

THROUGH THE GLASS DARKLY:
DISCHARGE PLANNING WITH THE ELDERLY
IN AN ACUTE - CARE HOSPITAL SETTING

BY

GLORIA L. DIXON

A Practicum Report
Submitted to the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

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"My purpose is that they may be encouraged in heart and united in love, so that they may have the full riches of complete understanding , in order that they may know the mystery of God, namely, Christ, in whom are hidden all the treasures of wisdom and knowledge." Colossians 2:2,3 (NIV).

Abstract

This study is an examination of the perceived self-health of twenty, recently discharged, elderly clients. Views on their recent experience in hospital, as well as their perceptions of the health care system, were elicited. The responses were analyzed in order to develop a basis for a discharge planning framework.

Findings included unmet psychosocial needs that included coping with changes in self-identification, body image, feelings of increased vulnerability manifested by expression of anxiety and depression. Only one client understood the evolving changes in funding arrangements between different levels of government and few clients could report memories of the condition of their lives prior to the introduction of universal medicare in Canada. Social work intervention in the discharge planning process should be directed at many levels of care. The effectiveness of discharge planning would be greatly facilitated by an understanding of the multiple, and sometimes conflicting, responsibilities facing the medical social worker.

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Introduction

This practicum has evolved from my interest and experiences in working with elderly clients in an acute care hospital setting. Our world is changing so very quickly and the differences in attitudes and perceptions between and within generational groups is a fascinating study particularly in the interface between a growing elderly population and a health care system struggling to meet demands with shrinking resources. Decker (1980:8) has described older people as "immigrants through time", meaning that they have "moved through time, have experienced the meaning of time and have come to know the pleasures and ravages of time". He considers three concepts to be central to our understanding of the gerontological culture: generation, maturation, and social age.

The term generation can be used to place persons in a lineal order but can also be used in a collective sense in that each of us are "members of a particular historical cohort" (Decker, 1980:9) and seems to be in agreement with Mannheim's (1952:291) idea that members of a generation share a "collective mentality". As such:

"The fact of belonging to the same class, and that of belonging to the same generation or age group, have this in common, that both endow the individuals sharing them with a common location in the social and historical process, and thereby limit them to a range of potential experience, predisposing them for a certain characteristic mode of thought and experience, and a characteristic type of historically relevant action."

What Mannheim really seems to articulate is that we are a product of our times and that because each generation is historically unique, each will respond in a different way from the other.

Second, the effect of maturation on our social behaviour, its effect on the beliefs and attitudes of those around us regarding their expectations of us and its influence on our expectations of ourselves may influence our adjustment to illness and wellness. (Decker, 1980:9)

Neugarten and Datan (1973) discuss a third concept of "social age". There are social definitions that also give meaning to our age. These vary according to cultural understanding as well as where we are functioning at any given time in a particular social institution. Examples of this may be seen in various stages of the family life cycle or occupational career. Our definitions of social age certainly appear to be reflections of past beliefs and societal limitation. Perceptions of when one is old diverge when viewed by different generations and different cultural norms.

Elderly clients in the hospital present the medical social worker with the interesting task of assisting the elder and their family with adjustment to illness (sometimes both chronic and acute at the same time) as well as planning for a successful reintegration into their community. Discharge planning has been a function of medical social

workers since the establishment of the first department of hospital social work at the Massachusetts General Hospital early in the 1900's. It has perhaps been seen as the primary role of hospital social workers with patients and families (Berkman and Rehr, 1972:578). Grace Fields (1978), in a compelling editorial for **Social Work in Health Care** said:

"People caught in a medical cure system that has not been able to effect the total cures they need are defined by utilization Review mechanisms as discharge problems. People are not discharge problems. They have discharge problems."

She further develops the idea that the difficult transition back to previous lifestyle and surroundings is a reflection of societal stress on the individual, the family and the community as a whole. Prolonged hospital stays can have a negative effect on patients and their convalescence and may result in both inappropriate and over utilization of a resource (Lurie, 1984) which is the most expensive feature of our health care system.

This practicum was designed to allow for a greater exploration of the role played by generation, maturation and social age in relation to recognition of symptoms and illness in elderly clients. Their views of our current health care system were also sought. With the crisis in health care funding today, it is important to understand the value placed on the system by its participants as well as their perception of why the crisis exists. We as a Canadian

society may be standing at a crossroad in the delivery of our health care. It is important that we participate fully in making well informed choices about the direction that it should be taking.

The practicum was undertaken as a project to define the role of the medical social worker in the discharge planning process within an acute care setting. This crossroad in provision of health care also demands that the profession look proactively at what its role may be in the future and work to be on the leading edge of providing health care that is a better fit with a rapidly changing world and mores.

A recent Statistics Canada survey released in 1992 shows that fewer than one per cent of 10,000 homemakers surveyed last year supported elderly parents by regularly helping with the housework, transportation or personal care. Women helped their parents more than men, but even amongst the female homemakers the rate of intensive family support was under four percent. Some of this can be attributed to a increased geographic mobility of this generation, however Ben Schlesinger, a member of the faculty of social work at the University of Toronto says economic stress on families today may restrict the amount of energy available to assist with elderly parents also (Winnipeg Free Press, April 28/92).

The practicum sought to gain an understanding of how clients saw the medical system as treating them as a group. It is presented as a preliminary theory regarding the role of the social worker in the discharge planning process as well as a recommendation for an expansion of traditional activities in this process. As resource dollars become scarcer, the importance of strengthening the ties between constituents, and various service providers cannot be underestimated. Suggestions with regards to clarification and expansion of traditional social work roles in the hospital setting particularly in the arena of discharge planning will be presented.

The practicum report will review relevant literature regarding concepts of health and wellness, concepts surrounding aging and identity to provide a basis for ongoing discussion related to gerontologic social work. Literature available in the area of discharge planning will also be examined with salient concepts being used in the discussion of the results of the practicum. Additional references to discharge planning literature will continue to be woven into the fabric of the discussion section. This is done in an effort to enhance both the readability and continuity of the document for the reader.

The practicum utilized a semi-structured interview format and the method of study as well as the process of its development will be probed. The report will present an

overview of representative clients who gave of themselves to facilitate a better understanding of the future role of discharge planning with the elderly as a constituent group. It is they who have made the major contribution to this effort, for the interview process for many brought to the fore many issues of personal and at times, emotionally painful significance. Their desire to share these in the hope of assisting the writer in understanding their cohort group and perhaps effecting a positive change in the future care of seniors was appreciated over and over again.

Chapter One

HEALTH AND WELLNESS

An understanding of the concepts of health and wellness was an important starting point for the work of this practicum. A medical model approach would focus on the absence of illness as a primary indicator for health. Gress and Bahr (1984) quote a range of literature that define health as a state, a process, a diagnosis, a task, a response or a goal. The World Health Organization's (1947) definition of health would seem to be the most generally accepted and it sees health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity".

If then, one views wellness as a process of development and growth throughout the life cycle, then tasks for wellness can be presented as a starting point for assessing such a state. Havighurst (1972) describes a model based on Erikson's eight developmental stages (1963). For those in the final stage of maturity (ego integrity vs. despair) wellness tasks include the following:

- a. Becoming aware of risks to health and adjusting their life-style and habits to cope with risks.
- b. Adjusting to loss of job, income, family and friends through death.
- c. Redefining their self-concept.

- d. Adjusting to changes in personal time and new physical environment.
- e. Adjusting previous health habits to current physical and mental capacities.

Graney (1985) sees the definition of wellness as a continuum from illness to wellness with a middle ground of absence of symptomatology. Physician assessments of older peoples' health are based on comparison to general medical standards whereas the assessments of the clients themselves are made in terms of their own functional ability and within their own age group (in which the presence of one or more chronic diseases is the norm). It is this functional model which seems to fit most easily into an understanding of the link between symptom recognition and the seeking of help.

Clarke (1987:4) suggests that the patient's recognition of himself as ill stems from a variety of factors ranging from ethnicity and sex to the degree of impairment in functioning and accessibility to medical services. She sees health and illness as being social constructs, not purely the result of a physiological process.

Mechanic (1982:55) discusses this topic of symptom recognition and his stated belief that even objective reports of screening and diagnostic procedures are "biased by the psychological processes affecting awareness, reporting, and action with respect to specific symptoms". He presents a model of information processing mechanisms

involved in individual perception and response to bodily complaints. The illness symptoms are self-defined and coped with in some way that is determined by the level at which the symptom is interpreted. The link between the illness representation and the client's coping mechanisms can then be understood.

Interestingly, Mechanic also makes use of the importance of history in the recognition of symptoms and in the individual assessment of their own "wellness". The three concepts of social age, maturation and especially generation all play an important part in the interpretation and processing of wellness cues. He suggests that because of the wide range of variation in health and illness behaviour from one culture to another and among varying ethnic groups, health attitudes and behaviour are learned.

The "vocabulary of distress" (Mechanic, 1982) is shaped by a cultural acceptance and appropriateness and contributes to their conceptualization and response to distress. This vocabulary is learned through the life cycle. Tied to this view are the influences on evaluation of symptoms and subsequent decisions regarding action on the interpretation of such.

A final category of variables affecting illness behaviour is the accessibility and social organization of the system of care itself. He quotes Fuchs (1974) with a stated position that practitioners tend to produce their own

demand to some extent, and thus the level of use of ambulatory services, specialists, and beds depends on the number available. Ecological factors such as distance to care, and social accessibility factors (availability of outreach, lack of stigma, and personal interest in the patient) affect the patient's decision to seek services.

Talcott Parsons (1951) conceptualized illness as a normative role that provided a reintegrative process for the ill individual. The sick role could be used as a normatively prescribed response or it could also be used as a deviant adaptation to avoid social role responsibilities (Johnson et al; 1988), to achieve other secondary gains with the legitimating circumstances of illness (Freidson; 1970) or to justify the failure to satisfy social role responsibilities (Cole and Lejeune; 1972). It is the physician-patient relationship which serves the social control function of minimizing the disruptiveness of sickness to the group or to the society.

Parsons' sick role has four components - two exemptions from normal responsibilities and two new obligations:

- a. The sick person is exempted from normal responsibilities, at least to the extent necessary to "get well".
- b. The individual is not held responsible for his or her condition and cannot be expected to recover by an act of will.

- c. The person must recognize that being ill is undesirable and must want to recover.
- d. The sick person is obligated to seek and cooperate with the physician or a competent treatment agent.

The physician functions as a social control agent because he/she both legitimize the sick role and also strives to return the individual to a more conventional social role.

This particular perspective has been carried even further with suggestions that the development of legitimized illness is a socially acceptable method of "coping with failure" and is a criterion for allocation of various "rewards" such as certain social benefits (Shuval, J. et al; 1973).

The motivations for the individual to undertake the sick role have been seen in two ways: that the role is assumed in response to symptoms or that there are benefits other than symptom relief to be gained by undertaking such a role. Both processes may contribute to both the entry into and the degree of the sick role (Johnson et al; 1988).

Any social work discussion on this issue of health, sickness and wellness would be incomplete without a reference from The Honourable Monique Begin, P.C. a former Minister of Health and Welfare (Canada):

"For all of us, health, as a goal to be achieved or a state to be maintained, is a lifelong task. It's everybody's business - both individually and collectively. And since health is adversely affected by poverty, unemployment, social stress, inadequate housing, unsafe working conditions and a host of other social and environmental hazards, it is also the business of our politicians. These are the public policy issues" (Rachlis and Kushner, 1989).

The political realities in the health care system manifest themselves to all whether patient or professional, taxpayer or politician. The charges of underfunding, out of control spending, too many physicians, too much physician control of access to health care, too many tests and unnecessary surgeries can dizzy even the most astute student of the economics of the Canadian health care system.

"Unnecessary surgeries, over-long hospital stays and the inappropriate use of institutions may have more to do with explaining the problem than lack of funds" states Rachlis (1989). The social worker within the health care system will need to make an assertive leap from simply moaning about underfunding to working within and outside of the hospital to ensure good health care. Constructive and creative design, implementation and evaluation of programs can lead us into a place of being seen as innovators in a new way of providing health care (not just illness care).

Chapter Two

VIEWS ON AGING

Miller (1979, 1987) posits the view that aging has been constructed to resemble a form of social deviance with a loss of some former adult roles and a paucity of specific roles for the elderly in modern industrial urban systems. He criticizes the view of symbolic interactionalists who would see "the type of aging processes which an individual will experience" as being "significantly affected by his/her interaction with the environment and persons encountered during life" (1987:142). This, he says, contributes to the labelling of older persons as deviant. It also provides the opportunity to various social control elements such as the medical hierarchy to exert influence on older persons to attempt to conform their behaviour to that which is expected by the society.

Macro-level theories of aging deal with the way that elderly individuals are tied to their society and the social status that is accorded them. Cowgill and Holmes (1972) have articulated a systematic theory of how modernization has led to a decline in the status of the aged. Their theory describes four dimensions of modernization:

1. Modern economic technology creates new positions increasingly held by younger people. As the older positions become obsolete, their status declines.

2. Increasing urbanization and mobility lead children to establish new families geographically distant from their parents. This segregates the young and the old in both a residential and social sense.
3. The progressively higher educational attainment of younger people provides them with more of an inherently valued commodity. These educational differences may serve to segregate the generations both intellectually and morally.
4. Advances in health technology increase life expectancy.

This means that people are able to remain in the work force longer, creating intergenerational conflict because of the blockage of upward mobility for the young. Retirement can be seen as a macro level attempt to resolve the conflict.

Sociologists have several criticisms of this theory - from unequal progression of modernization across the four dimensions previously described, to the conceptualization of the social status of elderly persons, difficulties with the relative timing of changes in modernization and social status, and finally the assumption that the status of the elderly was higher in earlier historical periods. A romanticized and uniform view of the past has contributed to many of the difficulties with this thesis (Dowd, 1980).

A second major approach to understanding aging rests on a perspective of age stratification. To assist in understanding, one needs to differentiate the two concepts of cohort and age stratum (Riley, Johnson and Foner; 1972). The cohort consists of individuals born approximately at the same time, who move through their life course together. The boundaries for a cohort are rather arbitrary and usually set by the investigator. The age stratum consists of individuals who are of a similar age at a particular time. Cohort membership is assumed with birth and retained throughout the individual's life span. As aging occurs, so does movement through successive age strata. This practicum was designed to allow for an expression of cohort uniqueness with less of a focus on clients' placement in a particular age strata.

Cohort similarities and differences are important because of their ability to reveal the "unique set of historical experiences" (Karp; 1982) between various cohort groups and allow for a more dynamic understanding of expectations and interactions with society as a whole. Persons who were children during The Great Depression, for example, "were shaped by that historical event and, consequently, interpret much of the remainder of their lives in light of that experience" (Karp, 1982:30).

Although Rose (1965) argues for the increasing emergence of the elderly as a distinctive subculture because

of their large numbers, increased energy and health, collective concerns which have mobilized them to become a visible lobby effort and growing geographical segregation, there is evidence that conflicts with the validity of his assumptions. The notion of a common lifestyle amongst cohort members can be called into doubt. Like members of all other age cohorts, they experience their chronological age in different ways.

Foner (1974) on the other hand , articulates a view that each successive cohort entering the old age stratum brings with it its own unique encounter with history. The values and interests it brings into that stratum will be different from those already there, weakening the unanimity or consensus of shared values. She feels that the potential for age based consciousness is mitigated by the overwhelming generational consciousness.

The past two decades have seen an increase in concerns about age. Public policy discussions regarding pensions, retirement positions, health care and related issues have raised the volume of the political rhetoric. The age consciousness itself has been called a phenomenon of the generational cohort (Cutler, 1981).

The individualistic bias of our North American culture is reflected in the focus on the adjustment of the aging person to their place in the society. This is said as a preliminary comment to further discussion of three other

variations of role theory that have been put forward. The assumption that this time of life is problematic (perhaps because of a lack of preparation for retirement or difficulty adjusting to role change) directs one's attention away from the structural foundations of age-related poverty and political neglect.

Activity theory hypothesizes that the adaptation of the individual to the society is threatened by their age related declines in the area of role occupancy. The claim is made that:

"...the older person who ages optimally is the person who manages to resist the shrinkage of his social world...(he) finds substitutes for work when he is forced to retire and substitutes for friends and loved ones whom he loses by death" (Havighurst, 1968:21).

On the other hand, **disengagement theory** views the decline of activities as a natural and inevitable severing of ties between the individual and society serving a function to both. It is particularly functional for society because it allows for a smooth passing of people through the positions which make up the society. It is considered functional for the individual in order to conserve energy because of failing health. More time is allowed for the individual to prepare for death (Hochschild, 1975).

Continuity theory as proposed by Atchley (1971) proposes that it is not the actual level of role involvement

or activity that is the important determinant of adaptation in later life as much as the **change** in role involvement.

An understanding of the older strata is not complete without an understanding of age identity and age definition. It is commonly acknowledged in the literature that ours is an ageist society in which both negative and positive stereotypes about aging exist. Kalish (1982) concluded that older people consistently viewed themselves much more optimistically than they are viewed by the non-elderly. To the extent that stereotypes about old age are negative, he found that people may try to exempt themselves from the status of old.

The Kuypers and Bengtson (1973) model of the **social breakdown syndrome** postulates how the elderly identity becomes vulnerable because of role loss, normative ambiguity, and a lack of confirmatory feedback from others. Outside portrayals as being obsolete and useless then take on increased meaning for the individual. The assumption of the sick role or a place of dependence may then occur. The model is circular, but exposes various points of entry through which either formal or informal intervention can take place to enhance self-reliance, coping skills, and individual self-esteem. Betty Friedan (1988), in commenting on men who assume a primary caregiving role with elderly wives, admits mistakes made by the early feminists who saw such a role as martyrdom and themselves as victims.

Instead, she now views the choosing of any role as giving us purpose and self-respect. The task of the assessor is to search for the purpose of the role.

Dowd (1980) utilizes a form of **exchange theory** in theorizing that decreased interaction with increasing age is a result of a decline in the resources that can be brought to encounters; whether those resources be material, positions of authority, access to power or even qualities such as strength. As their social network diminishes, these resources also deplete and a loss of respect ensues.

If an individual is not able to offer resources in return for needed resources from another, a dependent state would then be present. If human beings seek to be independent, autonomous and have control over their situations, then avoidance of these dependent relationships would be a logical step. Withdrawal may be a way to eliminate the psychological cost of dependency (Matthews, 1979).

Issues of dependency, identity, age definition, role involvement and role assumption are all central to the medical social worker's involvement with elderly clientele. The historical context which each cohort group brings emphasizes the need for the worker to be not only culturally sensitive but also historically sensitive. Quality discharge planning involves integrating knowledge of attitudes and behaviours regarding health, and an

understanding of the aged person in an ecological context. It calls upon the social worker to do more than simple assessment; it issues a challenge to involvement on every level of intervention with the client. It needs to be seen as an exciting process that uses the "theoretical aspects of crisis intervention, problem-solving, ego-centred therapy, systems approach and grief/loss counselling" (Diamond, Jansen-Santos, 1989).

Chapter Three

DISCHARGE PLANNING - A REVIEW OF THE LITERATURE

Discharge planning has fallen within the domain of the hospital social work department since the profession's earliest days and is often seen by the institution as its primary role (Berkman and Rehr, 1972). It is an interdisciplinary service to the patient, the family and the institution itself and should emphasize the active involvement of the client and family, provision of adequate information so that appropriate decisions can be made, and provision for follow-up of the discharge plan.

Discharge planning must not only serve to address the needs of the patient medically, but also in a psychosocial sense (Blazyk and Canavan, 1985). The crisis of discharge can mark the first occasion in which the patient and significant others must face the reality of the medical situation on their functioning outside of the hospital environment. The crisis situation, in fact, offers the social worker a unique opportunity to intervene in a way that may have long term beneficial effects for the client. "Paradoxically, the initial period of destabilization for the family system permits intervention that would be difficult in more stable situations" (Blazyk and Canavan, 1985).

The biomedical focus of hospitals cannot "alleviate the problems of stress, anxiety, depression, worry, and a host

of social ailments, social diseases and environmentally induced symptoms" (Rehr and Rosenberg, 1991:117). Discharge planning in its current model cannot adequately address these concerns with individual patients and as most social work departments do not follow their patients after discharge, it is difficult to assess the stability and adequacy of the discharge planning program as it currently functions in acute care settings. (Quinn, 1984)

The concern of both home care nurses and social workers today is that patients are being discharged from the hospital "quicker" and leave the hospital "sicker" than they did perhaps in the past (Kosecoff et al, 1990). This is particularly true in the United States where hospitalization has a direct monetary cost to the patient and a system of DRGs (Diagnosis Related Grouping) dictate a length of stay and attach monetary benefit to the facility to decrease the amount of time spent in hospital (Rehr and Rosenberg, 1991).

The patient's medical vulnerabilities are clear as their time in hospital progresses and the discharge plan must meet their need. The social worker, however, must pay attention to the psychosocial need of the client to prevent a recurrence of medical problems. A discharge plan may not adequately address both unless comprehensive, efficient coordination is provided.

Addressing the Issue of Quality in Discharge Planning

Cunningham (1991) addresses the differences between clinical quality and service quality. **Clinical quality** is what accreditation standards measure, traditionally defined by health professionals and health care regulators. It is what patients assume will be delivered by the hospital and its staff. **Service quality** is actually patient-driven quality. Terms like caring, communication, and concern are used to describe this type of quality. Finally, **economic or finance-driven quality** takes into account the cost-effectiveness of care. As an institution, and as a service, we need to become increasingly cognizant of our patients' satisfaction and evaluate our programs and interventions accordingly.

From the perspective of the institution, discharge planning is concerned with the desired level of utilization of beds and continuing patient turnover (McClelland, E., Kelly, K., Buckwalter, K., 1985). The ambiguities in definition of discharge planning hinder the clarification of the social work role and may hinder the process itself. An ecological approach relates discharge planning as not only interprofessional and client-centred but often interorganizational. James (1987) relates the effectiveness of the process as relying on the interactions of its different variables:

" the strength of discharge planning policy; the point of access for planning; the patient's state and personal network; and the nature of the treatment organization and its resource network".

The most frequently mentioned assertion in the literature is that discharge planning at the point of hospital admission is considered fundamental to the effective delivery of care in an elderly population (Naylor, 1990; McClelland et al, 1985; Schrager, J. et al, 1978; Boone et al, 1981). In fact, it has been said that quality discharge planning may prevent hospital readmission because forty to fifty percent of readmissions have been linked to social problems and lack of community services (Morrow-Howell et al, 1991).

Quality, integrated discharge planning serves to ensure quality in health care delivery in a cost-efficient and effective way (O'Hare, 1992). While the process itself receives much attention by many professional and health care provider groups, there is little research and explication of the component parts of the process. The art and science of the social work profession clash leaving what we do wanting in terms of specific activities that can be evaluated and measured at times and discharge planning would appear to be in this situation. Using literature available, one can begin to structure a model for discharge planning that may allow for more in-depth evaluation.

Discharge Planning Process

Discharge planning should begin at the time of hospital admission. The hospitalized elderly must adapt to a strange routine, "loss of privacy, uncomfortable procedures, and often radical alterations in role and self-image" (Naylor, 1990). This may be superimposed on grief because of a recent loss, fear of loss of independence or death and possible failure of previous coping strategies. Because of the disequilibrium imposed, there may be an inability on the part of the elder and even their family to make future plans. There may be difficulty understanding and retaining information throughout the hospitalization resulting in a lack of understanding about the illness, any subsequent disabilities and perhaps fear and stasis inadvertently resulting in a loss of autonomy for the patient.

Research (Johnson and Fethke, 1985) has found that several variables are important in predicting post discharge outcomes for the hospitalized elderly:

- a. Health professionals' assessment of the elder's health status.
- b. Elders' inability to maintain responsibility for their own health due to functional deficits, mental deficits, and emotional deficits (poor self-esteem).
- c. The use of community supports prior to admission.
- d. Elders' own assessment of their general health (those who perceived their own health as good or excellent had better health outcomes post discharge).
- e. Presence of family and other social supports for discharge.

Referrals to social workers for discharge planning may come from a variety of sources. These include: case-finding during discharge planning rounds (O'Hare, 1992), direct referral from medical or nursing staff (Ciotti and Watt, 1989), referral from the patient and family themselves and contacts with community agencies and helpers involved with the patient or family.

Diamond and Jansen-Santos (1989) categorized the five major areas of work in discharge planning.

a. Screening - Use of a high risk indicator screening checklist is advocated to ensure involvement of the social work department at the earliest possible time, even prior to admission if this is necessary. Hartigan (1987:31) has stated, "There is no single, universally applicable formula for determining which patients will benefit most from discharge planning...assessment of discharge needs is required". A screening checklist should not be viewed as taking the place of a careful psychosocial assessment however.

b. Assessment - A well-written clinical assessment should be undertaken during direct contact with the patient and family by the social worker. This serves as a guide to other health professionals during their work with the patient and allows for continuity between various team members. The initial interview will often give direction to the remainder of the intervention needed.

The interview should cover:

- i. general background information on patients: social, emotional, demographic, financial, and support networks available.
- ii. anticipated needs of the patient at the time of discharge (physical, financial, emotional, social).
- iii. ability of the patient and family to meet these needs and cope with the stress illness and hospitalization will engender.
- iv. available support and resources.
- v. the expectations and wishes of the patient and family regarding discharge planning.

c. Planning/Intervention - The social worker's role during this is multi-faceted. The trauma of illness, change in functional status and role discrepancies often elicit old conflicts and problems in patients and their families which had been believed resolved or at least buried. It is in the context of discharge planning that many of these unresolved matters emerge often manifested by disagreement with the discharge plan or an inability or unwillingness to support the plan (Ciotti and Watt, 1989).

Involvement of various members of the patient's supportive network may be required. Work on these issues is done under an umbrella of time frame limits (imposed by patient, family or the institution) with the concomitant pressures of dwindling community resources and significant

institutional demand for patient movement. The result of "blocked beds" within the acute care setting by patients for whom appropriate alternative accommodation is lacking is a restriction of access to acute care to others who may require it (Lagoe and Decker, 1991). Institutional pressure regarding the importance of discharge planning cannot be overemphasized. However, the generation of available hospital beds and an increasing number of physicians utilizing the service cannot replace a more integrated system of community care that addresses basic health care issues (Rehr and Rosenberg, 1991).

d. Follow-up

The transition from hospital to community based resources brings the gaps in service to a glaring reality. Although referrals are made to community service, follow-through on plans by both the patient/family and agency are not always completed. Assessment of the "success" and "adequacy" of the discharge plan are tenuous at best because of the infancy of the state of research presently in this area. Lack of follow-up by the social work departments in acute care settings leads to the operationalizing of successful discharge planning by measuring readmission rates for example. The pitfalls of using this measure have been discussed well by various sources (Wertheimer and Kleinman, 1990; Naylor, 1990; Morrow-Howell et al, 1991). Adequate

evaluation of the success of discharge planning requires a method that will measure multiple outcomes simultaneously. Much work needs to be done in this area to determine the success of current discharge planning work, as well as to assess the impact on discharge planning of the offer of more community services to decrease the cost of acute care to our government and ultimately to ourselves.

Transitional Tasks of the Patient and Family at Discharge

Patients and families have much to contend with during hospitalization. Once illness or injury have occurred and hospital admission is accomplished, the patient must cope with a new role - the sick role. This exempts the individual from most of the demands and obligations they would normally experience when not placed in this position. It should be differentiated from the "patient role". Although the sick role may or may not be transitory, the patient role from the point of view of the institution is definitely to be seen as a transitional phase. (Blazyk and Canavan, 1985).

The patient role is learned through socialization within the institution. Various informational aspects of the illness or injury are expected to be learned: knowledge given in the process of obtaining an informed consent, an understanding of therapies that may be undertaken, as well as what hospitalization means in terms of new behaviour.

This is particularly true when seen in terms of cooperation with staff and allowing a certain degree of personal dependence on the expected good will of the institution and its employees.

Blazyk and Canavan (1985) have described three tasks that patients and families face upon admission to the hospital. The first task of patients and their families is to come to an understanding of the impact of their illness. Maintenance of the family system's integrity and adjustment to their altered status is revised on an ongoing basis. The family's reaction to the admission crisis can be an important indicator of how they will manage the crisis of discharge. This again points out the need for early social work intervention into the system. The social worker who has consistently seen the patient and family through various steps of the hospitalization and proven themselves supportive can be a more effective agent of adaptation and change than one who "parachutes" into the situation when discharge is imminent.

The second task of the hospitalization involves the negotiation of role change on the individual and on the family system as a whole. When the patient's roles and sense of identity are threatened because of illness, a crisis of major proportions can ensue. Family systems theory states that altered functioning in one family member will require an accommodation on the part of other family

members. The homeostatic balance is upset and other role shifts are required.

The patient's continuing role in the family can be marked by the extreme cases of exclusion and overinvolvement. In the former, family members may maintain minimal contact and can indicate an inability on their part to come to terms with the patient's condition, or the non-productivity of the patient in the system. In the latter, one can see the family members who spend endless hours at the bedside with all family activity focused on that one person. Family therapy literature is replete with studies surrounding the impact of change on the family. The medical social worker must be particularly knowledgeable regarding the impact on the family system of one member's illness, sensitive to his/her point of entry and able to work in a goal directed fashion with patients and families to assist in realistic adaptation.

Planning for discharge is the third task for patients and their families and is where most social workers and their colleagues in other health professions see the bulk of their work. However, successful completion of this aspect of hospitalization is dependent on at least partial completion of the other tasks as described above. Realistic goal setting involves an understanding of what will be needed in terms of follow up care as well as an awareness of change in family functioning that will be needed.

The decision-making process required during discharge planning can be enhanced by four conditions (McKeehan, K., Coulton, C., 1985):

- a. adequate time - feelings of panic can ensue when there is insufficient time to make the decision. The importance of beginning discharge planning on admission is once again restated.
- b. maintenance of hope - clients who believe any alternative care plan is intolerable may retreat from any involvement in decision making and rely on others to do this for them. The social worker needs to be alert to this sense of powerlessness and work to alleviate it.
- c. social support facilitates healthy decision making. The social worker's role in advocating with family and colleagues regarding the patient's decision making process is central to the empowerment of the client.
- d. freedom of choice - When the perception is that there is no choice, clients may back away from involvement in decision making. It is important that there be some freedom of choice for the client in order to reinforce their stand for independence and personal competence.

Skillful use of referrals to and utilization of appropriate community resources complete the process of reintegration and adaptation. Referral for both concrete and interpersonal services carries a symbolic meaning for the patient and family that can be unappreciated by the

social worker. These referrals can be significant factors in addressing the social and emotional needs of the client and they should be carried out carefully with an awareness of the need that they will fulfil.

Ethical Dilemmas in Discharge Planning

The issue of whom this process of discharge planning is for plagues those who critically reflect on the experience. To whom does the social worker owe his/her primary obligation in its completion? The patient, the family, the institution that needs the bed for another patient perhaps more acutely ill, or to the society that allocates scarce resources in a way that is presumed to offer service as equitably as possible? Economic realities, advancing technologies, diminishing resources all contribute to ethical and value dilemmas for health care professionals. Social workers are particularly cognizant of this conundrum because of their place in the flow of service provision. They serve not one master but at least three or four, all of whom may offer competing interests.

It is interesting to note that with the amount of material written about the importance and necessity of informed consent (full knowledge) for research and treatment, there is very little literature that discusses the need for informed consent regarding discharge from hospital (Barber, 1980). "Although the patient has the

right to complete information and explanation concerning the needs for and alternatives to such a transfer, he or she has no right to refuse discharge from the hospital" (Abramson, 1981:37).

The individual's right to make his or her own decisions regarding issues that affect him/her and to do so without coercion is one of the pillars in our democracy. Our desire to protect such rights saw our country delineate these in the Charter of Rights and Freedoms. The self-determination of the client has also been a basic value of the social work profession - the NASW code of ethics states that the social worker should make every effort to nourish self-determination on the part of clients.

An insightful article by Margaret Rhodes (1992) spurs the profession on to look at our ethical boundaries with our clients, our colleagues and the issue of social justice in general. She traces our movement as a profession from attitudes of paternalism to client autonomy and worker stance of nonjudgemental acceptance or neutrality. As a multiplicity of theoretical stances and techniques present themselves, so do a variety of assumptions about the place of ethics in our everyday workplace. Differences between workers over differing interpretations of work with clients begs open discussion and critical thought based on the profession's ethical values.

Particularly important in the discharge planning process is the obvious way in which a bureaucratic structure can dehumanize the work and negate human service goals through the aspects of specialization, paperwork abundance and language. She encourages us to rethink our commitment to social justice and our concepts of client empowerment. Our creativity needs to be stretched and she says, our approach to problems needs to be more explicit in its political base. Professional specialization may have led us down a path that takes us in a direction differing from the profession's original political agenda.

The medical social worker dealing with discharge planning with the elderly client suffers burnout in part because of "the moral pain of not being able to do more and of living with impossible compromises. We feel worn down and worn away from our goals" (Rhodes, 1992:p.45). Expanding our vision in discharge planning could empower the profession to fulfil its mandate of improving the broader social context in which we all must share.

Discharge planning must entail consideration not only of the medical needs of the patient, but also recognize the psychosocial aspects related to hospitalization.

Chapter Four

DESCRIPTION OF THE STUDY

Context of the Study

The placement for the practicum was at Concordia Hospital, the investigator's place of employment. Several advantages were seen to utilizing patients of Concordia Hospital for the purpose of practicum interviews:

- a. There is a significant elderly population that enters Concordia Hospital for treatment. Procurement of clients was thought to be simple.
- b. The hospital is a small, community based institution and so the ability to sort through discharge notifications would be less complicated than at a larger institution.
- c. As a smaller hospital with a large number of beds being blocked by long term care patients, Concordia Hospital serves as a microcosm of a larger, systemic crisis coming to surface in Manitoba's health care system. The need for active and demonstrably quality, cost-effective discharge planning is acute here.

The Concordia Hospital was founded in 1928 and incorporated in 1931 as the Mennonite Hospital Society Concordia, as an "expression of compassion and concern for the Mennonite brotherhood and the community at large." (Concordia Hospital Mission Statement, 1990). It endeavors to provide quality care to its patients in both a scientific

and professional realm respecting human life and the dignity of the individual.

The Concordia Hospital is a 136 bed acute care community hospital located on the corner of Molson and Concordia Avenue. The hospital serves the northeast quadrant of the city which has a current population of over 110,000 and is projected to increase to 127,000 by 1996. Including the rural municipalities of East St. Paul and Springfield which also fall within the hospital's catchment area, the population is expected to rise to over 140,000.

Patients from other residential locations are also serviced if they are under the care of a member of the Concordia Hospital Medical staff or if they present in our emergency department. Because of the limited size and scope of resources at our facility, certain patient needs dictate a referral to tertiary care centres:

1. cardiovascular surgery
2. cardiothoracic surgery
3. neuro or neurovascular surgery
4. burn treatment
5. obstetrical services
6. pediatric services
7. dialysis
8. ophthalmologic surgery
9. some orthopedic procedures (eg. total hip replacement)
10. psychiatric services

Government approval was given for a 60 bed expansion in 1990 and construction began in 1991. This expansion of the facility is now awaiting final indication from the Manitoba government regarding how these 60 beds are to be utilized. This growth in both the size and service scope of Concordia Hospital brings an increasing responsibility to the social work department. We need to acknowledge our professional responsibility to both our clients and our employer in the area of information generation that will aid in appropriate program development and advocacy for clients with regards to provision of appropriate service.

At the present time, there are 1.1 social work positions within the hospital and 1.4 Home Care positions which are handled by VON nurses on contract to the hospital. The position of a Bed Utilization Coordinator is in the planning stages and it is hoped that the linkage between these three positions can be productive in providing an even higher quality of service to both the constituents and the hospital itself.

Procedure Utilized in the Study

Interviews with twenty clients sixty-five years of age or older were undertaken. Preliminary interviews were carried out from August to November 1991. Actual study interviews were done from December 1991 to May 1992. These clients had been admitted to Concordia Hospital for a

variety of medical and surgical reasons which will be discussed later in the results as well as elucidated in the appendices following the report. Each of these clients were interviewed upon discharge or following discharge by the writer. Various family support persons were also interviewed if they agreed to the request. Interestingly, approximately half of the clients interviewed had no family support persons that could be contacted. A semi-structured interview format was followed with emphasis on having clients reminisce about their attitudes towards health and illness as they aged and how these were affected by the context of their lives (eg. personal crises, sociological crises or upheaval) as well as their impressions of the evolving state of health care provision in Canada. Particular impressions of the discharge planning process, namely information giving, were elicited.

Clients were also asked to complete a Health Scale for the Aged (Rosow, I. and Breslau, N., cited by Stahl in Mangen and Peterson [eds.], 1984). A Self-Evaluation of Health question was asked as a validation effort with regards to the more functional questioning of Rosow and Breslau's instrument.

Clients were selected in a random fashion based on their meeting the criteria for the study and their willingness to participate. Approximately thirty were referred to the writer for inclusion in this project for a

variety of reasons and by a number of health care professionals within the hospital. Some expressed an interest in inclusion, others were noted by co-professional groups as having an expressed opinion on study topics that they felt would interest the worker (even if this opinion was perceived as negatively reflecting on the in-hospital process). There were some inclusion/exclusion criteria in place regarding qualification for study inclusion. These were:

1. Clients must have been mentally alert and able to give an informed consent to their participation.
2. They must be able to speak and read English.
3. They must be sixty-five years of age or older.
4. Prior to their admission, clients should not be residing in an institutional care facility such as a personal care home, although clients from guest home facilities would have been considered.
5. Clients were from the immediate catchment area of Concordia Hospital (East and North Kildonan, Elmwood, Transcona, East St. Paul). Two clients from out of town (Brandon, Swan River) were interviewed while recuperating post surgery in facilities or homes that were in the catchment area.

Ten clients were deselected because of the investigators questioning of their ability to give an informed consent, their hesitancy at undertaking the project

once given a full explanation or because of the additional emotional burden such an exercise would place upon them.

The issue of gaining informed consent was pertinent to both the substance and the research rigor of the experience and was closely examined with each client interviewed. It has been postulated that an informed consent in research suffers from a lack of awareness of the complex steps involved in reaching such a decision for the subject in question. It usually does not take into account the extent to which cognitive and other deficits may impact on the degree of "informed" consent (Stanley, 1981; Applebaum and Roth, 1981; Tymchuk and Ouslander, 1990). Cassileth et al (1980) found that in a group of non-psychiatric patients, sixty percent understood the nature and purpose of procedures, and fifty-five percent knew one potential major complication or risk.

The single methodology usually relied on in the research process involves the presentation of information to the client in a document that is usually read by and to them with explanations given as required. If the client agrees they are then requested to sign indicating their agreement with participation in the project.

Tymchuk and Ouslander (1990:246) protest against the view by some researchers that consent is only "tangential" to the project or treatment itself. They say that:

"Given the increased importance that is being placed upon the individual's right to make decisions for himself or herself, and the importance of the individual's understanding of and participation in his or her health care to compliance and outcome of treatment, the process of informed consent should be viewed as critical in and of itself."

Consent is an essential part of demonstrating a respect for the autonomy and self-determination of a subject in a exercise that is fraught with inequities and issues of power and control. The process Tymchuk and Ouslander (1990) suggest for obtaining informed consent was utilized during the practicum and added to the quality of the responses given because clients understood the types of information desired and at times were able to rephrase the question to the investigator in a format that indicated comprehension of research direction. The process involved:

- a. assessment of physical capacity to participate, especially vision and hearing.
- b. assessment of mental capacity to understand the nature of the consent. If there was a concern several repeated trials were given with client response to ensure adequate capacity.
- c. The level of schooling was asked in order to match the explanation to the individual. In a study with 123 elderly patients of a long term care facility, the average reading comprehension grade attained on testing was five (Tymchuk et al., 1986). The language of consent therefore needed to be presented in a simple,

straightforward manner that left no doubt in the minds of the participants as to what they were undertaking.

- d. Information was presented to the client both in written as well as verbal format. Their comprehension was assessed by asking them to relay back to the investigator their understanding of what had been said. If there was some difficulty as mentioned before repeat trials were given. The comprehension was then reassessed and consent once again obtained.

Study Methodology

The basis of the method used in the design of the practicum has been postulated by Glaser and Strauss (1980). The constant comparative method that is discussed by them allowed for a flexible yet structured framework for data collection. This will allow for the generation of a hypothesis that will encourage testing of its precepts in a more quantitative way.

The advantages to this method were particularly relevant to my preferences in fulfilling the practicum requirements. It lent itself well to a semi-structured interview format and facilitated creative generalization of known theories regarding issues of aging and illness. In turn, it also will allow other professionals to work and expand on components of the content seen as valid.

Glaser and Strauss also note that this method allows for many hypotheses to be synthesized at varying levels of generality. It incorporates constant evaluation, generation and integration of theory while still allowing for personal contact and spontaneous input from clients who are not required to "fit" their ideas into a concept defined by another person.

The method of investigation was a qualitative strategy utilizing naturalistic inquiry of the clients (Patton, 1987), several quantitative measures used to invite further discussion with clients and a content analysis of major themes expressed by all participants. The structure of the interview format was developed over a space of three months in interviews with clients both within and outside of the hospital setting. Questions were pretested and my elderly "experts" offered suggestions as to how a question could be more clearly asked, how the interview could be managed so as to elicit the maximum amount of information that could be gleaned. This process gradually increased the validity of the interview format as the content of the answers became consistently related to the issue being inquired about.

Patton (1987) discusses the dilemma of maintaining focus and establishing priorities at the beginning of an endeavour such as this practicum. This was indeed difficult and required several attempts to structure the interview format in a way that gathered pertinent data while

constantly delineating for the investigator the areas to remain focused on. Understanding the needs and capacities of both clients and their systems is an increasingly complex task. It is multi-layered and is a seemingly unending search for a more complete understanding.

Interviewing as a method of data collection proved to be a task calling for discipline, creativity, sensitivity, concentration, skill and interpersonal understanding. When these traits were not consciously utilized information flow was stilted. The interview in such an instance was as a stately house that held no furnishings, it had form but no real substance. Views were elicited, but lacked the richness of colour, of hue which added a quality to the results which offered as much meaning as the form of the answer itself. The practicum offered yet another opportunity to refine skills and emphasize the importance of active participation in our work with clients. Patton (1987:108) quotes Zeno of Citium in 300 B.C. saying: "The reason why we have two ears and only one mouth is that we may listen the more and talk the less."

The interview provided a unique opportunity for the investigator to "enter into the other person's perspective" (Patton 1987:109) and attempted to allow the revelation of feelings, history and emerging opinion within a context of knowing defined by the client and not by the investigator.

Clients were contacted by the investigator either shortly before discharge or at home following their hospital stay and asked if they would be interested in participating in the study. Appointments were then made for the interview and administration of the Health Scale for the Aged.

The maximum amount of time that passed between discharge and interviewing was 8 days. Most clients were contacted and seen on the average three days after discharge. Interviews were recorded with the permission of the clients, some declined this and so extensive note taking became necessary.

Rosow and Breslau's (1966) Health Scale for the Aged, as cited by Stahl in Mangen (1984), was administered prior to the actual interview. It served to add structure to the initial part of the interview, relieve the initial stress that was felt by most respondents and also provided a more quantitative mirror to the information provided as the interview progressed. It is a six item scale that was devised to measure functional health. The series of items asked are assessments of the respondent's perception of his or her ability to perform various physical and social activities that could be impaired by health related problems.

The items on this scale were derived from a larger series of twenty five items through Guttman analysis. Scoring norms can be found in Appendix A. A coefficient of reproducibility of .91 is cited by the authors.

Clients were also asked to evaluate their health when they were younger (in their 40's) and their health on the day of the interview. This single item instrument has been documented as the Self Evaluation of Health (Shanas et. al, as cited by Stahl, 1984). The authors distinguish between "subjective" (self-perceived) and "objective" (physician perceived) health. The instrument measured the global self-perceived health status of the individual and asks, "For someone your age, do you consider your health to be excellent, good, fair or poor?"

The single item indicator has been used with both a three response set and a four response set. The "excellent" category is dropped if desired. Shanas and associates did not document any tests of validity but other researchers have tested this indicator or a similar measure for convergence with physician's assessments of the health of the respondents. The work done by Shanas et al. (as cited by Stahl, 1984), demonstrated the effectiveness of the instrument in differentiating between ambulatory and mobility restricted clientele, between respondents with and without sensory impairments and between persons reporting various levels of incapacity.

Stahl (1984:102) states that since the indicator is so global, it is unclear whether it was initially developed by Shanas and associates. Their work however does document its effectiveness - hence the reference.

The indicator is quickly administered, straightforward and seems to be predictive of other health related social behaviours (Stahl and Gardner, 1976). It is generally regarded as among the best single-item indicators available for measuring the health of the elderly. Norms as determined by Shanas in a cross-national study looking at the social lives of the elderly with health status as one component can be found in Appendix B.

The average length of interviews was 90 minutes. Test interviews had been considerably shorter, but the investigator's focus had been on developing an effective interview structure with less emphasis being placed on actual content and exploration further to this. Once full attention was able to be paid to the content of the client's answers, the length of time necessary to adequately inquire into responses increased.

All clients were asked to sign a consent form prior to participating in the study (Appendix C). The form was read to them verbally prior to signing with appropriate explanations given regarding the confidentiality of information given and the choice of participation or non-participation.

All clients were identified by code letter (see client profiles in Appendix D), as were family members who agreed to participate. The following pieces of information were also noted:

1. gender
2. age
3. discharge diagnosis
4. length of hospital stay (LOS)
5. Were they seen by a social worker in the hospital?
6. Were they seen by the Home Care nurse in the hospital?
7. Living arrangements
8. Was their presiding physician in the hospital their primary physician in the community prior to admission?
9. If the answer to #8 was no, what was the reason?

Immediately following the interview tapes were transcribed, observations about the process recorded and coded so that valuable information and impressions would not be lost through the progression of time. Patton (1987:140) emphasizes that this period needs to be seen as a time for "quality control" to ensure that information and observations are useful, reliable and valid.

The interviews were first divided into segments sharing a common issue that was discussed. The responses were then organized using a content analysis to show a range of responses, look for trends, similarities and differences.

Chapter Five

Results of Interviews

Respondent's Insights

Interviews were conducted with 20 patients and seven family members of some of those patients. The family members included three spouses (all wives), one son, two daughters and one nephew. They ranged in age from their early thirties to age ninety one.

The population breakdown can be found in Table 1. Eleven men and nine women were interviewed. Their ages ranged from sixty-five to ninety-nine; the average age was 78.2 years. Nine of these patients lived alone, eleven lived with a family member who provided some form of practical support to the client. Fourteen of the clients had been seen by either the social worker, the home care nurse or both during their hospital admission.

Their length of stay ranged from three to sixty-seven days with an average being 23.05 days. Their diagnoses were varied but could either be categorized as cardiovascular in nature (eg. myocardial infarction, cerebral vascular accident, congestive heart failure) or primarily surgical in nature - gastrointestinal bleeding, gall bladder investigations, urinary tract surgeries, or bowel surgeries for obstructions. Three patients had diagnoses that included a form of cancer. To a minor extent, there were

also diagnoses of alcohol abuse, fractures of the hip and wrists and one case of spinal stenosis and esophagitis. Their diagnoses have been summarized in Table 2.

Table 1
Demographic Profiles Of Study Group

M/F	AGE	LENGTH OF STAY	SW	HC	ALONE	FP	FNP
F	70	19	Y	N	Y	N	N
F	76	27	Y	Y	N	Y	N
F	85	21	Y	Y	Y	N	N
F	95	35	Y	Y	Y	N	N
F	82	28	Y	Y	N	Y	N
F	77	4	Y	Y	Y	N	N
F	85	32	N	Y	Y	N	N
F	82	32	Y	Y	N	Y	N
F	73	23	Y	Y	N	Y	N
M	82	67	Y	Y	Y	N	N
M	72	50	Y	Y	N	Y	N
M	71	15	Y	Y	N	Y	N
M	75	8	Y	N	N	Y	N
M	65	10	N	N	Y	N	N
M	73	27	N	N	N	Y	N
M	99	20	Y	Y	N	Y	N
M	74	5	N	N	N	Y	N
M	70	10	N	Y	Y	N	N
M	91	25	Y	Y	Y	N	N
M	67	3	N	N	N	Y	N
11M : 9F	78.2	23.05	14	14	9	11	0

SW = Seen by Social Work during stay

HC = Seen by Home Care during stay

A = Lives Alone

FP = Lives with family who are primary caregivers

FNP = Lives with family who are not primary caregivers

Table 2
Summary of Client Diagnoses

Client Code	Diagnosis
A	Gastro-intestinal bleed
B	Left inguinal hernia repair, Right carpal tunnel repair
C	Congestive heart failure
D	Colles' fracture, Congestive heart failure
E	Cerebral Vascular Accident, Myocardial Infarction
F	Cholecystectomy
G	Myocardial Infarction
H	Cancer of bladder, Myocardial Infarction
I	Fall
J	TURP (urinary procedure)
K	Myocardial Infarction, Pneumonia, Respiratory failure
L	Fractured hip
M	Cholelithiasis
N	TURP
O	Exploration of common bile duct
P	Fractured femur, Moore's Repair
Q	Large bowel obstruction
R	Parkinsonism, Alcohol Abuse
S	Myocardial Infarction, Cardiogenic Shock
T	Spinal stenosis, esophagitis

Thirteen of the twenty were attended by their family physician in hospital with some contact from other specialists. Of the other seven, three attended a physician who had admitting privileges to another hospital, three did not have a primary care physician in the community and one attended a clinic where the physician did not have privileges at any hospital.

Although all clients interviewed were unique in their own way, a glimpse into the profiles of several of them may assist the reader in understanding the wide variety of situations and concerns they presented.

Mr. F. is a 74 year old man who was in hospital for five days with a cholecystectomy. He lives with his 73 year old spouse who is nearly blind and forgetful at times. Prior to retirement, he was a handyman and mechanic. Mr. F. is still very proud of his ability to "fix nearly anything".

The couple continue to live in their own home where they have been for the past thirty plus years. There are four children, all of whom live out of province with the exception of a daughter who farms on the Manitoba-Saskatchewan border. He was previously independent and wanted no home care on discharge from hospital. At home, he remains quite active, plays in a swing band that performs publicly at least twice a month. Mrs. F. requires assistance with all household tasks and some personal hygiene tasks because of her poor vision.

Mrs. G. is a 77 year old lady in hospital for four days after suffering a myocardial infarction (MI). She was widowed five weeks prior to suffering the MI. Mr. G. died at home from a similar cause - the couple had been married approximately sixty years. She has continued to live in their own small two bedroom bungalow in an area where neighbours have lived together as a group for some forty years or more. They are all about her age. Her only child died in infancy in Poland and she relies on a nephew to

maintain her yardwork and a ninety year old brother-in-law and his wife to provide social support.

Mr. O. is a 71 year old man in hospital for fifteen days with exploratory surgery on his gall bladder. Previously a switchman with the railway, he retired early because of problems with asthma. He lives with his wife in their own home in North Kildonan where they have been for the past thirty-one years. Three grown children living out of province visit once or twice a year.

Both Mr. and Mrs. O have had long histories of depression and anxiety. He was diagnosed with multiple sclerosis about five years ago. There was a significant history of contact with both the psychiatric and respiratory services of Deer Lodge Centre when it was utilized strictly for veterans. Since its sale to the Province of Manitoba he no longer feels as comfortable attending there and utilizes community resources instead. He perceives access to psychiatric supports especially as being difficult now and neither reliable or helpful to him presently.

The reader is referred to Appendix D for further profiles of clients who participated in interviews.

Self-Assessments of Health

Eighteen of the patients (and their families) rated their health as being excellent or good when they were younger (generally operationalized as when they were in their forties). Only two patients characterized their health as being only fair when they were younger. Twelve felt that their general state of health had been better, in fact, than many of their friends at that time.

Four clients stated that they never really had time to be sick, they continued working even when feeling ill because of financial needs and perceived threats to their job security. Five clients commented that they rarely if ever had been to a doctor prior to entering into their

fifties and sixties - Mrs. D. (eighty-two years old) commented that she rarely saw a doctor until after she retired.

" I never really wanted to see one (a doctor) until I started feeling sick a couple of years ago, then I had to go. In the old country (Germany) and in South America there was no money to pay and we never knew what they might do to you. They didn't have all the fancy tests and machines that they have now, and I always wondered if they would really know what was wrong anyway".

Interestingly enough, there were many comments alluding to an increased emphasis on health "protection" as a lifestyle choice. Many said that they never worried about their health, or the effect of their lifestyle on their health. Changes in lifestyle were not implemented until some had realized the onset of some chronic illnesses that they would live with the rest of their lives. Two mentioned that they had stopped smoking in their late forties in a move to improve their health. One man related giving up a ten year drinking habit that had begun to affect his relationships with his family. The change in lifestyle happened at age fifty-seven - he is now seventy five.

Mrs. E., an eighty five year old lady hospitalized for a cerebral vascular accident and a myocardial infarction has been widowed for five years. Her tears and anxiety were obvious, but the ambivalence about effecting changes in lifestyle and accommodation paralysed her ability to modify her current situation. This of course only served to increase her anxiety and intrapersonal pain. She said:

"I never really thought about being sick because I knew my husband would be there to take care of me. It is so frightening to think about being alone...what if something happened to me...I'm scared of dying alone. My son has his own family, they need him too...he can't be here with me all the time...It seems like all I do is worry and try not to think about how sick I am."

The changes that respondents did discuss making were such things as dietary restrictions, undertaking some form of exercise to increase their strength and maintain better cardiac health. The exercise ranged from walking for post-MI patients to using a small bicycle of a sort (Restorator). The client was not sure what the restorator did except to "keep my blood moving"! Reports of increased contact with the physician as well as on-going contact with some community health maintenance program were also mentioned. These ranged from VON visits to do health checks and set up medications to follow-up in a day program or clinic of some type.

Their assessments of their self health the day of interview seemed to be primarily based on their level of comfort in carrying out functional tasks. These were often defined by the clients at a very basic level - ability to walk independently, ability to toilet oneself and perform minimal personal care (wash and dress self). All of the older cohorts were repeatedly thankful to be in possession of their mental faculties. Several expressed pity for roommates or other patients they had seen at the hospital

who were very confused and showed behaviours related to their severe dementias.

Three patients rated their health presently as being excellent, seven rated their health as being good. Seven felt that they were in only in fair health but two of those expected it to be temporary - expressing the hope that they would recover to their former level of functioning. Three rated their health as being poor.

Rosow's Health Scale for the Aged (as cited in Stahl, 1984), is presented with my results in Table 3. This survey yielded interesting outcomes in terms of the number of clients reporting increasing difficulty with various activities requiring functional adeptness and energy. The decreased social interaction and experience within their community may have accounted for the fifty per cent response to having no difficulty in visiting friends, attending church or a movie for example. One could speculate that if there is no opportunity for these things, they may not be perceived as a problem. Their responses indicating an increasing number showing difficulties in more strenuous activities may give partial reason for their varying levels of social isolation. The extent to which an elder may be isolated socially, the maintenance of close physical proximity to their community and the degree to which their social contacts come to them all may have affected their responses to the Health Scale for the Aged.

Several clients spoke of their appreciation for living in an area where they knew and socialized with many of their neighbors. Miss C. had lived in her present home since she was born and had a wide circle of social contacts in the area who dropped in to visit her. Mr. F. and his wife have lived in their home for thirty plus years and both noted the ready assistance of friends in the area when help no matter how minor or extensive, would be requested. Mrs. G. preferred the peace and security of her own home and the care of her neighbors to the isolation of the hospital. Mrs. L. had lived in her home for some thirty years with the same neighbors beside her and across the back lane for much of the time. Their mutual observation of each other and frequent "check-ins" gave all great security and feelings of independence yet not requiring the expending of a great deal of energy to visit.

TABLE 3
Health Scale for the Aged

Question: Which of these things are you still healthy enough to do without help?

	Response	
1. Go out to a movie, to church or a meeting, or to visit friends?	Yes = 10	No = 10
2. Walk up and down stairs to the second floor?	Yes = 9	No = 11
3. Walk half a mile (about eight ordinary blocks)?	Yes = 5	No = 15
4. Heavy work around the house, like shovelling snow, or washing walls?	Yes = 4	No = 16
5. Which of these statements fits you best: (choice of three)	Positive Responses	
i) I am not limited in any of my activities.		4
ii) I have to limit some of the work or other things I do.		5
iii) I cannot work (keep house) at all now because of my health.		11
6. Is there any physical condition, illness or health problem that bothers you now?	Yes=13	No=7

Bandura considers perceived self-efficacy as one of the most critical components of self-reflective thought:

"perceived self-efficacy is defined as people's judgements of their capabilities to organize and execute courses of action required to attain designated types of performances. It is concerned not with the skills one has but with judgements of what one can do with whatever skills one possesses" (Bandura, 1986:391).

Holden (1991) agreed with other researchers (O'Leary, 1985; Strecher, DeVellis, Becker, and Rosenstock, 1986) that perceived self-efficacy exhibited a positive relationship with subsequent health outcomes. He does caution that this particular variable needs to be placed in a larger framework in order to adequately explain health related outcomes.

Simons and West (1984/85) have chosen to contradict the positive role of self-efficacy as a coping resource with seniors. They speculate that during periods of intensive life change, the level of perceived self-efficacy may serve to render the elder dysfunctional. Many, if not most of their major life events are uncontrollable and/or unavoidable. The authors suggest that unrealistic and frustrating attempts to master the situation may ensue. On the other hand, those with a low level of self-efficacy might be more predisposed toward coping strategies that involve acceptance of one's situation. The clients in this study certainly did not demonstrate this view. Those with high levels of perceived self-efficacy showed much motivation to give up the sick role while those with lower levels of self-efficacy tended to be accepting of their sick role position. Clients with multiple medical diagnoses who objectively should have assumed the sick role often perceived themselves as healthier than some of the respondents who were less encumbered with chronic medical diagnoses.

Clients in my practicum who viewed their health now as fair or poor consistently felt unable to do any work (ie. housework, activities to maintain their existence outside of the institutional care setting). Mrs. G, a feisty, frail looking petite Polish lady stated that she was unable to do any work now after a myocardial infarction, but "that is only temporary. In a few weeks, my heart be better, then I do some work again. That will be good for me, let me do something other than think about my troubles". She had reluctantly agreed to follow her doctor's advice and not do any housework or strenuous activity for three weeks after being discharged. Although the physician tried to persuade her to remain in hospital for a few days longer, at the four day mark, she demanded her discharge saying that she would prefer to sit at home.

Family support was important in assisting this lady to remain at home. She felt more comfortable in her own home with familiar friends and neighbours around and regularly checking on her. The social support network took over provision of meals, housekeeping and yardwork with her permission acknowledging that she would soon gradually begin taking over these tasks again herself. Most importantly, she expected herself to be ready to do these again within a short time frame.

A significant majority of respondents expressed little concern or worry over their future health or even their

health as it was on the day of interview. They expressed views of religious assurance, fatalistic thinking or of a feeling that they had lived a full life, were content and ready to die. Most appeared to be realistic in their plans, but for a few patients for whom the inevitability of physical decline would be fairly imminent, there was an obvious denial of this in their method of preparation. This may have been due to ignorance of the slow methodical nature of the long term care system. Kulys (1983) interviewed a group of elderly people to determine to what extent they anticipated, planned for and were prepared to deal with predictable future crises in their living arrangements, finances and health. Most of the study group had not made arrangements to cope with crises. One wonders however, if an expectation that one should anticipate and plan for a future crisis is not an expression of some possible latent ageist bias. This expectation would hardly be demanded to this extent in a younger age group either.

Satisfaction with Hospital Care

Most patients expressed a high level of satisfaction with their care by all disciplines in the hospital. Food was a common complaint among some of the younger male patients (too cold, too little variety, not enough on the tray etc) while the work of the physiotherapist was often good-naturedly moaned about. Mr. T. groaned that she

"forgets that I am not as young as I used to be" (he is now seventy) but in the next breath attributed his recovery to her persistence and expectation that he could always do more. This level of satisfaction is borne out in the literature - most studies have found that elderly patients are more likely to indicate that they are very satisfied with their health care than their younger counterparts (Linn and Greenfield, S., 1982). In fact, Hsieh and Kagle (1991) suggest that it is unlikely that they receive better health care as a group. Instead it is more likely that their satisfaction is due to expectations which differ from those of younger cohorts and to having their positive expectations fulfilled.

Breemhaar et al (1990) has added an additional set of variables to the dilemma of understanding client satisfaction in the hospital setting. Previous experience in hospital, demographic factors, locus of control and patient education could all be added into the equation.

Access to Information on Personal Health

Mr. K., a seventy three year old man in hospital for 27 days after suffering a myocardial infarction and respiratory failure, felt that adequate information was given him, but he felt that "the need for more tests never stopped. I never really understood what it was he was looking for...it never made much sense really because I was feeling better, I

knew I was going to make it back"... "The nurses were good at answering my questions, but then I never really knew what to ask".

Mr. M., a seventy five year old man in hospital with cholelithiasis felt that he "never was given a straight answer...each doctor seemed to give me a different opinion...they all wanted a decision, but how was I supposed to give one when they couldn't seem to make up their minds themselves". Once again however, the nursing staff "helped me understand what the doctors were trying to say, but they couldn't tell me what to do...so here we sit (outside hospital) trying to decide".

Many clients made the comment that they did not know what they perhaps needed to know or even wanted to know. Mr. O. was particularly angry with his physicians because he felt that after a surgery one year ago "they didn't tell me how serious it really had been...if I had known maybe I wouldn't have wasted a whole year worrying about how sick I felt...I feel like I lost a whole year - my daughter got married - I couldn't even go to the wedding because I felt so sick". He was in essence talking about his "need to know" so that he could set expectations for himself and plan realistically for events in his life.

Clients who had been hospitalized for certain surgical procedures or myocardial infarctions appreciated an informational handout that has been prepared by either

nursing staff or an outside committee (in the case of the cardiac teaching booklet) and is routinely given out to clients after admission. The groundwork of information upon which to develop questions was empowering to them and allowed a control over their care (Germain, 1977).

Breemhaar et al (1990:1383) speculated that ageist beliefs on the part of medical staff regarding the elderly's capacity to process medical information in particular contributed to a less than adequate supply of information. Breemhaar and colleagues suggest that many studies show that adequate and complete information flow to patients results in an increase in satisfaction, knowledge and a reduction of anxiety to the patient.

They found that "a regression analysis taking behaviour as a criterion showed that the smaller extent to which elderly patients asked questions was predicted by their strong feelings of gratitude" and a more external locus of control. Elderly patients tended to give socially desired responses and were afraid of being perceived as "complainers". This view was expressed frequently throughout interviews when asked to discuss where service provision or policy changes should be undertaken. Several alluded to their gratitude that they could be cared for when ill and in the case of one elderly lady - "that anyone cared at all" about her state of health and home management.

The social worker needs to be cognizant of the elderly client's need for information and through his/her interactions empower the client to ask questions, and to become an active partner in their own hospital care and planning for discharge. To feel satisfied with the elder's expressed gratitude and not risk their questions or disagreement with the medical team's recommendations for future plans may serve only to "stroke" the care provider and further feed into a cycle of dependency and perceived powerlessness for the patient.

Psychosocial Needs of the Respondents

Most of the patients chosen for the study would not have merited priority social work intervention in our hospital based on the nursing admission history and reports from staff during their admissions. As a rule, our department becomes involved only if there is obvious need for more complicated discharge planning through our regular referral and case-finding methods. Yet, the most shocking impression that I was left with was of the overwhelming emotional needs of these clients that had never been addressed in hospital. Many of the clients I visited for whom it seemed the interview would be straightforward began crying when discussing the impact of their surgery, illness or disability on their present lives.

The concerns they presented were similar to the concerns discussed by Neugent (1981). Fears regarding losses of familiar people and settings, a heightened sense of vulnerability, of physical and mental deterioration and of lifelong confinement were prevalent. Families, particularly children and nieces (nephews) also discussed the pressure of the illness on themselves - particularly if it was to be a progressive long term condition. For the children there was a frightening and guilt-provoking assessment of their responsibility to the parent. One felt as if "I just want to run away from everyone...No matter which way I go, the decision seems wrong...I hate myself for it and then I hate everyone else for making me make the decision". For many children the assessment of responsibility within the framework of their own lives creates considerable role dissonance. It may in fact impact negatively on their relationships with their own spouse, children and even social group (Stoller and Pugliesi, 1989).

Since the primary care-giving role of elderly parents often falls on the daughters, an understanding of the stress of multiple roles is required (Kaye and Applegate, 1990; Brody, 1985; Stoller and Pugliesi, 1989; Colerick and George, 1986). Many of these elderly parents have daughters who are emerging from the post 1960's work expansion and have developed a post retirement agenda that had not

included an active, daily caregiving role to a dependent parent. For women, the demands of being daughter, wife, mother, grandmother and outside worker may take their toll (Kaye and Applegate, 1990) and force a decision intended to decrease role stress.

In a study that compared caregivers who placed a relative in a nursing home and those who continued to provide care at home, it was found that the former group tended to be composed of daughters with "competing demands and greater economic resources, who also experienced relatively greater levels of caregiving stress (Colerick and George, 1986).

Since few health care professionals are in a place to understand the many levels of a family's stress, social workers must undertake to act as the advocates for the clients when proposed discharge plans may be detrimental to the patient and family unit unless modified. The opportunity to gain insight into the caregiver's experience of caring (Stoller, E. and Pugliesi, K., 1989) may initiate a more finely tuned discharge plan that will maximize the chances for a successful discharge.

Mrs. L. talked of her devastating recognition of vulnerability. An 85 year old widow whose husband died nine years ago, she prized her independence and never felt "old" until her fall on the back patio resulted in a fractured hip.

"I had never worried about myself...now I find myself thinking twice about everything and reminding myself that I'm getting to be a old lady...need to be more careful...it is a terrible thing to all of a sudden see yourself as old...I never used to see an old lady when I looked in the mirror".

Mr. T. was a seventy year old man who had been in hospital for ten days with spinal stenosis and esophagitis after being assaulted by several young men while working downtown as a security guard. After his wife's death in 1985, he returned to work after having been retired. He has been assaulted several times, this last time convincing him to do other things with his time. Now he found that:

"when I walked in the front door, I felt as if my wife had just died...all these years of working hard and running around - I'm still trying to get used to the fact that she is gone...I was thinking when I was in the hospital that maybe the reason I kept going back to that job after I'd get beat up is that maybe I didn't care whether I lived or died...that scared me - I've never thought about that before...decided that I had better do something about this before I'm just another guy in the obituary column".

There is much yet to be done in the acute medical care setting. Clients need to be assisted and heard regarding feelings of anger and depression at a loss of role identity. Institutional life may bring the thought of their progressing age and eventual mortality to mind because of recognition of limitations. The elder's sense of loss over a changed self-image needs to be addressed if the goal is to discharge a patient that is confident in his/her abilities and aware of available support systems. A frightening piece

of information was when two patients disclosed that they had thought of suicide during their hospitalization as an alternate plan if home had not been successful.

This lack of calling attention to their emotional needs has been associated with the elderly patients' high level of social desirability, fear of complaining and externality (Breemhaar, 1990). How to address these concerns with elderly clients in an acute care setting will be addressed in a later section with recommendations for action.

Views of the Canadian Medicare System

Constitutionally, healthcare is a provincial responsibility (Statistics Canada 1987, 3:8) and each province or territory has a health insurance plan that must conform to the minimum federal criteria as described in the Canada Health Act of 1984 (Health and Welfare Canada, 1986/87, 7-8):

- a: universality
- b: comprehensiveness with coverage for medically necessary hospital and physician coverage
- c: portability between provinces
- d: public administration
- e: accessability (user charges are banned and extra billing is deterred through funding penalties.

The evolution of the Canadian health care system has been provincially driven for the most part. Four of the

provinces had hospital insurance programs by 1950.

Saskatchewan was the first province to enact a physician services insurance plan in 1961, five years prior to the federal Medical Care Act of 1966 (Taylor, 1987:101; Taylor, 1989:4-5). By 1971, all provinces and territories had in place hospital and physician services insurance plans that covered the total population (Taylor 1989:7).

Funding of our health care system is from taxes and federal transfer and cash payments to provinces. Several provinces charge premiums. With public funding, there are no financial access barriers to care and the beneficiaries are not at financial risk (Rakich, 1990).

Given the average age of the study population (78), this would have placed most of them in their 40's or 50's at the time that this revolution in health care payment and access occurred. Many (surprisingly) could not recall the time of living without this social benefit. The memories of this time had faded a great deal for them. Many however talked about "deserving" their hospital care and their right to be allowed to stay in hospital until they felt ready to leave.

Mr. K. said: "I've paid my taxes all these years so that when I got to be older, these things wouldn't be a worry", Mr. J. a 99 year old man said, "I've paid my taxes for lots of years now, I fought in two wars...I deserve to be looked after now".

Many expanded on the theme of deserved entitlement by talking about a sense of anger and disillusionment at the discharge planning process which some felt forced them to go home sooner than they wanted to. Mr. Q. also reiterated feeling that he deserved to be in the hospital, "I paid my taxes....they shouldn't have been so quick to send me home...I guess I look pretty good but I still don't feel like I did before".

The anger and disillusionment was evident in some of their views on why the medicare system in our country is coming to a crisis point. Although many blamed it on "bureaucrats" and "corrupt politicians", there were remarkable comments blaming users of the system itself:

Mrs. P: "I don't know too much about how everything actually works, but it seems to me like there are an awful lot of people going to see the doctor who don't need to be there".

Mr. Q: "There are too many people getting too much unnecessary medical service".

Mr. K: "It seems to me that if there is trouble, it is probably because of abuse by patients themselves. People don't realize how much this costs - maybe if they had to pay user fees and insurance premiums they might not run to the doctor as much".

Mr. N: "I don't know very much about the financial end of things but it seems to me that there are lots of people jumping on the bandwagon. There are a lot of tests done that I wonder how many are really necessary, too many bureaucrats running things (in government there always are, you know)...maybe user fees would help, I would have been willing to pay so much per day during my stay I think.

Mr. O: "Really, it is a case of poor priorities on the part of everyone from the politicians to the people. Some have gotten so used to the good times that when tough times hit they can't cope. Those of us who were around during the depression remember what things really were like, we know that sometimes the belt has to be tightened and it is going to hurt...People have to start looking at the practical aspect of going to see a doctor and realizing that if they are not really sick, don't go".

Mrs. H: "People ask for too much sometimes...we have to remember that we can't have everything we want. Some people are in trouble now because they never prepared well enough when they were working, either financially or whatever. They weren't careful enough".

Mr. M: "There should be enough money in the system, the government only has so much you know. In the 1930's, farmers never went into debt, we just had to approach things differently. Nowadays, everyone seems too anxious and willing to get into debt and that includes the government".

Mrs. L: " There are a lot of people abusing the system - accepting services that are not needed, running to see the doctor for every little thing".

The relevance of this "blaming the victim" thinking should not be underestimated. Not only are patients ready to blame other patients for abuse of the system but so, it seems, are some health care professionals. One only needs to listen to various health care provider groups discuss the concept of instituting user fees to hear where responsibility for deficits is being assigned. Certainly, the idea of user fees to control demand for services is not new. In 1968, the Saskatchewan government introduced a series of user charges for physician and hospital services. In 1971, a succeeding government abandoned these. A study

by Beck and Horne (1980) analyzed how 40,000 Saskatchewan families utilized health services before the introduction of the charges, during their use and after they were abolished.

The main conclusions were:

a. Total provincial health costs remained about the same.

There was a small (6%) decrease in the use of physician services.

b. The elderly, poor and those with large families decreased their use of services. For example, use of services by the poor fell by about 18%. At the same time, there were more physician initiated visits, like annual physical examinations, for middle class patients.

c. There was no change in the use of hospitals - the biggest item in the province's health budget. (Beck, R.G. and Horne, J., 1980).

Mr. T., a seventy year old gentleman whose working career prior to retirement had focused on efficiency and productivity enhancement seemed to have the greatest amount of understanding about the reasons for budget problems and funding issues in health care. He talked about the decreasing federal transfer payments with a downloading effect to the provinces as a stress on the overall system. Interestingly, he was one of the few to discuss systemic aspects contributing to the problem.

"I think some salaries are too high, there is poor expense control particularly over tests, waste within the hospital. One example I can give is the food which is so bad that half the time I don't eat it...They should be looking at enhancing the quality of the food so that it isn't thrown away...there's a big waste. I sat in that hospital and watched things going on - the lack of efficient use of staff and materials was amazing.

There were nurses doing things that you could have hired someone off the street to do and trained them in a couple of days... Things like giving people a bath and walking them down the hallways..Having to go to another hospital for a test - think of all the wasted time and money that takes. It would be different if only a few people seemed to need that test (a scan) but I met quite a few people in there who were having to go for one and they all had to go out of the hospital. The costs of the ambulance, the nurse who had to come must be tremendous."

Rachlis (1989) convincingly argues that it is doctors and not patients who determine which health services are consumed. He decries the lack of science in medicine which allows for treatments with no scientifically demonstrated efficacy to be in place taking up valuable resource dollars. He says that diagnostic and treatment choices are determined by how the doctor is paid, their practice environment and the availability of hospital beds - "factors that have little or nothing to do with cost-effectiveness". He feels that there is an excess of doctors in Canada and that the mass media has either innocently or knowingly perpetuated a myth that more beds, more medicine and more doctors will mean better health.

If this study populations' sense that responsibility for our health care crisis is mainly due to abuse and overuse by patients, then we who have an interest in

fighting to preserve universal, accessible health care in Canada have much to do in education with our patients and their families. This cohort group's inability to remember life without the social benefit of medicare may mark the demise of a true appreciation for this service. The value which we place on it will not hold the same conviction without the remembrance of a people devoid of such a reassurance.

Mechanic (1982:16) describes medical care as an "iterative process"; patients learn on the basis of their experience and the responses of health care personnel how they are expected to use the system. Along with our role of empowerment of patients and attention to psychosocial needs is a place for social work in helping patients access community resources that may take them to a practical understanding of health care that need not be focused on hospitals and medical staff.

Education and advocacy for a more cost-effective way of dealing with health along its points on the continuum need to become part of our work with clients. Few clients or family members interviewed were aware of community supports that were available to them. These services ranged from assistance with yard work to self-help and support groups. Some were even unaware of services such as respite care unless they had previously accessed these before.

Thoughts on Discharge Planning with the Elderly

Most of the clients and family members interviewed were not aware of the discharge planning process occurring during their hospitalization. In fact, when explaining the goals of the research study to them most needed explication of what discharge planning was actually supposed to entail. This point brings to mind the issue - for whom is the discharge planning process for? If it is for the patient, then one should hope that they were aware that they were engaged in such a process. Respondents in this study seemed not to be.

For most of the clients, they were able to remember having had at least one professional ask them about their needs at home when discharged, often there was a cluster of about three or four professionals (usually the nurse, physiotherapist and the home care nurse or hospital social worker). Four patients said they could remember no one asking them how they would manage when they arrived home. Although when asked, most could remember being asked a question around this issue, few felt that there was a partnership of planning involved. In fact, Johnson and Fethke (1985) found in one study that although 86% of the hospitalized elderly patients were considered high risk patients in need of discharge planning, only 20% of them had received this service. The designation of high risk had been based on the hospital's own criteria.

The first time that most clients in this study remembered someone mentioning that they would be making plans for discharge were as follows:

Seven - shortly before discharge (day of, day before)

Seven - midway through the admission

Two - on admission

Four - shortly after admission

Their thinking behind their rating of this issue was most curious until taken in the context of their own health assessments. Mr. B., a dynamic sixty-seven year old man in hospital for three days following surgery for a hernia and carpal tunnel repair remembered the doctor telling him on the day of his admission that he would be home on the third day - "Its a promise!"

Mr. F., a seventy-four year old man previously independent was told on Day four that he would be going home the next day. He rated his time that discharge was mentioned as being midway through the admission. When questioned, he felt that the last day then seemed to take twice as long to pass :

"I felt like he was agreeing with me that I wasn't sick anymore...up until then I felt like a fraud for being in that bed because I didn't really feel as sick as some of the other guys in my room. But that last day just dragged, it seemed as long as the other three days put together".

These are contrasted by Mrs. P., a seventy six year old widow who was in hospital for twenty seven days. She exhibited much more anxiety and reluctance to leave hospital

for home, felt undeniably vulnerable and fearful outside of the structured, protective setting in the hospital.

Although she was told by the homecare nurse some seven to ten days in advance of discharge that they would be ordering home care services for her, she felt that she had been told of these plans only a day or two ahead of her discharge date. This was not because of some apparent mental impairment, but because "time went so fast after that", "I really didn't feel ready to go home".

Studies of discharge planning have indicated that such activity is not a priority for physicians and nurses until the days immediately prior to patient discharge (Johnson and Fethke, 1985; Waters, K., 1987a, 1987b; Bowling, A. 1984). It is evident however, that beginning discussion of discharge planning early on in the admission can assist a patient and their family in preparing for release from hospital and as indicated by Mr. F, allow for the transition from sick role to "former patient" with less anxiety.

There were a variety of comments regarding how they had heard about their discharge. Several respondents overheard comments between staff that indicated their discharge was to be soon. Three respondents felt that their physicians had been too abrupt with them when discussing discharge and had not allowed time for questions regarding their post-hospital course. In contrast to these, one gentleman was quite frustrated with his physician who could not seem to decide

on whether or not discharge was to be appropriate and this decision was pondered for several days. The man himself felt quite well and "I finally had to take the bull by the horns and tell him I wanted to go home today!" He went.

In talking about what sorts of concepts staff should keep in mind about elderly people, there were four general themes:

- a. " Do not treat us as older young people. Remember that we are not - do not have the same expectations of us in recovering that you have of yourselves".
- b. " Give us time - to recover at our own pace, to adjust to the changes that will happen when we go home. Changes are not comfortable to us now as we grow older".
- c. Most expressed gratitude for care and a number almost repeated the same phrase - "I'm just happy to be with people who care about me".
- d. Finally, all pleaded for their dignity. These requests were sometimes almost apologetically made - be honest with me, tell me everything you know about what is wrong with me and how I can expect my life to change. Show me you care - smile at me when you come in, sit and listen to my story. Remember where I've been and realize that just as my past successes and accomplishments come back to comfort me, so the painful memories return also. Mr. J. pleaded with his caregivers to remember that, although parts of his life were just history to them, he relived the horror of every moment

of World War I often now as he contemplated the end of his life coming.

At a developmental stage where one's long term memories become stronger and the short term memories become weaker, repressed experiences from the past may be "reactivated in extremely frightening and vivid imagery" (Cohen, 1991:227). If caregivers cannot afford their elderly clients the privilege of time and a willingness to listen, they may miss the most important part of their present stress.

Our remembered past is of great significance to us and we try to maintain our life story in good order. It does however, change subtly and purposefully as we grow older for it reflects how we have learned to live with ourselves. The memories can be selective based upon the demands of our self-esteem, but painful and guilt laden memories may also remain woven into the story (Johnson, 1976 cited in Coleman and McCulloch, 1985). Memories need not be relied upon for scientific accuracy but allow for entrance to the life experience of an individual and even a cohort group.

The study group's sense of dignity was woven into the process of discharge planning for them; they perceived a lack of respect for their personhood and autonomy. Four clients felt that the process had been too rushed (from their perspective) and felt that they had been "dumped" back into their home in a way that stripped away what little dignity they had thought they had left.

The message that discharge planning had not been a conscious goal oriented component to the hospital stay was enlightening. Surely if hospital workers practice what classic discharge planning literature suggests the patient and family would perceive it as a part of the process of hospitalization. Few respondents felt knowledgeable enough to participate fully in such a process - seemingly content to allow others, particularly health care providers, to make decisions both trivial and crucial, on their behalf. If empowering the patient and family to undertake decisions regarding health care is an aspect of our work, partnership must be the process. As will be discussed in the next section of this report, social work needs to become less global in our understanding of discharge planning and better able to define the various requirements of this aspect of medical social work.

The plea from clients to remember their cohort group as being unique from younger clients pleads for social work to increase their understanding of the aging process as well as the accompanying life-cycle stressors on other family members. Empowerment will only come as we learn to look beyond the gratitude to unexpressed need. If discharge planning can be therapeutic as Blazyk and Canavan (1985) suggest, aiding patients and families to become active partners early during hospitalization can assist with a smooth transition post-discharge. Release from hospital may

not be perceived as a "rush" if expectations for the course of investigation and treatment are set from the beginning.

Chapter Six

The Role of the Social Worker in Discharge Planning

Scope of the Discharge Planning Process

In order to function more effectively within the acute care hospital setting with its accompanying concerns regarding effectiveness of programming, the rather nebulous phrase of "discharge planning" needs to be divided based on accountability to different groups. With each group who have an interest in the discharge planning process, there is an attending change in focus of task. This will aid in operationalizing the roles that the medical social worker engages in within the health care setting.

My model for discharge planning (Diagram 1), is based upon a number of premises:

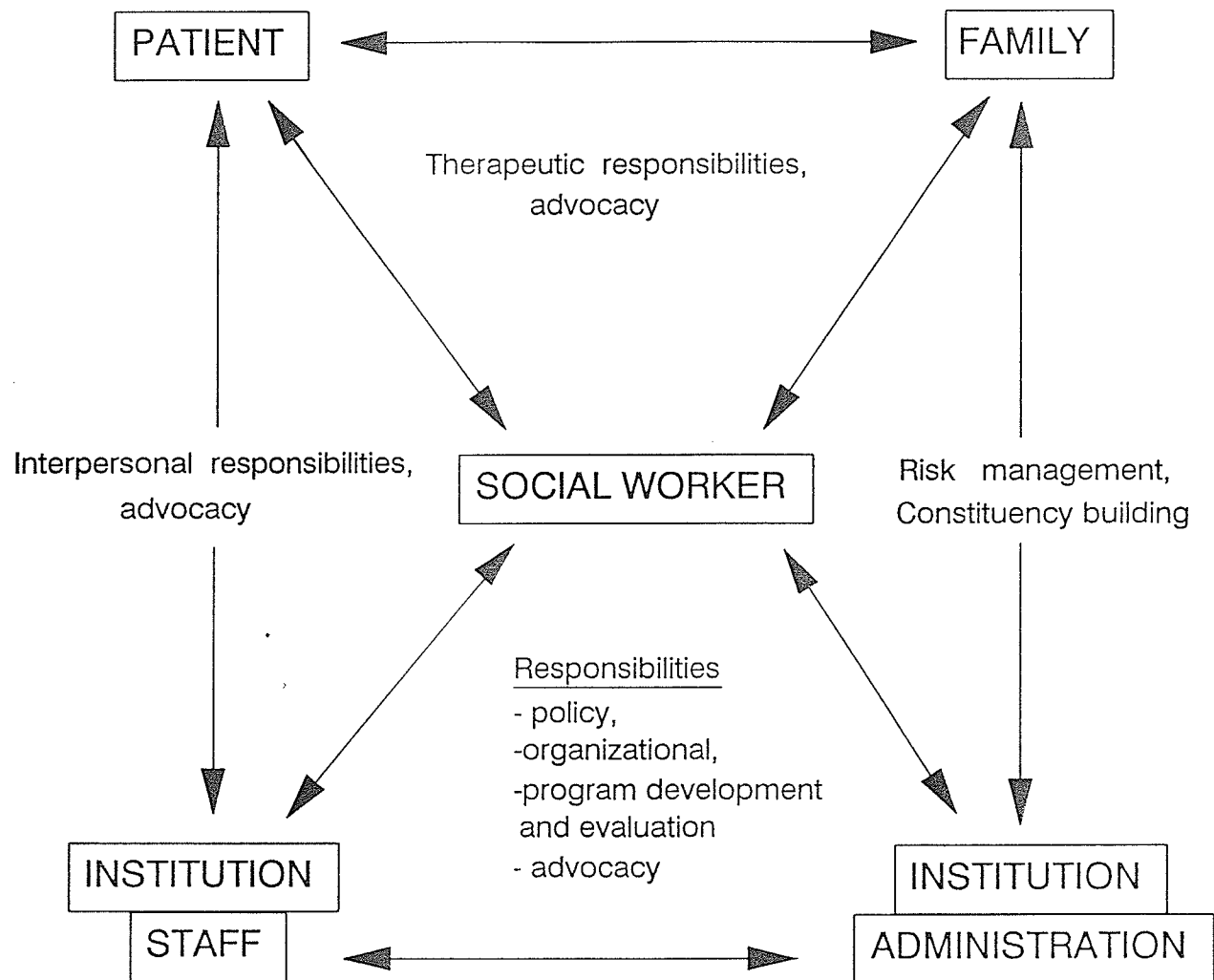
- a. Discharge planning occurs within an environmental context that is alien to most patients and families.
- b. Most patients live in an environmental context that is only superficially understood by the health professionals caring for them. Very few of us are able to spend the time with patients and their families so that an intimate understanding of them is possible.
- c. Social workers in the acute care setting need to focus their roles with each interest group and clearly delineate what minimal activities are expected in that setting. They also need to present a vision for what could be done and work towards closing that gap.

The variety of levels of intervention in discharge planning cry out for an expanded view of the process within the profession and within health care management. Groups requiring intervention are outlined in Diagram 1:

a. Patient - The social worker's intervention for discharge planning as previously mentioned must begin on admission. The role of proper assessment especially of internal resources (Zarle, 1989) such as strength, endurance, sensory input, knowledge, desire, courage, skills and communication and work on psychosocial strengths (Blazyk and Canavan, 1985) that will enable the patient maximum benefit during recovery are too important to be left until the few days prior to discharge. Assessment of external resources also requires some time. These may be housing, personal network, communication devices, transportation, finances and the need for support other than the functional provisions of the provincial Home Care division.

Provision of continuity of care through groupwork, community follow-up and support in the post-hospital phase is crucial to the preventative work of discharge. The recognition that following discharge many elderly patients will be reinstitutionalized argues for an integrated service approach in the period immediately following discharge (Emlet, 1984; Morrow-Howell et al, 1991).

Diagram One
Responsibilities of the Medical Social Worker in the
Discharge Planning Process



Fethke and Smith (1991) studied the length of time necessary to follow elderly clients in the community and prevent readmission to hospital. They found that a six week post-discharge rule defined a reasonable period in which elderly patients were at higher risk to be readmitted to either hospital or nursing home. Several study respondents alluded to an understanding that there would be a period of adjustment following hospital discharge. For those who felt vulnerable in a way not experienced prior to their admission, there was a hint of doubt that they would ever return to their previous level of confidence. The need for post-discharge support especially with the elderly was emphasized by them time and time again.

b. Family: The social worker is often called upon to act as the liaison between the family and the institution or even its staff. Facilitation of information flow as well is often necessary as families feel invisible within the hospital setting. Keeping family caregivers mentally and physically healthy is also a priority for the social worker. Not because, as Phillips (1989) says "it is nice", but because it can aid them in continuing with their role responsibilities and is "central to meeting the long-term care needs of elders". Phillips goes on to say the majority of elders who are discharged from hospital are returned to their homes. Most individuals need some form of assistance from another person (usually obtained from a significant

other). Thus, every health care decision that is made with an elder, on behalf of the elder or about an elder has implications for the lives and health of the elder's significant other(s).

Phillips's and Rempusheski's (1986) work suggests that the quality of that family caregiving relationship can be assessed by evaluating the "image the caregiver has of caregiving, the personal images that both the caregiver and the elder hold of each other, and the nature of the family relationships". The social worker's role with the family should not be seen as secondary but pivotal to her work with the patient. The complicating factors to discharge planning as discussed by Ciotti and Watt (1989) relate directly to the importance of the worker's involvement with the family as early in the admission as possible.

Education and skill building work with patients, families and community cohorts must occur for successful post-discharge outcomes (Lurie, 1984; Berkman, B. et al, 1990; Davidson, K., 1978). Families and elderly patients are typically reticent to ask for medical information, as is demonstrated in this study and others (Breemhaar, A. et al, 1990). Social workers must "search for the questions that are unasked to access the fears and concerns that are not yet spoken" (Trachtenberg, 1991). Empowerment and strength are maximized in clients when they make decisions based on a

firm understanding of their illness and confidence in their care providers.

c. Staff within the Institution

Social work must take the lead in enhancing the quality of discharge planning. Such strength of leadership will only come when we are confident of our skills that we bring to this area and less concerned with what has been called the increase in "tribalism and territoriality" (Dana, 1991:75). Teamwork can only be enhanced by "one less fighter in the ring". How much of our energy is taken up in a protectionistic mode that could be better used to serve all of our clients?

Dr. Howard Zucker is quoted by Dana (1991) as saying this about the threats that change pose for the realization of hopes for the health care consumer, provider and the health care team:

"Maintenance of morale is central in preparing for change. In the larger world economic and ecological limitations and pressures will, during the next thirty years or more, be expressed in social unrest, governmental upheavals, and rebellious outbursts by those who in reality have unmet basic health needs and who in fantasy believe that new governments or new heroes will rapidly make complex problems disappear.

In the smaller world of the health care professions the same tendencies are active. We are likely to experience powerlessness, depression, and fury as we are forced to accept changes in our life style, self concepts and professional identities. It is easier to blame other people and groups for these painful changes than to adapt to large impersonal forces - and by scapegoating to increase feelings of alienation. I see a lot of depression, anger, and demoralization in the health profession today" (Dana, 1991:84-85).

More attention needs to be focused on strengthening our capacities for developing and implementing what Dana calls proactive interdisciplinary strategies, including a stronger voice in social policy and system change. Social workers have a stake in our social policies - both personally and professionally (Lowry, 1983). If we are to have a role in shaping our professional futures, we must mobilize and educate clients, colleagues and ourselves about those policy changes which will impact upon the society in which we all live (Abramovitz, 1991).

Study clientele expressed a gap in their knowledge of how the medicare system was funded, the lines of responsibility and confusion about what the "problems were anyway". Several were able to say that they wished they knew more, most felt that they probably should know more about the workings of the health care system. This suggests that if more people understood the implications of policy changes and how they had been developed, a constituency stake in supporting or questioning policy could be formed. The opportunity for political and community based interest groups in development of programming can only be aided by client education.

There are many obstacles to good discharge planning. Inadequate communication, lack of collaboration and coordination of systems, conflicting role expectations on the part of the client and a lack of coping skills or

material resources are but a few mentioned (McClelland, E. et al, 1985). Along with Lurie (1984), McClelland and associates advocate viewing barriers from a systemic perspective. If this is to be done, the appropriate interventions must also be on a systemic level if the situation is to be addressed in an effective way (McKeehan, K. and Coulton, C., 1985).

Iglehart (1990), after a study of 229 California hospitals and their discharge planning programs came to the conclusion that "...the day-to-day routine activities of discharge planning are driven by neither social work nor nursing. The process seems to be driven by the needs of the organization in which it exists. For this to change, issues of territoriality must give way to issues of patient services. Social workers and nurses, when united, would represent a significant and powerful force in propelling system innovation and change".

d. administrative sector of the institution - The social worker is able to function in a risk management capacity regarding appropriate referrals and involvement, particularly if there is threat of litigation or dissatisfaction with the provision of care within the institution (Trachtenberg, 1991). Their role in assisting with the monitoring of bed utilization has previously been discussed here.

Because of the unique understanding of systems which the social worker is able to bring to the workplace, he/she offers a valuable resource to the hospital administration, assisting with both program development and constituency building (Lurie, 1984). A broad based constituency who feels a sense of ownership and allegiance to the community hospital will work to create a demand for programs that the hospital can coordinate. Former federal health minister Monique Begin remembered:

"I felt that a good idea should be judged on its own merits. I rather naively believed that the intrinsic value of a project spoke for itself..Now I understand that politics is a balance of forces and that it's strategy that makes you a winner or a loser" (Rachlis and Kushner, 1989:326).

The social worker is called upon to liaise with community agencies and resources frequently and as such must remember that he/she represents the institution with such community interest groups. The opportunity to strike a mutually beneficial partnership should not be overlooked.

The Advocacy Role in Discharge Planning

The social worker's advocacy role in discharge planning will take her into three primary spheres of influence (Lurie, 1984):

- a. political advocacy to improve government programs. Community organization can aid in this end and the medical social worker must use her community contacts to build community coalitions that will further support needed

programming at the institutional or community level (Lurie, 1984). Liaisons must be developed with legislators on all levels if one desires to advocate in a complete fashion for the clients utilizing the hospital resources. The scope of the issue must always be matched to the level at which it will be addressed.

b. developing resources to meet unmet needs. Because of their knowledge of the needs of many disadvantaged groups in our society social workers offer a unique and knowledgeable perspective in the area of program development. We must seek to become advocates for our clients and partners with government in developing community specific resources that will benefit both the clientele, agencies and the institution itself (Binstock, 1990).

If elderly clients are discharged home "sicker and quicker" as has been suggested (Kaye, 1988; Kosecoff et al, 1990) the advocacy role for the medical social worker is again stressed. Binstock (1990:245) pleads not only for direct advocacy for policies that will assist the vulnerable aged, but also quotes from the Presidential Task Force that he directed in 1968:

"...vulnerability in old age is the product of a life course of experiences, binding us all together...economic and social opportunities for current generations of the young and middle-aged are the most effective measures for ensuring opportunities for future generations of older Americans".

This increased sense of vulnerability was noted frequently by clients interviewed for the practicum.

If a reason for failed discharge planning is because of a lack of social or personal resources as suggested by McClelland (1985), then the medical social worker who neglects the advocacy and social action role dances with failure and does a disservice to his/her clients.

c. ensuring accessibility of clients and their families to needed programs and services. The need to remember discharge planning as both a therapeutic (Blazyk and Canavan, 1985) and a iterative (Mechanic, 1982) process will aid in advocating for needed access.

Evaluating Discharge Planning

Evaluations can occur in three areas of discharge planning - process, structure or outcome of care. Outcome evaluation is the most effective method for evaluation. The structure model may be the most concrete and obvious framework allowing for evaluation. The process elements will more directly define the actions of the discharge planner. Both the structure and process evaluation components, however, become problematic in evaluating the status of individuals at any future point in time. Outcome criteria are critical because of the usual loss of contact with the patient at the point of discharge.

Two types of evaluations are available: individual discharge plan evaluation and overall program evaluation. Evaluation of the individual client's discharge plan is based on success in meeting the mutually agreed on patient goals. Objective criteria make explicit the goals of the model in meeting individual patient needs.

Program evaluation in contrast is a formal activity which determines how successful the agency/department has been in meeting its overall program objectives. Muenchow and Carlson (1985:152) quite firmly say that two major outcome measures against which the success of the model can be measured are: "evidence that continuity of care was provided and that the patient was placed at the most independent level of care possible".

In their examination of seventeen discharge planning models (ten acute care, institutionally based and seven community and quasi-community based) explicit methods for evaluation of programs in how effectively they met these two objectives were absent in most. The lack of evaluation is a common problem to most quality review staff. Although various reasons are given by the authors, the one that seems most applicable to Canadian hospital social work may be that planning for today's immediate needs consumes the time of the staff person to such an extent that there is little or no thought for the projected needs of the future, no matter how close. The medical social worker in practice in busy,

acute care settings must take ownership of the need for evaluation in providing quality care, cognizant of the increasing need to demonstrate outcome effectiveness and placing evaluation in a priority position periodically.

A new age of health care provision which will seek to move more services to a community base and decrease the emphasis on institutionally-based services will force hospitals into evaluating our delivery of care - what works, what doesn't and what requires change. Richard Corcoran (1992) in a letter to the editor of The Gerontologist stated:

"The back-up of patients in hospital beds is not confined to metropolitan area or to New York State; nor is it specifically caused by an undersupply of either nursing home or hospital beds. Excessive hospital stays are symptomatic of the dysynchrony between individual care-needs and organized care settings that has crept into our health delivery systems during the past thirty years".

The "dysynchrony" between individual care needs and the organized care setting is the policy interface that will demand social work attention if we are to truly advocate for the best interests of our clients, their families and our employers. Advancements in the areas of day treatment facilities and day hospitals are an example of where the acute care social worker can provide the bridge between needs within the institution, continuity of care with clients once discharged and cost-effective care provision

for the community (Peck, 1991; Ferguson, 1991; Young, Chase and Mysak, 1983).

The expressed perception of some of the respondents that their hospitalization ended too abruptly; that in the case of Mr. A. he was extremely uncertain about a future at home alone and would have preferred to remain institutionalized is an example of the "dysynchrony" discussed above. Respondents referred often to health care and choice of hospitalization as an annuity of sorts. The expectations of need for care, support and control over decision making are at times in conflict and in my experience complicate the discharge process.

The conflict that occurs because of differing expectations needs to be addressed at all levels if the environment of discharge planning is to be understood (Germain, 1977). Not only is the role of negotiator to be acted out within the acute care setting, but also outside the institution. Providing liaison and acting as the mediator between government, institutions and community agencies will require a higher level of accountability and evaluation than is currently undertaken.

Community Organization and Discharge Planning

In order to achieve high quality discharge planning one needs to work with the voluntary, private and public sectors in a positive, spirited fashion. If we are to convince

funding sources that support of programs is necessary, our approach needs to mirror our concern, our knowledge base and a carefully reasoned strategy that shows appropriate planning for evaluation.

- a. accurate problem identification
- b. mobilization of resources
- c. management of methodology and skills
- d. monitoring of new information which may change the system itself (Lurie, 1984).

A first need is to bring together a power base of provider groups (hospitals, social agencies, advisory boards and local associations) who will provide a linkage between the care provider and consumer groups in a given locale.

A key issue needs to be emphasized and focused onto a workable, realistic goal. The constituency of the coalition needs to be able to achieve the goal in a reasonable time frame, and it must be a goal of course from which the hospital will demonstrably benefit. This will ensure institutional support and fulfill the mandate of accountability to the hospital for activities. Once the issue/goal is selected, a broader membership can be sought. As in any plan, development needs to occur in the areas of:

- a. long range goals
- b. short range goals
- c. ways of identifying the strengths and weaknesses of the chosen issue

d. creating a series of actions designed to achieve the goals (Shulman, Roseberg, Rock and Jefferson, 1976:103).

Discharge planning requires the social worker to understand the political processes such as compromise, mediation, arbitration and negotiation. An understanding of the psychological factors which may underpin resistance are as valid to the working of an institution as to the operation of a family system. Social workers must understand the "political implications of all phases of the discharge planning process and how it can effect social agencies, communities, patients and their families" (Shulman and Tuzman, 1980).

As should be the case, the discussion of discharge planning returns to the patient. The equation for quality discharge planning is not fulfilled unless all the above elements are in the place. Anything less is an exercise in crisis management for the social worker - certainly not the opportunity for growth in the patient, family and perhaps even the institution as Blazyk (1985) has made reference to.

When we speak about the vulnerabilities of our elderly clients, we must always be aware of the "vulnerability to what?" It is sometimes inappropriately interchanged with the concept of "risk" which refers to characteristics associated with a greater likelihood of specific negative events (Kane, 1990). As discussed earlier, the ethical

implications of our work must be more openly discussed in order to heighten our awareness of the impact of social work intervention with regards to the vulnerabilities of our clients. Respondents articulated in many ways their feelings of powerlessness and although not often expressed, their sense of vulnerability in relation to the very people and institutions that focus on providing care and attempting to meet the many needs of its community members. The rough fit between the many needs (physical, emotional, and material) and a structure that has an orientation towards only immediate physical needs was strikingly obvious.

The medical social worker must undertake to understand the process of discharge planning within its broader context and intervene at various levels for maximum benefit to clients. Intervention at any level must provide improved evaluation of work in order that discharge planning can become a progressive, creative process that can better address the needs of clients while ensuring a viable system of health care provision.

The need to be understand and integrate all aspects of providing service to elderly clients and their families must bring together knowledge of the aging process, identity maintenance, aspects of health and wellness and the personal issues carried through their lives by each cohort group. Quality provision of service can only be enhanced by an understanding of competing responsibilities in discharge

planning and their relative importance to each other. Evaluation of the various roles in discharge planning at different levels will help to ensure that appropriate resources are available for vulnerable clients and their families whether during hospitalization or following discharge. The advocacy role of the social worker in the hospital setting must become strong and place the profession in a position that allows influence in determining policy.

I close with a quote by Brody (1985) of Donald Kent who believed strongly in the importance of linking research about aging to practice and policy:

"Research, policy and practice are...not the same, but...they are not unrelated...policy that is not informed by knowledge may well be worse than worthless; it may be dangerous".

Chapter Seven

Summary of the Practicum Experience

This practicum was undertaken to define the role of the medical social worker in the discharge planning process within an acute care hospital setting. It sought to meld an understanding how clients perceived the hospital setting treating them as a cohort group. Clients' perceptions regarding their participation in discharge planning were elicited. They were asked to discuss their assessment of the Canadian_medicare as it is today as well as where improvements should come.

Preliminary interviews with ten clients were undertaken in the fall of 1991 so that the interview format could be refined. Throughout the winter and spring of 1992, interviews with another twenty clients and some of their families were carried out. These clients comprised the study population. Content analysis focused on similarities in responses as well as areas that were marked by differences in perceptions or conclusions.

Although clients that were selected for this study would, on the whole, not have been selected within the normal screening procedures used in our hospital for social work intervention during their stay, the most shocking finding was of the overwhelming, unexpressed emotional and social needs of these patients. Taken in the context of

Havighurst's (1972) tasks for wellness in this age strata however, these unexpressed needs are to be expected.

Clarke's (1987) suggestion regarding patient recognition of illness and Mechanic's (1982) thoughts on symptom recognition would seem to have been validated by client response in this study. Their perceptions of their health were notably influenced by their ability to maintain independent activity, as well as other factors - cultural, cohort comparison and the individual development of perceived health.

Parsons' theory of the sick role aided in understanding how clients assumed this role as well as indicating why there may be difficulties in giving it up.

The expectations of patients and their families of the hospital setting and their unique cohort history (Karp, 1982) that contributed to those expectations were discussed. Each cohort group brings a unique encounter with history into their later years (Foner, 1974). It is the awareness of this aspect of their lives which lends direction and parameter to the interventions which the medical social worker undertakes with them and on behalf of them with outside systems.

The challenge to the medical social worker in his/her role vis a vis the discharge planning process became increasingly clear. The standard dictums of early involvement, screening and partnership with the patient and

family were noted in the literature and corroborated during the study. The lack of perceived partnership between the clients and hospital personnel was marked. The majority of clients did not perceive this as a major criticism, but such a process offers significant benefit to the patient, family and institution. Even if the work of discharge planning was completed, the client's lack of recognition of the process as well as their opportunity to participate in a "knowing" way limits the benefits to the health care system as a whole. This ineffective use of such a powerful mechanism for political, policy and research intervention is a sad loss of opportunity to effect a positive, lasting change.

The opportunity to participate is lost not only to the patient, but also to the family. Hospital staff and the institutions interacting with the facility can benefit much by emphasizing the art of discharge planning and clearly demonstrating the process to all involved.

The role of the social worker in the discharge planning process was elaborated upon and a framework in which to explicate responsibilities and allow evaluation of the work in the process itself was proposed. The skills of the social worker uniquely qualify them to participate in a multi-faceted approach to discharge planning. The therapeutic and advocacy responsibilities with the patient can be contrasted with the responsibilities to the administration of the institution: policy and program

development and evaluation, organizational skills as well as advocacy within the institution itself.

The social worker bears responsibility for facilitating effective and therapeutic interactions between the patient, family and staff of the institution in order to maximize the functioning of all during the period of hospitalization and beyond. This contrasts with the responsibilities inherent in involvement in risk management activities with families and patients because of the hospital stay. The importance of the medical social worker's contacts with community constituents and his/her work to strengthen the joint commitment and will power to collaborate on programs that will benefit clients, agencies and hospitals are an equally important facet of discharge planning.

This practicum has allowed me to learn more about qualitative analysis and its application to the practice of social work. Practical skills involving the use of self in my involvement with clients and heightened skills in interviewing were also gained. The process of the practicum encouraged me to view discharge planning from a broader perspective. It assisted in clearly defining for myself the various roles that must be undertaken by the social worker if discharge planning is to be effective in a systemic way.

There were also the unexpected findings - the need for social work intervention and assessment with those who hurt in silence, the need for remembering patience and allowing

time to talk, and the importance of recognizing a client's need to be heard - not necessarily "talked to" or "talked with". These were simple lessons emphasized in the beginning of my clinical training. I have come to learn that as I mature both personally and professionally, the most important concepts I use were taught to me many years before. They are the foundation which provide quality and substance to everyday practice.

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Appendix A

HEALTH SCALE FOR THE AGED
(I. Rosow and N. Breslau, 1966)

Distribution of Responses

Number of "Healthy" Responses	Percentage of Total
6	12
5	20
4	16
3	15
2	20
1 or 0	17

Appendix B

SELF EVALUATION OF HEALTH

(E. Shanas et al., 1968; cited by Stahl, 1984)

Distribution by Country of Responses to Self-Evaluation of Health

Question (in percentages)

	United Kingdom	Denmark	United States
Good	57	52	52
Fair	29	32	30
Poor	14	16	18
Totals	100	100	100

Appendix C

Consent to Participation in Research Project

I hereby consent to participate in the health system and seniors research project as discussed with me by the project coordinator, Gloria Dixon. I understand that only information given by myself will be used and that ALL information gained from me will be strictly confidential. My name will never be used and in the the final analysis, my views may only be quoted under a code letter, protecting my identity.

I may request a summary of the findings of this project by advising Gloria Dixon of this.

I understand that my participation or non-participation in this project will have no bearing on my treatment at Concordia Hospital by the health care team, now or in the future.

Signature of Client

Date

Signature of Project Coordinator

Appendix D

Client Profiles:

A. This is a 91 year old bachelor who was in hospital for 25 days with a gastrointestinal bleed. He lives in a small bachelor apartment in a senior's subsidized housing block. The doctor began pressing the patient for discharge some nine days after admission. The patient refused discharge until sixteen days later. He had not been out of his apartment for three months prior to hospitalization because of the cold weather and physical weakness. Prior to that went out daily and was active in a local senior's centre. Presently is too scared to leave his home and orders in his groceries, allowing neighbours to pay his bills and do errands as their time allows.

He estimates that he has lost some fifty pounds over the past four to six months because of chronic digestive difficulties. Continues to experience bowel and abdominal pain even on discharge. Has a nephew in the north end who visits every few weeks and brings soup and provides social contact. All his other family were killed in the Ukraine prior to his arrival in Canada.

Receives Home Care every two days for cleaning and laundry assistance, meal preparation. Wants to be placed on the waiting list for a personal care home.

B. This sixty seven year old man was in hospital for three days with an inguinal hernia repair as well as a repair for a carpal tunnel. He lives with his wife in his own home. A retired storekeeper, he has continued to be active since retirement at age sixty. He currently builds and crafts handmade banduras, sings in three Ukrainian choirs which travel worldwide. He and his wife enjoy travelling to the US and to Europe as often as they can. Believes he must live each day to the fullest - doesn't anticipate living past his eightieth birthday. His mother died at age 74 and his father died at 83.

C. 73 year old spinster in hospital 23 days with Congestive Heart Failure. Is well-known to our facility, her chronic medical difficulties seem to require hospitalization several times per year. She and a 76 year old sister live in a small rather run-down looking apartment behind what was previously their family store (now empty). The family has lived in this home since 1921. Her sister was the primary caregiver for their father prior to his death and now provides the primary support.

Client retired at age 65 after years of working as a store clerk. The sisters have recently been feeling threatened by the actions of several area youths who have broken windows at their home and now are considering a move to a senior's complex that would provide increased security

and additional on-site services such as meal provision. It is a difficult decision because of the memories attached to their home and an intact network of friends who live nearby.

Sister does all cooking and cleaning. Home Care assists with cleaning and some meal preparation to decrease the burden on the sister. VON visit regularly for health maintenance checks.

D. 82 year old lady in hospital 32 days with a Colles fracture and congestive heart failure. She immigrated to Canada in 1964 from Paraguay where she had fled from Germany during WW II. Was widowed in Paraguay. Has lived with her daughter and son-in-law since her arrival in Canada. Previously worked in housekeeping at a local personal care home. A very alert lady with a wonderful sense of humour.

E. 85 year old lady in hospital 32 days with a CVA and MI. Lives alone in a senior's apartment block. Has been widowed for the past five years. Only son lives about 20 minutes away and is very supportive. Phones her every two to three days and visits regularly. Was very apprehensive on return home. Tearful, many anxiety attacks and frequent episodes of chest pain. There were several returns to our Emergency Department because of this and in fact required readmission on several occasions. Home Care services needed to be increased several times and the family doctor needed to

become more intensively involved in follow-up with this lady until her stress decreased and her confidence returned.

F. 74 year old male in hospital five days with a cholecystectomy. He lives with his 73 year old spouse who is nearly blind and forgetful at times. Is a retired mechanic and handyman. They continue to live in their own home where they have been for the past thirty plus years. There are four children, all of whom live out of province with the exception of a daughter who farms on the Manitoba-Saskatchewan border. Previously independent and required no home care on discharge. He remains quite active, plays in a swing band that performs publicly at least twice a month. He aids his wife with nearly all the household tasks because of her poor vision.

G. 77 year old lady in hospital four days after suffering an MI. She was widowed five weeks prior to suffering the MI. Husband died at home from a similar cause - the couple had been married approximately 60 years. She has continued to live in their own small two bedroom bungalow in an area where neighbours have lived together as a group for some forty years or more. They are all about her age. Her only child died in infancy in Poland, relies on a nephew to maintain her yardwork and a 90 year old brother-in-law and his wife to provide social support.

H. 82 year old lady admitted with MI and previously diagnosed cancer. In hospital for 28 days. Lives in her own apartment with several nieces providing assistance, at times taking her into their own homes to provide care after each of her recent hospitalizations. Prior to her retirement worked as a bookkeeper. Discharged to the home of a niece with VON and Home Care follow-up and a referral to a palliative care facility.

I. 95 year old lady admitted for a 35 day stay after a fall at the supermarket. Lives alone in a senior's block. Is a spinster - only social support is a niece who visits once per week and a regular home care worker who provides housekeeping and laundry assistance. Worked as a nanny and nursemaid until her 80's when she retired and moved to Winnipeg. Travelled widely throughout her career and has retained that independence to this day.

J. 99 year old male in hospital 20 days after having urinary tract surgery. Lives in an seniors' apartment block with his 92 year old wife. Couple had no children and all their siblings are deceased. Primary social support is a former neighbor's daughter who drives them about, assists with errands and considers them to be her pseudo-grandparents. The couple remain mentally alert but are very frail. They have been attempting to gain placement together

at a local personal care home for the past eight months and were placed on the limited waiting list one month ago because of their urgent need from the community's standpoint.

Although they would have preferred placement together, they are leaning towards a voluntary separation. Both are keenly aware of their limitations and also of the extra concern they cause each other. He is particularly cognizant of the increasing dependence on external support and care that he is requiring and feels himself becoming a burden to his wife.

K. 73 year old man in hospital 27 days after suffering an MI, pneumonia and respiratory failure. Retired from the railway at age 65. Lives in his own home with his wife. Has a large circle of supportive family, and friends. One son lives in St. Norbert, daughters live in Germany and Alberta. Very proud of his family of origin's role in sponsoring many German immigrants to Canada and assisting them to become successful here.

L. 85 year old lady in hospital 21 days with a fractured hip. She had fallen at home on a loose patio stone while planting flowers. Has been widowed for the past nine years, previously married for fifty years. The couple had no children. Worked as a hairdresser when younger - very

independent, enjoys living alone in her own home. Religious values give great strength to her. Primary social supports are nieces and nephews scattered around Winnipeg.

M. 75 year old man in hospital eight days with cholelithiasis. Brought himself down to Winnipeg from his home in Swan River for medical treatment. He and wife are living in a local hotel until his surgery is scheduled. He retired as a carpenter in 1980. They have one daughter who farms near Swan River. His wife is three years older than him and has been having health difficulties herself lately. He has had to assume many of the household tasks as she becomes unable to undertake things like cooking, cleaning and laundry.

N. 65 year old male in hospital for ten days following a retropubic prostatectomy. This Brandon area bachelor is a retired postal clerk and waited three months to have this surgery.

O. 71 year old male in hospital for 15 days with exploratory surgery on his gall bladder. Previously a switchman with the railway, retired early because of problems with asthma. Lives with wife in their own home in North Kildonan (where they have been for the past 31 years.). Three grown children living out of province.

Both he and his wife have had a long history of depression and anxiety. Previously diagnosed with MS about five years ago. There has been previous psychiatric contact as well as respiratory services at DLC prior to its sale to the provincial government.

P. 76 year old lady in hospital 27 days with a fractured femur and a Moore's repair to her hip. Widowed for the past 17 years. Lives in her own home with a 45 year old developmentally delayed son. Her other son works full time, is married and lives a short distance west of Winnipeg. He is able to provide only practical handyman assistance to his mother and brother.

She worked as a housewife all her life. Is extremely anxious about her coping abilities at home now and is conscious of the extra burden her son living at home with her now feels.

Q. 72 year old male in hospital 50 days after a large bowel obstruction. He was quite ill on admission and in fact was in ICU for 22 days. He lives in a small seniors block with his second wife of 9 years. Two step-daughters live nearby, three children from his first marriage live out of province.

His previous medical history includes three myocardial infarctions and two CVAs. A veteran of World War II with overseas service, he continues to have recurrent memories

which continue to haunt him. Describes himself as "always being a step behind since I came back...sometimes I think I came back to a different place". Extensive history of alcohol abuse on his part and reportedly by his wife.

R. 82 year old male in hospital 67 days after falling at home. Long history of alcohol abuse and has suffered from Parkinsonism for the past three years. He is a retired railway engineer who has been divorced from his wife for many years. There is one son who lives nearby and attempts to support his father to some extent. The issue of alcoholism is only beginning to be dealt with on the part of the son. Client lives in a seniors' block and his only social contacts really are his friends in the building.

S. 70 year old lady in hospital 19 days after an MI and cardiogenic shock requiring intervention in the ICU. Lives in a nearby seniors' block by herself. Husband has Alzheimer's and has been institutionalized at Deer Lodge Centre for the past three years. Up until this admission she has been a very active lady. Driving up until now - advised by her doctor to sell her car and not to drive anymore.. Son lives out of town but is supportive. She is primary practical social support for a disabled friend with MS who lives in the same building.

T. 70 year old male with spinal stenosis and esophagitis in hospital for 10 days. Lives alone in his own home. Wife died in 1985 after a lengthy illness. Only son lives in Thompson, Manitoba. He retired in 1964 because of his wife's poor health. After her death he then returned to work as a security guard until this hospitalization. Has been beaten up several times while working - the last beating resulting in this hospitalization. As a result plans to quit work and devote his time to increased charitable and church activities.

Appendix E

Format Used for Semi-Structured Interviews

1. Introduction of the Research Project and validation of understanding by client and primary care-giver if available.
2. Administration of the Health Scale for the Aged and the single item questionnaire regarding self-perception of health compared to that of their friends.
3. Questions regarding their perception of the health in their younger years and how if any they think differently now about the state of their health. eg. When you were younger, how was your health? As you have gotten older, how has it changed? Were you in a similar state of health to that of most of your friends your age in younger days? How is your health now compared to that of friends your age? Do you worry about your health? Do you live your life any differently now because of your health? If so, in what way?
4. Questions were asked regarding their hospital stay - their impressions of their care in hospital, what areas of care could be improved upon and what areas of care were done well. This section also had patients discuss the concept of discharge planning. When was the first time they were told

that they could plan for discharge with community support persons? Who told them of the discharge order? What health care professionals did they have contact with during their stay in hospital? Was there any one thing that was done that allowed them a sense of being in charge of what happened to them while in hospital?

5. Clients' opinions were sought on the state of the Canadian health care delivery system. They were asked if they remembered what their lives were like prior to the introduction of medicare. How did things change when medicare became available? What aspects of our current system do they place the most value on? They were asked for opinions on why there is a fiscal crunch in the health care system, and suggestions to alleviate this financial concern.