"IT'S A DO-IT-YOURSELF HOSPITAL": THE EXPERIENCES OF OLDER PERSONS WHO HAVE BEEN HOSPITALIZED WITHOUT FAMILY INVOLVEMENT

by

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ABSTRACT

The purpose of this qualitative study was to gain an understanding of the experiences of older persons who have been hospitalized without family involvement. A total of five men and women participated in in-depth interviews about their experiences. The principles of hermeneutic phenomenology and narrative analysis were used to tease out the major themes of the participants' experiences. A structural social work lens shed light on how the participants' hospital experiences were shaped by broader structural issues. Both formal and informal support were important factors for these older persons who did not have family support. The roles of hospital social workers, and volunteers were explored. Older persons who have had personal losses including physical decline, and loss of support systems, may feel powerless in a hospital setting. Empowerment-oriented social work practice can be used with seniors to help them link personal problems to socio-political issues. Implications for social work practice and policy are discussed. The limitations of this study and avenues for future research are presented.
# TABLE OF CONTENTS

ABSTRACT .................................................................................................................. i
TABLE OF CONTENTS ............................................................................................... iii
PREFACE .................................................................................................................... v
ACKNOWLEDGEMENTS .............................................................................................. vii

CHAPTER ONE – INTRODUCTION ................................................................. 1
Situating The Issue ................................................................................................ 1
  Family Support ................................................................................................. 3
  Informal Support ............................................................................................. 8
  Formal Support .............................................................................................. 11
What We Know About Older Persons Who Live Alone ..................................... 11
The Experience of Hospitalization ..................................................................... 15
The Role of Hospital Social Workers ............................................................... 17
Structural Social Work Theory ........................................................................ 18
Summary ........................................................................................................... 20

CHAPTER TWO – METHODOLOGY ......................................................... 22
A Qualitative Study ............................................................................................ 22
A Structural Social Work Lens .......................................................................... 23
Validity and Generalizability ........................................................................... 24
Participant Recruitment .................................................................................... 25
Sample ............................................................................................................... 26
Data Collection ................................................................................................. 28
Data Analysis ................................................................................................... 29

CHAPTER 3 – FINDINGS ................................................................. 31
John’s Story - “I Am A Very Tenacious Man” .................................................... 31
  Control and Independence ........................................................................... 33
  Building Trusting Relationships ................................................................. 37
Carrie’ Story - “I have a hell of a time, still, asking for help” .......................... 40
  The Experience of Hospitalization ................................................................. 42
  I Have A Hard Time Asking For Help ............................................................ 43
  Patient As Expert ......................................................................................... 44
  Volunteers - Redefining Family ................................................................. 47
Concerns About Healthcare In British Columbia ........................................... 51
Jane’s Story - “It isn’t the surgery I mind, it’s the hospital” .............................. 53
  The Experience of Hospitalization ................................................................. 55
  Time Equals Care ......................................................................................... 56
Gaps In Jane’s Social Support Network .......................................................... 57
Concerns About The Healthcare System ....................................................... 58
<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann’s Story - “I think you have to have a positive attitude”</td>
</tr>
<tr>
<td>The Experience of Hospitalization</td>
</tr>
<tr>
<td>I Didn’t Want Anyone to Worry About Me</td>
</tr>
<tr>
<td>Concerns About the Healthcare System</td>
</tr>
<tr>
<td>A Positive Attitude</td>
</tr>
<tr>
<td>Diane’s Story - “Be as cooperative as you can be, and as friendly as you can be”</td>
</tr>
<tr>
<td>The Experience of Hospitalization</td>
</tr>
<tr>
<td>The Importance of A Social Network</td>
</tr>
<tr>
<td>Working With The Hospital System</td>
</tr>
<tr>
<td>It Was A Matter of Luck</td>
</tr>
</tbody>
</table>

CHAPTER 4 - THE HOSPITAL EXPERIENCE - A SUMMARY | 78 |
Systemic Limitations Play Out At The Personal Level | 78 |
Making The Best Of It | 81 |
It’s A “Do-It-Yourself” Hospital | 82 |

CHAPTER 5 – DISCUSSION | 86 |
Applying A Structural Lens | 86 |
When There Is No Family | 88 |
The Role Of The Hospital Social Worker | 89 |
Volunteers | 94 |
Formal Support | 95 |
Limitations of This Study and Future Research | 96 |
Conclusion | 100 |

REFERENCES | 101 |

APPENDICES | 110 |
Appendix A | 110 |
Appendix B | 112 |
Appendix C | 114 |
PREFACE

During the last six years I have been working with older persons in various hospital settings. As a hospital social worker, my role is to assist seniors with their discharge plans and to link them to resources. Much of the work I do is with both older persons and their families. The Ministry of Health has expectations about the role of families in caring for older persons. There is an assumption that all older persons have families to care for them. In my work I have observed many different types of family systems. Some older persons have a great deal of practical and emotional support from family members. Others do not have this type of support because they do not have close ties with their family members. Still there are others who do not have family providing hands-on support. These, for example, may be seniors who are widowed or never-married, or seniors who have children who live out of town, or with whom there is not a close relationship. It is these seniors who do not have visible family support who are the focus of this study. Patients without visible family tend to challenge the expectation that the Ministry of Health has in terms of families caring for seniors. I wanted to learn more about the experiences of older persons who do not have family and how they coped while they were in hospital.

Based on my experience as a hospital social worker, and my experience as a family member of an elderly person, I believe too much responsibility is placed on family members. I do not believe that every family has the ability to give the kind of care being expected of them to their elderly members. Further, I am concerned that the Ministry of Health may be allocating insufficient resources, namely public home support services, to
care for all seniors regardless of whether they have family. This study will examine the current social structures that exist and address the question of whether or not elderly persons are oppressed by the expectations of the health care system? Who cares for our elderly population who do not have family?
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Thank you to my parents for always giving me the support and resources that I need. Thank you to my family and friends, for your patience and your encouragement. Finally, thank you to Stuart for helping me through this entire journey.
CHAPTER 1 INTRODUCTION

Situating The Issue

This chapter examines the issue of older persons in hospital without family involvement and the literature surrounding this issue. The statistics on the number of older persons and their healthcare requirements are discussed. The types of support upon which seniors draw: family support, informal support, and formal support, will be examined. The existing literature about the hospital experiences of older persons is explored. Next, the role of the hospital social worker is discussed. Finally, the theory guiding this research, structural social work theory, is examined. I am using a structural social work lens in this research in order to investigate some of the challenges older persons face in hospital.

Senior citizens make up 13% of British Columbia’s population. By 2028 over 20% of British Columbia’s population will be 65 years of age and older (www.healthservices.gov.bc.ca/bchealthcare/seniors, 2003). Vancouver Island has six of the ten oldest communities in Canada as determined by comparing the population of seniors to the population of their respective communities roughly 20% of the population in Victoria is over the age of 65 years (www.viha.ca, 2004). Many seniors will end up living alone. They may have never married or their spouses may have died. In British Columbia, by the age of 69, 22% of women and five percent of men will have lost their spouses. By the age of 90, 46% of men and 86% of women will have lost their spouses (Northcott and Milliken, 1998). Elderly persons who lose their spouses or were never married, and/or do not have children or other relatives, may find themselves living alone. However, there are also seniors who have children but do not have involvement with
family due to strained relationships, geographic distance, or personal preference in some cases related to fear of being a burden (Aronson, 1990).

Older persons are often portrayed as a drain on our health care system, for example, the government of British Columbia, Ministry of Health Services, states that “as BC’s population grows and ages … the demand and costs for health care continue to increase” (www.healthservices.gov.bc.ca, 2003). The Vancouver Island Health Authority estimates that persons age 85 to 89 cost the health authority $18,800 per person per year; this is compared to a cost of $1400 per person between the ages of 25 and 45 (www.viha.ca, 2004). These are the “facts” that seniors are given, accompanied by the underlying message that they cost the healthcare system too much money. The government expects families to be involved in helping seniors to stay in their homes. Home and Community Care “services are designed to complement and supplement, but not replace, the efforts of individuals to care for themselves with the assistance of family” (www.healthservices.gov.bc.ca/hcc, p.1, 2006). For those seniors who do not have family the extra support needed to keep them in the community may not be available so they may have no choice but to rely on or “burden” the government.

There are at least two implications of learning more about the experiences of seniors who do not have family involvement during hospital admission. The first is an increased awareness of this population. The assumption that the health care system can necessarily deposit responsibility for care onto family must be challenged. The Ministry of Health Services may become more aware of the need to increase formal supports when there is no family to take on a support role. At present the Ministry of Health Services discriminates against older persons who have health issues. The second implication may
be the opportunity to use this understanding to foster more effective support for those without family. Generally speaking, if medical staff do not feel that older patients are capable of meeting their own care needs they expect families to step up and meet the needs of their elderly family members. However, older persons who do not have family may need to have a support network in order to have their needs met. A support network may include both formal and informal supports. Some older persons without family will not have friends or neighbours, and thus support provided by the government is necessary. Other seniors may have an informal support system. Medical professionals need to be more open to the idea of involving the friends or representatives of patients without families, rather than the idea that next-of-kin are the only appropriate supports for the elderly.

Family Support

It is a fact that most persons over the age of 65 receive support from their family members. We live in a society that makes assumptions about seniors and their families: first we assume that all seniors have family, and second we assume that all seniors will receive support from their families. There has been a shift of responsibility from government to family: “responsibility for the care and support of elderly people is being shifted from the public sphere of government attention to the private sphere of families and informal ties and to the realm of private care markets that can, of course, only be accessed by those with the ability to pay” (Aronson, 1998, p.117).

Within the private realm of families, spouses provide more care to older persons than do other family members (Pinquart & Sorensen, 2003). Some research supports the notion that spouses may feel an obligation to provide care due to their marital vows
(O'Connor, 1999). In fact, there seems to be an expectation from society that families will look after their elderly members (Barker, 2002). However, it is not reasonable to expect that all spouses can be the sole caregivers for their partners.

According to Feld, Dunkle, and Schroepfer (2005) there is literature that describes why spouses act as caregivers:

Several strands of theory and research indicate that relying on one's marital partner for help is likely to be especially acceptable among couples who are older and/or in marriages of long duration. This work suggests that with increasing age and marital duration, partners are likely to exhibit high levels of interdependence and a more turning inward to the dyad for support (p.30).

However, there are circumstances under which spouses are not able to provide assistance to their partners. If the caregiver spouse has health issues, he or she may be less able to provide assistance. As well, if the caregiver spouse is the husband he is more likely to draw on formal supports than a caregiver wife (Feld et al., 2005). There may be an expectation that wives should care for their elderly husbands because women have experience with nurturing and taking on helping roles (Ingersoll-Dayton, & Raschick, 2004). Another reason that spouses may not be the sole caregivers for their spouses is determined by mental health status. Spouses who care for their elderly partners tend to have more depressive symptoms, and report more health concerns than non-caregivers in their age group (Burton, Zdaniuk, Schulz, Jackson, & Hirsch, 2003). Therefore, spouses may feel that it is their duty to provide care to their partners but there needs to be acknowledgement of the fact that it may not be in their best interest to do it alone.

After spouses, daughters are the next most likely caregivers for their elderly
family members (Quereshi and Walker, 1989). Aronson (1998) explains that it is the concept of "familism" that suggests it is families who are the appropriate source of care for elderly people. Aronson's qualitative study of female carers and receivers found that "the general social expectation of daughters was, as understood by these women, to be dutiful and responsive to elderly parents" (p. 124). Daughters provide unpaid labour when they care for their elders. There are expectations about the care giving roles of daughters:

Men, when they care for others, are often viewed with sympathy and praised for going beyond the call of duty. Women, although they may be lauded for doing their duty, are expected to care. This reflects not only our differing expectations of men and women, but also our assessment that the actions of such men are particularly praiseworthy because the decision is usually more costly for the male carer in terms of forgone earnings. (Neysmith, 1998, p. 239).

Daughters are more likely than sons to help elders with the activities of daily living (ADL), for example, grooming and dressing, and instrumental activities of daily living, for example, banking and grocery shopping (Litwin, 2004; Martin-Matthews & Campbell, 2003). However, sons of older persons are more likely to be caregivers the closer they are in proximity to their family member. As well, sons who do not have siblings are likely to take on the role of caregiver for parents (Martin-Matthews & Campbell, 2003).

Seniors who were never married may have close relationships with kin, and rely on their kin for support: "The thinking about the family relationships of the never married is contradictory ranging from the assumption they are isolated from their families, that
they do not have families, to the view that they are excessively involved in caring for family members, especially aged parents. The family life of the majority of never-married older persons revolves around parents, siblings, nieces, nephews, and other relatives” (Keith, 2003, p.54). In fact, Keith’s research shows that people who never married are much more likely to rely on family than they are to rely on friends, and if they cannot depend on family then they are more likely to access formal services such as home support. Keith acknowledged that elderly men and women who never married and do not have children, are more likely to go into nursing care facilities than are their married counterparts.

Families have been caring for elderly relatives for many centuries. Families are required to care for their elderly relatives, “the increasing numbers and proportions of older people within populations may very well strain the ability or the willingness of public systems of social security and social welfare to continue to meet the needs of elderly cohorts. As a result, the greater reliance may need to be placed in the future on the informal support that is provided by and within families” (Litwin, 2004, p.1-2). Family members do provide care to their elderly family members for a variety of reasons. Reciprocity is one reason that adult children in turn care for their elderly parents (Walker & Qureshi, 1989). Intergenerational exchange is another reason that families care for their elderly members. Intergenerational exchange is the exchange of resources, financial or informal support, within a family (Litwin, 2004).

Filial piety can also explain the family caregiver relationship. Filial piety is based on the principle that adult children have great respect for their elders and as a result they take direction from their elders. Filial piety is an East Asian tradition. Adult
children recognize the care they received from their parents and filial piety
directs them to provide care and respect to their older parents (Sung, 2001). The sons and
daughters of seniors may have a sense of filial obligation and thus will
act as caregivers. Litwin (2004) has found that sons are more likely to be caregivers out
of filial obligation versus daughters who may be motivated by intergenerational affection
toward their elders.

Family caregivers continue to be involved when their elderly family members are
in hospital. In Freeman’s (1999) study, it was generally the daughters of the participants
who were visiting in hospital and providing both practical and emotional support.
Freeman (1999) found that the family members also acted as advocates for their elderly
family members. Family members had to make the concerns of their loved ones known to
hospital staff.

There is an expectation that family members will be involved during
hospitalization, particularly in regard to discharge planning. The hospital staff rely on
family members to take over where they leave off when the patient goes home. Family
members are expected to change linens, shop for groceries, prepare meals, monitor
medications, and do housecleaning (Kane, Reinardy, Penrod, & Huck, 1999; Burton,
discuss the important role of family in the discharge planning for elderly patients. It
seems that discharge planners need to be satisfied that the family will be adequately
involved with the patient upon discharge (Dill, 1995). There are many examples of the
family having an essential role in order for the patient to be discharged from hospital. In
many cases it seems that the patient would not be discharged, the patient may have to go
into a nursing home, if family was not there to take on the caregiving role (Call, Finch, Huck, and Kane, 1999; Cox, 1996; Cummings, 1999).

The primary caregiver for an older person often spends a great deal of time and carries a great sense of responsibility. However, there are more people involved in supporting an older family member than meets the eye. Primary family caregivers often have supports of their own. Sims-Gould (2006) highlights the fact that there are often multiple persons providing numerous forms of support to an older person. The primary caregiver may provide direct help to the older adult but there are often other helpers providing assistance to the caregiver. Sims-Gould points out the fact that not only does the older adult need a network of care, the primary caregiver also needs to have network supporting her/him.

There are expectations that family will be involved in the care of older patients (www.health services.gov.bc.ca/hcc, 2003). However, family involvement may not always be in the best interest of the patient or the family. Family systems change with the health issues of senior family members (Tisher & Dean, 2000). For families who have had poor dynamics, introducing illness and expecting family members to become caregivers may be harmful for the elderly person and/or the caregiver (Lachs & Pillemer, 1995; Holstein & Mitzen, 1998). Walker and Qureshi (1989) found that informal, or care provided by family members to elders, may not be superior to formal care provided by the government, when families are not functioning well, “some of the most damaging and emotionally destructive relationships may exist within families, with negative consequences for all concerned” (p. 204).
Informal Support

When family is not able to take on the caregiving role, or there is no family, seniors often turn to other informal supports. Informal support may be provided by non-kin caregivers. Neighbours, friends, and churches, of elderly persons often take on caregiving roles. Barker (2002) has found that non-kin caregivers act out of kindness and building sharing relationships. A study by Fast, Keating, Otfinowski, and Derksen (2004) found that more than 78% of older persons received support from family, whereas 15% of the 1104 seniors in the study had strictly non-kin supports. The results indicate that older persons without kin may be at risk of receiving insufficient care especially if the members of care networks are not in close proximity. More than half of the older persons in the study did not have members of their care networks living with them. Fast et al. (2004) found that those seniors who had caregivers living with them had more help with daily tasks than those who did not have caregivers living with them. Older persons who have family in their care networks also have more help with daily tasks than older persons who have strictly non-kin networks. Older persons with very few people in their care networks are at greater risk of inadequate care than are those with several people in their care networks (Fast et al., 2004; Sims-Gould, 2006). In addition to kin, friends and neighbours, and volunteers, may be part of the care networks of older persons.

Volunteer agencies offer support to older persons in a variety of ways. Volunteer agencies have volunteers who may provide companionship, help with transportation, shopping, and assistance with homemaking. There are also volunteers who provide support to older patients in hospital. Volunteers may provide support and effectively do the duties of family after discharge from hospital (Dulka, Yaffe, Goldin, Rowe, 1999;
Volunteers provide services and carry out tasks that would have to be paid positions if there were no people willing to give of themselves and their time. Nonprofit and Voluntary organizations in BC have approximately 1.5 million volunteers. These volunteers contribute about 114,000,000 hours and do the work of approximately 60,000 full-time employees (www.nonprofits can.ca/files/nsnvo/fact sheet_voluntary_sector_bc.pdf, 2006). In terms of supporting hospital patients upon discharge, the role of volunteers has been changing. Patients are now discharged sooner than they were in years past and tend to be more frail. Volunteers may find themselves taking on a greater responsibility for discharged patients (Gottlieb, 2002). Volunteers may be assisting older persons with everything from meal delivery to escorting them to medical appointments. Volunteers may fill a void for those older persons without family or friends but there may, and should be limits. Volunteers may be “motivated to do all those things that the client would have looked to family or close friends to do, they also realize that limits must be imposed on their altruism” (Gottlieb, 2002, p.8).

It is also important to recognize that some older persons hire home support workers to fill the role that a family member might fill. The paid caregivers become such an important and routine part of seniors lives that they may be considered to be like family (Sims-Gould, 2006). Paid caregivers who do the tasks that family members generally do such as housekeeping, grocery shopping, and preparing meals, may be considered “fictive kin” (Karner, 1998).

When carrying out the literature review it became apparent that having family is a given for senior citizens (Freeman & O’Connor, 2002; Jordan & Lindsay, 1998; Morrow-Howell & Proctor, 1998). However, there is very little literature on how seniors without
Formal Support

Formal, or government support, is a necessity for many older persons. Both married and unmarried persons, those with family, and those without family, rely on formal supports to help them meet their needs (Kadushin, 2004; Ward-Griffin, 2002). In 2003, 566,500 (non-institutionalized) seniors in Canada were receiving home care. Over half of these older adults received home care entirely from formal sources (Rotermann, 2006). Seniors living alone are more likely to receive home care than those who live with others (Rotermann, 2006). In 2001, 23% of men aged 85 and over, and 39% of women aged 85 and older in Canada, lived alone (National Advisory Council on Aging, 2006). Older persons who live alone are also more likely to access formal home care sooner than those who are married likely due to the fact that they cannot depend on a spouse to provide support. Married persons are likely to have several impairments before accessing formal supports whereas unmarried people are more likely to access home support for one or two impairments (Mutchler & Bullers, 1994). The amount of informal support available does influence whether seniors will obtain formal support. Older persons who do not have informal support are more likely to turn to formal supports (Kadushin, 2004). Married persons also have the needs of both the care recipient and the caregiver to consider in terms of utilization of formal support (O’Connor, 1995), whereas older persons living alone have only their own needs to consider in terms of utilizing formal support.

What We Know About Older Persons Who Live Alone

In order to further situate the issue of this study, it is important to reflect on what
is known about seniors who live alone. There has been much research on the issue of living alone and loneliness in later life. There is also much research on the types of support that seniors who live alone receive.

Loneliness in later life is an issue for many older persons whether they live alone or with others. Seniors who have a social network may be less lonely than those who are isolated (Perlman, 2004). However, there are other factors which determine feelings of loneliness including socioeconomic status, health, social networks, and life circumstances (Victor, Scambler, Bowling, and Bond, 2005; Savikko, Routasalo, Tilvis, Strandberg, and Pitkala, 2005). There is a difference between loneliness and social isolation (Perlman, 2004). Loneliness is an identified emotional state, “an individual’s subjective experience about lack of satisfying human relationships, and thus loneliness would be a negative feeling causing distress to an individual” (Savikko et al., p.224). In contrast social isolation results from a lack of social resources (Cattan, White, Bond, and Learmouth, 2005).

Longitudinal studies are helpful in understanding when and why loneliness becomes an issue for older adults (Perlman, 2004; Victor, Scambler, Bowling, and Bond, 2005). Victor et al. (2005) conducted a longitudinal survey of 999 persons, ages 65 years and older in Great Britain. The researchers found that 68% of the participants indicated their level of loneliness did not change from 10 years earlier. However, 23% of participants indicated they were more lonely and 10% were less lonely than they were 10 years earlier. Aging does not necessarily mean that people will have increased loneliness.

Loneliness may be combated through increased social connections and developing relationships with meaningful bonds (Perlman, 2004). One study found that
home visits and telephone calls are less effective ways of dealing with loneliness than are participating in group activities (Cattan, White, Bond, and Learmouth, 2005). Others have found that there are also certain factors that protect older persons against loneliness including higher levels of education and self-perceived good health (Savikko, Routasalo, Tilvis, Strandberg, and Pitkala, 2005; Victor, Scambler, Bowling, and Bond, 2005). In a study by Savikko et al. (2005), of 4113 persons, ages 75 years and older, in Finland, 55% lived alone, and 45% lived with others. In this quantitative study, those who lived alone and had low levels of education, and poor health, indicated they were more lonely than their counterparts who live with others who have higher levels of educations and self-reported good health. Overall, 39% of the participants reported feeling lonely. Savikko et al. (2005) found that older women suffer more from loneliness than do men. Older women are more likely to report feeling lonely than are older men (Perlman, 2004).

The outcomes of loneliness in later life are varied. Bereavement, particularly loss of a spouse in later life, is a key cause of loneliness (Victor, Scambler, Bowling, and Bond, 2005). Bereaved seniors may be able to live alone if they have social resources and good health (Victor et al., 2005). However, older persons who are not able to manage living without their spouses due to loneliness are more likely to be institutionalized, and are at an increased risk of death (Savikko, Routasalo, Tilvis, Strandberg, and Pitkala, 2005).

It is also important to discuss what is known about how seniors meet their physical, emotional, and social needs. Older adults often rely on some type of support, whether it be assistance with activities of daily living, or socialization. As we know from the literature on family caregiving, informal support by family members is the most
common type of support. "The prime source of informal care for elderly people living alone is adult children, who, along with other relatives and friends, are often crucial for helping older adults avoid or postpone institutionalization" (Larsson & Silverstein, 2004, p.232). However, for seniors who live alone and do not have children, other supports, both informal and formal, are necessary.

Larsson and Silverstein (2004) carried out a study in Sweden involving 390 seniors who all lived alone. The researchers hypothesized that previously married persons and those with kin were more likely to have informal supports in their homes than the never married and childless persons, and that the never married participants were more likely to have formal supports either through the government, or hired privately, than are the previously married participants. The findings revealed that participants who were previously married without children had fewer informal supports than participants who had children. However, the researchers found that friends were the main source of informal support for all of the participants. Participants who were previously married and those who had children used public home-help or private services at the same rate as the never married and childless participants. This study suggests that living alone, regardless of whether kin are involved, is a large factor in whether or not older persons utilize formal support.

Some research suggests that some seniors who live alone attend seniors centres where they create friendships which go beyond the activities of the centre and may in some cases translate into informal supports in their homes (Aday, Kehoe, and Farney, 2006). In a USA study of 415 women attending a senior's centre, 274 of the participants lived alone, and 141 lived with a spouse. 71.2% of the women living alone indicated that
their mental health was improved as a result of attending the center. The women in this study indicated that the companionship they have from others at the center is very important and they are aware that they are at risk of isolation and loneliness if they do not attend the center (Aday, Kehoe, and Farney, 2006). There is a strong desire among seniors to continue to live in their own homes (Gustavson, and Lee, 2004). There is evidence that seniors who live alone are at a disadvantage to those who share their homes with others. In the USA, elderly people who live alone “experience twice the poverty than those who live with others, tend to be persons age 75 and older, are predominately women, and are at higher risk of hospitalization and institutionalization” (Gustavson, and Lee, 2004, p.5).

The Experience of Hospitalization

There are studies, both qualitative and quantitative, on the experiences of patients in hospital. Much of the research about older persons experiences in hospital discusses the role of the family during the hospitalization. In fact I found it very difficult to find journal articles related to the issue of older persons in hospital without family involvement. When I was searching for literature, I used the keywords “hospital” and “seniors” and “social work”. I also used the keywords “acute care” and “elderly” and “support”. The journal articles that matched these searches, included families in the data. When I used the keywords “hospital” and “older” and “non-kin”, there were no articles focusing on the hospital experience.

A 2004 study by Cynthia Jacelon focused on the perspectives of five persons aged 75 and older who were hospitalized. However, this study also included the participation of one family member for each participant and one nurse for each participant. The
research was not focused solely on the older persons' hospital experiences but also on the impressions of family and nurses in regard to how they perceived the older persons were experiencing hospitalization. This qualitative study analyzed the experiences of the participants in terms of health, dignity, and autonomy. The data revealed that older persons' integrity changes during the different stages pre-hospital, hospital, and post-hospital. Much of the hospital experience for these older persons focused on managing personal integrity (Jacelon, 2004). This study focuses on the experience of older persons in hospital who had family involvement but the findings regarding personal integrity may also be applicable to the experiences of older persons who are hospitalized without family involvement.

When older persons are hospitalized with the involvement of their families, the families may take on one of several roles (Jacelon, 2006). The family members may act as the decision makers for older adults, they may advise the older adult on decisions, or they may not take a directive role. Technically, patients have to give consent in order for family members to act on their behalf. Family members often provide support during hospitalization by visiting, bringing in toiletries, providing food, and frequent phone calls. Families may also look after their elder members homes and affairs while the elder is in hospital. Families are often involved in discharge planning, and providing extra support during the first few days that older persons are back in their homes (Jacelon, 2006). Other studies have looked at the issue of discharge planning and how older persons may or may not be included in all discharge decisions (Fitzpatrick, 1999; Wells, 1997). Older adults who do not have family involved during hospitalization may not have the direction and support that patients with family members often have.
In terms of recommendations by those who have conducted previous research in this area, Amy Freeman (1999) has discussed the need to explore the experiences of elderly persons in hospital who do not have family to assist with their care. The findings of Freeman’s (1999) study revealed ways in which elderly women are oppressed in a hospital system that considers them to be a “burden”. Freeman’s study identified that family involvement during hospitalization was absolutely essential. In fact, the participants in her study attributed their survival to their family members. The question is how do older persons survive in hospital without family?

The Role of Hospital Social Workers

Hospital social workers receive referrals from other hospital staff, and physicians (Capital Health Region, 1998). Social workers carry out psychosocial assessments for each patient referred. Part of this assessment involves identifying the patient’s supports. Older persons admitted to hospital without the involvement of family may be particularly likely to be referred to social work. Social work should be involved just after admission rather than waiting until the patient is ready to go home for assessment to begin (Boutin-Foster, Euster, Rolon, Motal, BeLue, Kline, and Charlson, 2005). The Capital Health Region (now the Vancouver Island Health Authority) Social Work Policy (1998) states:

**Discharge planning is a coordinated interdisciplinary process that begins prior to or at the time of the patient’s admission to hospital. Discharge planning is an essential component of the role and function of hospital Social Workers who are responsible for the coordination of discharge of patients with complex psychosocial problems and for linkage to community agencies, services and programs (VI a.30).**
Discharge planning is a process of identifying the needs of the client based on physical and cognitive functioning, and then matching those needs to services available. The goals of both the clients and the health care professionals are to implement supports that maximize client function and independence, in a safe environment (Kane, Bershadsky, B., & Bershadsky, J., 2006). Discharge planning with older persons often focuses on identifying what supports/services are needed for patients to return to their previous residences. Geriatric services such as home supports, adult day care, psychiatry, and outpatient rehabilitation, may be needed in order to support older persons at home. The utilization of the above named services may reduce the likelihood of older persons going into facility care. However, there may be clients who are best supported in long term care facilities.

**Structural Social Work Theory**

Structural social work theory seeks to change social structures in order for oppressed persons to become equal members of society. The current government, the Ministry of Health Services, sends a message to seniors that they are a burden on society. The government has gone to the work of calculating how much more costly medical care is for seniors than it is for persons between the ages of 25 and 45 years. The government sends a message to seniors and their families that it is their responsibility to look after each other. Structural social work theory brings to light the fact that seniors should not be blamed for structural problems. In other words, the government should have resources in place to help seniors regardless of whether they have family. Seniors without family should not feel that they have to fend for themselves.

In the 1970’s Maurice Moreau began the movement toward structural social work.
Moreau brought forth the idea that society is responsible for human inequalities rather than blaming individuals for their shortcomings (George & Marlowe, 2005). Structural social work theory falls under the broader theory of critical social work in which existing social institutions are challenged and structural transformations must happen in order for change to occur (Mullaly, 1997). According to Payne (1997) “The goal of structural social work is transformation. That is, it seeks to change the society in which this occurs, rather than simply dealing with the consequences of it” (p. 223).

Structural social work is the lens I am using in this qualitative study. I am using structural social work theory because as a hospital social worker I have a role to fill to ensure that older persons do not assume ownership for all of the issues that they experience while in hospital. Using structural social work theory as my lens I am examining whether patients are discriminated against based on their health and age. Using this theory I also explore whether patients feel they are a burden on the healthcare system. Through this lens I want to learn how older persons without family manage in a system that expects seniors to have family support during hospitalization.

Cox and Parsons (1994) have written extensively on empowerment oriented social work with older persons. The issue of aging is multi-faceted and when health issues come into play many older persons have a sense of powerlessness. As people age they tend to have changes in their physical abilities, and mental abilities. As well, loss of support systems may result in greater dependency on others, and loss of power (Cox & Parsons, 1994). Of particular note are the feelings of powerlessness that older persons may experience when they lose their family members or other informal supports: “The loss of informal support, whether through death or through relocation away from a familiar
place, increases elders' isolation as well as their dependence on more formal systems of support” (Cox & Parsons, 1994, p.23-24). Social workers can help elders to identify ways in which they feel powerless, and help them to understand that they are not alone “empowerment-oriented social work practice is a model through which social workers can assist older people to utilize their strengths, abilities, and competencies in order to mobilize their resources toward problem solving and ultimately toward empowerment” (Cox & Parsons, 1994, p.19). Older persons need to feel that they have the abilities to affect healthcare policy to improve services for themselves and others.

The research question I posed was: What are the experiences of persons 65 year of age and older, who have been hospitalized without family involvement? Using a structural social work lens, two sub-questions arise:
1) How are the experiences of the participants in this study shaped by the broader structural issues?
2) What services or people were helpful to the participants during their hospitalizations? The first question is more analytical and I was actively seeking the answers within the data. The second question was actually a question in my interview guide and so the participants provided very literal answers to the second question. The answers to these questions will be discussed in Chapter Five.

Summary

The purpose of this study is to gain an understanding of the experiences of senior citizens on Vancouver Island who did not have family involvement while they were in acute care. The literature review has highlighted the differences in support for older persons who do have family versus those without family. The experience of
hospitalization is impacted by the presence or family but to date little is known about the experience of patients without family. Social workers have a role to play with older adults in terms of helping them to identify and draw upon their support system.

Empowerment-oriented social work is a useful lens for insuring that the focus shifts from the older person as “the problem” to examining how social structures and systems may be contributing to the individuals’ experience. The structures that oppress seniors in institutions such as hospitals will be explored in chapter 5.
CHAPTER 2 METHODOLOGY

This chapter explores my reasons for choosing to make this a qualitative study. This chapter also explores how hermeneutic phenomenology, narrative research, and structural social work theory guided this study. Finally, the processes of recruiting and selecting participants, data analysis and study limitations are explored.

A Qualitative Study

A qualitative study can shed light on what it is really like to be an older person in hospital without the presence of family. A qualitative study brings to light the human experience. Qualitative research allows one to learn about the participants’ experiences and identify issues about which there is little knowledge (Morse & Field, 1996). There are two main reasons I selected a qualitative research design. First, qualitative research positions the participant as the expert and seeks to convey his/her story. Recognizing the participant as the expert creates a balance of power between the participant and the researcher (Kvale, 1996). Second, the participants share in-depth knowledge from which the researcher constructs meaning (Maxwell, 1996).

This study draws on the ideas of hermeneutic phenomenology. The life world or story of an individual is described through phenomenology. Hermeneutics, a branch of phenomenology, helps to discover the meaning in people’s stories. The context of an individual’s story cannot be separated from the interpretation of the story (Kvale, 1996). In order to understand the phenomenon of others, the researcher has to be open to the experiences of the participant. The researcher needs to set aside what he/she knows about the topic in order to be open to the participant’s ideas (Beck, 1994). Hermeneutics involves a process of moving from the parts of the experience, to the whole experience.
and back and forth again several times to reach an understanding of the data. When the researcher reaches a point at which the meanings of the experience seem reasonable, the interpretive process is complete (Kvale, 1996).

Narrative analysis fits well with hermeneutic phenomenology as it focuses on the meaning of people's stories. A narrative is a dialogue which describes a series of events (Lieblich, Tuval-Mashiach, & Zilber, 1998). “Narrative research focuses on the structure and content of stories people tell that help them make sense of their experiences” (Rossman & Rallis, 2003, p. 99). The idea that there are multiple meanings and interpretations of a dialogue is the basic tenet of narrative research. Narrative research is the analysis of a narrative whether it be transcribed interviews, diaries, or autobiographies (Lieblich, Tuval-Mashiach, & Zilber, 1998). Lieblich (1993) reminds the researcher to observe the participants during the interview sessions in addition to hearing about their experiences. When writing about the participants, the narrative researcher creates a story about each participant's experiences (Lieblich, 1993). As the participant’s story is created, the researcher is using a particular lens to make sense of the meanings. In this study I used a structural social work lens to make sense of the participants' experiences.

A Structural Social Work Lens

Structural social work theory is the lens used in this study because it brings to light the issues the participants experienced in hospital and places responsibility on the healthcare system rather than on the individual participants. Structural social work theory fits under the larger category of critical theory. The goal of critical or feminist theory is to expose sites of oppression (O’Connor, 2001). By exploring how structural issues have shaped the participant’s experiences, the participant’s are given a voice and structural
inequities may become visible (O'Connor, 2001).

Validity and Generalizability

The validity or credibility of this study was addressed in several ways. First the possibility of validity threat, the ways in which I may be wrong were considered (Maxwell, 1996). I verified that the data was accurate by transcribing audiotapes verbatim and then comparing the typed transcript with the audiotape again. There is also the possibility of validity threat during the interpretation process. To ensure that the views of the participants emerged during the interpretation process, I was forthright in terms of the lens I was using and my own assumptions. I also asked open-ended questions during the interviews to ensure that I was not leading the participants in a particular direction. The second interview that was done with every participant was also a way of receiving feedback on my interpretation of the first interview. The second interview allowed participants to verify the meanings of their experiences. Another aspect of validity is the identification of discrepant data (Maxwell). I identified data that did not fit with my conclusions and I considered alternative explanations. In chapter five there is a discussion of how I challenged myself to think beyond the framework I used and how I considered alternate explanations.

For the most part the data from this small sample is not adequate for generalizing to other populations (Rossman & Rallis, 2003). Kvale (1996) points out that contextualizing rather than generalizing is appropriate in qualitative research. Maxwell (1996) emphasizes that “external generalizability is often not a crucial issue for qualitative studies. Indeed, the value of a qualitative study may depend on its lack of external generalizability, in the sense of being representative of a larger population; it
may provide an account of a setting or population that is illuminating as an extreme case or ideal” (p.97). This contextual understanding may result in increased insights and questions that can be explored in future research.

Participant Recruitment

I was seeking participants on Vancouver Island who were 65 years of age or older, who had been hospitalized, and did not have family involved during their hospitalizations. Posters were used to advertise the study. Many of the posters were sent to senior’s centres, volunteer agencies, services for seniors, and senior’s residences, via Canada Post. Others were placed on public notice boards. The study was also advertised in a Victoria newspaper. I was restricted in my method of recruitment due to my employee status with the Vancouver Island Health Authority (VIHA). The Ethics committee of VIHA did not feel it would be ethical for me to recruit from within the health authority. Therefore all of my advertising had to be done through organizations outside of VIHA. Without access to participants within VIHA facilities and programs there were limited ways of accessing older persons who had been hospitalized without family involvement. As a result, recruitment was very challenging due in part to the impersonal methods that were required. I was not able to rely on colleagues or anyone within the health authority to identify potential participants. Recruitment was ongoing from February of 2004 to August of 2005. Five persons 65 years and older volunteered to participate in the study.

The fact that I was not able to recruit from within VIHA is an important factor in determining the sample of this study. Through my employment I meet many seniors who do not have family involved during their hospitalizations. There are seniors who may or
may not have a support network of any type. Some of these patients have issues around alcohol use or homelessness. Some of them are socially isolated. The hospital may be the only place in which socially isolated seniors are identified due to the fact that not all seniors have a family physician. In terms of my study I was not able to access seniors such as those described above because they are typically not linked to any organizations in the community. Therefore, the findings of this study may be biased because almost all of the seniors in this study are linked to some type of organization that provides social support.

Sample

The advertisement for the study requested the assistance of persons 65 and older who had been hospitalized without family involvement. Originally the advertisement for the study stated that the participants need to have been hospitalized in the last 18 months. I selected 18 months as the timeframe due to the fact that the BC Liberal government was elected in May of 2001 and had begun making cuts to the healthcare system shortly after their election. Specifically, this is when the government seems to have increased responsibility on families in terms of the care of seniors. Home support services had already been reduced, older persons were no longer receiving assistance with homemaking services. Home and Community Care could only provide personal care to older persons. The government also cut nursing positions which increased the workload of nurses (www.bcnu.org/whats_new_media/news_releases/2002/08-21.htm). The timeframe for the study was changed to three years as my recruitment phase occurred over a period of 18 months (February 2004 through August 2005). One participant who volunteered had been hospitalized four years ago. I decided to include her in this study.
because there is national research which indicates that during the past five years there have been significant changes to the healthcare system. In particular, the length of hospital stay has been shortened without adequate community services upon discharge (Fitzpatrick, 1999).

The advertisement for this study indicated that learning about the experiences of seniors without family is important for meeting the needs of future patients who do not have family, and making recommendations to service providers and policy makers (See Appendix A). Four women and one man volunteered to participate in this study. The definition of family was determined by the participants. All of the participants indicated that they did not have family present during their hospitalizations. All of the participants in this study defined family as biological kin whereas others in their lives were defined as friends or volunteers. The size of the study sample was based on the ideas of phenomenology in which the in-depth interviews generate much data focusing on the participants’ experiences (Kvale, 1996).

Four of the participants had a hospital admission within the year prior to the date on which I interviewed them. One of the participants was hospitalized four years prior to the date of the interview. The participants ranged in age from 65 to 83. All of the participants were Caucasian. Three of the participants were divorced, one was single, and one was widowed.

Only one of the participant’s contacted me directly after reading the study advertisement. The other four participants were informed of the study by either a friend or a volunteer coordinator. The participants then gave permission to their friends or volunteer coordinators to provide me with their name and telephone numbers. My initial
contact with each participant was over the phone. I explained the parameters of the study, including the consent form they would be required to complete. All of the participants agreed to meet with me for an interview.

Data Collection

All of the interviews took place in the homes of the participants at their request. I went over the consent form with each participant. It was important for each participant to know that their involvement in the study would in no way impact the services they had nor influence future service from the Vancouver Island Health Authority (See Appendix B). All of the participants signed the consent form before the interviews began. The first interview began with the question “Can you tell me about your most recent hospital experience?” This open-ended question gave participants the opportunity to describe their experiences in detail. I had a list of questions that I used as a guide during the interviews (See Appendix C). However, I did not always need to ask the questions as the participants often provided information through the description of their experiences. All of the interviews were audio-taped using a micro cassette recorder. The participants did not seem to mind having the interviews recorded. There were challenges with finding electrical outlets in which to plug in the recorder but all of the participants encouraged me to make myself at home and unplug other appliances if necessary. The first interviews ranged in length from 40 minutes to 90 minutes. A follow-up visit took place with all of the participants. The purpose of the second set of interviews was to clarify the data obtained in the first set of interviews. These interviews ranged in length from 30 minutes to 60 minutes. I transcribed all of the recorded interviews verbatim. I did not take notes during the interviews but I did make extensive field notes. I recorded my observations
and impressions as soon as I had left their homes.

As previously described, the participants volunteered to participate in the study after seeing the advertisement posted or by learning about it from a volunteer organization. I did not have a previous professional relationship with any of the participants. In the process of getting to know the participants better, and sharing information about myself, I did discuss with each of the participants, my role as a hospital social worker. However, in retrospect it may have been appropriate for me to discuss the possibility of future encounters with the participants since I work in one of the hospitals in which some of the participants were hospitalized. If the participants are hospitalized again I may be in the position of working with the participants as a social work professional. It may have been prudent for me to discuss with the participants how we will interact if we have future encounters. We should be able to acknowledge that we have met without divulging their role in my research. I now have in-depth knowledge of these participants but the information must not be shared with others.

Data Analysis

The data analysis began during the first interview. Both journaling and transcript analysis provided data on the experiences of the participants. I did four readings of the transcripts. The first reading allowed me to immerse myself in the data. After the initial reading I wrote out my thoughts and ideas about each of the participants. The second reading of each transcript allowed me to gain an understanding of each participant’s story, the main ideas and contradictions of each transcript were identified and compared to the others. The emerging ideas were discussed with participants in the second interview and then further delineation of the concepts occurred. This type of analysis fits
well with hermeneutic phenomenology because it is the process of moving between the parts and the whole (Kvale, 1996). There was a continuing process of comparing the emerging ideas against parts of the text and the entire transcripts. As a result, meanings were deciphered that go beyond the words of the participants. Further analysis of the transcripts revealed significant issues for each participant. These topics were teased out by examining how much time participants spent on the issue and how often they went back to the issue in a later part of the transcript. After the third reading, narrative analysis allowed me to shape each participant's descriptions into a story. The main themes emerged as I compared the similarities and differences between the narratives of the participants. By the time I had read each transcript for the fourth time, I was looking for the data to tell me how structural issues have shaped the experiences of each participant.
CHAPTER 3 FINDINGS

This chapter reveals the in-depth experience of each participant. I have developed a case study of each participant’s experience. Writing case studies allowed me to explain the unique circumstances of each participant while at the same time teasing out the data “to develop a picture of what had happened and what the current situation was” (O’Connor, 2001, p. 148). The stories of each of the participants are written to help the reader identify with the participants and better understand their experiences. I will begin with the stories of John, Carrie, Ann, Jane, and Diane (all names have been changed to protect the privacy of the participants).

John’s Story: “I am a very tenacious man”

John learned about this study from the volunteer coordinator at the volunteer agency that provides support to him. The volunteer coordinator knows John’s situation and knew that he had been in hospital without the presence of his family. John agreed to share his hospital experience and gave the coordinator permission to give his phone number to me.

John lives in a one-bedroom ground-floor rental apartment. There is a buzzer system to enter John’s building. He regards this as his front door as he does not lock the door of his apartment. John has home support workers, and a meals-on-wheels delivery, daily so he finds it simplest to leave his apartment door unlocked. There was a home support worker present when I arrived but he was finished providing care to John. The home support worker was not aware that I was coming. John and the home support worker seemed to have a good rapport. The home support worker left within a couple of minutes of my arrival.
John welcomed me to his apartment while staying seated in his wheelchair as his mobility is limited. He appeared to be quite a hefty man as he was sitting in his wheelchair. John was wearing shorts and a sleeveless shirt. The temperature in his apartment was quite warm so his choice of clothing was appropriate. John had bandages on his feet due to foot ulcers, and an indwelling catheter. John wears glasses and a hearing aid.

My first impression of John was that he is quite a jovial man. He invited me to find an electrical outlet to plug in the micro cassette recorder I brought to tape the interview. Pointing to a power bar on the floor he suggested with a chuckle that I "unplug something so you can plug in the recorder". I was a bit concerned because both his aquarium oxygen system and his computer were plugged in and I did not want to cut the power to either of these. John seemed much less concerned than I about the situation!

John spends much of his day in his wheelchair at a small table where he has a lovely view of a central courtyard with trees and plants. He can watch his television from this location, work on his computer, and see his fish in an aquarium.

During the interview I learned that John is 76 years of age. He had been an only child and had a tumultuous relationship with his father but he had a good relationship with his mother. He owned and operated his own company in the United States, and had a lot of pride in his work. John was married to a woman who was many years his junior. He is now divorced and his adult children live in the United States. John moved to Victoria after his divorce. He had visited Victoria with his wife several years before and he believes Victoria is “paradise”. He does not have any family in Victoria.

John presented himself as a good-humoured person. He seemed pleased to be
sharing his story about his hospital experience. It was an opportunity for him to speak freely. Perhaps since he had not previously had a captive audience to hear about his hospital experience, he spoke with enthusiasm. He would raise his voice to give emphasis to his descriptions. Throughout the interview John strayed frequently from his actual experience in hospital to share a part of himself which helps one to understand more about him.

John’s hospitalization was a planned geriatric assessment. He received a telephone call from Seniors Health to indicate his name had come up on the list for an inpatient assessment. The purpose of the assessment was to monitor John’s physical condition and how he was functioning over a period of time, to improve John’s function, and to increase, or alter, the home supports he had in place.

Two themes dominated John’s story about his hospitalization. The first focuses on John’s experience in terms of control and independence. The second theme draws attention to the importance of building trusting relationships with others.

Control and Independence

John began his story by explaining his need to be in control of his experience. He explained that his hospitalization was a planned geriatric assessment. The purpose of the assessment was to monitor his physical condition and his functioning over a period of time. John explained:

This is what happened. I got a phone call on Thursday saying I’ve got to be there on Friday morning, and I was not expecting it. They wanted to ascertain what my, uh my reaction to certain conditions. And appraise my psychology and that sort of thing. And find out if there is anything abnormal with me and
if so what and why, etc., etc. To build up a whole description.

Although somewhat taken by surprise, he did go into the hospital as requested. However, he was firm about the length of time he was willing to spend in hospital. John seemed initially reluctant to consent to the hospitalization because of what it meant to him. He experiences a loss of control over his day-to-day routine when he is in hospital.

John explained that it is the trusting relationship he has built with his Home and Community Care case manager that really swayed him to go into the hospital. He agreed because of her recommendation that he go into hospital for the geriatric assessment.

The respect between us is such that if she told me that green was blue I’d question it, I’d want an explanation but that’s why she is so good. She does take the time to explain. If it makes sense, ok, but if she says nothing, I have feelings of unacceptance.

His trust in his case manager allowed him to relinquish some control. John’s health issues have increased over the last few years and he has become more reliant on his case manager to set up the supports he needs in order to maintain his independence in his own home. John has learned over the years that he can trust his case manager because she has acknowledged and supported his goals around continuing to live in his own home and remaining in control of his own situation: "she never dictated, she never pushed, she let me make up my own mind".

Once in the hospital John did agree to extend the length of the assessment because he was learning new information about his health. John described some of the ways in which he learned new information about his health. He described the procedures that he had while in hospital from blood tests to having pictures taken of his heart:
They took some pictures of my heart with a new method, what do they call it,
uh it has to do with atomic energy ... take a picture of you know, like an x-ray
but an x-ray they tell you don’t breathe, BINGO! You could breathe and
everything else ... and different angles. They found out that I have a swollen
heart and I was glad to hear that and a few other things that they found out,
that I have arthritis which I knew already.

The medical investigations John had while in hospital resulted in definitive diagnoses.
John was “glad to hear” that he had a swollen heart because the issue was defined and the
aspect of the unknown was removed. John was able to be in control if he knew exactly
what he was dealing with.

John’s need to be in control was outlined in his description of the nurses and the
way in which they interacted with him:

I uh frankly think overall that what the nurses do, and they have good nurses,
there was one nurse there that surprised me frankly because I was not always
as positive as I sound now. Uh, this time around, even though they worked
twelve hour shifts they were very very nice and you had respect for them...

This time around they were more professional without being dominant. Cause
I’m not a man you can dominate.

John was concerned about a lack of consistency in the nursing staff. John seems
to be challenged by the current health care system in which nurses may not be scheduled
to work several shifts in a row and thus patients receive care from a different nurse every
day. He spoke of a particular nurse he found helpful:

The only trouble was that they had her in different sections and uh one time,
one day she might be here, next time she might be at the far end of the building, and you don’t get to, well you don’t feel as relaxed as it used to be. The way things were before, they weren’t perfect but that’s one of the things that I noticed and you got to know who your nurse was.

It was important to John that he receive nursing care from the same staff members. According to him this allowed him to build rapport with one or two nurses and he then knew what to expect when working with those nurses. John has had previous hospital admissions and he lamented about the fact that at one time patients would get to know their nurses well and have the opportunity to develop relationships.

John acknowledged that he has had to adapt to changes in his life as a result of declining health. These changes have affected his quality of life. John was quite matter of fact when describing his health and his knowledge about his health. He had to learn step by step how to cope with his health issues. He made an analogy to running a company and keeping your books up-to-date: “well just like you have to absorb information from the books, you’ve got to learn things about your health”. Another analogy was made between the advice of a mechanic and the advice of a medical professional. John described the process of taking his car to a mechanic and then not agreeing with the assessment of the mechanic. John described that he took the car home, picked up some books on mechanics and taught himself how to fix the car. Similarly, he explained that one needs to become familiar with health issues so that when speaking with health professionals there is a degree of knowledge and the health professional does not hold more power. John’s way of coping with the health system revolves around his own knowledge:
I saw it, I did it. As a consequence now you can talk to me and I can talk back to you the same way. If somebody tries to give me a routine or con me I won’t make a big deal about it because I don’t like arguing but I’ll say, well let me think it over, and I’ll just do it myself.

In addition to ensuring he had the necessary knowledge to avoid being taken advantage of, John described two other coping strategies:

**Two things help me cope, one is my sense of purpose or what I call my tenacity, and the other is my faith... I’ve done things that believe me were strictly on faith, and I found out that I was right doing so.**

John has faith in "the good lord". His tenacity and faith are life long coping strategies but they are particularly important to him now. John acknowledged that living with pain on a daily basis takes work and tenacity.

**I’m not that stubborn. I’m independent and a social person. As long as I believe I’m doing what I should do, and I try, if the good lord wants me to do it, I’ll do it. It’s a matter of faith but that’s where it’s at.**

In many ways John coped with his hospital experience using the same principles he has used throughout his life, remaining in control, and increasing his knowledge in order to maintain a balance of power with others. He is still the man who had his own successful business. He remains in control, he decides where he will go and what he will do but he has accepted that he is limited by his health issues.

**Building Trusting Relationships**

John has a son and a daughter, both of whom live in the United States. Both of John’s children have children of their own. He mostly communicates with them by
telephone. He does not see his children very often. John’s family were not present during his hospitalization due to distance and their own responsibilities. John explained that he does appreciate having his family around him “essentially it’s nice to have somebody come up once in a while and I’m, I like my kids around me and so forth and I love my grandchildren around me”. John acknowledged that he may have been more “relaxed” if his family had been present during his hospitalization. He said he spoke with his children on the telephone while in hospital.

John’s independent nature and his desire to live in Victoria outweigh his need to live near family. He does not seem to need family to take on the role of caregiver for him. He seems to be comfortable with the care that is provided by Home and Community Care. John is also very independent and in this way he feels he is managing his care needs both in the hospital and when he is at home. He is satisfied with having conversations with his family over the telephone, and the emotional support they provide without actually having them present.

John has learned how to work with the health care professionals in the hospital. He has contemplated the roles of the professionals and why they give patients a push at times:

I respect people who stand up and give you a hard time for your own good.
And they don’t take any nonsense. You can do that two ways and get the same result. One is you build up resentment and dislike, the other you build up an acceptance. I would say that the people that they had there were all conducive to a good relationship.

John identifies with others who are also tenacious. He respected the work of the nurses
and physiotherapists. He made it clear that he does not take orders from hospital staff but he is willing to cooperate with their requests especially when he understood that the hospital staff were not trying to control him but rather working to improve his overall functioning.

It was somewhat of a process for John to build trusting relationships with hospital staff. This was true in terms of discharge planning as well. He explained that the social worker coordinated the planning of his discharge to home. He explained that she “just wanted to make sure that everybody had done their job”. He was comfortable with the social worker as he had previously had a hospital admission in which the social worker assisted with his discharge plan. His previous hospital admission was an emergency admission. John explained that he had been taken to the hospital by ambulance and the only clothes he had were his nightclothes. The social worker helped to organize clothing and transportation for him:

The first time I went [to the hospital] I was a stranger in town. I don’t know anybody in town and everybody’s shocked about that when they realize I am truly alone in this world. All I had on was my hat and my pajamas, or my underwear I should say, and that’s all I had taken to the hospital. I had nothing, I didn’t even have slippers. Now I’m in a situation where I had to go home. What’ll I do? I couldn’t walk out in my scivvies, its uh, I will never forget the feeling I had then. But I have to say one thing, what they did, they got me a counsellor I guess. What she did, her job was to expedite everything. She made it easy because I came home by cab. Well she got in touch with somebody and they had a volunteer and so forth. That’s how they got me
home. But uh I also had somebody had to come to the house and get me some clothes. That made me feel a little better let me tell you and she did everything.

Family members are most frequently called upon to bring clothing into the hospital, and to take patients home upon discharge. When there are no family members, other informal supports, friends or neighbours, may be called upon. In John’s case, he was the only person with a key to his apartment, and he had no one in Victoria to ask for assistance. John seemed grateful for the assistance of the social worker. It is significant that both the hospital staff and John were surprised by the fact that he had no one in Victoria he could call on to assist with his discharge plan. There is an assumption by hospital staff that all patients have family or friends they can call on to provide practical or emotional support. Prior to his hospitalization John did not recognize the implication of not having a single person in Victoria he could call on to provide support. The linkage to volunteer resources started a support system for John so that at the time of his last hospitalization, volunteers were already in place to assist.

John’s hospital experience illustrates the need for control over one’s situation while in hospital. John did not have family members to act as advocates, gather information, or provide practical support during his hospitalization. What we have learned about John is that he is proud of his independence. He built relationships with hospital staff if they were willing to work with him rather than direct his care. John acknowledged the need to be on the same level with the nurses and physiotherapists rather than feeling that they were superior to him.

Carrie’s Story - “I have a hell of a time, still, asking for help”

I met Carrie as result of advertising my study with a volunteer organization which
works with senior citizens. The senior’s organization made Carrie aware of the study, and she agreed to participate. Carrie lives in an apartment in an assisted living facility, which is where she chose to meet with me. She leaves her apartment door unlocked at times if she is expecting a guest because she uses a walker and a portable oxygen tank and it does take her some time to walk to the door. The building has a controlled entry and Carrie feels safe in this setting.

My first impression of Carrie was that she is in poor health. Carrie remained seated but she welcomed me with a friendly smile. Carrie wears prescription eyeglasses. She appears to be of average weight. The noise of the oxygen and the nasal prongs she wears made it somewhat difficult to hear all of her words. During the interview I learned that Carrie is 65 years old. My impression was that Carrie appears older then age 65 due in part to her poor mobility and her respiratory condition. She has multiple medical issues including ulcers on her legs and decreased oxygen saturation. Carrie said she has eight chronic diseases but she did not give details on all of her health issues.

In order to understand how it came about that Carrie was hospitalized without family involvement, she described her family history. She has one sibling, a sister, who lives in the Gulf Islands. Carrie’s parents are deceased. Carrie described her experience of growing up in a home in which everyone avoided one another. She has very few memories of growing up with her sister and in retrospect she finds this "rather weird". As an adult, Carrie married an American citizen and lived in Texas. Her husband had teenagers from a previous marriage who she was helping to raise “that was wearing me out drastically. So when there was only one left, and she was almost 21, I bolted and said goodbye and came up here”. Carrie did not want her ex-husband or his children to be a
part of her life in Victoria.

Carrie has lived alone since her marriage ended and she left Texas, more than 20 years ago. She was living in her own condominium up until her last hospitalization. She tried returning to her own condo upon discharge from hospital but she was not able to manage. The senior's organization which provides support to her, assisted with a move to a short-term respite facility and then the permanent move to the assisted living facility. Her bachelor suite is small but she indicated that it is a good size for her because of her limited mobility. Carrie can call on the staff at the assisted living facility if she has a problem. She has her evening meal in the dining room at her residence. She also has regular visits from home nursing care to change the dressings to her leg ulcers.

The Experience of Hospitalization

What follows is Carrie's experience and how she coped as a patient without family involvement. Carrie required hospitalization to treat leg ulcers that were weeping and could not be managed by home nursing care. She was in the hospital for seven weeks. There were many challenges while she was in the hospital and she did not have any family members present to provide emotional or practical support.

After analyzing the transcripts from Carrie's interviews several times, I was able to separate Carrie's story into four parts. The first part is Carrie's struggle to ask others for help. This is an issue Carrie has had since she was very young, she learned that she did not want to ask her family for help. Carrie acknowledged that she has always had a difficult time asking for help, she would rather do things on her own. The second is Carrie's need to continually gain knowledge about her health issues so that she can make informed decisions about treatments. One of the commonalities between Carrie and John
is that they both have a desire to be knowledgeable about their own health issues. The third part is the importance of volunteers, both giving and receiving support. Volunteers have taken on many of the tasks that Carrie would ask family members to do if she had family present. Finally, is Carrie's concerns about the state of the health care system and the impact for herself and other patients.

I Have a Hard Time Asking For Help

It has taken Carrie a long time to realize that sometimes she has no choice but to ask others for help. Throughout her life she has tried to do everything on her own rather than admitting that she may need help. However, as her health has declined she has had to accept that she cannot do everything on her own. Throughout the interview with Carrie it was clear that she has a difficult time asking for help. Carrie could have had her sister present during her hospitalization but Carrie does not rely on her sister for support when it comes to her health. Carrie learned to be independent from a young age and it has been difficult for her to ask others to provide both practical and emotional support. She explained that the way she was raised has shaped the way she experiences life:

Well I was brought up to do everything right and alone, and do it right the first time, and all of that kind of shit that you carry with you. I have a hell of a time still asking for help, or asking people to do things for me. I'll try and do it myself several times rather than ask somebody.

Her difficulty in asking others for help extends to her family. However, she was not convinced that had she turned to them, that their presence would have been much help. She explained that she feels her experiences as a child did not prepare for being patient or developing coping mechanisms:
I was trying to avoid having dinner with my parents because that’s where I was used as a scapegoat for anything going wrong. I always felt like I was in trouble but I never knew what I had done. So uh that has nothing to do with being in the hospital but it does affect your outlook.

In the past, doing on her own has been a useful coping strategy for Carrie. Another coping strategy is her strong will. Carrie was able to articulate the difficulties of being a hospital patient, and the need to ask for help at times. She said the hospital experience is both physically and mentally difficult and that she had to have a strong will to manage:

It really is a downer to be in the hospital, mentally and physically. It just drains any will, especially when you are on all these drugs they give you. And they buy trainloads of morphine. They must, everybody is on morphine and uh there’s not much else that gets rid of the pain, but the side effects are hallucinations and nightmares. So that’s not too good. So it takes a pretty good stout will I think to be able to put up with once you get in the hospital for any length of time.

It was Carrie’s strong will and some assistance from others that got her through her hospitalization. Although it was difficult for Carrie to ask for help she did accept the support.

Patient As Expert

Perhaps consistent with her reluctance to ask for help, Carrie demonstrated a considerable effort to ensure she understood her health issues. She has read books on treatments, nutrition, and alternatives to western medicine. Carrie indicated that she has discussions with her doctors about all the options:
The ideal from my point of view would be somewhere in between the way medical doctors are trained today and the way the naturopaths are trained. Naturopaths go through five years studying. I mean it’s study and testing out, experimenting and all this stuff.

Carrie has been determined to keep treating her leg ulcers rather than considering an amputation:

When I came back from my December holiday last year (I went to Florida and the Bahamas), I had four ulcers on my legs. I went with two and I came back with four, all weeping and ugly looking. And that is when Dr. H at the foot-leg ulcer clinic said amputate. He didn’t think that it could be saved and I proved him wrong. But uh Dr. P, the surgeon, gave me a very very good rundown of what would happen. He just pulled up a stool and sat there in front of me and he started talking about having to cut it off above the knee and all this stuff. He said am I giving you too much information? I said no you haven’t, I need that much. It was a little too much so I went morose for a few days, and then I thought oh hell I’m going to have this leg longer than this. I don’t believe this. So this last year I’ve been struggling with it. We’re still working on it.

When the physician recommended amputation to Carrie, she disagreed with him. She did not view the physician as a part of her team. She refused to have the amputation. It is work for Carrie, the home care nurses, and the physicians to continue treating her leg ulcers. It takes her strong will, “I’m going to have this leg longer”, to carry on with the treatment and also the help of others, the team, “we’re still working on it” to prevent an amputation. Carrie acknowledged that the work of keeping her leg healthy is a joint
effort between herself and health care professionals. Her desire to do as much as she can
to maintain her health extends to nutrition. She explained that she tries to keep herself
healthy by eating well:

I eat goat cheese but I won’t eat cow cheese. You don’t know what they do to
the animals. Uh, well I have eight chronic diseases now. I don’t want anymore
of them, that’s enough for a lifetime. And uh therefore I get organic eggs,
organic cheese, goat cheese, and organic yogurt.

While in hospital Carrie had a difficult time meeting her nutritional needs:

Every time they seem for some strange reason or another, when I move from
one room to another they change my diet too. I became a vegetarian, I became
a post-operative with all this flat stuff, I don’t know if there is a word for it. An
uh getting nothing that is real for a whole week. I want to have some food …
So once I told the doctor, he said to somebody to have it changed. Finally I got
some protein. You need protein to heal. I wasn’t getting any protein at all and
uh next thing I know there is food in front of me. I’m a vegetarian all of a
sudden. I was getting things like cheese and things that I won’t eat.

This whole ordeal with receiving the wrong meals in the hospital was very difficult
because Carrie could not control the situation. She had previously educated herself about
the optimal nutrition for her health but her knowledge could not change the fact that she
was receiving the wrong meals. Carrie was upset that the hospital was not keeping track
of her needs. She needs to have control over the food that she consumes because she
believes it impacts her health and the eight chronic diseases that she already has. Carrie
expressed concern about the fact that the hospital does not know what foods are healthy
and good for patients:

I think yogurt is a wonderful, wonderful food. Its something that’s good for hospitals and they don’t even know that. People don’t have to chew it if they are having trouble with their oesophagus like I do, bad motility. Can’t eat certain things. That [yogurt] goes down beautifully with a fresh banana or something like that, you are getting all your potassium.

In 2003 the BC Ministry of Health changed the preparation and service of hospital food, by laying off hospital kitchen staff and contracting with foreign companies to prepare and deliver food to BC Hospitals. In Victoria, Morrison is the company that provides hospital food to patients. Many patients have their families bring foods which they find appetizing as they do not feel the food served in the hospital can meet their nutritional needs. Carrie did not have any family members to provide this type of practical support. Carrie was aware that she would need to bring in some of her own food, such as yogurt.

Carrie’s desire to become an expert on her own health has led her to a point of questioning the delivery of health care. Her hospital experience was challenging in terms of her nutrition but she did have the support of volunteers both emotionally and for discharge planning.

Volunteers - Redefining Family

Although it was hard for her, Carrie does accept help from others. During the two interviews with Carrie it became clear that volunteers are an important part of her life. Carrie herself was a volunteer for ten years. Carrie explained that she threw herself into volunteering in order to deal with her alcoholism:

I quit drinking in 1990. I was truly an alcoholic and uh that made quite a

47
difference to my life. I quit the drinking end of May. I got three volunteer jobs … and that kept me busy enough that I couldn’t go to the liquor store. And it is too expensive here anyway, you can’t afford it so I quit.

Carrie said she volunteered for 10 years. The people she met through her volunteer work then became her visitors when she was ill and in the hospital. Carrie explained that the visits were what helped her get through:

These people did come and visit every now and then, that seemed to ease the anxiety I had, and get me through that day or that week or whatever the situation was. I didn’t feel so lonely, like one visit from a person could last for three to four days.

Carrie suggested that being in the hospital can be difficult because of all the time one has to think about the present and the past. She acknowledged that she needs someone to listen to her thoughts and then have some reflection. Volunteers may be able to fill the role of "listener":

You can’t do it on your own. You have to get somebody to vent at who can see it from a totally different light…You can request a volunteer that you can talk with. Sometimes they will send you a social worker. Uh, I don’t find I can talk to social workers, that’s my prejudice but uh for certain if you are having surgery or no matter what your problem is, going into the hospital is one of the hardest things to do I think.

Carrie’s difficulty in asking others for help may explain why she does not feel comfortable talking to social workers. Carrie views the time spent with volunteers as more of a venting opportunity than an acknowledgement of needing help. There was a
loss of independence for Carrie in terms of giving in to the fact that she required hospitalization. She knew that she would not be able to cope on her own. Volunteers provided support to Carrie during her hospitalization, they also assisted with her plan for leaving the hospital, and they continue to support her at home. Carrie acknowledged the amount of time one particular volunteer was willing to spend “she certainly spends an awful lot of time on me. Hours and hours and hours”. Carrie explained that one volunteer in particular has become a friend, “I think we are more friends now than we used to be just a passing volunteer here and there”. The amount of time that the volunteer spends with her goes above and beyond what a normal volunteer might spend and as a result Carrie regards this relationship as more of a friendship. As well, the volunteer who Carrie regards as a friend was a support to her both during and after her hospitalization. In this way the volunteer may be considered to be like a family member.

During the process of planning her discharge from hospital, the hospital staff asked Carrie if she had arranged for care. Carrie indicated that the staff spoke only with her, they did not communicate with the female volunteer who was arranging to have Carrie move into a respite facility. Carrie said the volunteer:

Was the one who was doing all the phoning. The medical people, they were “have you got a respite place? Have you got a place to go?”. They just wondered so they could close that part of my file.

It is interesting that Carrie did not regard the questions of the hospital staff as their way of expressing concern for her in terms of where she would go from hospital. She may have been feeling as though she was a burden because she did not have family to help with her discharge plan, however she did not voice this. She explained that the hospital
staff did work with her in regard to the details of her discharge plan however, Carrie said communication was difficult because:

They talk quite fast which is typical, because older people talk a lot slower than young people do, so I really had to listen. "We’re going to try and do this and this and I’m going to give you some supplies to take home with you". And eventually it either gets done or is doesn’t.

The hospital staff did not communicate directly with the volunteer who was assisting Carrie with her discharge plan. It is unknown whether Carrie had indicated to the staff that she was relying on the volunteer to arrange her respite care. If Carrie had asked the staff to speak with the volunteer about the plan, they likely would have. Despite the communication issues, Carrie’s needs were met. Carrie was thankful and impressed at the work of the volunteer who assisted with her discharge plan from hospital, "It was pretty strange to have everything fit, like a jigsaw puzzle, but I can imagine the number of phone calls. She [the volunteer] does it because she knows people need help".

Carrie’s explanation of why the volunteer does the work that she does (because people need help) is significant. Volunteers give of their time for a variety of reasons. Altruism is one of the highest motivators for volunteers but there are other reason why people volunteer such as improving job skills and exploring their own abilities (www.givingandvolunteering.ca/, 2006).

The support, both practical and emotional, as well as the advocacy role of the volunteer who assisted Carrie, is much like the type of support patients often receive from family members.
Concerns About Healthcare in British Columbia

Carrie had a lot of concerns about the policies of the hospital and the state of healthcare itself. She was concerned that the nutrition needs of patients are not being met. She is also concerned about the current high demand for healthcare services, and the future state of healthcare with the aging baby boomers possibly requiring even more services. Carrie believes it is up to the government to acknowledge the pressure being placed on the healthcare system as the population ages. She however refused to take the blame for burdening the healthcare system. She explained that there are too many clients requiring healthcare services and not enough healthcare workers to meet their needs:

There are so many people here, that’s why our health is declining. And the services in the hospital have been declining too because there are too many people to spread it around. I don’t know what the answer to all this is. Hire more nurses? There aren’t anymore to hire apparently. Stealing from Alberta? That’s not very good.

Carrie has considered the larger issues of the healthcare system and how a shortage of healthcare services affects individual patient care. She seems to have gathered information from the media about the shortage of nurses and the possibility that they can be recruited from other provinces. Carrie gave a specific example of how she believes poor nutrition and understaffed hospitals results in health problems for patients. She said that patients develop pressure sores on their heals. She prepared herself for the fact that she was going to have problems with her heals:

Just very annoying to the patients not to get things done that are supposed to be done. Uh we all come out with bleeding heals or at least really really sore
heals because they don’t deal with anything like that. I know when I go I have to take a whole lot of lotion or Vaseline or something, and do it myself, they won’t.

The BC Ministry of Health has been preparing seniors for the current realities of hospitalization by making the public aware of the shortage of nurses, the shortage of hospital beds, and the shortage of Long Term Care facilities. Carrie lamented about the changes she has seen in hospitals and the fact that nurses do not have time to spend with patients:

Way back the nurses had time to chat with you. Now they don’t. You feel like you’re being neglected socially. It’s not their fault, it’s just that there are so many of us. It’s not the baby boom so much on the Island maybe, but there are so many people wanting medical things done, for them there’s not enough time. And there just seems to be a natural progression of one causing the other to fall down and be less than we expect. And people my age all remember how much more we had from the medical plan when we were younger.

Carrie feels that the fact that nurses do not have time to spend talking with their patients impacts their overall care. She makes it clear that she expected to have more interaction with nurses in terms of her emotional needs. Her physical needs were met but her psychosocial needs were not. The experience of hospitalization without family involvement for Carrie meant that her emotional support and socialization were provided by staff, fellow patients, and volunteers. For her, this need was poorly met.

As I was summarizing my thoughts on Carrie’s story it became clear that Carrie’s upbringing has influenced all aspects of her life including her experience of
hospitalization. Carrie has built a support network comprised mostly of volunteers who are available to her both during a hospitalization and when she is at home. Carrie has had very little choice but to become an expert on her own health issues in order to make informed decisions about treatment options. She was able to direct her own care during her hospitalization because she is informed about her health issues. She understands the dependence she has on the health care system and she has concerns about whether the services patients need will be available to all in the future. Carrie has learned that she needs to rely on volunteers to meet her emotional and social needs as hospital staff may not have the time to meet these needs.

Jane’s Story - “It isn’t the surgery I mind, it’s the hospital”

Jane became aware of this study through the volunteer agency which provides volunteer support to her.

Jane invited me to meet her at her apartment. She opened the door for me while using a cane to steady herself. My first impression of Jane was that she was very put together. She was wearing a colourful dressing gown, and her long hair was neatly pinned up. Jane had her makeup on and she was wearing her eyeglasses. She is a very petite woman. My first impression of Jane did not change throughout the interviews, she has always taken pride in her appearance and the way that she presents herself. She showed me a picture of her younger self and she lamented about the way in which her appearance has changed as she has aged.

Jane lives in a seniors subsidized housing complex. It is a secure building and Jane had to buzz me into the building. She lives on the ground floor level which works well for her and her cat. There is an outdoor patio which she has fully enclosed so that
her cat can spend time in the fresh air without escaping. Jane's one-bedroom apartment is not very large. She has many decorative possessions and unique furniture. The apartment feels quite crowded and there is not much natural light.

During the time I spent with Jane I learned that she is 81 years old. She is an only child. She was raised on Vancouver Island. Jane married an American man and lived in Indiana where her husband was a psychology professor. She divorced her husband and returned to Canada during the 1960s. Jane had a variety of occupations including optician, interior designer, and owner of a clothing store. She did not speak much about formal education, it seems she learned her skills while working.

Jane has lived alone for many years. She indicated that she lost some of her savings in the stock market and had little choice but to move into subsidized housing. There are no services in her apartment building but Jane has found the managers to be very helpful. She discussed her wish to live in a different area of the city but feels where she is currently is affordable.

Jane seemed pleased to have company and someone to listen to her thoughts on her hospital experience. She said that she enjoys having "intelligent" conversations and she has found that conversations with people who are working, or are educated tend to be the most interesting conversations for her.

Jane has been dealing with her health issues for several years now. She was having a lot of pain from her teeth which hindered her ability to eat. Eventually she had dental surgery to remove her teeth but her dentures do not fit properly and eating is still a concern. During the time that she has been dealing with her teeth, she had a fall and fractured her hip. Jane's hip fracture was in 2003, she spent time in the hospital healing
after surgery and since then she has used either a walker or a cane for mobilizing. The hospitalization experience Jane describes in detail for this study occurred in 2004. She had an emergency admission to hospital for a gallbladder attack. She has home support on a regular basis to assist with meal preparation and some personal care. Jane has some assistance from a volunteer organization in terms of getting out to appointments.

The Experience of Hospitalization

Early on in my first interview with Jane it became apparent that she is very good at describing her experience. She described, in detail, feeling unwell for several months and that it culminated in a major gall bladder attack that required hospitalization, her description is as follows:

Every two to three months to start with and then it got to be every two to three weeks, and uh then it got to be every two or three days, and I'd have sort of a nasty sharp pain and usually it was after I'd had supper. I'd get up and go to the bathroom and make myself upchuck, and the pain would go away. But the night of the big bang, I did the upchuck thing but the pain did not go away. And when it came time to face the fact, I was just plain scared and I was shaking. I was shaking so much my bed was shaking, and I don’t know if it was before or after I was sick that I managed to pick up the phone and dial 911.

Jane did not have any family she could call to help her and so calling the ambulance was the best way for Jane to address her medical emergency.

I have divided Jane’s story about her hospital experience without family, into three parts. The first part is Jane’s need to have hospital staff spend time with her in order
to feel cared about. The second part explores the gaps that exist in Jane’s support network. The third and final part highlights the concerns Jane has about the current state of the health care system. There are some similarities between Jane’s experience and Carrie’s experience, and John’s as well. Jane has been a very independent person much like John and Carrie. However, Jane does experience feelings of loneliness and dissatisfaction with her current situation whereas John and Carrie do not.

Time Equals Care

Jane was mostly appreciative of the nursing care she received in the hospital. She was concerned about the lack of time the nurses have, “there were two nurses that were gentle and pleasant. Sometimes they didn’t have time but at least they were pleasant and they did their job“. Jane was pleased that her physician came to see her everyday but she expressed her concerns about the hospital staff:

The hospital itself is understaffed. The girls are running around like nuts and they don’t have time. Sometimes, occasionally they’ve either got, or they make time to talk to someone but it’s not very good. When I had a store, one of my customers was a surgical nurse, this is at the old General. She quit because she had a heart and she couldn’t use it. She was allowed to use her hands and her feet and do medications but some of the patients were very down either with pain or depression, or both. And the fact that she could not care was getting on her nerves and she quit. And that was a senior nurse on the surgical ward.

It was this lack of “time to care” that dominated Jane’s experience. Jane said that patients can expect that the nurses will not have time for them. Jane said if she was helping someone else without family through the hospital experience, she would say:
Expect to be neglected because the nurses are just too occupied someplace else to get in when you need them. Expect to be put in a room where you might have a man in the room as well as a woman. Expect the food to be slop.

I asked Jane to explain more about the nurses spending time with patients. Jane said that some of the nurses will visit with patients when they have time but others are too tired to visit even if they do have a few moments. Both John and Carrie also discussed the lack of time that nurses have to spend with patients. The time that nurses spend with patients seems to be what Jane and Carrie both appreciate as they felt cared about when the nurses do more than just medical care.

Gaps In Jane’s Social Support Network

I was impressed several times by Jane’s ability to tell it like it is. Jane was very matter of fact about the reason that she did not have any family involved during her hospital experience, “I have no children, I have no parents, I have no brothers, I have no sisters, and my friends are all dead”. Jane feels quite alone. She does have a social support network including the volunteers who visit her, as well as the socialization she receives at an adult day program, home support workers who provide personal care and assist with meal preparation, and several younger friends who also visit and drive Jane to appointments. However, Jane recalls the past when she was managing a clothing store and had many interactions every day. She laments about her current situation in life, “now I’m nothing. I have lost $65000 which is all I had so that’s why I’m living in this dump. It is a dump, it is a part of Victoria I never would have chosen to live in”. Jane is dissatisfied with her socioeconomic status. She does not socialize with her neighbours.

Jane received support from her landlady in the form of caring for her cat while
she was a patient in hospital. Jane was also delighted to find that her apartment had been cleaned when she came home from the hospital, “when I came home nearly two weeks later my room was cleaned, my bed was changed and ready. It was even turned back so I could get into it. My landlady did it”. Jane’s landlady filled a role that is filled by many patient’s family members, providing care to her pet and preparing her apartment for her return home.

In terms of the volunteer support Jane receives she feels dependent on the volunteer drivers but she also feels limited by the service, “I need them. I have to see my doctor every two weeks. I am getting to know some of the drivers. You have to arrange everything. You can’t just spontaneously go do something because you can’t do it”. So although these services fulfill an important function in her life, many of her needs remain unmet. Jane feels that she needs to be able to access a service that can respond to her needs quickly.

Concerns About The Healthcare System

Jane had many concerns about the conditions of the hospital and the workload of the nurses. Jane indicated that she holds the government completely responsible for uncomfortable beds and overworked nurses. When describing her hospital experience Jane said:

All I was really wishing for, more than anything else, was a decent bed. If I ever have to go in for a long time I might ask if I can have my own bed delivered to me. God those beds are unbelievable. And one male nurse came in and I felt guilty about asking for a nurse to come because I know how busy they are but I just couldn’t stand it any longer.
Despite the fact that the nurses had little time for her, Jane has empathy for the nurses and their workloads. Her feelings of guilt about asking the busy nurses for help is significant. She believes the government is accountable for purchasing the cheapest beds, as well as the shortage of nurses. However, she did not acknowledge that the government is also responsible for making her feel guilty for asking for the care that she requires.

Jane was very dissatisfied with the hospital system in terms of her discharge plan. Jane explained that there was not much planning for her hospital discharge, “well when they told me they were sending me home, they didn’t ask me or tell me in advance”.

The events of Jane’s discharge day were quite disorganized. She had been told that she should arrange a ride for 2:00pm:

In the meantime though they brought the lunch trays up, not that they were all that interesting but it was food anyway, but they didn’t bring one for me. I was already listed as being out, at lunchtime. So it took nearly two hours for them to get me something to eat.

Jane’s friend who had previously agreed to pick her up when she was ready for discharge was not given enough notice of her discharge and he was not able to come to the hospital to get Jane until after he finished work at 5:00pm. “Which meant I had to stay in the hospital and they wanted to get my bed”. Jane said she was “angry” with the hospital system in terms of her discharge plan and the idea that they needed to move her out so they could receive another patient into her bed. “I was damn angry. I don’t think that Campbell [provincial premier] would be alive if he came to my ward at that time”. Jane’s statement implies that she feels that the premier is responsible for the “push” to discharge patients. Jane felt that she was causing inconvenience to her friend as she did not receive
sufficient notice of her discharge date. Jane had to rely on her friend to pick her up and as a result she had to work around his schedule. Jane is used to being alone and not having family to provide practical support but as her independence declines the impact of having no family becomes more apparent.

In summary, I found that Jane’s hospital experience was similar to both John and Carrie in terms of their concerns about the lack of time that hospital staff have to spend with patients. While John and Carrie seemed to feel that they were in control of their hospital experience, Jane did not seem to experience a feeling of control. Jane did have an emergency admission to the hospital whereas John’s admission was planned and Carrie’s was related to her chronic health condition. Jane felt that she should not make her needs known because the nurses were too busy. She also felt that there was disorganization around her plan for going home. Jane felt that the hospital dictated her discharge plan rather than involving her in the planning. Jane acknowledged that she does not feel that her support network meets all of her needs, and that she feels alone at times. Jane seems to be missing the support that family members may provide. Jane is angry about the current state of the health care system and she holds the current government responsible.

Ann’s Story - “I think you have to have a positive attitude”

Ann volunteered to participate in this study after she saw the advertisement I had placed on a community bulletin board. She contacted me and said she would like to participate. Ann and I were neighbours and she indicated that she wanted to help me with my studies. Ann herself is a UBC graduate.

I had developed an impression of Ann long before I interviewed her in regard to
her experience in hospital without the presence of family. Ann and I were neighbours and
we had been friendly due in part to the fact that we both have dogs. My impression of
Ann is that she is a resilient woman. On the day that we met Ann was doing quite well
physically but I had seen her quite frail and needing to use a walker on previous
occasions. She explained that her chronic disease has many ups and downs and some
days she is very weak. Ann is a tall, slim woman in her late sixties.

I met with Ann in her condominium which she owns. Ann has a dog and a cat
which are very important to her. Ann met me at the door and welcomed me into her
condo. It is a lovely suite with plenty of space and light. Ann tries to keep active. She
takes her dog out for walks daily if she has the energy. If Ann does not have the energy to
take her dog out, a neighbour whom is also a good friend of Ann’s will walk her dog.

Ann has never married and she does not have children of her own. Ann had a very
good relationship with her mother who is now deceased. There are no siblings. Much of
her life has been spent in Vancouver and Victoria. There are no extended family
members in Victoria.

I find Ann a very pleasant person to be around. She expressed a wish to be helpful
by participating in this study.

The Experience of Hospitalization

Ann was hospitalized in order to remove her spleen. Ann was aware that her
spleen was enlarged and she knew that she would require surgery to remove it at some
point. She was on a waitlist for the surgery however when her condition worsened she
had an emergency admission to the hospital in order to have the surgery quickly.

Ann’s hospital experience was similar to Carrie’s experience in that she went into
hospital for treatment of a chronic condition, she had support from her social network, and she did not feel that the presence of family would be a help to her during her hospitalization. I have divided Ann’s story into three parts. The first part is a description of Ann’s wish to not have anyone worry about her when she was in hospital. The second part, similar to Carrie and Jane, is Ann’s concern about changes in the health care system and particularly the fact that nurses do not have time to spend with patients. The final part that stands out in Ann’s story is her positive attitude about her hospital experience, and life in general. Ann acknowledges that she feels lucky to have her support network.

Ann’s most recent hospitalization was for a scheduled surgery to remove her spleen. Ann had to wait several months to have surgery as her condition was not considered a priority until her enlarged spleen began to put pressure on one of her kidneys. Ann described the experience of waiting about two months to have her surgery:

I think being at home is the hardest part because if anything happens you don’t know what to do. And it is very painful getting in and out of bed, and I had a walker. And so you feel more vulnerable at home. I don’t think they ever tell you how long it is going to take. You think you are never going to get better. And looking forward to it too. You are nervous going in, thinking about it. You just want to get in and get it over with. I think they decided in late August that I had to have surgery. Lets see I only had to wait about two months. I had the operation in, it must have been October. And I was told at the time by the surgeon that they take cancer patients first but I would get in as soon as possible. So I always wonder when they say they have these long waiting lists what’s going on, if you need it you get in.
Ann’s description of waiting for surgery seems to indicate that she was nervous but also pleased that her wait was not too long. When her condition worsened, she became a priority for surgery.

I Didn’t Want Anyone to Worry About Me

Despite being on a waitlist for surgery, and thus having time to prepare mentally for the procedure, Ann’s surgery itself was not without complications. Ann explained that she haemorrhaged after surgery and she had to be taken back to the operating room to stop the bleeding. “Now the doctor, when I did haemorrhage, he phoned Sally [Ann’s friend] because I gave her as my reference, and he told her what was going on but uh I found this out later”. At the time that Ann was having post-operative complications she was not well enough to contact her friend herself. This is an important aspect of Ann’s hospital experience because she did not have any family members for the physician to contact. Ann indicated that she felt that she was in control of her experience in the hospital for the most part but when she was very ill after surgery she was not in control. “I can remember they put something on my head but that was all, I was kind out of it”. Ann acknowledges the fact that she was not always aware of what was happening during her hospital experience but she did not seem bothered by this.

Ann spoke of the fact that she is a single child and her parents are deceased so she does not have any family in Victoria. Ann explained that it did not bother her to be a patient in the hospital without the presence of family:

My mother died just shortly after we came here so there was no one really.

And luckily the people in this building [referring to her condominium building] are very good and they looked after me and took Pepper [Ann’s dog]
for walks, so it was alright that way. But as for not having family, it didn’t bother me. I didn’t have anyone worrying about me.

While Ann did not have family present during hospitalization, she did have her neighbours to rely upon. Ann may have had a very different hospital experience without the support of her neighbours.

Ann explained the worry that she felt when her mother was a patient in the hospital after she had a stroke, “she could talk but she um I remember asking her are they taking good care of you? She said oh she said wait til I get out of here I can tell you a few things. And I thought that doesn’t sound good”. Ann indicated that the fact that she did not have family meant that family did not have to worry about her:

If you have a big family they can look after each other but if you’ve just got one or two, and I think they would be worried, and especially out at Victoria General. It’s hard to get to from here. If you have family that do not drive that’s another worry.

The support that Ann received from her friends who also happen to be her neighbours was not unlike the type of support a person may receive from family members. Ann did not comment on whether her friends worried about her during her hospital experience.

Concerns About The Healthcare System

Ann had some expectations about the type of care she would receive from nurses based on past experiences. Ann was somewhat disappointed in the lack of assistance she received at some points during her hospitalization:

I think the nurses probably have too much paperwork to do, they’ve lost the art of bedside nursing. I guess they have to have degrees today to get
anywhere. I think that’s a shame because sometimes you just need tender, loving care. At one point I told my surgeon, I said I didn’t know whether to cry or get angry but I decided to get angry. And just sometimes silly little things that bother you, not being able to reach for something, the off-hand manner of some nurses. However, they get you up and going. I don’t know if it is intentional but it works.

Ann explained that she told her physician that she learned that she would have to do much of her care herself:

One doctor came all the time and to make sure everything was ok, and he’s the one I told that it is a do-it-yourself hospital. Um, sometimes it was hard, at one point I wanted a walker so I could walk the halls and I kind of waited for quite a while to get it which didn’t help me any.

Ann was expecting some emotional support from the hospital staff as she refers to the need to have someone hold your hand at times. However, she had greater expectations in regard to receiving practical, or hands on assistance with tasks such as mobilizing and bathing. Ann’s expectations were not always met and she explained the “do-it-yourself” aspects of her hospitalization:

You are left alone a lot which you know I can understand because they are busy. But if you, actually in some cases, there was one male nurse who the other nurses said would not make beds. If you wanted your bed spread out you just made it yourself. Things like that, um getting slippers, you would get them yourself and really any tidying that you wanted done you did it yourself.

Ann may have benefited from having the practical support that family members often
provide to their loved ones the in hospital. Amy Freeman’s (1999) study on the hospital experiences of elderly women found that the participants all relied on family members for help with many aspects of care including help with bathing, mobilizing, and fetching items such as slippers.

Ann expressed some concern about the amount of time nurses spend doing paperwork. Ann felt that the nurses had to spend a lot of time at the nursing station writing in charts. “I think the nurses, during quiet time are doing all their book work and I guess its so much book work and not much individual patient care. I guess it is necessary for their protection to write everything down”. Ann expressed concern about the fact that she could see the nurses charting much of the time and the fact that they were “conspicuous” made her feel that they were not providing care to patients. “All I can remember is they seem to have these binders that they were always filling with notes and I thought that’s all they seemed to do, and I guess it is important”. Ann acknowledges the importance of the charting nurses do but she regards it more as a means for the nurses to protect themselves, than as a means of recording the patient’s condition.

Ann explained that it is important to have a certain amount of motivation to heal, and to be independent, but also to have enough support from hospital staff:

You don’t want to be cosseted, you’ve got to have a bit of fight in you but at the same time you want people that are gentle and caring, which is important. Um not that you want them to do everything for you but if need help its nice to know [the help is available].

A Positive Attitude

Ann’s ability to remain positive despite the challenges she faced during her
hospitalization was impressive. When asked about this, she acknowledged that her attitude helped her to cope during her hospitalization, “I am, I have very positive feelings. I never felt any feelings of poor me or anything like that. It’s just one of these things you have to go through”. Ann’s positive attitude was also related to the trust she had in her physicians. Ann said the surgeon visited her and made her feel at ease, “Just knowing he was there I trusted him so much. I knew that I was well taken care of. Yeah and he was very clear it would take a good three to four months to recuperate”. Ann was also pleased with her haematologist who she had been seeing for some time and had recommended that she have surgery:

The haematologist came in and of course she is so upbeat anyway. You know she is the type that she has so many patients who are terminal that you just have to try and tell them the best. And she would come in “everything is fine, its just the way it should be” and she would breeze off again, and that makes you feel good too.

For Ann, having her friends caring for her pets was the best form of support:

They all took Pepper out, and that was my main concern when I was in the hospital, what was I going to do with Pepper, and Sam, my cat had to be fed. She was under the bed all the time but Pepper really needed to be taken out and Sally made all the arrangements. I have a good friend in her. And she had it all organized who was going to walk Pepper and when. And then she came down and had her dinner with Pepper when I was in the hospital. So it was really good that I did know people here. I’m sure in some places, I came from Vancouver, I wouldn’t have had the same help there, in the condo there.
Ann’s community within her condo building was a great support to her. She felt prepared for her hospitalization and she knew that she just had to have the surgery and move through the recovery phase. Ann attributes some of her ability to cope to being lucky:

Even now I get this muscle where I lose a lot of strength in my muscle and I have a hard time walking but I know its going to go away so I don’t mind. My life is organized. I have things in the freezer, and I know that if I can’t get out to walk Pepper I’ve got friends who will. But I like to do it myself because it is good to get out. So yeah I think you have to have a positive attitude, its not something phoney I have manufactured. I think some people have it and other people don’t … I am very lucky.

Ann feels prepared to deal with whatever life hands her as she is comfortable with the support network she has built around her.

In summary, I found that Ann’s experience of being hospitalized without the presence of family has similarities to the experiences of John, Carrie, and Jane. Ann is concerned with the state of healthcare system. I found her statement about the “do-it-yourself” hospital to be particularly poignant. Ann’s hospital experience made her realize that if you as a patient want something done you need to be prepared for the fact that you might have to do it yourself. A striking difference between Ann and Jane are their attitudes and how they affect their lives. Ann tends to see the positive side of her situation and she has built a supportive social network around her. Ann does not want anyone to worry about her. Jane on the other hand is somewhat dissatisfied with her current situation and she does not feel that her social network meets all of her needs. One factor that all of the participants have shared is the need to be independent. Ann has spent years
maintaining her independence and she is pleased that she does not have to rely completely on others even when her health is very compromised.

Diane's Story - “Be as cooperative as you can be, and as friendly as you can be”

Diane was made aware of this study by her friend who had seen the study advertisement and knew that Diane fit the criteria of the study. When I first contacted Diane via telephone she indicated that she was willing to participate in the study but she was concerned that she may not remember all of the details of her hospitalization as it occurred four years ago. I assured Diane that it would be helpful to hear about all that she does remember about her experience of hospitalization.

Diane invited me to meet with her at her condominium in Oak Bay. I was somewhat surprised when I first met Diane as I was expecting to see a woman in her eighties who has compromised health. However, Diane appeared to be in good health. She was neatly dressed and her grey hair was styled. Diane was wearing eyeglasses. She is quite slim but not underweight. She does not use any mobility aids.

Diane welcomed me into her condo and we set up the tape recorder at her dining room table. Her condo is very clean and tidy. It is a spacious condo which she moved into after her husband passed away in 1981.

Diane was born in the UK. She and her husband also lived in the United States. Diane was married for many years and together she and her husband had two sons and a daughter. Diane's daughter lives in Saskatchewan, her sons both live in the United States. Diane and her husband moved to Victoria in 1979. Diane does not have any family in Victoria. Her granddaughter was living in Vancouver at the time of Diane's hospitalization but she has since moved to Alberta. Diane's daughter came to Victoria to
assist Diane at home after her hospitalization. There is a close relationship between Diane and her daughter. Her daughter plans to retire to Victoria in the near future and Diane is very pleased about this upcoming move.

The Experience of Hospitalization

Diane’s hospital experience was the most unexpected and likely critical of all of the participants in this study. Diane and Jane both had emergency admissions to hospital but unlike Jane, Diane did not have any symptoms of illness prior to the day of the emergency. On the day Diane went into hospital she woke up feeling unwell. She had symptoms of indigestion, but felt that something was off. Diane explained that she called her neighbour to let her know she was not feeling well:

I live alone so I phoned my neighbour downstairs, my friend, and asked her to keep an eye on me because I wasn’t, I thought I had the flu. She came up right away, took one look at me, and took me to the hospital.

Diane recalls that she was assessed very quickly and found out that she was having a heart attack:

The emergency room was full. I must have looked terrible because they took one look at me and they put me in the last bed they had in the emergency. And it was a heart attack but I didn’t know because I hadn’t had one before. And I was kept there overnight because there were no beds available which I think is still the case, and uh the following morning they sent me out, this was at The Jubilee. They sent me to The General because they had a bed there. And that night they sent me back to the Royal Jubilee for some tests, you know they wanted to see what my, whether my arteries were plugged. And they weren’t
too bad because they got me in time as they said.

Diane seemed very matter of fact when she explained the process of having her heart attack diagnosed and the treatment plan. She did not seem to be bothered by the fact that she was shuffled back and forth between hospitals in order to receive the treatment she required.

I have divided Diane’s narrative of her hospital experience into three parts. The first part is the importance of her social network. Diane revealed that she knows how important it is to have relationships with others when family members are not present. The second part is Diane’s belief in the importance of working with the hospital system. Diane believes that patients have a responsibility to work with the hospital staff in order for one’s needs to be met. The final part is the idea that luck is a factor in the hospital experience. Diane believes she was lucky to have had the care she did and that the damage to her heart was minimal because she was lucky to receive quick and effective treatment.

**The Importance of a Social Network**

It became clear very early on in Diane’s narrative that friends are quite important to her. It was a friend who determined that Diane needed to go to the hospital. It was a friend who contacted Diane’s daughter in Saskatchewan to let her know about Diane’s hospitalization, and Diane’s friends were available to her both during and after her hospitalization.

Due to the fact that her daughter was quite a distance away in Saskatchewan and having her own responsibilities there, Diane’s daughter did not get to Victoria until after Diane went home from hospital. Diane did not have concerns about the fact that she did
not have family present during her hospitalization. She felt she was well cared for by the staff. Diane explained that her daughter may have been more at ease had she been present during Diane’s hospitalization, “I think she might have preferred it, you know feeling she was around. No I was well looked after”. Diane explained that it is more difficult to be at home without the presence of family than it was to be in the hospital without the presence of family:

**Living alone when you reach a certain age, it can be scary at times. I keep a cell phone by my bath because you know you hear of a few people falling in the bath not being able to let anyone know.**

This concern has contributed to Diane’s decision to make a move from living independently to an assisted living residence. Diane described the new assisted living residence she is planning to move into which will provide a sense of security, and will also provide assistance with meals and cleaning, and socialization. The socialization aspect is not as important for Diane as she already has quite a social network through her involvement at a seniors centre.

Diane discussed her involvement in a seniors centre and the benefits of joining but also the effort it takes to get out and meet new people and participate. “I think I have always been fairly independent, its ability to meet other people and to put yourself in the position, you have to join clubs and classes”. Diane realized after her husband died that she needed to be around others rather than always being alone. Diane explained that she joined the seniors centre to have socialization.

Diane explained that she did not expect support from the seniors centre during her hospitalization but they did provide some practical support, “its always been a support
with my being alone, but not for my heart attack. Except for one or two of the men who
drove my friends you know to see me and things like that". Independence is important to
her but making friends at the seniors centre is also important. Diane explained that she
has never really had difficulty getting out and socializing but she realizes that it is a
challenge for some: “I have always been a social creature, I will talk to anybody, drive
them nuts! But uh, no you have to make the effort”. She is aware of the fact that seniors
who do not get out and socialize may feel alone, and that they will not have the support
system around them that is needed during a crisis such as a heart attack. Diane identified
that it is her responsibility to create a support network for herself.

Diane’s development of a social network has been gradual and progressive. She
was quite young when her husband passed away. At that stage in her life, without the
presence of family in Victoria, she realized she needed to develop relationships with
others. Throughout the years she gradually developed a strong social network. Diane did
not want many visitors during her hospitalization but she knew her friends would be
supportive both during and after her hospitalization. In this way Diane’s experience of
hospitalization may be different from a person who recently lost a spouse and does not
have any other family present. If seniors do not have a social network in place a medical
crisis could be very difficult both emotional and practical ways.

Working With the Hospital System

Diane did not have the same concerns about the shortage of nurses and the lack of
time nurses have to spend with patients, that the other participants had. Part of the reason
Diane felt that she had sufficient care may be due to the critical nature of her illness.
Diane was in the cardiac unit in which the nurse to patient ratio is generally one-to-one.
Diane was in this unit for close monitoring until two days before she was discharged from hospital. Therefore, Diane did not have nearly as much time in a four bed ward as most of the other participants in this study had. Diane made it clear that she does not feel the nurses are responsible for problems with the healthcare system: “The care was good, it’s the government stepping in with withdrawing things that is the problem”.

While discussing the care that she received, Diane explained that she was not adversely affected by cutbacks in the healthcare system but she has learned from the media that others are affected, “Well its getting worse isn’t it? The line-up is getting bigger because they are cutting down on the staff I gather. And uh I don’t know firsthand, I’m just going by what I read and what I hear”. Diane believes there are ways in which people can receive the treatment they require:

You know I have visited people since then [the time of Diane’s hospitalization] and it seems to be good care. The difficulty is getting into hospital and having to wait for months and years even, people that need a hip transplant, or a knee or anything like that. But I found the best thing is, a man I know at the centre, he was out that day you know when we had the ice. He shouldn’t have been because he was limping, and fell and broke his hip. And they took him right in the hospital and gave him a new one when I know other people have been waiting for 18 months for that surgery. So my advice is if your hip is bothering you go out and break it!

The advice Diane gives about doing what is necessary, such as breaking a hip, to get the treatment that is needed is significant. Seniors are now accepting that extreme measures may have to be taken in order to receive healthcare in a timely manner. Diane’s beliefs
about the current state of the healthcare system are based on her own experience, as well as what she has learned from both the media and other seniors.

It Was a Matter of Luck

Diane used the word “lucky” several times when she was describing her hospital experience and the fact that she received a very quick diagnosis and treatment. When I asked her about the use of the word and her feeling of being lucky she explained, “they thought they got everything in time without too much damage being done because of my friend taking me there. So I was lucky that way because I never thought of a heart attack”. In retrospect, Diane said she could have known she was having a heart attack because she knew she had risk factors:

I’ve always had high blood pressure and high cholesterol. Don’t ask me why,
I’ve never been a, I think I inherited it from my mother who had a series of strokes. But I presume she had it but in those days, she died in 1961, they weren’t, I don’t think you could take any medication for it.

Diane seemed to be very matter-of-fact when reflecting on her family history of heart disease. Diane recognizes that she may not have survived her heart attack if it were not for current treatments and medications.

Diane explained that due to her circumstances in the hospital she did not really want many visitors:

I felt supported but in the hospital I don’t think you really want it very much. I was in sort of a cubicle which was like my own room. And I had my own bathroom there, well a toilet and washbasin. And there was just a curtain on the door, you know what I mean? The staff were out in the hall with all these
little things. But I didn’t really want much in the way of visitors, I had one or
two close friends.

Although Diane did not want many visitors when she was in the hospital, she felt she was
lucky to have the support of her friends during her hospitalization. She acknowledged
that it is important to know that friends are able to visit when there is no family present.
Diane explained that she had more visitors and assistance after she went home from the
hospital than when she was an inpatient:

I had friends that came, not too many. I had more come afterwards when I got
out of the hospital because they don’t like interfering, I think is the word.

When I came out they gave me support, they drove me places and things like
that. It was very nice.

Diane’s strategy for coping with her hospitalization was mainly to do what was
recommended by the physicians and nurses, and to concentrate on regaining her strength
after a heart attack that she did not expect, but took in her stride. Having her friends visit
was an added support for Diane.

I found it interesting that Diane described herself as being lucky to have had good
and efficient care. Other participants in this study did not describe themselves as “lucky”.
The expectations Diane had about the care she received in hospital may have been low. If
she made few demands she would not be disappointed. Based on Diane’s description it
seems that her care needs and emotional needs were met by the hospital staff, and in this
way I, too, believe she was lucky.

In summary, I was impressed by Diane’s calmness about her health crisis. She
was distressed by the fact that her daughter was not present during her hospitalization.
However, I do believe that Diane’s experience was unique from the other participants in this study because of the fact that she received one-to-one care for the majority of her hospital stay. When the ratio of patients to nurses is high, often it is five patient to one nurse, the ability of the nurses to meet the expectations of all patients is diminished. The other participant all had concerns about he workload of the nurses.

There are aspects of Diane’s story that are similar to those of Carrie and Ann, but are quite different than those of Jane. Diane was quite clear that people who live alone and do not socialize are more likely to be lonely and will not have the support they need if they have a crisis situation. Carrie agrees with Diane and has included volunteers in her social network. Ann also recognizes the importance of having friends and neighbours to help her with pet care and emotional support. Diane is somewhat unique in her belief that patients need to be cooperative and friendly with hospital staff. Other participants may also believe in meeting the hospital staff half-way but they did not verbalize it in the same way as Diane. In fact, John, Carrie, and Jane verbalized their concerns about unfriendly hospital staff and the fact that it made them feel less cooperative. However, all of the participants recognize the stress that hospital staff, specifically nurses, encounter in their current work environment. Finally, the issue of luck was raised by Diane. She felt she was lucky that her friend brought her to the hospital when she did and that she received timely and effective treatment. Similar to Diane, other participants such as Ann described themselves as lucky in terms of their support networks. However, Diane was the only participant who believed she was lucky to receive the care that she received in hospital.
CHAPTER 4 THE HOSPITAL EXPERIENCE - A SUMMARY

There are both differences and similarities in the narratives of John, Carrie, Jane, Ann, and Diane. They are all very unique in their histories and their health issues. They are all caucasian and all of them were born in either Canada or the USA. They have a range of socio-economic backgrounds but now they all live in Victoria, and they all live alone. None of them have family in Victoria, and none of them had family present when they were hospitalized. All of them rely on a public health care system to meet their health needs. All of them have a degree of independence and autonomy. All five of these patients “made the best of it” in a “do-it-yourself” hospital. All five of these participants expressed their concerns about the state of the healthcare system in British Columbia.

John, Carrie, Jane, Ann, and Diane, all spoke about the dedication of nurses, the workload of nurses, and the belief that the time nurses spend with patients is directly correlated with the care that nurses provide. This study seeks to answer the question: What are the experiences of persons 65 and over who have been hospitalized without family involvement?

There are three overarching themes that provide answers about the experiences of the five participants in this study. The first theme is the personal impact of systemic limitations in regard to nursing shortages. The second theme explores the fact that despite nursing shortages the participants made the best of it. The final theme is the “do-it-yourself” hospital, the strengths and limitations.

Systemic Limitations Play Out At The Personal Level

All of the participants in this study expressed concerns about the state of the healthcare system. They are all very concerned about the high demand for healthcare
services and the shortage of hospital staff. However, their largest concern by far was the impact that this high demand and shortage of nurses, has on the care that patients receive. It became evident early on in the interviews with all of the participants that they see the physicians as the experts and as the people who have the treatment plan but it is the nurses who provide the bedside care. Therefore, the nurses receive the most credit, and also the most criticism. As a social worker, this study is by no means meant to critique the care that nurses provide to hospital patients. It is a fact that nurses are present and provide support to patients 24 hours per day. There is no other group of professionals who spend that much time with patients. It became very clear that the other medical professionals did not stand out in the hospital experiences of these participants in the same way that nurses did.

The participants in this study have seen changes in the healthcare system. Many of them reflected on a time when nurses were able to spend more time with patients. Systemic limitations around nursing shortages play out loud and clear at the personal level. Overall, the participants in this study indicated that the amount of care nurses provide is determined by the amount of time they spend with patients. Carrie, Jane, and Ann all felt that they were somewhat neglected by the nurses. The ways in which each interpreted this “neglect” varied. Carrie felt that she was socially neglected because the nurses did not have time to stop and have a conversation with her. However, Carrie acknowledged the workload of the nurses as a reason they do not have time to spend caring “the nurses do everything you know, and they are so over worked, terribly overworked”.

Jane also expressed great concern about the nurses lacking the time to spend
talking with patients. Jane believes that nurses likely have lower job satisfaction because they do not have the time to spend getting to know patients. An American study examining the perceptions of Registered Nurses and nursing students supports Jane’s belief (Buerhaus, Donelan, Ulrich, Norman, Williams, and Dittus, 2005). This study found that nurses feel that nursing shortages create problems with the quality and safety of the care that patients receive. As well, nurses believed that shortages made it difficult to maintain a patient-centred model of care in which the values of the patient guide the clinical process (Buerhaus et al., 2005). Jane was also concerned about the fact that the nurses were often out of her ward and so because she could not see them she felt physically neglected. Jane stopped asking for help because she did not want to “bother” the nurses.

Ann did not seem to have a problem asking for help but she acknowledged that just because you asked did not mean your request would be fulfilled in a timely manner, for example, it took a long time to receive a walker after requesting it. Ann realized that she would have to do many aspects of her care herself. Ann was concerned about the amount of time nurses spend charting and how obvious it is that they are spending time writing notes when they could be spending time with patients “all I can remember is they seem to have these binders that they were always filling with notes and I thought that’s all they seemed to do”. As nursing has evolved so too have practices and the emphasis on accountability. In fact, nurses have to learn how to document patient care using strict procedures as outlined by their employer and their union. Charting, or documenting, is an important aspect of patient care for both nurses and patients. Nurses can be held liable for inadequate charting. Nurses indicate that documenting patient care is an important aspect
of the overall quality of patient care (Frank-Stromborg, Christensen, and Elmhurst, 2001). Ann would have preferred to have the nurses spend time assisting her with activities of daily living rather than documenting the care that they were providing. Ann was not concerned about whether the nurses charted about what time she received her medication and whether she ate all of her lunch. It seems that with nurses in short supply they have less time to spend with patients, and nursing at the bedside takes a backseat to accurately completing patient charts which are legal records (Frank-Stromborg et al., 2001).

John did not indicate that he felt neglected but he acknowledged that having consistency in the nursing staff was necessary in order for him to trust the caregivers. John lamented about the lack of consistency of the nursing staff. Diane had the least amount of concerns in terms of the time that nurses spend with patients. Diane was focused on being a cooperative and friendly patient. Diane did acknowledge the problems associated with long waiting lists for surgery. She feels the government is responsible for the long waitlists but this was not an issue that directly impacted Diane.

Making The Best Of It

The second major theme of this study is the ability of the participants to make the best of their situations. Despite nursing shortages and the subsequent challenges for patients at the personal level, the participants in this study saw themselves as fairing quite well. Four out of the five participants did make the best out of their challenging hospital experiences as demonstrated by their positive attitudes about their experiences. The independence and autonomy of most of the participants in this study was striking.

The four participants who made the best out of their challenging hospital
experiences were John, Carrie, Ann, and Diane. John's tenaciousness, a characteristic he has maintained throughout his adult life, helped him through his hospitalization. Carrie revels in her independence but she recognized the need to rely on others to get her through her hospitalization. Ann acknowledges that she is lucky and much better off than others dealing with their own health issues, "I just think that there are so many people worse off than I am you know that there is no use whining about it, it's just life. We all get something sooner or later, you either get through it or you don't". Diane also had a positive, but very matter-of-fact attitude toward her hospital experience.

Jane on the other hand did not feel positive about her hospital experience. Jane was very focused on the lack of care and the downfall of the healthcare system compliments of “Mr. Campbell’s” government. Jane does not feel as supported by her social network as the other participants in this study. Jane acknowledges feeling isolated and not always being able to relate to her neighbours or other seniors with whom she attends activities. It seems that Jane’s ability to make the best of her hospitalization was limited by the gaps in her social network. Certainly Jane’s situation is not unique. There are many seniors who live alone and do not have adequate support networks. If at some point these seniors require healthcare, it is possible that their situations of isolation and loneliness may be recognized. However, healthcare providers need to have the time to spend with patients in order to really understand whether seniors have the supports they need.

It’s A “Do-It-Yourself” Hospital

One may argue that while the participants in this study were “making the best of it”, they were also doing much of their own care. There are both strengths and limitations
to the concept of patients carrying out their own care. However, there are likely distinct differences between the strengths of this model for patients who have their family present during their hospitalization, and patients who do not have family present during hospitalization.

In this study, it was Ann who used the words “do-it-yourself” hospital, and she was very concrete in her examples of having to carry out tasks on her own such as getting her own slippers, and making her own bed. Ann acknowledged that patients may in fact become more mobile and independent sooner as a result of being left to do tasks on their own. Ann questioned whether nurses intentionally ask patients to do tasks themselves or whether it is part in parcel of nursing shortages and lack of time for spending with patients. Carrie also discussed specific concerns such as having to look after her heels herself by applying Vaseline in order to prevent heel ulcers.

Another aspect of the do-it-yourself hospital revolved around nutrition according to two of the participants. Carrie brought her own yogurt with her to the hospital as she knew from a previous experience that she would not benefit from the yogurt the hospital provides, “I try and take some yogurt with me and put it in the fridge hoping nobody will steal it”. Carrie lost weight while in the hospital. Carrie believes that her lack of appetite and what she considered food low in nutrients may have been part of the reason it took so long for her leg ulcers to heal. Ann was also very concerned about the low nutritional value of the food she received. Ann indicated that it would have been helpful to have some fresh fruit. Both Carrie and Ann had to make requests to have the menu items changed in order to receive food they considered palatable. For patients who have family members present, and able to bring in appetizing foods, hospital food may not be such an
issue. Patients with family may consider this do-it-yourself nutrition aspect of hospitalization acceptable. However, for the participants in this study there were no family members available to bring in food. Carrie and Ann are not alone in their concerns about nutrition in hospitals. Malnutrition can result in serious health issues for older persons in hospital (Kelly, Tessier, Cahill, Morris, Crumley, McLaughlin, McKee, & Lean, 2000).

Based on the narratives of all five participants, a major disadvantage to a do-it-yourself hospital is the fact that patients may not receive the emotional support they need. Carrie said she felt socially neglected. Ann indicated that she was left alone a lot of the time. Issues around a lack of emotional support are likely not as great for patients who have family members present during their hospitalizations. Jane may have felt the least support of all the participants in this study. Jane explained that she believes the nurses are “victims” of a government that will not maintain adequate nursing levels. Jane believes the nurses need to have time to spend getting to know their patients. Jane said “I’m talking on behalf of the patients that are the victims of the neglect of the nurses, they’re the victims [the nurses] and we’re the secondary”. The participants in this study were able to “do-it-themselves” during many parts of their hospitalizations but they were not able to provide emotional support to themselves. For many patients a “do-it yourself” model means the patient and his/her family do-it-themselves but for the participants in this study it was mostly up to them as individuals.

John seemed to be somewhat less concerned about receiving emotional support during his hospitalization than the other participants. Carrie received emotional support from volunteers, and Ann and Diane received emotional support from friends.
Interestingly, the participants in Freeman’s (1999) study also indicated that they did not feel that the hospital staff were providing emotional support to patients. Therefore, even patients who have emotional support from family need to feel a connection with the staff that are caring for them. The participants in Freeman’s study recognized that they were receiving most of their emotional support from family, and they expressed concern for other patients who did not have family, or any visitors. With the exception of John, all of the participants in this study had visitors during their hospitalization. John did have support from a volunteer organization in place when he went home from the hospital.

Developing relationships with others whether it be a friend or a volunteer, is an important step for patients who do not have family involvement. The experiences of patients who do not have any visitors while in hospital, or any emotional supports upon discharge may be quite different than the experiences of the participants in this study. I will explore this further in the final section of my thesis, limitations of the study, and implications for social work.
CHAPTER 5 DISCUSSION

In this final chapter I will discuss the findings of this study in terms of existing research and theoretical understandings. Chapter three provided the data to answer the question: What are the experiences of persons 65 and over who have been hospitalized without family involvement? Analysis of the data also provides answers to the sub-questions outlined in chapter one. This chapter will explore the implications of the data gathered both in terms of structural social work theory, and in terms of the role of the hospital social worker, volunteers, and formal support. Practice and policy development will be addressed. This chapter will also summarize the limitations of this study and discuss avenues for further research.

Applying A Structural Lens

The following is a discussion of the answers to the sub-questions posed in chapter one. The first sub-question is how are the participant’s experiences shaped by broader structural issues? When I answered this question I was looking for data that shed light on the ways in which the participants were challenged based on their health and age. I was particularly sensitive to identifying how participants responded to structural issues, for example did they personalize the issues or recognize them as structural inequities. Finally, I was looking for data that explained what happened to participants’ sense of power while they were hospitalized. Older persons may feel powerless when they have personal losses such loss of health and loss of support systems (Cox & Parsons, 1994).

It was clear from participants’ stories that they felt they were a burden on the system. Several of the participants were reluctant to ask for assistance because they were aware of the demands on the nursing staff. Ann said “I think the nurses are just so busy
they don’t have time to check and that’s about it”. Jane’s statement also indicated that she was feeling that she was a burden “I felt guilty about asking for a nurse to come because I know how busy they are”. The participants did not always make their needs known because they did not want to make more work for nurses who they observed to be “running around like nuts” and therefore they were oppressed by a hospital system that is short-staffed.

The fact that participants did not make their needs known suggests that they may not have felt empowered. All of the participants have had personal losses such as changes to physical health, and social losses including loss of work role. All of the participants have had loss of support systems, particularly loss of family, either through divorce, or death. All of these factors influence whether or not older persons feel empowered (Cox & Parsons, 1994).

The data indicated that participants had concerns about how the nurses spent their time. The nurses spent too much time charting and as a result they did not have time to provide care. The healthcare system requires nurses to have degrees and be accountable and in the process they have lost the ability to provide “tender, loving care”. This is another way in which the “system” denies individuals the care that they need.

The second sub-question I posed was what services or people were helpful during hospitalization? I did not have to seek out the data for this question as it was answered directly by all of the participants. Several of the participants had non-kin relationships that were as important, and essentially replaced, family. The support from friends and neighbours was similar to the support family members provide (as discussed in the section on family support in chapter one). Volunteers from volunteer agencies also
provided support that was similar to that which a family member may provide.

**When There Is No Family**

Throughout this study the issue of the absence of family has been in the forefront. From a structural social work lens it is clear that there needs to be more “time” for health care professionals to spend with patients. The current health care system has professionals stretched by heavy workloads, there is no time for socialization. Seniors who do not have family visiting or acting as advocates, may feel neglected in a hospital environment. Seniors without family may be oppressed by a system that expects them to have family to meet both emotional and some practical needs.

Amy Freeman (1999) found that the participants in her study who did have family expressed concern for those who did not: “Participants consistently used the word “lucky” to describe the fact that they had family support and expressed relief at their good fortune” (p. 82). Based on Freeman’s study it seems that elderly patients without family are going to have a more difficult time in hospital than those who have family present. Most of the participants in the this study would agree that they felt that nurses in particular did not have enough time to spend with them. Older persons are not responsible for the healthcare crisis. Seniors cannot to be blamed for the unmanageable workloads of hospital staff. The healthcare system needs to change to meet the needs of older patients who do not have family. The healthcare system needs to provide more health care professionals in order to increase the amount of time spent providing care to seniors in hospital.

**The Role of The Hospital Social Worker**

It is significant that only two of the five participants in this study had social work
involvement during their hospitalizations. For reasons unknown, the other three participants were not referred to social work. The reality is that not every patient without family is referred to social work. According to Preyde and Chapman (2007):

It is common to have a protocol in place where other disciplines refer patients to social work as opposed to social work assuming the responsibility for screening all patients to identify those in need of social work services, including discharge planning. It has been indicated that the protocol of referral from other disciplines underestimates the number of patients in need of social work intervention (p.89-90).

It may be prudent for hospital social work protocol to be changed to consider having social workers screen all patients to identify whether or not they have family involvement. Older persons who live alone and do not have kin as part of their support network are more at risk of having unmet care needs than are those who have family (Fast, Keating, Otfinowski & Derksen, 2004). Social workers assess the physical, psychological, cognitive functioning, social supports and finances, of patients (Preyde & Chapman, 2007). The identification of key support persons such as friends who have keys to patients’ homes, and therefore can bring into their clothing, medications, toiletries, etc. into the hospital is important.

My practice with older persons in hospital has changed as a result of this study. I have learned from these five participants that being hospitalized without family is challenging but with adequate support they can manage. Having a support network, whether it is composed of family, or friends, or volunteers from an agency is essential to “surviving” the hospital experience. The experiences of the participants in this study were
consistent with research that shows that the greater the number of people in a support network, the more likely an older person is to have her/his care needs met (Fast, Keating, Otfinowski, & Derksen, 2004; Sims-Gould, 2006). For the most part the participants in this study had adequate support networks but I am now more aware of the fact that some older persons without family may not have their needs met during hospitalization if they do not have anyone supporting them. The participants in this study generally made their needs known to hospital staff and they were able to maintain their personal integrity (Jacelon, 2004). I am now more aware that there are older persons who will not ask for help with their meal tray, or ask to have slippers, and their needs will not be met.

This study has also changed my practice with older persons who are hospitalized with family involvement. It is now much more clear to me just how much the healthcare system expects of families. My own assumptions about the role of family have been challenged as it has become clear that family members are often the informal supports and the volunteers who care for older persons. In my practice now I try to educate other hospital staff about the expectations we tend to place on families. Older persons rely heavily on family members for care and we need to recognize the work of families.

From a structural social work lens, social workers have a role to play in addressing the issues that lead to the oppression of older persons in hospitals. In Canada, persons 65 years of age and older account for one third of hospital admissions (Rotermann, 2006). The average length of hospital stay for seniors is 11 days (Rotermann, 2006). These statistics make it clear that the needs of older persons must be acknowledged. One third of the patients in hospital should not have to feel that they are a burden. The health care system needs to acknowledge the impact of a nursing shortage.
Nurses have less time to spend with patients. Four out of the five participants in this study recognized the impact of nursing shortages.

Empowerment-oriented social work practice with older adults involves interventions on four dimensions: the personal, the interpersonal, the environmental, and the political (Cox & Parsons, 1994). When a social worker initially meets with an older person, the assessment of the problem begins by identifying needs and resources. At this initial stage the older person is likely viewing the situation as a personal problem. The social worker assesses whether the client is feeling powerless about the situation. The second aspect of empowerment-oriented social work practice is interpersonal interventions. Workshops and courses for older persons are a means of providing education and support. At this stage there is an awareness or consciousness that others are experiencing similar issues. The third aspect is environmental interventions. Clients may be able to make changes within their environment by learning about and accessing needed resources. The fourth type of intervention focuses on the political part of the problem and how to involve the client. At this level of intervention clients are able to link what initially may have seemed to be personal issues to larger structural issues (Cox & Parsons, 1994).

Empowerment-oriented social work practice can be incorporated into hospital social work practice with older persons who do not have family. Assessing the needs and resources of the patient, and whether he/she has the power to manage the issue is the starting point. Education about health issues, or community resources for patients while they are in hospital are interventions at the interpersonal level. Hospital social workers have a large role to play in terms of environmental changes. Social workers can help to
educate other hospital staff about the needs and unique challenges of older persons who are hospitalized without family involvement. At the political level, hospital social workers can help older patients to understand that the issues they are facing in hospital are not individual problems but rather systemic problems. Hospital social workers need to advocate for changes to the health care system.

Hospital social workers do have a role in terms of educating older adults in hospital about how they can make their needs known, such as speaking with nursing unit managers, and Members of the Legislative Assembly. Seniors without family involvement may also benefit from knowing others who have similar circumstances. The formation of a group, whether meeting in person, or connecting by telephone, or newsletter, can help older persons to recognize that their experiences are shared (Cox & Parsons, 2004). As individuals begin to connect, they can share their strengths and experiences, and may realize the power they have to create change (Boehm & Staples, 2002; Cox & Parsons, 2004). It may be difficult for older persons who do not have family to connect with others during hospitalization. However, it may be possible to establish a community support group for older persons without family through a geriatric outpatient program.

The participants in this study recognized that the issues they faced during hospitalization were not personal issues but were attributed to the current state of the healthcare system. All of the participants in this study had expectations about the care they would receive in hospital. Often their expectations were not met due to workload issues. Three of the five participants had planned admissions while the other two had emergency admissions. All three of the participants who knew they were going into
hospital had doubts and concerns, as Carrie said “going into hospital is one of the hardest things to do”. They had concerns about their abilities to remain in control while they were in hospital. The participants in this study found that their requests for assistance with bathing and mobilizing were not always met. They also found that their nutrition needs were not always met. However, the participants were able to recognize that these are structural problems not personal problems. Some of the participants held the government responsible for these problems indicating that more nurses need to be hired, and that nutrition services have been negatively affected by contracting out to private companies.

The participants in this study were familiar with the “cost” of healthcare. Several of the participants discussed the fact that their beds were needed for others. “They wanted to get my bed”, were the words used by Jane is describing her discharge. There was an awareness that the hospital beds are in short supply and one cannot spend anymore time than is absolutely necessary in the hospital. Several of the participants felt that the hospital staff were trying to speed up their discharges by frequently asking them about their plans. Many of these issues affected the participants in this study on a personal level but the problem exists at the structural level. The Ministry of Health clearly states that older persons use more health care dollars than any other segment of the population. The Ministry of Health along with the media send a message to older persons that they are putting a strain on the health care system. This kind of message may leave older persons feeling powerless, and fearful of accessing health resources. John, for example, was aware that if he did not go into the assessment bed when it was available he would not be offered the assessment again for a long time. Older persons may believe that their healthcare resources are scarce.
The participants in this study were able to make their needs known. They were aware of their strengths and their desire to remain in control during their hospitalizations. Whereas the participants in Amy Freeman's (1999) study indicated that the involvement of their families during hospitalization was crucial to their survival, the participants in this study were able to fend for themselves pre-hospitalization, and during hospitalization. The participants in this study who all lived alone and did not have family in Victoria were strong in the face of adversity.

**Volunteers**

Three out of the five participants in this study relied on volunteers for both practical and emotional support. Volunteers carry out tasks that are often completed by family members. The volunteers in the lives of these participants were involved both during and after their hospitalizations. I do question how these participants would have coped without the support of volunteers? The government also relies on volunteers to fill gaps that were created where formal supports have been removed. Volunteers are an economically viable resource for the government. However, volunteers age 55 and older (this age group provided 31% of the volunteer hours in Canada in the year 2004) are also aging and will require health services themselves (www.givingandvolunteering.ca/PDF/CSGVP_Highlights_2004_en.PDF, 2006). Therefore, as the population ages, the BC Ministry of Health may need to consider implementing more formal supports for seniors that provide assistance with housecleaning, transportation, yard work, and emotional support, just as volunteers do at present.

A further question that needs to be asked is how much can a healthcare system
expect of volunteers? What are appropriate roles for volunteers in the hospital, or in the homes of older persons? Most of the participants in this study did rely on volunteers for emotional support, help with household tasks, and even discharge planning. Without the assistance of volunteers some of the participants in this study would have struggled to have their needs met. Volunteers may be willing to provide emotional support and grocery shopping for older persons, but they may not be comfortable doing other tasks that family members often do such personal care. A study of 19 not-for-profit community services in a southern Ontario district revealed that volunteers are being asked to carry out tasks that have some element of risk (Gottlieb, 2002). One volunteer was asked to move the client’s oxygen tanks, another volunteer driver had to assist an older lady to dress in order to go to her medical appointment. Some volunteers have also been asked to carry emergency medical kits in their cars (Gottlieb, 2002). These are some examples that demonstrate that volunteers from volunteer agencies are being asked to help with tasks that would normally be done by a family member or formal supports. The implications for the not-for-profit agencies, the volunteers, and the clients, are yet to be seen.

Formal Support

Three of the five participants in this study utilized formal home support. These supports were arranged through Home and Community Care as part of their discharge plans from the hospitals. Older persons who live alone are more likely to utilize formal supports (Mutchler & Bullers, 1994). Without family support, seniors may require formal support in order to have their care needs met. In fact, formal supports seem to be a much needed resource for seniors who cannot rely solely on other types of informal support. An increase in formal supports available such as assistance with housecleaning, and
laundry, may be of benefit to seniors who do not have family support. However, it is important to acknowledge that the requirement of formal support can create feelings of powerlessness in older persons (Cox & Parsons, 1994). Seniors may feel their independence is at risk if they accept formal support into their homes. Several of the participants in this study did have ongoing help from formal supports. Carrie acknowledged that it was initially difficult to accept formal support because of her desire to be independent. John was very clear about his need to remain in control both in his own home and during hospitalization. John was accepting of formal home support because it is the means by which he is able to continue living in his own residence. John was able to form trusting relationships with his Home and Community Care case manager, and with his home support workers. John was certainly able to direct his own care by asking home support workers do help him with the tasks he could not do on his own. According to Cox and Parsons (1994) "meeting the challenge of accepting appropriate care is often the most powerful step that an elder can take toward maintaining the highest possible degree of personal integrity and independence" (p.192). Older persons can feel empowered when receiving formal support if they make their needs known, and continue to do as much of their own care as possible.

Limitations of This Study and Future Research

As discussed in chapter two the validity of this study needs to be considered. I did challenge myself to think beyond the framework I used and I did consider alternate explanations. The essence of each of the participants was captured in the data. My analysis did find meanings that went beyond the words of the participants (Kvale, 1996). None of the participants stated that they felt oppressed by the healthcare system but their
stories conveyed the challenges they experienced while in hospital. One of the participant’s, Jane, was quite unique from the other participants in her dissatisfaction with the support system that she has. I did not try to downplay Jane’s experience because it did not fit with the others, I acknowledged that she did not “make the best of it”.

Acknowledging the fact that the analysis may have different outcomes and identifying discrepant data are crucial to the validity of this study.

It is important to acknowledge the limitations of this study in hopes that future studies may be able to address some of these issues. The advertisement for this study did not reach every person 65 years of age and older on Vancouver Island who has been hospitalized without the presence of family. There are many seniors who fit the criteria for this study who did not participate in it. One reason has to do with social networks. Seniors who are not connected to volunteer agencies or seniors centres likely were not aware of this study because it was not advertised within VIHA facilities. All of the participants in this study were linked to some type of social network. The experiences of patients who do not have any visitors while in hospital, or any emotional supports upon discharge may be quite different than the experiences of the participants in this study.

Another limitation of this study has to do with the demographics of the participants. All of the participants in this study were single. Three of the participants were single as a result of divorce, one was never married, and the other had been widowed for over 20 years. There is much research on the role of the spouse as caregiver. If any of the participants in this study had recently lost a spouse the experience of hospitalization may have been very different. Elderly couples may rely solely on each other for support rather than having a social network. When one spouse dies the other
may be very alone if other supports were not in place prior to the death of the spouse. There is also some evidence that grieving the death of a spouse increases the risk for hospitalization in seniors who do not feel they have an adequate social network. According to Feld and George (1994) “The death of the spouse may create a shortage of supportive interchanges that help prevent and deal with health problems. Believing one has a supportive close friend or relative may buffer some of the health consequences of bereavement because the survivor expects such persons to help compensate for the loss of support from the spouse” (p. 291). All of the participants in this study were quite independent but if there had been participants in this study who were recently bereaved, there may have been more issues around insufficient emotional and practical support due to perceived lack of social resources.

Cultural diversity and socio-economic status are also important factors in this study. All of the participants in this study were Caucasian. The socio-economic status of the participants in this study was variable. Several of the participants owned their own homes while others rented. Some of the participants indicated they had more than old age security and/or Canada pension plan income. One of the participants in this study indicated that finances were a concern. However, if all of the participants in this study had identified with an ethnic minority, and lived solely on old age security income, the results of this study may have been quite different. Older persons who have ethnic minority status are more likely to experience feelings of powerlessness. According to Cox and Parsons (1994): “Elders who have experienced a lifetime of poverty or limited financial resources or who have suffered discrimination because of ethnic minority status, female status, or class-related factors are even more threatened by the challenges of late
life” (p.21).

Future research on the topic of persons 65 and older who have been hospitalized without family involvement may focus on the experiences of those who self-identify as being socially isolated. In order to reach persons who are socially isolated, the researcher will need to have ethical approval to interview participants while in hospital, or at least be able to identify participants while they are in hospital. Future research could also focus on the experiences of seniors and their families and how they negotiate with a health care system that expects them to manage their own care needs.
Conclusion

The experiences of persons 65 years of age and older who have been hospitalized without family involvement are all very unique but there are some common themes among the participants in this study. There is an acknowledgement of the lack of time that hospital staff have to spend with seniors. The participants in this study found themselves doing many tasks on their own. Despite the lack of care that they perceived, most of the participants felt that they “made the best” of their hospital experience. From a structural social work lens, I see a need to work towards empowerment for older persons. The hospital social worker has the ability to help seniors make their needs known. Volunteers provide many hours of informal support to seniors but there may be limits to their altruism. Formal support to older persons without family needs to be increased in order to meet their needs and to lighten the load on informal supports. Older persons need to retain their power in the process of allowing formal support into their lives. Further research is needed to learn more about the hospital experiences of older persons who are socially isolated.
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APPENDICES

APPENDIX A: Recruitment Advertisement

THE UNIVERSITY OF BRITISH COLUMBIA

Requesting the assistance of persons 65 years and older who have been patients in hospital in the last three years.

We are seeking to learn more about the experiences of patients that do not have family involvement.

Why?
This study is being conducted as part of the requirements toward a Master of Social Work degree.

What is required?
A meeting with you to discuss your experience.
This meeting will take place in a location and time of your choosing and will take approximately ninety minutes.

Why Participation?
We need to better understand the experiences of patients that do not have family involvement. We would like to hear what your recommendations are for others without family involvement.
Your input will help service providers and policymakers better meet the needs of those without family.

(con't)
APPENDIX C: Interview Guide

1) Can you tell me about your most recent hospital experience?

2) How did it come about that you went through this hospital experience without family involvement?

3) Were there any particular times or experiences in the hospital where you wished you had family involvement?
   - Can you tell me about this experience?
   - How do you think having family involvement would have made this experience different?

4) What services or people were particularly helpful to you during your hospital experience?

5) Can you tell me about your plan for leaving the hospital?
   - How was this plan developed?
   - How well prepared did you feel in regard to:
     a) medication
     b) home supports (if needed)
     c) what to expect when you went home
     d) the procedure for leaving the hospital and returning to home (or facility)?

6) What words of wisdom would you offer to someone else going into the hospital without family involvement?