think I’m ready to die soon (laughed) (difu: 710-717)

Evy was relieved when her daughter relaxed and the relationship approached the way it had been before Evy had been hospitalized.

My daughter has stepped back again, thank heavens. Our relationship is back to like it was before I went into the hospital.

Because it was, ‘Mother, you do this...’

So that first week I was home, she did my grocery shopping, and oh, she popped in to make sure—she wouldn't
believe me over the telephone that I was all right. She'd pop into see me. Things like that.

'Do you need anything, Mother? or do ya need anything? or can I do somethin' for ya?'

She wanted to do my laundry, and, 'course, she drove when I had to go back and see Dr. Eckles.

Dr. Eckles told me, 'I want you to drive over here yourself next time.' (laughed) So that was it. (eifu: 116-165)

When Amy was discharged, she stayed with her nephew and his wife for two nights and then returned home to resume life as it had been prior to her hospitalization.

The kids wanted me to go up to their house... I went up there for two nights, I guess, almost three days, and then I decided I'd go home... I don't want to go anyplace, I want to stay here. If something happens, I got the phone right next to the bed, and I would much rather be home... (aifu: (21-25)

Things here just sort of picked up where they left off, I talk to my sisters on the phone just about as often as before. My daughter calls me every other night. And a... we speak, just as long as everything is fine here and everything is fine there, we're happy...... So you see, I have a happy life. (chuckled) (aifu: 190-200)

The changes in family dynamics had the effect of keeping the hospitalized elderly person connected to their life-world while they were in the hospital and removed from their usual context. The increased attention from family members bolstered the elderly persons' personal integrity by enhancing their dignity and autonomy. Dignity was enhanced by demonstrating the elderly persons' value within their family. Autonomy was enhanced by the family member's ability to assist the elderly individual to feel that they had maintained control over their lives outside of the hospital while they were removed from it.
Elderly Persons Concerns About Being a Burden on the Family

The elderly women who participated in this research all lived alone. Evy and Mrs. D. were concerned about becoming a burden to their children. Mrs. D. explained her concerns

So he'll call me tonight sometime before he goes to bed. But see, I didn't want that. I didn't want them to think that they had... And this is what I tell 'em. I didn't want them to think that they had to check on me every day like they're doin' now, before I came up here. Now I want them to check on me because I think that they think I'm ready to die...

But both Donny [grandson] and his wife say this is what they want to be bothered with. Don says, "I wouldn't do it if I didn't want to do it." They really have been good, my son and my daughter-in-law too. (difu: 713-745)

The women accepted the increased assistance from family members, but feared becoming too much of a burden for their families.

Friends, Neighbors, and Other Visitors

Visitors, both personal friends and "duty visitors" such as church people, visited the elderly people in the hospital. For most hospitalized elderly people visitors were a positive experience. They kept the hospitalized people abreast of events in the world that they inhabited outside the hospital. Being visited and receiving flowers, etc. increased the elderly people's estimation of their worth in the eyes of others, thereby increasing their dignity and overall personal integrity.

Friends visited or telephoned the hospitalized elderly people. Carl told me about a call from a friend, "Then I had a call from a lady, she wanted to know what I was doing back in the hospital again. I said well, I had to have some things repaired. She said 'you gotta take care of yourself'. I said I take care of myself. She said, 'or else I'm gonna have to come up there and take care of you'" (cid:38-44).
Carl also had neighbors visit him. A woman who lived three doors down the street from Carl visited him while she was visiting her husband who was on the same unit in the hospital. Carl’s son went down the hall to visit the neighbor. (cpo 2/7/98: 18-19)

For those participants who attended a church (Carl, Mrs. D., Evy), visitors from the church were a welcome relief from the tedium of the hospital day.

Eleanor Eppes, the one from my block, she came up, ’cause she is our chalice bearer at church, and she does a lot of this work. And then, of course, Emma [the minister]. I’m still wondering what we call her. You can’t call her father, can ya? They don’t stay that long, but it’s nice to see ’em. (eicd: 160-175)

I asked Mrs. D. about visitors, she said, “Well, Don comes every day, and Donny comes pretty often and someone from the church comes almost every day—different people every day from the church.”(dpo 2/28:36).

The minister visited me four times while I was in the hospital. And Don thanked him. Don didn’t know him, and he met him last Saturday. And he thanked him and he says, ‘It meant a lot to my mother you comin’ to see her.’ He said, ‘Well, I figured she needed me.’ And he’s pretty nice (dif: 800).

Amy had a volunteer visit her one evening. Amy said, “the woman was a Good Samaritan. She came in her wheel chair. She has no legs at all. She was going from room to room visiting people (apo 9/15/97: 20-25). Both Amy and her roommate appreciated the diversion the visitor provided.

Bob was the only participant who did not welcome visitors.

Well, Yeah, I’m one of those people, when my wife went back and told some people that I was ill, they all wanted to come. And she told them ‘Bob doesn’t like it when you come’. I don’t care for it, I’d rather be alone except for my wife. And even with her, I like her to come and stay for an hour or so and then go home and leave me alone.

And, she didn’t tell my children until last night when I told her everything was good. Then she called my daughter, and my daughter called me last night. But other than that, I don’t like people to call me. I’m just... maybe I’m an irascible patient.

Its... when you’re ill you’re uncomfortable, you’re unhappy, you don’t want ah, people trying to cheer you up while
you're worrying and you have to put on a good face. You know, you have to keep, they come here and you have to keep them entertained. You don't feel like doing that. (bidc, 102-126)

Visitors help keep the hospitalized elderly individuals connected to their lives outside of the hospital. The effect was to increase their perceived value thereby increasing dignity and personal integrity.

Roommates

Hospital roommates had a significant effect on the elderly people in this research. Although there was some small benefit, having a roommate was primarily a negative experience for all participants because of loss of privacy. The roommates complained, they had different sleep/wake cycles than the elderly participants, and sometimes they cried out at night. They were on the telephone at all hours of the day and night, entered the elderly persons' conversations uninvited, and affected energy levels and sleep patterns of the elderly person. A discussion of characteristics of roommates will be followed by considering the positive and negative aspects of having a roommate in the hospital.

Characteristics of Roommates

Roommates often had little in common with the elderly participants in this study. The participants in this research were between 77 and 84 years of age. Their roommates varied in age from the 20's to the late 80's.

Some roommates were quite ill, experiencing altered states of consciousness or pain, which caused them to cry out frequently. Mrs. D.'s first roommate cried out intermittently during the first few days Mrs. D. was in the hospital. When the roommate was moved out of Mrs. D.'s room, Mrs. D. asked the nurse if her roommate had died. "She says, 'You can tell me the truth. Did she die next to me?"
She really wasn't a bad person." The next roommate that moved in with Mrs. D.'s was less compatible than the first. This roommate was an older woman with severe developmental disabilities who continually mumbled unintelligibly.

**Positive Aspects of Having a Roommate**

There were some positive benefits to having a roommate. Most notably, because there were two people in the room, the staff had to enter the room twice as often, which resulted in increased attention from the staff. For some elderly people, having a roommate provided some diversion from the tedium of being in the hospital. Amy spent time chatting with her roommate and getting to know her. None of the other participants had conversations with their roommates. Bob was in the hospital for two nights and had a different roommate each night. The first was a young man going through withdrawal from a drug overdose, the second a man anticipating a cardiac catheterization.

After Mrs. D. had spent two weeks with the same roommate on the skilled nursing unit, they did simple things for each other, such as convey messages to company if necessary arrived, or activate the call bell if the roommate couldn't reach it.

**Negative Aspects of Having a Roommate**

There were numerous negative effects of having a roommate in the hospital. In current American society, people share their space with only a few select individuals whom they know well. For all of the elderly participants, having a roommate was a dramatic departure from their usual way of being.
Hospital rooms were their bedrooms, particularly when the elderly individuals were on bed rest. It was quite unusual for them to be sleeping in the same room with a total stranger, and there were many examples in the current research of the intrusions which were a result of having semi-private rooms.

Lack of Privacy

The major impact of roommates on the experience of the elderly participants in this study was lack of privacy. The issues surrounding visual and auditory privacy were discussed at length in Chapter 7. Here it will suffice to say that the presence of a stranger in the elderly person's bedroom (hospital room) while the elderly person was living through serious and potentially life-threatening illness had a major impact on his or her experience. The presence of a stranger in every experience while in the hospital had the effect of making the elderly person's experience public in a way that the individual would have preferred not to have experienced.

Conflict Between Roommates

The elderly person and the roommate were not always in agreement about appropriate behavior. Amy said the roommate was a whiner and frequently "bothered" the nurses and that the nurses "tolerated" her (apo9/15/97: 33-45). In addition, her roommate resented the researcher being in the room; the roommate didn't like my making notes and asking Amy questions about being in the hospital. I noticed that every time I was in Amy's room, the roommate needed some service and asked me to do something for her.

Evy had trouble sleeping during the first few nights she was in the hospital. Her roommate tended to stay up very late at night. One night the roommate had
company until 1AM, another night she was on the phone until well after midnight. This was very disturbing for Evy who lived alone and was used to retiring between 9 and 10 PM.

**Competition Between Roommates**

In some cases the elderly participant and his or her roommate competed for the attention of the staff, a pattern Amy’s roommate followed. One of the nurses working with Mrs. D. explained the relationship between Mrs. D. and her roommate.

She and her present roommate, they compete for a lot of attention. Umm, if one is sick, the other one needs to be sick, and you spend a lot of time with the other one... They're like jealous of each other. They escalate each other almost. Umm, If I'm over doing a dressing on the other side of the curtain, she's [Mrs. D.] talking to me through the curtain and vice versa. At least with these two... It's not always... so, I guess it depends upon the people, but these two... These two seem to do this to each other.

Well, we try to think about that when we put people together, but we didn't know that this was gonna happen. We thought that Mrs. D. would be a good roommate for this other lady because she was alert, and ya know, had a potential illness that she was gonna get better from and go home. And instead, they tended to feed off each other so... (dim2: 70-100)

The elderly person and the roommate competed for space. The hospital rooms were quite crowded. When Mrs. D. was transferred to the skilled nursing facility, the nurses had to rearrange the roommate’s belongings in order to fit Mrs. D. into the room. In every case, roommates were continually negotiating for space for furniture. It was difficult to have more than one or two people visit at a time, because there was not enough room for chairs. In Carl’s room, his daughter had to sit on the commode when she visited, because there was not room for the commode and chairs too.
Roommates had the overall effect of increasing the threats to personal integrity while the elderly individuals were in the hospital. The threats came from diminished privacy, space, quiet, and sleep. The elderly individuals were subjected to the health problems of another person whom they did not know, to the visitors and staff attending to that person, to the bathroom habits and noises of a stranger; and they were expected to tolerate all of these threats with good grace while in a compromised state.

Summary

The staff, family members, friends and visitors, and roommates all had an effect on the hospitalized elderly person’s managing personal integrity while hospitalized.

Hospital staff behaved along two dimensions. The first dimension was “Attitude” which affected dignity and autonomy. Attitude encompassed the way in which staff members approached the hospitalized elderly person. Their behaviors ranged from patient centered behaviors which enhanced the elderly individual’s personal integrity to staff-centered behaviors which diminished the elderly person’s personal integrity. The second dimension was “Management of Care”. These staff behaviors affected the elderly individual’s health and autonomy and consisted of coordination of care and communication with the elderly person. The behaviors of this dimension ranged from effective management to ineffective management.

Nurses were ubiquitous and invisible. The only nurses that the hospitalized elderly people could identify were those who were memorable in their negative behavior. The elderly people characterized the nurses as individuals who would provide their medications and direct needs, while the nurses identified their role as providing education and emotional support.
The physician was viewed as the director of health care and although the physicians visits were always brief, all of the hospitalized elderly people were able to identify several physicians by name. The system reinforced the importance of the physician by making the physician the primary giver of health information.

Family members acted along two dimensions as well. The first was "Directedness". The family’s interactions with the elderly person ranged from acting in place of the elderly individual, through acting as an advisor, to not acting – being passive in relation to the elderly person’s health. The second dimension was "Supportiveness". Family members acted to keep the elderly person going in the hospital, keeping the elderly person’s life going, or staying in the background.

Visitors generally had a positive effect on the personal integrity of the hospitalized elderly people. Their role was to remind the hospitalized elderly person of life outside the hospital, thereby enhancing personal integrity.

Roommates were a threat to the elderly individuals’ personal integrity. The roommates had the effect of compromising many aspects of the elderly person’s experience, thereby increasing the threats to personal integrity.
CHAPTER X
REFLECTIONS ON THE FINDINGS

The goal of this research was to develop a substantive theory of the social processes engaged in by elderly people while in the hospital. The derived theory is entitled Managing Personal Integrity. Within the theory, *Personal Integrity* is defined as a dynamic, intrinsic quality of the self which has properties composed of physical and psychological attributes. The three properties of personal integrity are: health, dignity, and autonomy. There is a dynamic balance between or among the properties. Health, dignity, and autonomy may increase or decrease together, or an increase in one property of personal integrity can have the effect of compensating for decreases in other properties.

The process of managing personal integrity is a dynamic process. The elderly individual uses introspective, interactive, and active strategies to enhance his or her personal integrity to improve the chances of surviving hospitalization. The hospital is the setting for managing personal integrity and the process is affected by the individual's interactions with hospital staff, family, friends, and roommates.

The process begins when the elderly individual identifies an alteration in health. Throughout the time that the person is in the hospital, the focus of the strategies changes according to the phase of hospitalization. Early in the hospitalization, during the phase of stabilizing personal integrity, the elderly individual is focused on his or her health. During the phase of repairing personal
integrity which usually occurs during the middle of the hospital stay, the individual is focused on dignity. In the reintegrating phase, usually the last phase prior to discharge, the elderly individual is focused on regaining autonomy.

The developed theory, Managing Personal Integrity, must now be placed in context, including the researcher's stance and assumptions (identified in Chapter I), the body of literature (reported in Chapter II), and literature relevant to the developed theory. Implications of the findings for nursing education, practice, and research will be presented.

The Theory of Managing Personal Integrity and the Researcher's Stance

The researcher's stance grounds the derived theory in the researcher's experience. Ely, Vinz, Downing, and Anzul (1997) note that "[there is] a complex network of belief systems and positions embedding, superimposing, and undergirding any research project" (p.33). In this research study, my beliefs about the role of individuals in seeking health care and maintaining health informed the investigation. The theory grew from the data viewed through the lens of the researcher's beliefs combined with the theoretical framework of Symbolic Interaction.

The theory, Managing Personal Integrity, is consistent with my beliefs and is, in part, grounded in my years of experience as a nurse working with elderly individuals in hospitals. As a rehabilitation nurse specialist, I believe that all individuals have a responsibility to take an active role in managing their
health; that hospitalization changes the lives of those who experience it; that autonomy is important for all individuals; and that nurses and family members have important roles to play in supporting elderly persons through the hospital experience.

After listing my assumptions about elderly individuals and hospitalization early in the design phase of this research, I set the assumptions aside and did not return to them until the late stages of data analysis. During data collection I kept a reflective log in which I kept my ideas separate from the data as much as possible. Although both of these activities helped maintain an awareness of myself and opinions separate from the data, the uniqueness of a theory developed by the grounded theory method is related to the researcher as the instrument of both data collection and analysis.

Managing Personal Integrity
and Theories of Aging

Social-psychological Theories of Aging

Social-psychological theories of aging attempt to explain the relationships between elderly individuals and their environment. Early influential theories such as the activity and disengagement theories (Burbank, 1986), have fallen into disuse as newer theories provide better explanations and descriptions of phenomena associated with aging.

The theory of Managing Personal Integrity is a descriptive substantive theory explaining behaviors of elderly people during an episode of
hospitalization. The elderly participants demonstrated considerable variation in the deliberate application of strategies used in the process of managing personal integrity. The developed theory allows for the multiple realities in the perceptions of the hospitalized elderly participants. Managing Personal Integrity will be compared to select social-psychological theories below.

**Continuity Theory**

The continuity theory was originally proposed by Havighurst, Neugarten, and Tobin (1968) to explain the variation in patterns of behavior of elderly individuals. They proposed that the engagement and activity of older adults was influenced by the individual’s personality. They also proposed that social engagement or disengagement in the elderly was generally consistent with patterns of behavior from earlier phases of life.

In a more recent evolution of the continuity theory, Atchley (1993) proposed that “in making adaptive choices... older adults attempt to preserve and maintain existing psychological and social patterns by applying familiar knowledge, skills, and strategies [to a situation]” (p. 5). Atchley divided continuity into two dimensions: internal and external. Internal continuity is the development over time of constructs of “who we are, what we are capable of, and what is satisfying to us” (p. 15). External continuity or continuity of activities is the development of patterns of activities that are consistent with the individual’s ideas of self.
In the current research the elderly individuals attempted to preserve and restore their personal integrity by using strategies that were developed through their making meaning of their hospitalization. The elderly individuals made meaning of the events occurring during their current hospitalization based on both present and past experiences with hospitalization and illness. Each elderly individual engaged in strategies to manage his or her personal integrity, but the emphasis in applying the strategies was individualized. For example, one participant spent a great deal of energy worrying and taking action to affect the course of his hospitalization, while another participant seemed not to worry about her health and was willing to accept the course of her hospitalization implemented by the healthcare providers. Individualization of strategies may have been based on the individuals' success with particular strategies in the past. Although all elderly participants moved through the process of managing personal integrity, they had varying degrees of family involvement, spent varying amounts of time in each stage or phase of the theory, and engaged in strategies to varying degrees.

The continuity theory is appealing with respect to the theory of managing personal integrity. The theories are consistent in that the continuity theory explains variation in behavior of elderly people and the theory of managing personal integrity identifies variation in the application of strategies to manage personal integrity.
**Socioemotional Selectivity Theory**

The socioemotional selectivity theory of aging (Carstensen, 1992) is a descriptive/explanatory theory which was developed to explain the age-related decrease in social interaction evident among the elderly. The theory proposes that the reduction in the breadth of elderly individuals' social networks and social participation is related to a deliberate redistribution of resources by the elderly person (Baltes & Carstensen, 1999, p. 215). According to this theory, elderly individuals proactively manage their social worlds in order to maintain emotionally close social relationships while discarding more superficial relationships.

In the theory of socioemotional selectivity, as in the theory of managing personal integrity, elderly individuals engage in pro-active behaviors (strategies) based upon the meaning they derive from a social situation. Both theories are derived from a person-centered approach in which the actions of the elderly person are explained within the context of the elderly individuals' meaning-making. Both theories are supportive of the view of elderly individuals as those who are engaged in making meaning out of their social situations and acting to affect the future.

**The Model of Selective Optimization with Compensation**

A meta-model of aging has been developed to explain the successful adaption of individuals to the losses associated with aging through the use of three processes: selection, optimization, and compensation. (Baltes & Carstensen, 1999,
In this theory, selection has to do with the individual’s choice of goals and desired outcomes, while optimization and compensation are the means with which the elderly individual enhances or maintains the chosen goals. The process of optimization is maximizing one’s means to achieve the desired goals, while compensation has to do with acquiring new skills or strategies to achieve goals. All three concepts are fluid and are constantly being adjusted based upon the elderly individual’s abilities and desires.

The theory of managing personal integrity may be consistent with this meta theory of social-psychological aging in that the individual has selected the goal or outcome of restoring personal integrity while surviving an episode of altered health and the experience of hospitalization. In order to achieve this goal, the elderly individual engages in strategies which have been identified as introspective, interactive, and active. These strategies may be discussed in terms of optimization and compensation. Strategies such as life reviewing, worrying, adjusting attitude, managing information, managing image, reciprocating in relationships, and taking action, rely on the individual’s skills and talents and may be consistent with optimization. Strategies such as magical thinking, relying on authority, and maintaining health, may be compensatory in nature where the elderly individual compensates for decreased ability to maintain health by relying on healthcare providers to enhance the elderly person’s abilities.

These theories all view the elderly individual as an active and engaged member of society deliberately making decisions about how and where to engage in social interactions. While these social theories have been developing
throughout the last decade, as will be discussed below, theories about healthcare and the elderly are just beginning to view the elderly person as a partner in managing his or her health. While the theory of managing personal integrity is consistent with these social-psychological theories, it is at the forefront of thought in nursing and health with respect to the role of the elderly individual in managing their health, dignity, and autonomy.

**Erikson's Developmental Theory: Integrity versus Despair**

Erikson's classic developmental theory of aging describes eight stages of psychosocial development, ranging from infancy to old age, in which a vital balance between contrary dispositions is necessary for successful maturing (Erikson, Erikson, & Kivnick, 1986, p. 33). In the case of the elderly, these dispositions are integrity versus despair. Erikson et al. use the word integrity to mean an integrating of a lifetime of experience to the point where one is prepared for wisdom, a "detached concern with life itself, in the face of death itself" (p. 37). Erikson et al.'s use of the word integrity reflects a developmental life goal of integration of one's personality in preparation for the end of life.

There is little similarity between Erikson's disposition of integrity in old age and the concept of personal integrity developed in this grounded theory. In the present work, personal integrity is defined as a quality of elderly individuals composed of three properties, health, dignity, and autonomy, which have physical and psychological attributes. It is not a goal as in Erikson's theory, but it is an intrinsic part of all individuals. Personal integrity is not something to strive for,
but something that is present in varying strength in all elderly individuals in the current research. The individual strives to enhance or strengthen personal integrity by using strategies to improve health, dignity, and autonomy.

In their 1986 work, Erikson, Erikson, and Kivnick (1986) describe the need for “vital involvement” during old age. They define vital involvement as active engagement in “the world of people, materials, and ideas. [Vital involvement] is the essential basis both for bringing into balance the psychosocial tensions then focal and for re-experiencing and pre-experiencing the tensions not currently focal.” (p. 144) of each developmental stage. The notion of vital involvement, being engaged in and with the individual’s life world, is certainly in the current work. The theory arising from this research is based upon the notion that the elderly individuals are actively engaged in the process of managing personal integrity.

Successful Aging

In proposing a conceptual framework for “successful” aging, Rowe and Kahn (1997) reviewed progress in gerontology away from “preoccupation with disease and disability to a more robust view” (p. 439). In their work, they differentiated between normal and successful aging. “Successful” elderly individuals, according to Rowe and Kahn, have low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life (p. 433). “Normal” elderly individuals are at risk for
disease but are presently non-pathologic, although may have common age-related health problems such as increases of blood pressure and blood glucose (p. 433).

According to Rowe and Kahn's schema, the elderly individuals in the current research would be classified as "normal" in their usual and evolved way of being. Although all had chronic health problems and were at high risk for acute problems, in their usual and evolved ways of being were as functionally independent. Throughout hospitalization as well as before and after the episode, they possessed high cognitive function, and the elderly participants were actively engaged in their lives. Although the elderly individuals in the current research are not "successful" (p. 433) as defined by Rowe and Kahn, they are actively trying to maximize their health and activity and minimize their infirmities.

The substantive theory of Managing Personal Integrity is consistent with current theories of aging that portray elderly individuals as active and engaged people who apply a number of strategies to create meaning in their lives.

The Findings and Relevant Literature

The Elderly Person in the Hospital and the Literature Review

The Experience of Hospitalization

Behaviors identified by Koch (1994, 1998, Koch Web & Williams, 1995) were similar to the staff centered behaviors and ineffective management of care identified in the current research. Koch conducted qualitative research on the experience of hospitalization of elderly people in the United Kingdom. The themes identified by Koch were "routine geriatric style of care, depersonalization,
care deprivation, and geriatric segregation” (Koch, 1994, p. 976). The care provided to the elderly participants in Koch’s research was routine and impersonal. Two staff members would move through the ward giving care. They would move from one person to another in sequence from one end of the room to the other. Care was not individualized, the elderly persons were treated like objects and not as responsible individuals. The staff would converse mainly with each other and limit discussions with the elderly recipients of care. Care deprivation included staff lack of attention in matters of food, safety, comfort and hygiene (Koch, 1995, p. 188). Finally, the elderly patients were located in wards specifically designated for old people where the standard of care was different than wards for younger individuals. This had an isolating effect in that the elderly people were geographically separated from other hospital patients.

The conditions of care in Koch’s research were much worse than the conditions in the current research. It should be noted that Koch did not discuss any patient-centered staff behaviors or effective management of care. In the current research, staff attitudes and management of care were identified as important to the care of the elderly person both by staff members and by patients. Staff attitudes ranged from patient-centered behaviors in which the staff person considered the individual needs of the patient to staff centered behaviors which put the needs of the staff and institution before those of the patient. Management of care ranged from effective to ineffective.

As in my research, Ekman, Lundman, and Norberg (1999) identified both positive and negative care episodes. The patient participants in both this research
and Ekman et al. relied on the expertise of the caregivers. Caregivers in both studies engaged in patient-centered behaviors such as being helpful, friendly, and attentive. Ekman et al. labeled these patient-centered behaviors "confident care". Staff-centered behaviors such as poor physical care or disrespectfulness of patients were also identified in both studies. These were labeled "nonconfident" by Ekman et al.

One of the major differences between Ekman et al.'s (1999) findings and the current research is the behavior of the elderly people. Ekman et al. described the hospitalized person to be in a liminal state. Persons in a liminal state "often wear simple clothing and their behavior is normally passive, humble, and obedient" (p. 205). Although the elderly individuals in the current research experienced depersonalization and dressed in hospital clothing, they did not generally behave in a passive, humble, or obedient way. These behaviors were most evident when elderly participants in this research despaired and ceased to actively engage for a period of time. These periods were rare.

Another difference in the findings between the current research and Ekman et al. is that the elderly participants in Ekman et al.'s study described care as being incomprehensible. Elderly participants in this study did not identify care as incomprehensible. When the elderly individuals in the current research did not understand what was happening to them, they engaged in the strategy of managing information and asking questions. There are numerous instances in this research which demonstrate the elderly individual's active participation in the
hospitalization, engaging in introspective, active, and interactive strategies to influence the course of the hospitalization.

The introspective strategies of life reviewing, worrying, adjusting attitude, and magical thinking in the current research were similar to constructs identified by Huckstadt (1990) in her grounded theory of Enduring. This study described six constructs: 1) accepting assistance, 2) believing it will be OK, 3) playing the game, 4) protecting, 5) remembering, and 6) worrying. The constructs can be compared to the strategies used by elderly people in the current research.

Huckstadt’s (1990) construct “believing it will be OK” (p. 128) was similar to the strategy identified as magical thinking. By using both believing it will be OK and magical thinking the elderly participant thought that by simply being in the hospital their health problems would resolve.

The introspective strategy of “life reviewing” is more expansive than the construct “remembering” identified by Huckstadt. The act of “remembering” according to Huckstadt was specifically about the individual’s previous experience with illness. The purpose of “life reviewing” was positive, to reinforce the elderly person’s self-perception and capability and was not limited to illness-related experiences.

In both Huckstadt’s and the current investigation, remembering or life reviewing was identified as a technique. Huckstadt described positive and negative aspects of memory and focused on memories of previous illness. I described life review as a strategy to enhance personal integrity by focusing memories on at time when the elderly individuals were stronger than the moment.
at which they were engaging in the strategy. The participants did not focus on incidents in their past that had negative feelings attached to them, they told stories about times in their lives when they had either survived a difficult situation or took action that was particularly noteworthy.

Worrying was also identified in both Huckstadt's and my studies. Huckstadt (1990) characterized worrying as “the frequent distressing thoughts of informants that seemed to keep the enduring process continuing” (p. 131). Enduring, according to Huckstadt was conceived of as suffering through an experience. The more individuals worried, the more one endured (p. 125). In this research, worrying was characterized as a strategy designed to attempt to improve the elderly person’s control over his or her situation by identifying possible outcomes, both positive and negative, of the current situation. Although worrying did not improve the actual outcome, it helped the individual be prepared for possible outcomes.

Huckstadt developed the grounded theory of “Enduring” as the experience of hospitalized elderly people. Enduring was defined as “to continue in the same state... to remain firm under suffering or misfortune without yielding...(p.125). Hospitalized elderly people, family members, and the staff endured the elderly person’s hospitalization. The striking difference between the current research and Huckstadt’s work is that the current work characterizes the elderly individual in the hospital as taking an active role in creating and understanding the experience. Huckstadt’s approach characterized the elderly person as a passive stoic who endured being in the hospital.
The Elders’ Perspective on Quality of Care

Several of the themes identified in the literature investigating patient satisfaction were identified in this research. Respect for patient’s values (Gerteis et al., 1991), respect for patient preferences (Gerteis et al., 1991), respect for patient’s needs (Gerteis et al., 1991), coordination of care and scheduling (Gerteis et al., 1991; Minnik, Young, et al., 1995, Charles et al., 1994), communication (Gerteis et al., 1991; Minnik, Young et al., 1995; Cohen, Hausner, & Johnson, 1994), pain management (Minnik, Young, et al., 1995; Charles et al., 1994) transition to the community (Gerteis et al., 1991; Charles et al., 1994; Reiley et al., 1996), physical care (Gerteis, 1991; Minnik, Young et al., 1995), and nurse attentiveness (Drew, 1989; Santo-Novak, 1997) were issues of staff behavior and hospital routine identified in the data. Carl and Mrs. D. had issues surrounding discharge. All participants were concerned about issues of dignity, respect, independence, and nurse-attentiveness. The lack of timely information was a problem for Bob. At the same time that the elderly participants had these concerns, all of the elderly participants except Mrs. D., believed that they received good care while in the hospital. This suggests that the perception of the quality of care may not be related to the actual care received during any particular hospital experience, but is based upon experience over time and from the multiple interactions between hospital personnel and the elderly person.

The hospital staff was characterized as a modifier of the experience of hospitalization of elderly people in the current research. As a modifier, staff
behaviors were characterized either as attitudes toward the elderly patient or management of care. Attitudes were expressed by a range of staff behaviors along a continuum from those that were patient centered to those that were staff centered. Attitudes of staff identified here that were also identified in other studies are attentiveness, respectfulness, supportive scheduling (coordination of care), physical care. Management of care was characterized occurring along a continuum ranging from effective to ineffective. Management of care behaviors identified in the current research which were also identified in the patient satisfaction literature are coordination of care and communication.

The literature noted above focused on care provided by the hospital staff, and identified areas needing improvement. The current research was designed to gather information about the processes engaged in by the elderly individual during hospitalization. The current research focused on the elderly person’s actions in the face of these issues and the staff’s behaviors. The areas of concern for the participants in the current research such as respect, coordination of scheduling, physical care, and the desire for information, were similar to patient concerns in other studies. A major difference is that the purpose of the literature was to identify problems in care provided, not to describe the process of the evolving hospitalization. As an investigation of the processes engaged in by elderly people during hospitalization, the current research adds to the body of literature by identifying the elderly individual’s actions in response to staff behaviors.
Personal Integrity and Relevant Literature

The review of literature provided insight into the breadth and depth of literature investigating hospitalized elderly individuals. The purpose of the review of literature is to sensitize the researcher to possible issues in the phenomenon under investigation. Once the grounded theory has been developed, the researcher must focus on a body of literature relevant to the theory. This may be a different body of literature than reviewed previously (Hutchinson, 1993, p. 205). The theory of Managing Personal Integrity has led the researcher to examine literature from gerontology, philosophy, psychology, and sociology related to the concept of personal integrity and the process of managing of personal integrity.

The Concept of Personal Integrity

The term Personal Integrity was chosen as the label for the core concept of this research. The word personal suggests “pertaining to or concerning a particular person; individual” (Random House, 1992, p. 1008). I selected this word to suggest the uniqueness of each person. Integrity suggests “a state of wholeness” (p. 700) and strength (as when used to refer to the integrity of a bridge). The phrase Personal Integrity refers to the unique wholeness and strength of each person.

In this research, personal integrity is composed of three properties: health, dignity, and autonomy. Health is defined as encompassing the experience of the body and having both physical and psychological attributes. Dignity is the individual’s dynamic sense of worth. Autonomy is defined as the elderly person’s
freedom and ability to act on their own behalf. The properties are in dynamic balance with one another. Personal integrity is one quality of individuals. There may be other qualities of individuals which are outside the scope of this theory. Personal integrity is not intended to suggest the totality of the elderly person, but a quality of individuals that, when in balance, contributes to the overall wholeness of each person.

**Personal Integrity and Levine’s Conservation Model.** The phrase ‘personal integrity’ was used by Levine (1991) in her framework for nursing. She uses the phrase to refer to an individual’s “unique personhood, known as the self” (Schaefer & Pond, 1991, p. 26). Levine’s use of the phrase personal integrity, having to do with the self, seems to be consistent with one attribute “dignity” in the current theory. In the current research, dignity is a property of personal integrity composed of self-dignity and interpersonal dignity. In addition to personal integrity, according to Levine, an individual also has structural integrity and social integrity. Structural integrity has to do with the physical aspects of an individual and social integrity is the individual’s interactions with society.

Levine explains the relationship between health and personal integrity by stating, “conservation of the integrity of the person is essential to ensuring health and providing the strength to confront disability” (Schaefer & Pond, 1991, p. 3). Health is the self-defined outcome of adaptive strategies of an individual. The individual with strong personal integrity is better able to engage in adaptation to achieve health than a person who is less whole. In the context of Levine’s Conservation Model, health is an outcome of adaptation. In the model of personal
integrity proposed in the current research, health is one component of personal integrity. Good health, a state of wellness, being well rested, having sufficient energy, and the absence of pain enhance an individual’s personal integrity, while poor health challenges personal integrity.

There is no mention by Levine of autonomy, control, or independence in her Conservation Model. In the current research, autonomy is an integral property of personal integrity. The concept developed by Levine and the concept of personal integrity in this research differ in scope. Personal integrity in the current research has both physiologic and psychologic attributes as well as a social component (interpersonal dignity) It is a broader concept than that developed by Levine. Meanwhile the concept of health in the current research is more narrowly defined than health as described by Levine.

**Philosophy and personal integrity.** The philosophical definition of integrity is related to the concept of morality. Discussion of morals is outside the scope of this discussion, but the ideas defining integrity in philosophical terms are useful. Halfon (1989) explores the bounds of moral integrity. Halfon suggests that an individual may have several kinds of integrity including personal, intellectual, religious (p. 53). Integrity to Halfon is a quality of individuals who exhibit “commitments to do what they believe is best and that they maintain their commitments consistently under conditions of adversity” (p. 165). According to Halfon, the consistency of action exhibited by individuals with integrity is a manifestation of their wholeness (p. 7). According to Halfon an individual has several types of integrity, therefore personal integrity is not the total wholeness of
the person but “some part of the whole” (p. 161). This is consistent with the
definition in the current research, in which personal integrity is one quality of
individuals.

In discussing the definition of integrity, Carter (1996) concurs with
Halfon’s ideas of wholeness by suggesting that “completeness” (p. 7) or a
consistency of behavior is part of the meaning of integrity. Carter uses the word
integrity to discuss a quality of individuals which leads to an individual “living
rightly” (p. 7), that is, in a way in which the individual with integrity keeps
commitments, lives by the rules, and can be trusted. In Carter’s work as in
Halfon’s, integrity is again linked to moral behavior. Integrity according to Carter
is an element of good character.

Using the definitions that arise from philosophy indicates that personal
integrity is a unique quality of individuals characterized by self integration,
wholeness or completeness, and consistency of behavior. In philosophy, the term
integrity is linked to moral as well as consistent behavior. Individuals who act
“rightly” and consistently with their own beliefs are said to have integrity. This is
a different use of the word integrity than in the current research. The definition of
personal integrity developed in this research and the definition arising from
philosophy are consistent in the following ways. In both the current research and
philosophy, personal integrity is one quality of individuals, not the total
individual. Also, personal integrity is integral to the wholeness or completeness of
an individual.
Health as a Property of Personal Integrity

The conceptualization of health which emerged from the data in the current research had specific attributes and is narrower than the definition generally reported in the literature. In the current research, health is defined as having physical and psychological attributes including, pain, wellness/illness, energy level, and sleep. The elderly participants in the current research believed that the alteration of health that led to their seeking healthcare and admission to the hospital had potentially fatal consequences. The status of an individual’s health was integral to the way an individual lived. A decline in health represented a change in an elderly individual’s status which could affect their way of being in the world. Literature supporting these attributes, as related to health, will be presented below.

In a concept development paper, Simmons (1989) identified the two major attributes of health as biopsychosocial adaptation and self-actualization. Biopsychosocial adaptation was defined as “a dynamic equilibrium among the biological, psychological, and sociocultural systems of the individual, including the capacity to adjust to life events” (Simmons, 1989, p. 158). Self actualization was defined as “the maximizing of one’s potential through goal-directed behavior, reflecting personal growth and productive living” (Simmons, 1989, p. 158).

Within the scope of the substantive theory of Managing Personal Integrity health was not conceptualized globally but in relation to the experience of hospitalized elders. Health was identified as a cluster of physical and psychological attributes
eg. pain, wellness/illness, energy level, and sleep. Adaptation was not included in the concept nor was self-actualization.

In 1947 health was defined by the World Health Organization (WHO) (cited in Craven & Himle, 2000) as “a state of complete physical, mental, and social well-being and not merely an absence of disease” (p.252). Health as a property of personal integrity is consistent with the WHO definition because both definitions include physical and psychological attributes. But it is divergent in that the WHO defines health as including social attributes and being a state in which disease is absent. Health in the current research included only one's illness status.

An early conceptualization of health is as the absence of disease (Craven & Himle, 2000, p. 252). This view suggests health can be measured on a single continuum from health to illness. The conceptualization is more narrow than the concept of health in the current research. One of the attributes of health includes a continuum between wellness and illness. An individual's state of wellness or illness can be placed on the continuum relative to their previous status and the definition of wellness according to the society in which they live. Prior to the alteration in health that led to hospitalization of the participants in this study, the elderly individuals were managing their chronic illnesses and maintaining active lives where they were engaged in their usual way of being. Therefore, the definition of health as the absence of disease is not a useful definition in this project.

Health as role performance is another common theme in the literature (Simmons, 1989, p. 157). According to this model, health is said to be good or
adequate if an individual can perform their usual roles. This model is not consistent with the model of health developed in the current research. Here, health as a property of personal integrity, was one characteristic of elderly individuals which had an effect on their ability to engage in their usual roles, but life roles and health were not synonymous in this research. Also, as their health changed over time, the life roles of the elderly individuals adjusted according to their abilities.

The ability to engage in physical activities was identified as a component of the attribute of health - energy level. In her ethnographic study of elderly peoples’ perceptions and interpretations of their state of wellness, Miller (1991) found that physical activity and relationships emerged from the data as indicators of health. Individuals who identified themselves as well were physically active and had many relationships with friends and family. These findings are consistent with the current research in that relationships, although not identified as part of health, were recognized as an important factor in the elderly person’s experience of being in the hospital.

In relation to health, the individual’s ability to engage in physical activity was important, not the actual level of performance. Physical activity in the hospital was minimal. In this research it was found that patients spent much of their time either watching television or waiting for something to happen. This was true even after the initial phase of hospitalization when the acuteness of illness began to subside. Nolan, Grant, and Nolan (1995) also found that hospitalized
elderly people spent the vast majority of their time not engaged in any activity. Physical activity as an attribute of health is supported in the literature.

Health in the current investigation is conceptualized as a constellation of attributes which are present in all individuals. An individual could be said to have a greater or lesser degree of health, but they could not, not have health. Therefore, an individual could not be said to be unhealthy, as a lack of health. It would be said that the individual had poor health.

Dignity as a Property of Personal Integrity

The definition of dignity in this study is consistent with definitions found in the literature (George, 1998; Maris, 1994; Einhorn, 1992). Dignity was defined as the individuals' dynamic sense of worth. Self-dignity, the individual's sense of self-worth, and interpersonal dignity, the respect attributed to one by others, were attributes of dignity in the current research.

George (1998) described dignity as a "social-psychological state... a complex combination of the personal and the social or interpersonal." (p. 45). This characterization is consistent with the elderly individuals' dignity as a property of personal integrity. The elderly individuals in this investigation entered the hospital with a supply of inherent dignity. This is the psychological or personal component of the phenomena discussed here as self-dignity. Self-dignity is based upon past accomplishments and self-concept. This component of dignity can be defined as: 1) "bearing, conduct, or manner indicative of self-respect..." (Random House, 1992, p. 376).
The social or interpersonal component of dignity identified in this research and by George is related to the amount of respect with which other people treat an individual. The second definition in Webster's dictionary addresses this component of dignity as "2) nobility or elevation of character; worthiness." (Random House, 1992, p. 376). People treat another individual a certain way which conveys a sense of worthiness to that individual.

The two aspects of dignity, personal and social, are integrally connected. Dignity, according to George (1998), is both "bestowed by others in the immediate social environment and exists independently of it" (p. 46). The aspects of dignity work in a synergistic relationship. The ability of an individual to tolerate insult to his or her overall dignity is affected by the amount of self-dignity he or she possesses at the time of insult. Conversely, the meaning the elderly people ascribed to interpersonal transactions that they had with the staff either enhanced or diminished their feelings of dignity.

Each of the attributes of dignity in this research could be further broken down into components. Self-dignity was composed of self-concept and privacy. Interpersonal dignity subsumed the component of respect. This characterization of dignity was supported by Maris's (1994) findings in researching British nursing students' definitions of dignity. Maris (1994) found that the words most frequently used by students to describe dignity were respect, self, and privacy. These concepts were integral to the definition of dignity in the current research. These attributes are consistent with the definition of dignity as both a personally and socially constructed concept.

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Einhom (1992), investigated the definition of dignity as perceived by elderly people. Using multidimensional scaling analysis, Einhorn developed a model of the concept dignity that included four semantic clusters: cognitive, ascribed esteem, relational integrity, and respect. The cognitive component in Einhorn’s model was composed of the adjectives wise, clear-thinking, and capable (p. 37). Ascribed esteem was composed of the adjectives honest, honorable, and admirable. Relational dignity describes “the way a person with dignity treats others” (p. 37) and includes the adjectives compassionate, thoughtful, dependable, and sincere. Respect, the fourth component of dignity included the descriptors “respectable”, “self-respecting”, and “has dignity”.

Although Einhorn (1992) did not define dignity in the same way as George (1998) or this research, there are similarities. Einhorn’s four components can be aligned with attributes of self-dignity and interpersonal-dignity. The cognitive component in Einhorn’s model is related to self-dignity in that both address the individual’s ideas about their own dignity. Relational-integrity speaks to the process that elderly individuals engaged in when they used interactive strategies to enhance their image in the eyes of the staff. Ascribed esteem and respect are related to interpersonal-dignity in that both are characteristics of dignity that are demonstrated through the behavior of others toward an individual.

Further support for the concept of dignity having personal and interpersonal components was found by Pokorny (1989). In her qualitative research study, Pokorny (1989) identified five attributes of dignity. Three attributes, privacy, control, and independence, were client characteristics or feelings, and
two attributes, caring and competence, were demonstrated by nurses as part of a relationship that promoted dignity. Her approach clearly divided dignity into feelings of the individual (self-dignity) and interpersonal dignity. Pokorny’s conceptualization extends outside that of the current research. Although clearly identifying components of self-dignity and interpersonal dignity, Pokorny defined dignity as residing in the interaction process between the person and the staff, not within the individual. In the current research, control and independence were identified as attributes of autonomy, a separate property of personal integrity rather than dignity. Another departure from the literature noted above is Pokorny’s inclusion of control and independence in the conceptualization of dignity.

**Autonomy as a Property of Personal Integrity**

In the current research, autonomy is defined as having both physical and psychological attributes. It is conceptualized as the elderly individual’s freedom and ability to act on one’s own behalf. Autonomy has two attributes: Independence, the individual’s ability to act in a given situation, and control, the individual’s perceived power in a given situation.

Ramsay identified autonomy as “necessary” for an individual to have integrity (1997, p. 89). Similar to other philosophers, Ramsay defined integrity as linked to moral behavior. He said that integrity included adherence to “right principles and their harmonious coordination with sound practical reasoning” (1997, p. 3). In order to have integrity, an individual must have autonomy “the
capacity to reflect, deliberate, judge, and form self-constituting choices" (1997, p. 88). Ramsay’s definition of autonomy includes ideas similar to the attribute of control in the current study. In order for individuals to feel powerful in a given situation they must be able to reflect on the situation and make choices on their own behalf. However, autonomy, as derived in the current research, also included the physical ability to act on the choices that were made. Physical ability is beyond the scope of Ramsay’s definition.

The definition of autonomy in this study was found to be similar but not identical to that in the health literature. The current research found that elderly individuals felt that they had more control when they had sufficient information about their situation. In a study of participatory control in long term care settings, Stirling and Reid (1992) found that elderly individuals’ feelings of control increased by reciprocal interactions with their environment. They based their work on the cognitive social learning theory of control which “emphasizes that the sense of personal control is optimized when the people feel they have a clear grasp of how much... they can influence their situation” (p. 206). The researchers proposed that nurses would feel more effective, and patients would be more adjusted with increased feelings of control, when the nurses acted to enhance the patients’ feelings of control. Through an education program, the researchers changed the attitudes of nurses in the intervention group and had a positive effect on the feelings of control of patients.

Although Stirling and Reid’s (1992) research was conducted in a long term care institution in Canada, not in acute care in the United States, some
inferences can be made for the current research. In their research, as in the current study, elderly individuals who lived-in in a moderately restrictive institution experienced diminished autonomy by virtue of the context in which they were placed. Staff members engaged in behavior which could enhance or diminish the elderly individuals' sense of autonomy. Stirling and Reed's intervention study demonstrated that the staff could modify the experience of the person being institutionalized by acting as a mediator and engaging in behaviors which were characterized in this study as patient-centered. Stirling and Reed did not examine strategies engaged in by the hospitalized elderly people to improve their own autonomy.

Strategies Used by Elderly People to Enhance Personal Integrity

This study found that elderly people used introspective, interactive, and active strategies to manage personal integrity. Most of these strategies have not been identified elsewhere in the literature. The theory derived through this research contributes new ideas about the role and actions of elderly people in the process of hospitalization, in that much of the prior research investigating elderly people in the hospital view the patient as the recipient of care. The focus of this research was the experience and actions of the elderly patient while experiencing alterations in health within the context of hospitalization.

Introspective strategies are strategies that elderly individuals used to reinforce their self-concept or prepare themselves for an upcoming event. Introspective strategies included life reviewing, magical thinking, worrying, and

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adjusting attitude. One introspective strategy that has been previously identified in the literature is life review. The use of the term, life review, in the current research is not similar to the definition in the literature. Life review is defined in the literature as a one-to-one activity with a therapeutic listener conducted over a period of weeks and including an evaluative component of both recent and remote events (Burnside & Haight, 1992, p. 857; Haight & Burnside, 1993). The purpose of life review in the present research was to enhance the individual’s dignity by reminding them of a time when they survived a difficult experience or acted in a noteworthy manner. Although the effect of life review may have been enhanced by sharing it with another individual it was primarily an introspective strategy designed to work on the self.

As discussed earlier, Huckstadt (1990) identified constructs in her grounded theory of Enduring which were similar to the introspective strategies of worrying, magical thinking, and life reviewing. The uniqueness of the perspective of the current research is that through making meaning out of their experience, the elderly individuals employed these strategies to affect their meaning-making and prepare themselves for the next event in the process of hospitalization.

Interactive strategies are strategies that the elderly individual uses to affect personal integrity through interactions with hospital personnel, families, and others. Reciprocity in relationships is an interactive strategy identified in the current research which has been investigated by other researchers. The definition of interactive strategies most similar to that identified in the current research is put forth by Rempusheski, Chamberlain, Picard, Ruzanski, & Collier (1988) “a
voluntary action by the patient/family intended to acknowledge care received and to achieve a balance in the relationship" (p. 48).

In a concept analysis, Marak (1990) identified the primary attribute of therapeutic reciprocity as open mutual exchange where the humanity of the staff person and the patient are available to each other. The openness described by Marak suggests shared control and mutual responsibility between nurse and patient. During data collection, I did not observe episodes of care that fit this definition of therapeutic reciprocity; rather I observed elderly individuals attempting to initiate this type of relationship.

In a meta-analysis of 15 years of qualitative research investigating individuals with chronic disease, Thorne & Paterson (1998) noted a shift in the perspective of the research from viewing the person with the disease as "client–as–patient" to "client-as-partner". Although many of the specific strategies identified in the current research have not been previously identified in the literature, identification of strategies, particularly interactive strategies, in the current work is consistent with the trend identified by Thorne and Patterson. The interactive strategies of managing information, managing image, and relying on authority have not been discussed elsewhere in the literature with respect to the elderly person in the hospital. The idea that elderly individuals in acute care settings make decisions about sharing information about activities and health behaviors, about how to present themselves to the staff, and about whether or not to rely on the authority of the healthcare provider is unique to this research.
Research on these strategies could contribute to the body of knowledge of the elderly person as co-manager of their care.

**Active strategies** Maintaining health, taking responsibility, and taking action are active strategies engaged in by the elderly person in the hospital identified in this research. These strategies have not been identified elsewhere in the literature as behaviors initiated by the elderly person to improve the outcome of hospitalization.

Behavior similar to, but not synonymous with, that identified as active strategies have been discussed by DeGeest, Renteln-Kruse, Steeman, Degraeve & Abraham (1998) as compliance and adherence to the medical plan of care. Compliance and adherence are used interchangeably in the literature to mean "the extent to which a person's behavior coincides with medical or health advice" (p. 467-468). This is a medical-centered view of elderly individuals' ways of making meaning and acting on behalf of their health. The active strategies are defined as actions deliberately engaged in by the elderly person which arise from the meanings attributed to a given situation such as taking responsibility for implementing the changes in their care instituted by a healthcare provider. These terms reflect the elderly individuals' actions, not reactions to direction given by the healthcare worker. The contribution to the body of knowledge made by this orientation to the elderly person is that the elderly person is viewed as an active member of the health care team, not a patient to be acted upon by the team.
The Process of Managing Personal Integrity

Three phases of hospitalization were identified in the current research. During each phase a different property of personal integrity was the primary focus of the elderly individual. Research discussing the experience of hospitalization in terms of phases has not been published. The current research provides a unique framework for viewing the process of hospitalization. The idea that the hospitalized person's focus changes as their hospitalization progresses while the healthcare provider remains focused on the individual's health could contribute to research on patient satisfaction as well as improving the outcomes of hospitalization by improving the congruence between the patient focus and staff awareness.

The longitudinal perspective of the current research is unique. Other researchers (Huckstadt, 1990; Koch, 1994) interviewed individuals who had been in the hospital for varying periods of time, but did not investigate the changes of specific individuals over time. The technique of in-depth investigation over the course of an elderly individual's entire hospitalization added new information to the body of knowledge by illuminating changes in focus that occurred during the hospitalization of elderly participants in this study.

One body of longitudinal research that may serve to illustrate the uniqueness of the current research is the study of chronic illness and development of a trajectory (Corbin & Strauss, 1991; Strauss et al., 1984). The purpose of the research was to provide a conceptual model for understanding the course of chronic illnesses so that healthcare providers might be able to "shape and
manage" (Corbin & Strauss, 1991, p. 156) the course of the trajectory. In the research by Corbin and Strauss as in other research in this sample, the responsibility for action is with the healthcare provider, not the individual who has an alteration in health. The role of the person with the chronic illness was to be the recipient of care. Although the meta-analysis of qualitative research on individuals with chronic illness (Thorne & Patterson, 1998) noted a shift from the perspective of Corbin and Strauss (1991), much of the current research is focused on the care giver and not the actions of the person who has a health problem.

The process of managing personal integrity can be applied to elderly individuals who are in the hospital, regardless of the nature of their medical illness. The model of Managing Personal Integrity is focused on the meaning making and action of the elderly person who is experiencing the hospitalization. This point of view is unique to this research. The point of view that persons with illness freely make choices about how they will interact with the healthcare provider and about what actions they will take to manage their health, may provide insight for the healthcare provider in how to assist the elderly individual to manage their health rather than direct the management as is suggested by most research.

Research into one of the stages of the process of hospitalization as identified in the current research has been previously conducted. The period of adjustment following a hospital stay, one stage of the current model, has been investigated by Lough (1996). Using a grounded theory approach, Lough
identified the core variable of the period immediately following a hospital stay as “a tentative situation” (p. 806). This period was characterized by Lough as a time when the elderly participants in her study were challenged by the demands and stressors of health management during this period of the chronic illness trajectory (p. 806). Three key processes were identified: “ups and downs associated with managing the illness, caregiver issues, and quality of life challenges” (p. 806). The “ups” for these participants were social support and pride in their ability to manage their health. The “downs” were related to the difficulties of managing their illness and concerns about medications. Caregiver issues focused on the increased dependence of the elderly participants on other people. Challenges to quality of life were characterized as hopelessness, self-blame, and uncertainty about life.

Lough’s (1996) research provides an in-depth analysis of one stage of hospitalization identified in the current research. This stage was the period of adjusting. During this stage in the current research, the elderly individuals took responsibility for managing their health by organizing their daily activities to include new medications and treatments required to manage their evolved health status. Several participants had increased contact with their family, and all elderly participants moved toward the evolved usual way of being.

The current findings are consistent with Lough’s (1996) findings in several ways. First, obtaining and managing medications was an issue for participants in both studies, as well as learning new ways of managing their illnesses. Participants in both studies had increased contact with social support.
systems comprised of family or friends. The departure from agreement in the two studies is with respect to the quality of life issues. While Lough’s participants expressed hopelessness and uncertainty, the elderly participants in the current research were looking forward to new activities and getting “back to normal”. They did not exhibit hopelessness, they all spoke about re-engaging in previous activities and making changes in behaviors to improve aspects of their personal integrity.

Differences in findings could be the result of differences in underlying perspectives of the researchers. Lough (1996) based her study on the Chronic Illness Trajectory Framework (Corbin & Strauss, 1991) discussed above. The participants all had chronic illness and had been hospitalized numerous times. The participants in the current research all had chronic health problems but all had not been hospitalized repeatedly for their current health problem. Although concerned about their health, the elderly individuals in the current research were able to look past the current illness and hospitalization and see a future in which they could live in an evolved usual way of being.

Context and Mediators of Managing Personal Integrity and Relevant Literature

The Hospital, Context of Managing Personal Integrity

A recent portrayal of hospitals (Glass, 2000) resonates with many of the experiences of individuals in the current research. The journalistic/documentary radio program, This American Life, identified many of the themes of
decontextualization and strategizing identified in the current research. During the introduction to the program, Glass described the experience of hospitalization:

In the hospital we give up our normal schedule and sleep patterns. We give up our normal food and clothing. We are in a place that has its own rules, its own language, and its own customs. We're not exactly helpless but often we're not far from it.

And, in the midst of all this, there is this delicate human interaction which we have to negotiate. And its one on which our lives, our actual lives, can depend. We have to deal with doctors and nurses and all sorts of other staff. We have to get what we need from them in a situation where they have all the power and knowledge and they may not be as concerned with our care as we are ourselves....

Some of the most delicate and charged diplomatic negotiations happen every day over matters of life and death at your local neighborhood hospital as patients try to get what they want and staff tries to do what they think is best. (I. Glass, 1/00)

In this quote, Glass (1/00) eloquently describes the experiences of individuals who are hospitalized. He identifies many of the issues about the hospital as the context for the experience and the strategies engaged in by some individuals. Many of these ideas can by found in the theory of Managing Personal Integrity. Both Glass and this research identified issues of health, dignity, autonomy, decontextualization which comes from being in a restrictive institution, staff behaviors, and interactive strategies in which individuals engage to manage their personal integrity. The current research validated the experience described by Glass, conceptualized the concepts and the processes involved in the experience, and added a description of how an elderly individual made meaning out of being in the hospital and engaged in behaviors that were designed to have an effect on the process. The current research identified phases of being in the hospital where the individual's focus changed over time. These additions to the
common description by Glass have provided information on how the elderly individual manages the process of being in the hospital.

**Semiprivate rooms** As a result of the original Medicare Act (Public law 89-97, signed July 30, 1965), the semi-private room is ubiquitous in American hospitals (Silberman, 1999). Research conducted on Nightingale Wards (Koch, 1995) in England and Sweden (Ekman, Lundman & Norberg, 1999) illustrates the improvement in privacy brought about by the comparative privacy of the semi-private room. However, even in semi-private rooms, the elderly people in this research experienced decreased privacy. More research is need to evaluate the benefits and problems of private versus semi-private rooms in hospitals.

**Hospitalized Elderly People and Healthcare Providers**

... In the hospital, where doctors govern everything we do, our direct experience of them is... marginal: we're patients twenty-four hours a day, and our doctors' appearances on their rounds seem a matter of nanoseconds, something we might miss entirely if we were to blink. What's weirdest of all in this experience is the stark contrast between our doctors' pervasive power and their absence....


This quote catches the essence of the experience of being in the hospital with respect to the physician. In the current research, the physician was found to be so important that all participants could name several physicians although the elderly person had had only momentary contact with each of them.
Staff in the current research were characterized as modifying the elderly individuals' ability to manage personal integrity by affecting health, dignity, and autonomy. Staff behavior that affected dignity and autonomy were categorized along a continuum between patient centered behaviors, those which promoted the individuals' dignity and autonomy, and staff-centered behaviors, those that furthered the aims of the institution.

Gerteis et al. (1991) and Minnick et al. (1995a, 1995b) investigated patient satisfaction with health care provided in hospitals. Gerteis et al. (1991) found patients to be concerned with seven aspects of care given by healthcare providers: respect for patients' values, preferences, and expressed needs; coordination of care and integration of services; communication between patients and providers; physical care; emotional support; involvement of family and friends; and transition to the community. Minnick et al. investigated the quality of health care in regard to the following specific areas of care: physical care, pain management, emotional support, and receiving information. The current research also identified these services as areas for concern.

Dimensions of care identified by Gerteis et al. (1991) are synonymous with staff behaviors in the current study. Six of the seven dimensions of care identified by Gerteis et al. were supported by the data and incorporated into the theory of managing personal integrity. Gerteis et al.'s dimensions of respect, physical care, and emotional support (named connectedness in the current study) were identified being in positive relationship with patient dignity and autonomy. The staff behaviors in the current research which had an impact on health were
communication and coordination of care, the relationship between these behaviors and health was also positive. Effective communication and coordination of care improved the hospitalized elderly person's health by diminishing the likelihood of complications and improving the individual's rest. These were also identified by Gerteis et al. as dimensions of care. Transition to the community was identified as an important dimension of care by Gerteis et al. In the current study transition to the community, or “returning home”, was identified as a stage of managing personal integrity.

The dimension of care identified by Gerteis et al. that was not present in the current research is involvement of family and friends. In the current research, family and friends were important to the elderly person in the hospital, but the interaction between family and staff was not identified as important except as a measure of the respect the staff attributed to the elderly person.

The elderly participants in the current research had generally positive opinions of staff, but there were examples of staff behaviors that were controlling and directive. These behaviors were defined as staff-centered behaviors in relation to dignity and autonomy and ineffective communication in relation to health. Controlling and directive staff behaviors were identified by Hewison (1995) and Draper (1996). In an observational qualitative research study, Hewison (1995) identified categories of interactions between elderly patients and nurses on Nightingale Wards for the elderly in England. The nurse interactions were categorized as examples of overt power (directing the activities of the patient),
persuasion (convincing the patient to do something the patient doesn’t want to do), and controlling the agenda (limiting the conversation).

Draper (1996), also identified categories of staff behavior. Although the nurses who participated in Draper’s qualitative study declared that the elderly individuals with whom they worked should be treated as individuals and that the elderly people should be allowed to make decisions with respect to the conduct of their daily lives, in practice the nurses engaged in behaviors that controlled the elderly individuals’ lives. The behaviors exhibited were all related to restricting the choices of the patient and varied by degree. Draper characterized the degrees of limiting choices as compromise, massive encouragement, and forcing.

The current research sought to focus on the processes engaged in by the elderly participant whereas previous research focused on the behaviors of the staff. Staff members in the current research behaved in ways such as managing care and communicating with patient that are consistent with literature on patient satisfaction. The congruence of the findings of the current research with findings of major studies on patient satisfaction lends strength to the theory of Managing Personal Integrity. The current research is a departure from the literature in that the research above presents the staff as central to the hospitalization of the elderly person. The current research views hospitalization as the context for processes engaged in by the elderly person, and the staff as having the ability to facilitate or inhibit the elderly person’s process.
The role of the family in the current research as a modifier of the processes engaged in during hospitalization has not been previously identified. Support provided by family members to elderly individuals when they returned home from the hospital was consistent with family behavior identified by Congdon (1994). In a grounded theory study identifying processes surrounding discharge from the hospital, Congdon found that families provided support for the discharged elders as they returned home. This was true in the current research where family members provided transportation from the hospital as well as increased surveillance of the elderly person during the period immediately following discharge.

Other research on families reviewed in Chapter II treated families as reporters of care (Tappan & Beckman, 1992), or as recipients of care (Bowman, Rose, & Kresevic, 1998; Johnson et al., 1998; Leske, 1996; Peirce, Wright, & Fulmer, 1992). The current research did not identify families in either of those roles but as support to the hospitalized person. The activities engaged in by family members were aimed at keeping the hospitalized elderly people going. Family members visited the elderly people and kept them connected to the daily events of life outside of the hospital or maintained their lives outside of the hospital by walking the dog, managing the mail, etc. Although the literature identified a need for meaningful interaction between families and staff, that was not observed in the current research. Interactions between hospital staff and family members were minimal and confined to casual conversation.
The Contribution of the Research to the Body of Knowledge

As the review of literature shows, many of the themes identified by the current work have been previously identified. This research adds to the body of knowledge about hospitalized elderly individuals in several ways. First, the concept of personal integrity as a quality of elderly individuals composed of the properties health, dignity, and autonomy is a new concept. Although health, dignity, and autonomy are properties of elderly individuals that have long been identified as important, these properties have not been combined into the concept of personal integrity prior to this research. The proposition that these properties are in dynamic balance with one another and an alteration in any one property can effect the other properties is adds new knowledge.

The second contribution to the body of knowledge is the perspective that the hospitalized elderly person is actively engaged in making meaning and strategizing to effect the outcomes of hospitalization. This frame of reference goes beyond the trend identified by Thorne and Patterson (1998) where the client is being thought of as a co-manager. In the current research, the client is viewed as the manager of their personal integrity with the family and healthcare providers engaged in supportive roles. This viewpoint is a dramatic departure from the traditional position of healthcare providers directing hospital care. From this perspective grew the idea of strategies employed by the elderly person to effect the outcomes of hospitalization by enhancing his or her personal integrity.
Identification and categorization of the strategies employed by elderly people during an episode of hospitalization is another contribution to the body of knowledge. Prior to this research the literature does not provide a conceptual discussion of the range of activities used by elderly individuals to affect the outcomes of situations. The categorization of strategies as introspective, interactive, and active provides a framework for research into elderly individuals' management of their life-worlds.

Much research has been conducted on the role of the healthcare provider. This research contributes to that literature by identifying behaviors of the healthcare provider through the meanings attributed to their behaviors by the elderly person in the hospital. The two dimensions of hospital staff behavior, attitude and management of care, were described. The effect of these behaviors on an elderly individual’s health and autonomy have not been previously discussed from the perspective of the elderly client.

The family’s role as supportive of the elderly individual is also a contribution to the literature. There has been little or no published research which identifies the family of an elderly individual in the hospital in the context of supporting the elderly individual’s activities.

Finally, a major contribution to the body of knowledge of this research is the identification of phases of hospitalization. There is no prior mention in the literature of changes in the focus of the hospitalized person as hospitalization progresses. This work establishes a theoretical baseline for future investigations of the life-world of hospitalized individuals.
The contribution of this research is that it helps illuminate the elderly persons' experience and social processes while in the hospital. The usual portrayal of the elderly person in the hospital is as a passive recipient of care. This research illuminates the dynamic processes engaged in by elderly persons to affect the outcome of their experiences.

The Limitations of the Research

The purpose of grounded theory research is to develop substantive theory grounded in the experience of the participants. Such theory is designed to have predictive power within a specified context (Strauss & Corbin, 1998, p. 267). The merit of such a theory is "to speak specifically for the populations from which it was derived" (p. 267). The theory of Managing Personal Integrity identifies the processes elderly individuals engage in while immured in a hospital with no identified geriatric care program. The hospital is in a rural, middle class area of New England with few minority patients or staff. The validity of transferring this theory to other contexts is dependent on the similarity of the new context to the one described here. A period of testing the theory in another setting prior to application is suggested by Lincoln & Guba (1985). Assuming similarity of context is established, implications for nursing are suggested below.
Implications for Nursing

The theory developed in the current research has implications for nursing education, practice, and research.

Education

The research suggests that nurses should be taught to recognize that elderly people in the hospital are using strategies to enhance their personal integrity. Nurses could be taught to engage in client-centered behaviors that could enhance the elderly individuals’ managing of personal integrity. These staff behaviors would include: being attentive to the elder; engaging in connected behaviors such as comforting and providing emotional support; approaching the elderly person in a friendly and helpful manner; being unobtrusive; demonstrating respect for the elderly person at all times; including the hospitalized individual in planning their schedule; being gracious when problems with care arise; and gently providing good physical care. The staff behaviors described here are not new, innovative ideas, however, they are not behaviors that are universally in use.

Nurses need to become more aware of interactive strategies such as managing information, reciprocating in relationships, relying on authority, and managing image engaged in by hospitalized individuals and assist the individuals’ management of personal integrity. Ways of enhancing an elderly individual’s dignity while providing care and administering procedures could be taught to all hospital staff during their basic education and hospital orientation.
Consent for invasion of personal space and physical body is crucial to improving the dignity of elderly people.

If the staff in the current research had employed some of the behaviors above it would have made a difference for the participants. For Bob, receiving more information in a timely manner would have improved his experience. For Mrs. D., the experience would have been improved if she felt all staff members treated her with respect. For Evy, having input into her schedule would have reduced her worry over her diabetes management.

Teaching nurses about the phases of hospitalization could enhance their awareness of process during hospitalization and help them plan interventions with the patient's phase of hospitalization in mind. For example, the nurse might prioritize teaching by phase of patients' hospitalization. During the stabilizing phase while nurses and patients are focused on the patients' health, nurses may want to teach patients about the plan of care and the interventions being instituted to improve their health. During the repairing phase, when the patients' focus changes to dignity, the nurse may want to encourage patients to have visitors and wear their own clothes to diminish the decontextualization of being in the hospital. During the reintegration phase, nurses could actively engage patients in planning their schedule while in the hospital and encourage patients to get out of bed and out of their rooms on a regular basis, perhaps scheduling meals in a dining room. During this phase, nurses and patients could work together to prepare patients to return home and assume responsibility for their own care.
Nurses who were interviewed for this research had a difficult time finding an answer to the question “What is unique about your practice, what difference will it make to elderly persons to have you provide care for them?”. When nurses cannot identify the uniqueness of their practice, patients will not be able to identify individual nurses. Education that enhances the nurses’ perceptions of themselves as independent practitioners may enhance the individuality of nurses which, in turn, may allow nurses to develop unique relationships with patients which enhance the patient’s personal integrity. Coaching nurses on how to approach hospitalized individuals so that the patient knows the person is a nurse would improve the mutuality of the relationship.

Practice

The hospital was the context for the experience of hospitalization. The hospital was characterized as a fairly restrictive institution in which the staff (workers) have control over the people (live-ins) who are receiving services from the staff. Designing health care settings in which the hospitalized elderly person can share the control over their experience would enhance the elderly person’s personal integrity. This could be achieved through improving the opportunities for participatory decision-making. For example, improved patient control over scheduling would increase the elderly person’s sense of control. Appointments could be made between the elderly person and the service needed, the same way that appointments are made for outpatients. The nurse could facilitate this process by meeting with the hospitalized person in the evening to schedule the next
morning, in the morning to review any changes, and late morning to schedule the afternoon. Scheduling would provide for the elderly person to set aside periods where they could rest or receive visitors. This sort of schedule would also improve the information received by elderly persons, providing an update on their plan of care three times each day. Hospital organizations need to find ways of being more patient-focused and less institutional-focused. Improving the patient’s control over their activities and schedule would improve autonomy. Including the patient as a member of the team, as in the model for rehabilitation, would improve their feelings of control. The idea of scheduling hospital business according to a patient-friendly schedule is idealistic. A hospital would have to restructure the way business is done to accommodate such a plan.

Models to increase the system’s attentiveness to the needs of elderly people need to continue to be developed and tested. Both the geriatric resource model (Innouye et al., 1993; Francis et al., 1998) and the Acute Care for the Elderly Unit (Palmer, Landefeld, Kresevic, & Kowal., 1994) have merit as health care delivery systems. As hospitals are renovated and new hospitals are built, designs need to take into account ways of promoting personal integrity. These measures might include private rooms or better sound absorption. Providing true privacy (audio and visual) without isolation is a challenge.

Decontextualization was a problem for the elderly individual in the current research. Hospital protocols could be changed to minimize the decontextualization and to improve the sense of control experienced by patients. For example, if hospitalized individuals could wear their own clothing, or at least
have a choice of clothing from a small selection supplied by the hospital, it could enhance their dignity. Developing ways for the hospital staff to incorporate information about the elderly person's life outside of the hospital would help the person remain connected to their home-life.

Providing information in a timely manner was identified as a problem by the hospitalized elderly participants in this research. One of the issues raised was who was authorized to discuss the patient's case with them. Perhaps the people designated to provide information could be expanded, and an appointment could be made with the hospitalized individual daily to discuss their situation.

**Research**

The substantive theory *Managing Personal Integrity* explains the processes engaged in by the participants. The concepts and propositions of the theory need testing in other settings and with other populations. Areas of future research are presented below.

**Research Investigating the Person as Manager of Personal Integrity**

All of the elderly participants in the current research were white, middle class, and lived in a rural area. Questions which need further research are as follows: (a) whether elderly individuals of different race, culture, socioeconomic status, or region, engage in managing personal integrity by ascribing the same or similar meanings to events based upon their life experience and culture as did the participants in this study; (b) whether elderly individuals with altered cognitive...
status engage in managing personal integrity; (c) how other attributes identified in the review of the literature (depression, functional ability, age, gender, etc.) relate to managing personal integrity; (d) whether the individual’s medical or nursing diagnoses relate to their ability to engage in managing personal integrity; (e) and whether an individual’s management of personal integrity is correlated with quantitative measures of ability and severity of illness.

Research Investigating the Concepts of Managing Personal Integrity

In order for substantive theory to evolve into formal theory, it must be amplified and tested on different populations in different contexts. Each concept of the theory must be further developed. The relationships between the properties and attributes of the theory must be tested and their descriptions enhanced. The current research made identified properties of personal integrity. Further research may identify other properties such as spirituality. Further comparison of the substantive theory to other theories will strengthen the propositions and concepts. Investigation of introspective, interactive, and active strategies will help to identify the value of individual strategies in relation to the theory.

As the theory evolves instruments can be developed to measure the strength of an individual’s personal integrity and their ability to engage in strategies to enhance their personal integrity.
Research Investigating the Process of Managing Personal Integrity

No research has been recorded regarding phases of hospitalization. Research into the phases of the process of managing personal integrity is important to further identify this phenomenon. Questions which might be explored include: What are the seminal events of each phase? What events indicate a change in the sequence of phases? Does moving a patient from one unit of the hospital to another have an effect on the phase of hospitalization? Another area in need of investigation is the relationship between the concepts and propositions of the theory and the phase of the theory. While in the hospital, a specific property of personal integrity is in the forefront during each phase. Is this also true in the pre and post-hospital stages of managing personal integrity? Does previous experience with illness and hospitalization affect managing personal integrity? Are some strategies more effective than others in different phases of the process?

Research Investigating the Context of Managing Personal Integrity

The hospital where this research was conducted has not identified a model for providing care to elderly individuals. The process of managing personal integrity could be setting-dependent, therefore research conducted in other settings would help define the parameters of the theory.

Does the kind of hospital (large, small, teaching, city, rural, etc.) have an affect on the individual’s ability to manage personal integrity? Do elderly people who are in a hospital that has a geriatric program (ACE unit or GRN model of
care) engage in the same strategies to manage personal integrity as did the participants in this study?

Do elderly people in nursing homes engage in managing personal integrity? Do elderly people in the community engage in similar processes in their everyday lives?

Further research needs to be conducted to evaluate the benefit of a semi-private room over a private room.

Research Investigating Modifiers of Managing Personal Integrity

The focus of this research was the elderly person in the hospital. Using the theory as a framework for research on modifiers of the process may lead to substantive theories about the family and staff with respect to the hospitalized individuals' managing personal integrity.

A grounded theory study with similar methodologies to this research focused on the processes engaged in by nurses to promote patients' personal integrity would enhance the substantive theory of Managing Personal Integrity.

Do nurses who work in hospitals with dedicated units (ACE units) or a GRN model of care behave differently as modifiers of the process of managing personal integrity?

Another grounded theory study investigating the processes the family of an elderly person engage in to modify the process of managing personal integrity would also enhance the current theory.
Summary

The substantive theory Managing Personal Integrity has been discussed with respect to the researcher's stance and relevant literature. The theory is consistent with the researcher's rehabilitative philosophy and activity and continuity theories of aging. The findings were compared to research which took similar approaches or had asked similar questions (Koch, 1994, 1998; Ekman et al., 1999; Huckstadt, 1990). The perspective of symbolic interaction in which the elderly person is actively engaged in creating meaning and engaging in strategies to affect the outcomes of hospitalization set this research apart from the other studies. The concept Personal Integrity was compared to other uses of the phrase found in the literature, and found to be broader than Levine's (1991) definition of personal integrity but not as broad as the philosophical definitions put forth by Carter (1996) and Ramsay (1997). Following the discussion of the concept of Personal Integrity each property of the concept was compared with relevant literature. The definition of health in the current research was found to be narrow. This is related to the fact that attributes of health arose from the data. Many of the aspects of health that are found in the literature were not observed within the context of this research. The definition of dignity was consistent with definitions found in the literature. Finally, the definition of autonomy was compared to definitions found in the literature and found to be similar but not identical.

Strategies used by elderly individuals for managing personal integrity were unique to this study. Although some strategies have been identified by other researchers, the focus of that research was the role of the nurse, not the elderly.
individual. The concept of trajectory has been applied to disease states but there is little research on phases of hospitalization. The portrayal of the hospital as context of the current theory was compared to other descriptions of the hospital and found to be consistent. Relationships between hospitalized elderly people and hospital staff or family members were found to be consistent with those noted in the literature. Of particular note is the conceptualization of the family as supportive of the elderly person.

Finally the meaning of the current research, limitations, and implications for nursing education, practice and research were presented.
REFERENCES


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APPENDIX A

NEW YORK UNIVERSITY COMMITTEE ON ACTIVITIES INVOLVING HUMAN SUBJECTS APPROVAL

MEMORANDUM

TO: Cynthia Jacelon

FROM: Marti L. Dunne, Deputy Chairperson

DATE: July 24, 1997

RE: “An Exploration of the Experience of Hospitalization of the Elderly” (School of Education/Nursing, no agency, diss., approved)

The above-referenced protocol has been approved by the University Committee on Activities Involving Human Subjects for the project year:

7/23/97 to 7/22/98

Please note the following:

• Where consent forms are used, subjects must be given a copy of the signed consent form before the subjects’ participation.
• All data, as well as the investigator’s copies of the signed consent forms, must be retained by the principal investigator for a period of at least three years following the termination of the project.
• Should you wish to conduct research for this study beyond , the following materials must be submitted for Committee review:
  - “Annual Progress Report” (available from the Office of Sponsored Programs);
  - current consent form(s);
  - if applicable, updated letters of approval from cooperating institutions; and
  - if applicable, any new or revised material, such as revised procedures, recruitment methods, statements to subjects, or consent forms.

If you have any questions regarding the Committee’s requirements, please call Nancy Ford at:

cc. Dr. Carla Mariano—Faculty Sponsor

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NOTIFICATION OF APPROVAL OF A RESEARCH PROJECT BY THE INSTITUTIONAL REVIEW COMMITTEE OF BERKSHIRE MEDICAL CENTER

June 19, 1997

Ms. Cynthia S. Jacelon, RN

Leverett, MA

Dear Ms. Jacelon:

The Institutional Review Committee, which met on June 19, 1997 has approved the Protocol "An Exploration of the Experience of Hospitalization of the Elderly." The Committee agreed that a consent form would be necessary in this study. This approval was granted following careful review of your research protocol and consent form and receipt of a statement agreeing to:

A. Obtain informed consent from each patient studied.
A. Abide by the policy and procedures of the Berkshire Medical Center with regard to use of human subjects in investigation.
B. Keep appropriate records concerning your subjects.

You will be called upon by the Committee annually for a report on your study, as well as a list of patients enrolled and your method of obtaining informed consent.

Sincerely yours,

Richard Perera, M.D., Chairman
Institutional Review Committee
APPENDIX C

EXPLANATION OF RESEARCH FOR ELDERLY PARTICIPANT

THE EXPERIENCE OF ELDERLY PEOPLE DURING HOSPITALIZATION

The purpose of this study is to gain information concerning the experience of older people in the hospital from their point of view. You can participate in this study by allowing the researcher to spend time with you while you are in the hospital to see what it is like for you. You will also be asked to allow the researcher to interview you around the time of admission, near discharge, and two weeks after that. Each interview will last for about an hour. You will be asked to identify a family member or friend who will also be interviewed about your hospitalization.

Your participation is voluntary and you may withdraw from the study at any time. The information obtained from your participation will not be identified by your name, or in any way which would identify you as the subject. This is true for the research report and any publications arising from the project.

The principle investigator of this study is Cynthia S. Jacelon, MS RN CRRN, doctoral candidate. This research is being conducted under the supervision of Carla Mariano, Ph.D., RN in partial fulfillment of the requirements of Doctor of Philosophy from the Program in Research and Theory Development in Nursing Science at New York University. The investigator will be available to answer any questions about the study at [contact information].

To indicate your willingness to participate in this research please check the appropriate line below, and sign your name, and place the sheet in the provided envelope. If you are interested, the researcher will visit you later today. If you are not interested, there will be no further contact.

Thank you for your cooperation.
Cynthia S. Jacelon

_____ I am interested in participating in this research.

_____ I am not interested in participating in this research.

Name
APPENDIX D

HOSPITALIZED ELDERLY PERSON INFORMED CONSENT

I agree to participate in the research study about the experience of elderly people during hospitalization conducted at Berkshire Medical Center by Cynthia S. Jacelon. The research is in partial fulfillment of the requirements for the degree of Ph.D. in Nursing at New York University for the researcher.

The purpose of this research is to obtain a better understanding of what the experience of hospitalization is like for elderly people. Findings from this research may be useful to help nurses and other people understand the experience.

Participation in the study involves being interviewed three times for approximately one half to one hour each time. A friend or family member whom I designate will be interviewed one time while I am in the hospital. The focus of this interview will be my friend or family member's ideas about my experience of hospitalization. One of the Registered Nurses working with me will also be interviewed about my care. I may be contacted in order to clarify unclear statements.

The interviews will be audio taped and transcribed in writing. All information gathered for the research will be strictly confidential. The researcher will not share any information with the nursing staff. At the completion of the study, the audio tapes will be destroyed. I understand that I will not be identified by name in any written notes or transcriptions. I may request to listen to the audio tapes of my interviews.

In addition to being interviewed, I understand that the researcher will be spending time with me while I am in the hospital. She will not be providing any care for...
me but will be present in my room for two hour periods throughout the day, evening, and night.

In order to obtain information about my medical condition, I give permission for the researcher to read my medical record.

There is no physical or psychological harm anticipated from participating in this study. Participation in this study will not effect my treatment. I may withdraw from the study at any time with no interruption of my treatment. I may interrupt the interviews at any time. The interview after discharge will be arranged at my convenience.

Results of this study will be published and/or presented for use by nurses and others health care providers. I may have access to the results of this study if I request them. If I have questions about the study, I may contact the researcher at the address and phone number below.

________________________________________________________________________ Date ________________
Participant Signature
________________________________________________________________________ Date ________________
Cynthia S. Jacelon
APPENDIX E

EXPLANATION TO FAMILY MEMBER

An Exploration of the Experience of Hospitalization

The purpose of this study is to gain information concerning the experience of older people in the hospital from their point of view. Your hospitalized family member or friend has agreed to participate in the study. Your family member has identified you as someone who may be willing to be interviewed about what you think your family member is going through while they are hospitalized. The interview will last for about an hour and will be conducted at your convenience, while your family member is in the hospital. The interview will be held away from your family member’s room.

Your participation is voluntary and you may withdraw from the study at any time. The information obtained from your participation will not be identified by your name, or in any way which would identify you as the subject. This is true for the research report and any publications arising from the project.

The principle investigator of this study is Cynthia S. Jacelon, MS RN CRRN, doctoral candidate. This research is being conducted under the supervision of Carla Mariano, Ph.D., RN in partial fulfillment of the requirements of Doctor of Philosophy from the Program in Research and Theory Development in Nursing Science at New York University. The investigator will be available to answer any questions about the study at [contact information hidden].

Thank you for your cooperation.

Cynthia S. Jacelon
APPENDIX F

FAMILY MEMBER INFORMED CONSENT

I agree to participate in the research study about the experience elderly people during hospitalization conducted at Berkshire Medical Center by Cynthia S. Jacelon. The research is in partial fulfillment of the requirements for the degree of Ph.D. in Nursing at New York University for the researcher.

The purpose of this research is to obtain a better understanding of what the experience of hospitalization is like for elderly people. Findings from this research may be useful to help nurses and other people understand the experience.

Participation in the study involves being interviewed once for approximately one half to one hour. The focus of the interview will be the experience of my hospitalized family member as I see it. I may be contacted after the interview in order to clarify unclear statements.

The interview will be audio taped and transcribed in writing. At the completion of the study, the audio tapes will be destroyed. I understand that I will not be identified by name in any written notes or transcriptions. All information gathered for the research will be strictly confidential. The researcher will not share any information with the nursing staff or my hospitalized family member. I may request to listen to the audio tapes of my interview.

There is no physical or psychological harm anticipated from participating in this study. Participation in this study will not effect the treatment of my family member. I may withdraw from the study at any time with no interruption of my family member's treatment. I may interrupt the interview at any time.

Results of this study will be published and/or presented for use by nurses and others health care providers. I may have access to the results of this study if I request them. If I have questions about the study, I may contact the researcher at the address and phone number below.

__________________________________________ Date _________________
Signature

__________________________________________ Date _________________
Cynthia S. Jacelon

PATIENT NAME _____________________________________________

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APPENDIX G

EXPLANATION TO NURSES

Nursing Research on your Unit
Beginning August 1997

The purpose of this study is to gain information concerning the experience of older people in the hospital from their point of view. Elderly clients will be asked to participate in this study by allowing the researcher to spend time with them while they are in the hospital. The researcher may be traveling to any department of the hospital with the client. In addition to spending several hours each day with the hospitalized client, the researcher will interview the client around the time of admission, near discharge, and two weeks after that. Each interview will last for about an hour. A family member or friend who will also be interviewed.

The researcher may be on your unit at any hour during the day or night. Because the researcher is trying to understand what it is like for elderly people to be in the hospital, she will not participate in any nursing care except in cases of emergency. She will be asking one registered nurse to participate in an interview regarding the client who is participating in the study. The interview is expected to last for about an hour and will be at the RN’s convenience while the client is in the hospital. For each client it will be a different nurse. The researcher will also be gathering information from the client record and other sources of information about the client (Kardex, med sheet, nursing report, etc.)

Your participation is voluntary and you may choose not to be interviewed. The information obtained from your participation will not be identified by your name, or in any way which would identify you as the subject. This is true for the research report and any publications arising from the project.

The principle investigator of this study is Cynthia S. Jacelon, MS RN CRRN, doctoral candidate. This research is being conducted under the supervision of Carla Mariano, Ph.D., RN in partial fulfillment of the requirements of Doctor of Philosophy from the Program in Research and Theory Development in Nursing Science at New York University. The investigator will be available to answer any questions about the study at [Redacted].

Thank you for your cooperation.
Cynthia S. Jacelon
APPENDIX H

NURSE INFORMED CONSENT

I agree to participate in the research study about the experience elderly people during hospitalization conducted at Berkshire Medical Center by Cynthia S. Jacelon. The research is in partial fulfillment of the requirements for the degree of Ph.D. in Nursing at New York University for the researcher.

The purpose of this research is to obtain a better understanding of what the experience of hospitalization is like for elderly people. Findings from this research may be useful to help nurses and others understand the experience.

Participation in the study involves being interviewed one time for approximately one half to one hour about the experience of one of the elderly people to which I am assigned. The interview will be scheduled at my convenience. I may be contacted after the interview to clarify unclear statements or answer specific questions about the interview.

The interview will be audio taped and transcribed in writing. At the completion of the study, the audio tapes will be destroyed. I understand that I will not be identified by name in any written notes or transcriptions. The elderly person will also not be identified. All information gathered for the research will be strictly confidential. The researcher will not share any information with the elderly person. I may request to listen to the audio tapes of my interviews.

There is no physical or psychological harm anticipated from participating in this study. Participation in this study will not effect my job. I may withdraw from the study without consequences. I may interrupt the interviews at any time.

Results of this study will be published and/or presented for use by nurses and others health care providers. I may have access to the results of this study if I request them. If I have questions about the study, I may contact the researcher at the address and phone number below.

_________________________________________ Date __________________
Registered Nurse Signature

_________________________________________ Date __________________
Cynthia S. Jacelon

Participant Name _________________________________

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APPENDIX I

INTERVIEW SCHEDULES FOR ELDERLY PARTICIPANT

Admission Interview

I am interested in knowing more about your experience with being in the hospital.
To begin with, what is it like coming into the hospital?
What has happened that has led you to be admitted to the hospital?
What have you been told about going to the hospital?
What do you think it will be like to be in the hospital?
Tell me what you think a typical day in the hospital will be like?
Have you ever been in the hospital before? What was that like?
When you were in the hospital before, was it this hospital? What unit were you on? What was that experience like?
What effect do you think being in the hospital will have on you once you return home?
What other people are affected by your hospitalization?
Is there anything you would like to add that would help me to better understand what being admitted to the hospital means to you?

Note: This interview schedule is intended to be a guide and not rigidly adhered to.
Elderly Participant Discharge Interview Schedule

What has it been like for you while you have been in the hospital?

What is your primary concern at this time?

What effect do you think being in the hospital will have on you once you return home?

Tell me about the relationship between you and (RN).

What effect did (RN) and the other nurses have on your stay in the hospital?

Tell me about the relationship between you and (Family member)

What effect did (family member) have on your stay in the hospital?

How has your doctor effected your hospitalization?

Is there anything you would like to add that would help me to better understand what being in the hospital has meant?

*Note: This interview schedule is intended to be a guide and not rigidly adhered to.*
Elderly Participant Follow-up Interview Schedule

Now that you’ve been at home for two weeks, I’d like to ask you about what it was like being in the hospital.

How has being in the hospital effected you since you’ve been home?

What do you remember most about being in the hospital?

Tell me about the relationship between you and your family member since you’ve been home?

Is the relationship different than it was before you went into the hospital?

Have you spoken to any health care personal since you have been home? (Doctor, nurse, etc.)

What is your main concern at this time?

Is there anything you would like to add that would help me to better understand what being in the hospital has meant since you’ve returned home?

*Note: This interview schedule is intended to be a guide and not rigidly adhered to. The follow up interview will have an emphasis on participant checking.*
APPENDIX J

INTERVIEW SCHEDULE FOR FAMILY MEMBER

I am interested in knowing more about your (family member’s) experience being in the hospital. To begin with, what do you think it is like for (family member) to be in the hospital?

What happened that led (family member) to be admitted to the hospital?

Did you have a role in getting (family member) to go to the doctor or get admitted to the hospital?

What did (family member) tell you about going to the hospital?

What is (family member)’s primary concern at the present time?

What is your primary concern about (family member) at the present time?

What do you think it is like for (Family member) to be in the hospital?

What effect do you think being in the hospital will have on (family member) once he/she returns home?

What effect does your being here with (family member) have on his/her experience?

Tell me about the relationship between you and (Family member)

Is there anything you would like to add that would help me to better understand what being in the hospital means to (family member)?

Note: This interview schedule is intended to be a guide and not rigidly adhered to.
APPENDIX K

INTERVIEW SCHEDULE FOR NURSE

I am interested in knowing more about (Participant) experience in the hospital.

To begin with, what do you think it is like for (Participant) to be in the hospital?

What brought (participant) to the hospital?

What is your role in relation to (participant)?

What is (participant)'s primary concern at the present time?

What is your primary concern about (participant) at the present time?

What do you think it is like for (participant) to be in the hospital?

What effect do you think being in the hospital will have on (participant) once he/she returns home?

Tell me about the relationship between you and (participant)

What effect does your being (participant)'s nurse have on their experience of hospitalization?

Is there anything you would like to add that would help me to better understand what being in the hospital means to (participant)?

Note: This interview schedule is intended to be a guide and not rigidly adhered to.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tr>
<td>9/9/97</td>
<td>Support group</td>
<td>2/8/98</td>
<td>PO Mrs. D.</td>
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<tr>
<td>9/11/97</td>
<td>Family Interview Amy</td>
<td>2/9/98</td>
<td>RN Interview Carl</td>
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<td>2/9/98</td>
<td>PO Mrs. D.</td>
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<tr>
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<td>2/9/98</td>
<td>Admit Interview Evy</td>
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<tr>
<td>9/12/97</td>
<td>PO Amy</td>
<td>2/9/98</td>
<td>PO Evy</td>
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<td>PO Amy</td>
<td>2/10/98</td>
<td>RN Interview Evy</td>
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<td>Admissions office visit BMC</td>
<td>2/10/98</td>
<td>PO Evy</td>
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<tr>
<td>9/14/97</td>
<td>PO Amy</td>
<td>2/10/98</td>
<td>PO Mrs. D.</td>
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<td>2/11/98</td>
<td>PO Mrs. D.</td>
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<tr>
<td>9/29/97</td>
<td>Follow up Interview, Amy's Home</td>
<td>2/11/98</td>
<td>PO Evy</td>
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<td>9/30/97</td>
<td>Support group</td>
<td>2/12/98</td>
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</tr>
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<td>2/13/98</td>
<td>PO Mrs. D.</td>
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<td>2/13/98</td>
<td>PO Evy</td>
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<tr>
<td>10/7/97</td>
<td>PO Bob</td>
<td>2/14/98</td>
<td>D/C Interview Evy</td>
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<tr>
<td>10/7/97</td>
<td>Admit Interview Bob</td>
<td>2/14/98</td>
<td>PO Mrs. D.</td>
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<td>PO Mrs. D.</td>
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<td>2/17/98</td>
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<td>10/28/97</td>
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<td>2/22/98</td>
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<td>PO Mrs. D.</td>
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<td>12/23/97</td>
<td>Support group</td>
<td>2/26/98</td>
<td>PO Mrs. D.</td>
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<td>2/4/98</td>
<td>Gift of Candy to Admissions Office</td>
<td>2/28/98</td>
<td>PO Mrs. D.</td>
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<td>3/1/98</td>
<td>Interview RN2 Mrs. D.</td>
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<tr>
<td>2/6/98</td>
<td>Admit Interview Carl</td>
<td>3/1/98</td>
<td>D/C Interview Mrs. D.</td>
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<tr>
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<td>Admit Interview Mrs. D.</td>
<td>3/2/98</td>
<td>Follow-up Interview Evy</td>
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<tr>
<td>2/6/98</td>
<td>PO Carl</td>
<td>3/2/98</td>
<td>Telephone call Mrs. D.</td>
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<tr>
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<td>PO Mrs. D.</td>
<td>4/1/98</td>
<td>Telephone call Mrs. D.</td>
</tr>
<tr>
<td>2/7/98</td>
<td>Family Interview Carl</td>
<td>4/5/98</td>
<td>Support group</td>
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<tr>
<td>2/7/98</td>
<td>PO Carl</td>
<td>4/6/98</td>
<td>Follow-up Interview Mrs. D.</td>
</tr>
<tr>
<td>2/7/98</td>
<td>PO Mrs. D.</td>
<td>7/23/98</td>
<td>Support group</td>
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<tr>
<td>2/8/98</td>
<td>D/C Interview Carl</td>
<td>8/19/98</td>
<td>Support group</td>
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9/8/98 Support group
10/20/98 Support group
11/2/98 Support group
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12/15/98 Support group
1/5/99 Support group
1/28/99 Support group
4/15/99 Support group
5/17/99 Support group
6/15/98 Support group
7/11/99 Support group
7/29/99 Support group
8/12/99 Support group
9/13/99 Support group
10/12/99 Support group
10/25/99 Support group
11/16/99 Called Mrs. D. for participant check: message left
11/16/99 Sent letter to Evy
11/16/99 Called Evy for participant check: phone disconnected
11/16/99 Sent letter to Mrs. D
11/17/99 Return phone call from Don. Mrs. D.'s son
11/20/99 Received return post card from Mrs. D.
11/28/99 Telephoned Mrs. D. for an appointment
12/7/99 Participant checking Mrs. D. visit Mrs. D.
APPENDIX M

ADMISSION INTERVIEW SUMMARY

** Node 1 2 4 (What will it be like)
** Node 1 2 7 (B been told)

WHAT DO YOU THINK WILL HAPPEN WHILE YOU'RE HERE?
WHAT HAVE YOU BEEN TOLD ABOUT GOING TO THE HOSPITAL?

AMY (node 1 2 4) I don’t know, maybe change a pill, maybe, I don’t know. Maybe it was my fault last night when I took my pills, ’cause I took them late.

CARL I don’t know, they’ve run everything today. They checked my blood vessels and everything, down in my hips and my legs. And uh, I don’t know, they call everything OK. Course, I’ve got a bit of a cold I’m fightin’ with

BOB (node 1 2 6, 1 2 7) I don’t know, well, first thing tomorrow morning I’m going to have a nuclear stress test done. I expect to be released in the afternoon, and then come back again for other tests.

DEB (node 1 2 7) Well, Don (son) brought me, and they told me... what they were going to do because I had pneumonia... they were going to treat me for that and they were going to take all these different samples of blood. They told me what everything was for.

    Dr. Daniels said it’ll be just a day or two. Well, I said I wouldn’t go (to the hospital). When (Dr.) Daniels went down to the waiting room to tell Don (son). When I got out there I said to Don, “Well, if it’s not too bad I’ll only have to stay a day.” Dr. Daniels said “Wait a minute, what did I tell you?” I said “a day or two”. Anyway, That’s why I decided (to come)... Well, I was going to come here anyhow, whether I decide to go or not.
** Node 1 2 5 (What brought you to the hospital)

** WHAT BROUGHT YOU TO THE HOSPITAL? **

** AMY (node 1 2 5) **

Well this time I came because I had such a horrible pain. I wasn't sure, but they had given me instructions in Boston on how to do this...you wait 5 minutes if you have a severe pain. I thought it was indigestion so I took antacids. I thought 'oh well, that ought to straighten me out' and I went back to bed. The pain was ferocious.

So I said 'OK, I'll take a nitroglycerin'. So I took one and timed myself. In five minutes it had gotten no better, it had gotten worse. So I took another nitro and called my sister. We timed it, the pain was like a ball in the middle of my chest, hard. And I says 'Call 911, it's the only thing to do'. 'Cause they told me don't take a ride in a private car. So Ok, we call 911, the ambulance comes and takes me to town.

** BOB (node 1 2 4, 1 2 5) **

Well, we've had, I've had this problem for a number of years. We first diagnosed it in '92. I had come in for what they called a Cabbage because I had terrible anginal pain. Then a couple of years later I had a heart attack. Then I was OK, going to the gym, doing exercise, watching my diet, excetera, excetera. And then I got hit with this (pain) two weeks ago.

Well, I had chest pains, I've been having them on and off for a couple of weeks now. I did go to my physician last week and he thought perhaps it was esophagitis from which I suffer.

For a while it was getting better, then this morning when I woke up it was painful. It wouldn't go away after I took nitro a couple of times. So my wife drove me to the hospital, and here I am.

** BOB **

I know this hospital quite well. I've been here a number of times, not only for my heart but for other things.... The staff is very proficient... I mean, one doesn't come to the hospital for a vacation, but if I had to I would come to this hospital...

I have not found this a bad place to be when I was ill.

** CARL **

My daughter saw blood in the toilet. She's a great one for the emergency room. I don't know, I can't remember why they admitted me. My daughter here she could explain. I thought I was feeling OK, they checked out pulse and everything else ya know. As I say, my daughter knows more about it than I do. She got to talk to him [the MD] more than I did.

** MRS. D. **

Well. I'll tell ya I must have been in a bad way...So my Don came and got me over [to the doctor's office] within about 20 minutes. He [the doctor] examined me – he could hear the pneumonia. The doctor said 'I'm gonna take
you to the hospital'. Well, I gave some arguments but he didn’t pay much attention to me. The doctor went out in the hall and talked to my Don Then the doctor came back to me and said “Have you decided?” I said “Decided what?” he said ‘That you will go to the hospital’. I said “I knew that before you went out”.

WHAT WAS IT LIKE COMING TO THE HOSPITAL?

** MRS. D (DEB) ** I got word from the doctor’s office at like five after, and I was in the hospital, I think, by quarter of ten. I’ve been here all day. I was in the emergency room all that time. I was kind of disgusted. He [the doctor] handed me a slip of paper. My son had the paper and it said go straight to emergency and go right up [to the floor]. So I didn’t have to sit and watch all that, but somebody didn’t read the symbol on the paper right

** MRS. D (DEB) ** Well, to tell you the truth, I didn’t feel too good about coming to the hospital, but I couldn’t think of anything. I just want to get here and have him (doctor) tell me to go back home. I didn’t want to leave them at home, and I didn’t think I needed to come to the hospital. Dr. Daniels thought different. So anyhow, I know that this is the best place, ya know.

** CARL (node 1 2 2) ** I don’t like it. Well, I mean it’s a wonderful place, but I would rather be home where my roots are so to speak. Unless they found I was going to croak or something with a heart attack, which they didn’t.

** Node 1 2 1 (Effect on others)**

WHAT OTHER PEOPLE ARE EFFECTED BY YOU BEING IN THE HOSPITAL?

** AMY ** Nobody

** SISTER ** Me...

** AMY ** Well, her right now, but after Sunday...

** SISTER ** and the family

** AMY ** She’ll be going. Then I have a sister that lives in Boston. Oh god, when she finds out I’m in the hospital, ooh, she’ll have a fit.. She was the one that came, when I went to the hospital in ’95 every day, whether I was in Boston of Worcester...every single day.

She’ll go wild when she here’s I’m back in the hospital. She won’t like that one bit.
BOB My wife, primarily. Of course she told my children, you tell them, and they’re concerned. I told her to keep it quiet this time. I don’t like to be disturbed when I’m in the hospital, by phone calls and all that. I tell them generally not to call me unless they’re too upset and want to hear my voice.

CARL Just me and my daughter.

MRS. D My grandson and my son

WHAT DOCTORS HAVE BEEN TO SEE YOU?

CARL Dr. crane was here to see me today. He’s my primary… Let’s see, who was the one with the whiskers and everything? And let’s see, a light complexioned fella and I didn’t get his name neither.

+++

** Node 1 2 6 (Have you ever been in the hospital before?)

HAVE YOU EVER BEEN IN THE HOSPITAL BEFORE? WHAT WAS IT LIKE?

BOB Yes, I think I was on this unit last time.

BOB Well, I’ve always found that as far as the hospital was concerned and the nurses, very, as I said before, very professional, very pleasant, it’s just a matter of getting over what’s troubling you.

I’m sick and tired of coming into the ER. I figured out today that this is the seventh time since 1992. I’m beginning to believe I ought to have a room all to myself!

CARL I was here a couple of weeks ago for surgery on my neck. (carotid endarterectomy) It is still kinda swollen yet, but eventually, I think it’ll straighten down. The doctors don’t believe in sewin’ your neck up unless they sew your head back down! (HAHA )
MRS. D In the last three years, I’ve been here four times... I fall. They haven’t been able to figure out why I had a fall. I had a stroke several years ago. I fell in my apartment, I was writing letters at the dining room table, I got up to answer the phone and my leg was asleep. I went down, I sat on my ankle and broke it.

Then the time before that I fell walking the dog. I slipped off a curb and down I went – boom! I had four stitches in my nose. I was really a mess.

Last Thanksgiving I woke up in the middle of the night and felt wet. I went into the bathroom to look in the mirror I was the bloodiest mess, my nose was bleeding. I called my son, and I called the ambulance. The ambulance guy told my son they almost lost me on the way here.

I’ve had pneumonia once before, many years ago.

+++

** Node 1 2 8 (B main concern)

WHAT IS YOUR MAIN CONCERN AT THIS TIME?

BOB Well, I’m most concerned about the fact this might go on and on and on. I begin to think in terms of it’s better to be dead.

Because, I mean, this is hardly a life. You begin to get a pain, you begin to worry about it. So that’s what I worry about most. It’s how long I’ll live. Can’t they do something to give me a couple of years without any problems?

+++

** Node 1 2 9 (B role nurses)

WHAT ROLE DO YOU THINK THE NURSES WILL PLAY IN YOUR HOSPITALIZATION?

BOB They will do what they have to do, they will give me my medications, get my vital signs every couple of hours, Keep me more or less clean, I guess. I can’t expect anything more from them. They’re very busy. It’s a very busy hospital today. They’ve (the nurses) been running their asses off. I can hear them running from one room to the next. I sort of sympathize very much with them. I leave them alone as much as possible. I don’t touch that button (the call bell).
** Node 1 2 2 (Admit effect hospital)

** WHAT EFFECT DO YOU THINK BEING IN THE HOSPITAL WILL HAVE ON YOU ONCE YOU RETURN HOME?

** AMY ** I'll be lazy when I get home. Who wants to make breakfast, lunch, and supper when it's been served to you?

** BOB ** Well I don't know if there's any aftereffect, after you leave the hospital. Be glad to get home, glad to go about your business. You wish you hadn't had to come back.

** MRS. D ** Other times I've been in the hospital it takes a couple of days to get back on your feet. I don't look for anything worse than that.

They might have the nurses (visiting nurses) stop in twice a week. They did that for my leg. If they want to do that, that's alright too.

** 1 2 3 (Anything else)**

** AMY ** I'd like to go home quickly, instead of staying in the hospital. If you don't stay and something happens, it's your fault.

** SISTER ** Well it's really just for observation.

** AMY ** That's all they can do, they can't open up your chest again, at least I hope not.

** BOB ** I must say I've been in despair all day about being in the hospital again. It's a (pause) I don't know what to call it. It's a plague. This time I'm pretty damn sad about it. Most of the time I go in with the idea 'well they'll take care of me, I'll feel better, I'll go home, I'll be better, it won't be a problem anymore for a while'.

I thought I was doing pretty well and to find now there are more problems is despairing. When you get to be 82, 83 years old, you know, you want a little peace. And there seems to be no peace.

I know my wife worries a little worried when she goes home from the hospital. I tried to reassure her (chuckle) that I'm not gonna croak, not yet. I'm worried, but I don't feel that what I have now is fatal. My doctor said that everything I have is repairable. But that doesn't mean you can't croak in an hour. So you think about it often. I just have some unfinished business that I want to finish before I go. That bothers me too.

** MRS. D ** I'm not happy. I'd rather go home and see my dog. I just have faith in my doctor. And this is gonna help me. I want to go home of course, but I think he's gonna fix what I got wrong with me, ...I gonna go home fairly soon.
APPENDIX N

SUMMARY OF THEORY FOR ELDERLY PARTICIPANT CHECKING
Surviving Hospitalization: Elderly People Managing Personal Integrity
Cynthia Jacelon
NYU Doctoral Student

Elderly individuals survive hospitalization by managing their personal integrity. Personal Integrity is a dynamic quality of individuals and has three properties: health, dignity, and autonomy. Hospitalization is a process with three phases. The phases are: 1) the Stabilizing Phase, 2) the Repairing Phase, and 3) the Reintegrating Phase. In each phase, the elderly individual uses strategies to enhance personal integrity. The strategies used were introspective (acting on self), interactive (acting on others), and active (taking action).

Prior to the onset of the health problem which led to admission, the individual was at home. While at home, the elderly person became ill. When the illness became unbearable, the elderly person took action. Personal integrity was placed in jeopardy both by the initial insult to health and by being in the hospital. Throughout hospitalization, the elderly person worked to manage personal integrity. In the face of many insults such as poor health, thwarted dignity, and altered autonomy, the individual managed the risks to personal integrity by engaging in strategies of risk reduction. Managing personal integrity was an
active process in which the elderly person acted to enhance the chances of his or her survival.

The elderly person's success in managing the threat to personal integrity was mediated by the people with whom they interacted. These people included hospital staff, family members, friends, and hospital roommates. Each of the individuals in these groups understood the experience of the hospitalized elderly person in a unique way. Their actions, based upon their understandings, either enhanced or diminished the elderly person’s ability to maintain personal integrity.

The elderly person wanted to return home in a condition like he or she was before they became ill. They engaged in strategies to manage personal integrity to that end. The consequences of unsuccessfully managing personal integrity were failure to return to pre-hospital levels of function or death. The elderly individuals were afraid of “not being like I used to be,” dying, or having to live in a nursing home. Being in the hospital meant the possibility that they would be permanently changed.

Strategies for Managing Personal Integrity

Personal integrity is endangered by being in the hospital. In the process of maintaining personal integrity, the elderly individual acts as a manager and uses strategies to reduce the jeopardy to personal integrity. Strategies are actions deliberately initiated by the elderly individual in the hospital to attempt to enhance personal integrity by enhancing one or more of the properties and attributes of personal integrity.
Throughout the hospitalization, the elderly person works to manage the properties of personal integrity (dignity, control, and health). In the face of many insults such as poor health, thwarted dignity, and altered autonomy individuals manage the risks by using strategies to effect the result of returning home to their pre-hospital usual state.

**The Theory: The Process of Managing Personal Integrity In The Hospital**

The process of managing personal integrity begins at home when the elderly person is in their usual state. While in his or her usual state, the elderly individual became aware of a developing health problem. The model has four stages of pre-hospital activity: 1) being in the usual state, 2) identifying the problem, 3) confirming the problem, and 4) transition, the emergency department. As the context for managing personal integrity changes from home to hospital, the nature of the management changes. At home, the process proceeds in stages where one stage builds on a previous stage. Once the health problem has been confirmed and the person is admitted to the hospital, the phases of managing personal integrity in the hospital begin.

There are three phases of managing personal integrity in the hospital:
1) Stabilizing, 2) Repairing, 3) Reintegrating. During each phase, one of the attributes of personal integrity, health, dignity, or autonomy, is the primary focus of the phase for the elderly individual. During the stabilizing phase, health is of primary importance; during the repairing phase, dignity is the primary focus of managing personal integrity, in the reintegrating phase of hospitalization, autonomy becomes the focus, as the elderly person prepares for discharge. If at
any time during the hospitalization there is a change in the status of one of the attributes of health, dignity, or autonomy, the individual may return to an earlier phase in the process. The phases of managing personal integrity in the hospital are a dynamic and evolutionary process rather than the linear pre- and post-hospital stages.

After discharge from the hospital, the process continues in three more stages. There is a period of 1) getting home, 2) returning to normal, and the 3) evolved usual state. At this point the elderly person has survived the episode of endangered personal integrity.
February 4, 2000

Cynthia S. Jacelon, MS, RN, CRRN-A
PhD Candidate
Leverett, MA

Dear Ms. Jacelon,

Enclosed with this letter comprising my comments as auditor of your dissertation is a copy of my curriculum vitae. You may use this letter and appropriate portions of my CV in the appendices of your dissertation.

I have read and reviewed 319 pages of materials related to your dissertation, including: content outline [6 pages], chapters 1, 3-9 [283 pages of text including 17 tables and figures], references [4 pages], memo on the color of personal integrity (11/5/98) [1 page], analytic memo “the core story: endangered personal integrity” (2/7/99) [3 pages], NUD*IST formatted list of codes related to personal integrity [10 pages], list of files coded “worrying” [1 page], an admission interview with coding [13 pages], printout of data at the “managing attitude” code [4 pages].

Overall, I can attest to the dependability and confirmability of this study. I have been able to follow the steps of the inquiry and the findings agree with the data.
Comments on dependability
in chapter 1 you clearly identify the assumptions underlying the inquiry. The knowledge gap to be filled by this study is clearly outlined. The methodological process is detailed explicitly in chapter 3, including a narrative on specific activities beginning with proposal defense in June 1997 through data analysis. A figure depicting this trajectory and processes would provide an at-a-glance view of the length and complexity of the process as well as illustrate visually the concurrent collection and analysis of data. The procedure described for labeling new codes and checking previous data is an excellent illustration of establishing data saturation. You describe a complex system of organization of your logs, separate file folders with computerized storage, labeling of files to impart participant identification, type of file, and chronology by actual date of activity. The decision and rationale for use of first name for 4 elders and Mrs. D. for the 5th participant would clarify and prevent misinterpretation in the use or non-use of a formal title when referring to elders. It is not until reaching chapter 7 (p. 3) that a description is given on how elders introduced themselves, and one can assume this is an explanation about your decision to use Mrs. D. for the elder who introduced herself in the formal manner. A key of these labeling acronyms, letters, numbers, summarized in a table (within the text or in the

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the appendix) would be helpful as a quick and easy reference for readers, particularly when reading labeled text in later chapters. Also, including a note about use of NUD*IST text units to labeling description would further clarify the nature of the labels seen in the later chapters in which numerical text units are given.

Comments on confirmability
Chapter 3 addresses key decision points in the development of the theory. Coded data and an analytic memo of 2/7/99 illustrate earlier thinking about the core process and its properties; further extension and clarification of the properties are described in Chapter 3. This description clearly illustrates how codes, properties, attributes, definitions, and dimensions evolved into the final induced theory. Detailed codes and sub-codes lend support for the properties of health, dignity and autonomy and their attributes. Examples noted in the text, including interview data, participant observations, and reflective notes illustrate further support for the theory, its properties, and mediators.

Chapter 4 succinctly captures the essence of each participant with excellent use of verbatim narration from the interviews, organized by the chronologically of the 3 interviews conducted with each elder. A theme salient to each participant sets the tone and attitude for each elder. This is clearly illustrated with verbatim examples in the chapter and as elicited from the coded admission interview with Bob. The depth and breath of the data are evident in these descriptions. A chronology of depth is seen from examples cited in initial impressions of participants through follow-up interviews post discharge from the hospital.

Chapters 5 through 9 are complete in illustrating the development of the theory, its properties, and mediators, clearly derived from the data. The rich, contextual illustrations capture fully the participants (elders, family members, staff), the setting, and the process.

Thank you for the opportunity to participate in the audit of your rigorous and very well presented study. This study certainly fills a gap in the current literature. I wish you a successful defense of your dissertation and I look forward to seeing the products of this research in the literature.

Sincerely,

Associate Professor of Nursing
APPENDIX P

AUDITOR'S CREDENTIALS

Curriculum Vitae

VERONICA FRANCES REMPUHESKI

PERSONAL DATA

Position & Employer:

Associate Professor (tenured)
University of Rochester School of Nursing
601 Elmwood Avenue, Box SGN
Rochester, New York 14642

Professional Nurse licensure:

1994 - present
New York, #462221
1985 - 1995
Massachusetts
1981 - 1986
Arizona
1976 - 1981
South Carolina
1975 - 1977
Colorado
1968 - 1978
California
1967 - present
New Jersey, #42737

EDUCATION

Date Degree Institution Field(s) of Study
1991-2 Fellow March of Dimes Summer Nursing Research Institute Family Research
1985 Ph.D. University of Arizona, Tucson, AZ Clinical Nursing Research

1984 Certificate Jagiellonian University, Krakow, Poland

1979 Certificate Georgia State University, Atlanta, GA

1976 M.S. University of Colorado, Denver/Boulder, CO

1975 B.S. Seton Hall University, South Orange, NJ

1975 Certificate Seton Hall University, South Orange, NJ

1966 Diploma Clara Maass Medical Center

School of Nursing, Belleville, NJ

Doctoral Dissertation:
"Exploration and Description of Caring for Self and Others with Second Generation Polish American Elders"

Dissertation Director:
Jessie V. Pergrin, PhD, RN, FAAN

Masters Field Study:
"Sexuality in the Aged Female"
Curriculum Vitae, V. F. Rempushekski/Page 2

PROFESSIONAL APPOINTMENTS

<table>
<thead>
<tr>
<th>Dates</th>
<th>Position, Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/94 -</td>
<td>Associate Professor (tenured, 6/1/97);</td>
</tr>
<tr>
<td>6/94 - 1/99</td>
<td>Associate Dean for Research, and Director, Center for Nursing Science &amp; Scholarly Practice, University of Rochester, School of Nursing, Rochester, NY</td>
</tr>
<tr>
<td>10/83 - 5/91</td>
<td>Director, Gerontological Nursing, Beth Israel Hospital, Boston, MA</td>
</tr>
<tr>
<td>10/85 - 5/91</td>
<td>Academic Appointments, Boston, MA (1987-93); Adjunct Associate Professor, MGH Institute of Health Professions (4/90-8/92)</td>
</tr>
<tr>
<td>10/35 - 1/94</td>
<td>Nurse Researcher &amp; Associate in Research, The Center for the Advancement of Nursing Practice (7/87-1/94)</td>
</tr>
</tbody>
</table>

8/81 - 9/85  
Research Associate, University of Arizona College of Nursing, Tucson
Temporary & Part Time Clinical & Teaching Roles, Tucson, AZ (during period of full-time doctoral study, 1981-85) at:
- St. Mary's Hospital & Health Center (1-5/82);
- NurseFinders of Tucson (8/81-3/85);
- The University of Arizona (7-8/81).

8/79 - 3/81  
Assistant Professor

8/76 - 5/79  
Instructor, Baccalaureate Degree Program, Clemson University College of Nursing, Clemson, SC (academic year)
Temporary Summer Clinical & Teaching Roles (during period of academic appointment, 1977-80) at:
- Anderson Memorial Hospital, Anderson, SC (6-8/80);
- Continuing Education in Nursing Program, Clemson University College of Nursing, SC (5-6/79);
- Health Care Management Institute, Rancho Palos Verdes, CA (6-7/78);
- Camp HOPE, Clemson SC (7-8/77).

5/73 - 8.75  
Instructor & Staff Nurse, Columbus Hospital, Newark, NJ

5/72 - 8.74  
Assistant Instructor, Clara Maass Memorial Hospital School of Nursing, Belleville, NJ.

6/71 - 11/71  
Staff Nurse, S.S. HOPE (Voyage IX, Jamaica, West Indies), Project HOPE, the People-to-People Foundation, Inc., Milwood, VA.

10/70 - 5/71  
Staff Nurse, ICU/CCU, Veterans Administration Hospital, East Orange, NJ.

9/69 - 11/69  
IV Therapy Nurse (temporary, P.T.), East LA Doctors Hospital, Los Angeles.

6/68 - 8.70  
Assistant Head Nurse & Staff Nurse, Retail Unit, Los Angeles County-University of Southern California Medical Center, Los Angeles, CA.

6/66 - 5/68  
Staff Nurse, ICU/CCU, Clara Maass Memorial Hospital, Belleville, NJ.

7.66  
Camp Nurse, Camp Madeline Multford, Dingman's Ferry, PA.
Curriculum Vitae, V. F. Rempusheski/Page 450

PUBLICATIONS (Reviewed + data based)

Articles:


Rempusheski, V. F. & Chamberlain, S. L. (1989). Nursing research image at Beth Israel Hospital, Boston. *Journal of Nursing Administration, 19(10), 6-7.*


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