LAKEHEAD UNIVERSITY

THE CARE OF THE CHRONIC, NON-ACUTELY ILL ELDERLY PERSON IN ACUTE CARE HOSPITALS IN LIGHT OF THE BIOMEDICAL SCIENCE APPROACH

by

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The Care of the Chronic, Non-Acutely Ill Elderly Person In An Acute Care Hospital - In Light of the Biomedical Science Approach

Kevin D. Willison

ABSTRACT

The purpose of this study was to investigate aspects and specific events of health care intervention techniques rendered to chronic, non-acutely ill elderly patients, (henceforth known as CNIE), while in an acute care hospital. The patients' own perceptions were sought to ascertain if the care given was patient-centred or more characteristic with the traditional biomedical science approach (BMS). This latter approach, according to many researchers, remains the primary mode of hospital health care intervention.

The BMS approach is described by sociologists and others as a health care strategy that is overly cure oriented rather than care oriented. It is impersonal, objective, and dualistic - the very opposite of a patient-centred approach. Using a patient-centred care survey to carry out empirical research, I set out to ascertain, at a local level, the extent and degree a BMS approach existed within Thunder Bay's three acute care hospitals.

The sample included 32 participants who were or remain heavy users of health services. These individuals were either waiting for placement or recently placed into another care facility. At the time of the interview, qualified participants were located either in one of three Thunder Bay acute care hospitals, a private nursing home, one of two city Homes for the Aged, or in their own home. All shared their perceptions of the care they received while in hospital.

CNIE patient demographic characteristics - sex, age, marital status, length of present hospitalization, former occupation, mother tongue, hospital recently treated at and reason for hospitalization - were documented. Six care indices were embodied in the patient-centered survey. These included Communication, Education, Emotional Support, Patient Needs and Preferences, Consistency of Quality of Care and Physical Comfort. Descriptive statistics were used for analysis of the results.

Based on the comments obtained from the CNIE population sample, findings suggest that, although present or former patients were satisfied overall with the care they received while in an acute care hospital, there are particular reported problems in different domains of the care rendered to them which are congruent with characteristics/aspects of the traditional biomedical science approach. Results also suggest that the need for a paradigm shift - from a solely objective, rational and impersonal approach (vis à vis a biomedical science orientation) to a more biopsychosocial-like approach, (a "revolution" in the Kuhnian sense of the term), may not be as monumental a task as some researchers would suggest.

Recommendations for further research are made.

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This thesis is dedicated to my mother, Mrs. Joyce Mitchell, whose own chronic illness has acted as a catalyst to complete this study.

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CHAPTER I

Introduction

Rationale Of The Study:

Patient satisfaction with hospital care is a significant indicator of care intervention effectiveness[1]. A review of the literature indicates that health care professionals utilize the biomedical science model (also known as the biomechanical/medical model) as the primary guiding paradigm in the type of intervention employed towards patients in hospitals. This emphasis lacks sufficient attention to the users' or clients' perspectives and experiences when accessing and receiving health services (see for instance Kelly et al.,1992:3). This study, however, will draw upon a sample of chronic, non-acutely ill elderly persons [henceforth known as CNIE][2] in Thunder Bay Ontario, in order to ascertain their perspectives on the quality[3] of care they received while in hospital.

According to Lawton (1990:4) chronic illness has become better recognized by researchers (as indicative of published material in medical, psychological and social-scientific

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[1] An association between patient satisfaction and patient-centred care will be assumed in this study.

[2] A chronic, non-acutely ill elderly person (elderly meaning 60+ in this study), is one who had an acute phase of illness, was subsequently treated at hospital and is presently in the recovery/stabilization phase of their illness (but still chronically ill and dependent on continual assistance) and is needing/awaiting placement into another care facility.

[3] For purposes of this study, "quality" will refer to the degree to which health services provided is or was patient-centred.

journals) as <u>the</u> major socio-medical problem of the day. However, most health care services remain oriented toward acute episodic sickness (Todd et al.,1984; Robinson et al.,1989: 153).

Chronic illness 'victims' are described as those who undergo "unstable trajectory phases" (Strauss et al.,1988:110) whereby an individual's illness condition falls in and out of a period of an acute, stable, unstable, deterioration or dying phase[4] . Such phases of illness have serious consequences for a patient's identity, mood and behaviour (Strauss et al., 1988: 100) necessitating a <u>non</u>medical management program as well, so as to take into account his or her social and psychological needs (Roy, 1992).

Researchers such as Barba (1977), Alexander (1975), Strauss et al. (1988), Haug (1981), Lock et al. (1988), Engel (1977 and 1980), Najman et al., (1991) and Hewa (1992) clearly indicate that our existing health care system is largely inappropriate for meeting the concerns and social needs of populations such as the chronic, non-acutely ill elderly. Why?, because the biomedical science model {BMS} primarily focuses on acute illness and cure. This traditional paradigm - which is embedded in the organizational infrastructure of the hospital (as exhibited in its goals and policies) - leaves few incentives for health care providers to meet the contemporary needs of the chronic elderly (Hospitals,1989:17). The perceived challenge, therefore, is to

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[4] The concept of trajectory includes the total organization of work done around the chronic illness (Marshall et al.,1991:5).

reorient the manner in which health care services are provided. As Barba states:

> "The challenge to the health care delivery system is to face realistically the fact that we can no longer afford to think about long-term illnesses in the framework of the medical model..."
>
> (Barba,1977:205)

Statement Of The Problem

Against this background, the problem for study was stated as two research questions:

(1) Does acute hospital care in Thunder Bay reflect the characteristics of a Biomedical Science approach?

(2) Does the existence of a biomedical form of health intervention promote or impede patient-centred care and, as a result, promote or impede patient dissatisfaction?

While it is recognized that there are some formal caregivers who stress that the need for a patient-centred (i.e. biopsycho-social-like) paradigm or form of intervention is already being addressed, this research asks the question - how successful has this growing emphasis been to date at a local level?

Purpose Of The Study

The purpose of this study was to address the two research questions using, for illustrative purposes, a population sample of thirty-two chronic, non-acutely ill elderly persons residing (or within the past two months discharged from) one of three acute care hospitals. Demographic data in seven areas (age, sex, marital status, former occupation, length of present hospitalization, diagnosis and mother tongue), were compiled. A "quality of patient-centred care" survey was devised and administered to determine the perception of CNIE patients' satisfaction with the care received in hospital. How this survey was developed and deployed is discussed in chapter four of this study. Responses from this instrument which included open-ended questions were used to examine the following two strains of thought:

#1

> There is a strong interrelationship between a patient's level of satisfaction with care received in hospital and a patient-centred approach on the part of hospital staff.

Rationale Patients need to be treated as humans, not as objects or as diseases as is typical of the biomedical science model approach. For patients to be treated as humans, focus should be on individual psychosocial requirements. Maintaining this human element in care intervention promotes patient satisfaction.

#2

> There is a strong interrelationship between a patient's level of dissatisfaction with care in hospital and that of the propensity for care received to be or have been primarily mechanistic and impersonal in its approach.

Rationale Dehumanization/depersonalization results when psychosocial and other similar needs of the patient are ignored. This is created and perpetuated by sole reliance on a biomedical science model of treatment. Often, this is a result or by-product of a system overly focused on cure rather than care. Care becomes forfeited. In short, a scientifically-oriented, short-term, medically intensive strategy is inappropriate for chronic, non-acutely ill elderly patients who need, as other patients do, a more humanistic, biopsychosocial-like intervention strategy.

Contribution To Research

As society is by no means static, neither should our health care system. It is hoped that this research will help build on our existing knowledge in the field of social medicine and to facilitate changes so that the health system becomes more humane (more patient-centred) for individuals such as those in the CNIE population. Further, assessing quality of care processes (what is done to patients) provides some measurement advantages over studying outcomes as not all patients who experience a poor process of care suffer a poor outcome (Kahn et al.,1990:1969).

Policy planners in both the health and social service fields need to focus on this type of research especially as the use of acute care hospitals by the elderly is rising rapidly, particularly in the age group 75 and older (Lamont et al.,1983:282; Kraan et al.,1991:ix) and because most industrialized countries are experiencing population aging (Aronson,1985).Chronic degenerative diseases are making greater claims than ever before on health care resources (Cox,1979:240; Barusch,1991:xii). By the year 2001, for instance, the elderly will comprise 12 percent of the Canadian population and will consume 45 percent of the acute care hospital resources as measured in terms of patient-days (Szafran,1985:2).

Sociologists can make a valuable contribution in helping to ascertain, document and analyze the present situation, giving information on which to base a policy of effective and humane care for the growing proportion of chronic, non-acutely ill elderly people who utilize acute care resources. Through such a contribution, sociologists may then help health care professionals, primarily nurses and doctors , to achieve their primary goal: good patient care (Cox,1979:241).

According to Charon (1992:5), sociology is critical and humanistic in its concerns. Caring, specifically patient-centred caring, is a humanistic endeavour. Respect for patients' needs and wishes is central to a humane health care system (Cleary et al., 1991:255). In essence, this study is aimed at ascertaining just how humanistic the health care system for CNIE patients in Thunder Bay is and supports the idea that the basis of medicine should be subject to sustained examination to "ensure the best fit of premises to contemporary health care needs" (Foss et al., 1987:3).

Limitations Of The Study

(A) The six care domain indices used in the survey to measure the quality of patient-centred care are by no means all-inclusive.

(B) It is possible that participants were reluctant to honestly express their perception about the quality of care they received. This phenomenon is known by sociologists as "Demand Characteristics": the natural human tendency to say what others want to hear. Sometimes this includes a tendency to say things that are socially acceptable. Barusch (1991:53) presents the example of an older man reluctant to describe the stress he is experiencing because, for his cohort, it is not considered appropriate to complain. This researcher limited this effect by stressing during the interview that I was not an employee of the hospital and that <u>all</u> responses would be considered appropriate. Further, to give greater assurance to the participant, all interviews were conducted in the patient's room while hospital staff were not present. When possible and agreeable with the respondent, the respondent's door was closed. As well, the survey was worded and communicated as neutrally as possible to prevent overly negative or positive weighting of the questions.

(C) A further limitation was the difficulty in measuring patient satisfaction in a very chronic, severely impaired population. This limitation was offset, however, by pretesting the survey format. Input on the scale was obtained by 4 seniors (through the help of the Council On Positive Aging - Thunder Bay) who had previously been hospitalized. An addition of 3 qualified and willing respondents from area city Homes for the Aged were also part of this pretest. Further input was obtained from experienced clinicians, faculty members and the assistance of members from the Multidisciplinary Research Committee in association with the Northern Centre for Aging and Health

(Lakehead University - Thunder Bay). In the end, the survey was considered to be comprised of questions which would yield the information necessary to address the primary concern of the research.

Thesis Format:

This thesis consists of six chapters of which this is the first. Chapter two consists of a literature review. Two major areas will be covered : The conceptualization of the medical model (biomechanical/biomedical science approach) as a form of health care intervention; and the premise of patient-centred care as an alternative approach.

Chapter Three discusses the concept of "paradigm" and the theoretical underpinnings of a "medical revolution" or "paradigm-shift" that various researchers feel is necessary particularly in the treatment of the CNIE population. Here, the work of Thomas Kuhn, G.L. Engel, A.W. Imershein and others who address this issue, will be discussed.

Chapter Four describes the methodology and procedures of the study. Special emphasis is placed on the socio-metrics of the sample and the administrative procedures of the "Patient-Centred Care Survey" developed and deployed for this study. A brief review of the literature highlighting the importance of the indices used in the instrument of this study is also presented.

Chapter Five presents the findings of the study and the descriptive statistics. Chapter Six, the conclusion, provides a summary, recommendations and suggestions for further research.

Chapter II

REVIEW OF LITERATURE

The literature review will be presented in four sections. Section one reviews literature that addresses the characteristics of the population under study as well as the nature of the problem considered. Section two addresses changing demographic trends within society. Within section three, a review of literature on the Biomedical Science Approach will be presented. Problems inherent in this paradigm of thinking and form of intervention in the health care system, particularly as it relates to the study population, will also be addressed. Lastly, the premise of patient-centred care, as an alternative approach to health care intervention, will be conveyed in section four of this review.

Given the multidimensionality of this study, a relatively large amount of time in this chapter addresses concepts whose meanings have emerged in multidisciplinary contexts and which are often discussed in journals not routinely read by sociologists (Maddox et al.,1989:236). Given the vast amount of geriatric/ gerontological literature (Alexander,1990:27), this chapter represents only a cross section of the available material. It should also be noted that the subject of "paradigms" and a call for a "paradigm-shift" in health care is discussed in chapter three of this study.

THE SAMPLE AND NATURE OF THE PROBLEM UNDER STUDY

Older patients are especially appropriate to study because they consume a large proportion of medical care (Roy,1992:4; Hall et al.,1987:262). The elderly make heavier proportionate use of health services than the non-elderly (Williamson,1988:247). Among these elderly are those who are the "delayed placement" of geriatric patients who have been recommended for discharge to a long-term care institution, but who remain for long periods of time in the acute care setting until a bed in an appropriate long-term facility becomes available. This is a growing phenomenon in Canada (Rosenthal,1992:170; Hall et al.,1982; Lagoe et al.,1991; Cunningham,1991; Alexander,1990).

Physicians are not prepared to tolerate the growing number of nursing home entrants who are waiting in hospital for an available nursing home bed. This is despite the fact that these elderly individuals tend to be the most seriously ill persons of all the high users (Shapiro et al.,1986:173). According to Aronson et al. 1987 (as cited in Globerman (1991:182) in an acute care hospital, older patients with non-acute conditions are not viewed as appropriate clients (see also Falcone et al.,1991:341). Problems in communication and insufficient or delayed care may result (Globerman, 1992:182; Evers,1981:581). In short, although hospitals are providing more long-term care services in order to accommodate our aging society, hospitals are <u>not</u> designed to care for these patients (Falcone et al.,1991:340).

There is a prevailing perception by health professionals that long-stay patients are a "problem" (Aronson et al.,1987) and that there is a lack of appropriate policies and/or programs to benefit such patients (Rosenthal,1992:170). Physicians are particularly concerned about these patients since they occupy between 10 and 30 percent of all acute care beds that could otherwise be filled with acute cases (Alexander,1990:27; Maguire et al.,1986:1252). Nurses and other health care staff often lack the time and training to care for long-stay patients properly (Aronson et al., 1987; Rosenthal et al.,1980).

Rosenthal (1992:182) points out that, from a policy perspective, the "problem" of the long-stay geriatric patient in the acute care hospital is nothing new. In Canada, it has been recognized for well over a decade (Rosenthal et al.,1980). Despite considerable speculation as to the causes of this situation, its consequences for the elderly patients is still largely undocumented (Alexander,1990:28).

According to Crichton (1990:119-120); Globerman (1991:232); Seymour (1991:27) and Lamont (1983:281), there is an increasing utilization of acute medical care facilities among the elderly as compared with other age groups in the population. This is particularly true for those with chronic dysfunctions (Riley,1990:403). While the risk of chronic illness is not solely confined to older adults[1], the link between age and dependency is sufficiently high to justify concentration on long-term care of older adults (Maddox et al.,1989:243). Crichton (1990), for example, indicates that the age group 65 to 74 uses about twice the number of acute health services per capita as the age group

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[1] Not all individuals sixty-five and over of course suffer from debilitating chronic dysfunctions. A large healthy elderly population exists.

15 to 44. The age group 75+ uses almost four times as many services per capita as the age group 15 to 44 (and, according to Bell [1992:135], up to ten times the health care services of a person between the ages of 20 and 50). This pattern of disproportionally high utilization is even more marked in use of hospitals. The age group 65 to 74, for instance, had over six times more hospital days per capita than the age group 15 to 44[2]; and the age group 75 + had almost 15 times more hospital days per capita than the age group 15 to 44 (see also Maguire et al., 1986:1253).

Chronic illness is a major problem of the elderly. The older population has at least one chronic disease with the typical picture being the presence of several chronic conditions (comorbidity) that must be managed simultaneously (Eliopoulos, 1987:8; Wallace et al.,1992:18; Knottnerus et al.,1992:15). According to the Ontario Health Survey (1992:6), the percentage of people with three or more health problems is four percent for children and forty percent for seniors. While most people in highly industrialized countries who are sick suffer from chronic illnesses, the chances of having a chronic disorder increases with age (Ontario Health Survey,1992:6; Lewis,1989:119; Knottnerus,1992:17; Dalziel,1987). Statistics Canada (1990:5), indicates that in 1985 individuals over sixty-five were twice as

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[2] Interestingly, women over 65 have a four percent lower rate of hospital admissions than males in the same twelve month period (Ontario Health Survey,1992:40).

likely to report arthritis, respiratory troubles, rheumatism and hypertension and three times as likely to report heart trouble than younger individuals. Disability days are more common among females and people over 65 (Ontario Health Survey,1992:8). Overall, disability rates are 7.7 percent for males and 7.1 percent for females under age 55 while 75.3 percent of males and 85 percent of females aged 85 and over have some form of disability (Statistics Canada,1990:5).

Statistically, the older the elderly get, the more their health care costs. Those over 75 years of age, for instance, represented 5 per cent of the population but took up more than one-third of all hospital days in 1989 (Mickleburgh, 1992:A1). According to Baker (1988:95), those aged eighty-five and over require the most health resources.

The world's aging population will place an increasing strain on the health care infrastructure until well into the next century (Cox,1979:240; Bell,1992:132). Chronic degenerative diseases are making greater claims than ever before on health care resources. The importance of this cannot be understated given that the changing demographics of Canada, representative of an aging population, will, in effect, simultaneously increase the prevalence of chronic disorders within society.

DEMOGRAPHIC CONSIDERATIONS

Seniors comprise an increasing proportion of Canada's population (Statistics Canada,1990:5; Alexander,1990:27). According to Aronson (1985), most industrialized countries including Canada are experiencing population aging. This phenomenon is expected over the next several decades in all regions of the world (Uhlenberg,1992:450).

Demographically speaking, the Canadian population will be much different in the next century. It will continue to be characterized by a low birth rate with older people constituting a growing share of the total population (Uhlenberg,1992:433,452). According to Baker (1988:31), the most important reason for population aging is the decline in the birth rate (see also Stone et al.,1986:1.1). Increased child rearing costs, urbanization, and industrialization, have gradually reduced the benefits of large families.

Another factor creating population aging is that life expectancy at birth has dramatically changed over the past 60 years. In 1921, for instance, life expectancy for males was 58.8 and for females 60.6. By 1981, life expectancy for females had reached 79.1 and for males 71.9 (Statistics Canada,1982). The projected life expectancy at birth for males for 1996 is 74.9 and for females 81.6 (Baker,1988:31).

As life expectancies rise, a greater percentage of the population will be over 65 and within that cohort the proportion of people over 75 years will rise sharply (Aronson,1985:115). Chappell estimates that by 2031, about 45 percent of seniors in Canada will be aged 75 and older (Chappell,1990:11).

According to Mickleburgh (1992:A8) and Stone et al., (1986), the number of Canadians over 85 is growing at a much faster rate than the number over 65. In 20 years there will be 724,000 of them, up from an estimated 280,000 now. Five percent of those between 65 and 69 are in a long-term-care institution compared to more than 30 per cent of those 85.

Of those aged 65 and older, it is projected that by the year 2001 they will constitute 11.9 percent of Canada's total population and 20.2 percent by 2031 (Chappell,1990:9)[3]. According to Mickleburgh (1992:A1), by the year 2021, there will be more than six million people in Canada over the age of 65, twice as many as there are today. Nearly one out of every five Canadians will be a senior. Currently, almost one out of every ten Canadian citizens is over sixty-five. By the turn of the century that ratio will change to one in six (West,1991:iii).

In 1976, the elderly (socially defined as a stage of life starting in the early sixties [Uhlenberg,1992:449]) constituted 8.9 percent of the population of Ontario. According to the Ontario Hospital Association, by 1985 this proportion had risen to 10.7 percent . By 2001, it is projected that seniors will make up approximately 14 percent of the population of the province of Ontario (Hospitals,1989:16).

In 1986, Thunder Bay's population over the age of fifty had reached 27 percent. By 1991, this rose to an estimated 27.5 percent and it is projected to climb to 27.9 percent by 2001, 32.5 percent by 2006 and up to 36 percent by 2011 (Chronicle-

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[3] Chappell (1990:11) suggests that this latter figure will represent the peak proportion of seniors to that of the entire population.

Journal, 1992:E4).

In many industrialized countries, changes need to be made to the health care system to improve services for an aging society. Major reforms will need to take place to successfully adapt to an aging population. Experts on aging agree that Canadian health and social institutions are ill-suited to accommodate the present and future needs of today's elderly (Seymour,1991:27). Most health care services, for instance, remain oriented toward acute episodic sickness (Todd et al., 1984; Robinson et al., 1989:153). Our health care system needs a more encompassing definition of health care (Baker,1988:95,98; Chappell et al.,1986). The tendency of general hospitals to focus on acute episodic illness, rather than the needs of the chronic, non-acutely ill elderly, is perpetuated by a health intervention strategy known as the biomedical science approach.

THE BIOMEDICAL SCIENCE APPROACH

The continued existence of the biomedical science approach or paradigm (also referred to as the medical, biomechanical, disease, or technocratic model) within the Canadian health care system, is documented by such researchers as Allan et al. (1988); Antonovsky (1989); Baker (1988); Blishen (1991); Hewa (1992); Lock et al. (1988); Pavelich (1992); Smith et al. (1990); Street (1992); and Strauss et al. (1988). According to Wallace et al. (1992:18) the majority of medical care for the elderly is predicated on this approach (see also Harrington et al., 1985).

Basch (1990:75) describes the biomedical science model as an approach best defined as a Cartesian-Newtonian paradigm which unifies the principles of Western scientific thought. These principles include: (1) mechanistic explanation: nature is a grand, complex machine functioning under relatively simple laws which can be unravelled; (2) determinism: natural phenomena follow causal linkages, which can be identified by methodical study of cause and effect; (3) reductionism: complex phenomena are comprehensible by systematic dissection into constituent segments - that is, the whole can be understood by a study of its parts; (4) materialism: the issues are perceived as interrelationships all external to the scientist; and (5) quantitative expression: the relationships among phenomena can be expressed mathematically - that is, we can only study what we can measure.

Biomedical approaches have achieved only partial, if not minimal success in the treatment of chronic benign pain (Roy, 1992:xiii). Further, the biomedical science approach does not provide satisfactory solutions to contemporary health disorders such as cancer, respiratory and heart disease (Hewa,1992:8). Such conditions are typical of chronic degenerative disorders found in the ill elderly population as representative of those obtained for this study.

What the BMS approach does do is focus on acute illness. It stresses a health intervention strategy oriented towards cure (Cox,1979:237). This traditional paradigm - which is embedded in the organizational infrastructure of the hospital, leaves few incentives for health care providers to meet the current needs of the chronic elderly (Hospitals,1989:17). Such needs, according to Kelly et al. (1992:3), include complex health and social care requirements (see also Falcone et al.,1991:341).

Anyone with a chronic dysfunction is likely to experience two or more of the following phases of illness: acute, comeback, stable, unstable, deteriorating and dying (Kelly et al.,1992). These phases were initially presented by Vladeck in 1985 (Strauss et al.,1988:14) [refer to Appendix 2]. Unfortunately, however, care received is not representative of all chronic illness experience (Strauss et al.,1988:4-5). The care that is rendered in acute care hospitals is primarily oriented towards crisis (acute) intervention (Mechanic,1993:100). Thus, CNIE patients, who reside in other phases of their "health career"[4] tend to receive a form of care inappropriate to their real needs or concerns.

According to Strauss et al. (1983:3,4), current organizational arrangements of hospitals are strikingly inadequate, hence unintentionally brutal - trapped as they are by the dominant image of acute illness and its concomitant physician-dominated care. This is despite the fact that chronic diseases have become the dominant health problem in the western

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[4] The term "health career" , according to Kelly et al. (1992:6), has been chosen carefully. "Health" is defined as including social, emotional, psychological and physical well-being while the word "career" incorporates an on-going process of change, a "progress through life" analogous to the experience of a working career (refer to Appendix 2). [See also Evers,1981b; Price 1987:702-703].

world (Antonovsky,1989:244; Moros et al.,1991:162).

Major factors in the growth of long-term illness include technological advances in therapeutics, and the elimination or control of infectious and parasitic diseases (Strauss,1975:2-3). According to Maddox (cited in Maddox et al.,1989:237), a demographic transition has also occurred characterized by reduced infant mortality rates, increased life expectancy at birth and age-specific increases in longevity in the latter years. A correlate of this demographic transition was, and is, an increased incidence and prevalence of chronic as compared with acute illness and disease (see also Knottnerus,1992:15).

Medical advances that have extended longevity, however, <u>have not</u> dealt with the shift from acute to chronic illness in an aging society (Roth et al.,1991:349; Somers,1971:20; Mechanic, 1993:100,101; Cooper, 1990:14,15). The following review of literature will expound on this argument.

As McCarthy (1984:v) describes it, the prospect of a limitless advance of science and technology, accompanied at each step by moral and political improvement, has exercised a considerable hold over Western thought. Medicine's scientific foundation was important because medicine drew from it the same privileged epistemological status as that accorded to science. The history of medicine then, was frequently expressed in triumphant terms: as a process of refining, of separating the pure, neutral, scientific essence from everything that had contaminated it (Wright et al.,1982:4).

To Allan et al.(1988:23), the germ theory marked the beginning of biomedicine. This revolutionalized biomedicine by providing a scientific rationale for a continued commitment to the Cartesian belief in the opposition of mind and body. According to Antonovsky (1989:249), the germ theory as a guiding principle in our health care system is still triumphant.

According to Wright et al. (1982:6), medical knowledge in our society claims to have a technical status which removes it from precepts such as religion or ethics which are seen as contestable but those of science incontrovertible . To Crichton (1990:155), Canadians accepted the medical model for they believed that science resulted in progress and they wanted a method for developing the future technology of medical care.

In this study I follow Howard Berliner's definition of the term "medicine" : the theory and practice of healing in which (1) invasive manipulations are used to restore/maintain the human organism at a statistically determined equilibrium; (2) the patient's role is largely passive and the healing is accomplished through external means; and (3) ill health and disequilibrium are assumed to be materially generated by specific elements such as viruses, bacteria, parasites, genetic malformations, etc., and can be empirically observed (Berliner,1982:162; refer also to Berliner,1985).

Berliner's term "medicine" is synonymous with "scientific medicine" as it postulates rational theories of disease aetiology. Biomedicine (BMS) is today's scientific medicine

(Foss,1987). According to Caper (1988:51), the medical profession has encouraged the image of medicine as a science-based discipline.

The image of medicine as a science-based discipline received a great boost when "The Flexner Report", commissioned by Andrew Carnegie, was completed in 1910. This report advocated that medicine ought to follow the Johns Hopkins University medical school program. This model, which was quickly adopted by both the United States and Canada, has a strong biomedical and clinical emphasis (Flexner,1910). The impact of this report is not to be underestimated as it has perpetuated a reliance on "high-tech" diagnostic procedures as well as a biomedical form of health care intervention (Estes et al.,1989:590) [Refer also to Berliner, 1985:101-127].

The crippling flaw of the medical model, however, is that it does not include the patient and his or her attributes as a person (Engel,1980:536; Hickey et al.,1992:3). Once scientific medicine became the dominant mode of medicine, a method of perception that denied the significance of subjectivity took hold (Jecker et al., 1991:287). The significance of patients' subjective preferences, experiences and feelings was negated. Strauss et al.(1988:16-17) concur, noting that the biophysical / biomedical approach to health care intervention excludes cultural, emotional, social, and other problems (e.g. economic, environmental and political factors - refer to Brown [1979]), that play an important role in human disorders (see also

Brown,1991:596,602; Foss,1989:165; Blishen,1991:162; Lalonde, 1974). The scientific, positivist, medical paradigm is unable to explain the nature of these connections and in consequence, health care policy ignores them (Blishen,1991:160).

Medical practitioners fit illnesses into abstract diagnostic categories that are independent of the environment, culture and society (Allan et al.,1988:24,26). To receive care, therefore, the person's subjective sense of what is wrong and the complexity of social-environmental relationships involved must be reduced to a biological malfunction. The patient's disease, then, is understood apart from contextualizing factors, and causation is presumed to be monoetiological.

The BMS model can make provision neither for the person as a whole nor for data of a psychological or social nature (Engel,1980; Hollandsworth,1988:425). The reductionism and mind-body dualism upon which the model is predicated requires that these first be reduced to physicochemical terms before they can have meaning (Engel,1980:536). This supports Fabrega's contention (1990:612) that the BMS model does less well with respect to the promotion of social harmony, the maintenance of the sacredness of the individual (e.g. wherein a patient is treated as a human being rather than an object), and his/her interpersonal and social ties in the context of illness.

Hall (1976:79) suggests a need for a better understanding of the interdependence between health and other major social systems such as education. Effective health care systems are more and more dependent upon harmonious interaction with other disciplines such as medicine, nursing and sociology (see also Brown,1991; Mechanic,1993:99). To Allan et al. (1988:24), such fields as anthropology, sociology, nursing, homeopathy and other disciplines can question the effectiveness of the medical model approach in today's health care system.

Sociological considerations are important in ascertaining the etiology (causation factors) and development of chronic conditions, as well as both professional and organizational responses to these conditions (Maddox et al.,1989:236). Sociologists may also strive to develop a symbiotic relationship with health care workers such as nurses to assist them in their primary objective - good patient care (Cox,1979 :237). The medical model, however, disregards the increasing evidence that the diseases people are confronting today are both multifactorial and involve interacting physiological, genetic, psychological and sociological components (Allan et al.,1988:26; Cassel,1974; Engelhardt,1974; Dubos,1959). Physicians, biomedical scientists and health professionals need to recognize the incompleteness of their endeavours when they exclude the humanities (Engelhardt, 1990:239). According to Eisenberg (1988), however:

> "...because being able to describe the pathophysiology of disease is so central to the culture of biomedicine, physicians continue to be sceptics about social research, when they are not downright arrogant in their dismissal of it" (Page 488).

For Helman (1990:87) the biomedical science approach goes with the assumption that human universals, once found, can be abstracted from the jungle of cultural differences; that psychological and sociological aspects (and other human factor considerations) may be discarded since they are not quantifiably measurable. Here, the modern Western view of clinical reality assumes that biological concerns are more basic, "real", clinically significant, and interesting than psychological and sociocultural issues.

Conditions such as chronic pain, however, should be firmly viewed as complex biopsychosocial phenomena (Roy,1992:3; Blishen,1991:161-162). The importance of this is addressed by such researchers as Hickey et al. (1992:9) who state that individuals over seventy, are more likely to experience comorbidity and, with this, a likely further onslaught of other conditions such as depression, apathy, anxiety and/or other related symptoms (see also McEwan et al.,1991). Chronic pain victims often present somatic and depressive symptoms as well as social withdrawal (Roy,1992:4,9).

Psychosocial dysfunctions that often accommodate illness conditions underline the need and importance of social support, particularly while in hospital. Social support has been shown to have a significant effect on physical and psychiatric morbidity, mortality and a sense of subjective well-being (Cohen et al.,1985; Teresa et al.,1987). According to Blishen (1991:161), pre-existing psychological and physical states appear to condition, and are conditioned by, an individual's perception of such factors as the social environment. A senior's sense of ability , for instance, to take charge of activities, promotes a happier and often naturally longer life (Keeton,1992:46). On the other hand, psychosocial problems such as depression are perpetuated when individuals have few opportunities to become involved in meaningful activities (Evers, 1981:584). This, unfortunately, is a common problem for seniors residing in acute care hospitals. This lack of autonomy can be detrimental to emotional, behavioral and physical well-being (Hofland,1988:5).

Helman (1991:1080) points to a widening gap between lay and medical perspectives on ill health. The medical perspective, using the biomedical science model, has its emphasis on physiologic data while the "illness" perspective (the lay person's interpretation) is the subjective experiences of the sickness and the meanings that are given to such experiences. Physicians diagnose and treat disease, whereas people suffer illnesses (Eisenberg,1977).

To Lee et al. (1992:402) and Alan et al. (1988:24), disease is frequently viewed by medical practitioners as a malfunctioning of the body chemistry, tissues, organs, and thus is a physical or pathological concept. Medical staff see improvements largely in terms of overcoming the disease. Patients meanwhile conceptualize their illness as the experience of having the disease itself. Interestingly, patient satisfaction is more strongly associated with medical staff attending to their psychosocial fears rather than just their pathological disease characteristics (Lee et al.,1992:409-410). Clearly then, the concept of 'illness' ought to encompass the sociopsychological aspects of chronic disorders to take such factors into account.

According to Clive et al. (1983:319), the disease model implemented in the health care system (indicative of the biomedical science approach) explicitly labels patients and the manifestations of the label are implicit and generally left to expert clinical interpretation. Interpretation is, however, confounded since the labels are assumed to apply either completely or not at all towards describing a patients' condition.

Holden (1990:223) states clearly that the medical model encourages the perception that the patient is "essentially and only their medical diagnosis," and, as a result, hospital staff relate to patients as if they are a kidney, a gall stone, an ulcer, etc. . According to Allan et al. (1988:25), such diagnostic labelling forces medical practitioners to label everything, even when no valid labels exist. This leads to treatment of disease as an end in itself, not as a means for a better life, to self-defined goals or happiness. Diagnostic labelling of the medical model robs people of their control over their lives, and what they feel about their bodies (Hall et al.,1986 as cited in Allan et al.,1988:25).

Remen (1980:8) suggests that too often a diagnostic label may cause one to believe a situation is frozen in its present form, thereby seriously limiting potential by promoting hopelessness. A label (e.g. "diabetic") also tells us little about the person to whom it has been applied , who they are and who they can become.

According to Weick (1983:467), built into this process of diagnosis and treatment is an analytic-linear-dualistic bias which reinforces a pathologic (disease) view of human troubles. This dehumanizes the patient. By formulating a medical diagnosis, the patient is converted into an object and from there, placed into a homogeneous group (Turk,1990: 255). According to Roy (1992:4) and Baker (1988:6), however, the elderly are <u>not</u> a homogeneous group: they vary considerably by gender, class, ethnicity, geographic location, state of health and age. Further, chronic conditions exhibit differing characteristics, including considerable variability in the manifestation of pain and symptoms (Hickey et al.,1992:7). To maximize the quality of care then, both physician and patient must seek to understand each other's goals. Patient goals do not flow just from the nature of the disease state but also from the nature of the patient as a human being (Steffen, 1988:59).

Lewis (1989:201) suggests that modern scientists, with their fascination for prolonging life, have continued to strive for new methods of eliminating disease and extending youth. According to Strauss (1975:4), health care personnel think about conquering chronic disease in the same manner as if it were epidemic (short-term) in nature. Yet, while it is perfectly true that some chronic diseases can be "conquered", not all can and certainly not soon. To Pavelich (1992), this form of thinking continues as individuals, for whom no curative measure is known, are often forced to endure a program designed for patients who are recovering (see also Muller et al., 1988:368). Clearly, then, a potential failing of the disease model is that it does not easily deal with the anatomic and physiologic changes collectively called "normal aging". Normal deterioration cannot be attributed to disease (Wallace et al.,1992:19). Old age and disease are <u>not</u> synonymous (Seymour,1991:27; Baker,1984:543; Estes et al.,1989: 588). The patient with chronic pain, therefore, according to Roy (1992: xiii), often represents a failing in conventional medicine (see also Brown,1991:602).

As people age, enduring chronic illness tends to replace the briefer acute illness episodes of youth (Prigerson,1992:379; Hickey et al.,1992:1). In old age, chronic illness occurs at **four times** the rate it does in younger years, while acute illness occurs at a lower rate (Eliopoulos,1991:45). Yet, the Western physician often loses interest in chronic diseases for they are preoccupied with the intrigues of diagnosis and the heroics of curing. He or she may even resent the patient when he/she cannot fulfil this goal. Such an orientation clearly does not make short-stay hospitals a comfortable nor suitable place for long-term stay (Alexander et al.,1975:568; Liaschenko et al.,1991:276).

To Hoffman (1974:53) the general hospital is strongly committed to the classical medical goals of healing and curing - it is oriented towards the treatment of acute, transient illness and the whole tempo of the hospital is designed for intensive and immediate treatment. Liaschenko (1991) supports this by stating:

> "Modern health care practices support the myth that suffering is avoidable. Suffering is viewed as a problem to be solved, moulded and manipulated until it is amendable to some form of intervention, usually technological" (277). [See also Mechanic, 1993:100].

According to Williamson (1988:250), hospitals are increasingly places for cure rather than care or convalescence. The most efficient bed use is seen to be the one that permits the most patients to be treated in the shortest space of time with little emphasis on long-term outcome.

Seymour (1991:27) points out that, by definition, hospitalization in an active treatment hospital is not long term. Yet, for many ill elderly persons, admission to an active treatment hospital is the entry into the long-term service and care systems. Chronic condition(s) cause functional impairment that lasts for months or years or indefinitely (West,1991:4). The management of chronic illness usually continues over an extended period of time (Hickey et al.,1992:3). The permanence and irreversibility of long-term illness and disability pose a basic contrast to Talcott Parson's model which conceives of illness as a temporary event followed by full recovery (Ruffling-Rahal,1985:17; Brown,1991:597; Parsons, 1951).

To take one example, chronic pain is not the same as acute pain. The former requires a rehabilitative approach while the latter demands a curative approach (Roy,1992:ix; McCusker et al., 1989:504). Chronic pain primarily remains impervious to permanent cure (Roy,1992:xiii). According to Spence et al. (1968:976), however, when medical staff perceive that "nothing can be done" - when all medical, technical, and scientific strategies fail to heal or cure the patient - medical "care"[5] towards the aged long-term patient becomes characterized by negativism, defeatism and professional antipathy. This can be reflected in the actions health professionals have towards their patients.

Bowers 1988, for instance, (cited in Rosenthal,1992:171), found that families of institutionalized elders were distressed by the staff's failure to provide what she termed "preservative care," that is care directed toward preserving the elder's dignity, control over the environment and hope.

As noted by Preston (1986:123), for those who are incurably ill, (as typical of the chronic, nonacutely ill elderly population), either with fatal or non-fatal diseases, caring is extremely important (see also Levine et al., 1987). To Watson et al. (1988) we are now beyond the era where cure/curing should take precedence - we have entered an era where care/caring must take precedence. Preston (1986:122) mentions, however, that given the primary focus of our health care system towards cure,

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[5] There is need to distinguish between 'caring for' and 'caring about'. According to Jecker et al. (1991:302), health professionals care all the time as he or she is a 'caregiver'. Given a biomedical approach to health intervention, such caregivers may lack an attitude of caring 'about' patients (refer to Hutchinson et al.,1991 for a discussion on the attributes of caring).

Further, similar to Jecker et al. (1991), in this study, 'care' and 'caring' are used interchangeably. While there may be important differences of meaning to each term, these are beyond the present scope of inquiry.

reliance on this goal tends to make the physician disregard the need for caring. Evidence for this is indicated by Drew (1986), noting that patients are not satisfied with the quality of human interaction found in health care delivery. What is missing is the humanistic art or act of caring (Chipman,1991). It is that indescribable extra touch of human understanding and kindness that elderly patients long for.

To Hall (1976:79), if care and cure may be thought of as two sides of a coin, it may be said that the cure side has been deeply etched while the care side has been neglected and eroded. According to Liaschenko et al.(1991:275), the practice of medicine continues to be overly cure oriented. Guidelines for the care of the chronically ill and aged remain quite unclear (Roth et al.,1991:344).

According to Cooper (1990):

> "The most obvious incongruity between the traditional goals of medicine and the needs of the chronically ill comes from the reality that cure is not a reasonable goal in chronic illness. The goal in chronic illness is not to restore the patient to optimal health by obliterating the disease, but to maximize the patients' ability to live with the disease" (Page 11).

Leininger (cited in Marriner 1986) believes that 'care' is the human service quality that makes health consumers either satisfied or dissatisfied with health services. She goes on to say that it is the care, not the cure, that health consumers really value. Healing and curing are distinct functions. Failure to recognize the difference between them frequently puts the doctor and patient at cross-purposes (Preston,1986:63).

According to Seymour (1991:27), cure refers to diagnosis and treatment of disease, whereas care refers to the assessments and interventions used to make judgements about the well-being and welfare of the person (see also Donabedian,1988:180). Most importantly, cure is often implemented by doing things to a patient while care is fundamentally offered by doing things with the patient.

Radecki et al. 1988, show that physicians tend to spend less time with older patients than with younger patients. They conclude that elderly patients are not receiving the attention that they should be getting. Keeler et al. (1982) came to the same conclusion noting further that average encounter times dropped for older patients. Collectively, these researchers suggest that the quality of care older patients receive is poorer than that received by younger patients (Globerman,1991:234).

To Preston (1986:63), while curing depends on biophysical remedies, healing is often the result produced primarily of caring. A patient who has successful surgery for the removal of a tumor, for instance, may be cured of disease but may have a remaining illness due to fear about his or her condition. As Hesse (1984) states, non-physical factors may significantly interfere with the patient's motivation for rehabilitation.

A cure orientation may, as well, create more problems than it solves. According to Hollandsworth (1988:425) and Steinmetz et al. (1992:433), for instance, medical and surgical treatments, while extending life on one hand, may actually reduce its quality on the other by requiring lengthy or multiple hospitalizations and intrusive and often painful procedures with demeaning and highly aversive side effects (e.g. iatrogenic complications - Alexander, 1990:30) [see also Hertzman et al., 1990; Illich, 1976; Gillick et al.,1982; Langham et al., 1991:78]. Such can deprive people of their human dignity (Allan et al.,1988:26). The technology of keeping people alive has actually far outdistanced the ethical ability to decide when to keep them alive (Allan et al.,1988:29).

Crichton (1990) says that many patients thank their doctors for improved mobility and longer life. But many who are growing older, or those who have to care for the elderly, wonder whether medical technology is keeping some people alive too long. "The preservation of life for as long as possible is a basic tenet in our belief system and, once a patient is admitted to institutional care, doctors and nurses do everything they can to keep that patient alive <u>even</u> if he (or she) is in a generally poor condition" (Page 122).

As noted by Pavelich (1992:21) and Samarel (1991:105), the acute care orientation also views death as a failure, almost shameful, and denies consideration to it. The goals of care according to the medical model are to prolong life, provide cures, prevent death, and ensure survival. Thus priorities of care, according to this paradigm, are survival with a primary emphasis on physical care. Small wonder, then, that the attitudes of medical and hospital staff toward long-stay patients are often less than desirable (Shapiro et al.,1992:1348; Marshall,1981; Alexander,1990:28; Adelson et al.,1982:277,280).

Barrow (1986:376) indicates that some hospital staff members react to the dying process by withdrawing emotionally at a time when the patient most needs their support. Najman et al. 1982 (cited in Globerman,1991:235) have found that doctors had negative reactions to people they have difficulty curing (see also Cooper, 1990:11; Newbern, 1987).

The chronically ill are actually seen as threats to a physician's skill - they cannot always cure - they cannot prevent death. Sankar (1988:160) quotes a physician as saying:

> "I don't like dealing with the chronically ill. When I see a patient I like to be able to make a difference,to fix someone, to cure. But to wait around for an acute episode is a waste of time"

To Preston (1986:xiv), this is a by-product of the medical setting, acquired by virtue of the physicians' unique training and experience. The medical subculture and its values are imposed on the physician and he or she in turn imposes them on his or her patients.

One may clearly see therefore, as Aronson (1985:122) has pointed out, that what is required is not simply a quantitative increase in resources dedicated to the care of the elderly, but also a qualitative reformulation of the assumptions that exist in the system itself.

There are, in fact, distinct parallels between the inherent philosophy of positivism and that of the biomedical science approach. First, let us consider the principles of positivism. According to Restivo (1991:28) positivistic theorists (1) believed in a universe ordered by discoverable and invariable natural laws; (2) ignored the supernatural or at least what was considered as supernatural; (3) focused on the phenomenal world, the world immediately accessible to our basic senses: (4) believed in the mutability of the external social order (i.e. that nature can be controlled); (5) were concerned with organic truth, useful and precise knowledge, facts; and (6) believed that their approach must lead to universal acceptance of their plans and discoveries for social action.

Positivism and the biomedical science approach share in an ideology which Robert Merton describes as a "scientific ethos". This ethos of science is the belief that scientific endeavours embody intellectual honesty, integrity, organized scepticism, disinterestedness, and impersonality (Bunge, 1991:532; Merton, 1973:225). Indeed, the triumph of science, and the emergence of exaggerated versions of it like positivism, has resulted from its ability to convince others that it is associated with removing questions of ethics, morality and human values from inquiry - that science is value-free (Restivo, 1991:28)[6] . In short,

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[6] It was Foucault who argued that an individual's ability to conceive him or herself as a "finitive being" and as a "potential object" of his or her own investigation, made the birth of empirical medicine possible in the seventeenth century (Foucault,1975). The subsequent growth of positivist medicine in eighteenth and nineteenth century Europe served to inscribe the opposition between mind and matter, object and subject and fact and value ever more emphatically into our definition of "being" (Wright et al.,1982:56). From this context, events are regulated by

positivists believed that they were completely emancipated in their thinking from ontological, metaphysical and ethical presuppositions (Mannheim,1936:89).

As noted by Revisto (1991:86), like the positivists before them, modern scientists proclaim ethical neutrality by insisting that their exclusive concern is with the advancement of knowledge. They, in short, affirm an occupational philosophy which appears to absolve them of any responsibility for intruding into a society's social values. This permits the stress on science to be perpetuated and gives reasons why scientific discoveries in the medical disciplines have influenced nursing practice, education and research (Deloughery, 1991:40).

The traditional medical model rests on the scientific assumption that every event has a cause or, in other words, every illness has an etiology. Alternatively, medical research proceeds on the assumption that correct identification of the etiology will serve to isolate the cause (or causes) of illness on the basis of which treatment and cure ultimately depends (Holden, 1990:227).

According to Ehrenreich (1978:13) medicine has also come to be based on the machine model wherein the body is conceived of as a machine made up of a group of interacting chemical and physical parts independent of the mind. The machine model includes the idea that the individual parts of the body, like the parts of a

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impersonal 'natural' laws, rather than social ties. The practice of medicine, as a result, moulds itself into a positivistic orientation.

motor car, may fail to stop working and may sometimes need to be replaced (see also Bolaria et al., 1988:2). To Weick (1983:467), within this model of disease, the treatment modes towards patients tend to be surgical procedures, pharmacologic agents, or therapeutic techniques. Modern "spare part" surgery with its widespread usage of organ transplants and electronic aids such as pace makers reinforces the image of the body as a machine (Helman,1990:23).

Masi (Part 1,1988:2177) points to the bias of the health care system in its use of technology in the treatment of illness. Williamson (1988:245) concurs with this stating that health care has become an increasingly technical field which explains why the dominant ideology of the health care system ascribes a passive acquiescent role to the patient.

A medical-student-turned-author writes:

> "As a student of the medical profession, I know I am being trained to rely heavily on technology, to assume the risk of acting is almost always preferable to the risk of not acting" "I see in all of us, including myself, absorbing the idea that when it comes to tests, technology, interventions, more is better"
> (Klass,1987:48,50)

Technical knowledge, according to Blishen (1991:160), has been created through the application of the biomedical paradigm. Evans and Stoddart (1990:6), [as cited in Blishen,1991:160], stress that the success of the BMS paradigm assisted the health care system (as well as the medical profession) to gain extraordinary institutional dominance, defining both how health was to be pursued and what counted as health.

For McCarthy (1984:v), critical distancing from tradition (e.g. from a more patient-centred approach to health care) has gone hand in hand with alienation and anomie. He indicates that medical "progress" (accompanied by technological "progress") has by no means been a neutral process for it has all too often meant the loss of self-determination and freedom due to our acquired (often unconscious) dependence on science. As doctors become distracted by technology, the human element becomes secondary (Carlson,1992:229). Dependence on "science", in effect, is at the expense of the humanity of the patient (Liaschenko,1991:276).

According to Meterko et al. (1990:S1), multiple medical specialists and technicians, plus increasingly sophisticated treatments, may cause patients to receive a more fragmented and less continuous health care experience. Further, the patient's perception that they have a personal doctor who cares about their well-being may be diminished.

Traditionally, hospitals have been most concerned with high technology (Rocheleau,1983:1). The development of highly technological, tertiary and inpatient medical care has also preoccupied the attention of our teaching institutions (Goroll et al.,1987:xi). According to Rosenberg (1992:733), there is less and less stress on the importance of patient history and greater stress on the various "high-tech" procedures (see also Langham et al.,1991:77). But this can easily lead to problems since within the "high-tech" environment of today's acute care facility, the perspective of the patient as a dynamic human being, as a whole person, can be quickly lost (Tappen et al.,1992:149).

The medical model focuses mainly on those aspects of illness that can be subjected to scientific, usually laboratory measurement (Hewa,1992:2). The technical medical record (the patient's chart) contains no information about interpersonal quality of care (Meterko et al.,1990:S2). Resistive to this approach are the elderly (Rocheleau,1983:1) but short-term general hospitals remain resistive themselves towards ideological innovations such as the need to treat patients in new and different ways (Rocheleau, 1983:9). The emphasis in the past has not been on maximizing function or returning the elderly person to their home; rather, the emphasis often has been on infantilizing and disenfranchising patients (Buckwater et al., 1991:483; Sankar, 1988:158). Clearly, rather than advocating empowerment, hospitals promote dependence, powerlessness and alienation which is particularly felt by the hospitalized or institutionalized elderly. Powerlessness is apt to be more problematic for elderly persons because of functional losses and chronic illnesses that often accompany aging (Buckwater et al.,1991:449).

Physician -training

According to Blishen (1991:76), the most important socializing influence on the student is the medical school. There, professional values, interests and goals which shape the caregiver's perspective become engrained.

While some argue that psychosocial considerations have been seriously addressed and have been integrated into the medical curriculum, prevalent problems remain. According to Gordon (1988:20), for instance, despite many changes, many important approaches (e.g. the mind-body dualism) remain the same. Current medical education is still biased toward the view that the body is a machine and ignores many of the cultural, social, environmental and psychological factors in human existence (Hewa,1992:10)[7].

For Antonovsky (1989), an alternative paradigm such as the biopsychosocial approach to health care intervention has not only failed to supplant the biomedical model, it also has had marginal impact to date. "The latter [BMS approach] is alive and well and there are few signs of its being questioned by the mainstream of medicine" (Page 243). Little if any progress has been made in the replacement of the biomedical model.

According to Hickey et al. (1992:14), the experience of chronic illness is multidimensional, involving psychological,

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[7] Warren (1971) and Alford (1975) [as cited in Imershein, 1977:39], propose possible reasons for the difficulties in implementing alternatives such as a biopsychosocial paradigm. Alford, for instance, notes that proposed recommendations may be no more than ideological statements with minimal indication as to how they might be implemented. Exemplars (models) for the direction of alternative modes of organizational activities are needed without which no real changes are likely to occur. According to Imershein (1977) "Without an alternative paradigm in which these recommendations could be clearly defined, the proposals for change could simply be interpreted into the already ongoing operations under the current paradigm" (Page 39). According to Armstrong (1987), this is exactly what has happened to the biopsychosocial model. Consider also Antonovsky (1989:247), who states that a dominant paradigm remains dominant by incorporating relatively peripheral aspects of its challenger.

medical and social aspects - all of which must be addressed in the education of health care providers. According to Antonovskys' research physicians forego such factors since there is a greater guarantee then that they will remain autonomous and in full control of their domain of expertise (1989:250). To expand on this, according to Street (1992:8), the continuation of a BMS approach to health care permits physicians to remain in control of subordinated occupations such as nursing.

As to physician-patient interaction, according to Barrows (1990:4-5), despite the importance of effective communication this skill is not given proper emphasis in the training of medical personnel, especially doctors . The highest ranking operatives in the health care system - the doctors - receive little to no professional training in interpersonal communication skills (Pilpel,1990:29). The special communication needs of older people need to be addressed in the training of health care providers (Hickey et al.,1992:7). Unfortunately, the training they do receive perpetuates the failure to negotiate shared clinical realities with their patients. This robs their therapeutics of much of their healing efficacy (Good et al., 1981:195). Elderly patients are still spectators rather than participants in their own health care (Williamson,1988:249).

According to Mechanic (1993:101), students typically enter medical education with humane and caring motives, but increasingly become cynical as they confront the demands of their training programs. A caring attitude towards the patients they serve often dissipates (see also Haas,1978:214,216). Strauss et al. (1988:16) notes that, because of their acute care orientation as well as their work schedules, few nurses and probably fewer physicians are equipped to provide multifaced (i.e. psychosocial) assistance (see also Waitzkin,1991).

For Antonovsky (1989:249), the most difficult task for even the most brilliant of physicians is keeping up with the literature of his or her own specialization. Reluctance to revise the traditional conceptual apparatus on which his or her practice is based (via a BMS approach) becomes common. Physicians come to believe that it is far easier to use computers and algorithms to become more 'scientific'.

According to Mickleburgh (1992:A8), another major problem in meeting the unique care needs of the ill elderly is that it is still possible to graduate from most medical schools with no exposure to such fields as geriatric medicine. On medical licensing exams, only 1 per cent of the questions deal with geriatric matters. Further, he notes that doctors shy away from geriatrics as a specialty because it is not seen as glamorous and is generally poorly rewarded. Since 1981, Canada produced 967 pediatricians but only 68 graduates in geriatrics (Mickleburgh, 1992:A1).

Eliopoulos (1991:vii) demonstrates that few nurses have received specialized training in gerontological nursing. According to Bueno (1991:7), nurses (the primary caregivers) are socialized to be rational, scientific thinkers. They are taught to search for logical explanations and to apply deductive or inductive research and problem-solving techniques.

Matthews et al. (1988:159) emphasize that yet another problem is that personal care is not emphasized in current medical education. There is a lack of well established methods of how it ought to be studied and taught.

Lubkin (1986) indicates that hospital staff are primarily trained to handle the acute phase of illness thus providing only medical counselling and procedures. According to Preston (1986:64), medical students are taught to react to medical problems with curative measures - not how to recognize nonphysical sources of distress and the need for healing. They respond to almost all pleas for caring by administering curative therapy - a drug or an operation. They are not comfortable with caring because its effects are not measurable; it produces no useful statistics. Medical tradition still holds that to become successful physicians, students should master, if not suppress, their emotional and psychological responsiveness (Hewa,1992:11). Medical students come to believe that "they have no time for the frills of emotional involvement and quickly learn to close off feelings that interfere with their work... they are eager to start what they consider to be their "real" medical studies" (Haas et al.,1987:143; see also Haas et al., 1988).

Thomas Preston, a renowned American cardiologist, says that the explanation for physicians' arrogance is not in the individuals but in the training they receive and in the structure of the professional setting. Somehow in the process of becoming a physician, loyalty is focussed on the profession that nurtures and sustains, and everything else becomes subordinated to that end - including the patient (Preston,1986:xii).

To West (1991:6), no matter how much education most of us have experienced, we haven't been old yet, "And if you haven't been old yet, you can't fully appreciate what it is to be old" (West,1991:6). All the more reason, then, to take into consideration the elderly patient's perspective in his or her care.

Yet, the biomedical theory of illness has indoctrinated physicians (the practitioners of biomedicine) to give precedence to matters related to disease (disordered physical-chemical or physiological systems) rather than a consideration of the whole person (Fabrega,1990:613). Lay theories of illness are neglected and existential personalized meanings associated with illness generally minimized (Fabrega,1990:609). A patient's values, desires, and beliefs may be too easily ignored by the physician who, "in trying to cure, relieve and comfort, forgets to listen" (Steffen,1988:59). The ill and their intimates (e.g. family) can profit from counsel that goes far beyond what most physicians and nurses are trained to give (Strauss et al.,1988:5).

Coburn et al. (1983:410) suggest that from 1945 on, the medical profession has been at the height of its power with interests imbedded in legal and administrative structures. Power is allocated to physicians to the point that patients have little say in what is done to them. As a result, priority is given to hospital-based procedures. This shows in part how the Canadian medical establishment possesses medical dominance analogous to that of the established church in the medieval period (Stacy et al.,1986:1). This dominance is not merely through an imposed ideology but through the living out of class values, informally and unconsciously often in a variety of social institutions (Green,1990:226).

It should be clear to the reader that a medical model is the very opposite of a patient centred approach to health care as it fails to take into consideration the unique and individual needs of such populations as the chronic, non-acutely ill elderly. To understand the importance of this statement, let us focus on what "patient-centred care" entails.

CONCEPT OF PATIENT-CENTRED CARE

According to Henbest et al. (1992), patient-centred means "putting the person of the patient at the centre of the consultation and attempting to understand the patient's thoughts, feelings and expectations, as well as his or her symptoms" (Page 311).

For Nellie C. Robinson (RN), a patient-centred framework for restructuring care can "facilitate the redesign of delivery systems that will rebuild trust and confidence in quality of services, meet consumer expectations, and allow for considerations to be given to human and financial resource limitations......operationalizing a framework that places the patient at the centre of all operations is therefore the appropriate response to achieving high-quality services, cost efficiency; and patient, nurse, and physician satisfaction.... Within a patient-centred environment, the patient is the primary focus of nursing care activities, staff and services are organized around the needs of patients, and emphasis is placed on meeting individualized patient care needs" (Abdellah et al., 1961).

Williamson (1988) suggests that within a consumer oriented service, "it is particularly important to involve the elderly as active participants in their own health care if their cherished independence is to be maintained" (Page 247).

According to Delores Gaut (1983), there is no clear-cut rule for the use of the word "caring" - the family of meanings all relate to three categories: attention to or concern for the patient; regard for, attachment to or fondness for the patient; and responsibility for or providing for the patient.

Patient/resident-oriented care has been found by King et al. 1971 and Raynes et al. 1979, (as cited in Garety et al., 1984 :183), to be characterized by health practices that are flexibly planned to meet individual needs. This is in contrast to institutionally oriented practices which foster the smooth running of the institution, often at the expense of the patient (Garety et al.,1984:183). Two such management practices, for instance, noted by King et al. (1971) as being typical of institutionally oriented care, are : rigidity of routine and depersonalization. Depersonalization and dependency begin on admission to hospital with the shedding of clothing, possessions and control. Patients may easily start to feel vulnerable as they wait for procedures and medications. These problems are magnified for the older person (Seymour,1991:26).

Although well-being as an accompaniment to long-term impairment cannot imply full restoration of former capability, it can reflect a "spirit of singular achievement", particularly in confronting the erosions of personal autonomy and coping with the irreversibility of the condition. Significantly, long-term illness can itself incorporate life meaning and social participation, making health and well-being inherent aspects (Ruffing-Rahal, 1985:18).

Robinson (1991) suggests that in order to successfully create a patient-centred environment as the mission of the hospital, its overall basic philosophy, values, beliefs and priorities need to be related to patient-centred care delivery. In short, aspects such as the method of care delivery require examination and redesign to facilitate the goals of a patient-centred environment (Robinson,1991:33). Such goals are intended to emphasize that the service exists for those who use it and who should therefore determine how it is run (Williamson,1988:256).

Various researchers suggest that the facilitation of patient-centred care (as opposed to the continued utilization of a BMS approach) will come about only when a new conceptualization or theoretical framework in thinking (and thus acting) transpires. According to Lebacqz (1992), "the best of medical practice always acknowledges that received paradigms may be limited and that new perspectives are needed" (303).

In this chapter, the limitations of the traditional, positivistic and narrowly conceptualized biomedical (disease) model approach ('paradigm') have been discussed. In chapter three of this study, the theoretical basis and limitations of 'paradigms' shall be explored. In addition, the call for a "paradigm-shift" or "revolution" for our existing health care system (to bring about improved care for such patients as the CNIE population) will be considered.

CHAPTER III

THEORY

> "Whereas the medical model may be appropriate when considered in the context of acute illness, it has become a misdirected, yet powerful and pervasive force, in the management of chronic illness, long-term care, and even our understanding of the aging process".
> (Roth et al.,1991:349)

As discussed in chapter two, researchers such as Helman (1991) and Hewa (1992) indicate that the paradigm which currently dominates the Canadian health care system is the biomedical science model. This model defines the type of "care"/intervention given towards individual elderly patients. Such researchers suggest that, as a result, perceptual incongruence between the care-giver and the care-receiver arises - resulting in dissatisfaction. In other words, as the primary goal of the health care system is to cure while the primary goal and/or need of such patient populations as the chronic, non-acutely ill elderly is for care, an improved balance between the care/cure dichotomies must come about to facilitate patient-centred interaction.

The biomedical science approach is clearly an inappropriate intervention strategy in the "care" of the chronic elderly. Its dehumanizing qualities [as noted by such researchers as Haug (1981), Strauss et al. (1984), Corbin (1988), and Cooper (1990)] include : (1) ignoring psychological, social, cultural and environmental considerations, hence excluding non-medical, non-scientific factors as to their impact on health and illness; (2) stressing an analytic, intensive, reductionist and parsimonious scientific approach thereby upholding a positivistic-like orientation; (3) its promotion of passivity or passive cooperation in those patients for whose benefit the system is supposed to work; (4) its emphasis on an intrasomatic, technocratic and precise form of rationalization which leads to a narrow focus or emphasis on cure rather than rehabilitation , coping or the quality of care rendered to the patient.

According to Chappell et al. (1986:155), it has become necessary to reconstruct the health delivery system since, if the current disease-oriented approach continues to be the single approach towards the chronically ill elderly, the real needs of this unique population will continue to be unmet.

For improved care towards CNIE persons in an acute care hospital, an alternative model to guide health care intervention is required (refer to Blishen,1991:160). A shift in conceptualization, from a biomedical science approach to a biopsychosocial-like approach, is needed (refer to Tables 1 and 2). This new model (or "paradigm-shift"), would cultivate a patient-centred approach by striving to integrate the psychological, social and medical factors associated with illness into the health care regimen (refer to Maddox et al.,1989:258). A paradigm-shift in the existing mode of health care delivery would reorganize its activities (Imershein,1974:10) for the betterment of those it is supposed to serve - the patient.

Table 1[1]

The Differences Between The Biomedical Science Approach versus The Biopsychosocial-like Approach

Characteristics Of A Biomedical Science Approach	Attributes Of A Biopsychosocial-like Approach
Cure	Care or prevention Palliative
Acute care oriented	Natural chronic degeneration considered
Diseased Body	Sick person
Etiological (physical) factors	Risk or situational factors
Technical	Nontechnical
Nonpersonal	Personal
Technical Mastery	Helping to cope
Individual seen as a disease	Individual connected to environment
Disease mechanisms	Disease origins
Disease or disability seen as a thing	Disease or disability seen as a process
Death (Failure/Denied)	Death (Natural/Accepted)
Prevent Death	Assist with dying process
Prolong Life	Comfort
Survival	Maintain quality of life
Person dependent	Person autonomous
Body and mind are separate	Body, mind, and spirit inseparable

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[1] Adapted from the following sources: Samarel (1991:105), Foss et al., (1987:105) and Buntrock (1988:20-21). Refer also to Chapter II of this study.

Table 1 - Continued

The Differences Between The Biomedical Science Approach versus The Biopsychosocial-like Approach

Characteristics Of A Biomedical Science Approach	Attributes Of A Biopsychosocial-like Approach
Body seen as a machine in good or bad repair - patient is treated like an object	Body seen as a dynamic system - patient is treated like a person

Table 2[2]

The Differences Between The Biomedical Science Approach versus The Biopsychosocial-like Approach - Professional Caregivers' Roles, Activities and Attitudes

Characteristics Of A Biomedical Science Approach	Attributes Of A Biopsychosocial-like Approach
Health Care Professional Role	
Authority	Therapeutic partner
Emotionally neutral	Caring is a component of healing
Emphasis on efficiency	Emphasis on human values
Physician directs and orders care	Skills of many healers used. Patient has say in care intervention strategy or technique.
Professional Activities	
Specialized	Integrated, concerned with whole patient
Treat symptoms and disease ontologically	Search for causes and patterns as well as treating symptoms and disease: emphasis is on <u>multiple</u> variables affecting wellness

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[2] Adapted from Buntrock (1988:21-22).

The biopsychosocial model takes into account the missing dimensions of the biomedical model and it is free of the reductionist restraints the medical model imposes (Engel,1980: 535,538). Further, this model[3] of medicine embraces chemical, biological, psychological, social and environmental factors which contribute to health and illness (Hewa,1992:8). There is now greater evidence that the economic, social and cultural structures of society profoundly influence health (Antonovsky, 1989:245). According to Strauss et al.(1988:35), clinical care would be better supplemented by a consideration of such variables. Because health attitudes and behavior are influenced by cultural and social values, the biopsychosocial approach places great emphasis on an understanding of these important factors (Hewa,1992:12).

A biopsychosocial model of care parallels the attributes/ goals of a patient-centred approach. Medical practitioners, for instance, who incorporate a biopsychosocial paradigm can be helped in determining how the patient perceives his or her own health or illness (Hewa,1992:8). The biopsychosocial approach, for purposes of this study, is considered synonymous with a patient-centred mode of health care intervention as both insist that the patient also has knowledge, responsibility and wisdom as well as rights and power which can be shared or withheld from the physician (and other health care staff), as the patient chooses

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[3] The biopsychosocial model was initially proposed by George Engel (1977).

(refer to Antonovsky,1989:250). Further, both embody the philosophy that it is the patient, the person, who must be treated and/or cared for, <u>not</u> solely the disease.

Seymour (1991:27) observes in the context of implementing a biopsychosocial approach that nurses who work with the elderly in acute treatment hospitals may begin to ask what the basic needs of these ill elderly are, once the goal of cure can no longer be met.

There are distinct advantages in utilizing a biopsychosocial mode of health care intervention. Consider, for instance, the following. In the use of the biomedical model, the diagnostic label is applied only after measurable abnormalities have appeared. In contrast, the biopsychosocial model enables the physician to recognize illness and begin treatment <u>before</u> the abnormalities appear. For example, the term "indigestion" is often used without precise medical meaning - nausea, heartburn, abdominal pain, vomiting - all have been called indigestion. However, these symptoms may reflect such various causes as emotional stress, acute infection or perhaps even cancer. The physician trained in the biopsychosocial model can trace the precise causes of these symptoms by supplementing laboratory data with a host of psychosocial and other observations and commence treatment before the symptoms develop into serious illnesses (Hewa,1992:10).

> "In recent years, we have recognized that laboratory measurements of health and illness are insufficient, and that the mechanistic approach of the biomedical model has reached its limits. The growing dissatisfaction with this model indicates that it can no longer provide satisfactory solutions to contemporary health disorders such as cancer, heart and respiratory diseases. The biomedical model does not take into account the environmental, social and cultural factors that influence these common diseases in Western societies" (Hewa,1992:7-8).

Yet, according to Antonovsky (1989:247) little if any progress has been made in replacing the biomedical model. Anomalies, phenomena that this paradigm cannot account for, have been ignored by and large. But they accumulate and may trigger a "revolution" - a "paradigm-shift" (Horgan,1991:40; Imershein, 1977:33).

Every scientific model becomes exhausted after a time - that is, the existing methods and theories no longer provide satisfactory solutions to emerging problems (Kuhn, 1962 as cited in Hewa, 1992:3). Only through a "revolution" may a rejection of a dominant paradigm (i.e. the biomedical science approach) and acceptance of an alternative one (i.e. a biopsychosocial-like/ patient-centred paradigm) transpire (Imershein,1980:314). According to Henbest et al. (1992:311), a patient-centred approach to health care demands a shift from thinking and responding in terms of disease and pathology towards caring and understanding people and their problems (see also Henbest, 1990 :28). This new model of health care delivery, this "revolution", will require a reorganization of an enormous body of knowledge

(Hewa,1992:4)[4].

The integration of the concept "paradigm", (a term initiated by Thomas Kuhn[5]), as it is used to describe a unique body of knowledge inherent in such models as the biomedical science model, is not new. Researchers such as Buntrock (1988), Foss et al. (1987), Imershein (1974), and Hewa (1991), have made large use of the word "paradigm" in their writings (see also Price, 1987). In particular, Buntrock (1988) and Imershein (1974) have used Kuhnian terminology in their Ph.D. dissertations and associated articles. These researchers, as have others, have addressed the need for a paradigm-shift in health care delivery.

In his book entitled, <u>The Structure of Scientific</u>

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[4] This "revolution" may take on a variety of forms. A biopsychosocial model is but one of a variety of proposed new conceptualizations for a modified health intervention strategy. Bronfenbrenner (1979) [as cited in Barusch,1991:5] presents, for instance, an ecological perspective to direct attention (importance) to the interaction between a person and his or her environment. This perspective takes into consideration (embodies) norms, societal values, cultural practices, policy makers, service providers, and the care receiver.

Another form in which a "revolution" may be exhibited is, according to Foss et al. (1987), known as the "Infomedical Model". This highly sophisticated approach links information from multiple levels of organization of mind, body and culture. This is an approach based on postmodern principles of interactionism, emergence, loop structure, mutual causality and self-organization (Foss et al., 1987:ix,2).

[5] Thomas S. Kuhn is presently the Laurance S. Rockefeller Professor of Philosophy at the Massachusetts Institute of Technology. A graduate student in theoretical physics, he did a 180 degree turn by pursuing a career as an historian of science. His emphasis specifically is on the substantive content of science - how changes in the focus and organization of scientific knowledge come about. More than most historian philosophers of science, he has dealt with the social structure of the "scientific community" as basic to the operation of paradigms and more generally, to the development of science (Merton,1973 :xxviii).

Revolutions, (1970), Thomas Kuhn addresses three central issues. These areas are: (1) his concern with the dynamic process by which scientific knowledge is acquired; (2) his keen interest in grasping an understanding of why and what particular problems (puzzles) scientists undertake; and (3) his arguments that the specific analysis and/or approach undertaken by researchers is embedded (engulfed) in a particular research tradition, and is a by-product of a taken-for-granted set of assumptions and principles through which a particular system is transmitted and enforced (e.g. the educational system and its usage of textbooks) (refer to Merton, 1973:554). These three areas shall now be further explored.

According to Price (1987:200), the concept of 'paradigm' had been developed by Thomas Kuhn (1962)[6] to describe a pattern of concepts and beliefs which hold sway within a given community, be this professional, scientific or lay. A paradigm is used by that community to make sense of the world, to order values and actions (see also Horgan,1991:40). This follows the thinking of Antonovsky (1989) who states that "scientific paradigms, no less than ideologies, have intellectual, psychological and social roots" (243). A "paradigm" therefore, according to McEwan

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[6] Kuhn equates paradigms with exemplars, or "the concrete puzzle solutions which, when employed as models or examples, can replace explicit rules as a basis for the solution of the remaining puzzles of normal science" (Ritzer,1991:118). Although Kuhn's conceptualization of 'paradigm' is considered by some to be limited (e.g. Ritzer,1991:119), his book had (and continues to elicit) enormous influence by making it clear that science was not, nor ever has been, the possessor of certain truths, but rather fictive "paradigms" (Ruland et al.,1991:371).

(1993:iii), is an organized model capable of explaining past and/or current behavior and which offers a 'road map' or 'blueprint' for future behavior. It is an accepted way of talking and thinking (Imershein,1974:73). It is based on "accepted examples of actual scientific practice - examples which include law, theory, application, and instrumentation together - and provide models from which spring particular coherent traditions of scientific research" (Kuhn 1970 as cited in Foss et al., 1987:6).

For Kuhn (1970), a new paradigm represents a refocus of the "old" body of knowledge [7]. Through this process , new insights and new interpretations of phenomena are gained thus leading to new forms of instrumentation to reify an accepted body of knowledge[8]. This transformation of vision, of seeing one's worldview differently than before, is brought about by re-education, by learning to see and accept a new gestalt which will cause the scientist to "see" differently than before.

Pre-existing paradigm presuppositions (which differ between

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[7] Patrick Brantlinger notes that when an orthodox paradigm is in a state of crisis it is never simply abandoned; rather, it accumulates anomalies until there is an eventual breaking point (whereupon a new paradigm is given birth) [Brantlinger, 1990:34]. Ludwig Fleck adds to this by stating that a structure (i.e. a paradigm) is created step by step. It starts as a unique event or discovery as seen from the history of thought (Fleck,1979:125).

[8] Ludwig Fleck advocates that what is already known influences the particular method of cognition. Cognition in turn enlarges, renews and gives fresh meaning to what is already known (Fleck, 1979:38).

For Thomas Kuhn, "Normal Science" is considered a period of accumulation of knowledge in which scientists work on and expand the reigning paradigm (Ritzer,1991:118).

or among paradigms) act as significant influences on the genesis or formulation of an individual's or group's attitudes. Since existing attitudes towards the chronically ill elderly, such as those currently awaiting placement into another care facility, tend to be negative (Shapiro,1986; Najman et al.,1982; Warren, 1983:435), a paradigm change and subsequent attitude realignment become a necessity.

Paradigms, such as the biomedical science model, gain their status because they are more successful than their competitors in solving a few problems that the group of practitioners has come to believe as crucial or important (Kuhn,1970:23). The biomedical science paradigm provides specific criteria (as shown in Tables 1 and 2) for choosing problems. It provides a generalization, and an explicit statement of scientific law that 'codifies' scientific theories and concepts. However, paradigms can insulate the medical community from socially important problems since they are not flexible constructs - reality is filtered in terms of the instrumental and conceptual tools that the paradigm supplies[9] (Kuhn,1970:37).

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[9] While this may be perceived solely in a negative light, one should consider how research could proceed without such slants (Kuhn, 1970:5). By focusing attention upon a small range of relatively esoteric problems, a paradigm forces scientists to investigate some part of nature in a detail and depth that would otherwise be unimaginable (Kuhn,1970:24). Few of these elaborate efforts would have been conceived and none would have been carried out without a paradigm to 'guarantee' the existence of a stable solution and to define the problem in the first place. In short, no natural history can be interpreted in the absence of at least some implicit body of methodological and theoretical belief for it permits the evaluation, selection and criticism of the research done .According to Eagleton, "there is no such thing as

For Imershein et al.(1979:313), "paradigms" serve to guide the vast range of scientific activities (thus guiding perception). A medical paradigm-community (wherein membership is primarily made up of physicians, hospital administrators and medical educators) is defined by shared adherence to a given paradigm (Imershein,1980:313). Taken together, their perception of the nature of problems, professional tasks, and appropriate solutions, provides a basis for "doing" medical practice (modified Imershein et al.,1979 :314).

Medicine, according to Atkinson (1988), is not necessarily taught in terms of an explicit paradigm. Rather, a paradigm is implicit in the taken-for-granted occupational culture. "Medical students encounter it through exemplars (underlying assumptions) and assimilate it through the accumulation of firsthand "experience". It is thus incorporated into the "practical reasoning" of the novice and rapidly becomes part of his or her stock of knowledge and assumptions" (180) [see also Imershein,1980:313; Imershein, 1977:33].

The medical model/disease approach to health care intervention is a consistent and persistent attempt to force nature into conceptual boxes as supplied through such means as professional education with its emphasis on specialization. The

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presuppositionless thought for all of our thinking may be said to be ideological" (Eagleton, 1991:3-4). The key problem that arises by an over reliance on such paradigms as the biomedical science model is an ideological narrowness of perspective (or what some refer to as "closure" of conceptualized thought). This severely limits means of resolving acquired or evolving anomalies.

formulation of such "boxes" is predicated on the assumption that the medical community knows what the world is like (Kuhn,1970:5).

Kuhn also addresses how textbooks act as pedagogic (teaching) vehicles for the perpetuation of normal science[10]. These textbooks (which embody "accepted" knowledge), truncate (funnel) the scientist's sense of alternatives (Kuhn,1970:137) - they cause a discipline to focus only on specific areas of study. As Blishen (1991) indicates, "how a problem is framed will determine which kinds of evidence is disregarded or given weight" (Page 160). In short, texts are a by-product of selection and distortion which, like paradigms, become narrowly focused on what is deemed important by the scientific community. According to Kuhn, textbooks are rewritten to reflect changes in focus. Once rewritten, they inevitably disguise not only the role but the very existence of the revolutions that produced them (Kuhn,1970:141-142). In short, scientific revolutions become "invisible" by means of texts that make the history of science look linear or cumulative (Kuhn,1970:139). Science then takes on an "air of correctness, of a logical and rational progress" rather than a hit and miss (unstable) process. This thinking permeates the scientific community to the point that scientists often boast that a science has reached its present state by a series of individual discoveries and inventions that, when

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[10] Ludwig Fleck states that "because initiation in science is based on special methods and teaching, we must list textbooks as a socio-intellectual form. Through texts, a vivid picture is created through simplification and valuation" (Fleck,1979:112-113).

gathered all together, constitute the modern body of technical knowledge (Kuhn,1970:140).

Paradigms of scientific thought, however, actually evolve historically. The history of scientific ideas is a reflection of the history of a society's culture. Each scientific revolution alters the historical perspective of the community that experiences it (Kuhn,1970:ix). It is the criteria of particular paradigms which determine what is judged as 'worthy research' for instance, and thus judges what are seen as 'advances' or not. Put another way, it is the manner in which science is conceptualized that affects how practical problems in clinical work are framed, the type of research that is carried out, and how research findings are used to act as a guide to train health professionals as well as the way the organization of health care services are to be structured (Dyck,1990:338).

An example of this is how the collective phenomena of ageing, births and mortality have become the academic monopoly of historical and mathematical demography. As a consequence, the social and moral significance of these events is subdued in favour of exact calculation (Turner,1984:30). This is unquestionably exemplified by science in its usage of 'laws', 'theories' and 'objective observations', all of which are immersed in a particular world view[11]. Paradigms, which reflect

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[11] The pursuit of "Truth" and "objectivity" in medical sciences is only one element within a socially determined and embedded rationalization process through which dominant meanings (embodied in models) and 'facts' are produced. Only by distinguishing between rationality (an aspect of mind) and rationalization (a social

this world-view, become accepted examples of actual scientific practice providing models from which particular coherent traditions of scientific research come about. These models help build consensus among researchers as well as the genesis and continuation of a particular research tradition (Kuhn,1970:11).

One of Kuhn's propositions is that a scientific community's acquisition of a particular paradigm facilitates producing criteria for choosing specific problems which are assumed to have 'solutions' (Kuhn,1970:37). Such selected problems, Kuhn asserts, are the only problems that the scientific community will admit as being "scientific" or encourage its members to undertake. Other problems are rejected and labelled as 'metaphysical' - as the concern of another discipline or simply too problematic to "be worth the time" (Kuhn,1970:37). Through collegial consensus then, directives by which to approach the world and directives by which to approach inquiry, transpire (Foss et al.,1987:48-49). This phenomenon is exhibited in the biomedical science approach as it continues to be guided by the assumptions (and directives) of scientific positivism.

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process) is it possible to clarify the relationship of medicine, science and ideology (Young,1983:203-204).

Table 3[12]

Logic of the Scientific Method

DIRECTIVES BY WHICH TO APPROACH THE WORLD	DIRECTIVES BY WHICH TO APPROACH INQUIRY
Reductionism	Objectivity
Mechanism	Ahistoricity
Causality	Aculturicity
Determinism	Impersonality
Dualism	Universality
	Self-correctiveness

We may come to understand paradigms then, as spoken of by Kuhn (1962,1970) as well as other researchers, as representations of collective thinking patterns and/or traditions. These traditions are articulated through empirical work. What does not fit into such traditions or conceptualizations are perceived by the scientific community as being curiosities, errors, ambiguities or heresies (Mannheim,1936:62, 101,198).

As we look more closely, however, at the biomedical science approach, or any model for that matter, we need to heed the thinking of Werner Heisenberg who believed strongly that "<u>every</u> word or concept, clear as it may seem, has only a limited range of applicability" (cited in Watson,1979:22). The biomedical model is so deeply interwoven with certain ways of thinking that it is often forgotten that this is but one perspective. It is often regarded, therefore, as the only representation of reality, but, like other overlooked perspectives it defines, classifies and assesses relationships among phenomena <u>in a particular way</u> (Eyles

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[12] Refer to Foss et al., 1987:49 .

et al., 1983:15). Such unconscious, taken-for-granted assumptions are partially explained in the works of Pecheux.

The position of a discursive formation within a complex whole, which includes its ideological context, will typically be concealed from the individual speaker. This is an act of what Pecheux calls "forgetting" and it is because of this oblivion or repression that the speaker's meanings appear natural or obvious to him or her. The speaker "forgets" that he or she is just the function of a discursive and ideological formation, and thus comes to misrecognize himself or herself as the author of his or her own discourse (cited in Eagleton,1991:196). The danger in presuppositions lies in the fact that an ontology handed down through tradition may obstruct new developments in thinking (new modes of problem solving) and cause conventional theoretical thinking to continue on unquestioned (Mannheim,1936:89). According to Allan et al. (1988:23), the medical model has done just that. It has precluded advances in the conceptualization of health, it has blocked a vision of the person, health and environment and has prevented a view of health as a multidimensional, complex phenomenon (not merely the absence of disease).

According to Kuhn (1970), all researchers are in fact directed according to what datum (body of knowledge, assumptions and inferences) is in place. Accordingly, that which is deemed "reality" will determine what instruments will be used to retrieve this datum as well as what concepts will be utilized (as deemed relevant) for interpretation of such phenomena[13]. Kuhn further asserts that paradigms determine large areas of experience and are therefore shaped by social forces [14] . Yet scientists typically reject this notion stating that change is not a by-product of anything that is social, lest their work be labelled "ideological". Rather, scientists advocate that their approach is logical and objective - that new knowledge does not prove that their prior knowledge was incorrect but merely an addition to existing knowledge [15]. Kuhn reminds us, however, that science only acts by the criteria of a chosen paradigm. Different paradigms lead to different research strategies and foci. As a consequence, presuppositions and bias permeate a researcher's conclusions.

According to Atkinson (1988:179), commentators on medicine and medical knowledge have repeatedly acknowledged that the

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[13] Here the work of Ludwig Fleck needs to be considered. Fleck earnestly believed that a concept is the result of collective not individual effort. For him, every theme in the sequence of ideas originates from notions belonging to the collective (e.g. disease as punishment for fornification). In short, cognition is not an individual process of any theoretical particular consciousness, rather, "it is the result of a social activity since the existing stock of knowledge exceeds the range available to any one individual" (Fleck,1979:38-41).

[14] This thinking is somewhat similar to the University of Edinburgh's "Strong Program". This program claims that all knowledge is shaped by society and moreover is about society - that it has a social content (Bunge,1991:534).

[15] This mentality of "value-free" science reflects what (Robert) Merton referred to as the "ethos of science". Here, Merton summarizes science as advocating that it embodies intellectual honesty, integrity, organized scepticism, disinterestedness, impersonality and, is by no means a social by-product - that it is free in other words from ideological presumptions (Merton, 1973).

phenomena of ill-health and health are "socially constructed"[16]. The perspectives of such fields as anthropology, history, philosophy and sociology attest to this.

The practices of physicians and the attitudes of patients in any given country at any given time are governed by the beliefs and social structures of the community (Sigerist, 1984:14). In fact, the legitimacy of a professional culture is made by linking certain professional ideological themes to general social values. In this process, these values are purposely related to widely held images of the profession. For the practitioner, the continued emphasis on the professional cultural themes will hopefully generate ideological consensus; it also strengthens collegial ties thereby promoting professional solidarity (Blishen,1969 :163). It becomes apparent that the most important characteristic of any professional group is its professional culture: its values, symbols and norms. Values embrace the fundamental beliefs of the profession upon which its continued existence depends (Blishen,1969:22). Alliances to the shared values of a dominant paradigm (such as the biomedical science

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[16] According to Payer (1990:154), while scientifically conducted studies can show us that a certain course of treatment or action can result in certain risks and benefits, the weighing of these benefits and risks will always be made on a cultural scale. To Basch (1990:77), points of cultural variation with respect to health involve ideas about nosology, etiology, and therapy, or more simply, the kinds of classes of illnesses, how and why they occur, and what can be done about them.

model within Western society) become particularly strong[17].

While the barriers towards incorporating a biopsychosocial (patient-centred) approach to health care appear to be overwhelming, support by the medical community for such a new paradigm may be on the horizon. Although questions remain as to how such a paradigm may actually be integrated into the practice of health care delivery (given a lack of empirical research on this area as well as clear policies), the basis of a paradigm-shift in our health care system is slowly emerging. Buntrock (1988) in particular believes that a paradigm-shift is now emerging, based on the increasing number of journal articles addressing alternative forms of intervention. Success has not yet been achieved however. Buntrock mentions, for instance, the need for a new paradigm to be integrated into the education and socialization of those who have the authority to practice it (Buntrock,1988:98-99). As to the concept of patient-centred care within acute care hospitals, this remains, for a variety of researchers (e.g. Henbest, 1992), more rhetoric than reality.

Empirical evidence to ascertain the success to date within

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[17] This professionalization process reveals a symbolic - ideological and interactional hidden curriculum namely, "to develop a protective carapace in order to maintain control of professional roles, relationships and identities" (Haas,1987 :399). By policing themselves, albeit loosely (due to ever increasing State intervention), doctors minimized the likelihood of some external regulatory agency having a significant say in how the profession conducted its affairs (Naylor,1986:21). In short, physicians were and remain the primary "gate-keepers" of the dominant ideologies surrounding health care in Canada.

acute care hospitals in Thunder Bay (Ontario) of a patient-centred (biopsychosocial) approach to health care is one of the central aims of this study and a focus of the remaining chapters.

CHAPTER IV

Sample Characteristics and Instrument

THE SAMPLE

The purpose of this study required that CNIE patients be interviewed from a variety of locations. These locations included either an acute care hospital (McKellar General, St. Joseph's Hospital or Port Arthur General), individual homes, a Home For The Aged (either Dawson Court or Grandview Lodge) or a Senior Citizens' Home (Beacon Hill Lodge). All participants resided in Thunder Bay (Ontario) at the time of the study. Data collection took place over a three month period.

The total population which I started with was 255. This number is derived from those individuals in Thunder Bay who are "officially" on a waiting list for placement (via Placement Coordination Services)[1] to a care facility (e.g. a nursing home). However, this study's sample criteria (as described on the next page) dramatically reduced this number to 48 of which a total of 32 individuals (66 percent) participated in the study. Five of the participants were hospitalized in hospital "A", 16 from hospital "B" and 11 from hospital "C".

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[1] The Thunder Bay Placement Coordination Service (PCS) is operated under the auspices of the Ontario Ministry of Health based in Toronto.

The criteria regarding eligibility for participation in this study were as follows:

- Willingness to participate
- 60 years of age and over
- Cognitive[2]
- Ability to communicate (and in English)
- No longer in an acute phase of illness but in need of continual care due to chronic dysfunction(s)
- Awaiting placement while in an acute care hospital <u>or</u>
- Discharged from an acute care hospital no longer than a two month time period[3] thereby being recently placed into another care facility or back home

TABLE 4
LOCATION AT TIME OF INTERVIEW

	Treated At Hospital A n=5	B n=16	C n=11	Combined Sample n=32
Hospital	5	10	2	17 (53%)[4]
Other Care Facility	0	6	6	12 (38%)
Home	0	0	3	3 (9%)

Access and Origin of Participants

Of the 32 chronic, non-acutely ill individuals who participated, 17 (53 percent) were interviewed while still in hospital, 12 (38 percent) were interviewed in another care facility (either a Thunder Bay Home for the Aged or a nursing home), and 3 (nine percent) were interviewed in their home (refer

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[2] The subjects were screened by clinical staff of each of the three participating hospitals and other care facilities as being cognitively intact and able to respond verbally to questioning.

[3] A two month time period for placement was made to address possible problems regarding recall.

[4] Percentages presented in chapter IV tables are rounded to the nearest whole number.

to Table 4 above).

During the course of this study, access to patients differed according to the unique organizational structure of each participating health care facility. Permission to access Placement Coordination Service (PCS) files was granted which permitted me to trace the whereabouts of qualified participants. A list of candidates for interviews was composed. A list was presented to hospitals "A" and "B" (to administration and nursing staff) and other care institutions, screened (as noted above) and interviews commenced once consent to participate forms had been signed. Hospital "C" developed their own list of qualified participants which was compared with PCS records. Prior to research being conducted at all of the participating care facilities, ethical approval (or permission by the Residents Board from the nursing home and Homes for the Aged) was successfully obtained. This process varied from requiring 2 weeks to up to 3 months.

There was a total of nine qualified participants who resided in their homes. These persons were first mailed a signed cover letter from the director of the placement coordination services' office based in Thunder Bay encouraging them to participate in the study. One week later, they were telephoned and asked if they were willing to participate in an interview. Three, according to their informal (primary) caregiver (e.g. spouse), were too ill at the time to participate, three refused and three agreed.

TABLE 5

THE PATIENT SAMPLE

	Treated At Hospital A n=5	 B n=16	 C n=11	Combined Sample n=32
Gender				
Males	1	8	4	13 (41%)
Females	4	8	7	19 (59%)
Age				
60 - 69	0	2	1	3 (9%)
70 - 79	1	5	4	10 (31%)
80 - 89	4	8	4	16 (50%)
90 - +	0	1	2	3 (9%)
Marital Status				
Married/Remarried	2	4	1	7 (22%)
Single	0	4	0	4 (12%)
Divorced/Separated	0	1	0	1 (3%)
Widowed	3	7	10	20 (63%)
Mother Tongue				
English	3	8	4	15 (47%)
French	0	1	2	3 (9%)
Polish	0	1	1	2 (6%)
Ukrainian	1	3	2	6 (19%)
Swedish	0	2	1	3 (9%)
German	1	0	0	1 (3%)
Finnish	0	1	0	1 (3%)
Croatian	0	0	1	1 (3%)

POPULATION DEMOGRAPHIC PROFILE

Gender

The study population comprised 13 (41 percent) males and 19 (59 percent) females (refer to Table 5).

Age

Age range was 62 to 94 years of age (see Tables 5 and 6). The mean age was 81 years (see Table 6). Nine percent of the sample were aged 60-69, 31 percent were 70-79, 50 percent were aged 80-89 and the remaining nine percent were 90 years of age or older (refer to Table 5). Age distribution between male and female participants of this study was very similar.

Marital Status

Of the total sample, 22 percent (of n = 32) were married (with a living spouse); 3 percent were divorced or separated; and 12 percent were single. The majority, 63 percent, were widowed (refer to Table 5).

Mother Tongue

The sample reflects the ethnic diversity of Thunder Bay (Ontario). As indicated in Table 5, mother tongue of the participants comprised 47 percent English, 19 percent Ukrainian, 9 percent Swedish, 9 percent French, 6 percent Polish, 3 percent German, 3 percent Finnish, and 3 percent Croatian.

TABLE 6

MEAN AND RANGE OF AGES OF PARTICIPANTS

	Treated At Hospital A n=5	B n=16	C n=11	Combined Sample n=32
Age				
Mean	81	79	84	81
Range:				
Low	72	62	67	62
High	88	90	94	94

Occupation

As indicated in Table 7 , none of the sample (of n = 32) used in this study came from what Porter et al. (1967) or Statistics Canada (1981) would consider as a professional background and only one individual was categorized as having a semi-professional background. Three of the participants (9 percent) represented the manager/official and proprietor category; three represented the clerical and sales category; and yet another three (9 percent) of the total sample was reflective of a semi-skilled background.

This sample is more reflective of a skilled, blue-collar labour force as the highest number of males in the sample - 38 percent of n=13, followed by the second highest number of females - 26 percent of n=19, were listed in that category. Representing the highest number (or largest segment) of female respondents' occupational background was the homemaker/domestic category (of 47 percent) which represented 28 percent of the total sample.

Nine percent of the sample were unskilled. This sample is representative of Thunder Bay (Ontario) as addressed in such works as It's A Working Man's Town, by Dr. Thomas Dunk (1991).

TABLE 7
OCCUPATIONAL BACKGROUND[5]OF SAMPLE

	Treated At Hospital			Combined	%	%
	A	B	C	Sample	Male	Female
	n=5	n=16	n=11	n=32	n=13	n=19
Professional	-	-	-	-	-	-
Semi-Professional	-	1		1(3%)		1(5%)
Managers/Officials/ Proprietors	-	3	-	3(9%)	2(15%)	1(5%)
Homemaker/Domestic[6]	2	3	4	9(28%)	-	9(47%)
Clerical and Sales	-	2	1	3(9%)	2(15%)	1(5%)
Skilled	3	4	3	10(31%)	5(38%)	5(26%)
Semi-Skilled	-	2	1	3(9%)	2(15%)	1(5%)
Unskilled	-	1	2	3(9%)	2(15%)	1(5%)

Reasons For Hospitalization

Table 8 provides information on the reasons why participants were hospitalized. The data indicate that 53 percent of the sample were primarily admitted due to heart complications (e.g. stroke, angina, murmur, etc.). This is representative of the national trend (Statistics Canada,1990:5). Other primary reasons for hospitalization include falls (e.g. broken hip or ankle),

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[5] Grouping of occupations is based on Porter et al. (1967) classification scheme.

[6] This is not found in the Porter et al. (1967) classification scheme. Refer to Statistics Canada (1981) The Standard Occupational Classification - 1980.

chronic arthritis, alcoholism, Parkinson's disease, cancer, chronic obstructive lung disease, blood clot, tumor and loss of limb (amputee).

It is important to note that most subjects were coded in hospital as having more than one diagnosis (that is, having multiple physical disorders). This is common for elderly patients being treated or awaiting placement in acute care hospitals (refer for instance to Young et al., 1988; Lewis,1989:119).

TABLE 8
REASONS FOR HOSPITALIZATION[7]

	Treated At Hospital			Combined Sample
	A n=5	B n=16	C n=11	n=32
Heart (e.g. stroke)	3	8	6	17 (53%)
Fall (e.g. broken Hip)	0	3	2	5 (16%)
Chronic Arthritis	0	1	0	1 (3%)
Alcoholism	0	0	1	1 (3%)
Parkinsons	0	1	0	1 (3%)
Cancer	0	1	1	2 (6%)
Chronic Obstructive Lung Disease	0	1	1	2 (6%)
Blood Clot	0	1	0	1 (3%)
Tumor	1	0	0	1 (3%)
Amputee	1	0	0	1 (3%)

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[7] Most CNIE individuals interviewed had multiple chronic dysfunctions (e.g. both heart and bladder problems). Dominant cause of hospitalization is indicated above.

Length of Stay In Hospital

Length of stay in hospital, as shown in Table 9, was calibrated in weeks. Mean length of time in hospital for CNIE patients in hospital "A" was 45.8 weeks; for hospital "B", 21.1 weeks and for hospital "C" the mean was 22.7 weeks . A combined sample mean of length of stay in hospital was 29.9 weeks (over 7 months).

Of the sample, at point of interview, the range of stay in hospital overall went from a low of 3 weeks in hospital to a high of 96 weeks (almost 2 years).

TABLE 9

PARTICIPANT'S LENGTH OF STAY IN HOSPITAL (WEEKS)

	Treated At Hospital A n=5	Treated At Hospital B n=16	Treated At Hospital C n=11	Combined Sample n=32
Mean	45.8	21.1	22.7	29.9
Range:				
Low	6.0	3.0	3.5	3.0
High	64.0	96.0	52.0	96.0

TABLE 10

LOCATION PRIOR TO HOSPITALIZATION

	Treated At Hospital A n=5	Treated At Hospital B n=16	Treated At Hospital C n=11	Combined Sample n=32
Home	5	15	11	31 (97%)
Health Care Institution[8]	0	1	0	1 (3%)

Location Prior To Hospitalization

Table 10 above indicates that thirty-one of the participants (97 percent of the sample) were at home prior to being hospitalized. Only one (3 percent) came from another care facility.

Living Arrangement Prior To Hospitalization

Fifty-six percent of the total sample lived alone prior to hospitalization while 44 percent had lived with one or more persons. For males, 38 percent (of n=13) lived alone while 54 percent had lived with one or more people (refer to Table 11). Interestingly, the situation for female participants prior to hospitalization was very different since 68 percent (of n=19) lived alone while 32 percent had lived with one or more individuals (refer to Table 12 on next page).

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[8] Health care institution may include either a city of Thunder Bay Home for the Aged or a Nursing Home.

TABLE 11
LIVING ARRANGEMENT PRIOR TO HOSPITALIZATION - MALES

	Treated At Hospital			Combined Sample
	A n=1	B n=8	C n=4	n=13
Lived Alone	-	2	3	5 (38%)
Lived With One or More People	1	5	1	7 (54%)
Not At Home[9]	-	1	-	1 (8%)

TABLE 12
LIVING ARRANGEMENT PRIOR TO HOSPITALIZATION - FEMALES

	Treated At Hospital			Combined Sample
	A n=4	B n=8	C n=7	n=19
Lived Alone	3	5	5	13 (68%)
Lived With One or More People	1	3	2	6 (32%)

BASIS OF THE INSTRUMENT

In order to ascertain the degree to which health care services rendered to CNIE individuals was patient-centred, this researcher used open-ended and close-ended questions via an interview technique. The structured scale (refer to Appendix 1)

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[9] One male patient interviewed in hospital had not come from home but had lived prior in a Home for the Aged within the city of Thunder Bay (Ontario).

was largely derived from the "Picker/Commonwealth Patient-Centred Care Survey" developed in Boston, MA at Beth Israel Hospital[10]. Their scale, developed in 1990, is unique in that it takes into account the patient's rather than the hospital's perspective of how well care (patient-centred care) was provided. Thus, it addresses the question "Is care centred around the patient or is it centred around the goals of the health care institution?" Since the traditional goal of hospitals has been to follow the biomedical science approach, (an approach which is not patient-centred), the survey in this study was implemented in Thunder Bay's (Ontario) acute care hospitals to ascertain the relative strength or hold the BMS form of intervention still has.

The patient-centred survey was divided into the following six areas: (a) Communication [C]; (b) Education [E]; (c) Emotional Support [ES]; (d) Patient's Needs and Preferences [PNP]; (e) Consistency of Quality of Care [CQ]; and (f) Physical Comfort [PC] (Refer to Appendix 1). The survey consisted of 67 items, six of which were in the form of open-ended questions.

To emphasize the importance of the six areas addressed above, I shall now undertake a brief literature review.

THE SCALE INDICES

COMMUNICATION

According to Samuel Gorovitz, lack of communication between doctors and patients is a root cause of many of the current

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[10] Since the Picker/Commonwealth Patient-Centred Care Survey is copyrighted, permission to use components of it was requested and granted.

problems in health care. He states that medical students and residents need to learn more consciously how to understand and talk with patients (cited in WellBeing, 1991:9). Dr. William Silen, surgeon-in-chief at Beth Israel Hospital based in Boston, MA states that many of today's doctors have "abdicated themselves from the responsibility of talking with their patients" (Wellbeing,1991:9).

Elderly persons are likely to need more than abbreviated instructions or hurried responses to questions (Craig,1991:30). In a study conducted by Henbest et al. (1992), they found that the frequent assumption that it takes longer to conduct a patient-centred consultation was not supported. They suggest that lack of time cannot be legitimately offered as an excuse for not having patient-centred consultations (Page 316)[11]. Doctors in Canada, however, who are paid by medicare for the number of patients they see are less likely to take time with the elderly (Mickleburgh,1992:A8).

Helman (1990:121) suggests that clinical consultations are conducted in a mixture of everyday language and medical jargon. This is mainly because the language of medicine itself has become more and more technical and esoteric over the past century or so and increasingly incomprehensible to the lay public. This may further result in low levels of recall of information by the

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[11] According to Henbest (1990:33), a patient-centred approach is not just a matter of behaving in a patient-centred way during a consultation but is also a matter of the way in which the doctor (and other health care professionals) conducts his or her overall medical practice.

patient (Levy,1986:241). Written information for patients as well continues to be produced in a language too difficult for its intended audience (Levy,1986:250).

Further, where medical terms are used by either party, there is often the danger of mutual misunderstanding; the same term may have entirely different meanings for doctor and patient. The use of the same terminology therefore is not a guarantee of mutual understanding as the terms used and their significance may be conceptualized by both parties in entirely different ways. (Helman, 1990:121).

Hickey et al. (1992:6) suggest that poor communication results when older people wait for care providers to ask them specific questions about their symptoms rather than volunteering information. This occurs because such older patients believe it is the professionals' role to direct the flow of communication as well as to decide what is relevant (refer also to Matthews et al.,1988:159). According to Henbest et al. (1990:32-33), doctors are more likely to be of help to their patients if <u>they</u> facilitate the expression of patients' thoughts, feelings and expectations about their problems.

To Stacy et al. (1986:37), the ability to understand another can only come about by dialogue. Dialogue rests on the conviction that we have different ways of looking at things and that different perspectives ought to be valued. This brings about effective communication. According to McCarthy (1984:xiii), in cooperative processes of interpretation, <u>no</u> participant(s) should be given a monopoly on correct interpretation. For both parties, the interpretive task consists in incorporating the other's interpretation of the situation into one's own in such a way that the "divergent situation definitions can be brought to coincide sufficiently". However, Steffen (1988:59) suggests that the knowledgeable physician, just because he (she) knows more medicine than the patient, can easily manipulate the dialogue so that his (her) goals trump those of the patient (Steffen,1988:59). Power, that accrues to professionals because of their specialized knowledge, correspondingly creates vulnerability in patients since they lack this knowledge (Weick,1983:468).

EDUCATION

According to Pavelich (1992:22) and Hall et al. (1992), the conventional approach to patients severely ill or dying is to limit consultation and participation. Nurses rarely ask the patient what he (or she) wants (Barnes,1963:13). Patients want, however, more information from their caregivers such as physicians (Wellbeing,1991:9).

Cobb (1976) (cited in Roy,1992:103), provides a definition of social support, saying that it is primarily an information system belonging "to one or more of the following three categories: (1) information leading the subject to believe that he (she) is cared for and loved; (2) information leading the subject to believe that he (she) is esteemed and valued; and (3) information leading the subject to believe that he (she) belongs to a network of communication and mutual obligation. Seymour (1991:26) states, however, that medical staff tend to spend more time with and show more interest in younger patients. Older patients may be treated as if they are too old to make decisions about their care as well as too old to understand. Further, according to Williamson (1988:255), elderly people are seen as senile, assumed to be confused and held to be of relatively little worth (e.g. no longer productive).

EMOTIONAL SUPPORT

Patients are deeply concerned about the non-technical side of medicine. Hockey (1977:147) states that the provision of personal care is conducive to the preservation of the patient's dignity and self-respect.

Murphy, 1982 (cited in Roy,1992:25) states that elderly individuals who did not have confiding relationships, demonstrate a higher level of vulnerability to depression (cited in Roy,1992:25). However, scientific and technological advances within the health care system have created a more specialized, less personal environment (Wellbeing,1991:5).

The immediacy of treating physical needs often distracts caregivers in providing emotional support. According to Barusch (1991), sometimes the caregiver will "find it easier to do for the patient than to be with the patient" (page 81). As this suggests, emotional needs become neglected.

As Hoffman states, for the physician, only a few moments on ward rounds is taken greeting the patient while passing a doorway; for the nurse, a hurried and perfunctory performance of bedside duties is done (Hoffman,1974:59). Rieman (1986) found three themes emerging from patients' descriptions of noncaring nurse behaviours: physically present but emotionally distant, devaluation of the patient as a unique individual, and inhumane and belittling actions.

To Edgman-Levitan (1992:1), adequate emotional support is important to outcomes as well as to how patients feel. Studies have shown patients who have such support may leave the hospital earlier, require less medication, comply more readily with treatment regimens, experience fewer side effects from certain drugs, and feel more satisfied with care.

According to Berkman (1989:107), diminished social contact and support may lead to adverse health outcomes among older persons. Hinkle (1961) (cited in Roy,1992:103) reported that a person's social and interpersonal environment not only exerts profound influence on mental health, but also has serious implications for physical health.

PATIENT NEEDS AND PREFERENCES

Elderly patient needs and/or preferences vary from one individual to another. According to Meterko et al. (1990:S4), patients may express that their care at hospital was "excellent" or "poor" and that they were "satisfied" or "dissatisfied". To Steffen (1988:59), patients may want timely and complete information or, they may want no information at all. Another patient may value dignity equal to any other goal.

Cronin and Harrison (1988) found that certain minimum care requirements such as feeding and cleanliness must be met before more qualitative aspects of care, such as empathy, can be addressed.

Chipman (1991:174) states that a noncaring behaviour is exhibited by: not providing comfort to the patient, or aiding to his or her discomfort; not meeting a patient's needs in a timely fashion; and, not giving of self or providing privacy.

West (1991) reports that quality and choice of food is important. "If you've ever been a patient in a hospital, you know how bored you can get. You look forward to mealtimes in a way you might never do at home, simply because a meal may be the high point of the day ...... you can get a good indication of how much love and care is put into taking care of the residents (patients) by looking at the quality of the food and how it is prepared and served" (Page 101).

CONSISTENCY OF QUALITY OF CARE

According to Lisbeth Hockey (1977:147), care is a concept implying a measure of constancy and continuity. These two aspects, reinforced by other factors such as empathy, are some of the main components in the nurse's contribution to care.

PHYSICAL COMFORT

Chipman's (1991) study found that meeting patients' needs in a timely fashion and providing comfort measures for patients were indicators of caring behaviour.

According to Cluff (1981:306), physicians seldom attend to

(a) the patient's ability to cope; (b) their level of discomfort; (c) their patterns of living; (d) emotional status; and (e) occupational ability.

PATIENT HOSPITAL CARE EVALUATION SCALES

Mathews et al. (1988:170) suggest that patients are the best judges of the personal features of clinical care. Davies et al. (1988:33,44) have found that health-care consumers are the best source of data on the interpersonal aspects of care received and can provide a valid assessment of quality. Further, they indicate that bias from personal characteristics is not strong enough to invalidate their ratings. Unfortunately, little attention has been given to the question of how much involvement in their own care patients really want (Ende et al.,1989:23). According to Thomas Delbanco et al. (as cited in Knox, 1991:4), the hospital world is miles behind other industries in asking customers (consumers of health care services) specifically what they like and don't like. Further, he notes that few doctors have sought systematic feedback about their practices (Delbanco,1992: 416).

According to Meterko et al. (1990:S1), there is no standardized tool for measuring patient perceptions and their satisfaction with hospital care. Most studies that used interviews or open-ended techniques to explore patient concerns were performed in British hospitals over a decade ago (Meterko et al.,1990:S4). Further, according to Meterko et al. (1990:S6), no comparative studies exist of hospitals that examined whether patients rank hospitals differently by different features of care available.

According to Chipman (1991), relatively few investigations have been carried out regarding the meaning of caring in nursing practice. She stresses that "further clarification of the meaning and value of caring in nursing practice is still very much needed" (172).

A qualitative study by Ray (1989) compared patient perceptions of caring as well as physicians' and allied health personnel's perceptions of caring. He found that patients expressed the need for human care and that they had to develop strategies to get what they needed or give in to what they saw as injustices to their humanity.

Tappen and Beckerman (1992) used a case study approach to point out gaps in attention to basic needs of the hospitalized frail adult. This study found a frequent failure to access and intervene to meet the individual patient's basic need for dignity and individualized care. Their study was limited however to a sample size of five and was based on the perception of the informal (primary) caregiver.

Najman and Levin (1981) did an exhaustive literature review dealing with the impact of medical care and technology on the quality of life. Only 3 of the 23 articles found assessed the patient's subjective responses to the interventions employed.

It should be noted that the concept of "quality" is an imprecise term (Donabedian,1966:167). A definition of quality continues to elude health-care providers (Steffen,1988:56).

Criteria of quality care may be nothing more than value judgements (Donabedian,1967:167). Hollandworth (1988:427) lists 83 different instruments used to calibrate this. He indicates that reaching a consensus in terms of an assessment model for quality of life is elusive and that the methods used are too vague (425).

Efforts to define quality in acute-care facilities have been limited to quantifiable data such as mortality rates, lengths of stay, rates of infection and so on. Unlike many other sectors, few hospitals have attempted to define "quality" in terms of customer needs, wants and expectations. In fact, hospitals have rarely thought of patients as being "customers" (Bell,1992:133).

Most patient satisfaction scale measurements are under the rubric of quality assurance. According to Zlotnick et al. (1991 :207), traditional quality assurance (QA) systems focus on acutely ill patients and are based on the BMS model. Further, such hospital criteria do not include such factors as palliative treatment needs.

Despite instrumental deficiencies in gathering data on patient perceptions of care received while in hospital, a recent attempt has been made by Beth Israel Hospital in Boston by developing a scale that seeks to discover dimensions of personal service denoting quality from the patient's point of view. This scale, known as the "Picker/Commonwealth Patient-Centred Care Survey," strives to take into consideration such aspects as: (1) respect for patients' values, expressed needs and preferences,

(2) need for information and education, (3) need for physical comfort as well as (4) emotional support and alleviation of fear and anxiety (Koska,1990; Picker/Commonwealth Report,1991:1; Delbanco,1992; Knox,1991).

The Picker/Commonwealth Survey may be used as an interview tool to help researchers learn what patients experience in the hospital. The survey was implemented in a U.S.A. nationwide pilot study of over six thousand patients in 1989. Given that it is the best research instrument tool developed to date, investigators at the department of clinical epidemiology and biostatistics at McMaster University in Ontario have utilized major components of it recently (1991) in surveying over 3,900 patients in a cross-Canada survey. Unlike their study, this study focuses solely on the chronic, non-acutely ill patient population of Thunder Bay, Ontario.

Until recently, the elderly have received little attention as a unique acute-care patient population (Alexander,1990:27; Marshall,1987:205). While there have been a large number of studies involving outpatient satisfaction with health services, literature on the satisfaction of hospital inpatients is sparse (Doering,1983:291). By incorporating components of the Picker/Commonwealth Patient-Centred Care Survey in my own investigation, an attempt is made to help offset this sparsity.

PRETEST OF THE INSTRUMENT

To ensure greater content validity of the research questions for this study, a pretest was implemented in two steps. Prior to this pretest, ethical approval to carry out the research was granted by the Lakehead University Ethics Advisory Committee. In step one of the pretest, with the assistance of the Council On Positive Aging (Thunder Bay) four previously hospitalized seniors were contacted. They provided feedback on their understanding of the survey and gave helpful input in such areas as wording and length of the interview.

Step two of the pretest included the administration of the survey to three qualified and willing respondents who had recently been placed at a Home for the Aged. Permission to carry out this research by the Residents' Board of Grandview Lodge and Dawson Court (two Thunder Bay city Homes for the Aged) was granted. This helped to further refine the survey before being fully implemented.

During the process of survey development and initial implementation phases, feedback from many area clinicians, university faculty and other interested individuals, as to the scale's content, wording, and length, was obtained. The goal was not only to ensure overall scale effectiveness but also to meet with area hospital ethics boards' recommendations.

PROCEDURE

Willing and qualified participants, (n = 32), having once understood the purpose of the study, were asked to sign a consent form prior to being interviewed.

The "Patient-Centred Care Survey", as presented in Appendix 1, was used in this study. Only relaxed verbal responses by the chronic, non-acutely ill elderly participants were sought as most of those interviewed did not have the physical capacity to fill out a form. A large proportion of the interview focused on specific events that occurred during hospitalization. All but two willing participants were able to complete the interview in one session.

Responses sought in section one of the survey were "Always", "Some of the time", and "Never". In part b of section one, responses was either "Yes" or "No" although participants were given opportunity to elaborate on their answers. In section 2, responses sought were mostly in the order of "Yes", "No", "Sometimes" and "Not Sure". Additional scales were added when appropriate - e.g. "no important questions"; "R [respondent] didn't want any say'; "R never needed help", etc. (refer to Appendix 1).

Given the physical limitations and chronic condition of the participants in this study, it was important to limit the interview to 45 minutes or less. As elderly respondents appear to require more response time than younger participants, this too had an effect on how many questions could be asked. Such in turn necessitated that the scale be limited to seven pages in length.

LIMITATIONS OF PROCEDURE

While this was not a random sample of CNIE patients (thus limiting generalization to all CNIE patients), the responses give us an indication of how patient-centred care indices affect the CNIE patient. Further, since the presented tables and results are based on a small number of subjects, the information provided may be highly variable and should be interpreted with caution.

METHOD OF ANALYSIS

The purpose of this study was to ascertain, at a local level, if the hospital care intervention strategy rendered to the chronic, non-acutely ill elderly was patient-centred or was more characteristic of a biomedical science approach.

To determine this, a "Patient-Centred Care Survey" was used. This utilized six dimensions (domains) of care indices to simplify analysis of the responses about problems with specific areas of care . The respondent's answers were transferred from the questionnaires, placed under a care domain indicator (either under the heading communication, consistency of quality of care, physical comfort, education, emotional support or patient needs and preferences) and then converted into percentages. These percentages, which describe or evaluate hospital care encountered by the CNIE sample, illustrate and highlight the strengths of the local health care system in terms of being either "patient-centred" in its orientation or more in line with a biomedical science model approach to health care intervention.

This study utilized descriptive statistics as the method of analysis of participants' responses. Bar graphs were constructed (using Harvard Graphics 3.0) and summary tables provided to give clarity to the study's findings.

Participant dialogue is also integrated within the Findings section of this study in response to the open-ended questions used in the survey. By using two techniques, one quantitative and one qualitative, different forms of responses could be gathered (Dijk et al.,1990:293). Further, the inclusion of a qualitative method, such as an open-ended and close-ended interview technique, provides insight into behaviours, moods and interactions that would be difficult to obtain using only quantitative techniques (Clarke et al., 1990; Robertson,1982 :550). To ensure confidentiality, no participant names were used. In addition, participating hospitals were given pseudonyms. Primary findings are to be found in Chapter V.

CHAPTER V

Findings and Discussion

Summary

The thirty-two patients who agreed to participate in this study represented diversity in terms of language, marital status, reason(s) for hospitalization, length of stay in hospital and occupational background (for specifics refer to chapter IV).

Similar to Matthews et al.(1988) study, participants seemed pleased with having the opportunity to express their opinions and concerns. These opinions embody the qualitative contents of this chapter. The measuring instrument used to gather these responses came from the "Patient Care Survey" (refer to Appendix 1). The quantitative data gathered were collapsed and tabulated using descriptive statistics and placed in the tables and figure 1A as shown in this chapter.

The two primary research questions considered in this study were:

(1) Does acute hospital care in Thunder Bay (Ontario) reflect the characteristics of a biomedical science approach?

(2) Does the existence of a biomedical form of health-care intervention promote or impede patient dissatisfaction?

This study's findings indicate that characteristics of the biomedical science approach remain in the health care system (in Thunder Bay, Ontario) and that, as a result, patients' satisfaction with specific care indices is impeded. However, the supposition that CNIE patients would be extremely negative to the care they received because of its basis in the BMS model was supported only to a certain degree. The following contents will clarify this statement.

TABLE 13
Problems Reported By Patients In Percent (n = 32)

Item Number	Description of problem event	Percentage of patients reporting problem
	Communication	
1	Nurses were rushed and appeared too busy to properly care for patients.	88 %
2	What one doctor or nurse had to say differed from what another doctor or nurse had said.	47 %
3	Doctors were rushed and appeared too busy to properly care for patients.	47 %
4	Did not have enough say about hospital treatment.	44 %
5	Did not receive understandable answers from doctors to important questions.	41 %
6	Treated or examined without explanation of its purpose.	34 %
7	Did not receive understandable answers from nurses to important questions.	31 %
	Physical Comfort	
8	Patients' comfort was not a priority to doctors.	75 %
9	Hospital ward too noisy.	63 %
10	Patients' comfort was not a priority to nurses.	56 %
11	On average, waited more than ten minutes for help after pushing call button.	38 %
12	Needed, but did not get, help going to bathroom in time.	25 %

TABLE 13 - Cont.
Problems Reported By Patients In Percent (n = 32)

Item Number	Description of problem event	Percentage of patients reporting problem
	Education	
13	Nurses did not ask if patients had questions regarding their condition.	84 %
14	Doctors did not ask if patients had questions regarding their condition.	81 %
15	Did not receive understandable answers from doctors or nurses about the results of major tests.	78 %
16	Did not receive understandable answers from doctors or nurses about why major tests were being done.	53 %
17	Did not receive explanation about purpose of medications and/or their reactions.	50 %
18	Patients felt that information about their condition was withheld from them by nurses.	47 %
19	Patients felt that information about their condition was withheld from them by doctors.	31 %
	Patient's Needs and Preferences	
20	Patient was not happy with the quality of food and drinks available.	41 %
21	Patient was not happy with the choice of food and drinks available.	38 %
22	Patient was not bathed as often as he or she would have liked.	38 %
23	Patient did not receive enough privacy.	34 %
24	Staff did not have a positive attitude towards the patient.	16 %
25	Hospital ward did not seem clean or tidy enough.	13 %

TABLE 13 - Cont.
Problems Reported By Patients In Percent (n = 32)

Item Number	Description of problem event	Percentage of patients reporting problem
	Patient's Needs and Preferences (Cont.)	
26	Patient did not feel safe or secure in hospital.	9 %
	Emotional Support	
27	Doctors did not help with patients' anxiety.	69 %
28	Nurses did not help with patients' anxiety.	66 %
29	Doctors and/or nurses talked in front of patients as if he or she was not there.	53 %
30	Nurses were not supportive.	53 %
31	Not easy to find someone to talk to about personal concerns.	44 %
32	Did not have a relationship of trust with doctor in charge of treatment.	28 %
33	Doctors were not supportive.	28 %
34	Did not have relationship of trust with nurse's treatment.	22 %
Consistency Of Quality Of Care		
35	The quality of care got worse from the time they entered the hospital till point of study interview.	53 %
36	The quality of care differed from one shift to the next.	47 %

As shown, there are specific domains of care for which participants have reported as having high levels of dissatisfaction. A summary of the key problems encountered by this sample is shown in table 14 and figure 1A.

Table 14

INCIDENCE OF VIOLATION OF PATIENT-CENTRED CARE - ITEMS RATED BY 50% OR MORE PARTICIPANTS (n = 32) [See Figure 1A]

Item Number[1]	Description of problem event	Percentage of patients reporting problem
	Education	
13	Nurses did not ask if patients had questions regarding their condition.	84 %
14	Doctors did not ask if patients had questions regarding their condition.	81 %
15	Did not receive understandable answers from doctors or nurses about the results of major tests.	78 %
16	Did not receive understandable answers from doctors or nurses about why major tests were being done.	53 %
17	Did not receive explanation about purpose of medications and/or their reactions.	50 %
	Consistency of Quality of Care	
35	The quality of care was worst from the time they entered the hospital till point of study interview.	53 %
	Physical Comfort	
1	Nurses were rushed and appeared too busy to properly care for patients.	88 %
8	Patient comfort was not a priority to doctors.	75 %
9	Hospital ward too noisy.	63 %
10	Patient comfort was not a priority to nurses.	56 %
	Emotional Support	
27	Doctors did not help with patients' anxiety.	69 %
28	Nurses did not help with patients' anxiety.	66 %
29	Doctors and/or nurses talked in front of patients as if he or she was not there.	53 %
30	Nurses were not supportive.	53 %

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[1] Refer to Table 13 for corresponding item numbers.

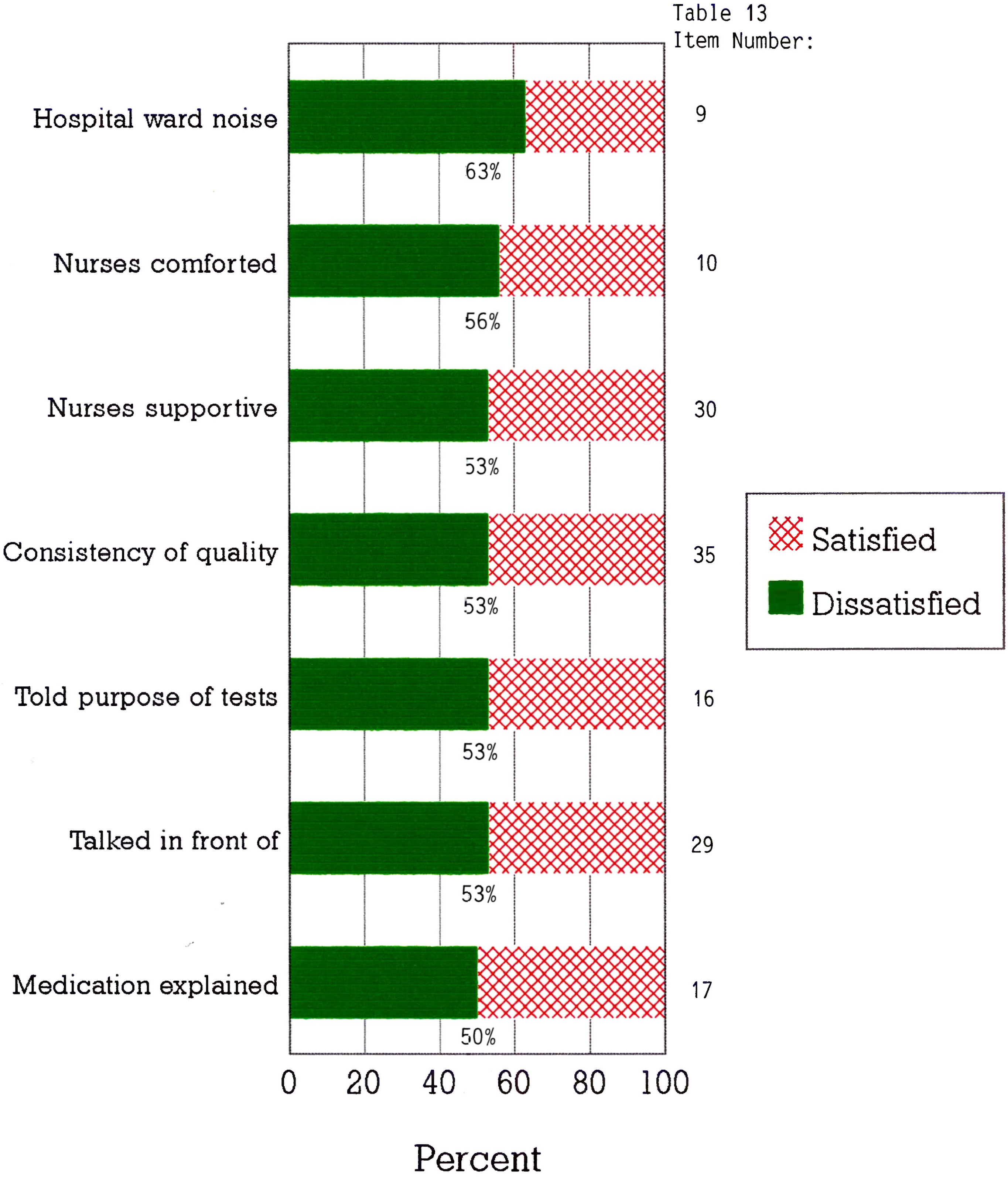
Figure 1A - Incidence of Violation of Patient-Centred Care

Items Rated By 50% or More Participants

(n=32)

Figure 1A - Incidence of Violation of Patient-Centred Care

Items Rated By 50% or More Participants (Continued)



(n=32)

As documented in figure 1A, eighty-eight percent felt that the nurses were too rushed and thus appeared too busy to care for them in a proper manner. One patient noted for example:

> "A simple smile from them [nurses] would be encouraging"

Only nineteen percent of the respondents were happy with doctors who asked if they had questions regarding their condition. Sixteen percent were satisfied with nurses in the same category. This trait of poor communication between the health care provider and the CNIE recipient of care supports Globerman's (1992) and Evers (1981) finding that when patients are viewed as "inappropriate clients" such problems as poor doctor-patient interaction will occur. For Matthews et al. (1988:160), lack of open and direct communication as well as failure to encourage questions or comments remains a problem for patients in hospital.

Patients' comfort was not perceived by the CNIE sample as being a priority to doctors. Seventy-five percent were dissatisfied on this account as were 56 percent who felt that their comfort was not a priority to nurses. Medical staffs' failure to acknowledge difficulties experienced by CNIE patients (e.g. lack of comfort) has, for this study, proven to be an additional source of dissatisfaction. One participant, in addressing this problem, is quoted as saying:

> "Too much work they say - you can pee in bed"

And another is documented as saying:

> "[I] asked for a flannelet blanket - the nurse said there wasn't one but my friend immediately got up and found one"

Such inattention to patient's comfort requires a much greater sense of empathy on the part of health care personnel.

In the category of "Emotional Support", 47 percent were satisfied with the degree of support provided by nurses; 31 percent were satisfied with doctors in helping them deal with their anxiety, and only 34 percent were satisfied with nurses in the same category. These percentages reported by CNIE participants support Preston's (1986) stance that, given the primary focus of our health care system towards cure, reliance on this goal tends to make health care professionals, such as doctors and nurses, disregard the need for caring. Liaschenko et al. (1991:275) state that the practice of medicine continues to be overly cure oriented whereas the provision of emotional support tends to be neglected. Radecki et al. (1988) and Keeler et al. (1982) clearly indicate that elderly patients are <u>not</u> receiving the attention they should be getting.

Sixty three percent of the participants stated that the hospital ward was too noisy. Measures to enhance the environment to make it more conducive to perceived needs can go a long way in permitting CNIE patients to feel a greater sense of well-being.

Fifty-three percent of the sample were dissatisfied with the consistency of care they received. Participants in this category indicated that the quality of care received was worse from the time they initially entered the hospital till the point of the study interview[2]. This finding supports the finding of Spence et al. (1968:976) that when medical staff perceive that "nothing can be done" - when all technical, medical and scientific strategies fail to heal or cure the patient - medical "care" towards such patients as the CNIE population becomes characterized by defeatism, negativism and professional antipathy. An example of this is when medical staff come to spend far less time with the patient than they did originally. One patient, for instance, is quoted as saying:

> "I no see a doctor for over a year. When something happens to me, nurses check me and then go to him"

Fifty-three percent noted they did not receive understandable answers from doctors or nurses about why major tests were being done. The majority of those who were satisfied in this category stressed to me that they had to "stick to their guns" to get an answer. Further, there were only 22 percent who felt they received understandable answers from doctors or nurses regarding their results from the major tests conducted. As noted earlier in this study, the language of medicine has become more and more technical and esoteric over the past century or so (Helman,1990: 121). Medical personnel, as a result, need to learn more consciously how to understand and talk with patients.

As noted by Craig (1990:30), elderly persons need more than hurried responses or abbreviated instructions to questions they

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[2] Mean of the sample's length of stay in hospital equals 29.9 weeks (see Table 9 [page 78] in chapter IV).

have raised. Yet, for this study sample, fifty percent stated that they did not receive a suitable explanation about the purpose of their medications and/or their reactions. Many of the participants mentioned that they were taking multiple drugs (e.g. six or more) about the purpose by which they really had no idea.

Fifty-three percent of the respondents felt dissatisfied with doctors as well as nurses who talked in front of them as if they were not there. This tendency may reflect the fact that medical education is still biased toward the view of the body as a machine thereby ignoring such factors as the social and psychological needs of the patients being treated or attended to (Hewa,1992). CNIE patients are <u>not</u> objects - they need, as other patients, to be interacted with, <u>not</u> ignored.

Further problems were also encountered by CNIE respondents. As shown in table 13 for instance, an additional eight indices exist which fall between the 40 - 50 percent range of reported patient areas of dissatisfaction. These areas are:

(1) Doctors were rushed and appeared too busy to properly care for patients (47%)

(2) What one doctor or nurse had to say differed from what another doctor or nurse had said (47%).

(3) Respondents felt that information about their condition was withheld from them by nurses (47%).

(4) The quality of care differed (was worse) from one shift to the next (47%) [e.g. certain staff working on a particular shift were felt by participants to not do as well with caring for them as other staff had).

(5) Did not have enough say about hospital treatment (44%)

(6) Participants did not find it easy to find someone to talk to about their personal concerns (44%).

(7) Did not receive understandable answers from doctors to important questions (41%).

(8) Patients were not happy with the quality of food and drinks available (41%).

The above and the mentioned fourteen indices mentioned previously (re. table 14), are highlighted to emphasize those areas for which patient-centred care seems most lacking. While such problem areas may not be removed entirely from the acute care setting, (due to various constraints - e.g. economic), many of the participants in this study believed that these areas could have been adequately attended to had medical staff (primarily doctors and nurses) appeared willing to talk about these issues.

The findings shown in tables 13, 14 and figure 1A provide empirical evidence in support of the literature that stresses the need for an improved patient-centred/biopsychosocial approach to health care intervention. It is suggested that more emphasis on psychosocial needs would help alleviate problems experienced by the CNIE patients in acute care hospitals.

Various researchers believe, however, that the facilitation of a patient-centred (biopsychosocial) approach is inhibited by a host of factors. Evers (1981:209) indicates, for instance, that geriatric texts offer little guidance on how hospital staff members can, as individuals and as a collectives, actually work <u>with</u> patients. According to Cummings et al. (1991:46), despite the fact that many nursing faculty now agree that geriatric content is essential at an undergraduate level, few professional-nursing curricula include courses on geriatrics.

For Smith et al. (1990:2) many health-care institutions pay only lip service to the necessity of care planning as (1) there is a lack of punitive consequences for not planning care and (2) there is a failure to keep permanent records of the care plan. Medical assessments (i.e. diagnosis) versus a nursing assessment, are commonly used to generate patient problem lists. These type of care plans repeat common nursing interventions over and over.

Another obstacle to a patient-centred approach is that hospital staff, according to Hesse et al. (1984:748), may continue to cast the elderly patient in a passive role. The technologically complex interventions typical of acute-care may require only passive cooperation from the patient. The traditional medical model views the patient as a passive host of disease processes tended by experts who always 'know best' and who believe that the patient's conceptualization of his or her predicament has little relevance (Shanley, 1981 :199). Successful rehabilitation, however, requires a different and more active form of participation by both patient and family.

In an open-ended interview conducted by Matthews et al. (1988:170), a patient is quoted as saying:

> "I'd like to establish a pattern of relationship that is more on a sharing basis. Cooperative, not paternalistic. I'd like someone who's not afraid to get the patient involved in decision-making, who appreciates our input. We know about ourselves and often what our illness is"

According to Williamson (1988:252), the traditional paternalistic "Doctor knows best" approach is one that is intrinsically opposed to real patient involvement. For patients to be more involved in their own care, hospital staff must change their paternalistic attitudes.

Delbanco (as cited in Koska,1990) has noted that a crucial aspect of patient-centred care is getting patients more involved in their care, both during and after the hospital stay. Barbara Giloth (also cited in Koska, 1990), director of patient education in Chicago with the American Hospital Association, states that patient-centred care means more than just being nice to patients, it requires the development of interventions that meet patient needs as patients perceive them, not as hospitals or professionals do. Documenting CNIE patient perceptions of the care rendered to them while in an acute care hospital is an important component of this study and shall now be further considered.

Qualitative Data Summary

While participants were happy to have the opportunity to express their opinions and concerns regarding the quality of care they received while in hospital, much of what was said was in response to the questions asked. Answers tended to be brief and to the point. This phenomenon concurs with the finding of Critchley (1985) who asserts that the elderly tend not to be overly talkative. He notes, for instance, that elderly women (who made up 59% of this study), often refrain from expressing themselves and speaking due to fear of being rejected by others (Critchley,1985:69).

Comments provided by patients were recorded during the time of interview. Participant perceptions are arranged into two categories: (1) Reported areas of satisfaction and (2) Reported areas of dissatisfaction.

Reported Areas of Satisfaction

The favourable features of care, primarily about doctors and nurses, as cited by the thirty-two participants while in (or within a two month period discharged from) an acute care hospital included:

* "Quick to respond"
* "Nice bed....good view of [from] window"
* "A young nurse treated me like her Grandfather - I was happy"
* "I had a good time"
* "Friendly"
* "Quick"
* "Time given to me - never rushed"
* "You weren't just a patient, you were a human being"
* "I'm happy I didn't have to stay alone at home. I didn't need to struggle by myself"
* "The care from the social workers was excellent"
* "Very happy with Physio and how they treat other patients"

These features best represent forms of care that are patient-centred. Here, the needs/concerns of patients were met or at least attended to, thus giving to patients an overall sense of satisfaction in particular (specific) care domains (e.g. communication).

Reported Areas of Dissatisfaction

Comments derived, particularly from the open-ended questions, tended to elicit many more negative responses than positive ones. Twenty-eight of the 32 respondents (87 percent), reported six or more problems encountered in the acute care hospital setting. The unfavourable features of care cited by these participants in this study included:

* "Some nurses tend to be very demanding and rough"
* "[I'm] placed into diapers instead of [getting] assistance".
* "No help in opening containers of food"
* "I want to be treated human here - I'm not [a] criminal here!"
* "Didn't listen to me"
* "I had a fall when I transferred south to east [wards] - it took me two weeks to get results"
* "Doctors do the talking - this guy is god!"
* "Doctors sent me home in forty below weather - I had to come back after a day"
* "Bed too high - hard to transfer"
* "Many of the nurses did not know their patients entirely"
* "Nurses very much lack training with gerontology patients"
* "Bars in the bathroom [are] all on the right hand side - I'm left handed!"
* "Patients with family [are] treated differently - without family, [they are] treated as if not real people"
* "Brutal orderlies, no consideration from orderlies"
* "Staff causes unnecessary pain"
* "I never saw the doctor"

* "Nurses are sometimes rough"

* "Toe was black - I told doctor to cut toe but they cut my leg off!!" [from the knee down]

* "They don't understand me"

* "They're all deaf - [they] don't listen to my concerns"

* "Nobody like old people - there are some young nurses - they don't work from the heart"

These features best represent forms of care that are not patient-centred. The needs/concerns of patients were not met, giving to patients a sense of dissatisfaction in particular care domains (e.g. physical comfort). It is contended that such negative outcomes of care reflect characteristics/attributes of a biomedical science approach (as addressed in chapters two and three of this study). Here, the forms of care rendered tend to be impersonal, 'objective' (task-oriented versus care oriented), and primarily oriented towards quick turnover, curing versus caring or convalescence.

General hospitals, therefore, have three choices regarding chronic illness: (1) continue grudgingly to admit such patients and provide them with minimum care; (2) refuse to admit chronic patients on the basis that such illness doesn't belong to the general hospital; or (3) accept the fact that chronic and degenerative disease have become the principal health problems in the delivery of health care today, and make appropriate adjustments. The adjustment of hospital services will require changes in goals, orientation and commitment of staff (Hoffmann, 1974:50). Key to the development of this adjustment (or paradigm-shift), as addressed in this study, is the need to integrate a more patient-centred (biopsychosocial) approach to health-care intervention.

The survey also gathered the following responses from the following questions:

Question: What do you think the nurse in the hospital should be doing?

"Talk to me!"

"Take care of you. Straight honest answers"

"Someone to come and help you"

"Many things different - talking to the person - true talk - not secrets - tell people what they think"

"Someone who's going to help you ....friends really"

Question: What do you think the doctor in the hospital should be doing?

"To look after the person - to cure"

"Be very friendly, very capable"

"To help me get better"

"Visit patients in the hospital more often - to talk to them nicely"

"Come and see me - help me out"

"Cure you"

"Doctors are doctors - they're suppose to help you when you're sick, ill or something"

These responses describe a difference in the participants' expectations concerning the perceived role of doctors versus the perceived role of nurses. Reasons for this will be briefly explored.

According to Jecker et al. (1991:285), there remains a traditional stereotype that caring is the domain of nurses and women while curing is an area suited for physicians and men. Our culture has induced males to practice medicine but encouraged women to assume healing roles which fit our culture's idea of femininity (ibid.:287). Such is likely to perpetuate a structured subservience which, in turn, reinforces the dominance of medicine over nursing (Pittman, 1985 as cited in Street, 1992:41)[3] .

Jecker et al. (1991), make this statement:

> "Because patients exert influence over professionals' self-perceptions, patients' attitudes have the potential to strengthen and reinforce traditional stereotypes, obstruct efforts to re-define professional relationships and provide political fuel for traditional hierarchies. In this way, the idea that 'doctors cure and nurses care' continues to exercise a pervasive influence on health professionals' self-images and inter-professional relationships"
> (Pages 285-286)

Responses derived from this study appear to support the above statement. Only twenty-eight percent of the respondents, for instance, felt that doctors were not supportive while 53 percent perceived that nurses were not supportive (refer to Table 13 - items 30 and 33). For this particular category, being 'supportive' appeared to be more associated with the role of the

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[3] According to Price (1987:705), nurses have more extensive contact with patients compared with all other health care providers. Yet, power is allocated to physicians (of whom most are men), to the extent that nurses (a female dominated occupation), are under their authority (Street,1992:8).

nurse rather than the doctor[4].

Question: Was the care you received at first in the hospital different from the care you received later on?

As shown in table 14 and figure 1A, 53 percent of the participants indicated that the quality of care initially provided to them in hospital grew worse up to the point of the study interview. Of those who commented on this, the following was recorded:

"[An] I don't care attitude"

"[Became] lackadaisical. Now they shove pills at me - 'here take these!' "

"Start excellent, now, very poor"

"More attentive at first"

As indicated in the literature review (chapter 2 of this study), medical professionals have difficulty with dealing with those they cannot cure (refer for instance to Globerman, 1992; Evers, 1981; and Falcone et al., 1991). The above comments appear to provide weight to this argument.

Question: How do you define "quality of care". What is important to you in the care you receive in hospital?

While participants were able to express what they felt to be areas of satisfaction and dissatisfaction in the quality of care rendered to them, most were not able to elaborate on what they felt to be "quality of care". Comments that were made include the

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[4] Evidence to support this came from various participants, two of whom, with reference to the physician being supportive, stated "I don't know if they can do that".

following:

> " To be treated like a human being"
>
> " Taking care of you is good care"
>
> " That I would be looked after well - and that they're concerned about me"

Interestingly, virtually all responses by the participants, to the above question, embodied a psychosocial dimension or attribute - most dealt with areas that a biopsychosocial model would (could) address as opposed to a biomedical model.

As to patient perceptions of their desire (preference) for involvement while in hospital, refer to table 15.

TABLE 15

Patient Preferences For Involvement (n = 32)

ITEM	OVERALL PERCENTAGE RESPONSE FROM PARTICIPANTS				
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure
[1] A Person Should Go Along With Their Doctor's Advice Even If They Think It Is Wrong.	6%	22%	38%	28%	6%
[2] A Hospitalized Patient Should <u>Not</u> Make Decisions About His Or Her Own Medical Care.	16%	44%	12%	19%	9%
[3] Even If Medical News Is Bad, A Patient <u>Should</u> Be Told About It.	41%	50%		3%	6%

As shown in the above table, 66 percent of the sample disagreed / strongly disagreed with going along with a doctor's advice if they thought such advice was wrong. While six percent were unsure, it appears evident that the population sample desires at least some degree of autonomy in terms of having a say in their health care. According to Ende et al. (1989):

> "It is important to realize, however, that patients may not want to exercise their right, preferring instead to transfer the decision making power to their physicians. In doing so, they are not abrogating their rights but rather granting permission to the physicians to take charge of certain decisions"
> (Page 28)

Interestingly, Table 15 adds support to Ende et al.'s statement. The majority of participants in this study (60 percent) did not wish to make decisions about his or her own medical care. However 31 percent did, which seems to be a healthy percentage for a sample of older chronic patients. Reasons for this phenomenon have been explored by several researchers.

According to Ende et al. (1989:28), for instance, patients do not want to be the principal decision makers. Patients, particularly those who are seriously ill, desire a lesser role in making decisions - they would much rather prefer having a physician make the decisions for them (Ende et al.,1989:27).

To Beisecker (1988:335), older patients are prone to behave in a manner consistent with the traditional Parsonian passive role. As a result, they do not want responsibility for making medical decisions nor do they wish to challenge a doctor's authority (see also Prigerson,1992:380). Terminally ill elderly patients, in particular, have been shown to want to forfeit the responsibility of determining their own medical care (Ende et al.,1989:23). Further consideration of this will be made later in this chapter.

Not having a desire to have input in one's own medical care may also be a result of a patient feeling he or she has a lack of control over such matters. According to Stirling et al. (1992: 207), patients are often dependent on the health-care professionals for guidance, information and assistance. Health-care staff, as a result, may inadvertently take control over the patient's care in a paternalistic manner thus reinforcing a sense of dependency (a lack of control) by the patient which leads him or her to behave in a passive manner. According to Haug et al. (1981), older patients are likely to be more passive than others.

Despite limited desire to make medical decisions, most of the participants in this study (91 percent) have a strong desire to be informed. This result concurs with the result of Ende et al. (1989:28).

As to patients' evaluation of their hospital care overall, refer to table 16 on the next page.

TABLE 16

PATIENTS' OVERALL EVALUATION OF THEIR HOSPITAL CARE (n = 32)

Overall Care Received From:	Excellent	Very Good	Good	Fair	Poor	Not Sure
Hospital	9%	38%	31%	16%	6%	
Nurses	9%	25%	47%	19%		
Doctors	9%	34%	38%	9%	9%	
Other Professional Staff	13%	22%	53%		6%	6%

Contrary to what was expected, after having heard and recorded the many and varied forms of dissatisfaction reported by the CNIE population, this group of participants expressed overall satisfaction with the care that they received . Further, sixty-nine percent of the respondents indicated that they would recommend the hospital they were presently or formally in to friends and/or family members if they needed to be hospitalized. In this same category, 13 percent noted that it depends (e.g. on what nurse was on shift) while six percent were not sure.

There are selected key indicators of care received (as noted in table 13) that reflect areas of overall satisfaction. Only 31 percent of the sample, for instance, indicated that they did not receive understandable answers from nurses to important questions (apart from those questions related to major tests); thirty-four percent noted that they were treated or examined without explanation of its purpose; twenty-five percent indicated that they had needed, but did not get, help going to the bathroom on time; thirty-one percent of the sample stated that they felt information about their condition was withheld from them by doctors and, only 9 percent of the respondents said that they did not feel safe or secure in hospital. Seventy-two percent of the respondents were satisfied with the amount of time it took to get help after using the call button.

Further findings of this study, which I found particularly surprising, were that 84 percent of the participants perceived that medical staff had a positive attitude towards them; 72 percent stated that they had a relationship of trust with the doctor in charge of their treatment; and 78 percent indicated they had a relationship of trust with nurses' treatment.

What is not reported in the tables but important to consider, is that within the study 69 percent of the participants perceived that nurses treated them with respect while 75 percent felt that doctors treated them with respect. As well, 88 percent of the respondents noted that the ward appeared clean and tidy which also contributed towards their level of satisfaction.

Other areas of satisfaction reported by respondents include: sufficient privacy (65 percent); happy with the choice of food and drinks available (62 percent); and happy with the quality of food and drinks available (59 percent). Fifty-two percent (of the 25 to whom the category was applicable - given their degree of dependency) reported being satisfied with the availability of help to bathe as often as they had wished.

The information noted above (regarding areas of satisfaction), provides evidence that some behavioural components of a biopsychosocial-like approach (paradigm) does appear in some respects to be integrated within the health-care system. <u>However</u>, there are various researchers who would caution that there may be underlying reasons why elderly patients would under-report dissatisfaction about the care they received. The following shall briefly consider this phenomenon.

Patients, particularly elderly patients who report having little schooling (as reported by several respondents in this study) do not consider themselves as authorities on the quality of technical procedures (Wellbeing,1991:5) and are therefore <u>not</u> inclined to comment or complain about such procedures. Medical aspects of inpatient care are likely not well understood by patients "who may therefore limit their praise and criticism to areas in which they feel qualified to pass judgement" (Doering, 1983:292). This is supported by Carstairs's finding that "patients were more likely to say that they would complain about hospital food than about information provided by their physician" (cited in Doering, 1983:292).

Imershein et al. (1980b:465-466) indicates that patients tend to regard health care providers as the only ones having the necessary expertise to make important decisions. They conclude by asserting that whatever viewpoint patients bring to the medical setting, their perspective becomes coopted in favour of that of the providers. My research concurs with this finding as evidenced by the following recorded excerpts.

> "I had no power to tell them this is good, this is bad for I have no education. What they gave me I just take it"

> "To tell you the truth... I cannot tell doctor what to do - [he/she has] higher education - I don't have first grade - no schooling"

In this study it was also particularly evident that CNIE patients had much greater interaction with nurses in their care than they had with doctors. Interestingly, patients who do not see doctors often do not feel as qualified to comment on their performance as they would towards nurses whom they see frequently. Nursing care is extremely salient to patients (Doering,1983:297). In short, inpatients tend to be more critical of nursing care than of physician care because they have more contact with them and thus feel "qualified" to comment on their performance.

According to such researchers as Miles (1991), individuals who lack social or emotional support at home are prone to loneliness, high levels of stress, anxiety and depression. Individuals, as a result, may long for adult social interaction. It is possible, therefore, that the respondents in this study who reported having lived alone prior to hospitalization (representing 18 of the 32 people or 56 percent of the sample)[5] reported being satisfied with being in the hospital simply

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[5] Of those who reported having lived alone prior to hospitalization were five of the 13 males (38 percent) and thirteen of the 19 females (68 percent).

because their room mates and hospital staff met their psychosocial need for company.

The occupational status of women in this sample may have also had an affect on reporting satisfaction with hospital care intervention. Nine of the 19 females (47 percent) stated that their occupation was/had been a housewife. According to Miles (1991), housewives have lower self-esteem as well as a low sense of accomplishment compared with women who work outside of the home. House work tends to be socially devalued (Miles,1991:15-16). This may decrease their sense of wellbeing and increase their sense of powerlessness. Women who work at home receive very little emotional support even from close relatives and may feel very alone, bored, and frustrated as a result (Miles,1991:90,95, 187). For some then, new stimuli such as a change in one's environment - from being at home to being at a hospital - may in and of itself bring about personal satisfaction.

Women who are chronically ill but still primarily responsible for homemaking and caring for a male partner when they are in their home setting, may feel that the break of being hospitalized may be more important for them than for a chronically ill man who has someone to care for him. The benefits of not having to cook for oneself or others, for instance, may actually make a hospital stay seem more like a holiday than a place to obtain medical intervention. This also may have affected the overall rates of satisfaction with care reported in this study.

Interestingly, in old age, emotional support for women is more likely to come from other women than from men. Wives instead of talking with their spouse, for instance, often seek support from others (Miles,1991:98). Female CNIE patients (who represent 59 percent of this study) may, therefore, feel "at home" in the company of other females (e.g. female nurses) and thus report a measure of satisfaction with their experience while in an acute care hospital.

As noted in the introduction, a limitation of this study is that both male and female participants may have been reluctant to completely express their negative perceptions about the quality of care they received. This phenomenon may occur for various reasons such as the participant believing that it is socially unacceptable to complain. Yet another reason, and perhaps more viable, is that persons in this study may have felt a sense of fear in openly admitting that there were problems. "Biting the hand that feeds them" may not be considered too wise given that many are dependent on hospital staff for even the most basic of needs (e.g. toileting). There were occasions in this study when patients would suddenly stop talking (in midsentence) if they thought medical personnel (particularly nurses) were going to enter their room. Some respondents even whispered their answers and there were those who, in response to some questions, would simply shake their head yes or no so as not to be heard. Such fear amongst participants occurred more frequently amongst female patients than it did for males. It is possible, therefore, that a reporting of satisfaction with care in specific care domains was more out of fear for possible reprisals by hospital staff than feeling comfortable with giving fully disclosed answers.

While the above reasons why CNIE patients reported overall satisfaction with their hospital care may appear speculative, they deserve consideration. Even if one chooses to give serious consideration to these factors or not, reported incidences of patient satisfaction should by no means negate attention to the fact that there are a number of problem areas in health-care intervention techniques rendered towards the CNIE patient population that greatly need to be attended to. Comments made by participants about areas of dissatisfaction with the care received, the fourteen indices of violations of patient-centred care noted by 50 percent or more of the respondents, and the complaints which received a 40 - 50 percent negative response rate, are key indicators that characteristics of a biomedical science approach remain in the health care system.

CHAPTER VI

Summary

Overview

The aim of this study was to demonstrate understanding of the biomedical science model as a form of health care intervention and to ascertain to what degree behavioural or attitudinal characteristics of that model may still be in evidence in the quality of care rendered to a sample of CNIE patients who have spent time in local Thunder Bay acute care hospitals.

Chapter I presented the issues and parameters of the problem. Chapter II discussed in greater detail the problems CNIE patients face while in acute care hospitals and addressed a thorough cross-section of the literature describing the characteristics of the biomedical science approach.

Chapter III elaborated on the concept of 'paradigm' and how it has been taken from the history of science and applied to the medical dimension. Such authors as Imershein, Hewa and Engel suggest that medical practices, behaviours and attitudes consistently emanate from the shared structure and assumptions of the dominant paradigm. They also suggest that better care will only result if an overall paradigm-shift occurs (i.e. from the biomedical model to a biopsychosocial model). In this they draw on the work of Thomas Kuhn when he suggests that paradigm-shifts tend to be based on scientific revolutions rather than on a gradual, accumulative basis.

Using a patient-centred care survey to carry out empirical research, I set out to ascertain, at a local level, the extent and degree a BMS approach existed within Thunder Bay's health care system. As noted in chapter IV, the sample included 32 participants who were or remain heavy users of health services. These individuals were either waiting for placement or recently placed into another care facility. At the time of interview, qualified participants were located either in one of three Thunder Bay acute care hospitals, a private nursing home, one of two city Homes for the Aged, or in their own home. All shared their perceptions of the care they received while in hospital.

CNIE patient demographic characteristics - sex, age, marital status, length of present hospitalization, former occupation, mother tongue, hospital recently treated at and reason for hospitalization - were documented. Six care indices were embodied in the patient-centred survey. These included Communication, Education, Emotional Support, Patient Needs and Preferences, Consistency of Quality of Care and Physical Comfort. Descriptive statistics were used for analysis of the findings.

Results of this study suggest that, in this sample, most CNIE patients were satisfied overall with the quality of care given while in one of three acute care hospitals in Thunder Bay (Ontario). <u>However</u>, it is a significant finding that there are fourteen indices of care in which critical responses by participants amounted to 50 percent or more of the sample. An extra eight indices received responses of dissatisfaction between forty and fifty percent.

It is my contention that many of the problems reported by the sample population may be traced to "residual" characteristics of the still favoured (dominant) BMS approach to health-care intervention as documented by such researchers as Blishen (1991), Hewa (1992), Pavelich (1992), Street (1992) and Baker (1988). These researchers document the limitations of the BMS approach as being impersonal and overly 'objective' and mechanistic in its orientation thereby promoting patient dissatisfaction.

This multi-site study indicates as well that steps towards a paradigm-shift in health-care delivery (i.e. towards a biopsychosocial/ patient-centred approach) may be on the horizon although a complete shift has not yet transpired. This finding supports the finding of Buntrock (1988) as well as the theoretical assumptions of Hewa (1992). This study also lends support to the finding of Armstrong (1987) who contends that a biopsychosocial model for health-care delivery has to date been blocked from having full effectiveness due to the continual dominance of the biomedical science model in the health-care system. This is evidenced in the need for improvements in the provision of care towards the elderly in the scale indices used in this study as shown in table 13 in chapter V.

IMPLICATIONS OF STUDY

This study has implications for three important areas: (1) the need for improved patient-centred care towards CNIE patients; (2) for medical staff to be more aware of the importance of learning a patient-centred/biopsychosocial-like approach to health care intervention and (3), the need for further research.

The major implication for increased need to provide patient-centred care, is that interpersonal aspects of care greatly matter to patients. Only when more focused attention to this issue is made will problems experienced by patients - as conveyed in this study - be better addressed and resolved.

Studies have shown that when specialized training is provided to properly attend to the needs of specific client groups (e.g. geriatric patients), care for such patients becomes improved (refer for instance to Hickey et al.,1992). The implications then for medical staff to learn how to deploy patient-centred care follow directly upon the implication for patient-centred care (as noted above).

To accomplish the task of re-orienting the health care system towards a focus on the patient, the emphasis on cure must be counter-balanced with an emphasis on care. To do so, the goal of promoting a paradigm-shift from a BMS approach to a biopsychosocial-like approach in the health care system is a crucial step. One means to improve the quality of care provided to CNIE patients, for instance , is to ensure that their opinions be given greater consideration so as to increase their sense of autonomy, well-being and sense of satisfaction with specific areas of concern (e.g. quality of nurse-patient communication). As Ende et al. (1989) stress, it is the health-care professional (e.g. doctor) who needs to initiate such dialogue. Unfortunately, to date little attention has been paid to the relevancy or utility of patient satisfaction data (Doering,1983:292).

Finally, this study has implications for the need for further research which shall now be briefly discussed.

Suggestions For Further Research

It would be useful to replicate the present study using a much larger sample of chronic, non-acutely ill elderly persons. This would entail conducting research beyond the confines of Thunder Bay. By doing this, the attitudes of CNIE patients relative to their satisfaction or not with hospital care could be determined better.

Also of value would be a separate study that would investigate the perception of acute hospital medical health care personnel (e.g. doctors and nurses) as to whether or not their place of employment is currently aligned more to the biomedical or to the biopsychosocial approach. If at all possible, the use of a participant observation method on such a study could prove valuable and interesting as patients and staff might be reported on in their natural settings.

The sparsity of empirical research on ascertaining the quality of care rendered to such patient populations as the chronic, non-acutely ill elderly, needs to be rectified. Sociologists, working in conjunction with other disciplines such as Nursing, should pursue research that addresses the multidimensional and complex needs of our aging society. Priority to such research will hopefully accelerate a more complete and successful paradigm-shift from an impersonal (static) biomedical science approach towards an enhanced (dynamic) patient-centred (biopsychosocial) approach.

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Appendix 1

** PATIENT-CENTRED CARE SURVEY **

1) **Duration In Hospital:** ______________ 2) **Sex:** ☐ Male ☐ Female
(Please specify weeks)

3) **Reason For Hospitalization:** ______________________________

4) **Age** : ☐ 60 - 69 ☐ 70 - 79 ☐ 80 - 89 ☐ 90 +

5) **Marital Status:** ☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed ☐ Remarried
☐ Other (Specify:________________)

6) **Prior to hospitalization, did you live by yourself or with someone else?**
☐ 1 By yourself ☐ 2 With someone (inclu. children) ☐ 3 Refused

7) **Mother Tongue:** ☐ English; ☐ French; ☐ First Nations (Native);
☐ Polish; ☐ Italian; ☐ Ukrainian; ☐ Slovak; ☐ Finnish;
☐ German ☐ Other (Specify:________________).

8) **Presently In Hospital?** ☐ YES ☐ NO (DO NOT READ)

9) **Treated At:**
☐ St. Josephs Hospital
☐ Port Arthur General Hospital
☐ McKellar General Hospital

10) **If NOT presently in hospital, what is present location?**
☐ Home (House/Apartment)
☐ Nursing Home (Beacon Hill Lodge)
☐ Grandview Lodge / Dawson Court
☐ Senior Citizen Apartment
☐ Other (Specify:__________________)

11) **What was your location prior to hospitalization?**
(Please Specify: ______________________________)

12) **Presently waiting for long-term placement ?** ☐ YES ☐ NO

13) **What has been your major occupation in life ?**
(Please Specify:______________________________)

How long ago were you discharged from the hospital?

______ N/A ________Number of days ____________ Number of weeks

14) Have nurses treated you with respect?:
[ES]

____ Always ____ Some of the time ____ Never

15) Do Nurses ask if you have any questions regarding your condition?:
[E]

____ Always ____ Some of the time ____ Never

16) Do you feel that Nurses ignore your concerns?:
[ES]

____ Always ____ Some of the time ____ Never

17) Has your comfort been a priority to nurses? :
[PC]

____ Always ____ Some of the time ____ Never

18) Have doctors treated you with respect?:
[ES]

____ Always ____ Some of the time ____ Never

19) Do Doctors ask if you have any questions regarding your condition?:
[E]

____ Always ____ Some of the time ____ Never

20) Do you feel that Doctors ignore your concerns?:
[ES]

____ Always ____ Some of the time ____ Never

21) Has your comfort been a priority to doctors? :
[PC]

____ Always ____ Some of the time ____ Never

22) Were you satisfied with the noise level in the hospital?
[PC]

____ Always ____ Some of the time ____ Never

How do you feel towards the following:

Hospital **Nurses** Have Been:	Always	Sometimes	Never
23) [C] (A) Rushed	X	X	X
24) [ES] (B) Supportive	X	X	X
25) [ES] (C) Helping YOU deal with YOUR anxiety	X	X	X

Hospital **Doctors** Have Been:	Always	Sometimes	Never
26) [C] (A) Rushed	X	X	X
27) [ES] (B) Supportive	X	X	X
28) [ES] (C) Helping YOU deal with YOUR anxiety	X	X	X

Question [PNP Section]	Yes	No	Comments - Probe
29) Does (Did) the ward seem clean and tidy enough?			
30) Do (Did) you feel safe and secure in the hospital?			
31) Do (Did) you feel you are (were) given enough privacy?			
32) Does (Did) the staff have a positive attitude towards you?			
33) Are (Were) you happy with the quality of food and drinks available?			
34) Are (Were) you happy with the choice of food and drinks available?			
35) Are (Were) you offered or helped to wash and bath as often as you wish?			

Modified Pickert-Commonwealth Patient-Centred Scale:

36) When you had important questions to ask a NURSE , did you ALWAYS get answers you could understand?
[C]
1. Yes
2. No
3. Sometimes
4. No important questions
5. Not Sure

37) Do you think that the NURSES withheld information from you?
[E]
1. Yes
2. No
3. Sometimes
4. Not Sure

38) Did you have confidence and trust in the Nurses treating you at the hospital?
[ES]
1. Yes
2. No
3. Sometimes
4. Not Sure

0.01) What do you think the Nurse in the hospital should be doing?

39) Did you notice any change in the quality of nursing care from one shift to the next?
[CQ]
1. Yes
2. No
3. Sometimes
4. Not Sure

0.02) (b) What changes did you notice?

40) When you had important questions to ask a DOCTOR , did you ALWAYS get answers you could understand?
[C]
1. Yes
2. No
3. Sometimes
4. Not Sure

41) Do you think that the DOCTORS withheld information from you?
[E]
1. Yes
2. No
3. Sometimes
4. Not Sure

42) Did you have confidence and trust in the <u>Doctors</u> treating you at the hospital?
[ES]

1. Yes
2. No
3. Sometimes
4. Not Sure

0.03) What do you think the <u>Doctor</u> in the hospital should be doing?:

____
____

43) Sometimes, in the hospital, one doctor or nurse will say one thing and another will say something very different. Did this ever happen to you during your hospital stay?
[C]

1. Yes
2. No
3. Sometimes
4. Not Sure

44) Did anyone in the hospital ever examine you or treat you without ever explaining first what they were going to do?.
[C]

1. Yes
2. No
3. Sometimes
4. Not Sure

45) Did you have enough SAY about your treatment in the hospital?
(If R Says They Just Did What The Doctor Said, Repeat Question)
[C]

1. Yes
2. No
3. Sometimes
4. Had Too Much Say
5. R Didn't Want Any Say

46) Did the <u>doctors</u> or <u>nurses</u> EVER talk in front of you as if you weren't there?
[ES]

1. Yes
2. No
3. Sometimes
4. Not Sure

47) And how easy was it for YOU to find someone on the hospital staff to talk to about your personal concerns -- very easy, somewhat, not very, or not at all easy?
[ES]

1. Very
2. Somewhat
3. Not Very
4. Not At All
5. R Had No Personal Concerns/Never Wanted To Talk

48) When you needed help with getting to the bathroom, did you usually get it in time?
[PC]
1. Yes
2. No
3. R Never Needed Help

49) How many minutes after you used the call button did it usually take, on average, before you got the help you needed?
[PC]
(If R Doesn't Know What A Call Button Is, Clarify: "This is a button you push when you want a nurse to come and help you.")

(If R Says "It Varied", Probe: "How long on average?")

________ # of Minutes

50) Did someone on the hospital staff always explain why MAJOR tests were being done in a way that you could understand?
[E]
1. Yes
2. No
3. Sometimes
4. No Major Tests

51) After the MAJOR tests were done, did a doctor or nurse ALWAYS explain the results in a way you could understand?
[E]
1. Yes
2. No
3. Sometimes
4. Explained To Spouse Or Other Caregiver
5. R Did Not Want To Know
6. Not Applicable

52) Did someone on the hospital staff explain the purpose of the medicines you were taking in a way you could understand?
[E]
1. Yes
2. No
3. Sometimes
4. Explained To Spouse or Caregiver 5. No Medications

0.04) Please share briefly how you define "quality of care". What is important to YOU in the care you receive in hospital?

____
____
____

53) Was the care you received <u>at first</u> in the hospital <u>DIFFERENT</u> from the care you received later on? [**PROBE**]
[CQ]

____
____
____
____

54) Overall, how would you RATE the care you received at the hospital --was it excellent, very good, good, fair, or poor ?

1. Excellent 2. Very Good 3. Good 4. Fair 5. Poor 6. Not Sure

55) From Nurses: ____________________

56) From Doctors: ____________________

57) Other Professional Staff: ____________________

58) Would you recommend the hospital you attended to your friends and family if they needed to be hospitalized?

1. Yes
2. No
3. It Depends
4. Not Sure

0.05) Please tell me 2 things (items) that caused you to be DISSATISFIED with the care you received in hospital:

a. ____________________

b. ____________________

0.06 Please tell me 2 things (items) that caused you to be SATISFIED with the care you received in hospital:

a. ____________________

b. ____________________

For each of the following statements, please tell me if you:
1. Agree Strongly 2. Agree 3. Disagree Strongly
4. Disagree 5. Not Sure

59) [a] A person should go along with their doctor's advice even if they think it's wrong.

____

60) [b] A hospitalized patient should NOT make decisions about his or her own medical care.

____

61) [c] Even if medical news is bad, a patient SHOULD be told about it.

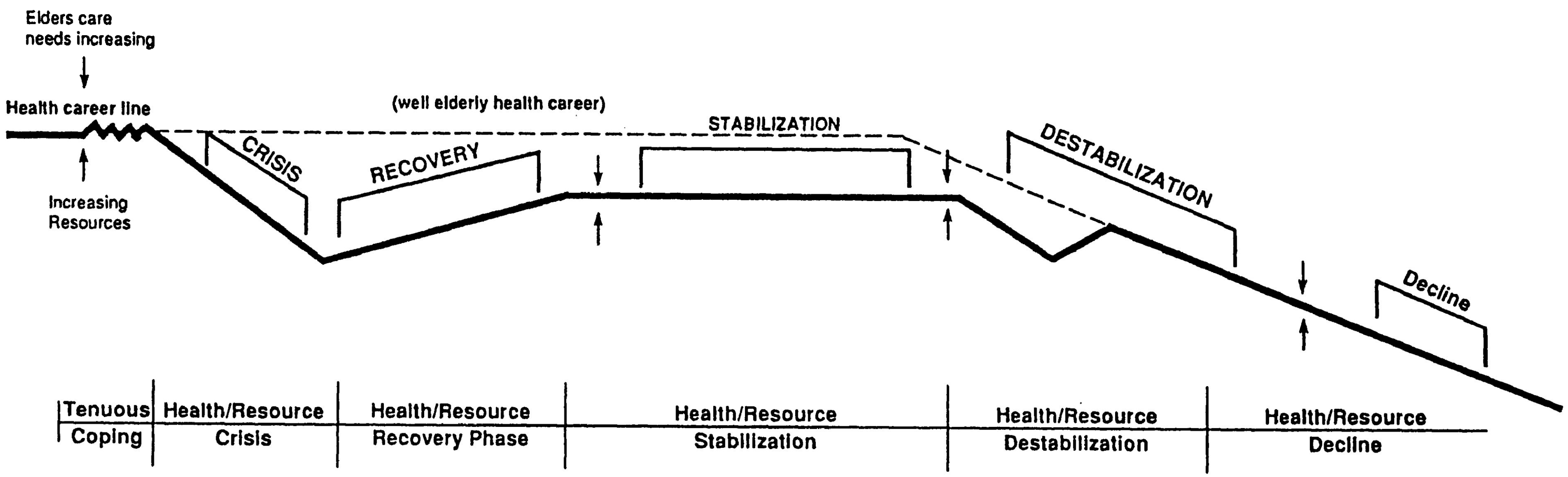
____

Thanks. That's our last question. Do you have anything else you would like to say?

____
____
____
____
____

Appendix 2

CASE EXAMPLE: PHASES OF ELDER'S HEALTH CAREER OVER TIME



*Each person's health career is unique

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