Health promotion and the elderly - are the concepts compatible?

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HEALTH PROMOTION AND THE ELDERLY - ARE THE CONCEPTS COMPATIBLE?
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ARE THE CONCEPTS COMPATIBLE?

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# TABLE OF CONTENTS

Declaration  
Acknowledgements  
Summary  
List of Tables

## CHAPTER 1 - THE ELDERLY - CURRENT AND PREDICTED TRENDS

1.1. INTRODUCTION  
1.2. OBJECTIVES OF THE STUDY  
1.3. DEMOGRAPHY OF THE ELDERLY  
1.4. DEFINITION OF THE MAGNITUDE OF THE PROBLEM  
1.5. ECONOMIC ISSUES  
1.6. MORBIDITY TRENDS - A PREDICTION  
1.7. WHO ARE IN THE "AT RISK" GROUPS?  
1.8. SUMMARY

## CHAPTER 2 - HEALTH OF THE ELDERLY - THEMES AND ISSUES

2.1. THE NEW PUBLIC HEALTH  
2.1.1. PRIMARY HEALTH CARE  
2.1.2. EQUITY  
2.1.3. HEALTH PROMOTION  
2.2. HEALTH CARE ISSUES  
2.2.1. COMMON HEALTH PROBLEMS  
2.2.2. COMMUNITY VERSUS INSTITUTIONAL CARE  
2.2.3. THE ROLE OF CARERS  
2.2.4. TRANSITION FROM HOSPITAL TO HOME  
2.3. LEARNING TO ADAPT  
2.3.1. CAN WE TEACH OLD DOGS NEW TRICKS?  
2.3.2. HOW ARE THE ELDERLY DIFFERENT AS LEARNERS?  
2.4. SUMMARY
CHAPTER 3 - COMMUNITY AND THEORETICAL PERSPECTIVES

3.1. SOCIAL VIEWS AND THEORIES ABOUT THE ELDERLY 35
   3.1.1. DISENGAGEMENT THEORY 36
   3.1.2. ACTIVITY THEORY 37
   3.1.3. SYMBOLIC INTERACTION AND SOCIAL INTEGRATION THEORY 38

3.2. HEALTH PROFESSIONALS' ATTITUDES 40
   3.2.1. THE CULTURE OF HEALTH PROFESSIONALS 40
   3.2.2. HEALTH PROFESSIONALS AS HEALTH EDUCATORS 42

3.3. SUMMARY 44

CHAPTER 4 - CASE STUDIES - RATIONALE AND METHOD

4.1. GROUNDED THEORY 46
   4.1.1. THEORY DEVELOPMENT 47
   4.1.2. DATA COLLECTION AND ANALYSIS 48

4.2. THE CASE STUDIES 51

4.3. INTERVIEWING THE ELDERLY SUBJECTS 52
   4.3.1. RECORDING DATA 54

4.4. DATA FROM OTHER SOURCES 57
   4.4.1. HEALTH PROFESSIONALS 58
   4.4.2. CARERS 59

4.5. THE SOCIAL CONTEXT 61

4.6. SUMMARY 63

CHAPTER 5 - CASE STUDIES - FROM DATA TO PROPOSITIONS

5.1. CASE STUDY 1 - MR RC 64

5.2. CASE STUDY 2 - MRS CP 77

5.3. CASE STUDY 3 - MR HM 87

5.4. CASE STUDY 4 - MRS BE 97
DECLARATION

This thesis is submitted to the Department of Public Health and Nutrition, University of Wollongong, in fulfilment of the requirements for the Honours Degree of Master of Science (Community Health). It does not incorporate any material previously published or written by another person except where due reference is made in the text. The work described in this thesis is original work and has not been previously submitted for a degree or diploma in any university.

Judith A. Davis
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How far back in one's life to honour those people who helped bring you to this point of maturation? My Mother Ena May who gave birth to me and has always loved me, even when sometimes she didn't understand me. My family, who have caught brief glimpses of this chameleon as she flew in and out of her state of origin, have always been there and loved me. Friends who years ago encouraged and challenged my intellectual potential, like Joy. Powerful influences in my personal growth and awareness, like Jennifer Mary. Peers who opened up the possibilities of undertaking qualitative research in a positive way, like Rod. Loving friends who gently highlighted the warts in my original, embryotic efforts, put up with my tantrums and stomping, and loved me just the same - Anna, Delia and Dianne. New and old friends in Wollongong and NSW, who through the time of this research gave support, encouragement, and the hugs I needed to see me through, Kate, Greg, Felix, Peg, Kevin, Beth, Robyn, Rae, Heather, Irene, Deanne, Elaine, Zofia, Graeme, Sandra, Jan, Adrian, Dennis, Mark and all the others. My dear friend Francesca, who is now with God, but has been there with me in spirit throughout this year...Requiem. I love, and thank you all.

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I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I -
I took the one less travelled by,
And that has made all the difference.

Robert Frost
This study addressed the issue of health education for elderly people following discharge from hospital to home. The research method was qualitative, and used the grounded theory approach. Data was collected using participant-observation and informal open-ended interviews. Elderly people, their carers, and health professionals were interviewed. The case studies were recruited from elderly people who had recently been discharged from hospital, and referred to the care of community health nurses in a specific geographical area. No distinction was made regarding, gender, diagnosis, or the level of care required on discharge. The specific issues addressed in this study were how the education needs of the elderly were determined, and how that health teaching was undertaken. More importantly, also addressed was the issue of how that health teaching was perceived by the elderly themselves.

The most powerful issue that emerged from the elderly was how they viewed themselves. Their definition of elderly had little to do with chronological age, rather they identified "old" as dependent. The perceived ability of the elderly to learn was seen as central to the way health professionals related personally to the elderly and to how information was subsequently given to them. There is a need to recognize the majority of elderly people as active, willing, and able participants in health promotion activities. Hospital personnel generally lacked knowledge of the home environment and the needs of the elderly once they left the hospital milieu. Involvement of the carers in education about post hospitalization care was also found to be inadequate in most cases. A further difficulty was the breakdown in lines of communication between the hospital and community health professionals.
LIST OF TABLES

Table 1 - POPULATION PROJECTION FOR THREE AGE CATEGORIES: 1985 - 2000. 5
Table 2 - COMPRESSION OR EXTENSION OF MORBIDITY. 8
Table 3 - REGIONAL COMPARISONS OF PROFESSIONAL AND NON-PROFESSIONAL EMPLOYEES: 1981. 61
CHAPTER 1  -  THE ELDERLY - CURRENT AND PREDICTED TRENDS

1.1 INTRODUCTION

The population of Australia is aging. At present 11-12% of the population is over the age of 65 years. By the year 2000, a figure of 17-18% is anticipated (Department of Immigration and Ethnic Affairs, 1985). For some years now, health professionals have promoted the philosophy that care of the aged is best centred in the home rather than in institutions (Cant & Legge, 1984). To provide the care needed by an increased number of aged people in their homes, greater emphasis on staff and service needs is essential. One aspect of need is the health education of elderly patients, and their carers, on discharge from hospital after acute or chronic illness. Health teaching should be seen as a responsibility of all health professionals involved in the care of the elderly person. Further, and more importantly, the teaching should have as its focus a holistic definition of health, and a commitment to health education and promotion, not merely to maintenance.

Very little research is available on this type of educational input by health professionals. When health teaching has been cited, little analysis of the content or effectiveness of the teaching has been made (Pender, 1974; Waters, 1987). Evans (1983) researched health teaching undertaken by graduate nurses, and found that the major impediment to the effectiveness of their teaching was a lack of input in their undergraduate education about teaching/learning principles. Ewan (1990) points out the need for exposure of students at undergraduate level to teaching/learning principles, and to the healthy elderly. The early exposure of students to elderly people is crucial to the development of positive attitudes about the elderly.
Other discussion on the issue of health promotion in the elderly centres more on the need for health professionals to recognize the concept as being viable and valuable, rather than presenting models of how that might be achieved (eg Davies, 1990). Further, it often concentrates on diseases like cardiovascular, cancer and osteoporosis; and assumes as its basis a medical model for the delivery of care. A medical model rests on interventive and curative strategies, and often limits care to physical problems. The need for health professionals to recognize a social model of health and to base their assessment and delivery of care to elderly patients on that model is critical. The social model holds that health status relies on factors outside of the physical well-being of individuals. Attention is focused increasingly on the need to acknowledge the degree to which the environment, socio-economic status, and educational background, influence health status. A social model of health has important implications for the assessment of needs of the elderly and of how services are structured to meet those needs. It will be shown that a strong relationship exists between social well-being, or happiness, and how elderly people perceive chronic disease. That is, if old people are socially healthy, they cope more positively with disabling conditions.

The social model of health and health care provision acknowledges the efficacy of a multi-disciplinary client-centred approach to health care delivery. In order to improve the health status of the elderly, there is a need to move from a nurturing, protecting, paternalistic approach characteristic of much of health care for the elderly, to encouraging independence, optimal level of functioning and empowerment of the elderly in informed decision-making regarding their health practices. These concepts are discussed in later chapters. It will be shown that these attitudes to care of the elderly are entrenched in stereotyped social views of the aged held by health professionals.
This study concerns itself with the health teaching of the elderly in the process of their discharge from hospital to home. International research on this topic to date suggests that such teaching is either absent or inadequate (Barnett, 1986; Kromminga & Ostwald, 1987; Waters, 1987). Teaching, as a basic competency for the nurse is well documented (International Council of Nurses, 1985 quoted in Kozier & Erb, 1988). Teaching is also implicit in the holistic, problem-solving approach adopted by nurses in philosophical statements surrounding the discipline of nursing. Despite this recognized role, nurses have commonly abrogated that responsibility in their practice (Syred, 1987; Wilson-Barnett & Osborne, 1983). While it is recognized that this is a general deficit in the competencies of the nurse practitioner, for the purpose of this study only those issues related to the teaching of the elderly are addressed.

1.2 OBJECTIVES OF THE STUDY

In an attempt to address issues surrounding care of the elderly on discharge from hospital to home, the following objectives will direct the inquiry.

1. the perceptions of health teaching by the elderly, particularly with regard to coping with activities of daily living, (ADL).
2. whether the health teaching provides the primary care-givers with adequate information.
3. the extent to which health teaching is congruent with the needs of the elderly
4. the implications of the findings for health professionals involved in discharge health teaching.

The study examines the demographic trends of the aged over the next few decades, and the anticipated health problems they will encounter. The ability of healthy elderly to learn is linked with aspects of health promotion appropriate to their needs. For those elderly who
remain outside of the health care services the focus and importance of primary health care, and maintaining their independent status are addressed.

Differences in how the elderly learn, and the context in which that learning should best take place are important to the understanding of how health professionals might target and present health education programmes to the aged. The self-perception of the elderly has a significant impact on programme marketing, content, and context.

How the elderly, and their carers, perceived the teaching they received is a major focus of the study as is the process of discharge from hospital to home. It has been demonstrated that re-admission to hospital is reduced if appropriate discharge planning takes place (Andrews, 1986; De Rienzo, 1985). Despite this evidence, the discharge planning process for the elderly remains fragmented, inappropriate to their needs, and often excludes the primary care-giver. Holistic assessment of needs, utilizing an appropriate ADL tool, cognizance of the situation at home, and communication between hospital and community personnel are also addressed as issues surrounding care-giving within the community and institutions, the economics of health care services, and the human cost incurred by carers. Inappropriate admission to nursing home or hostel beds often results from failure to support care-givers adequately (Gillies et al, 1987). Some of those difficulties result from a reluctance on the part of either the elderly or their carers to access resources, or an unwillingness to use those resources. Multiplicity of services, over and/or underservicing, and lack of knowledge by the elderly and their carers are cited as common problems in the delivery of health care.

1.3  DEMOGRAPHY OF THE ELDERLY

Australian numbers and population projections for the elderly are summarized in Table 1.
TABLE 1. POPULATION PROJECTION FOR THREE AGE CATEGORIES: AUSTRALIA 1985-2000

\*'000 (percentage increase from previous year)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>AGE GROUP</th>
<th>65-69 years</th>
<th>70-79 years</th>
<th>80 years and over</th>
<th>Total 65 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td></td>
<td>544.5 (1.1)</td>
<td>771.5 (3.4)</td>
<td>292.8 (3.6)</td>
<td>1608.8</td>
</tr>
<tr>
<td>1986</td>
<td></td>
<td>576.4 (4.2)</td>
<td>793.3 (2.8)</td>
<td>304.7 (4.1)</td>
<td>1665.2 (3.5)</td>
</tr>
<tr>
<td>1987</td>
<td></td>
<td>588.8 (3.8)</td>
<td>812.9 (2.5)</td>
<td>315.5 (3.5)</td>
<td>1717.2 (3.1)</td>
</tr>
<tr>
<td>1988</td>
<td></td>
<td>613.0 (4.1)</td>
<td>826.1 (1.6)</td>
<td>327.8 (3.9)</td>
<td>1776.9 (2.9)</td>
</tr>
<tr>
<td>1989</td>
<td></td>
<td>635.9 (3.7)</td>
<td>836.7 (1.3)</td>
<td>341.4 (4.1)</td>
<td>1814.0 (2.7)</td>
</tr>
<tr>
<td>1990</td>
<td></td>
<td>653.4 (2.8)</td>
<td>855.0 (2.2)</td>
<td>354.6 (3.9)</td>
<td>1862.9 (2.7)</td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td>641.4</td>
<td>1060.2</td>
<td>484.6</td>
<td>2186.3</td>
</tr>
</tbody>
</table>

Source: Department of Immigration and Ethnics Affairs, 1985, Australia's population trends and prospects, 1985, AGPS, Canberra.

Of the elderly, 95% live in the community, either alone or with family, and only 5% occupy nursing home or hostel beds (Abbey et al, 1987). This compares with other Western industrialized nations where 5% in supportive accommodation is the norm (Brocklehurst, 1987). Female relatives provide the care for those elderly people living in their homes but needing assistance. The support of this minority group of elderly people, and their carers, has been the focus of research undertaken by Kendig (1981), Pierangeli & Spencer (1987) and Gillies et al (1987). Their interests centred on two major issues. Firstly, the need to balance the amount of support given to the elderly: too little accelerates their physical decline and too much nurtures dependence. Secondly, that the primary care-givers are relatives and friends, whose needs have generally been understated if they were acknowledged at all.

Public policy has forced "...women, married or single, as persons unequivocally obligated to care for elderly persons as a first priority over engaging in paid work" (Groves, 1987). This unpaid work, described by Groves as a "labour of love" is interpreted as a burden undertaken at great personal cost to carers. Further that "...the point at which referrals are made to...services is, often, when caring actually breaks down" (op cit p 144). The issue of
informal, non-professional care is deserving of increased attention by health care providers if
the trend of retaining the elderly in the community/home is to continue.

1.4 DEFINITION OF THE MAGNITUDE OF THE PROBLEM

The major problem of planning for future needs of the growing numbers of elderly is in
providing sufficient information to direct resources toward those needs. Clear definitions
and objectives should be set around identified areas of need. According to Hugo et al (1987)
"a move towards needs-based service delivery systems in Australia will depend upon relevant
information being collected from representative samples of older people". However the
paucity, and lack of precision of data remains the major obstacle to planning. It is suggested
by Howe (1981) and Philips (1988), that the impact of the growing number of elderly has
been poorly addressed. Both comment on the need to have more precise demographic data
that would enable government to make accurate forecasts.

Economic projections of the significance of an aging population have been made on the cost
to the social security system, rather than to the health care system. Philips (1988) attributes
this to several basic, but unanswered questions. Firstly, while we know from demographic
data, that there is an increasing proportion of elderly within our total population, we do not
know the degree of morbidity that will accompany that increase. The "...vexing question of
whether or not the elderly are becoming healthier" (op cit p73) is an impediment to precise
planning strategies. With increasing health education programmes mounted at both state and
national level, the elderly of the future are expected to be less encumbered by the chronic
diseases plaguing the elderly of today. But will they be? The question is, how to predict
morbidity in this group.
1.5 Economic Issues

The second question posed by Philips (1988), is whether the growing number of elderly threaten to create an economic crisis for the health care system at all. A Canadian economist suggested that,

the increasing numbers of older people do not by themselves imply an impending crisis. However, the relative intensity with which the health care system is treating the elderly is rising dramatically and much faster than for the rest of the population. (Barer et al, 1987, p 74)

The issue is to determine whether increased servicing of the elderly is the correct response to their health needs. It has been argued that the commitment of more resources to care of the elderly would be appropriate, "if the specific types of morbidity for which effective treatments were previously unavailable now became treatable" (op cit, p 74). "It would be inappropriate however if it were based on false perceptions of the effectiveness of health services or on the economic aspirations of health care providers or on demands of patients which are unrelated to actual health care needs" (op cit, p 74).

In order to plan for the future, it is vital that economic decisions are based on data. If we are simply looking at an increase of numbers, then is a proportionate increase in funding appropriate? If increased numbers are compounded by an increase in the morbidity of those elderly, will that be an added strain on those resources? Servicing by the health providers also needs examination. The questions to be asked here focus on appropriateness, intensity, overservicing, specificity, and effectiveness of services provided. Scrutiny of service may well result in the re-allocation of resources to "those services which are known to be effective" (op cit, p75). How one measures effectiveness is another area of debate. Costing of services has tended to avoid the issues of quality, satisfaction by consumers and other factors deemed to be "too hard".
The mechanism of costing services to the elderly has ignored the human cost incurred. Some of that cost is in the physical care given by relatives and friends, which might otherwise be provided by paid professionals such as community health nurses. Cost should also be counted in terms of loss from the work force of those relatives caring for the elderly person. In human terms, the cost of life chances for those carers who put aside their own personal aspirations for the elderly person, is enormous.

1.6 MORBIDITY TRENDS - A PREDICTION.

An attempt has been made by Fries (1989) to predict morbidity in the elderly. His thesis is that with an increase in good health habits, adult life expectancy remaining relatively constant, and the time of morbid events postponed, then morbidity could be compressed into a shorter period of time. His possible scenarios for morbidity are illustrated in Table 2.

![Compression or Extension of Morbidity Diagram]

Scenario one represents the pessimistic view of morbidity, and the second a more optimistic position. It is clear from increasing longevity, that there is a reduction in mortality rates. This is a direct result of disease control and advances in medical technology. Along with the reduction in mortality has come an increased degree of morbidity amongst old people. While Fries admits that the data on morbidity trends are "weak", he also states,

Major chronic diseases must be occurring later in life if the prevailing risk factor models are accurate, because these models stipulate that if the accumulation of toxic exposures, smoking, total fat intake is slower, the clinical threshold must be reached later in life. (op cit p 212)

Differences in life style and levels of education suggest a future increase in already apparent social differentials in health status. Fries admits difficulties in predicting morbidity trends. The effects of Auto Immune Deficiency Syndrome (AIDS), intravenous drug use, violence, environmental problems, and the lower socioeconomic groups' lag in healthy lifestyle are all unpredictable factors. For this reason he presented a pessimistic scenario of extended morbidity, as well as one that reflected a degree of optimism. The optimistic scenario relies on an ongoing commitment to primary prevention and health promotion. Health education and healthy lifestyle benefits are manifested only after a protracted period of time. Patterns of behavior established in young adulthood will influence the degree of morbidity experienced in old age. Health promotion campaigns should continue to encourage better food habits, cessation of smoking, and regular exercise programmes. A distinction is drawn between those diseases which are seen as preventable e.g. heart disease and hypertension, and those where risk factors are not yet sufficiently isolated e.g. Alzheimer's and Parkinson's disease.
1.7 WHO ARE IN THE 'AT RISK' GROUP?

Which groups of the elderly are most at risk? We know that the greatest users of health services are the poor, less educated elderly (Wan et al, 1982; Western, 1983). Within those categories, women use health services more than men because of an increased incidence of chronic illness. A survey of approximately 11,000 elderly people (>60 years) living at home, in Adelaide and Melbourne was conducted in 1981. This was a joint undertaking by the Australian Council on the Ageing and the Australian Department of Community Services (ACOTA, 1985). Analysis of overall frequency of use of health services by the elderly, showed that differentiated usage of those services was by age range, not gender. Within the 65-74 age range 77.9% had used health services in the previous three months. This increased to 83.1% in those aged 75 and more. Elderly males, however, are more likely to need assistance with a wider range of activities such as cooking and cleaning. Despite this high usage of health services, the elderly generally saw themselves as being in good health. "Overall, 21.5% of elderly thought their health was excellent, 45.2% thought it good, 28.4% said it was fair, while 4.9% thought they were in poor health" (op cit, p 200).

Within both groups, those elderly who live alone appear to be more independent than those who live with others (Wan et al, 1982, p 60). A large survey of the housing of the elderly was conducted in Australia in 1976. The population represented 790,000 aged single persons and couples and their dwellings. Small towns and rural areas were excluded from the survey as were nursing homes and hospitals (Western, 1983, p 315). That survey revealed a grim picture. It was found that on average, 11% of the elderly were living in accommodation considered to be "unsatisfactory or beyond repair" (op cit, p 316). The proportion of elderly occupying this unsatisfactory accommodation varied from one state or area to another: 6% in a major city, to 21% in a small state.
1.8 SUMMARY

Old age need not be plagued with long term chronic diseases. Existing data suggest that we have an incomplete picture of the health status of the increasing numbers of elderly. It has been postulated that health promotion is impacting on morbidity and mortality figures. High risk groups are recognized within the general population and are obvious targets for primary care and health education attention. Care of the elderly within their own homes is a double-edged sword. While policies are directed toward maintaining the elderly at home, insufficient resources are allocated to community care, and inappropriate attention is afforded to the caregivers and their needs.

Abrogation of the health teaching role by health professionals needs urgent attention. The recognition of the importance of health promotion for young and old adults is imperative if compression of morbidity in later life is to become a reality.
CHAPTER 2 - HEALTH OF THE ELDERLY - THEMES AND ISSUES

2.1 THE NEW PUBLIC HEALTH

The new public health paradigm moves away from the medical model and into a broader definition of the needs of individuals. Within the conceptual framework of the new social model of health is the notion of health encompassing all facets of our daily lives. In that sense, issues such as pollution control, environmental protection, food safety, and social well-being are intimately involved with physical, mental and psychological well-being (Palmer & Short, 1989; Australia's Health, 1988). New public health links with the more traditional view of public health and adds to its mandate "...the need to draw on knowledge from different perspectives, and the importance of a social movement as a stimulus, support and base" (Palmer & Short, 1989, p 50). Effectively, this model acknowledges that health is not solely an activity and a responsibility of health professionals. It also implies that "...reappraisal of the 'pastoral', or caring, role of medicine; and the need to evaluate the effectiveness and efficiency of medical practice" (op cit p 51) is needed. The social model of health suggests that each facet of the environment contributes significantly to good health, and to ignore any of them is to ignore the intricacies of the human organism and its needs.

Planning for provision of health services for the elderly is dependent on the definition they, and the service providers, have of health and therefore of the risk of ill health. If one accepts a holistic view which encompasses the total needs of the individual, then the task of providing good health care belongs to every one in the community. In a document issued by the World Health Organization (WHO), Targets for Health for All (1985), the responsibility for health was taken into the national and international arenas. This concept encompasses government and policy makers, industrialists, primary and secondary producers, service providers of all categories, and city planners. If the definition is restricted to care of physical
health alone, parameters change. These ideas are central to the discipline of anthropology, but "have only recently received significant currency in the American public health movement" (Ames & Janes, 1987). In that sense the new public health acknowledges the cultural influence, and differences inherent to groups and individuals. Culturalisation of individuals needs to be recognised in order to understand health behaviour.

The core of the social model of health is the concept of primary health care delivery, a focus on preventive strategies, identification of risk groups, and early interventive measures. The elderly would benefit from this holistic view of health assessment. The model acknowledges the impact of environmental issues on health.

2.1.1 Primary health care.

Criticism about the lack of primary health care or preventive strategies is common within the health industry. Pro-active measures, in terms of control and maintenance of current health problems and prevention of further disease, should be a goal. The healthiest groups of elderly are single or divorced women (Wan et al, 1982; Western, 1983) These women represent 76% of the elderly living alone in the community. Although women are known to have a higher incidence of chronic illness, single women report themselves to be in good or excellent health (ACOTA, 1985, p 200). The implication from a primary health care perspective is that, whilst the physical condition of the elderly may be characterized by a high degree of morbidity, the physical disabilities do not become the dominant concern if the elderly perceive other factors in their lives as positive.

Just as individuals define their own well-ness, so does society define the parameters of what constitutes health. For the most part, service providers in developed countries can claim to provide excellence in the physical care of the community. The biomedical paradigm
influencing most health care providers, however, appears to have some difficulty in acknowledging the efficacy of the social, psychological, emotional and sexual aspects of health. Whilst the rhetoric within the philosophy of many agencies includes a broad definition of health, often practice does not reflect the rhetoric.

One of the major goals of primary health care is the empowerment of the individual to take control of his or her own health (Better Health Commission, 1986, p 8). This concept contrasts with the education and socialization of professionals which reinforces control and decision-making as implicit in their practice. This socialization, particularly of medical students, has been described in some detail by Becker et al (1961) and Ewan (1986). Professional autonomy is taken for granted, and as Ewan states, "It is a constant background feature and a structural characteristic of relationships between doctors and other hospital personnel" (1986, p 67). This learned, and firmly entrenched belief carries itself through to contact and control with patients. Practitioners can rationalize this use of control in terms of legal responsibility, technical competence, and scientific knowledge. The real issue is one of maintaining control, and a belief that medicine is capable of curing disease, and saving lives. Evans (1990, p 79) states, "A certain narrowness of vision, imbued by decades of medical education focused on the laboratory and inspired by determinist paradigms...has also produced much misapprehension and misattribution in the common doctor's view of the achievements of his craft".

An increased supply of doctors, and the accompanying need to generate income has led to a proliferation in the use of medical technology. The medical profession has, "embraced with considerable enthusiasm" this burgeoning medical technology industry (Palmer & Short, 1989, pp 283 -288). This technology adds further power and knowledge to health professionals, it also increases the jargon which confounds consumers, and in particular, the elderly. Nurses, and other allied health practitioners, who function within a far less
independent mandate, exercise similar exclusivity with language, knowledge, and an ability to control the service they provide to consumers.

Consumerism is embryonic in terms of its impact on medical practice in Australia. Community members who participate in consultation with the health care system, often find themselves "...disappointed, frustrated, cynical and wary of future involvement" (Palmer & Short, 1989, p 276). The reality is that the medical profession is in a position of power, and the elderly present little resistance to that power base. The structural domination of the medical profession is a potent force which exerts considerable pressure to achieve its own goals.

Alongside the prevailing professional belief system is the assumption that people want direction and are prepared to acquiesce to the professional's advice. This position is stated more strongly within the Parsonian conceptual framework which proposes that socially determined role relationships serve the social good. Illness is seen as a social deviance which so impedes the individual that he or she is unable to fulfil the usual social role. Power is transferred to the professionals in return for their clinical competence, expertise, and pragmatic efficacy (Parsons, 1967). This is not to imply that physicians are entirely responsible for the position of inequality that develops as a result of this shift of power and decision-making. Both the individual and the doctor contribute to this agreement about which roles they play and at what point power is transferred from the individual to the professional. However, there are times when the rules of that transference are influenced by the definition of the situation by one or other of the players.

Within the primary health care context certain assumptions are in place which determine how the roles of professional and client are interpreted. Principally, the belief of the physician is that he or she is the only one with the knowledge and skill to cure the patient. However, it is
claimed that approximately 80% of people who present themselves for care to a general practitioner have a functional illness that could be treated by, "...any talented healer who displays warmth, interest and compassion regardless of whether he has finished grammar school" (Massey, 1976, p 713). Massey further proposes that yet another 10% of people will have a condition that is incurable and will require symptomatic relief and supportive care. The remaining 10% of symptoms will require the skills of a medical practitioner.

Effective and efficient delivery of primary health care, especially to the elderly, involves the need to tease out those health deficits that will benefit from the attention of a medical practitioner. Transferring management of components of care to other health professionals and/or family, is not only appropriate but is more cost effective. There is an increasing awareness in the community of the need to "contain health costs" (Wallack & Winkleby, 1987), and further, the limitations of medicine in the prevention of illness. The elderly represent one of the most expensive groups of consumers of health care services and are therefore obvious targets for health education programmes. "Contrary to many popular misconceptions, studies indicate that older persons are concerned about their health and interested in information and behavioral strategies directed toward improving it" (Smith, 1988). It is at the first level of contact with the health care system that the elderly require a degree of sensitivity to ensure that "...the degree of accessibility, and the quality of services provided may constitute the major determinants in outcome resulting from an encounter between an elderly person and the system" (Andrews, 1990).

Several issues become apparent. Of most concern to this research is primary health care with appropriate preventative health, or education, input. In order to encourage the continued good health of the growing number of elderly in the community a focus on well-ness should be implicit in all health care directed toward the elderly. The Better Health Commission (1986) identifies "Death after a healthy old age" as one of its goals for older Australians.
This goal implies that old age need not be steeped in disabling conditions which of necessity reduces the quality of life. Health professionals need to acknowledge the readiness for learning about health among the elderly and to use opportunities to advantage. We need to recognize and question our acceptance of disability with increasing chronic illness as a necessary component of aging, and to recognize the capabilities and benefits which follow a life experience of learning.

2.1.2 Equity.

Kickbusch (1987) points out that developed countries are failing to achieve equitable delivery of health care services, and this inequity is in urgent need of review. A prominent area of inequality in Australia is the care given to the elderly. Howe, (1981); Kendig, (1981); and Hicks, (1984) discuss the need for planning and equity of social conditions for the elderly. "Arrangements for the elderly must be flexible enough to cope with changing economics and changing attitudes" (Hicks 1984, p 5). Hicks' discussion, like that of many authors, emphasizes the need for the elderly to be afforded a standard of care and quality of life equal to that of others in our society. The achievement of those goals relies on an appropriate needs assessment being carried out by a qualified multi-disciplinary team. Further, it requires that those who provide the care in the community have the necessary knowledge and support to fulfil that role.

The key concerns that emerge in relation to planning centre around the need for accurate data, appropriate definitions of the impact that the growing number of elderly will actually have on our resources, and the need to support those carers who continue to maintain the majority of the elderly at home. Alongside those issues is the need to assess and to channel resources to those service providers who are meeting the defined needs most effectively. As the majority
of elderly living in the community are generally active and healthy, it is essential to ensure that the focus in care and planning encourages that situation to continue.

2.1.3 Health Promotion.

It is somewhat ironic that when an elderly person is ill, measures are taken to restore or rehabilitate his or her functions. Surgical procedures are undertaken, physiotherapy and rehabilitation after a stroke, etc. There is faith in the potential of the organism to respond and it very frequently does respond. This faith and this approach need to be extended to the fit - but aging - organism. The attitude that "one is not getting any younger" produces resignation and discourages rational ways of preventing disabilities. This our society can ill afford, since the numbers of elderly are rising and every effort should be made to keep them as fit and independent as possible - even if the span of life cannot be significantly extended. (Gore, 1972, p 84)

This was written nearly twenty years ago, yet we have not progressed significantly in this direction. The medicalisation of care directed toward the elderly is the antithesis of the principles of health promotion which are empowerment, self-care, and dissemination of knowledge (Green & Raeburn, 1988; Kickbusch; 1989; Labonte, 1986).

Health promotion is the process of consciousness raising within a community about health problems. It involves use of the mass media and targeting the most urgent public health issues. Health education on the other hand, can be presented using specific programmes directed toward providing information to groups within the community. Health promoters appear to have a clear understanding of these concepts. But are those concepts accurate, and further are they based on the needs, in this instance, of the elderly? The question again begs a clear definition of health. O'Neill (1988) asks "...should the knowledge needed to act necessarily be provided through science? Are not art, religion, poetry and philosophy modes of understanding human reality that could also provide useful indications of how to reach well-being?".
Professionals should not make assumptions about the knowledge the elderly require, or the ranking of priorities they may have of their health needs. Vauclay et al, (1984) have noted that the elderly "...fear illness and loneliness more than any other condition". These comments came from interviews with a large sample of active elderly people living in an inner metropolitan area. Fear of crime and other safety factors become of paramount importance with declining years, and are identified as one of the advantages of living within hostels and/or nursing homes. The responsibility for health education programmes to address these basic needs, and to link old people into communication systems is one of the easier tasks that might be undertaken. Chapter 3 will explore the facets of holistic health and the relationship between activity, mental stimulation and good health.

2.2 HEALTH CARE ISSUES

2.2.1 Common health problems.

There are specific diseases common in old age that have potential for preventive intervention. Risk factors that exist for middle aged adults are equally risky for the elderly. Smoking, hypertension, obesity, and high blood lipids all contribute to circulatory diseases. In the elderly those disease account for a third of hospital admissions and more than a quarter of visits to doctors (Davies, 1990). Other diseases that increase the morbidity and mortality of the elderly are cancer and osteoporosis. The three major sites for carcinoma in men over 75 are lung, prostate, and colorectum, and women colorectum, breast, and lung. Screening for cancer in the aged population is poorly monitored by health professionals. Elderly women are "likely to be lifelong non-users or under-users of screening for cancer of the cervix" (Davies, 1990, p 318).
The elderly are often accepting of disabling conditions and tend not to report diminishing loss of hearing and sight to their medical practitioner. Of concern is the effect of iatrogenic illnesses which Kane et al (1985) identify as the most common preventable diseases in old age. "These include drug reactions, enthusiastic medical investigation, neglect of 'minor' functional problems". These are "...sins of omission and of commission" according to Kane et al, and reflect a lack of interest and or skill of medical practitioners in care of the elderly.

Osteoporosis, accidents, falls, and fractures are major causes of injury to the elderly, and obvious targets for attention by health care providers. Often attention to safety within the aged person's home is sufficient to prevent minor accidents. It is within this context that the new public health has relevance for the elderly. Review of medications, encouragement to undergo screening for known "risk" cancers, and early intervention to failing sight and hearing, would significantly contribute to the good health of the elderly.

Research supports the fact that the elderly who are active, and close to support structures self-report a high level of wellness. Vauclay et al (1984) highlighted limited mobility which consequently reduced independence for the old person as one of the major variables in how they dealt with impairment. It is estimated that 78% of the aged population is affected by health problems. "Of this group, 76% of males, and 78% of females suffer from one or more chronic conditions" (Graycar & Kinnear, 1981). Chronic illnesses are perceived by the elderly and many practitioners as an inevitable part of the aging process. Neither the elderly, nor the practitioner may give those illnesses due attention. The elderly are more likely to present with acute illness than with chronic conditions which might well be cured (Johnson, 1972).
2.2.2 Community versus institutional care.

Life satisfaction was measured by the ACOTA (1985) in a sample of over 2000 elderly people from two capital cities in Australia. In summary they found,

In terms of specific satisfactions, being satisfied with one's social life had a very strong positive relationship with subjective well-being. Satisfaction with frequency of outings was also positively associated with expressed well-being (p 398).

"A strong negative association ...found between subjective well-being...frequency of consultations with a doctor or specialist all adversely affected expressed well-being" (op cit, p 397). The research by the ACOTA was undertaken with elderly people at home, while Cant & Legge (1984) compared elderly at home with those in institutions. More positive comments were made by those elderly people living in the community than those in institutions. Elderly people who were institutionalized were more likely to comment on how they might be viewed by others "I am a nuisance", whereas the elderly in the community tended to concentrate on their current, or past role "I am happy to help people, happy to be a mother, happy to have good neighbours" (op cit, p 20). Research undertaken by Wan et al (1982, p 61) asked elderly in the community how their health compared with that of others of the same age, "...it was found that three-fourths of the respondents reported having either excellent or good health", only 4.7% reported that their health was poor. It appears that elderly people living in the community view their health, and themselves in a more positive sense than those living in institutions.

It is usually the quality of life of the elderly person that is the yard stick by which the suitability of alternative accommodation is measured. Carers of the elderly rate that criterion highly when choices about care are presented to them. The elderly cite loss of independence as one of the major issues when decisions are being made about care (Bennett & Wallace, 1983). Howe (1981, p 179) uses much stronger language in describing the importance of
care in the community over institutionalization. She uses terms like, "an alternative to neglect", "a measure of overcoming deprivations they might experience". Often, however the choice does not exist for the elderly person, who may have to rely on minimal support within the community if they do not have a "significant other" to provide that care.

There is a need to balance the negativity present in Howe's remarks. In a recent survey of Australian nursing homes and hostels, a significant proportion of residents were very satisfied with the care they were receiving. An Issues Paper, "I'm still an individual" highlighted the comments and complaints from residents. Some of the major complaints made by residents focus on food choices, privacy, lack of control, and religious and cultural freedom. This paper was a part of the strategy by the Australian Department of Community Services and Health, (1989) to produce recommendations and guidelines in the proper conduct of nursing homes and hostels. This undertaking has resulted in a "Proposed Charter of Residents' Rights and Responsibilities" (op cit, p 103) which is currently under review.

Serious attention is being given to these issues, and government funding sanctions are being used to enforce quality control of institutions. Resident involvement in decisions about management, freedom to comment critically about service provision, and assured privacy have been identified as some of the priorities. The incentive for institutions to respond to these controls is high. Without allocation of sufficient funds, they would be unable to function profitably. The number of hostel and nursing home beds per head of population in Australia appears to be adequate. The problem is in maintaining a quality of care-giving in those institutions which is in line with resident expectations. The majority of nursing homes and hostels in Australia are owned by private organizations (Howe, 1981). Quality assurance, and review of organizational structure may well be the fillip to secure, for the elderly, the kind of care they identify as being suitable.
The other more pressing problem for carers and the elderly is gaining access to beds in hostels or nursing homes, if that is the choice. Early and sometimes inappropriate admissions to those beds over the years may now be impeding access to the severely disabled elderly today. As a result waiting lists for beds is high and carers often find themselves in a position of caring for an elderly person for some years. It was found by Gillies et al (1987), found that admission is often precipitated because the carer's own health deteriorates to the point that they are unable to continue to provide home care.

The choice and/or decision about where care will be given is often multifactorial. The decision is not simply the choice between home or an institution. It is also tied to the personal view of the elderly person and their carer, the availability of support, and the access to beds in an institution. Significant emotional issues face the elderly person and the carer in this decision-making process.

Many strategies could be put in place to assist the elderly who wish not to enter full-time institutional care. Adult day care centres (Osterman, 1986), are just one example of a middle road delivery of care between home and institution. Four models of these centres are described. Some provide professional care by medical and nursing personnel for elderly people who are recovering from an acute illness. A psycho-social model is in place for those elderly with psychiatric disorders, another model deals with care of elderly with chronic disabilities. Finally, there is a model which focuses on social stimulation (op cit, pp 50 - 51). Day care facilities for the elderly have often suffered criticism because of a seeming lack of structure and function. However, a mixture of the models described by Osterman may well be integrated into these facilities for the elderly, without that being stated or identified by the organization. These centres serve two major purposes. One is that of respite for the carer, and the other is to allow the elderly some form of interaction with peers. We need to recognize the value of alternatives in care of the elderly, their right to a high level of care, and
their innate right to be involved in the decision-making that takes place wherever that care is given.

2.2.3 The role of Carers.

"About 10 years ago academics discovered the fact that people actually take care of themselves. This was a process rather reminiscent of the academic discovery of poverty in the sixties" (Kickbusch, 1989, p 125). This facetious, but well grounded comment may be the key to the high level of interest that has emerged over the last decade about carers. Sceptics may interpret that interest as being based on the economic gains for government in terms of encouraging unpaid, informal care to continue. However, research into elderly people at home identifies high levels of self-care by the elderly themselves (ACOTA, 1985). Where a carer is involved, that care is often shared between the elderly person and their carer/s (op cit, p 442).

There is tension between women's need for economic and social independence and their traditional role as unpaid carers. This tension manifests itself in several ways. The needs of the elderly take over the lives of their carers. They are "sandwiched" between their own children and parents (Miller, 1981). Often the support needed to deal with these issues is not available, and the carers experience high levels of stress. Decision-making about care of the elderly person is often left to the female carer. Research has shown that if the carer can no longer manage the level of care required and decides to place the elderly person in a nursing home, they face their own guilt, and negative sanctions from their family (Melville, 1983).

Non-involvement of the carers in education may represent failure by health professionals to acknowledge the level of care provided, and the needs of carers. There may also be a genuine lack of awareness of the level of support available to the carer. This gap in the
discharge planning process was highlighted by Zelewsky & Deitrick (1987) when they surveyed the needs of carers. Within that study they isolated the need for education of carers as a major component in assuring the ability of the carer to cope. Failure to recognise the value of "lay" people has been well documented (ACOTA, 1985; Gillies et al, 1987; Groves, 1987; Howe, 1987; Levin, 1986). It has been estimated that 85% of care provided in the community is undertaken by carers, or "lay" people (Levin, 1986). The relationship between formal and informal care givers is poorly understood, and "many of these services rest upon a creaky, under-resourced and largely voluntary base" (Healy, 1990, p 148). It is well recognised that despite an awareness of the cost benefits of maintaining the elderly at home, allocation of sufficient resources to enable that to be achieved has been poorly addressed by health care systems (Ford, 1981; Graycar & Kinnear, 1981; Groves, 1987; Howe, 1981; Kendig, 1981; Labonte, 1986; Palmer & Short, 1989). This lack of resources has resulted in additional strain being placed on carers.

An innovative program was undertaken by Oktay & Volland (1987), when they organised "Foster home care" for elderly people. The group of elderly in this program had no relatives available to care for them at home. They were all hospitalised, and the only apparent option was for them to be placed in nursing homes. This project answered several needs. First, it showed that "...closely supervised caregiver can provide skilled care as well as personal care and supervision" (op cit, p 1510). Second, it avoided admission to an institution, a fact that seems important for the majority of elderly people (op cit, p 1510). Finally it proved to be cost effective, compared to institutional care. The foster carers were paid for their services, and the cost analysis against equivalent care in a nursing home, was a saving of 17%. This program could be used as a model for elderly people being cared for by relatives. It would serve, not only as a form of respite for carers, but also as a means of providing stimulation and varied interaction for the elderly.
Motivation of "lay" or non-professional carers, is internal and varied (De Lehr, 1990). In a survey of dependent elderly Gillies et al (1987) identified several major reasons given by carers. Despite the differences in the relationship between the carer and the cared for person, three issues predominated. Firstly, that they loved the elderly person. That factor was strongest when the carer was a spouse of the elderly person. Secondly, was a sense of duty. The sense of duty was strongest in the carer who was looking after a parent-in-law.Thirdly, it was seen to be the right thing to do. The carers who identified that as a reason were those caring, again, for a parent. Other reasons offered were, "no alternatives available", "not really making a decision to provide care" (op cit p, 54). Not wanting to be separated from the cared for person was the only variable that differed from other research about carers (Rossiter et al 1984). The ACOTA (1985) survey reported that the tasks undertaken by some carers appeared to be quite overwhelming, and yet less than one-third of them sought help with that caring. Despite the fact that a lack of freedom and privacy were identified as a major source of concern for carers, 42% of carers received no assistance at all with their caring role. The major worries expressed by carers in that survey were for the safety of the elderly person, and their ability to keep caring for them over long periods of time. Another major concern expressed by carers was the issue of who would care for the elderly person if they (the carer) should become ill (op cit pp 470 - 479).

Many carers give up either full or part time work in order to care for the elderly person (ACOTA, 1985; Finch & Groves, 1983; Gillies et al, 1987). Carers are predominantly female and account for 76% of the carers (Gillies et al, 1987, p, 43). The age range of those carers was between 24 - 89 years. Duration of care-giving varied from a few months to over 10 years. Approximately 88% of the carers were married. Most carers had children, only 7.5% did not. Many carers have chronic illnesses themselves and this adds extra stress to the
level of care they are required to give their elderly relatives (Gillies et al, 1987; ACOTA, 1985). Predicted future trends in availability of carers give cause for concern.

...with a divorce rate which has risen steeply since the early 1970's, the possibility that a woman will need to become economically self-sufficient, after marital breakdown, is a very real one. We do not know what effect this increased divorce rate is having on family obligations with regard to the care of the elderly; for instance, on the role of the 'ex' daughter-in-law in caring. (Groves, 1987, p148)

Cost and other factors involved in care at home.

The cost, to the health services, of maintaining the elderly at home is significantly lower than the cost of hospitalization (Bennett & Wallace, 1983). This is due, at least in part, to the unpaid services of relatives and friends who adopt the role of carer. As discussed in Chapter 1 most economic theorists fail to incorporate in their analyses the costing of relatives and/or friends who provide the majority of the care needed to sustain the elderly at home. Levin (1986, p 285), points out that "So ordinary are these lay health care functions, that until recently they were virtually ignored in accounting for a community's or nation's health resource". Family care is the mainstay of aged care, and yet "...the relationship between informal and formal care is insufficiently understood" (Healy, 1990). The gap that exists in the provision of services is filled by informal carers.

2.2.4 Transition from hospital to home.

Early discharge from acute care institutions places increased burdens on care givers. The level of dependence of the elderly has been shown to increase during hospitalization, and use of community services remains high for up to twelve months following discharge from hospital (Victor & Vetter, 1984). Re-admission rates of the elderly were also high in the twelve months following discharge from hospital care, especially in those elderly people with
lack of appropriate support at home. Planning and decision-making about appropriate care should take place in the process of discharge of the elderly from hospital to home.

Hospitals are re-imbursed by Federal Government for the care of individuals. In the near future payment may be based on a Diagnostic Related Group (DRG) model which was developed in North America and is under review within the Australian health system. The model allows payment for maximum days of stay in a hospital bed against a criterion of age, disease and complications (Birmingham, 1986). Two considerations are critical for the discharge of the individual on or preferably before, that pre-determined maximum stay. One is the planning of the care whilst hospitalized and the other is the discharge plan itself. There is an intimate relationship between health teaching and discharge planning.

Many authors have explored the advantages, both economic and qualitative, of discharge planning (Bowling & Betts, 1984; Potterton, 1980; Rasmussen, 1984; Romano, 1984). Almost without exception studies identify two major deficits in the content and process of care and discharge of the elderly. Firstly, they report a lack of communication between the hospital and community health care providers. It seems as though lines have been drawn around the perimeter of the hospital which repel admission of alien personnel. There tends to be limited flow of information between hospital and community staff. As well the knowledge base of hospital personnel about facilities available within the community is often deficient. Patients are seen to "belong" to the hospital and input from professionals based outside of the institution is often perceived as intrusive. There is a need to develop a semi-permeable membrane around the hospital to allow osmosis of information and personnel.

Secondly, there is lack of consensus about who should be the primary care-givers on discharge. Research has highlighted the need for critical attention to be given to this problem which contributes significantly to the fragmentation of service provision (Howe, 1981;
Kendig, 1981). The community health nurse (CHN) is identified by Bremer (1989) and Kromminga & Ostwald (1987) as the appropriate person to be the primary care-giver and in a better position to identify client needs.

A critical component of the health teaching and the planning for the discharge of the elderly is assessment of their ability to manage their activities of daily living. Tools appropriate for the assessment of A.D.L's are addressed by Gresham & Labi (1987), and it is apparent that the tool should be sensitive enough to highlight the total needs of the elderly. The determination of health status in the elderly is complex and, while improving, is limited. It begins with the difficult problem of defining health, which has already been discussed in some detail, and then in determining the most important elements or dimensions impacting on the elderly person. Isaacs & Neville (1976) comment on the skill and experience of the interviewer as an important element in the assessment of the elderly. The major focus of most assessment tools is physical needs. Further attention must be given to the dimensions of social and intellectual health. Health professionals lack of knowledge about theories of aging may explain the lack of attention given to these facets of care.

Neidlinger et al (1987) undertook an evaluation of a discharge planning protocol for the elderly. The plan, which used a team approach, was devised by a gerontological nurse specialist. The evaluation showed the efficacy of the protocol. Several advantages were noted. Firstly, economic gains to the hospital improved with the plan in place. The economic gain for the hospital was based initially on earlier discharge of the elderly. As a result of good planning of the care during and following hospitalization, there was also a reduction in the re-admission rate. Secondly, the community health resources required to meet the needs of the elderly were used more effectively. It was concluded by Neidlinger et al that "...certain DRG categories could be targeted" in future research on discharge planning. Appropriate planning for discharge should discourage premature discharge. If discharge
planning to achieve optimum recovery fails, re-admission to hospital is highly likely. The end result of this process is increased cost to the community, and more importantly a decrease in the quality of life for the individual concerned. The ability of the elderly to function at a high level of independence and well-ness should be the primary goal.

2.3 LEARNING TO ADAPT

The adult human being becomes a marvellously adaptable, competently functioning person within a complex society. How he progresses to this point from a beginning as a highly dependent, relatively noncapable, newborn infant is a question of great intellectual interest and importance. (Gagne, 1973, p 1)

Whilst Gagne concentrates on the conditions in which learning takes place, he also lays a good foundation for our understanding of the importance learning has for development of the individual. Learning has the ability to improve that image we have of ourselves. Adult self-directed learning, "...suggests associations of freedom, autonomy, independence and learner primacy" (Brookfield, 1985, p 19). For the elderly, these are valuable goals which are intrinsic to their acceptance of responsibility for their own health.

2.3.1 Can we teach old dogs new tricks?

The ability of the elderly to engage in learning depends on the same precursors as it does for any other individual: motivation and self image as a learner. The development of an image of one's learning abilities is acquired from previous formal and informal learning situations and is often reflected in the level of education attained. The elderly are as potentially capable of learning and subject to the same limitations as any other group. The only impediments to their learning capacity are ill-ness, lack of motivation and a poor self-image as a learner. Studies with the elderly have shown that,
...in relation to older people's intelligence the average decline was negligible until the
ninth and tenth decades, when the loss reached approximately two per cent per annum.
(Russell, 1987, p22)

The assumptions that society makes about the capabilities of the elderly are central to
opportunities for learning and how that learning is structured. The potency of knowledge is
beyond dispute, to withhold knowledge is to control individuals, and to inhibit their growth
and development. Some theorists would go further with that argument. Boyer, discussing
Knowles' and Rogers' theories of adult learning points out "...a goal of education if we are
to survive in a rapidly growing society, is the facilitation of change and learning" (Boyer,
1984, p 69). For the elderly the need to learn, in order to survive is possibly more important
than we have previously recognized. The ability of this generation of the elderly to change
and adapt has been tested with major crises. The economic depression in the late 1920's
early 1930's had an enormous impact on development and values. An eighty year old man of
today was in his late teens at that time. Employment opportunities for men were low, for
women almost non-existent. Food was scarce, and housing arrangements mostly limited to
renting. If you were lucky enough to have a job, you stayed with it. The degree of personal
satisfaction gained from that job was an indulgence most could not afford to consider. What
learning took place in this milieu of poverty and challenge? Acceptance of imposed
conditions, challenges to norms and values, adjustment to crises, and separation from family
support, were characteristic of the learning that occurred during the depression.

The second world war placed even greater pressures on survival skills. Women during that
time, learned to assemble aeroplanes, to farm, produce munitions, and to fill whatever gaps
had been left by the men who went to war. Men, many scarcely twenty years of age, were
sent into combat zones to deal with situations which were horrific, and from which many
never returned. Many who did return brought with them sleep-disturbing memories, fears,
grief, pain, and a premature maturation, too suddenly and without consent. These men came
from a generation characterized by clear stereotyping. Men were men, and did men's work,
women were women, and did women's work. In their absence all of that had changed, and constituted an added burden of moving back into the life they had known prior to the war. This generation learned many things. That learning came with difficulty, there were few guidelines to help, and they adapted as best they could. Now in their later years, facing rapid and considerable social, cultural, economic and environmental change we have reason to assume that they can adapt again if provided with appropriate information and support.

2.3.2 How are the elderly different as learners?

Knox (1977) talks of "fluid" and "crystalline" intelligence. He makes a distinction between pedagogy, or how children learn which he describes as fluid or un-set, and crystalline which has connotations of wisdom, reflection and experience which is more characteristic of an adult learning set. All theorists of adult learning or androgogy, make the distinction between these two quite diverse styles of learning. Knowles (1970, 1984a, 1984b), in his discussions around the issue of adult learners, highlights the importance of involvement with decision-making in planning and participation in learning. Adults are usually highly motivated to learn. The immediacy of application of knowledge is an added factor which enhances their capacity to absorb information. The elderly must be seen as active, intelligent and able to be responsible for their own care. The basis of all theoretical propositions about learning is the acknowledgement of the individuality of learners. Appropriate assessment of the elderly, requires a particular acknowledgment of that individuality.

Unlike children, who have no prior experiences to draw on, adults bring with them the ability to transfer problem-solving skills learned in previous experiences. Learning which accompanies maturation, experience, and self-exploration is not generally acknowledged by professionals. The elderly are advantaged in that they are able to step outside of the
boundaries which restrict the young. Attitudes and values which can be quite rigid when one
is younger and in need of reference, or group support, become more fluid with age.

A further distinction to be made about how adults learn is in the way material is presented.
The style and pacing of learning has particular significance for the elderly, given that the
responses of the elderly slow with increasing age. Kim & Grier (1981) conducted a survey
of medication instruction for the elderly and found that, with a slowing of the "pace" at
which information was given and when a response was required, learning improved. Not
only was there a greater retention of knowledge about medication, but they demonstrated
with a pre and posttest, that there were fewer errors in administration of medication. This
trial was conducted using a control group who were given instruction at a "normal pace".
Kim & Grier concluded, "As evident in the literature and in our study, speed of instruction is
a major variable influencing learning in the elderly" (p 467).

2.4 SUMMARY

Hanna proposes that the usage of the word "age" has been corrupted,

From its Latin root and through French and English history "age" has meant simply a
period of time: young people are just as "young aged" as other people are "middle
aged" or "old aged". The word age is a neutral term designating any period of one's
life. (1982, p 17)

Physical and mental disease can occur at any age. In that sense we are reminded that, "...the
only characteristic which distinguishes all old people from all other people, is the effect of
biological ageing" (Brocklehurst, 1987, p 29). Dependency and interpersonal stress is often
the result, and the assumption that the elderly are the only dependent, non-productive, and
expensive group in the community should be resisted.
At this very instant all of us are growing older. For those who believe in the myth of aging, this is an occasion for sadness. But for those who understand the practical necessity for a myth of growth, growing older is an occasion for rejoicing, for it means that the older we are the more we have grown. (Hanna, 1982, p 20)

Health professionals need to be cognisant of the range of possibilities in old age. The majority of elderly people are independent and outside the health service umbrella of disease and disability. Encouragement for the elderly to remain healthy, early detection of disease, and strategies that will minimize the effects of chronic illness are valuable goals. Attention to the environment of the elderly person, a commitment to health promotion, and a realistic view of the capabilities of medicine will lead to a better understanding of the elderly and their needs.

Involvement of the elderly in identification of needs, program content and implementation, would focus care and preventive measures in an appropriate direction. Acknowledgement of the learning capabilities of the elderly, the need to pace information at a manageable level, and using the considerable resources that the elderly bring to the learning environment will ensure the best possible interaction between professionals and the elderly.
3.1 SOCIAL VIEWS AND THEORIES ABOUT THE ELDERLY

The elderly in western countries have become the focus of attention for politicians, health professionals and economists. The increase in numbers of the elderly highlights the need to concentrate on the issues of old age in our society. Sociologists have defined the elderly, along with youth and the unemployed, as a sub-culture (Becker, 1963; Goffman, 1961). As with any sub-culture the aged are seen to possess certain characteristics that distinguish them from the rest of the community. These characteristics are examined by Radford (1987). He describes a range of "myths" about the elderly which include, "unproductive, asexual, senile, and ineducable".

Many of these misconceptions present the elderly as stagnant, worthless, inflexible and generally a burden on scarce resources. Smith (1988, p46) questions the accuracy of some studies of the elderly:

These fallacious studies, of a limited and unhealthy older population helped to create the pretence that ageing and old age are characterized by illness, dependency and physical decline.

Many studies have shown the elderly to be not only extremely active, but to have a high sense of well-being and purpose to their lives (Ruffing-Rahal, 1989; Vauclay et al, 1984). It is clear that a wide range of opinion about the elderly exists. These diverse attitudes exist in the minds of health professionals, economists and politicians as they do in the general community. A factor which must also be borne in mind is that the elderly are not a homogeneous group but are diverse in experience, circumstance and potential. Several theories of the social process of aging have been proposed. The three major theories are those of disengagement, activity, and social integration.
3.1.1 Disengagement.

The theory of disengagement was originally formulated by Cumming & Henry (1961). They studied 275 people between the ages of 50 and 90 who were "...in good health and had the minimum money needed for independence". The theory of disengagement focuses on decreased interaction between the elderly people and individuals within their social environment. The degree of disengagement, and the groups from whom they disengaged was variable.

Theorists from the Functionalist tradition like Parsons (1967), viewed this process as necessary to maintain the equilibrium of society and satisfy the needs of the social system. Further he saw that it, "...freed the old people from ascriptive ties, which is a central theme in the development of advanced societies". This theory has generated much discussion and debate. One of the critics of the theory Hochschild (1975), saw it as providing an "escape clause". This criticism could be interpreted in two ways. Firstly, disengagement might be accepted as such a legitimate process of aging that it could preclude essential medical or psychological examination, and secondly it gave license to those aged who chose to withdraw from social interaction to do so. A further criticism made by Hochschild (1975) was that the sample studied by Cumming & Henry was not representative of the older population. Other critics concentrated on the claim of disengagement being inevitable and universal. Rose (1964) suggested the theory was ethnocentric and applicable only to industrial society. Further criticism made by Maddox (1964) argued that the theory did not address the personalities and temperamental differences found amongst old people.

Other critics of disengagement are the Marxist sociologists. They argue that within capitalist society where people are valued primarily in economic terms, the elderly, who use rather than contribute to the economic resources, are poorly valued. Not only are the aged de-valued,
but the society belittles and discriminates against them to such an extent, that they disengage from the set of social conditions experienced as "...predominantly...stigmatizing and neglectful" (Phillipson, 1982, pp x - ix). The logic of capitalism as a productive and social system is at odds with the needs of the aged. The most pertinent criticism of the theory of disengagement is that it is probably a reflection of lack of mental and social stimuli, rather than of age per se (Atchley, 1971; Kerns, 1980). Whatever the cause for disengagement, it diminishes the ability to participate in health education programmes. The challenge raised by the observation of disengagement among at least some of the elderly is restoration of their self esteem.

3.1.2 Activity theory.

Activity theory was born in early studies conducted by Havighurst & Albrecht, (1953), Havighurst, (1961) and Kutner, (1956) who found a strong relationship between remaining active and being happy. It is significant that those early studies recognized the importance of factors which contributed to the holistic health of the individual. Much of the literature relating to the elderly pays scant attention to the fact that physical, social and intellectual stimuli promote well-being and better mental health.

The need to maintain good mental health is borne out by research done in a psychiatric hospital in Australia where over 30% of the admissions to the psycho-geriatric ward were found to be inappropriate (Western, 1983, p311). The admission of these elderly people was on grounds of confusion or depression. It was concluded that mental hospitals "...are being increasingly used as depositories for...elderly people" (op cit p, 311). Apart from the economic cost to the health care system of unnecessary admission to expensive hospital beds, the cost to the individual in human terms is inestimable. The elderly already struggle against the label of "senility" without it being confirmed fallaciously by a medical diagnosis.
A study undertaken with a group of elderly people in a geriatric nursing home showed that a combination of high level of mental and physical activity, and planned visits from undergraduate social work students significantly affected both the health status and "zest for life" (Haemmerlie & Montgomery, 1987) of the group. Aligned with that was an obvious slowing of the rate of long term decline compared to a similar group of elderly in the nursing home who had not been exposed to those conditions of stimulation and visits. In the follow up period which ended after twelve months, the changes in the control group were maintained. This study involved the elderly themselves in making an assessment of how they felt. This approach of activity, stimulation, and involving the elderly people in self-assessment is a key issue for professionals who work with them.

The potential to be found within activity theory was recognized by Clark & Osgood (1985) when they involved elderly people in the theatre. It was their belief that this art form would appeal to and stimulate the elderly. It did more than that, it opened the way for them to involve themselves in theatre productions. Some contributed to costumes and scenery; others acted in the plays and displayed talent untapped until then. Research into well-being as opposed to ill-health of the elderly, has been recognized to be "conspicuously absent within an Australian context" (ACOTA, 1985, p 399).

3.1.3 Symbolic Interaction and Social Integration theory.

The theory of social integration gained popularity within the symbolic interactionist school of sociological theory. Symbolic interaction theory emphasizes the importance of communication and interaction with others in development and maintenance of self-concept and self-esteem. Social activity is seen as the very core of activities. Along with that belief are certain assumptions regarding social reality and self-identity. Berger & Luckman (1966);
Blumer (1969); McCall & Simmons (1969) identified these assumptions. Firstly, there is a complicated process by which the social interaction develops the identity of self, of others and the situation. Secondly, through repeated interaction in similar situations a more definite and stable definition of one's self evolves. Thirdly, there are modifications made to one's identity as the individual, situation and others involved in that interaction change. Finally, the removal of individuals seen as "significant others" will require a reformulation of the identities that have been formed.

This theory sits very comfortably with the commonplace observation of the constant shifting and re-organizing undertaken by all individuals. Indeed, whilst this theory is applicable across the life span, it is specifically relevant to the elderly who experience immense changes in their lives. Loss of job, income, esteem, power, loved ones and even possessions, compound in a way that requires a fluidity in their social reality. The theory of social integration is highly relevant to the study of the elderly, for it explains the feelings of isolation, and sense of value; and gives an insight into why some old people might move into disengagement.

Durkheim when he wrote of suicide (Spaulding, 1951), defined the need for social integration in order for the individual to find a sense of meaning outside of oneself. This concept involved the need of individuals to connect with other members of a larger social group. He stated that,

A society, group, or social condition is said to be integrated to the degree that its members possess a "common conscience" of shared beliefs and sentiments, interact with one another, and have a sense of devotion to common goals. In a condition of weak integration, life derives no meaning and purpose from the group. (quoted in Johnson, 1965, p 876)

Gerontologists, with a background in sociology, have applied the principles of this theory in an attempt to explain the dynamics of elderly living in both retirement housing and other age-
related accommodation. Roscow (1967) found that morale amongst elderly people in retirement housing was higher than among those living amongst other elderly people, in the general community. This difference was explained by Roscow "...to the extent that integration into groups is related to residential concentration, identification will similarly be correlated with density" (1967, p 261). He was suggesting that high density exposure to one another reaffirmed both the individual and group's values and norms. There was, in other words, strength in numbers.

Further social gains cited by Roscow were opportunities for remarriage, generation of new activities and a lack of pressure to compete with the younger world they lived in. In terms of those elderly who lived within apartments or housing outside of the retirement villages similar scenarios were described, even though their life satisfaction and morale was marginally lower than their peer group within the village accommodation. Hochschild (1975) conducted qualitative studies of a small group of residents within one of these "age-saturated" communities. He found a high level of interaction and reciprocity of services amongst them, "...the many small, quiet favours, keeping an eye out for a friend and sharing a good laugh" (p 409) contributed to their high sense of belonging. This strong "sense of community" was also reported in a comparative study of planned retirement communities conducted by Osgood (1982).

3.2 HEALTH PROFESSIONALS' ATTITUDES

3.2.1 The Culture of health professionals.

Health professionals share the common beliefs about the elderly which predominate in the community. Those beliefs influence the care they offer. Geiger (1978), undertook a comparative analysis of American social work, law and medical students and their
perceptions of the elderly. Questions centred around their knowledge of the aged, and the aging process, and whether they would want to work with, or for them. It was disturbing, but perhaps not surprising to find that the knowledge base of the students in each of these disciplines, was poor. When asked to rank order groups of people to work with, the elderly rated last on the list for medical students. They preferred surgical, paediatric and obstetric patients rather than working with the elderly. Sadly, 88% of medical students in this survey would only consider working with old people as a last resort. Social work and law students displayed more knowledge about the intellectual ability of the aged than the medical students. "Eighty-six percent of social work students agreed about intellectual ability being retained in old age, whereas 59% of law students and only 35% of medical students did" (op cit, p 592).

These attitudes may well be the result of the deficit in the medical students' curriculum. The particular American university in which the survey was done, however was one of the most prominent institutes in the world of gerontology. Despite that, "...only one course in the medical school provides the future doctor with several lectures on aging" (op cit, p 594).

The need for academic institutions to respond to the demography of sex, race, and increasing numbers of aged is critical. Australian health professions training has responded to this need to some degree during the 1980's but significant scope for improvement remains.

Undergraduates, especially those in the health allied professions, should have early exposure to healthy, active elderly so that positive attitudes about them might be developed. The combination of poor attitudes about the elderly and a lack of focus on health promotion in the delivery of care by health professionals results in a deficit in care.

Whilst Elford reassures us that medical practitioners can not, "...consider themselves to be individual moral agents" (1987, p 103), practitioners generally set their own parameters of practice despite the perceived sanctions from within their professional bodies. Delivery of care is self-directed, and free from outside evaluation. To that extent they define their role
with consumers, and it may vary from one individual practitioner to another. The interaction which results brings the doctor status, respect, special privileges and pecuniary rewards (op cit, p, 98).

For all the reasons discussed, the agendas of health professionals are often at variance with those of the consumer. Pragmatically speaking, the doctor does not save lives, he may only prolong them (Evans, 1990, p 80). In reality Evans states that sometimes even that is not possible. Further it is claimed that, "...modern medicine was not necessarily ineffective, but that its effectiveness had been 'under-investigated'" (Cochrane, quoted in Palmer & Short, 1989, p 51). Treatment prescribed can often be more injurious to the individual than the disease itself. An increase in reported iatrogenic effects of medication, surgery, and other intervention is the risk of new scientific discovery. It is into this daunting arena that the elderly step, with some trepidation, and few skills to deal with its complexity.

3.2.2 Health professionals as health educators.

Given that health professionals tend to practise in curative or maintenance paradigms, it is not surprising to discover difficulties in their acknowledgment of the value of health promotion for the elderly. A major factor contributing to the abandonment of the teaching role by nurses, and other health professionals in the context of care of the elderly, is the negative sociological view of the elderly. Embedded within the literature about teaching of the elderly is a common belief that they have a decreased capacity to learn - a belief disproved by numerous studies (Knox, 1977; Picton, 1987; Smith, 1988). Health professionals also lack commitment, confidence and time, all of which contribute to this deficit in care of the elderly (Myers, 1988; Simmons, 1986; Wilson-Barnett & Osborne, 1983). The teaching of the elderly tends to focus on crisis situations, and there is little commitment to preventive health
strategies. Many professionals admit to an intellectual acquiescence to the inevitable disabling conditions of the elderly.

Lack of attention to health promotion has been addressed by Kane, (1990); Kickbusch, (1989); Lindeman, (1988); Markey & Igou, (1987); Pender, (1974). The issue of level of education and information given by health professionals has been addressed in Chapter 2 but added to that are several other considerations. Written information given to patients has been found to be poorly understood. Lindeman noted that, "...only 22% understood the literature written at eighth grade level" (1988, p 32). Language used may be either unknown or poorly understood by the elderly, the size of print, and interpretation of symbols, may all confuse.

Time constraints, cost involved in providing health education programmes when elderly people are hospitalized, and lack of support by physicians are also reasons for failure to provide appropriate health teaching (Markey & Igou, 1987). Professionals often lack the confidence to undertake this teaching, and may use these excuses to rationalize their failure to undertake the responsibility. Some of this failure may be reflected in the "victim-blaming" which is described by Labonte (1986). Blaming the victim for illness makes certain assumptions. Firstly, that the person knew what to do in order to prevent the particular disease. Secondly, it overlooks the fact that concern for health may not be the strongest, or most immediate concern. The elderly, whose chronic illnesses result from poor health habits in adult and middle age may not have had access to information when it would have helped them protect their health (Smith, 1988). In educational terms, it also assumes that having "told" someone what to do, is enough. It therefore allows the health care system, or society, to wash their hands of the responsibility (Better Health Commission, 1986, pp 37 -38). Victim-blaming has lead to a degree of inequity of care, and reduced access to resources for the elderly and other disadvantaged groups (South Australian Health Commission, [S.A.H.C.], 1988). Although governments and service providers have addressed these
difficulties in position papers, it is at the grass roots level of care that the attitudes of health professionals toward the elderly have their most potent impact. Ensuring that attitudes about the elderly do not inhibit the delivery of a high quality of care is a challenge for health care providers. Attitude change, therefore is a high priority in basic and continuing education.

3.3 SUMMARY

Jones describes "Self-motivated 'busy' people" as having a positive attitude about their health (1989, p 15). Elderly people who are in good health have positive attitudes toward aging (ACOTA, 1985). For those elderly who report themselves to be either in "fair" or "poor health" aging was seen in negative terms. The stigmatising influence on old people of disabling conditions often forces them to withdraw socially. Locker describes the "stigma of disability" in terms of some diseases that are "clean" and others that are "polluting" (1983, pp 135 - 137). Conditions such as heart disease, may well be seen as "clean" or acceptable as they do not intrude on the elderly persons interaction. However it could be extrapolated that deafness, reduced mobility, and "difficult" old people might attract a "polluting" or stigmatised label.

The range of social views and theories of aging is extensive, so too are the individual differences amongst the elderly themselves. Unimpaired elderly need experience few limitations. Old age can be a time of new opportunities and friendships, challenges and a chance to excel at untried activities. It can also be a time of detachment, despair and abject loneliness. Health promotion strategies can assist in raising the public consciousness about the aged, their differences, and potential. In that sense, "The moulding of a social milieu that promotes enlightened self-interest is not a public denial of personal rights but rather a public responsibility to the individual" (Better Health Commission, 1986, p 39).
An understanding by health professionals about the aging process and sensitivity to the needs of the elderly is of paramount importance. There is a need to ensure that curricula for all health professionals contain theoretical and practical content that sensitises students to the needs of the elderly. Acknowledgement that loss of independence and self esteem creates a downward spiral effect on the elderly/disabled is crucial for appropriate assessment, diagnosis and treatment. If the health status is not kept in balance, "...their disability becomes the pivot around which interaction with others revolves" (Locker, 1983, p 139).

The health care system needs to respond to the elderly in a more informed sense. Whilst much has been achieved in this area deficits still exist. In the provision of services cost is the strongest pivot around which decisions are made. The elderly, are the most expensive consumers of health care services. This generates a moral dilemma of delivery of expensive services to the elderly which has been argued eloquently by Elford (1987) and Evans (1987). The core of their discussion is the value of the elderly compared with the young in our society. That vexing and complex issue remains unresolved and will command increasing attention and public debate.
CHAPTER 4 - CASE STUDIES - RATIONALE AND METHOD

4.1 GROUNDED THEORY

This study is qualitative and inductive. From a symbolic interactionist perspective grounded theory provides a way to study and understand behavior and interaction. Definitions of social reality emerge during the exchange between researcher and participant. Often the issues discussed during this exchange have either been poorly understood by professionals or not addressed at all. The grounded theory approach is, "...useful to health practitioners where the interaction with the health care system is only one factor in how a health care problem is managed" (Chenitz & Swanson, 1986, p 7).

Elderly peoples' perception of health education undertaken in the process of discharge from hospital to home has attracted little attention from researchers. It is in this sense that grounded theory as an approach to generating new perspectives was chosen for this study.

The use of grounded theory, was formalized by Glaser & Strauss (1967). Prior to 1967 similar approaches to those described by Glaser & Strauss were used by a number of workers. Becker et al (1961), for instance had conducted research into the culture of medical students. They described their inquiry as "unstructured" and as having "no design". In fact, the research design was one in which grounded theory was developed, although that term was not then used.

The analysis of data collected using a grounded theory approach requires a series of structured phases, outlined in detail by Glaser & Strauss (1967). They described qualitative research as "analytic induction" (1967, p103). Data are collected using participant-observation and informal open-ended interviews. McCracken describes these long
interviews as "...designed to fashion a relationship between investigator and respondent that honors what each part should and should not give to the other" (1988, p 65). The interviews are flexibly structured, where "...ideally, the respondent does most of the talking" (Babbie, 1986, p247). Another description of the interviews by Chenitz & Swanson (1986, p79) is "...conversations with a purpose". Information derived from the interviews leads the researcher to pursue whatever path will lead to an understanding of the social reality and to the formulation of theories (Becker et al 1961; Glaser & Strauss, 1967; Munhall & Oiler, 1986; Stern, 1980). According to Van Maanen (quoted in Yin, 1984, p 25) the essence of qualitative research is "...the attempt to avoid prior commitment to any theoretical model".

Variables which the quantitative researcher is aware of, and controls, are mostly unknown by the qualitative researcher. The skill of the researcher in this method is not just in the reading and re-reading of the data to discover the codes and theories, but more importantly in the ability to put aside personal values and bias to allow unimpeded emergence of those codes and theories. The process of analysis leads to the emergence of core categories, conceptual density and eventually the formulation of theory. This type of inquiry proliferates hypotheses, and this proliferation of data and theory is a problem for qualitative researchers. These issues will be addressed in the next section.

4.1.1 Theory development.

What is a theory? At a very basic level a theory is "...a hunch, a guess, a speculation or an idea that may explain reality" (Field & Morse, 1985, p 2). In more precise terms, a theory could also be defined as "...the researcher's perception of reality in which constructs and concepts are identified and relationships are proposed or predictions made" (op cit, p 3). Whatever definition one chooses, the most important point is that a theory remains a conjecture. Theories are open to refinement, redefinition and refutation.
However qualitative data are analyzed, whether painstakingly by the researcher or by a computer programme, the end result is the emergence of themes, codes and eventually, propositions. These propositions lead the researcher into the formulation of a theory or theories. A field worker, "knows what he knows" and, "in his bones" feels the worth of that final analysis according to Glaser & Strauss (1967, p 225). It is acknowledged that researchers are "theory-laden" or "theory-influenced" (Charlesworth, 1982, p 17). The researcher needs to be aware of individual bias when undertaking a path of inquiry that aims at generating theory, and also to acknowledge the learning/knowledge that is brought to the inquiry. This knowledge is described by Strauss (1987) as a positive factor. He uses the term "experiential data" to encompass all the "in the head" experience and knowledge that, for the researcher, is grounded understanding.

The developers of grounded theory caution the researcher about closing the inquiry too soon. There is the need to continually compare, integrate and code the in-coming data; the need to feel and see the "theoretical saturation" of information of which Glaser & Strauss (1967) speak.

4.1.2 Data Collection and Analysis.

Controlled sampling techniques are not employed in qualitative field research, and are, according to Babbie (1986), inappropriate. Purposive sampling, that is selecting those people who have most knowledge about the subject under study, is the most appropriate method. The term "theoretical sampling" is used to describe both the number and category of people the researcher includes in the sample. Determination of sample size in grounded theory is concerned more with "saturation" of information generated, than the numbers of subjects (Glaser & Strauss, 1967, pp 49-51).
The concept of "explanation-building" is the term used by Yin (1984) as a parallel to "saturation" of information. The other term used is "snowballing" (McCall & Simmons, 1969; Kennedy, 1984). This implies simply that during the course of interviewing, other people who are involved in or around the issues of the inquiry will emerge as valuable sources of information.

Lofland & Lofland (1984) suggest that the overall goal of qualitative data collection is to, "...collect the richest possible data and to earn an 'intimate familiarity' with that sector of social life which has 'tickled' your interest "(p 11). The richness of the data collected in the qualitative method of inquiry poses many problems for the researcher. The most pressing of those problems is the analysis of the data (Babbie, 1986; Becker, 1958, 1961; Dean et al (1969); Glaser & Strauss, 1967; McCall & Simmons, 1969; Miles & Huberman, 1984a, 1984b; Spradley, 1980). Two major difficulties are encountered. Firstly is the problem of voluminous amounts of material gathered, and secondly there is the need to show that the results have both validity and reliability.

Analysis of qualitative data involves looking at "slices of data", word by word, line by line, theme by theme. The notion of first level coding was posed initially by Glaser & Strauss (1967), and developed by Miles & Huberman, (1984a, 1984b). First level coding is used to build up a pattern that emerges from the data. It allows the grouping of categories, theories or concepts. The similarities and differences between information become clear. Some assumed or old information is reinforced, and new or altered combinations emerge. This emergence of new phenomena was discussed by Becker et al (1961, p 18), when they described the need to, "...use methods that would allow us to discover phenomena we were unaware of at the beginning of the research". The need for the researcher to be adaptable and
flexible is important. If a cage of intellectual commitment to known theories confines the researcher, new insights may be missed.

The subjectivity injected by both the researcher and the subjects themselves is central to concerns about reliability. One approach to increasing reliability is triangulation. Triangulation refers to the use of multi-faceted methods of data collection (Jick, 1979). Yin (1984, p 20) adds that "...various strategies (of inquiry) are not mutually exclusive". Reliability of data is also confirmed if they are consistent with previous studies undertaken and with the researcher’s own knowledge, or experiential data base. A further measure of the reliability of findings is found in testing of propositions or hypotheses that emerge with similar groups of individuals (Chenitz & Swanson, 1986, pp 12 -13).

Content of the information obtained through interviews can be validated with the participants. Providing transcripts enables the individual time to read and reflect. Clarification for both the researcher and the participant can then be undertaken at subsequent interviews. Validity is confirmed when particular themes and codes thread through interaction with participants. Yin (1984, p 137) adds that internal validation is enhanced by "Review of the draft ...by informants themselves". Collecting data from other sources allows further opportunity for the researcher to confirm that information is correct.

Whilst the experimental scientific approach ensures reliability and may be appropriate in physical sciences, in the social world where "reality is constructed" (Berger & Luckmann in Jennings, 1985, p4) its validity is open to question and a different approach is needed. Grounded theory is a most appropriate method to use when there are questions of "why" and "how" to be answered. It is the most valid and reliable technique for generating information that leads to formation of theories. In an attempt to establish the reality experienced by individuals, the researcher needs to move into their world of understanding and reality. It is
only as participant-observer that knowledge of the social world of people is understood, and able to be articulated with confidence by researchers (Kennedy, 1984). At the same time it poses practical difficulties. The intimacy of the contact made within the framework of participant-observer data collection requires from the researcher a high degree of objectivity. The multi-faceted nature of the inquiry necessitates a high energy input from the researcher and a diversity of activities not usually found within the quantitative method. Paradoxically the "...softer a research technique is, the harder it is to do" (Yin, 1984, p 25). There are, as McCall & Simmons (1989) describe "...some amount of genuine social interaction, some direct observation of relevant facts...some formal and a great deal of informal interviewing, some counting, some collection of documents and artifacts, and open mindedness in the direction the study takes" (pp 1 -2).

Reliability of the data in this inquiry was apparent within the emerging data from the elderly, their carers and health professionals. Validity was measured in two ways. First all participants were given transcripts of their interviews for review, and second the emerging data showed persistent themes and codes which described the experiences of the elderly. Reliability was dependent on evidence from other research about the elderly, and "in the head" knowledge of the researcher.

4.2 THE CASE STUDIES

A case study approach was taken in the collection of data. Interviews were usually conducted in the home of the participant, recorded and subsequently transcribed onto a computer data base. Information about hospitalization was available through records kept by community health nurses.
Six case studies were undertaken with three women and three men whose ages ranged from 65 - 76. One other case study was undertaken with a 29 year old carer. Two of the elderly women were either widowed or divorced, one lived on her own and the other with her son and daughter-in-law. Each of the others was cared for, in their own homes, by their spouses. Three interviews were conducted with each of the elderly participants.

All were recently discharged from hospital and referred to community health services. Subjects were contacted as soon after discharge as possible. Only those elderly who had been discharged no more than three weeks prior to the first interview with the researcher were considered. Community nursing services in a northern Wollongong metropolitan area provided names of potential participants. Nursing staff were asked to seek permission of the elderly to be participants in the study (Appendix A). Once that permission was obtained a follow up letter (Appendix B), a telephone call and visit were made by the researcher who was then able to explain more fully the time commitment and information needed. This gave the elderly person another opportunity to withdraw if he/she felt any reluctance to be involved. Following discussion with the elderly person, a signed consent was obtained. (Appendix C). None of the elderly who was approached by the community health nurse showed any hesitation in sharing their time and energy. No one withdrew from the research during the data collection time frame. Sadly, however, two of the men died within two months of completion of the study.

4.3 INTERVIEWING THE ELDERLY SUBJECTS

The data were collected over a period of six months. The interview questions were based on the issues surrounding the perceptions of the elderly about the information they were given on discharge which relates to coping with activities of daily life. The interviews were reflexive, allowing exploration of key issues as they emerged. A prepared list of questions
(see Appendix D) was used as a prompt to ensure that basic demographic and health data were obtained. The initial interview lasted for approximately an hour and a half. Given that this was the initial contact with the interviewees considerable effort was made to help them feel comfortable about the commitment that they were about to make to this research inquiry.

The first interview was an important time for both the elderly person and the researcher. It gave the subjects time to assess the involvement required of them, and to look the researcher over, which they did. From the researcher's point of view it provided the opportunity for commencement of the relationship with the elderly person and their carer. It also provided an opportunity to look at the physical surroundings, assess the relationship between the elderly person and their carer, and to form an impression of the elderly person. None of the elderly had been involved in this kind of interview before, and far from being anxious about it they seemed to enjoy the attention afforded them and the opportunity to talk about their life and experiences. In retrospect it was the neophyte researcher who needed most assurance. The researcher entered the field with "absence of threat and acceptable incompetence" (Lofland & Lofland, 1984, pp37 - 38). In the words of Hercule Poirot, cited in Lofland & Lofland, "I invite their gentle ridicule" (p 38).

Acceptance of the researcher by the elderly person and their carer was germane to how effectively the interviews proceeded. The subjects became a part of the researcher's life very quickly. The necessity to remain at an objective distance from the elderly and the needs they expressed at the interviews required continual intellectual acknowledgement by the researcher. That was an unexpected and potent force.

There can be a continual and often subtle sense of separation between the observer and the observed that is painful and poignant. For a creature as desirous of acceptance as homo sapiens, this can be hard indeed. (Lofland & Lofland, 1984, p 31)
Richness came not just from the willingness to share the fabric of their lives, but also from the wit, knowledge and experiences of these elderly people. Over and above that, came an expressed concern to help with the research.

Each elderly person was interviewed three times. The interviews were conducted in their own homes, often with their spouse participating. After the first contact, interviews took more time. On average two hours was spent at subsequent contacts with the elderly person, and there was difficulty terminating some of the interviews. Frequently the elderly person, and the spouse, used the interviews as a means of defusing some of the issues surrounding the recent hospitalization, and the problems that had ensued. Time was allowed for the elderly participants to just talk about themselves. Once they realised the researcher was interested in knowing them personally, flood gates of information opened. The sharing of personal history provided an understanding of their educational, socio-economic, and cultural background. That information formed the basis for explanation of how they dealt with increasing age, illness, health professionals and the health care system. As well, it provided the researcher with an overview of their networks, social activities, and interaction with family and friends. The gap between interviews was no more than two weeks. This time frame allowed the researcher to transcribe and send a copy to the elderly person. In most instances the elderly person and their carer had discussed the interview and had issues or questions that they wanted to pursue with the researcher. One of the primary goals of this inquiry was to identify those perceptions about the process of health teaching. Discussion around that issue became the central theme of much of the dialogue with the elderly people.

4.3.1 Recording data.

It was originally intended that data be hand-written at the time of the interviews and typed immediately afterwards. Fortuitously, at the very first interview, the elderly person
suggested that a tape recorder be used for subsequent interviews. The researcher had been reluctant to suggest a tape recorder for fear of inhibiting the dialogue and thereby risking the filtering of information given by the subjects. Interestingly all the elderly thought using the tape recorder was not only practical, but seemed to add to the importance of their input to the research. It was often difficult to separate the chat from the information needed to answer the questions posed by the researcher. Skills required of the researcher in interviewing are, according to Yin (1984, p56) being able to "...ask good questions...be a good listener...be adaptive and flexible". The constant cups of tea, asides in the conversation, and general interest topics that came into this time with them was very rich in terms of knowing each of them on a more individual basis. From then on, with their permission, all interviews were taped, transcribed and a copy of the interview returned to them for validation and comment. In keeping with the assurance of anonymity, names were removed from all information stored and each subject was given an acronym. Far from being cautious about the computer print-out that was sent to them, most of the elderly shared the information with relatives and/or friends. The recording of interviews, and the accompanying memos that were kept added to the tapestry that unfolded over the time spent with each subject. Reflection following each contact was a productive strategy for generating theory and future lines of enquiry. Reading and thinking about the written information, the non-verbal input, and intuitive feelings continued throughout the data collection.

The comments and editing of the interviews by the subjects allowed the researcher to validate information obtained. It also allowed the elderly person time to reflect on what they had said. The risk of that strategy was that some information was removed from the transcript once the elderly person saw it in print. They found some of it to be either too intimate, private or potentially hurtful to someone else. Even the data that were edited out by subjects allowed the researcher further insight into the social reality of that elderly person.
Participant-observation included attention to the social interaction, body language, environment, and level of intimacy between the subjects and their carers. Particular notice was taken of the interaction between the subject and their carer. The level of intimacy between the elderly person and their spouse/carer varied. One of the subjects apologised each time for the absence of her husband, and throughout the whole period of data collection he never appeared. He was usually outside in the shed working. Her explanation was that he was embarrassed because he suffered from a mild disability which inhibited his social interaction with people. In fact he was, according to her, a rather depressed individual, who did not interact very well with some of their children, nor with her. Despite the fact that they shared a house, she was very alone on a day to day basis, a fact that would not be recognised by many of her friends, and by only one of her children. At the other end of the scale, were spouses who did not leave the room whilst the interviews were being conducted. Those spouses involved themselves in the discussions, added pieces of information, reminded the subject of details that may have been omitted, and generally attended to the elderly person. Talking with the subjects and spouse/carer independently proved to be one of the more difficult tasks. Further comments will be made about the interaction with the elderly and their carers in Chapter 5.

Memos were compiled by the researcher after each interview. Thoughts, reflective comment, feelings and ideas were committed to print for further consideration as the relationship with the people developed. This collection of memos was made as soon after interviews with the elderly, carers and health professionals as was possible. Often the memos acted as triggers for the next interview, or highlighted some issue that was not fully discussed at the time. Memos contained comments such as,

Some of the thoughts that came through to me when talking with (subject and spouse) was the importance they placed on being positive and co-operative with health professionals. An attitude of quiet acceptance of the health professionals control and non-communication. That makes me so frustrated, I find myself apologizing to them for how things are in hospitals, all the time knowing that it really shouldn't have to be
that way, and how come we have not addressed the real needs of patients. We talk about quality assurance, patient needs etc it's all talk, well, most of it. How much has that attitude the elderly have about professionals impeded the amount of information they have and need, to deal with things at the moment?

There is a dichotomy here of how this person is operating. On one hand they (elderly and spouse) are saying "God's will be done, and you can't change that" and on the other hand "you will get what you pray for". Cognitively what it implies is an acceptance of whatever comes along; how would you motivate people with this kind of faith to learn and to change their life-style?

She's overweight, has smoked for 55 years, gave up 5 years ago. No advice from doctors about losing weight, or how important that is in terms of her cardio-vascular status. Why do we (health professionals) keep on making assumptions about whether it's worthwhile concentrating our efforts on people in terms of behaviour changes? It seems to me that the general practitioner (GP) just sees her as a nice person who probably doesn't think about a great number of issues: that isn't the case. Can't he see that? Can't he recognise the fact that she gave up cigarettes, by herself, after 55 years is a significant change in behaviour? She wants to live for another ten years.

This man needs no help from us (health professionals) he has made major changes to his life, without any health education advice following major surgery. He is an active man, mind is keen, he loves to problem solve. Sees life as a precious, and enjoyable commodity. His family are all-important to him, they are around him all the time, sons, daughters-in-law, grandchildren etc. His wife just loves him, he was showing her how to cook something when I arrived, it was kind of cute listening to him. She seems more reserved and not very comfortable socially, he is as gregarious as can be.

Some of the memos were light, observational comments, while others ranged into complex problems of educational motivation, lack of appropriate information, and acknowledgement of positive perspectives of the elderly peoples' lives.

4.4 DATA FROM OTHER SOURCES

Additional information was gathered from the care-givers and others providing support. Three carers, and sixteen health/helping professionals were interviewed. It proved to be too difficult to organise private interviews with the other carers. The major problems were the dependence of the elderly person on their carer, and the physical closeness in the housing
arrangements, which impeded conversation taking place with the carer that was not overheard by the elderly person.

4.4.1 Health professionals

The health professionals included a general physician, physiotherapist, nutritionist, health education officer, general practitioner, discharge planner, community health nurse practitioner/manager and occupational therapist. These professionals were interviewed to validate emerging theories, and to add another perspective to the data. Information from these interviews allowed the researcher insight into the knowledge base of, and sensitivity to, the needs of elderly people by health professionals.

Some of these professionals were hospital based and others worked in the community. The focus of the interviews with them centred on their philosophy of care, degree of exposure and involvement with health education of the elderly. Again a tape-recorder was used to record data and a print out was sent for validation. All of the health professionals responded thoughtfully, both at interview and then in their response to the print out. Many of them added comments to the initial interview when they returned the data to the researcher.

These discussions provided insight into the practices within the hospitals and community, and the communication between the various health services. They also provided further opportunity to validate the experiences reported by the elderly during their hospitalization. Choices about which professionals to interview were related to those who had the most contact with the elderly. The snow-balling effect lead the researcher into contacting various people around the Wollongong area.
Memos were made following interviews with each of the professionals and again, provided the researcher with complementary views or views which varied from those of the elderly people.

Community health nurse...validated most of the interview and thoughts about Mr and Mrs RC, that was useful, it made me feel that I was 'on track' so to speak. Useful to do that for many reasons other than validation of what they had said and how I had interpreted it, but also to affirm a few details that were not clear to me. Those issues revolved around the discharge process, previous contact with the family, nurse's impressions of coping abilities of the family etc.

...reminded me that it would be good to talk with the discharge planner, I will do that in the next few days. The form used (to provide information from the hospital to the CHN) appears to be impoverished, does not supply detail around a 'needs' basis. That is quite interesting given that a nurse specialist is doing that (discharge planning) job. I'll clarify that issue when I see her.

...the reinforcement from the CHN about how unapproachable the surgeon is, seems that there is little dialogue between him and patients/staff. Communication between CHN and hospital, poor apart from what goes on between the discharge planner (DP) and the CHN personally. Usual story, we need semi-permeable membranes instead of hospital walls.

Memo following interview with the DP not a great deal of thinking has gone on in terms of where everyone fits, some issues such as possibilities for CHN involvement-they could come into the hospital, invite them in. Hospital staff would have to initiate that as it's very much a matter of territory-the CHN needs to be invited.

Information from health professionals strengthened and validated data from the elderly people and their carers. It also added to, or refined some of the emerging themes and codes. At a very early stage in the writing of memos, the "snow-balling" effect became obvious. The memos acted as a trigger to contact someone else, for further information.

4.4.2 Carers.

The logistics of talking to carers on their own were difficult. Two of the carers gave very frank and revealing interviews, but arranging to meet with them required considerable
sensitivity. In spite of their willingness to be honest about the frustrations of the constant care and responsibility for the elderly person, there was a sense of disloyalty in verbalizing those feelings. It was necessary to reassure those carers that these feelings were in common with other carers. Despite that reassurance the carers took great care in affirming the worth and value of the elderly person in their care in order to balance out their comments. The carers were interviewed twice. At the initial interview time was spent making the carer comfortable in sharing feelings related to the burden of care. Assurance about the commonality of those feelings was difficult to convey. Information about how long they had been giving care, how the intensity of that care had altered over time, and the impact on the lives of themselves and their families were the major areas of concern for each of the three carers. The second interview with each was conducted within a week and was used to pursue the issues the carers had raised at the initial interview. In each case a copy of the interviews was sent to them for validation. One carer, who became a case study participant, was interviewed at home. Initially this carer's mother was to be part of the research, however when arrangements to interview the mother were made, the elderly woman was hospitalized. A decision was made to make this carer one of the case studies. The sense of freedom in those interviews contrasted with those with the other two carers. Memos which followed some of these three contacts were;

Has taken on the care with a sense of it's the right thing to do and would not put her mother in a nursing home unless it became absolutely necessary. States she could not cope with the thought of caring for her if she became senile, and would put her into care then. Having stated that, then talked a great deal about how guilty she would feel about that decision. Has given up a great deal of her own activities prior to her mother becoming ill, and seems to welcome the diversion/purpose that the caring for her mother brings. Is good at getting what she wants in the way of information from the health professionals. Good backup from the GP who is very supportive and takes a great interest in both she and her mother. The GP doesn't seem to recognise the impoverishment of this young carer, she is only 25 years old. Nice looking woman, she smokes, is obese, asthmatic and quite content to just let her life flow by. Is that OK?

Felt embarrassed to say anything about the mother-in-law. Is conscious that she (the elderly person) is a charming lady who gets everything she wants, and is really quite easy to get along with. That aside, she (carer) feels that she's been left with a big load
to carry. She wasn't working at the time Mrs BE moved in with them. Mrs BE's daughter is in Sydney, has a professional career and two children to bring up on her own. It seemed logical that she come and stay with the son and herself. The son (her husband) is a pretty 'macho' man, that was obvious when I've visited the home. The carer on the other hand is fairly laid back and takes life pretty much as it comes. Would not do this again. Whilst it hasn't disrupted her life too much, she has not allowed it to, it has nonetheless become her major focus. She feels sad that she has lost the friendship with her mother-in-law, in a sense, as unfamiliarity has tended to breed contempt. The amount of charm, and manipulation that I have seen exhibited in this home is finely tuned. The blue-eyed (hence the BE acronym) just looks right at you, attends very well in conversations, talks about many things, and within a short period of time, has you eating out of her hand. Clever lady.

These memos are self explanatory, and added insight into the relationship between carers and the elderly. The carer of Mrs BE did not allow me to tape any conversations, and remained quite uncomfortable at sharing the intimacies she did. As a result of that, sensitivity required that a tape recorder was used at interviews with only one of the carers. In that instance the carer had made quite cognitive choices about taking on the caring role and appeared to be comfortable with both the role, and the problems attached to that role. More detailed information is presented in Chapter 5 about the interviews with carers, and health professionals.

4.5 THE SOCIAL CONTEXT

The city of Wollongong is a part of the Illawarra region. The region is located on the south coast of New South Wales, 90 km south of Sydney, the capital of that state. The Illawarra comprises an area governed by three municipal councils. It is the second most populous non-metropolitan area in Australia. The residential area between central Wollongong and its northern suburbs is contained within a narrow 27 km long strip between the coast and the mountains. The major travel route in the area passes through heavily populated suburbs in the south, and winds around the base of the escarpment in the far north. Public transport offers a poor means of travel for aging people who are either unable or unwilling to drive in such demanding conditions. The hilly topography in many areas also creates access
problems for aging people with poor mobility (Gillies et al, 1987). The population of 239,000 is predominantly working-class. These figures are presented in Table 3.

Table 3  
Regional Comparisons, 1981.

<table>
<thead>
<tr>
<th></th>
<th>Prof/Tech/Admin Occupations</th>
<th>Clerical /Sales Occupations</th>
<th>All 'Blue-Collar' Occupations</th>
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<tr>
<td></td>
<td>M   F   T</td>
<td>M   F   T</td>
<td>M   F   T</td>
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<tr>
<td>Kiama M</td>
<td>25  31  27</td>
<td>11  43  22</td>
<td>58  21  46</td>
</tr>
<tr>
<td>Shellharbour M</td>
<td>9   15  11</td>
<td>9   48  20</td>
<td>81  37  69</td>
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<tr>
<td>Wollongong C</td>
<td>15  20  16</td>
<td>10  48  22</td>
<td>74  31  61</td>
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<tr>
<td>Wollongong SD</td>
<td>14  20  16</td>
<td>10  48  21</td>
<td>74  32  62</td>
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<td>12  48  23</td>
<td>69  30  57</td>
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<td>Sydney SD</td>
<td>23  20  22</td>
<td>18  53  32</td>
<td>56  26  45</td>
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<tr>
<td>Australia</td>
<td>20  21  20</td>
<td>16  48  27</td>
<td>55  27  45</td>
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</tbody>
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(Legend:  M = Municipality/Shire.  C = Council.  SD = Statistical district)


More than half of the population has at least one parent born overseas, with 14.5% originating from non-English speaking countries. It is one of the most ethnically diverse districts in the nation. The region, its employment and economic base, has relied heavily on the steel industry. Over a period of fifty years the population has trebled in size, making it the third largest urbanised district in New South Wales (Healthy Cities Illawarra, 1990).

The percentage of aged in the Illawarra area has increased at a greater rate than the national average. Over a five year period from 1976 - 1981, the average growth rate of the over 65 population in Australia was 18.2%. Within the Illawarra area, that increase was 27.2%. In
one of the three municipal council areas in the Illawarra the increase, over that five year period was 42.4% (Gillies et al, 1987).

4.6 SUMMARY

Data from case studies and interviews are discussed in Chapter 5 and propositions derived from the case studies are discussed in Chapter 6.
...the distinctive need for case studies arises out of the desire to understand complex social phenomena. In brief, the case study allows an investigation to retain the holistic and meaningful characteristics of real-life events (Yin, 1984, p 14).

The case study method of inquiry brings richness to the data, and at the same time difficulties for the researcher. There are two issues Cornwall (1984) identifies as significant to this method of data collection. First, the relationship with the people becomes so intimate that the researcher becomes a part of the families he or she is researching. Cornwall researching family relationships in working-class East London reported that this difficulty arose when she adopted a "sisterhood" relationship with the women in her study (p, 13). Another potential problem "...is the differences in social class and educational background which are common in relationships between academic researchers and their subjects" (op cit, p 13). This may generate an awkwardness that needs to be acknowledged in how the subjects perceive the researcher. Academics may be seen as intelligent, erudite, and an "expert" in their field. It is often difficult for subjects to realise that the research process is also a learning process for the researcher, and in that sense they are equal, as the participants are also learning to be a subjects (Stake, 1978).

Second, is the subject's "impression management" which in Goffman's terms is manifest in "managing appearances" and "controlling information" (1959, p 241). Herein lies the problem of validating information. The initial pictures that are painted by subjects of their lives are ones they perceive will be socially acceptable to the researcher. It is only over time, and with increased confidence and trust in the researcher, that the real picture emerges. That picture will hopefully portray the nuances of their lives, and the colours of their social reality. It is this picture the researcher encourages subjects to paint. Like children, some immediately commit themselves to bold, and revealing tapestries. Others may reveal small pieces of the
A profile of each of the elderly people, and their spouses/carers is presented in this chapter. It is hoped that the reader will gain an understanding of each of the "young-old" people who gave so generously of their time and personal history. The level of sharing of information increased over time with each person, and that is reflected in the profiles. The case studies are also an attempt, by the researcher, to honor each of the people who participated in the inquiry. I trust that I do them justice.

A nagging, and constant thought is one of uneasiness in committing the content of these interviews to print. One can be left with what Lofland & Lofland describe as,

...an "ethical hangover", a persistent sense of guilt or unease about what is viewed as a betrayal of the people under study. The closer your emotional relationship to these persons, the more you can feel that in transforming personal knowledge into public knowledge, you have committed a kind of treason (1984, p 154).

In an attempt to maintain the highest degree of anonymity possible, some of the information has been altered. Those alterations do not change the data, but serve to protect the elderly people, and their carers. Transcripts from the two men who died soon after the data collection was completed are included with the express permission of their wives.

5.1 CASE STUDY 1 - MR RC.

The case study of Mr RC highlights the relationship between hospital and community services in the process of discharge from hospital to home. It also identifies some of the issues that affect the relationship between the elderly, health professionals generally, and medical practitioners in particular.
Access to Mr RC had been arranged through the local community health nurse (CHN) about a week prior to the first visit. The information given to me by the CHN was that during recent hospitalization and surgery, it was confirmed that Mr RC had a cancer which had spread through his abdominal organs. It was not considered that chemotherapy, or any other intervention was indicated as the cancer had progressed into lymph glands, and the decision had been made to keep him as comfortable as possible. The prognosis was considered to be poor, and the CHN was calling daily to attend to his dressing. Post-operatively his scar had broken down and required re-suturing. Mr RC was relatively pain free, but was experiencing some difficulty with mobility. There was a problem with venous return from his legs, and the CHN had noted some breathlessness when she had last visited him.

Mrs RC graciously welcomed me to their home. Their house was a modest, weatherboard building which looked well maintained. The garden was tended, and it appeared that the lawns had recently been cut. My first impression of Mr RC was that he looked a little fierce. Whilst he greeted me politely, there was a sense of reserve on his part and I was conscious of being scrutinised fairly closely by him. Given that he had been discharged from hospital only recently, and had required intensive care in the first few days post operatively, he looked relatively healthy. His colour was good, and he was sitting comfortably on a recliner chair in the front room. Mrs RC and I chatted for quite a while about the research, my contact with the CHN's and other trivia, while Mr RC assessed the situation, and me in particular. Mrs RC was relaxed and open despite the trauma she and her husband were experiencing. My initial assessment of Mrs RC was that she had enormous personal strength, and would probably cope with most things. This impression was confirmed as my involvement with them grew. As this initial visit progressed Mr RC invited me to use his given name. He asked me a few questions about myself, and it became clear in the first few hours we spent together that he was socially adept. He attended well during conversations
and made sure that not all the interchange centred on him. He made it clear that he was very conscious of the added burden his illness had caused Mrs RC. When he spoke about that, and how little he could now do to help her any more he sounded angry.

Mr RC was 72 when we met, his wife is fourteen years younger. It was a second marriage for both of them, each of their previous spouses had died suddenly. There was a combined extended family of six children and seven grandchildren. All of the children and grandchildren lived in the area. Mr RC's school education was at secondary school level, his parents background was working class. Employment for Mr RC, was for many years with one of the large industries in the Illawarra region, and he retired from a foreman's position in 1982. Prior to retirement gardening was his only real relaxation outside of work. The most important, and absorbing interests, for both he and his wife were organizations within their church. Activities of these organizations occupied most of their spare time. They spent a great deal of time visiting "those old people" in hospital and at home who needed support. Both he and his wife were devout Catholics.

The reason for his hospitalization was for investigation of a lump. At surgery, it was apparent that the cancer had spread through many of his abdominal organs, as Mrs RC reports,

...he (the doctor) said that they hadn't been able to take the kidney out because a vein was in the way and they wouldn't have been able to control the bleeding, the cancer was in the liver as well. They just opened and then sewed him up again.

Prior to this admission to hospital Mr RC had been relatively healthy apart from an operation for varicose veins, and a prostatectomy about nine years ago. There was no evidence of cancer at the time of removal of his prostate. When asked about events leading up to this hospitalization the following comments were made.
Mrs RC: As we said earlier on, we're getting older and you can't expect to be the same as you were, and can't do the things we used to do. Where I saw the biggest change was I went away for two weeks, when my sister was dying and when I came back I saw he (Mr RC) had lost weight, and just had not coped while I was away. Previous times when I've been away, and that's only 3 times in our married life that we've been separated, he had managed very well. On those occasions people asked him out to tea and he had gone; this time he hadn't gone, he just didn't feel like going.

Mr RC:...basically she (Mrs RC) just said you've got to go and see a doctor.

Mrs RC: He must have realised himself by then that all wasn't well. What he was told when we did go to the GP was that it was all muscular and it will be alright, I didn't wear it really. A fortnight later I said it's no better, we're going to go back and see him again...which we did and then they did start doing all the X-rays.

The second interview which took place a week later included some of the following comments from both Mr and Mrs RC. Mr RC had been discharged from hospital only two weeks prior to the first interview. Mr RC relied on his religious beliefs to help him cope with the situation, which he knew was serious. He felt that his faith was keeping him from becoming too depressed and gave him something to hold onto,

We pray a lot, some people might think why? We believe that if you ask the Lord Jesus for things he will give them to you. It gives you something to hold onto if you don't believe that there is a God then you would/could feel very depressed and or isolated at a time like this. I believe that God's will be done...you've got to reconcile yourself to the situation and understand that you're not going to improve yourself by forcing yourself, so you've got to kind of give in. I've more or less accepted it, well what's happened has happened, you can't do much about it, you endeavour to, I'm being the best I can. I was saying to the CHN this morning when she said the wound was healing up well, "it's funny that it is healing up and yet I'm not feeling so good". She said well, "OK but don't forget that your problem isn't just that, there are other problems too"...what you've got to do is overcome it as much as possible, that's hard to do at times.. you try to be as happy as you can, as pleasant as you can. You never know as time goes by that things might improve dramatically, you just don't know. It's always a possibility. So you don't press the panic stations you just battle on. and do the best you can, make the best of what you are, accept God's will and let his will be done.

In my memo following that first visit I had commented on how difficult it would be to motivate someone if illness was seen as an inescapable reality. Some other comments following that visit were, that he (Mr RC) trusts the specialist, and accepts that the surgeon is not a good communicator. The informal support structure around Mr RC is so constant that
he didn't appear to be getting enough rest. Despite that, it was obvious that their broad support structure of family and friends assisted them in coping with the illness very well. I was conscious that my visits may have become intrusive. When I talked with Mr RC about this he encouraged me to come whenever I wanted. Mr RC appeared to enjoy the diversion of the research as his illness had become central to the activities in the home. I liked him a great deal, he was a tough, straight man and she, a thinking and kind woman. My memo ended on a note of questioning how the deep faith of Mr RC fits with making positive moves to improve his health status. Would there be a tendency to just accept God's will, does that acceptance then lead to complacency? I asked Mr RC what he thought,

Oh no, I think ...well,...I suppose. I'm sure God will never try us beyond our strength, I feel convinced about that. By the same token I think that we should make every endeavour to get well while you've got the opportunity, there are means and ways of trying to do it, tablets and things, the CHN comes in every day to dress it (the wound) for me. It's healing well, why would it do that if I was going to die?

Mr RC struggled with a mixture of inevitability and hope. On one hand a large wound that was healing very well, and on the other hand a diagnosis which indicated a limited life span. A significant amount of Mr RC's conversation revolved around the doctor who had performed the operation.

Well the surgeon who did the operation is known for not being a great talker. I did get a smile out of him one day. He asked me how I was a few days before I eventually left the hospital, he said that I could go home if I wanted to, that he would be happy about that. I hesitated, but said that I would go home.

At a later interview,

Well, I think for a start one of the main things is that you've got to have confidence in the person who's treating you, that was the doctor of course. Some doctors come across very easy and some doctors come across pretty tough and fairly hard. My doctor was one of those, he didn't talk much he seems a bit hard, but once you get to know him, he's a different man altogether. Some people have never seen him smile, but I had him smiling down there the other day. He's a busy man and a very clever man, some people think he's a bit of a b..... If I go to a doctor I tend to build up a bit of confidence in that man and then if they tell you anything, then you kind of accept what they say and that's the way I've been with the couple of doctors I've had anything to do with.
When the CHN was asked about whether she would approach the discharge planner for more information or the surgeon she stated,

Certainly I would go back to the DP, or the nurse unit manager (NUM) of the ward from where he was discharged. I would think very long and hard before going back to the surgeon in this particular case...it would be almost useless to do that.

The discussion with Mr and Mrs RC moved toward health professionals generally. Questions were asked about how comfortable they felt, and how well they interacted, with them. Time is a constraint for the GP, the elderly recognize that, and often stated that they didn't want to waste his time. That attitude is not exclusive to the elderly. When close relationships are established with the GP a difficulty is that advice proffered may be taken lightly. Conversely, the significance of the "specialist" for the elderly is very strong. They saw both nurses and doctors who specialized, as having a particular knowledge that they respected.

Mrs RC: My doctor (GP) usually leaves it open and says, if things are not clearing up come back and see me. So it wasn't hard for me to go back when things weren't improving for Mr RC, but I can understand that for some people that might be difficult.

Later, in the same interview,

Mrs RC: When we go to the GP, we feel we are taking up his time, he is so busy, the waiting room is always full and we feel we should just say what is important and then go. A thing you have to remember is that specialist doctors don't know you like your GP. You can get quite comfortable with your GP because you see them more often.

In the final interview with Mr RC, I concentrated more of the conversation around health education. Mr RC had mentioned before that he felt that doctors knew what they were talking about, despite the fact that some of them were not good at passing that information on to patients. Mr RC had repeatedly rationalised lack of time, and the busy-ness of doctors. I wanted to determine what sort of an impact health education from doctors might have on him.
Mr RC: The fact that a specialist surgeon, who I have a great deal of respect for, I would hesitate not to take notice of what he had to say to me, and I don't know if I mentioned that when he did tell me the situation I was in, that he did say, "well don't drop your bundle, there's plenty of hope yet".

Mrs RC: With the visits (to the specialist), they seem to have been hurried, not that we couldn't have asked him things, but you felt that you had to get out quick, there are other people waiting, or it's his lunch hour, things like that.

Despite the fact that the surgeon was held in such high esteem by Mr RC, no information was given by him to either Mr or Mrs RC about the course the cancer might take, nor was any professional advice given by the surgeon about pain control, or possible complications that might occur. When I asked Mr RC about his faith in the specialist he said,

If you want to go back into antiquity, when we were going to school, there were people in the community you looked up to, there were the nuns, priests, doctors and schoolteachers, they all had some sense of respect in the community, well that doesn't happen as much these days.

Whilst that respect in the community may not happen as much these days, for Mr RC it was a potent factor in his relationship with the doctor, one that may have precluded him from appropriate information being shared within an equal relationship. The GP continued to visit Mr RC at home and appeared to adopt a quietly supportive role. As well as the CHN and GP Mr RC had been visited by the oncology sister from the local hospital. There was a hospice in that hospital, and because of his poor prognosis Mr RC was already in contact with that facility through the oncology nurse. Mrs RC knew that if she needed respite, or if Mr RC's condition deteriorated to a point that she could not care for him, that admission to the oncology unit could be easily facilitated. The oncology nurse/s were seen as answering many needs,

Mr RC: Yes, and she's very nice, I can't fault any of them, if you've got a question they endeavour to give you an answer.

Mrs RC: The biggest thing is their support, you wouldn't ring the doctor with all the little things you want to know, but you can ask them and they know.

Mr RC: To me, they've all been terrific. I have been treated very well and can't be critical I suppose I could have been told a few more things by doctors, but that's the
way they operate. Unfortunately you're often the person that has to ask the doctor, not the other way around. There are a lot of them that sit there and say nothing, and you've got to talk to them.

JAD: (researcher) Would you rather have all the information than none at all, even if that information is fairly painful?

Mr RC: Well I'd say I would, I've been told, and while he hasn't been dramatic about it, like myself he's trying to look on the bright side of things. He's told me straight, that he couldn't do anything for me. So you've just got to go along and do the best you can while you can and hope for the best, trust in the Lord as I said before.

The process of discharge from the hospital to the community was of particular interest in this research. It had become apparent that little contact had been made between the hospital staff and Mrs RC. In early discussions Mrs RC had recounted that Mr RC was disoriented for about a week following his surgery. Any information would have needed to be given to Mrs RC, however very little had been forthcoming. The only contact made with Mrs RC was to hand her some antibiotics as she left the ward, I confirmed that with Mrs RC, ...nothing at all while in hospital. The day after the surgery the doctor came in while I was sitting with Mr RC and said to me that when they opened him it was a bit of a mess in there. When we walked out of the hospital, the sister said "here's a script, an antibiotic for his kidneys", but that conversation was directed toward Mr RC not to me. Yes that's all, there was nothing. I was told nothing about the CHN apart from the contact number, no name was on that. If they didn't come then we were to 'phone them. No comment about the wound, if I needed any help, I would have put pressure on the wound if it started to ooze, but that was told to me by the sister who came after we came home. If I was really worried I would have 'phoned the after hours doctor. I think I could have had more information about what to expect and what to do; you're excited and nervous about getting them home, and wondering how you are going to cope with them, and how much help he would need and whether I would be able to cope, but if the time came when I needed help, it would have been useful to know, it's not until you get them home than you realise that you do need more information.

During the conversation Mr RC mentioned that someone in the hospital had come to look at his wound so that they could tell the CHN what it looked like, but neither he nor Mrs RC knew who that person was.

The first interview with Mr and Mrs RC had highlighted a breakdown in communication between the hospital and their contact with the CHN. This raised for me the need to explore
the policy, process and relationship between the discharge planning and the community health services. The other issue was how much Mr and Mrs RC had been told about the cancer. Initially when I talked with them, it appeared that they were not aware of the seriousness of Mr RC's condition. I needed to affirm with the CHN how information was relayed to her, and how she articulated with other health professionals giving care to Mr RC. The following is an excerpt from the conversation I had with the CHN caring for Mr RC, soon after my initial contact with him. We started the conversation by determining just how discharge planning is organized in the hospitals.

CHN: As far as I know the discharge planner (DP) visits the people in the wards as much as she can possibly do it. From what I know of talking with DP, she has seen the patient in the ward before they are discharged, but that can't always happen of course. She gets the details from the ward staff and phones it through to us.

This conversation confirmed the gap between the hospital and community in terms of communication. Given the seriousness of Mr RC’s condition I was surprised that a more personal form of contact had not been made between the ward staff and the CHN in the area. A few days after the telephone contact, a form comes through the mail to the CHN. There is no new information on that form. At no time in the communication was mention made about discussions which may have taken place with either Mr or Mrs RC about the diagnosis and prognosis. The question of whether the CHN considered visiting the hospital and liaising with the DP would be useful in breaking down some of these barriers was raised. Whilst she agreed that this was a better way to communicate with the hospital personnel she added,

CHN: I’ve been doing this job for almost 13 years on very very rare occasions I’ve been asked to come to the hospital, and this was back when I was employed by the hospital as a community health nurse.

Whilst the CHN expressed the need for more time to be available to visit clients, the quality of care appeared to be high, and client satisfaction reflected this. Some criticism has been levelled at the time available to nurses in the community for patient/client contact. Gillies et al
(1987, p 96) in a study of dependent elderly and their carers reports that although carers reported that they were encouraged to telephone the CHN area office if there were any problems they felt that they were never able to do that, as time spent with the CHN was insufficient to elicit information and or needs, nor did the time allow appropriate interchange to take place. In contrast, the subjects in this study did not report dissatisfaction with the time available to interact with CHNs.

Involvement of the carer in the discharge process was also a gap in the service provision identified in the case of Mr and Mrs RC. When I interviewed the DP we addressed the issue of carers, the level of care they are expected to provide, and the need to involve them in the discharge process. The response from the DP about involvement of carers was,

I think it's absolutely essential that the care-giver is involved in the whole process. Often when we have a person with quite a few problems, and the question has not been asked of the neighbours, do you mind calling in once a day etc. no one has contacted the family about what they are expected to be doing until the 24th hour and then a frantic call. Then we look at the notes, see that the problem has been noted etc and the relatives say, "no way", I'm not doing that. You've got to confirm with the rellies (relatives), often I say I'll just 'phone your daughter and tell her what I've told you, then you both know. I like to see them together so they hear what I say and when I go away they can sort out the conversation, you know, she didn't mean that etc. The patient has so many people around, the doctor, nurse, physio, pharmacist, they get confused, they need the relatives to be aware of what is going on and who is saying what. I always make a habit of leaving my name with them and call myself the discharge sister, because planner is a funny name for them. They can always 'phone me then to clarify things if they need to. If I've got someone who is going home and has multiple problems I often organise a case-conference before the person goes home. It's no good me referring to the CHN and then think that the council nurses (another group of nurses in the community, employed by the council/shires) might help as well, you can often find that it's all too confusing. We get everyone together so that they can meet the patient, meet the family and everyone knows who is doing what. That has happened about 6 times in the 3 years I've been here. It means that they can decide who is going to be the prime carer when the person goes home. Otherwise you get duplication, and you find people unsure about who is telling them what, and who they should be listening to. I'm often saying to the Social Worker we need a case-conference before they go home, it's only fair, especially if you are expecting a CHN to do a lot of care.

The rhetoric does not fit the practice it seems. Neither Mr or Mrs RC were able to give me the name of any of the nursing staff in the hospital who had been involved in the discharge of
Mr RC. Further, the CHN's name was not given to them, just a telephone number to make contact if there were any problems. The CHN's office is open only from Monday to Friday during the day, any help they might require after that would have been through their GP. Despite the fact that Mr RC had a very deep wound, which was oozing, no spare dressings, or advice about what action they should take if it started to bleed, was given by hospital staff.

These are the final words recorded in the interviews with Mr RC. Although I saw him once more before he eventually died, he was too unwell at that visit to do more than just say hullo, and "goodbye".

JAD: What about you sir, do you have any final words of wisdom for me?

Mr RC: I do feel the same as Mrs RC in regards to post-operative treatment, it would be nice to know what to expect from either the doctors, or others maybe that's not a lack of thought, but a lack of time. One thing is that it gives you a lot of confidence when you are pre-warned, I think that's about all I can say about that Judith.

The major areas of concern in the care of Mr RC seemed to centre on lack of information given to him and to his wife, and the breakdown between hospital and community services. As well was the issue about the wisdom and power of health professionals. This is a well recognised block to communication for consumers within the health care system, and for the elderly in particular. The end result of this situation is an impoverished interchange of information. The disempowerment of the elderly was discussed with some health professionals within the hospital milieu. Social workers (SW) are intimately involved in assessment of the needs of the elderly in many acute care hospitals, their interest in the dynamics of this situation of disempowerment was discussed.

In fact when someone comes into hospital a whole process of institutionalisation goes on when all their power and control is taken away from them whilst we deal with the medical and other issues. It impacts on power and communication and that can be seen in a power-play which comes from people standing over them and talking to or at them, rather than with them. The fact that they don't complain about things that are happening to them whilst they are in this powerless situation is obvious, they are strapped to a bed and are totally dependent on the people around them for care: it makes for a very unequal power relationship, and it makes quite a difference to the way they act. Even
simple things can make a difference, the SW would sit down with them, as opposed to standing over them, something as simple as that can have an enormous impact on how the person feels, it is one way we have of making the communication more equal, and of making the person feel more like a person and more able to see that their needs are important. That by no means overcomes the whole institutional process, that creates a whole different effect. How accurate is the information we get from patients depends a great deal on how in control they feel. The information I might get from someone in hospital compared to an interview with them at home, would be quite significantly different because they are in control at home. It would lead me to believe that we need to be aware that the information we get would be within the context that they see us as the powerful people in control; unless we address that we are likely to get mis-information all the time.

The sentiments expressed by the social worker were echoed by other health professionals who recognised the inequalities and yet also felt the need to acknowledge that priorities often shifted within the delivery of care. General practitioners appear to be impeded in their relationships with old people by time constraints. In an interview with a GP whose practice consists of a large number of elderly people he expressed the view:

Within a medical practice all of your time is based in the best use of time measured against the economics of the situation. It's very difficult. There is a great dilemma for the GP wanting to give holistic care which includes health education, and making a living as well. This approach is not made cost effective in the current system of medical service delivery. Again, understanding that many people would consider that not a necessary part of the visit to you. Sometimes you have to just let that go, and provide them with the service they want. That's very hard for some doctors with a strong commitment to "good" medicine.

Rationalisation of time is not the exclusive domain of acute care settings. There is a great pull between providing "good" practice parameters for health professionals, and a need to individualise the attention given to patients/clients. The GP also commented on specialists and health education,

Following up what you said about the old person taking more notice of the specialist doctor in terms of health education, I think you will find the same being true for nurses i.e. diabetic educators. I am quite happy that the diabetics in my practice use that service, I don't have the knowledge that the diabetic educator has. Some other GP's however may well be quite comfortable/competent to do that education.

In summary the case of Mr and Mrs RC shows that issues which may need to be addressed in the discharge of elderly people are closer liaison between the hospital and community
services. The significant gaps are related to a lack of information flow between those services and a failure to recognize the difficulties faced by the elderly and their carers at home. Another feature of this case study was the failure of the specialist medical practitioner to communicate effectively. An important feature of this case study was the support from family and friends which acted as a protective umbrella for Mr and Mrs RC. The religious faith of these two people was a vital component in their coping abilities.

5.2 CASE STUDY 2 - Mrs CP

This case study provides a picture of how well the elderly are able to change health behaviors without assistance from the health care system. The study also demonstrates the high social activity level of some elderly people and their goal of longevity. More importantly perhaps, is the issue of the lack of health education input by specialist medical practitioners. Finally this study demonstrates the gap which exists between hospital and community services in terms of health education potential for elderly people.

As well as asking community health services to assist in accessing elderly people to be involved in the research I decided to join the local lawn bowling club as an avenue of contact. Not only did this give me the opportunity of meeting the next participant of this study Mrs CP, it also provided me with an opportunity to witness the informal support structured by the elderly in the community. Mrs CP had not been referred to a CHN, and any assistance needed was provided by family and friends. The bowling club had established an excellent network for its members who were hospitalised or at home convalescing. Visits to ensure that laundry was attended to and personal needs met appeared to be a high priority of the network. Awareness of the need to monitor the number of visitors during convalescence, had generated a roster system to avoid over or under attendance of club members. One of the women in the bowling club attended to this function, supported by several other committee
members. The same situation existed in the mens' executive committee, and was treated with equal sensitivity and thoughtfulness.

Mrs CP was still being visited at home and it was during a visit to the bowling club that I talked with the members who were a part of the network. One of the women offered to telephone her and ask if she would be prepared to be involved in the research. After a few days the lady contacted me and gave me Mrs CP's telephone number. It was from the friend that a "report" of Mrs CP's recent hospitalization was obtained. At a routine visit to the GP for insomnia it was discovered that Mrs CP had a severe blockage of her carotid arteries. Following referral to a specialist and, as a consequence, ultrasonography, it was revealed that one of the arteries was severely occluded. A decision to operate was made and Mrs CP had made an uneventful recovery and was at home following seven days in the local hospital. Her friend told me that she was a very popular woman, a regular attender at the club and a great participator in club activities.

Mrs CP was 76 when I met her. The barking of her little dog greeted me at her top storey unit. My immediate impression was that she looked like a "grandmother". She was living alone at the time of our first meeting as her daughter had just moved out to live with her prospective husband. This daughter was her only child. Mrs CP had been married twice, the daughter had been adopted when she was married to her first husband. The second marriage brought several step-children and an extended family with whom she was very involved. Contact with that extended family, and her second and now separated husband, was easy and quite constant. A daughter-in-law lived next door and was leaving just as I arrived for my first visit.

Support by family is a constant variable in the self-reporting of feeling happy (Altergott & Duncan, 1988; Brocklehurst, 1987; Vauclay et al, 1984). Mrs CP was a happy lady and her
involvement with her family appeared to be a major factor in that happiness. She knitted and crocheted for children and grandchildren who visited her often. There were many pictures around the unit of babies and children. Organization of daily activities into a routine that is meaningful to the elderly person is also said to be important (Ruffing-Rahal, 1989). Mrs CP had a very organised life, one day at the bowling club each week, another day for her card-playing friends, and visits to other social events were just a part of her "normal" activities over a period of one week. Her social integration was high, she was popular with her friends, accepting, warm and good humored. I liked her immediately, and she allowed me easy entree into her life.

In the memo following my first visit with Mrs CP I commented about her high motivation at being able to quit smoking. I used this motivation as a strategy to encourage addressing the other health problems of weight, which was approximately 10kg over her desirable weight for age and height, and exposure to smoke. Mrs CP appeared to be an excellent target for modification of health behaviours. Other points made in this memo revolved around her social activity and good support structures. The final comment made was the fact that Mrs CP had not been referred to a CHN who could have reinforced the advice that Mrs CP had been given, and provided further health education.

We talked of her recent hospitalization and surgery. It appeared that the wound was healing very well, it was a neat scar and she was wearing a frock which did not irritate the new scar tissue. She had been told to avoid too much sun and to not irritate the wound in any way. Apart from that advice no other information was given to her. The long term issue for Mrs CP was that the other carotid artery was also occluded and surgery to that would be considered at a later date. She was to have further ultrasonography to monitor the situation. Mrs CP was overweight, this had not been discussed with her by either medical or nursing staff during the hospitalisation. The issue of weight was not addressed by the specialist
although it is a significant factor in terms of her cardiovascular status. When I asked her whether she was surprised that the specialist did not talk with her about her weight she commented,

> Well, no. You see my specialists, they don't seem to talk to you much at all. I don't think either of them had a very good bedside manner, but that was above the point, because they did a good job. Yes, they are both specialists, to them I was probably just another person. This is probably why they don't say anything to you, they are only interested in their job, doing what they've got to do.

We talked about her GP and how he had dealt with her weight over the past years. It appeared that he had not taken more than a passing interest in it, and had left it pretty much up to Mrs CP to do something about it. She comments,

> Well he (GP) has said to me at odd times, why don't you get your weight down, and he did give me some tablets, but they made me so sick I only took one lot, and I just threw them away. But there are so many women around my age, and we've all put the weight on, and you don't know what it is. My GP has said to me, what about losing some weight, and I've said I'd like to, but I don't know how to, because I suppose I really eat the wrong foods. I'm not a big sweet eater, but I don't cook for myself properly and I have sandwiches or something like that, well it's the intake of bread I suppose. I could lose a stone or two, and I gladly do that. I would like to lose that. You see I've been working amongst food for a long time, I worked for 17 years as a cook in a nursing home, but I didn't taste anything, well very seldom. But they say that people who cook a lot tend to put it on, I don't know whether that's true or not, but I just can't lose it, I'd give anything to lose a bit of weight.

I asked her if anyone had ever sat down with her and examined her eating habits, and they had not. Given that she had managed to quit smoking after 55 years I questioned her about motivation to lose weight, could she really do it?

> Well if it was something that I liked, (the dietary advice that was offered) I would enjoy doing it. Well I don't think it would take much to spur me on, because I can do anything if I try.

When asked what effect would it have on her if the surgeon had actively encouraged her to lose weight:

> Well I suppose if it was injuring your life I suppose I would, wouldn't I, or I'd have a good go at it at least.
During the conversation about her fitness level and the effects she might expect from the surgery, she commented that the surgeon had stated that the operation had given her another ten years of life. Mrs CP talked about wanting to live until a "ripe old age",

I have a 79 year old sister, I lost a sister at Christmas, she was 83, she was a little frail thing. You see people dying around you all the time don't you. There were people who lived to a good age in the old days too you know. Inside I feel about 50, I think you feel...well it's up to the individual, I mean I enjoy life and I don't feel any older than 50. I enjoy company, plenty of company.

We talked of her view of "old". Like Mr RC she did not count herself as belonging to that group. Conversation that revolved around the elderly tended to be directed at a quite distinct and different group of elderly people. When I asked her about this Mrs CP commented,

Because I worked amongst old people for about 15 years, and I know what it's like, they come into there (nursing home) and they don't know anybody, and the odd one comes in that has their memory but they can't do anything. They can't do anything for themselves, they can't have a shower or bath because they are not able to, now that's what you would call old, when you can't do for yourself. But you see I live here on my own, well I don't have anybody to have to come and do anything for me so far. It's lovely if you can live to a ripe old age, I see people who are well in their 80's and you think to live that old, is a real goal isn't it?

Mrs CP had smoked cigarettes all of her life until the past five years when she gave it up. That decision to quit smoking was taken without any advice from health professionals. I noted that the daughter and her fiancee both smoked in her unit. At the bowling club the smokey atmosphere was quite pronounced, and there appeared to be little attempt by the club to either segregate smokers, or to provide efficient air-conditioning to extract fumes. We talked about information she might have been given about passive smoking and the effect on her health status. In the history taking by both her specialists and the hospital, no comments were made about her previous smoking, and questions were not directed toward her exposure to passive smoke. She was only asked if she smoked, and when she said "no" the conversations went no further. I asked her how often she would be exposed to smoke,
A couple of days, but at the bowling club not many of the women smoke. The men do yes, but not many of the women. The places I go where people smoke, well unless the smoke comes into my face, I don't take any notice of it. It doesn't worry me at all. I leave the doors open and there is plenty of fresh air, it doesn't worry me. I mean I can smell it when I open the door and I know that she's (daughter) been here.

Given that no real effort had been expended on health education issues related to Mrs CP's cardio-vascular status, that is her weight and exposure to passive smoking, I asked her whether she thought her age might have some influence on that.

Well that's right, you see my blood pressure has always been OK and so why worry at her age, that sort of thing. The old people in the home, I used to think well why deprive them of different things at their age, so it's the same thing isn't it really? My specialist, he told me (having previously stated that the specialist did not give her any advice) to do some walking. This little dog takes me for a walk a couple of times a day. But I am walking a little more now. I walked from Wollongong hospital, that's down hill, I can have a look in the shops and have a good walk down. I take the bus up there and then walk back. I did take another walk this morning into town.

The major reason for Mrs CP visiting her GP was to talk about her insomnia. This was not addressed in the hospital, nor was the situation resolved as far as she was concerned. It appeared that she managed five hours sleep a night, but that sleep pattern had been disrupted when her daughter left home a few months earlier. We discussed this, and pursued her feeling of insecurity. Her little dog was a good guard dog and would bark if anyone was around the outside of her unit, which was the only access door,

Well, I try not to take the tablets, but I don't sleep properly, but I'll get over it...mainly since my daughter left, it's being on my own, but I don't want to be giving myself tablets all the time. Yes he's (little dog) fantastic. Well my daughter-in-law lives next door, and when she's home I don't feel quite so bad. She comes in and talks, or we go to housie (a game not unlike bingo) just up the way, and at the moment she's away. But she comes in here and nine times out of ten has dinner with me, or I go in there and have dinner with her. There are people upstairs, but I don't know their numbers. There is a chappy down the back whose 'phone number I have so that if anything happened or I got sick I could 'phone him. But I hope that it doesn't come to that, but I don't think of those sort of things. No, they didn't ask me in the hospital about my sleeping, it was just your details, religion etc. not about my sleeping. You've got to tell them what's wrong with you and that's that.

At my final visit Mrs CP was very distressed. Since I had last seen Mrs CP her husband, from whom she separated some years ago had died. They had a good friendship and he
would come down to take her to lunch at least once a month. He had died about 5 days ago, and Mrs CP was obviously quite shocked by his death. He had a heart attack at Central station (main station in Sydney) on his way to visit one of his bowling friends who is dying from cancer, and to visit Mrs CP. Mrs CP was surrounded by several of her friends, and her daughter, she comments,

I am quite shocked about his death. The good thing is that he and I remained good friends. I had 'phoned him to let him know that a friend of ours from the bowling club was dying. He's been dying for years actually, but this time he really is. Well he (my husband) said he would come down and see him, it was at central station that he collapsed and was dead on arrival at the hospital. Just recently he said to me "Mrs CP, I've got a bit of heart trouble", that's all he said. When I asked him about it he said he had been to the specialist, but that he wouldn't be doing anything about it. I don't know what that meant. His daughter didn't know anything about it, we talked at the funeral and she said that he hadn't mentioned any of this to them. Thank goodness he just died. I couldn't bear him to be like some of those old people we had in the nursing home.

Mrs CP is going for ultrasound on the other carotid artery in a few weeks time to see if there has been any further occlusion. The likelihood of further surgery is possible, but that decision rests with her.

As the discharge planner was intimately involved with the total process of the discharge of the elderly from hospital I decided to talk with her about the health education issues raised by Mrs CP's case study. It was the DP's opinion that the doctor certainly had the greatest impact on the elderly in terms of advice about health issues. She added that it was a difficulty to encourage that to happen, and pointed out that the greatest criticism made by elderly people was the lack of communication from the doctor responsible for their care. The discussion went on to ways of encouraging some change to that situation, on-going education and input at graduate level about teaching/learning principles. She commented:

I think it's too late for the ones that are around now, the medical schools have a lot to answer for; they need to look at their curriculum. How do they teach communication skills etc. The don't have good role models within their own profession to help. They don't have the Visiting Medical Officers (VMO's) around enough, even if they were good role models. When you go to talk with the specialist about things, he thinks you should really be dealing with his registrar or resident, he's a bit above all of this. I do
A dietitian (DIET) was asked to comment about the general issues needing to be addressed for old people and nutrition generally. Were the needs of the elderly any different from the rest of the population, and how might some of the problems be addressed.

DIET: Education I think, especially in elderly men. That generation who have always had a woman around to get their meals, and then for some reason they are left on their own and they don't know how to cook, or they can't be bothered. Elderly people on their own are a problem, but men more so. One of the problems is there isn't enough data about elderly people and nutrition. We have Recommended daily intakes (RDI's) which go up to 65years and then there is very little data about what the needs are for people over 65years of age. There is nothing that we can use as our data base to measure the nutrition of the elderly, it is one of the recommendations from a recent conference, sponsored by the Department of Health. The elderly are put aside a great deal. Another factor that came through (in the same conference) was that they can live from 65-105, that's a forty year range, you can't afford then to lump the elderly together, so we decided to put them into healthy elderly, minimally dependant, maximally dependant. There were specific definitions from the Professor who spoke. Actually the activities of daily living which were used to delineate their degree of dependence revolved around food. Shopping, cooking, preparation etc. We can't expect people who have been doing things in a particular way for 50-60 years to change overnight. We need to consider that they have 50-60 or more years of experience behind them. The elderly are as capable of learning and of making changes, as any other group. Ideas about nutrition change as well of course, and that must be even more confusing not just for old people but the population at large.

The health care system does not promote prevention, or reimbursement for the GP/Specialist to undertake that role. In fact the community relies on television and other health promotion exercises undertaken by Federal and State governments. Only recently have those health promotion exercises become targeted to include the elderly. Given that an emerging theme was that many elderly people did not see themselves as being either "old" or "senior" citizens, their interest in programmes labelled for the elderly may be reduced. A GP comments,

We have a group (of elderly people) within our practice who walk once a week. My own mother got involved with that through some friends. It is actually run through the senior citizens, but the group meet at a neutral venue; I'm sure that some of the people who have joined that group would not have done so if they thought it was run by the senior citizens. Old people should be encouraged to join in activities other than those
seen as the traditional things organised for elderly groups. I see no reason why they shouldn't also use the resources of school/TAFE e.g. manual arts rooms etc. We have a family practice i.e. there is a commitment to the care of all ages, with a sensitivity to how disease/illness compounds on families. Our philosophy in the delivery of that care is both holistic and qualitative. When you talk about health education for the elderly the issue is the same for all age groups, and that relates to time available, the motivation of the individual and our knowledge of that individual. There is a particular "style" in the delivery of health care; by that I mean that some people come to the doctor for their immediate needs only. They may not want, or welcome discussion about other areas of health e.g. education.

Dissemination of information to the elderly appears to be a problem. It was explained by a woman who was politically and professionally involved with the elderly, expert on the elderly (EO), as only accessing those people who chose to use the senior citizens centres. The majority of old people have never attended these centres (ACOTA, 1985, pp 301 - 305).

Libraries and councils expend time and energy on information systems that are easily accessible to the elderly. The question of why elderly people do not access this information was discussed,

EO:...I don't think they like to admit that they have a problem. I find out more from my mother (who goes to the meetings, she's 87) than I do when I go to the meetings. When I need to call in and pick her up, I often sit and have a cup of tea with the old people, and I hear much more than I might at the official meetings.

Failing to recognise a potential health problem themselves is one issue, the other is how health professionals deal with consciousness-raising and rehabilitative programmes once a problem is recognised. In an effort to clarify this several health professionals were asked to comment on how well the health care system was responding to the need, and to what extent they were prepared and able, to conduct these programmes.

Physio: We are just starting to work out programmes on how to help them when they get home, we have a high number of re-admissions with respiratory problems. We are trying to work out how we could do some group work, hopefully to cut down on the re-admission rate. We really should be doing a better job than we are doing, we ought to be out there doing walking programmes and keeping them healthy out there. We can make the excuse that we are an acute hospital and don't need to take any responsibility for that, but that's just not good enough. I think it will flow on from the classes (asthma) we have just started to do, that will be the next thing we do. The other thing is that the people who would be interested in, and able to be involved in those kind of programmes don't meet very often. The rehabilitation staff from a Geriatric Assessment Team (GAT) do an over 50's walking programme.
HEO (Health Education Officer): The whole issue of health education has not been seen as yet as an acceptable discipline, that's the major problem. Then when you move that onto older people, the attitude is "they are old, why worry" - yes you're right, the two don't go together in people's plans. They (elderly) are one of the greatest user of health services, they are costly, more of them etc. We want to keep the older people healthy, it is starting to get through, but only just. Health professionals like the buzz and rewards from curative stuff of course. You might not see anything much at all for your efforts, and if you do you're lucky. Health promotion is the way to go. I see that it will go the "Healthy cities" way, I see that's the way it has to go. More global thinking is required regarding the role of health promotion particularly in the Healthy Cities model. I think that nurses and doctors need training in health promotion and the role that community services/resources play in keeping people integrated and healthy: that link and connection between the hospital and the community needs to be made and continually reinforced.

Many health professionals, in particular those who were more experienced, expressed a high level of frustration about the dimensions of their current practice, and the need to review the status quo. For many of them the philosophical commitment to self-help and qualitative care of their clients was frustrated by bureaucratic health care services and rigid guidelines that existed within those services. Lack of undergraduate and graduate exposure to other paradigms and encouragement within the health industry to reflect on practice was a current theme. Those professionals who had taken time to reflect on their practice had done so very thoughtfully and with due cognizance of the difficulties one encounters when introducing change. Some of that feeling is expressed in the following comments,

Physio: I would like to see peer groups more responsible for their less fortunate/able members, e.g. the fit elderly encouraging and assisting the "disabled" elderly to be more active; including them in their activities so that we don't have the fit elderly racing around everywhere and the state looking after the "disabled". What is more the fit elderly have probably got the time to put into community service. The ideal would be for elderly activities to have a range of participants = INTEGRATION, like disabled children attending normal schools and all the activities being planned around the mix of able and disabled. As a health professional I think we present education sessions on "How to live with (disease/problem)" so that when an ailment strikes a person instead of finding themselves at the physiotherapist and others for treatment, they take themselves to self-care evaluation sessions which would operate on the philosophy. "OK I've got (whatever) how can I make the most of this?". I don't know if it would work or if the elderly would want such an approach. It would be excellent if doctors participated in that system and referred their patients to the appropriate self-care sessions; but self-referral would have to be the best method of referral (Utopia!!). Physiotherapists do a lot of 1:1 patient education as part of their treatments - causative factors of disease, lifestyle changes, habits of maintenance of physical abilities, safe activities versus damaging activities which increase or decrease pain, use of supports to maintain good posture, alternative pain relief remedies to drug therapy, self-care
"handouts" and pamphlets, group exercise and education sessions particularly for arthritis but also for hemiplegia, & hydrotherapy sessions.

In summary the case of Mrs CP and interviews with a range of health professionals illustrate that barriers exist to the effective implementation of health promotion and health education for elderly people who encounter the medical or "sickness" system. Those barriers include attitudes which exist amongst health professionals about health education and the elderly. The stereotyped view of the elderly often results in health education not being undertaken with them. Time and cost factors that educational input requires are regarded as too costly in curative institutions, and not recuperable within health professionals' private practice.

5.3 CASE STUDY - 3 - MR HM

This case study illustrates the health education input by health professionals during hospitalization, and the follow up of that teaching in the community. Also demonstrated within this study is the attitude elderly people have about specialist health professionals.

The community health nurses had contacted me again, they were very generous in the time they had spent finding participants for me. I contacted Mr HM and organised a time to visit him. Mr and Mrs HM were very welcoming when I arrived at their home. We had coffee and talked about general matters. There was a criminal at large in the area and Mr HM had just completed fixing security screens to all the windows of their home. The conversation revolved around the way things have changed during their life time in terms of safety and security, they recounted the freedom when homes could safely be left open for family and friends to come and go with ease and safety.

Mr HM had recently been discharged from hospital following a heart attack, he was 75 when we met, his wife a few years younger. They had three children and six grand-children. Two
of their children lived locally, and they spent a considerable amount of time with them. Mr HM had been educated at post-primary level and had a trade. During his working life Mr HM became deaf in both ears from industrial noise and as a consequence wore bilateral hearing aids. It should be stated that his deafness occurred over a period of five years, and yet it was seven years later that he was fitted with his hearing aids. Added to this disability was exposure to chemicals in another work situation, which precipitated cardiac palpitations. Palpitations were not new to him. From the age of sixteen he had smoked, until by the age of thirty he was smoking 60 cigarettes a day. At the age of thirty-seven he developed some palpitations, self-diagnosed it as being cigarette induced and stopped. He had never taken it up again, and the palpitations ceased soon after he quit smoking. In 1980 Mr HM suffered a mild stroke, which resulted in lack of co-ordination, which resolved and there were no complications from this episode apart from what he described as some "weakness in the heart". In 1988 he was diagnosed as having Diabetes Mellitus, and was currently on oral medication and diet to control that disease.

Mr HM was a self-confessed workaholic. During the first interview he told me about how he worked several jobs in his early life, and went to bed at night worrying about how to make ends meet. Mrs HM told me he was a great worrier and tended not to share those thoughts with anyone. Mr HM was very good with his hands, and had built his own home in earlier years. At the time he was building their own home there was an economic depression, and yet he had the courage to borrow money to complete that task. His bank manager at the time expressed his surprise at the risk of incurring debt, but loaned him the money just the same. There was no time for relaxation and sport during his working life, and following his retirement in 1980 he took up lawn bowling. Mr and Mrs HM had undertaken a few holidays together, caravanning around the east coast of Australia. During the past few years Mr HM had interested himself in tapestries. He made one for each of his children, and some were hanging on the walls of his home, they looked very professional and he was quite
proud of them. He and his wife lived alone in a town-house, which was well furnished and only a few years old. Mr HM had a garage cum workshop which housed many tools he had acquired over the years, he spent many hours there.

The CHN was visiting him to monitor his diabetes and make sure his recovery post heart attack was satisfactory. He had been given a "patch" to control the pain from angina. The patch is like a bandaid attached to the chest wall which releases the drug aginine, this drug is absorbed through the skin. It must be changed every 24 hours. He appeared to be making good progress and was being very sensible about his diet, exercise and pain control. The GP was attending to him, and visits to the cardiac specialist had been organised post hospitalization. Mrs HM attended to him well and had made it her business to learn as much as she could about his diabetes. Her cooking revolved around his nutrient requirements, and she monitored his input very well.

We talked about the education he had been given about his diabetes, and then subsequent heart attack. Mr HM had had a virus and did not feel very well, he visited the GP who diagnosed him as having diabetes. He continues,

He sent me down to have the test done, and there was too much sugar in the blood to do the test, and she rang the doctor up and he said, well do a blood test; which she did and when I went back to my GP he told me I definitely had a diagnosis of diabetes. He put me on some tablets, and from then on I was on those tablets right up until I had the heart attack. No he didn't talk to me much, he gave me the stuff to test my urine each morning, and said that he didn't mind if it went up to a certain point as long as it didn't go much higher. I asked him (GP) whether I should go to a dietitian, and he said no, at this stage you shouldn't worry. Well, I had two tablets to start off with and then he reduced it to one, and after I had it for so many months I was going alright until I had the heart attack.

The information they were given was all verbal. Mrs HM commented that basically he was told what not to eat, that the diet was very strict. No written material was provided, nor referral to the Diabetic Association educators. Their daughter told them about a seminar
being held in Wollongong, and they both went along to that. Mrs HM comments about the content of that and the diabetes generally,

Well it (seminar) was mainly on the new insulins and needles, more for people on insulin. It was advertised over the air, and our daughter she phoned up and made an appointment for us to go, it was in the old quarters at the hospital. The sugar came down very quickly with the diet, it was good and the GP just said keep on the way you are going.

After a while the diabetes was no longer manageable, Mr and Mrs HM talk about that,

Mr HM: I felt happy about the little bit of information we had up till that stage; but then it blew up to billyo (meaning, went out of control) when I had the heart attack, and they gave me a few doses of insulin. The GP told me I had angina, that was some months before this happened, probably a couple of years before.

Mrs HM: Two weeks before the attack, you were complaining about getting some pain in the chest, but that would wear off.

Mr HM: Yes, I would stop and rest and it would disappear. Then I would go out in the garden, and after three or four pushes of the spade I would have to knock off again, which wasn't my style. That went on for a couple of months probably, then on a Sunday morning I walked down to get the paper, and coming back I got the attack, stopped, it went away, I had the anginine tablets; but sometime during the day something happened and I took another one. Later in the day, we were having some rain, and Mum (Mrs RC) said I'll go up and close the windows, and I said, no I'll do it, and while I'm there I'll have a shower. I went up, it (the pain) was a little bit off, but it went away, then I got in the shower and when I was drying myself off it hit me properly, so I popped another tablet under my tongue came downstairs, and layed down; but I got a bit clammy and I thought I'll just go to bed, the pain hadn't gone...No I hadn't been told how many anginine to take before getting some help, just if you feel the pain coming on pop one under your tongue and sit down, and wait for the pain to go. That was the only thing I was told.

The talk about the heart attack and hospitalization,

Mr HM: Yes they put something into one of my veins, after the pain had gone I thought they might discharge me, but then they decided they were going to admit me. I had to wait until 3a.m. before they got a bed for me. Anyhow they put me on a monitor, and then moved me into the half-way place. One of the nurses came to me and handed me that brochure and tried to explain to me what would happen, and that I would need to use the tablets under my tongue each day if anything started to flare up. The literature they gave me was good, one young nurse came in and tried to explain it to me, but when you're a bit het-up and can't think straight, you can't absorb what they have to tell you in the few minutes they've got. So the literature is given to you to absorb in the best way you can.

Mrs HM: They took you to show you films remember.
Mr HM: Oh yes they did, that was closer to me going home. They gave us lectures on stress and that sort of thing to try and overcome it, and when you start to get all these troubles to try and relax. I would take more notice of the films and videos now than what I did then.

JAD: Did you get involved in any of this Mrs HM?

Mrs HM: The only time was when the doctor insisted I be there when the dietitian was there about the diabetes, but as far as the heart was concerned, no. When he came home I was a bit concerned at first, worrying about what might happen, but as time went on and I could see he was improving, and there was no pain then. I was more relaxed then. But it is a bit of a worry when they first come home.

JAD: Were you pretty clear about what you should be doing Mr HM?

Mr HM: Well that's another thing they did say when you start doing something and the pain starts to come on you again, you knock it off (stop the activity), you are getting a warning. Oh, yes I've read them (articles from the National Heart Foundation) on and off quite a bit. When it came to me going home, one of the young nurses said to me, Mr so and so is going for a stress test, but you won't have to go for one because you're over 75. I took it that I was getting old. I never looked on old age, because actually from when I was 40-45 up until now, things went around so fast I didn't know I was getting old. I feel, oh, around about 50.

Mrs HM: I see old as not being physically able to look after yourself. What about the old diggers (first world war veterans) Father? There are one or two that we miss, there is one old chappy, the last time we saw him he was on two crutches, we haven't seen him for a few weeks, so we don't know if he's passed on or not. But when you see those old chappies going down there, you think, well they are old.

Mr HM: I think that at my age I have a bit more respect for elderly people than I did 15 years ago, I've got a different attitude, because I see what's going on around me. In the old days they got shoved in a corner and coped the best way they could. Now there are more facilities for them.

Mrs HM: Before they were looked after at home because there were not the facilities, well now there are. I can remember my Mother, we just had to look after her, there was no where for her to go, and she just went back into her childhood. It was a big problem. The nursing homes are cramped and there aren't enough people to look after them.

JAD: If someone had talked to you when you were younger, very busy and stressed, what impact would that have had on you?

Mrs HM: He would have ignored them Judith.

Mr HM: It would have gone over my head.

Mrs HM: It would have, he's that type.

Mr HM: You can't help yourself, that's the way you're reared. I've always been the same.
The conversation turned toward Mr HM's regard for health professionals. He, like others in the study, placed a great deal of faith in the knowledge of health professionals. I asked him to comment about that and to clarify just who he thought had the greatest impact on him during the contact he had made with his illnesses and hospitalization.

You feel that those people are trained and they know what they are doing, I was quite happy to let them do what they've got to do. They've been trained that way, and they have the knowledge of what they are doing. I would listen more to the nurse, she is the one who is with you more, the doctor comes in and just says hullo and does what he has to do maybe changes medications, and is gone, the nurse is there and she knows how you have been. So you would take more notice of the nurse than the doctor actually.

The discussion then turned to how the information had been related to Mr HM, in particular with regard to his diabetes,

Mr HM: That's a thing, when they gave me the diet chart, interpreting what units are and carbohydrates. No it wasn't explained, but it's on the chart and it's common sense but you need to read it and learn it, they were just words we hadn't used before, it's a different language.

Mrs HM: Not much time was spent explaining this, not really, about a quarter of an hour. Mr HM came home with his slips of what he'd had for meals, (these are the menus which accompany meal trays and show the types and amounts of food) now that was a good help to me when he came home. That was his own initiative. He kept them in his drawer, and I used to go by that to organise his meals. Now I know what to do.

Mr HM: Trying to decipher between carbohydrates, units, we didn't understand that.

Mrs HM: You see our doctor (GP) asked him, how many carbohydrates do you have for breakfast? well he wasn't doing it, so he wasn't able to tell him: so I excused myself and said, well excuse me I'm the cook in the house and up to date I've been working it out and it's taken me all this time to work it out. Possibly the next time we come Mr HM will be able to tell you how many carbohydrates he's had. So I had to chip in there because I felt I'm not letting you get away with that, because he insisted that I see the dietitian with him in the first place. But I can understand that if anything happened to me then Mr HM would have to know what to do. It is essential that he knows what he can and can not have to eat.

Mr HM: Yes, I think I could work it out. You see I got confused in the hospital when I had to order today for what I was going to eat for the next day, well I'd put down two pieces of bread and they would cross that out and put down one, so some one was going through that.
I asked Mr HM what he felt the biggest disadvantage for him was in learning about his diabetes.

Mr HM: The words I didn't understand, that's what I found the hardest, and also it was hard to concentrate at the time.

Given that Mr HM was finding the assimilation of this information very difficult I asked Mrs HM had she been involved in any of the education being given to Mr HM,

Yes, the doctor did insist that I be there when the dietitian came, that was all.

Mr HM: He asked me about that and seemed to doubt me when I told him yes, she had been in when the dietitian came.

Mrs HM: Well that's right he told the doctor that I'd been, he was most insistent. But as far as the heart, no one told me anything, I didn't know what to expect. If anything happened again I would 'phone the ambulance. The ambulance man told me, if you need us again, just ring straight away, don't worry about getting the doctor. We've got that number on both the 'phones now, upstairs and downstairs. They were marvellous. He told me that before he left with Dad (Mr HM). No one at the hospital when he was in there with the heart attack told us how to get help quickly if it happened again, the ambulance men did that.

Despite the fact that Mr HM's heart attack and diabetes combined placed him at high risk of having another, there was virtually no discussion about how to monitor the angina when it recurred or the number of anginine tablets that could be used prior to seeking medical assistance. Mr HM comments about this,

I was told if the pain keeps coming then get help, but I was not given a 'phone number. Three I think was the number of anginine I was told to take before getting help. Someone told me, or I read it. Nothing was explained about the relationship between the patch and the anginine tablets, no one told us anything, they gave it to me to wear and that was that.

During the admission process at the time of his heart attack there was some conversation taking place between the specialist and the nurse in coronary care. It was thought that the medication he had been taking for his diabetes may have precipitated the attack. This conversation did not include Mr HM, who merely recounted it to me when we talked about information that he was asked for at the time of hospitalization. He was not asked about his
previous history which included palpitations at an earlier age. He recounts that incident and the response from his GP at the time,

Mr HM: At the fertiliser place I went to work here, I was in rolling maintenance, in the acid-making area and there were fumes coming into us all the time. Where they used to burn this stuff, they had a lot of trouble, I used to have to work with these things to get them right, I wore glasses and they would get all marked, the fumes were so powerful, and I started to get palpitations. I asked the doctor about it, and would it be injurious to my health, and he said I wouldn't say that, but if you think it is I would give up the job. I was about 45-50. And so I left and went back to a job in the council. I said to the doctor that it was getting into my lungs and blood stream. But he wouldn't say that, there would have been a mass walk out. The palpitations stopped once I got away from that job.

That was the last interview I had with Mr HM, we had completed the data collection and a copy of the interviews were sent to him. When I telephoned a week later to check that all was well, his son answered the telephone and told me that his father had died. I talked briefly with Mrs HM, sent a sympathy card, and she contacted me soon after the funeral. Two things came out of this contact with Mr HM which were both unexpected and of some comfort to his family. Firstly the transcripts from the interviews had been shared with his family. His son in particular expressed that he had learned a great deal about his father that he had not known before. Some of that had to do with the high work ethic that Mr HM had, and the resulting stress that may have contributed to his heart condition. As well as gaining a real insight into that part of his father, he stated that he would not lead his life in the same way and risk the consequences of not balancing his life with adequate relaxation and exercise. Secondly I had not erased the tape of the last interview with Mr HM. In my letter to Mrs HM following Mr HM's death I told her that I had that tape in possession and would be happy for her to have it. Her response to that was immediate and as a result the family and she kept the voice of Mr HM. I met with two of the children, who asked to meet with me to talk about their father some weeks after his death. They were very grateful for the chance to talk about him and to share some of the intimacies exchanged throughout the time of the data collection. It certainly made me feel good to be able to reciprocate in a real way with this family.
I talked with several health professionals about the health education programmes conducted in and out of the hospital milieu.

DIET: It's difficult to know where to start, but at a conference that I was at recently about nutrition and the elderly I realised that there was a lot going on regarding nutrition and the elderly that I knew nothing about: and a lot of areas down here that I'm not involved in and maybe could be. I suppose the point of the seminar was to make us more aware. The whole scope of the elderly is not something that I've really looked at here. I deal with them on a one to one basis about their specific dietary problem e.g. diabetes, diverticulitis but not the elderly as a whole. The other thing that struck me was about meals on wheels (MOW), and I have absolutely no input or contact with the MOW that are produced here at the hospital at all. So that is something that I've put down as one of my personal goals that I might like to get involved in later on: that's if I need to be involved in it.

OT: We have in the past attempted to run a cardiac out-patients programme, that has been shelved due to lack of resources. Our other gap for cardiac patients is the education about how much activity they can do, and an activities based programme where the person is being monitored to see what is/not safe. That kind of programme is run in the USA, but there is nothing like that here (there is in other parts of this state). We are looking at monitored activities programmes, not just programmes that address issues surrounding heart disease.

JAD: One of the major things that comes through to me is the gap that exists between the hospital and the community, often the connection isn't being made between the services. I'm wondering how aware people in the hospitals would be of the services that your team is providing, what is your reaction to that?

HEO: Definitely. I think that it should be part of the professional development, and it's something that the area health service should take on, orientation, staff development and keep on doing that, keep reminding people about what is going on. Even the fact that we are based in the hospital, most of the staff in that hospital wouldn't know we were there. There is a big lack of commitment to educating people to think about a longer term view of health, they patch them up send them out and think that's the end of it, there is no follow through, no link. No connection about what happens when they go home. It comes back to on-going education, keep it on people's agendas, keep it current, keep it in front of them and see it as part of their job to link into the community resources.

The confusion felt in the alien environment of the hospital adds to the difficulties in obtaining appropriate data. As well, delineation of "roles", amongst categories of health professionals brings with it the danger of fragmenting care. Differing philosophies, and levels of experience amongst health professionals also contributes to the focus of care and level of involvement with the elderly.
OT: The only thing I can come up with is motivation, if the family and patient are motivated they've got a very good chance. Beyond that, the older the population you are dealing with the less able they might be to cope, although I wouldn't like to make generalisations. I have seen a number of determined old people, who on my professional assessment haven't got 1 chance in 100 of making it and they have: and I've seen the other end of the scale when they should do well and because the motivation isn't there they don't.

OT: One of the reasons that we undertake some activities that might be perceived as belonging to nursing, is that the nurses just don't have the time in the hospital to do it all. Many of our objectives, skills etc overlap, they are also complimentary in nature

GP: Within medicine, as in nursing, the specialization of practice fragments care to patients. Quite honestly, if the physician sees the patient about arthritis, they are highly unlikely to concern themselves with anything else...there is far less time allocated to individuals by specialists (doctors) than the GP.

Another issue that emerged was the abrogation of the teaching role by some nursing staff. I asked the expert on the elderly what she thought,

EO: I don't think that is a fair comment. I don't think that nurses have been properly taught to do that, it isn't something that is easy to do, it takes confidence and mostly they need time, nurses in hospitals don't seem to have that time. They don't either see that teaching is a part of everything that they do, they might be very confident in their clinical skills, but not in teaching.

This case study demonstrated the deficits in the health education input by health professionals. Whilst education needs were addressed within the hospital milieu, the principles implicit to learning such as appropriateness of the level of information given, time for absorption of that information and evaluation that knowledge is understood, were not apparent in that teaching. The follow through of any teaching undertaken in the hospital, was lacking in the community. How the elderly view themselves was another issue raised in this case study. Also within this study was identified the independence and ingenuity of the elderly in looking after their own educational/information needs.
The case study of Mrs BE and her carer is particularly helpful in exploring the issues surrounding the impact of prolonged care of an elderly person in a family. It also allows some insight into how elderly people view their usefulness and future when facing disabling effects of chronic long term illness. This study also serves to illustrate the level of care provided by family and friends in order to maintain the elderly at home.

This lady was referred to me by the community health nurse who was assigned to her care following two weeks in hospital with cardiac failure. In 1985 she had undergone cardiac bypass surgery following a heart attack twelve months earlier. Since that time she had repeated hospitalizations with further heart attacks. A decision had been made by the surgeon not to operate again, and she was living with chronic shortness of breath and repeated attacks of cardiac failure. This lady was 70 and had been living with her son and daughter-in-law for sixteen years. She was exceptionally charming and very interesting to talk with. Her son was one of two children, the other a daughter who lived in Sydney. There were seven grandchildren altogether, three of whom lived in the household she shared. Originally the living arrangement was a caravan in the back yard of their home, subsequently the son built a granny flat which he attached to the back of the home for easy access. Mrs BE was well read and travelled, she had been educated at secondary school level and had been employed in a professional basis during her working life.

She divorced her husband thirty years ago, and although she subsequently lived with another man for some years, never re-married as she valued her independence too highly. It was after this man died that she moved in to live with her son and his family. The decision for her to move was a joint one. Mrs BE found the financial burden quite heavy once she only had her own income, and the family were worried in case she couldn't cope on her own. At
that time Mrs BE was perfectly healthy and not in need of any assistance. It has only been in the last year as she became ill and required assistance with meal preparation, medication and showering the relationship became strained between she and her daughter-in-law. The major responsibility of care fell on the shoulders of her daughter-in-law, her son assisted with very little apart from moral and financial support. Mrs BE often required oxygen and there were two cylinders in her flat on the day that I first visited her.

Mrs BE made it very clear at the first visit that she considered herself to be a burden. When we talked about this it was in whispers, as the family were in the next room. The door between her unit and the house was always open in case she needed assistance quickly. It prevented her from engaging in private conversation. Mrs BE had decided that she wanted to die, she believed in God and an after life and had no fear of death. She stated that each time she woke up in hospital following severe anoxic episodes, she felt sad that she hadn't died. Her behaviour with her family, and interaction with people who visited her did not fit with that attitude. For the casual on-looker she would have appeared as a gentle, lively, and very charming lady who enjoyed life. She cried at that first interview when she shared these thoughts about death with me, there was a sense of welcoming relief from the constant bouts of illness and the worry she caused her family. My memo following that visit commented on how much easier it is to share these issues with a stranger and how surprised many people in her life might be if they understood the degree to which she welcomed death.

When we talked about her care in hospital, she had nothing but praise for all the staff she came in contact with during her frequent visits to the regional hospital. She was well known by the local ambulance staff who had transported her many times, they responded promptly and efficiently whenever they were called to her assistance. One of her grandchildren was a doctor in the local area and she assumed that the high level of the care she received each time she was hospitalized was influenced in some way by that. She added that she did not have
difficulty interacting with medical practitioners and other health professionals, and asking questions about her care. Her personality was so appealing that I doubted that any of her needs were neglected when she was hospitalized.

Mrs BE: Right from the time I had my major surgery, I have found that people have been prepared to sit down and talk with me about what was going on. My GP down here is particularly good, and is always happy to give me the time that I need. Mind you I ask questions, and I'm not backward in doing that. I would imagine that some people might not find that as easy to do. The other thing is that my grandson is a doctor down here, whether that has had any impact on how I've been treated or not I don't know.

JAD: What about dietary advice/exercise?

Mrs BE: Well, I lost weight each time I went into hospital, but I am overweight at the moment, I don't seem to be able to lose that. The trouble is I like my food, and I can't really motivate myself to do what I need to do to lose that weight. As far as exercise, well when I was in better health, and didn't have the breathlessness I would do some walking, not a lot. I did smoke too, and although I had cut down, I did continue after my by-pass surgery. I gave that up for some months. I used to clean my teeth, suck on a mint so that my GP wouldn't smell the smoke (following open-heart surgery, and several subsequent heart attacks) he assumed that I had stopped smoking, mind you he didn't ask me.

JAD: What about nursing staff and their involvement with you in terms of health education?

Mrs BE: Well, they didn't seem to have time. When they did talk with me it was often about more social things e.g. their boy-friends. I have had more health education from the doctors who have cared for me.

JAD: You said the first time we talked that you were ready to die, is that still true?

Mrs BE: Yes, when you believe in God, the thought of death isn't a problem. I feel that my family have had a lot of worry about me, they spend a great deal of their time taking me to hospital, visiting me, I feel a worry. If you asked them they would say not, but I think I am a big worry for them. There is very little that I can do, some days I don't move from my room. I've lived with my family for some years now, even though I know they will always care for me, I feel quite a burden to them. I would like to die, I'm ready for it. I believe in God, my life has been pretty good so I'm not frightened of death. I look at the old people from the nursing home, and think I would rather be dead. How awful to have to rely on someone changing you like a baby. Once you can't do for yourself, then you might as well die.

At my first visit she had just been discharged from hospital only the day before, and was still quite short of breath at that interview, which allowed me talk with her daughter-in-law who was her principal carer. Mrs BE had been in and out of hospital quite frequently over the past months. There was a complete record kept of dates of admission, details about the
hospitalization, changes in her medication and any other details she thought to be important.
I commented at the time in my memo about how convenient that was for me, later I thought her behaviour rather obsessive. In fact much of the conversation centred around the fine details of each admission to hospital.

Mrs BE's principal carer was her daughter-in-law. This lady was in her mid-forty's, and had been married for over twenty years to Mrs BE's only son. They have four children and three grandchildren, all living in the local area. Two of her sons still lived at home, one employed in a trade and the other a second year University student. Each time I visited the home the carer's parents were there, they were very supportive of their daughter and assisted with some of the shopping and housework. The house was noisy, welcoming and full of people. Mrs BE had complained to me at the first interview of the lack of privacy and the high noise level which caused her some difficulty as she was slightly deaf. My observation of the interaction between the carer and Mrs BE led me to believe that the carer had distanced herself from Mrs BE. When I talked with the carer about this she stated that prior to Mrs BE moving into the home there had been a very good relationship between she and the carer, a friendship that was regrettably now lost.

Apart from the difficulty of finding some space to talk with the carer, there was a great deal of resistance to making any comments about Mrs BE that might appear negative. Eventually we arranged to meet at one of the local clubs for lunch. The carer organised her week in such a way that at least one day was left entirely for her own activities. This included taking herself out to lunch, and some shopping. The level of physical activity undertaken by the carer was low, and she was approximately 15kg overweight a fact that did not worry her. When I arrived at the club to talk with her she was finishing off a large high carbohydrate lunch and was very nervous about the impending interview with me. Her level of confidence was low and she had little intellectual stimulation outside of family activities. Often
grandchildren were left with her for the day and it appeared that her family were quite
unaware of the impoverishment of her daily life. Her husband was a large man who
dominated conversations and filled the house with his presence. After a few visits with him
in the home, I appreciated how difficult it might be for her to verbalise feelings about the
constancy of care required of his mother. His contribution to this care seemed to be
restricted to putting her numerous tablets out for her each morning while delivering the early
morning cup of tea made by his wife.

Following a great deal of peripheral conversation we settled into a serious discussion about
her caring role.

CARER: It's worked out pretty well, I don't think I'd do it again but. It's a heck of a
responsibility and it all falls back on the one person, but it's all worked out
tremendously well given that we are mother-in-law and daughter-in-law. The beauty of
it is that this part out here is self contained, she could do all her own cooking and all of
that when she was well. She had her by-pass about 4-5 years ago. She was OK up
until then, she'd go away for holidays and do all sort of things, very independent lady,
extremely so.

JAD: So since '89 things started to happen, and it's been a constant in and out of
hospital.

CARER: Well since she had her by-pass she hasn't been terribly well, that by-pass
didn't really fix her problems. She smoked still, she didn't tell her doctor that, she
didn't keep to her diet. She smoked right up until this last big attack in November last
year. She did give it up once but then she took it on again. About a packet a day. From
the time she had that by-pass she never walked, and she never ate properly I
mean she would eat pork sandwiches and fat.

JAD: When was this before or after the by-pass?

CARER: Before and after. Even after getting such a scare, the biggest one in her life, it
was almost like here's a second chance... do something about it...but she didn't. The
doctors talked with her about diet and exercise; yes, everybody did, her doctor down
here has been marvellous, but she didn't take any notice. He spoke to her until he was
blue in the face, but you just couldn't change her.

CARER: People have given up on all of that now. Well you do, you feel like you are
nagging them, and you don't want to put them or yourself in that position. All these
problems like her dead arm (some peripheral vascular impairment), and all of that she
would still go on smoking. She'd go down to the doctor's with a peppermint in her
mouth so he wouldn't guess that she had been smoking, I mean he still doesn't know!
She's given it up now, but she's a worry, independent right through to the last.
CARER: Since last July there has been a pretty constant commitment to caring for her. She spends a lot of time in hospital, we no sooner get her home and feeling OK and she gets so breathless again and back to hospital. We keep her door open now so that we can keep an ear on how she is, sometimes she is so weak that she couldn't possibly walk through to our room. It's a bit like having another child in the house.

CARER: No I'm not housebound, well not totally because I won't accept to be house-bound. I usually arrange for someone to be here if she is ill, but if she isn't that I make my own arrangements about going out. My Mum and Dad help out whenever they can but there is only so much they can do for me. They support me a lot which makes my load a little easier, they understand how much effort goes into caring for her at home. My husband, well he's reasonable, but in the end I'm the one wearing it, mostly, if anything has to be done, it's me. I make sure that I go out at least once a week, otherwise I would be resentful of the time commitment. The rest of the family seem to think it is only my responsibility to care for her. She isn't even my mother, and while my husband helps with the care, what he does is very little really, he sees it's very much "womens work". Not working makes me feel like a boring old housewife, and I'm not old. I fear losing the social contact with others.

This case study demonstrates the degree of pressure experienced by a carer in coping with a relative suffering from a chronic illness. In this instance the carer involved was not utilising any of the facilities available in the community to assist with care in the home of a dependent elderly person. She was, however, in need of moral support and of intellectual stimulus which was missing from her daily responsibilities. Added to those issues, and intimately involved with them, the carer was overweight and in need of health education advice which was not forthcoming from any of the numerous health professionals involved with this family. In terms of Mrs BE, no pro-active measures were being taken by the health professionals caring for her that might have improved her chronic condition. There were many assumptions being made by the health carers about Mrs BE's health behaviors. The fact that Mrs BE welcomed death and her feelings of uselessness and dependence, had not been explored with her by anyone. Her cheerful profile was very effective at keeping that reality from being exposed.

5.5 CASE STUDY 5 - MRS TO

This case study illustrates the difficulties which can arise in providing appropriate psychosocial support after discharge. The sensitivity of a home situation is often not appreciated
within the assessment process, and care required by the elderly person may well be related more to their domestic situation than their own illness/disease. Mrs TO also presents us with a picture of the high degree of stoicism and independence which is to be found in many old people developed over long years of coping with very difficult situations.

Mrs TO was introduced to the study by the CHNs who were visiting daily to dress her wounds, and she was happy to be involved with some research. Mrs TO had spent only one day in the local hospital having had part of three toes on each foot removed because of reduced mobility, pain and inconvenience caused by chronic arthritis. She was 72 when we met and lived with her 73 year old husband. There was an extended family, all of whom lived locally. She and her husband have six children and twenty grandchildren. Contact with the family was good, and despite an offer of assistance when she came home, Mrs TO had chosen to cope on her own. With the aid of a wheelchair she managed the housework and only required minimal assistance from her husband with cooking and showering. This lady was shy, private and an independent woman who had grown up in the country, one of seven children. Her education was at post primary level but she was never employed. Her life, prior to her marriage, was helping her mother with the farm work, and raising the other children. There appeared to be very little in her life that presented difficulties for her. Like Mr and Mrs RC she spent most of her time working for Catholic organisations. Her activities outside of that were gardening, knitting and sewing. She walked to the shopping centre several times a week and looked very healthy. Within a week of discharge she was out mowing the lawn, an activity she had undertaken some years ago as her husband suffered from a condition that made physical activity painful for him. I never met her husband. He was usually in the shed tinkering with things, but it was never suggested that I meet him.

As my involvement with her progressed I realised that one of the major problems for her was the psychological trauma her husband suffered as a result of constant pain over a long period
of time. When she talked about him, it was in whispers and in confidence. It appeared that Mr TO was depressed most of the time and did not provide her with the company one might expect at this time of married life. Mrs TO was defensive about him and offered many excuses for his behaviour. She had not discussed her husband's problem with any of the children, although one of her daughters was aware of how difficult it was for her. There were many hours when she was alone at night when Mr TO had retired to his bed at an early hour. Although the family were nearby she spent more of her time with her church activities than with them. My impression was that Mr TO's depression, and his unsociable behaviour, kept them separated from other people. Mrs TO believed that you did not intrude on other people, and that one just accepted the circumstances of life. The memo following my first visit to her commented on her stoicism and abject loneliness despite what appeared to be a good family structure. She asked me to forward the copies of our interviews to her daughter's home so that her husband would not be curious about the contents. Much of her conversation with Mr TO was filtered as he was easily upset and took some time to settle down once he had an outburst of any kind. It was not unusual for him to go to his bed for several days if he felt he could not face the world, and whilst she understood his strategy and was sympathetic when he did this, it reinforced her isolation and unhappiness. It was obvious throughout our interviews together that she wanted me to think well of him, and much of her time was spent assuring me that he was a good man. That protection of him was made more apparent when she returned the transcript of our longest interview. The majority of the content revolved around Mr TO and how she had dealt with his moodiness and depression over the years. This part of her life had never been discussed with anyone before. Almost all of the dialogue that had taken place about her husband had been removed by her when the transcript was returned to me.

In the next memo I recorded my concern for her isolation and made mention of the fact that in many ways she had disengaged herself. My other comments had to do with the fact that she
is a thoughtful, introspective woman who has put much of herself aside for Mr TO. During all of our conversations there was a feeling of her unease at talking with me. I assured her that she could withdraw if she chose to do that, but there seemed to be a need in her to talk. The fact that I was not a local resident, and would in fact be returning to the other side of Australia once the research was finished seemed to assure her that any input from her would be lost amongst the dust-collecting bookshelves of some library. After my involvement with her I realised that much of what she told me was also carefully filtered, and it was only on re-reading the interviews with her that I recognised her need for someone to understand the pressures on her within the relationship with her husband. It also affirmed for me the difficulties the CHN would have in eliciting this kind of information.

The only contact Mrs TO was having with health professionals was the CHN who was attending to her dressings, her GP and the specialist who had performed the operation on her toes. I asked her to comment on help she might need, and any conversations that took place with health professionals about how she would cope when she was discharged from hospital,

You asked me about my family, I didn't have any problem. They are here when I come home and whenever I need them. This time around Mr TO looked after me, the weather was good and he was fine, he has had some trouble with his back recently, but it was alright when I came home, and he can cope. His neck gives him a lot of pain, and he doesn't like going out where people are looking at him, which is understandable. I can't remember them asking me about whether I needed any assistance when I came home. I was only there for the day. The family would come in if I needed them, I was only in the wheelchair for 2 days. The CHN asked me if I wanted home help, and said no that I would be OK. The house wasn't dirty. I went around in my wheelchair one day with the kitchen tongs picking up my threads from the sewing. But no, I can't remember anyone sitting down with me like you are now asking me about how I was going to cope. No the specialist didn't ask me if I needed any help. I went in to see him about having them (toes) done, and he said I'll put you in as a day patient, you'll be OK. He said "are you a good nurse?" and I said, "not bad". He said your feet will be bandaged for a few days, and I said I'm used to bandaging shins and things, I'll be OK. Then I'll see you in ten days, you'll have to be off them for a few days, but my husband will look after me and the family are around, we were talking just like I'm talking with you now. So I said, no I don't have a problem.
Her expressed level of independence would certainly convince you that all was well in her life.

Mrs TO: I mowed the lawns the other day, I'm fine. I only call on the family when there's something I can't do, actually I don't use the word can't; sometimes I get stumped on something, but usually I can work things out. But they are there when I do need them.

Mrs TO was only admitted overnight for her surgery at the local hospital, and despite her age, and the disabling nature of the surgery there was very little dialogue with her about her situation at home.

Mrs TO: Yes they didn't talk to me much. The doctor came through and talked with me, he asked me how old I was, and I said 71, he said is that old? It never enters my head to think about being old. I did say to my daughter recently, if ever I'm really ill, and can't look after myself, then I want to have a meeting with you all, and get me into a home. They've all got families and I don't want them worrying about me. Yes, when you can't care for yourself, that's old. Mr TO's mother was 95 when she died. She travelled around all the time staying a few weeks here or there. I think when you see people with a walking stick and can't get around, that's old. I suppose too having 6 children and 16 grandchildren, that you think young, it keeps you young. I don't agree with a lot of things that young people do, but you realise that 19 and 20 year olds are men and women, my children were married at that age. Living together, I don't agree with that, but that's not my business.

We talked about how she related to doctors and nurses.

Yes, I don't find any problem with that. Most doctors that I have had anything to do with have been great. (talked about tablets for arthritis being taken with meals, had been feeling sick and had not realised she should not take them until she had her meal. Doctor said "read the bloody label").

Her faith seemed to be very important in terms of how she managed to cope with her husband's illness and depression, and her own loneliness in that situation.

Mrs TO: My faith, well I didn't go to church for a number of years, because two of my sons married outside of the church, which did upset me, I felt guilty; they'd been to a catholic school. And I would go occasionally with the other children, but about five years ago when Mr TO got the cancer, I went back to Mass. I didn't get to meet the priests, because I wasn't involved in anything at school, and I'm someone who just comes and goes. Anyhow I think the lady next door asked the priest to come and see Mr TO. He would come and see Mr TO every Thursday night and bring communion to him on a Friday. We got to know him very well. He has healing masses up at the church, I know if I was desperately worried I could go and speak to Father, or the men from St Vincent de Paul, you know that it won't go any further. But I know that I am
a quieter person inside, that's how I deal with the depression. I am much calmer, and ask God to help me. He's (Mr TO) always been a hard worker, so it must be hard for him to accept. He got nerves from the noise he was exposed to at work and then his neck got bad, they tried him on many tablets, that didn't help. He finally saw someone who manipulated his neck, but that didn't help much either, but then he went to the pain clinic, and that did help, it was a freezing process. Then that stopped and he is having some acupuncture, that's helping. Two to three weeks he goes back, we ring up if he needs to go back earlier. He doesn't give in easily, he puts up with a lot of pain. Sometimes he says so himself, he has a TENS machine, and sometimes I say do you want the machine on, and he says yes...he tends to hang on.

Sharing the kind of intimacies that this lady needed to share would have been almost impossible because of the network within the area that she lived. I discussed this issue with two health professionals.

CHN: Most times of course it's a matter of who the old person feels comfortable with. They will choose who they will confide in, as we all do.

Specialist Physician: Some of the younger doctors in the hospital who treat elderly people find that they are unable to communicate effectively with them. That varies a great deal of course. If they have grandparents of their own, they are more sensitive to the elderly. In my experience, the elderly prefer to deal with someone who is more their own age. The other side of that is that the older the professional is, the more life experience they have, the more tolerant of disease they may become, they also see being elderly as something that is becoming real for themselves - that personalising of old age impacts on delivery of care, I think.

The issue of appropriate assessment of the elderly was discussed with a few health professionals. Geriatric assessment teams (GAT) have considerable expertise in assessment of the elderly and commented:

GAT: We decided that it wasn't possible to standardise the assessment, because the needs are so variable. In that respect with each referral the focus might be quite different: that might differ from alterations to the home, walking aids etc. Sometimes it might be more of a family problem, where the carer is breaking down, in which case the social worker would come in. That's how we set it up, and it really isn't a standardised approach.

In the case of Mrs TO her needs appeared to be more at a psycho-social level, she used an inordinate amount of time talking around the problems of living with her husband. There was an equally inordinate amount of time spent convincing me that he was a "good man" and that she couldn't or shouldn't really complain about him. The difficulties of eliciting
information at interview with the elderly have been highlighted by Isaacs & Neville (1976), Labi & Gresham (1987) and Gresham & Labi (1987). While Gresham & Labi concentrate their attention on the sensitivity of the assessment tool as the major concern, Isaacs & Neville emphasise the skill and experience of the interviewer as the most important element in the assessment of elderly people. These issues were discussed further with an experienced social worker who had worked for many years with elderly people in hospitals.

SW: There are a whole gamut of welfare services at a psycho-social level that involve the social worker, those needs should be looked at in terms of the individual needs of the patient and family and fitting them to the whole range of support services, geriatric and volunteer services is what the social worker is doing. She is assessing the patient, negotiating around services and fitting them to the individual patient's needs. I think one of the major emotional impacts, for the social worker, is the dealing with the issues around the ageing process; loss of function, physical function, loss of a lot more for the partner than just physical function. It may not even be a particular counselling process for the family. It may be that they want support services to keep them at the level where they are at the moment, and not wish to talk about their feelings at all. Different groups in society have different approaches to counselling and talking about feelings and to support groups and services. I would say about 50% of the geriatric population want support groups to maintain their position in the community. Within the geriatric group loss of function seems to bring up lots of feelings of loss of power and control.

JAD: They seem to get frustrated and angry.

SW: Yes, and to be able to work skillfully with those feelings, whilst still identifying that there is a need. For example, being able to work with the person in a way that restores their power and control, and to be able to put them back in control and puts them in charge of decisions, is a very large part of the SW role.

JAD: Do you think that older people are less skilled than others at expressing their feelings, or is it expressed more in behavior?

SW: Well the SW skill would be assessing the power balance in the family, there would be some elderly people who would rule the roost, and others who are more in a lack of power situation. The SW would take the view that the old person was their first, and most important, client. If the person was having difficulty in expressing their needs, the social worker would spend time in assisting them to express those needs. We use a family systems approach, and at times the dynamics within that family are very complex. Often the SW is helping to deal with power issues within that family that should have been dealt with some time ago.

Much of Mrs TO's approach to her problems with her husband separated her from friends and family. She appeared to be "disengaging" from selected people and situations which were awkward for her husband to deal with. The effect of this was that most of her friends
and relatives were totally unaware of the level of loneliness and isolation she was experiencing. Do health professionals acknowledge this problem?

OT (Occupational Therapist): Yes, one of the problems for health professionals is perhaps recognising that time when elderly people are starting to disengage from friends, situations and life. There is a grey area when maybe if you used some strategies you could influence them for that disengagement not to happen and to pull themselves out. We don't know enough about disengagement I don't think to be as effective as we might be...it's tied up with thinking that all old people naturally go through that, and of course they do not.

This case study focuses on the problem of assessment of needs. In a sense it also questions the skill of health professionals in dealing with the psycho-social issues presented by Mrs TO. Of the sixteen health professionals interviewed in this study only two demonstrated a broad knowledge of the theories of aging that would equip them to provide the level of attention that Mrs TO might require. The other point to be made is that Mrs TO may not welcome that help, and there would be a fine line drawn between knowledge of her situation and the degree of intervention that would be welcomed and would also be appropriate.

5.6 CASE STUDY 6 - MISS OW - (CARER)

This case study concentrates on the carer of a chronically ill elderly person. The study identifies the need of carers for information from health professionals to assist them with care-giving. Personal needs of the carer which affect their ability to continue providing care may fail to be acknowledged and/or identified within the health care system.

Miss OW was 29, the youngest of five children, she had lived at home with her mother and father all her life. Her father had died seven years ago and it seemed natural for her to continue to live with her mother. The rest of her family three brothers and one sister lived some distance from Wollongong. Two brothers lived interstate, another ten hours drive and her only sister a five hour drive away from the family home. Miss OW's sister had recently undergone major surgery for cancer and was just completing her first course of
chemotherapy, as a result she was unable to assist with the care of their mother. In fact Miss OW had decided not to inform her sister of the seriousness of their mother's condition for fear that it impeded her sister's recovery. The mother was very distressed that she was unable to assist her sick daughter, despite the fact that her own medical problems were too debilitating to allow her to do that.

Miss OW's education had been completed during secondary school and she had undertaken employment in supermarkets at the check-out. Before we met she had been on unemployment benefits for over a year and was now receiving a "Home carers" pension. This pension is given to people undertaking full time care of dependent people at home. It was through one of her brothers that she was made aware of her eligibility to receive this pension. Miss OW was an attractive obese lady with a great sense of humour and a very straight way of dealing with situations and people. Her own social life revolved around a few old school friends. Their major activity was visiting the many recreational or service clubs in the area, drinking and eating. Miss OW did not exercise nor did she belong to any clubs or groups. Her intellectual stimuli came from frequent video watching and sparring with health professionals. During one of the interviews she stated that she had given up most of her social activities prior to her mother's recent illness as she was becoming bored with it all. She further commented that her mother's illness provided her with diversion and purpose. During one interview a full hour was spent with Miss OW recounting her mother's illnesses over the past few years, she had details of her admissions to hospital, alterations to medication and visits by health professionals.

When we talked about her own health Miss OW told me that she suffered from sinusitis and asthma. During the time I visited her she suffered from a cold and was frequently using her ventolin inhaler. We discussed the relationship between smoking and respiratory illnesses and whilst she was cognitively aware of the issues, her rationale for continuing to smoke was
that she was worried about her mother and smoking calmed her down. Miss OW had the intelligence to acknowledge the effects that long term smoking had had on her mother's health. She planned to cut down, if not quit, her smoking and do something about her weight in a while. One of the other reasons proffered for not quitting her smoking was that she could put on even more weight, and that it was her only vice. Her siblings were of no immediate support to her. Whilst Miss OW was in touch with them all by telephone, she felt that there was an expectation that she could cope with the situation. This was an impression she herself had structured with the family, and when she did call for assistance they appeared to be surprised that she needed it. None of the family spent any time in the family home to assess the degree of help that their mother required on a day to day basis. Miss OW did the cooking, washing, cleaning and toileting of her mother. There were many sleepless nights for Miss OW and her concern for her mother's deteriorating condition kept her awake ready to attend to her if necessary.

Despite the fact that a CHN visited every day, there was little time available at that visit and the focus of attention was on Miss OW's mother. It appeared that Miss OW did not confide in the CHN and used her neighbour, who worked in a nursing home, as her support and confidante. The majority of Miss OW's time was spent alone, although one of her friends stayed overnight with her whenever her mother was hospitalized. Throughout the time of the data collection a dangerous criminal remained at large and security was an issue for everyone involved in the research. The home that Miss WO and her mother shared was small and crowded, while the garden and lawn were well maintained the interior was in need of some attention. The home was crowded with the aids and appliances needed to assist in the day to day care of Miss WO's mother.

Miss OW's mother was 74. The major health problem was angina which was diagnosed five years ago, and in the last two years peripheral vascular disease had caused increasing
circulatory problems for her. A month before my contact with Miss OW her mother had been hospitalized with gangrenous toes which were to be amputated. Eventually a decision was made not to do that as her angina and general medical condition made general anaesthetic a potentially harmful procedure. This 74 year old lady had smoked all her life up until the time of her admission to hospital with gangrenous toes. Throughout a long association with her GP and cardiac specialist no advice was given to stop smoking. In her early life this lady was very active, had involved herself in many church activities, cycled and went ballroom dancing every week. It was only on the last visit to Miss OW that I actually met her, as each time I visited their home she was in hospital. At that visit I was introduced to her, she was a slightly built woman quite short and very sociable. On that day she was entertaining some of her old friends in her bedroom with stories about her frequent hospitalizations. Her cardiac condition was deteriorating and she was experiencing increased chest pain, shortness of breath and difficulty with mobility. The doctors at the local hospital had told Miss OW that she could die at any time.

At the initial interview we talked about the decision for Miss OW to care for her mother.

Miss OW: I wouldn't expect those of them who are interstate to sell up and come up here to look after her. They are there if I want them...they would come if I needed them.

JAD: What was the biggest motive for you in deciding to care for your Mum?

Miss OW: Mum can't move to where they are, I'm here. If she were to get confused with Alzheimer's or something I couldn't deal with that. We had a situation when she was in hospital recently and the drugs had an adverse effect on her: she went off her trolley (meaning she was irrational), was aggressive, confused, in disneyland really. She was having all kinds of conversations that didn't make any sense. They 'phoned me to come in and settle her down. She accused me of being drunk, told me she just wanted to get out of there. They had asked me about her drinking, they thought she was alcoholic. They wanted to know how much she drank, they wanted to know if anywhere locally she could get some drink. Actually there were lots of family problems that were worrying her at the time, and that all just came in on her. For a few days is was hard to know whether she was talking the truth or not. I said to one brother if she had continued to be like that, that I couldn't take her home. The lady next door works in a nursing home with people like that all the time, she told me she couldn't take her parents home if they were like that either, so that made me feel less guilty about that. My opinion is that it isn't right to put them in a nursing home if there
was no need to do that. If she got too difficult to look after, then I would, but I would be up there every day, I'm at the hospital every day now.

Considering that Miss OW had adopted quite a responsibility with the care of her mother, we talked about how she would accept assistance.

Miss OW: I wouldn't find that hard at all to ask for help. The lady next door knows where I can get help and she advises me, she is good at talking things over with and stops me feeling guilty.

Apart from information and advice from the next door neighbour we discussed the other people who provided Miss OW with knowledge she needed to provide the care to her mother.

Miss OW: the GP is excellent, he 'phones me about the Warfarin in particular to make sure I'm giving her the right dose, he's worried about her taking that and the other drugs, sometimes it drives me mad, but I know he's just concerned about her. The sisters at the hospital tell me that they write a letter to the CHN about the dressings. The CHN is only doing the dressings at the moment. She also (CHN) told me what was available and what wasn't available for me. The GP tells me about any of the new tablets, some I know about because she'd been on them for years. At the moment he's put her on an extra Lasix tablet a day, and she's on a restricted fluid intake. They give me, from the hospital a list of the drugs, what they are for, the dose and times they are to be given.

Was the information she was given always understandable and/or appropriate?

Miss OW: Not from one of the hospitals. In one case when they did tell me it was such a surprise. After her heart attack, the doctor told me, yes she's had a heart attack, and it's not very good, but OK for her age, her kidneys instead of working at 60% at her age they are working at 40% which is enough. As for her feet, we'll have to wait and see. One foot was gangrenous. I said jokingly to the doctor, well she can't mow the lawns any more. He said "once she feels well enough she could...yes, I suppose she could as long as she doesn't overdo it". I said terrific, she couldn't mow the lawns before!! But the message I was getting was she was going to lead a normal life, and they told me that a few times. Mum had been in for about two weeks, at the time of the talk with first doctor, and in altogether for five weeks. All this has happened this year, she did a few things, she used to do the weeding and grew vegetables, but I would do the washing and things and anything heavy. I thought that's great, and she said she was coming home on leave. Just as I was leaving the hospital after that, one of the head sisters said, your Mum is probably going home on leave.

There was no doubt that Miss WO's mother was going to die before long. I talked with her about how this was dealt with by the health professionals. It appears that when her mother
came out on leave one of the nurses talked with Miss W.O. She explains what happened at that time,

Anyhow she explained to me that Mum was probably not going to live more than a year, and that they couldn't do any more for her. I didn't know if she was the social worker or the sister. Anyhow I got really cranky, and thought how dare she talk to me about that, and if it's true why didn't they tell me before? Not long before that one of the doctors who was looking after her toes said she wouldn't be going home until they were fixed up and she could walk around and do what she did, that was a week before I was told this by the head sister. I was fuming, I told a friend about that...I said they're bloody stupid up there. When I went up that night I talked to one of the sisters, and said, right tell me what do I expect when she gets home. I said to her look, talk to me about Mum's condition because I've only just heard that Mum wasn't that good. And I said to her, look I can't cope, and the sister was being very good about it and explaining things to me, she said look we forget, because we are dealing with things all the time, just what the family have to go through. Look I've been through it, and it won't be easy for you. So we had a really good talk. I had a problem with one of the other sisters, eventually I talked with the SW about her, who said she would talk with that sister. It turns out that the one who did talk to me in the first place was the head sister. Even the doctor was vague, he was using all these medical terms, and I said just put them into plain words so that I can understand. He was going on about angina, what I didn't understand was when to take her to hospital or when not to when she was having angina. I didn't understand about all that had to be done, so he told me.

It appeared that her direct manner allowed her to get the information she needed. She was not intimidated by health professionals and was very forceful in obtaining an understandable explanation of what was happening with her mother.

Miss OW: That's right, I just ask them straight out. I know that my GP doesn't mind me calling him at any time and will tell me anything I need to know.

Miss OW's entire focus was on the care of her mother. An unsatisfactory social life, unstimulating employment and an apparent lack of purpose to her life had lead her willingly into the care of her mother. Despite the fact that she was able to talk with her friend's family about the problems involved in the daily care of her mother, she was very much on her own. One interview that lasted for well over two hours provided me with her mothers's full medical history and the dynamics of her family. I had noted in my memo that Miss OW had largely ignored her own health status and social interaction in favour of caring for her mother. Within that memo I had also commented on the fact that there appeared to be very
little else that interested Miss OW and I wondered where she would channel her energies when her mother died. We talked about this,

Miss OW: I don't know, I've been living with her all my life, 29 years. I know that Mum frets when I don't get to the hospital when I say I will, things like that. It really has just hit me that she may not be around, I don't know how I'll feel. I've had sinus badly and the pre-menstrual tension, and I've had ulcers on my mouth, and I just haven't been well. I know the migraines I get are due to nerves. I got cranky the other day with all of this and thought why aren't the rest of the family here to do it, but I got over that. But what I'll do when she goes, I can't think about that it's just too hard. I don't get the same sense of satisfaction out of caring for Mum as I did when I was working. Maybe that's tied up with having my own money too, and not being paid by the Government to do what I do for her. Mum doesn't think that anyone else but me knows how to do things for her, it makes it hard for me to leave the house with a comfortable feeling. My job that I gave up, wasn't much of a job, but it gave me contact with people my own age.

Following the interviews with Miss OW I talked with some health professionals about the needs of carers, and of the burden of care. There was a sense amongst many professionals of the carer's life being subsumed under those of the person they were caring for, this was expressed particularly by a nursing lecturer (LECT) who had specialized in care of the elderly in acute care settings and within the community.

LECT: I knew that once these elderly people went home, that there was a sacrificial person who would be used up by this person who didn't realise that they were using up someone else's life as well as their own. That struck me as being very unfair, that one wasted life was bad enough, but to throw another one on top of that was terrible. When carers starts to respond to other peoples needs more and more, often they do not notice it happening until suddenly that person becomes their way of life. If that is removed it interferes with the carer's whole modus operandi, it becomes a threat to their identity/core. I'm not saying that they (carers) are happy in that relationship, it's often a very depressing one, but coupled with a sense of responsibility and a sense of Christian belief that "you look after your own", "you pay back your debts". I don't see that as pathological, necessarily.

Health professionals experienced their own dilemmas in terms of the level of responsibility the health care system expected relatives to accept. The differences within families appeared to be quite diverse in terms of commitment to care of the elderly person.

Physio: I think there is pressure put on relatives, people would have been kept in hospital for weeks/months longer in the old days, but now we just have to have the beds. So I'm sure there is pressure, we need social change to educate people that this
is how it will have to be. Often the caring for old people entails a good deal of effort and sacrifice on the family and/or individuals. I think we try not to think about it, it's just too hard, for me it certainly is. There's a degree of guilt involved in that, that one should care for them. I don't know whether one should expect relatives to give up a job to care for an old person. It's my impression, that old people don't want to live with their children, they want to go it alone, even under really difficult circumstances. They want them close, but I don't even know how close. The other side of the story is that middle-aged children want to look after their parents, it's mad, I can't do anything for my madly active father, he does everything for himself. We see that when the old person comes in, and the daughter/son are wanting to do things for them, and they want to be on their own. In fact we have relatives saying that we won't take the elderly person home, and then we are stuck with a situation of what to do with them, they want us to find an interim arrangement until they are more able to care for themselves. In fact that happens quite a lot. The other thing is that relatives don't get enough time to absorb what has happened, and the changes that are involved.

JAD: When that issue comes up in team meetings, how do professionals react to that feedback from relatives that they aren't comfortable or happy or want to take the old person home?

Physio: I think we would make a concerted effort to show the family that they could cope, and make a real effort to help them to cope with this person. If the family don't respond with that approach, we would look for an interim placement. The reality is that it is almost impossible to do because of bed shortages of course.

JAD: Often the experience from the community health nurse is that the old person may be rehabilitated to a point beyond their capabilities prior to admission to hospital. When they go home they often hand the responsibility back to the relatives. What has your experience been in this regard?

SW: Yes, all the emotional issues will essentially determine what use the elderly person in the family makes use of services and people, according to what their emotional agendas are they will make decisions. They can organise to make the best services not work if they don't want them to. The emotional and family issues related to loss of control and loss of function in their mother or father, and how children react to that is one issue. The other side is that is how loss of physical or mental function is interpreted by the family, that has a strong part to play in what happens next.

The strain on carers was often manifested in a deterioration of their own health status. Gillies et al (1987) demonstrated that while the health of the elderly person may remain the same for a considerable period of time, the deterioration of the carer's health is often the trigger for admission to care of the elderly person, or the need for increased assistance from community resources. This was discussed with health professionals. Knowledge of resources available and the subsequent use of those resources was also addressed.

JAD: Could you talk about carers and their health. Within the literature is recorded the fact that carers themselves are often not well. A constant theme is that carers have "nervous disorders", what would you say about that?
LECT: This stems back to the fact that CHN does not seem to be able to spend the time giving the kind of time/support that is needed by the carer. That time has been invisible in the literature and the records, it's just not validated. Many CHN's who have gone into the field have been put into a position of just doing the dressings and other things, as a result the carers are probably not doing as well as they might have done some years ago. Much of this may have to do with literature that has been written about discharge planning has been by people other than nurses, all this invisible work has not been recorded.

HEO: I have seen the other side of that issue, of carers knowing about services, but not using them, where carers do not know what is available and are quite stunned when they realise how much help is actually available to them. Often there is still resistance to use these services, they (the elderly) feel they are going to lose their independence, it's a funny one that. It's the older person saying that they don't want them there, and trying to get through that is really hard. So what we have done with the Alzheimer's groups is to get the carers together and give them support, really doing for them whatever they need. Sometimes that is as simple as giving them the information about their entitlements etc, we would get someone in from the social security, or from whatever organisation it is they can provide them with the information they need. Even explaining about the dementia, some of those carers didn't even know what they were actually dealing with.

JAD: Some carers/old people will not use services, very little of that has to be do with letting them into the house, it has more to do with other agendas, like moral responsibility, not trusting that people will take the same care, what's your experience.

HEO: That's right, well my major experience with carers is with the Alzheimer's disease and related disorders association (ADARDA) group and lot of them have this great sense of responsibility, many feel that they "should" do certain things, rather than I "want" to, it is tied up with all of that. Some have to make decisions about nursing home placements, and that is real guilt stuff. We have carers who come to the groups even after the old person has died and they are still whipping themselves; all the guilt, you know "I should have looked after them at home until they died".

Considerable discussion with health professionals centred on the focus within the acute care setting, and the difficulty of shifting that in order that carer's needs are acknowledged. Health education appeared as an integral part of that involvement by health professionals with carers and this theme was also pursued further.

GAT: Well in the geriatric assessment team, involvement of the carer is implicit. In fact in the care of demented people, often the care is directed toward the carer and not the demented individual at all, necessarily. In hospital it is easy to ignore the carer, because the focus is very much on the person who is ill, you can't do that in the community.

LECT: Nurses do it very well, they just do not recognise that they are doing it. They wouldn't document what they do as education. Not all of them, but the ones who do it, do it very well. CHN's do it particularly well.
Physio: The knowledge of health education principles is a deprivation that we have, in
that we are not trained in health promotion/education at all. I think physios have a lot to
offer in prevention, but we don't have the tools. How do you deal with motivating old
people and keeping up their energy to do things. The new graduate Physio still prefer
to treat than prevent which leads me to believe that the focus of care hasn't changed in
undergraduate programmes. I recently got an agreement amongst all the area Physios
that if we spent 10% of our time on prevention, then that would be minimal, but at least
a start. But putting that into effect is another thing. They hang on to the treating.

DIET: In our postgraduate programme we had a teaching component, that was
inadequate, but you don't know at the time that it isn't. The longer you are dealing
with people, the more you realise what you need.

Fragmentation of the teaching role within the hospital became apparent during a discussion
with a nurse unit manager (NUM). The specialist nurses undertook their own teaching.

NUM: The nurse wouldn't tend to do a lot of education, the dietitian comes, so we
don't do a lot of dietary education; glucometer education we do, the readings and so
on, but insulin administration is done by the diabetic educators. Continuity is there
with the one educator doing it all the time with that one patient.

Within the community the team of professionals within the health education unit undertook a
variety of programmes dependent on identified needs.

HEO: The kind of programmes we run for the elderly and their carers are, arthritis,
medications education in the community, and we are looking at starting that in the
hospitals this year. Falls and fractures prevention, exercise - like the walking for
pleasure, activities and exercise for pleasure. Aquarobics, and any of these
programmes we would run others for older people, their carers, senior citizens groups,
just whoever asks for them, or expresses interest in them. Stress management, healthy
weight loss, stroke education, volunteer education programmes, support groups,
communication skills, health in retirement, developing of services etc.

The burden of care undertaken by carers is considerable. This case study highlights the
complexities of answering the needs of care givers within the community. Providing
appropriate information to facilitate good care, attending to the personal and professional
needs of carers requires constant attention by health professionals. The principles of health
teaching and knowledge of family dynamics need to be addressed within the health care
system. Closer liaison between hospital and community resources to reinforce health
teaching should be pursued by health professionals.
5.7 CASE STUDY 7- MR WI

This case study exemplifies the independent, highly active elderly person. Mr WI was still involved in the day to day running of a small business following major cardiovascular surgery. He was creative in dealing with his own health care needs and was functioning very well outside the health care system. This study identifies more clearly the diversity amongst the elderly and adds to the discussion about how the elderly view themselves and their capabilities.

Mr WI was 65 and in the care of the community health nurse only for daily dressings. He had undergone major surgery in a Sydney hospital for femoral artery bypass. Following discharge from that hospital he required admission for wound debridement in the local general hospital. On discharge from the local hospital Mr WI had a large wound which required daily dressings, and it was because of this contact with the CHN that I was given his name. His history of cardiovascular disease had started in 1989 when it was found, at a visit to his GP with abdominal discomfort, that he had an aortic aneurysm. This diagnosis had resulted in him being admitted for immediate surgery. He was in hospital for sixteen days.

Mr WI was a busy man. At the first interview with him, which was conducted in the office of his small business, I competed with frequent 'phone calls, enquiries from customers and the usual workshop banter. We initially met in the kitchen of his home which was attached to the business and I waited while he showed his wife how to make scones. It was a particular recipe that he had found that was low in cholesterol and he was cooking them for the first time. His wife acquiesced to the advice proferred by him and seemed happy to let him direct her in the shape, size and number of scones that could be made from the batch he had mixed. Mrs WI's English did not seem fluent and she was withdrawn compared to her quite
gregarious, organizing husband. They appeared comfortable together and there appeared to be little doubt that Mr WI was the driving force in the family.

After watching his food preparation lesson and observing the social niceties, we took our leave of Mrs WI and went outside to his office. I had no private conversation with Mrs WI at all, it appeared that Mr WI was prepared to talk with me about himself but did not feel that Mrs WI could offer anything to me that would clarify or add to his comments. He talked of her in fond terms and made it clear to me that they were good friends who enjoyed travelling together. Their ethnic background was mid-European, and they had been in Australia for forty years. They had married in their own country and the first child was three years old when they arrived, and settled, in Wollongong. There were many family connections in the old country, and they used that as a good reason to travel extensively every year, a luxury afforded by their thriving business. Mr and Mrs WI had four children, two boys and two girls. The children were all married, lived locally and between them had six grandchildren. The two sons were employed and partners in the business, although Mr WI came every day and dealt with the administration.

Family was everything to Mr and Mrs WI and they saw family members every day. As well as the two sons, one of the grandchildren worked in the business, and Mrs WI cooked lunch and morning tea every day, hence the scones. Weekends were taken up with family activities and the major form of socialization was family oriented. Mr WI fished, as did his sons and some of the grandchildren. They cooked the fish together and shared their catch with the family. Mrs WI willingly provided baby-sitting for the younger grandchildren, and spent, according to Mr WI, most of her time knitting, sewing and cooking for the family. His sons appeared to be very comfortable with Mr WI's presence in the workshop, and interrupted several times to seek his advice. In my time with him there did not appear to be any resentment that he attended the business so regularly, in fact there appeared to be a warm
camaraderie between Mr WI and his sons. More than the ease observed between Mr WI and his sons was an acknowledgment of Mr WI's expertise and his vast knowledge of the business and the intricacies of the products they were supplying.

Prior to his surgery in 1989 Mr WI had been well apart from hypertension which had been diagnosed twenty years ago. He stated that he was constantly overweight, usually about 8kg, and that he had smoked approximately 75 cigarettes a day for over twelve years. His level of physical activity was minimal and his pattern, prior to his surgery, was to visit his club after work each day, drink eight or ten beers and come home for dinner. During the time that his GP had treated him for hypertension there had been no serious attempt on the part of the GP to address the issue of Mr WI's heavy smoking. The pattern with the GP was gentle bantering about smoking, as the GP himself smoked. It appeared from the history Mr WI gave me about his eating prior to the major surgery that his diet was high in fat, and subsequently kilojoules.

Mr WI's life had been turned around following his surgery, and much of that was to do with the determination of the man. He enjoyed life, was very energetic physically and mentally, valued the family involvement and wanted to live for a long time. I found him the most tiring of the elderly people to interview, his mind was constantly moving from one situation to the next. During my conversations with him his eyes were constantly observing the activities in the workshop and while he attended to the conversations with me, it was obvious that I was interrupting a very busy day for him. His ability to organize himself in the way that he did left me feeling that the services offered by the health care system would need to improve to compete with Mr WI's level of functioning and problem solving.

We discussed how his health behaviour changed following surgery. His smoking had ceased completely and his eating habits had undergone immense change. His motivation to
change was high and the tactics used by health professionals to encourage these changes were discussed with him.

Mr WI: When I was up in Sydney before my big operation (aortic aneurysm) the specialist told me about my diet and giving up smoking. He said to me "I don't care what you do, smoking or not, it's up to yourself. But here's some advice, buy yourself 500 packets of cigarettes and I know for a fact that you won't be around to finish them, you'll be underground. But at least you can see how you either live and not smoke or smoke and die". Soon as I had my operation I didn't smoke again. I knew I had to stop when he said that to me, and that finally it would kill me. It frightened me, but I don't want to die, so I gave them up. It made it easier to give it up when you know it will keep you alive.

JAD: When you had the surgery on your femoral artery recently, did someone talk to you about your diet?

Mr WI: No, in Sydney when I had that surgery in 1989 they gave me all the information about diet, the physiotherapist I think she gave me a diet sheet. I was about 8kgs overweight at that time, which was about normal for me. I lost about 2kg when I was in hospital, but I think I've put it back on again. I've cut down on fats and eggs. They gave me a full list of what I should and shouldn't be eating. Oh yes, we avoid fat, fish and chips, salami, pork, hardly eat eggs and when I do it would be boiled. Sausages, I don't eat them, I call them holy sausages, only God knows what is in them. Recently though I've had a few fish and chips, and barbecue chicken, I love that, I've slipped back a bit with the diet. It's hard to lose weight, especially when you drink. I don't drink beer much now. I like wine too. That professor told me to keep away from beer, no red wine, only whites. Well they are the few things that I like. I used to go down to the bowling club between about 5-7p.m. and have 8-10 beers, you could set a clock on me getting home, and we would then have dinner. Well I don't do that now, I stay home. Everything has changed. I don't mind not going to the club anymore really, the breathaliser has something to do with it as well. I don't want to be picked up by the police over the limit, I've been lucky a few times not to have been caught.

JAD: Did anyone talk to you before you left the hospital about what you should do in the way of exercise or diet?

Mr WI: No one down here talked to me about diet or exercise. They haven't got time for that. In fact there was one nurse there who was very difficult to deal with. My wound was left for 3-4 hours one day, she wouldn't come until she was good and ready. Anyhow the doctor and matron did something about that when I mentioned that to them, and she came in and apologised. It was a big wound, you could fit an egg in the wound at that stage, it's nearly completely healed now. I was only told to walk around the hospital ward, I used a walking frame and then crutches, but then I was OK. The doctor (specialist) said walk but not too much, mind you he didn't tell me how much was too much. My other leg feels like pins and needles. The one they've operated on feels good. I've almost stopped limping now.

Given the size of his wound and the seriousness of the surgery, we talked about information that was given to him about care of the wound itself.
Mr WI: They told me at the hospital that the CHN would be coming to dress my wound, the sister in the ward gave it to me with a phone number to contact if they hadn't arrived. But that was OK. They didn't say anything to me about the wound oozing and what do about it but it wouldn't worry me I have a first aid kit here and I would have put something on it. Mind you the hole that I had in my groin after they scraped the wound out for the second time was as big as an egg, it's almost healed now.

Mrs WI had seemingly adopted a low profile in the story so far, and I asked Mr WI how she was involved during the hospitalizations.

Mr WI: She's a real worrier, she was in the hospital all the time, she nearly slept there. We are a close family, they visited all the time. Mrs WI never heard from the doctor at all, I had to tell her what was going on. I am the head of the family and as much as possible I protect her from worrying more than she does. They want to do the other leg and I've told Mrs WI I'll wait a little longer before I decide what to do. She's still recovering from the shock of the last surgery I had really. Actually as each day goes by and I realise how uncomfortable the other leg is the more I know I'll have to have it done as well.

We talked about the impact of health professionals in the advice they had given Mr WI.

Mr WI: Well the specialist has the most experience than any of them, even the GP needs to do more, he needs to do some more reading I think, he didn't have a lot of the answers I wanted talked about. I have had high blood pressure for about 20 years and that has always been high, I adjust my medication according to the reading. I do that myself, I gave up waiting down there in the surgery waiting for him to take it. He (GP) knows what I'm doing. I've talked to a few friends of mine as well, it saves going to the surgery. I'm too busy down here to be sitting up there. When he put me on some tablets I got dizzy, and when I talked with him he told me to cut down. I know about cholesterol. Mine used to be 9, it went down to 7 two years ago, but no one has checked it since then. The funny thing is that before I went to hospital about a month ago they did my blood and there was no cholesterol result on there. I said to the doctor (specialist) where is the cholesterol? He said that you have to ask for that especially, and he wasn't interested in that.

Mr WI's motivation to quit smoking had been as a direct result of the specialist's conversation with him. The method of actually quitting was his own, he was not given any advice about who might assist him in giving up cigarettes and he sought no advice from the health care system.

Mr WI: I did it all on my own, why would I need anyone else to help me do that? Taste one of these (offers JAD a lozenge). They are the "fisherman's friend" (a lozenge to cut down on throat irritation), I cut them up and have a piece of one when I feel like a smoke I have one of these. It's just enough to keep it ok, it's just enough. I tried another sweet but that left a terrible taste, so I came up with these. When my GP
told me to give it up, I said why do you smoke?, he smokes cigars, he said "I smoke to relax". I did too, but I'm ok now. I'm automatically relaxed now.

Much of his relaxation was the fact that he did not have the level of responsibility for the business that he had in the past. His sons had shown that they could run the business competently without him, but he enjoyed the constant contact with them, and the associated feeling of usefulness and value he derived from this contact.

Mr WI: Actually although the business is now in the hands of my sons, I am here every day and do most of the administration. They still ask my opinion about things, they have a lot to learn. I've been in this game all my life. I've forgotten more than they know. They are good boys, but I can still teach them a few things and I enjoy watching what they do and maybe suggesting an alternative way of doing things. Sometimes they take my advice and sometimes they just do it their own way, usually they find out that I know best, I like that.

My interviews with Mr WI were very much to the point, little time was wasted and the picture I was left with was one of a very active and self-contained man. The behaviour exhibited by Mr WI supported the activity theory of the elderly which identifies a strong relationship between remaining active and being happy (Havinghurst, 1961; Havinghurst & Albrecht, 1953; Kutner, 1956). Mr WI's need for assistance with health problems was minimized because of a high motivation to live and a knowledge that he needed to be pro-active in the management of his health. When I examined the data to incorporate comments from health professionals that would relate to this last case study I found that there was virtually no discussion that concentrated on this particular group of elderly people. That lack of attention by both the health professionals and the researcher supports the view that elderly people are often viewed as dependent, unproductive and incapable of carrying out their activities of daily living. This view is mostly inaccurate and continues to influence the focus of health care to the elderly (Ewan, 1986; Geiger, 1978; Hicks, 1984; Radford, 1987; Smith, 1988).
5.8 PROPOSITIONS

Not surprisingly, case study analysis is the most difficult stage of doing case studies, and novice investigators are especially likely to have a troublesome experience (Yin, 1984, pp 99 - 119).

Advice about strategies that might be employed to assist the researcher to analyse qualitative data abound (Becker, 1958; Chenitz & Swanson, 1986; Dean et al, 1969; Field & Morse, 1985; Glaser & Strauss, 1967; Lofland & Lofland, 1984; McCall & Simmons, 1969; Miles & Huberman, 1984a 1984b; Spradley, 1980; Yin, 1984). That advice ranges from "pattern-matching analysis" and "explanation-building" Yin, (1984, pp 103 - 108) to "card sorting contrast questions" Spradley (1980, p127). Whatever style the researcher adopts to analyse the voluminous amount of data collected, the principles of the approach remain the same. The basic premise is the need to read, re-read and then read again, all the data. To spend time reflecting and making sense of what you have heard and heard, and to finally arrive at the "theory saturation" and unshakeable position that Glaser & Strauss (1967) assures the researcher will be reached. The data appears to talk to the researcher. At that point the researcher "knows what he knows" and the feeling "in your bones" that Glaser & Strauss describe eventually decides the end of the data collection (1967, p 225).

On-going analysis of memos and the early examination of data was useful and provided early opportunity to develop the skills required to read through the large amounts of information that was being collected. Throughout the data collection codes were slowly emerging. Information that reinforced or added to those emerging themes was identified, categorised and used to develop a matrix. The pattern which developed in this matrix allowed the major themes to fall into their logical headings. "Slices of data" and "continual intermeshing" of data, along with the analysis, directly influences the closure of data collection (Glaser & Strauss, 1967, pp 67 - 73). Wherever variations of the pattern or codes occurred further examination of data and/or questioning of participants was used to confirm or modify the analysis.
The warning to resist early closure of data collection is given repeatedly by qualitative researchers, but more particularly by Glaser & Strauss, (1967) and Strauss, (1987). The major strategy to prevent early closure is seen by Glaser & Strauss to be "the systematic use of comparative analysis" (1967, p 256). It is further suggested that use of comparative analysis, at an early juncture of data collection, provides "a broad, rich, integrated, dense and grounded theory" (op cit, p256).

One of the most striking features which emerged from the interviews was the diversity amongst the elderly. From Mr WI who epitomised a highly active, creative individual to Mrs BE who waited for death as a welcome friend. The view the elderly had of themselves was interesting. Being elderly was paralleled with dependence. It was only then that the label "elderly" was seen to legitimately apply to over 65 year old people. The importance of that view relates to health education programs and other initiatives and how health care professionals might need to reassess their marketing techniques. Given the range of individual differences amongst the elderly people in this research it appears that terminology applied to the over 65 population is inadequate.

A theme that persisted throughout interviews was the lack of attention given to health education by health professionals. Despite the fact that many professionals attempted to address educational needs, they either gave insufficient time and/or information, or they failed to ensure that the focus of education followed discharge. The elderly, without exception, regarded specialist health professionals as having a particular knowledge and expertise. Unfortunately that belief was not used to advantage by the majority of specialist practitioners involved with the care of the elderly, particularly in the area of health education.

Health professionals, and nurses in particular, were shown to encourage dependency on their care. This is linked, especially in hospitals, to the custodial role adopted by institutions and
the fear of litigation. The gap between hospital and community services was another strong factor and one which impeded service delivery and fragmented care for the elderly. This fragmentation of care was found to be a reflection of the differing philosophies of care amongst health professionals. A failure to recognise the vast individual differences amongst the elderly contributed to that situation, as did lack of appreciation of the home environment and support structures available to the elderly person and/or their carer.

Lack of attention to carers' needs, acknowledgement of the information and/or assistance needed to undertake the care, was largely ignored by health care professionals. Carers were not involved in the discharge process of the elderly person, and many assumptions were made by health professionals about the carers' personal resources to enable them to provide care to the elderly person.

Glaser & Strauss comment that:

His (the researcher) sociological perspective is never finished, not even when he writes the last line of his monograph - not even after he publishes it, since thereafter he often finds himself elaborating and amending his theory, knowing more now than when the research was formally concluded (1967, p 256).

The point of closure eventually arrives, even though the researcher knows that there is always more knowledge to be gained, different paths to pursue, other questions to ask. It is almost with a sense of reluctance that the final words are written about the data. The time to separate from the people involved and the information they generated is difficult. However that time arrives, and the need for an objective summation is apparent. Disengaging from the emotive tie with participants and their stories is a painful one, unexpected and undertaken with considerable reluctance. It is that same sense of "ethical hangover" and "kind of treason" described by Lofland & Lofland (1984) that can prevent the final commitment to writing of the inquiry. That aside, it is now done.
Emerging from the data are the following propositions.

a. Health teaching involving the elderly fails to acknowledge that many people over 65 do not consider themselves to be "elderly" or "old".

b. The older generation is conditioned/socialized into a belief about the "power" "wisdom" "knowledge" of health professionals. Those beliefs could be used in a positive way, especially by specialist practitioners, to alert old people to good health behaviors.

c. Differing philosophies of care amongst health professionals, and the gap between hospital and community services, impact on care of the elderly.

d. Carers undertake a considerable "burden of care" of the elderly. The need for assistance and, in some cases, preparation for that role, has not been recognised by the health care system.
CHAPTER 6 - FROM PROPOSITIONS TO POSSIBILITIES.

The principal area of interest in this study was elderly participants' interpretation of health teaching undertaken in the discharge process from hospital to home. Propositions that emerged from analysis of the data are those major themes which persisted throughout the interviews. The open-ended nature of questions in the interviews allowed the direction, and a gradual "explanation-building" (Yin, 1984) developed. Views expressed by the elderly were discussed with health professionals and others involved with their care. Those discussions affirmed and added to, the major themes of the interviews with the elderly and allowed the researcher an opportunity to examine the emerging propositions from various perspectives. The propositions will be discussed individually in this chapter.

6.1 A VIEW OF "OLD" AGE

Health teaching involving the elderly fails to acknowledge the fact that many people over 65 do not consider themselves to be "elderly" or "old".

The elderly people in this study proferred the view that being old was related to dependency. None of the elderly in this study considered themselves to be old. That belief has particular implications related to the delivery of care and health teaching strategies. An example of how this sense of being old was expressed by the participants can be seen in the following comments from Mr and Mrs RC.

Mrs RC: I don't think it's age, I think it's more a state of mind or maybe feebleness of body.

Mr RC: I wouldn't have thought at all about being old, at that stage (before he became ill) I was still doing the things I used to years before, therefore I'm quite OK, that would be how I would feel about that. I've never thought about being old, all my life I've never stopped to think about my age and that meaning that I'm old, it's never gone through my mind. What do I mean by old, I mean people who just get shoved around, and that is that they can't look after themselves in a normal manner.
All of the health professionals in this study commented about the difficulties in accurately defining the elderly and the vast differences amongst them. The following comment was typical of those offered by health professionals:

Dietitian: The elderly are put aside a great deal, I acknowledge that. A factor that came through at a conference recently was that the elderly can live from 65-105, that's a forty year range. We can't afford then to lump them all together, we decided to put them into categories of healthy-elderly, minimally-dependent and maximally-dependent. Actually the activities of daily living which were used to delineate their degree of dependence revolved around food - shopping, cooking, preparation etc.

Within one of my memos I commented that if individuals over 65 do not classify themselves as old, how could they (the over 65) be encouraged to involve themselves in programs targeted specifically toward the needs of the "elderly". "People are disinclined to see themselves as "old" or "senior citizens"" (Healy, 1990, p 130). Senior Citizen Centres are poorly attended because of the stigmatism attached to them (ACOTA, 1985, p 305). Many health care delivery strategies continue to segregate the elderly. While this may be planned with good intent, it reflects the poor understanding that exists about the nature of the population of elderly people in the community. A social model of health as opposed to a medical model, focuses assessment and delivery of care on the total "social" identity and reality of individuals and acknowledges the learning potential and differences amongst older people.

Without exception the elderly participants in this study believed that being active, close to their family and friends were important factors in their lives. Activity theory highlights the relationship between continued mental and physical stimulation and a positive adjustment to old age (Havighurst, 1961; Havighurst & Albrecht, 1953). Activity theory supports the notion of both motivation, and a futuristic perspective for the elderly. Valuing the feelings of wellness and happiness, involvement with families and friends, can act as modifying, or catalytic factors to healthy behavior patterns. "Programs which increase coping skills and a general sense of power and effectiveness can take many forms, and are clearly a most
important component of health promotion strategies for older people" (Jones, 1989, p 16). Learning enhances self esteem and in elderly people this may influence, or prevent disengagement (Phillipson, 1982).

The elderly are quite capable of learning and changing their health behaviors, this was demonstrated by several of the participants in this study. Current practices of teaching in the discharge process from hospital to home are influenced by the stereotyped views held by health professionals of the elderly and thus fail to address key issues of self perception and motivation to develop or maintain a healthy future.

6.2 OLD PEOPLES' VIEW OF HEALTH PROFESSIONALS

The older generation is conditioned/socialized into a belief about the "power", "wisdom" or "knowledge" of health professionals. Those beliefs could be used in a positive way, especially by specialist practitioners, to alert old people to good health behaviors.

A theme that persisted throughout interviews with health professionals was that, as they became more experienced in dealing with the elderly, they recognised the immense differences among them. They also experienced difficulty in putting aside their stereotyped view of the elderly. In general, interest in working with elderly people is not high among medical students and practitioners (Geiger, 1978; Ewan, 1986). Whether a lack of knowledge about healthy elderly people, with compounding negative community stereotyping produces this attitude is not clear, however, amongst health professionals care of the elderly is not generally a high priority career path.

Comments were made by the elderly people in this study about the need for medical practitioners to be honest, even if that information were painful. Specialist doctors were
excused by the same elderly people from having dialogue, because they were only there for the specialized surgery/medical intervention and then to refer back to the general practitioner. They were, however, regarded as an authoritative source. Typical comments were:

Mrs CP: Well I know that the specialist is only there to do what he has to do, but if he'd told me that by losing weight I might live for another 10 years, then I'd take notice of him.

Mr WI: When that specialist said to me "you buy 500 packets of cigarettes and smoke them, but I'm telling you that you'll die before you finish them". That was enough for me, I've never smoked since then.

It would be inaccurate to suggest that all old people welcome advice or would be willing to alter entrenched health behaviors. The issue is rather more of accurate assessment of their needs, providing them with information and the willingness of health professionals to encourage the elderly in making decisions based on that information.

The helplessness of many older people - their need for empowerment - is not confined to self-care. Some health services, not least among them hospitals, need to be reoriented to promote greater support for the health needs of older people. This may turn out to be more radical and less wishy-washy than it sounds: the current climate in which no ambitious young registrar wants to be a geriatrician may have to be questioned (Leeder, 1990, p 11).

Medical practitioners and other health professionals gave their perspective on this theme:

Physio: It's not until you are more experienced yourself and have had a lot to do with old people that you realise that most of them are quite creative in what they do and that they want to be involved in their care. You know sometimes it's very difficult to see that amongst the busy days, the heavy work load we carry and the level of responsibility we have for our practice. I also know that health education takes a low profile in our practice, mainly because it's time consuming and it's something we are not prepared for at undergraduate level.

There is also a negative side to the elderly public's perception of the authority of the health professions. The "Gullible Public...has accepted the common doctor's view of himself as infinite in wisdom and sagacity" (Evans, 1990, p 79). As a corollary to that there is an expectation that doctors will be able to "work wonders beyond their capabilities". Politicians have chosen to exploit the "decision-making appetite" of doctors and allow them
to make decisions about matters which are not medical problems at all (op cit, p 79). Four of the five elderly commented on the patronizing attitudes and lack of information they received during their hospitalization. The exclusivity of the language used by health professionals distances them effectively from the average person, and adds to the mystification built around collective medical knowledge. Withholding information disempowers anyone and more especially the elderly who are already disempowered by attitudes to them which prevail amongst health professionals.

Given the high regard the elderly in this study, at least, had for health professionals in general, and specialists in particular, it would seem that advice if offered would be well received. While health professionals continue to stereotype the elderly in the way that many of them do, a real commitment to health promotion of the over 65 population will not gain momentum. "The medical profession at large has been slow to accept the possibilities of rehabilitation of the elderly" (Phillipson, 1982, p 88). Valuing and then developing health preventive strategies for the elderly requires urgent attention. There is also a need for,

...a distinction to be made between teaching people what the health professionals think they should know and devising educational programmes that reflect what is important and significant to patients. The patient educator must learn to suspend professional attitudes and habits, and enter into the patient's world, so that she or he comes to understand the patient's rationality, mentality and problems (McEwen et al, 1983, p192).

6.3 DIFFERING PHILOSOPHIES BETWEEN PROFESSIONALS

Differing philosophies of care amongst health professionals, and the gap between hospital and community services, impact on care of the elderly.

A major area of concern expressed by both professionals and participants in this study was the fragmentation of services. A core problem is the difficulties health professionals
experience in linking care provided within institutions with those in the community. This is not a new problem, but it is a most important factor in assuring continuity of appropriate care for the elderly person. Level of communication and collaboration between health professionals and the elderly was variable. Varying philosophies of care compounded this problem.

The following comments highlight some of those differences and the difficulties of interaction between hospital and community health professionals:

Social worker: We are very careful when patients go home that they have been given the right options and contacts. It is in our best interests too, so that they don't come back into an already over-loaded system. It's our medical wards where patients are admitted again, and again and again; so we often know the elderly patients very well. The reason that we would take a great deal of interest in them is that we have had so much contact with them. One of the difficulties for us is having the time and venue to liaise with those professionals providing care in the community.

Occupational therapist: Only occasionally is there an interface between you and community groups and talk about some of these gaps, due to our lack of time and the difficulty of everyone getting together. The mechanism is there through quality assurance, patient care committees, but it gets down to a lack of time. We are all tied up with getting on with the immense load we all have to deal with on a day to day basis, and not enough time to reflect and plan outside of that. The colleagues I work with are generally - well I see a balance between those kind, caring, compassionate (all of those wonderful things), and on the other side those who make judgments about the elderly, which have nothing to do with the individual old person at all. Obviously various professions have different focuses and emphases, social workers are going to be more tuned into grief and loss than say physiotherapists, but again one can't generalise. As we become more experienced we realise the vast differences in old people.

All of the elderly in this study identified a gap in communication between hospital and community, and this following statement best summarises this situation:

Mrs RC: When you're going home you're frightened. Mr RC was still very weak even though he was putting on a brave front, I knew that things weren't good. It wasn't until I got him home that I realised what I needed to know, actually no one spoke to me personally. Conversation was directed to Mr RC and he was still a little confused about things at that time. It was pretty impersonal, we didn't have the name of the community nurse, just a number to call, it felt a bit scary.
Education of health professionals in relation to liaison between hospital and home requires a spirit of collaboration. Rusch (1986) reporting on a programme for nurses and physicians on patient and family needs, comments:

Establishing of a common perspective to which both nurses and their patient-family groups can relate, this blending of home and hospital setting for each patient's benefit improves service satisfaction for professionals and consumers alike (p 38 - 41).

Technology may also have a role to play. Romano (1984) describes computerised discharge planning where all components of care, admission, assessment, screening and referral are undertaken with integrated assessment utilising data from health professionals involved in the care of the elderly. Nurses, who provide the bulk of health care services to the elderly, are the most educationally deprived health care workers. Despite that Bremer (1989) reports that if the community health nurse is the case manager a decrease in fragmentation of services results. Additionally there is a "...re-focus of the services from the current response to acute illness mode to a prevention model" (p 183). There are conflicting views about the effectiveness of community health nurses in the literature, but what is clear is the need for closer liaison between the hospital and community professionals, and for on-going education for all health professionals, at both under and post-graduate level.

A study carried out in an acute academic medical centre demonstrates that, "Timely and effective discharge planning can optimize the patients' ability to return home and can reduce the likelihood of rehospitalization or placement in an institutional setting" (Saltz et al, 1988, p 344). The study employed the collaborative services of a geriatric assessment team and a discharge planner. Problems in the discharge planning process identified by nurses and strategies instigated to overcome them have been varied. The net-work of friends and neighbours are often not known by hospital staff. Structuring of care plans which identify major problems of the elderly help to lessen the gap between ward and home (Barnett, 1986; Kitto & Dale, 1985).
In spite of good discharge planning some elderly people will be readmitted to hospital eventually. Recurrent chronic problems, falls, incontinence and confusion accounted for 59% of readmissions in a survey undertaken by Andrews (1986). Nevertheless, efficient discharge planning is essential and must involve cooperation which extends beyond the walls of institutions to those health care professionals responsible for care in the community. Appropriate needs assessment which identifies the focus of that care is a vital component of health care delivery and teaching.

6.4 CARERS' "BURDEN OF CARE"

Carers undertake a considerable "burden of care" of the elderly. The need for assistance and, in some cases, preparation for that role, has not been recognised by the health care system.

Some of the factors that inhibit self-care by the elderly may be implicit in the concerns and actions of the carers themselves. In that sense carers' behavior is similar to that of health professionals. On one hand they want to care for the elderly person and protect them from harm, and at the same time may be frustrated with their pace of functioning. As the rate at which the elderly are able to accomplish simple tasks decreases, professional and non-professional carers progressively assume those tasks and roles for them. That reaction may be counter-productive for the elderly person. Not only does it encourage dependence on the carer, it eventually lowers the confidence, esteem, motivation, and ultimately the incentive of the elderly to manage their own lives. Much of the dependence of the elderly person becomes a self-fulfilling prophecy of increasing need for attention.

Carers surveyed in a large Australian study (ACOTA, 1985, pp 470 - 475) reported a desire for time free to pursue their own interests, keep up friendships, and take a holiday. Lost
employment was another dissatisfaction. Many carers commented that it was almost impossible to plan from one day to another. Interestingly 49.8% said they had no problems or worries at all in caring for the elderly person.

Whilst only two carers were interviewed separately from their charges in this study, their views reflected the findings from the ACOTA study. Comments from Miss OW demonstrate some of the difficulties experienced with constant care of an elderly person.

You see I live here in the family home, it was just a natural thing that I would take care of Mum. I couldn't ask the others who are married and have children to move interstate. I'm unmarried, not very happy with my job and it seems OK that I stay home with her. I owe her that, she and Dad have been very good to me, when he died and I just stayed on here with her, she learned to rely on me. It worries me, as I told you before, that she might get demented. If that happened I would have to think about a nursing home, but I feel guilty even thinking about that. Mum doesn't trust other people to come in, the community health nurse is OK, but if I wanted to take off for a night it's hard to get away. It's only now while she's in hospital that I can get out and do a few things. The responsibility of her when she's first home from hospital is pretty tough, I worry a lot for the first few nights. Actually I don't sleep well at all, I keep an ear open for her breathing, it's like having a baby you think is going to die in it's sleep. Mind you if she did die, what could I have done? It's really hard, I try not to think about it too much. She's become my world really, when she dies I don't know what I'll do - I'd rather not think about that. Would I get help if I couldn't manage caring for her, yes I would but she wouldn't like it I know that. At the moment I do everything washing, ironing, cooking, cleaning and looking after her, it's a lot.

The problem is widespread in Australian society. A survey of elderly people following discharge from hospital (Hawe et al, 1986, p 251) found that,

...immediately after leaving hospital more patients were living with family or friends than were prior to hospitalization and there was a slight increase in the number of patients who were living in nursing homes. However, by three months after discharge, the living arrangements resembled the pattern of arrangements before the hospital admission. At 3 months after discharge from hospital 66% of patients were fully independent with regard to basic activities of daily living...but only 34% of men and 17% of women were fully independent in broader activities such as shopping and meal preparation. By this stage, 88% of patients were in daily contact with family carers who were providing for many of their elderly relatives' needs.
Community health nurses support these findings. The fear of litigation which pervades the hospital environment and the need to accomplish tasks quickly due to low staff numbers contributes to an increase of dependence in the elderly in managing their activities of daily living while recovering in hospital and on discharge. Hospital staff also adopt an attitude of protection of the elderly patient, which is based largely in their stereotyped view of the elderly. There is often a lack of awareness of the support system at home, and health professionals generally fail to communicate effectively with the family and/or carers to ascertain base line data from either family or the community service providers. Institutions need to address these issues. Community nurses could be invited into the hospital to liaise with health professionals about the care plan. Relatives should be involved earlier in the discharge planning than they are at the present time and the elderly themselves need to be involved, whenever possible, in this process of planning of their lives.

The following comment comes from an academic nurse who has spent considerable time in caring for the elderly and their carers. Whilst the extract is long, it exemplifies comments from other health professionals about the relationship between elderly people and their carers.

Academic nurse: I set up the role of discharge planner at a hospital, and I found that I was involved with the discharge of elderly people, to predominantly female carers. I also knew that most of the people being discharged were going to throw that family into total chaos. Simply because they were being discharged very early with very complicated conditions and treatments required; that's not even touching on the emotional support issues, like the mutilating surgery and loss of sexual function/mobility things like that. I found that my total personality changed, trying to change the attitude of people within the hospital that this was happening, and that there was much more to it than just clearing the beds for the next patient. I set up a link between the community and the hospital, so that I could go to the community case conferences. What I actually did was get funding for a "day-away" centre. (Vivid description of how the centre functioned, that it was geared toward activities the old people wanted, not those that the nurse might decide were appropriate. "R" rated movies were on the list of requests from the elderly people). The centre was on the hospital grounds, staffed by one nurse and a helper. It was for the old people and their carers to have a day off. It was based on carer need, if the carer needed 4 days off a week, that's what they got. We were absolutely swamped with people. I had about 65 people going through a week. No more that 18 in a group, and it was so successful that I got a bigger area. The other thing was that people who were going to be discharged were brought down from the wards for the day, especially the Alzheimer's and schizophrenics. They would come down for a few hours, and as soon as they got
agitated they would go back to the ward. Gradually the time they stayed increased, and it was a re-socialising leading to discharge. It was suggested that I stream people according to their pathology. However what I did was put them all in together and they loved it. They called it "The Club". What I found interesting was the carers they would not let them (the old person) go, it was done for the carers, but they just couldn't let go, their whole life was so involved around this person, that they couldn't let go. I gave them some diversionary things to do, and gradually they would detach, eventually they would drop the elderly person off at the centre, go out for the day and come back later and pick them up more refreshed. Guilt was mostly the problem I think for carers and also not trusting anybody. They had seen how society had treated the elderly person's differences, so the carers were very protective.

While care for the elderly in the community remains the responsibility of relatives and friends there is a need for the health care system to respond to the needs of those carers. Some of those needs have been reviewed in Chapter 2. Within the discharge process and the teaching undertaken in that process, the carers have often been overlooked. Recognition of the burden of care undertaken by carers, and a commitment to finding strategies to assist in the delivery of that care to the elderly is of paramount importance.

6.5 - CONCLUSION

"Theory building is the search for essences, pervasive and determining ingredients, and the making of laws. The case study, however proliferates rather than narrows. One is left with more to pay attention to rather than less" (Stake, 1978, p 7). That is certainly the outcome in this study. Many of the issues surrounding the care of the elderly in our community present more questions than answers.

Who are the elderly?

Numerous attempts have been made to define the elderly. In an attempt to address the variability among the aged terms such as "young old" (<65 years age), "old old" (>75 years old) "independent old", "dependent old" and "oldest old" have been used (Altergott, 1988; Hanna, 1982; Manton, 1989; Neugarten, 1982). Other authors have used a subjective
approach and questioned the elderly about their sense of well-being (Cant & Legge, 1984; ACOTA, 1985). Comments from the elderly included statements about their feelings "I am lonely", "I am bored", others reflected themselves in a social role "I am a mother" (Cant & Legge, 1984, pp18 -20). The development of an appropriate set of nomenclature which reflects the self concept of over 65 year old people is important.

Factors which contribute to the elderly feeling satisfied with life are, "...good neighbours and friends, good health, happy marriage and a happy family; being content with what you have got" (Brocklehurst, 1987, pp 40 -41). Significant numbers of the elderly remain in a physically active phase in their advancing years and:

Competent older people seek meaningful ways to use their time. Some stay at work, some undertake second careers, some retire, and some seek self-fulfilment through education or various forms of leisure activities. Many are serving their communities in remunerated or non-remunerated ways. They represent a great pool of expertise and talent in the society, much of it underutilized (Neugarten, 1982, p 118).

Much of the projected data related to numbers and extent of morbidity are extrapolated from base line information as we know it now. The situation is, however, dynamic. To a large extent the morbidity is in the hands of health professionals and their present philosophical approach to care. The future problem, if that is what it is, of aging in Australia has not been researched "imaginatively enough", nor does the research currently undertaken reflect the "broader questions" posed by the aging population (Hicks, 1984, p 6). The possibility of a return transition from dependent to independent status must be taken into account (Rogers et al, 1989).

What services do the elderly need?

Frequent users of services tend to be old-older people (>75) rather than young-old (<75). As well, Women and those living alone are more likely to receive social but not health services
than men or those living in larger households (Neugarten, 1982). Within both of these categories of users of services are those elderly people in lower socio-economic groups.

Despite the diversity of aged care services available and the heterogeneity of people being cared for, it is frequently argued that non-institutional forms of care should be promoted over institutional alternatives. The relatively high level of provision of nursing home beds in Australia is cited regularly and it is argued that non-institutional alternative forms of care are not only cheaper than institutional alternatives but that they also accord with the preferences of the aged (Bennett & Wallace, 1983, p 35).

Bennett & Wallace argue that the debate about costs involved in institutional versus non-institutional care, may be overstated. "We believe that the methodological considerations as well as a detailed analysis of the characteristics of the users of aged care services may lead to somewhat different conclusions. The options open to Australian policy-makers in this area may not be as clear cut as many people have argued (p36). This view is supported by Davis (1987) "...the problem depends more on policies with respect to the aged than on the number of elderly" (p 60). We could examine strategies used elsewhere "...countries with older populations and more expensive retirement income systems are already coping or making the necessary adjustments to the older population...and so Australia should have relatively little difficulty in also adjusting to demographic change. Australia's population policy should also aim at making more efficient use of its existing human resources" (Foster, 1988, pp 30 - 63).

Extending service utilisation research so that data reflects a more holistic view of the reason why the elderly use certain services is of paramount importance. The "elderly" have many needs which are generally unmet within the present climate of care delivery. From the labelling process which the term "elderly" brings to the negative and stereotyped view which persists, the over 65 population struggle to find an individual identity. Service provision is often targeted at them as a group, always assuming homogeneity of need and discounting the variation of differences to be found amongst them. With increasing numbers and longevity, this population of individuals will continue to present a challenge to service providers and
health professionals. That challenge is not just in the mainstreaming of care, nor in the need to apply some lateral thinking to the delivery of that care, but more importantly to recognise that the over 65 population will represent in the next decade the majority age group in our society.

**How do health professionals contribute?**

It is now that change can be effected in the delivery of health care services to the young group of over 65 in the population.

The most important factor in determining the long-term treatment was not the type of drug, or the physical or mental state of the patient, but the **doctor**. It has been said before, and bears re-stating, that education of health professionals, both at undergraduate and practitioner level, is vital. But the consumer needs education, too. Often, older people visit the doctor with the expectation, if not the demand, that they will receive a tablet to cure their ills. This can particularly apply to women, who report more illness, make more visits to doctors, more often take medication - and whose relative number will increase as the population ages. Older people need information about medication and its effects. As well, the kind of programs and activities which increase self-esteem and a sense of control over life may assist in overcoming any conditioned reluctance to ask for this information, if the doctor does not offer it (Jones, 1989, pp 16 - 17).

It would be inappropriate to suggest that medical practitioners should accept the total responsibility for influencing the negative social attitudes which persist. This thesis has demonstrated the need for the community to work actively toward reducing the marginalization of the elderly in the population and to developing positive views of aging. The elderly are predominantly independent, healthy and living outside of the custodial care of the health care system. To a large extent that is due to the commitment made by their family and friends, who adopt a caring role which could not be subsumed within the health or community services budget.
For some health professionals commitment to care of the elderly with their accompanying chronic illnesses, is impeded by the difficulty they have in accepting those chronic illnesses. A common problem for people with chronic illnesses is legitimation, the need for others to accept the reality of the pain, incapacity, and accompanying distress (Locker, 1983, p 131). This legitimisation of disease is linked with the concept of ill-ness as a form of deviant behaviour, and reinforces the "victim-blaming" syndrome which can influence care delivery. Those professionals who on the other hand, expect and accept the inevitability of chronic illness in the elderly may be empathetic but prepared to undertake only minimal investigation or intervention. Kane (1990) warns "No amount of compassion will displace the failure of not attending to that which could have been corrected" (p16).

*How can we support carers?*

Carers and their needs are only now being recognised and addressed by health care providers. This predominantly female group of people should not be seen as endless resources to be "used" to prevent admissions to institutional care, but rather as catalysts to maintaining and improving the health care status of the elderly in their care. The educational needs of carers are often neglected, their need for respite is neglected and the "burden of care" they bear is largely underestimated. Along with an increased valuing of the over 65 population in our community will hopefully also come an increased valuing of this caring role which has been labelled by some as a "labour of love". Unfortunately, that labour of love can become tedious, physically debilitating, and a mechanism by which personal goals and aspirations of the carer are totally subsumed.
**Quo Vadis?**

It has been suggested in this thesis that the next cohort of over 65 year old people will be healthier, more assertive about their needs and rights, and spend more of their life outside the health care system. We would do well to recognise that the cohort of "elderly" in the year 2000 will have made a considerable contribution to the economic and social growth of the society in which they live. To that end the point is made that, 

Should the future bring continuous economic growth the aged will have contributed in no small way to that success. They will also enjoy its benefits in greater accumulation of superannuation and savings for retirement, sustained or increase levels of home ownership and consequently, greater disposable income to spend on leisure and consumption (McCallum, 1990, p 197).

The level of discrimination against elderly people that we have witnessed so far, may become a feature of the past. It would be inappropriate to portray the elderly as a "sentimental ideal" and to ignore the fact that some are and will remain difficult, inflexible and in need of custodial care, but that is not the norm, nor does it indicate the future we should look toward. Politically and socially change will accompany the efforts of educational, health and community institutions as a growing awareness of over 65 year old people develops within society.

Two general, and optimistic future trends are posited by McCallum (1990). "First, integration of the aged with the rest of the population; and second, concentration on measurable need as the criterion for public support rather than the status of being aged". This means also that younger groups who are in need may access services and resources developed for the elderly. In this way the marginalization of the elderly in the community will be eliminated. Mainstreaming and a commitment to equity in access to services for the elderly is paramount: "Integration is a two way process of removing special treatment and opening access to new areas". It is a process of replacing "age" with "need" and with
Reshaping the public view. Public "compassion" for the aged is a mixed blessing, but one that is partly based upon prejudicial and inaccurate perceptions of them as needy, frail, disabled and so on" (pp 186-199).

Change is a two way process and requires a commitment by both parties. Given the right environment and the good will, we can improve the quality of services and care afforded to the over 65 population. Our vested interest in improving conditions for the elderly may well be related to our relatives and friends, our increasing age and perhaps a sense of outrage at some of the humiliation and separation of elderly people from the rest of society.
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DEFINITIONS

Activities of daily living (ADL) the activities usually performed in the course of a normal day in an individual's life. This concept is used as a basis for the planning of care. Gresham & Labi, (1987, pp 66 -69) state three criterion for tools to be regarded as appropriate in the measurement of needs;
   i. a mechanism for scoring,
   ii. use in a survey or other type of research, and
   iii. applicability to a general rehabilitation population.

Androgogy Usually implies student-centred learning, i.e. the student controls (to a large extent) the way content will be assimilated, and the learning environment. The word derives from: andro-man, gogy-art, and science of teaching. Often a mixture of these methods is used by individuals at any given time in their learning patterns.

Care-givers Individuals, professional or non-professional, who attend to the needs of individuals, in this case the elderly, at home.

Category "Since any distinction comes from dimensionalizing ie a basic operation of making distinctions, these distinctions will lead to categories. (Thus, machine-body connection is a category)" (Strauss, 1987, p 20).

Coding The general term for conceptualizing data; thus coding includes raising questions and giving provisional answers (hypotheses) about categories and their relations. A code is the term for any product of this analysis (whether category or a relation among two or more categories) (op cit, p 20).
Community Options (CO). An agency, funded under the HACC program to provide services to enable disabled people to remain in their homes. This agency articulates with other health service providers.

Conceptual density "The multiplicity of categories and properties and their relationships" (op cit, p 20).

Core category "A category that is central to the integration of the theory" (op cit, p 21).

Diagnosis related group (DRG)

A designation in a system that classifies patients by age, diagnosis, and surgical procedure, producing 300 different categories used in predicting the use of hospital resources, including length of stay. The system is being tested for use in anticipating the cost of reimbursement to hospitals by studying the population served to improve the cash flow to the hospital. It is performed using grouped data about how much each particular DRG may be expected to cost in hospital services (Mosby's Medical and Nursing Dictionary, 1986, p 342).

Discharge planner A health professional, usually a registered nurse, who undertakes the process of discharging patients from hospital to home.

Discharge planning A process by which, "...plans are made by an agency to facilitate a safe, timely and cost effective discharge of a patient to either a home care setting or an extended care facility" (Birmingham, 1986, p xi). Discharge planning is based on the ADL's and those identified needs within the nursing care plan, using the nursing process.

Elderly Individuals who are 65 years or older.
Experiential data  Data "in the head", drawn from the researcher's personal, research, and literature experiences. (Strauss, 1987 p 21).

Health education officer (HEO)  A professional person, usually in allied health, who undertakes programs in the community.

Health professionals  Those individuals, with recognized qualifications, who provide services within the health care system.

Health promotion  "Is the process of making the general public aware of a disease-related factor...creating an awareness of the need for change and an environment conducive to change through more direct education strategies" (Labonte, 1986, p 342).

Health teaching  Relates to those activities that are undertaken to increase learning; that learning involves issues relating to the health of the individual, family or group. Relies on a clear definition of "health".

Healthy Cities  A pilot project sponsored by the Australian Government in 1987 involving three "cities". "This project assumes that since all political and economic institutions are accountable for public health, a collaborative strategy should be developed and implemented at the local level (of government" (Healthy Cities Illawarra, 1990, pp 1 - 7). The Australian initiative was a result of the WHO EURO Health Cities Project commenced in 1986.

Holistic  The total or whole, approach. In terms of both assessment, and delivery of health care. This would include attention to the physical, social, psychological, sexual, nutritional, cultural, environmental, and religious needs of an individual.
**Home**  Normal place of residence, could be own home or one shared with relatives or friends.

**Home and Community Care (HACC)**  A program set up by the Australian Federal Government in the 1980's to provide support and services to allow for disabled people in the community to remain in their own homes.

**Lay care**  "Is a generic term that implies that individuals share responsibility for their own health and that of others across the entire spectrum of health" WHO (1984, p 74).

**Nurse Unit Manager**  A registered nurse responsible for areas within a health organization. That area may be geographical eg in the community, or care-specific eg surgical patients.

**Nursing process**  A problem-solving approach to nursing care. The steps involved are, assessment, diagnosis, planning, implementation and evaluation. It is on the basis of identified needs within ADL’s that the nursing process identifies care needed.

**Pedagogy**  Usually implies teacher-centred learning, ie the teacher controls both the content and the learning environment. The word derives from: peda-child, gogy-art, and science of teaching.

**Self-care**  "...is lay individuals interaction in specific social situations that perform health related behaviours, including decisions to seek and comply with professional care" (Dean, 1989, p137).
**Theoretical memos**
Writing in which the researcher puts down theoretical questions, hypotheses, summary of codes, etc. - a method of keeping track of coding results and stimulating further coding, and also a major means for integrating the theory. (Strauss, 1987, p 22).

**Theoretical sampling**
Sampling directed by the evolving theory; it is a sampling of incidents, events, activities, populations, etc. It is harnessed to the making of comparisons between and among those samples of activities populations, etc (op cit, p 22).

**Theoretical saturation**
When additional analysis no longer contributes to discovering anything new about a category (op cit, p 22).

**Theoretical sorting**
Sorting of the theoretical memos in the service of integration. Codes are also sorted, toward the end (op cit, p 22).
APPENDIX - A - LETTER TO COMMUNITY HEALTH NURSE

Campus East
Cowper St
Fairy Meadow 2519

Dear Sister.

Thank you for agreeing to assist me in my research. I am undertaking post-graduate studies at The University of Wollongong. My interest is in the health teaching component in the discharge process for the elderly from hospital to home. More particularly I am interested in the perception of that teaching by the elderly themselves. I am not concerned with the gender of the aged person, or the reason for their hospitalization. The criterion for them to be involved with this study are; that they are 65 years or over; being discharged to their home (whether that home is one shared with friends or relatives), that there is not mental problem that would inhibit them being interviewed. As well as the aged person, I will want to interview the care-givers involved. That might include those professional and non-professionals who are undertaking care of the elderly..

I have attached a letter which will go to the elderly people who agree to participate in this research. I intend to share with you the major issues that come from this research. I appreciate the time and energy involved in helping me and thank you in anticipation. I will make some arrangements with nursing administration about how we will liaise.

Sincerely,

Judith A Davis
APPENDIX - B - LETTER TO THE ELDERLY

Campus East
Cowper St
Fairy Meadow 2519

Dear

Thank you for agreeing to be involved in my research. My main interest is to talk with you about your recent hospitalization and the information/education you were given about how to cope when you were discharged home. I would like to see you at least three times over the next two months, more often if you wish.

You will be free at any time to decide that you no longer wish to be involved, and there will be no pressure from me for you to change your mind. As well as talking with you, I would hope to speak with those people who help to care for you. That would include your friends, relatives, community health nurse, physiotherapist or any other individuals.

What I want to do is to determine whether the information given to you and or your carers, ensured that your care following discharge from hospital was adequate. There certainly is no intention on my part to make judgements about that, I am more concerned about what you thought about the process of your discharge. I will be in touch with you soon to make arrangements to visit you at a mutually convenient time.

Again, thank you,

Judith A Davis
APPENDIX - C

CONSENT TO INVOLVEMENT WITH RESEARCH.

The objectives and aims of this research and my involvement, has been discussed with me by Judith. I understand the information given to me and realize that I am free to withdraw from the study at any time without any pressure on me to remain as a participant in this research. It is also clear to me that anonymity and confidentiality of the information I offer during interviews will be maintained at all times.

Date...........

Signature...........................................Participant/Carer.

Name (in block letters)..............................................

Address.....................................................

...............................................................

Contact telephone number.........................
APPENDIX - D

INTERVIEW QUESTIONNAIRE

DEMOGRAPHIC DATA

1. NAME:  
2. AGE: 
3. Address: 
4. Religion 
5. LEVEL OF EDUCATION 
6. Profession/occupation 
7. RETIRED?  IF SO HOW LONG? 
8. Marital status 
9. CHILDREN/GRANDCHILDREN, numbers of each 
10. SIGNIFICANT OTHERS 
11. GENERAL STATE OF HEALTH 
12. REASON FOR RECENT HOSPITALISATION 
13. Knowledge about that illness prior to admission 
14. Knowledge about that illness following discharge 
15. HELP NEEDED PRIOR TO ADMISSION 
17. HELP NEEDED FOLLOWING HOSPITALISATION. 
18. INDIVIDUALS WHO GAVE ASSISTANCE PRIOR TO ADMISSION TO HOSPITAL.. 
19. INDIVIDUALS WHO GAVE ASSISTANCE FOLLOWING DISCHARGE FROM HOSPITAL. 
20. WHO HAD THE MOST SIGNIFICANT CONVERSATION WITH YOU ABOUT YOUR ILLNESS AND MANAGEMENT WHILST YOU WERE IN HOSPITAL? 
21. HOW WAS THAT EDUCATION/TEACHING GIVEN?
22. WERE CARE GIVERS INVOLVED IN THE DISCUSSIONS ABOUT YOUR ILLNESS AND ABOUT ANY PARTICULAR NEEDS YOU MAY HAVE ON DISCHARGE?

23. WHAT WOULD YOU LIKE TO TELL ME ABOUT YOUR EXPERIENCE WITH THIS HOSPITALISATION IN TERMS OF HOW YOU ARE FEELING AND MANAGING?

24. HOW WAS INFORMATION ABOUT YOUR NEEDS GIVEN TO THE AGENCIES/RESOURCES THAT YOU ARE USING?

25. ARE THERE ANY OTHER RESOURCES THAT YOU NEED THAT WERE NOT IDENTIFIED WHILST YOU WERE HOSPITALISED?
Dear Sir

Please find attached my research proposal which has been accepted at academic level to undertake an Honours Master degree in Science (Community Health) at your institution. In order to comply with the requirements of your committee I would ask you to give consideration to the ethics of this research inquiry.

The elderly people and their carers will be referred from Community health nurses in the northern suburbs of Wollongong. Consent to access participants has already been obtained from the Illawarra Area Health service. The elderly will be a group who have been discharged from hospital to home. The only criteria for them to be involved in the research is their age i.e. over 65, a willingness to participate in the inquiry, and a need for referral to a community health nurse for care following discharge from hospital.

Following contact with the elderly person and their carer they will be given the following information; the basic purpose of the study, an assurance of confidentiality and anonymity, approximate time frame for involvement with the study, the right of refusal at any time, the
right to withdraw from the study without coercion from the researcher (see Appendix C). Each participant will be asked to sign a consent form which reflects those facts. Each elderly person and their carer, if they are willing to participate, will be given a pseudonym which will ensure their anonymity in the data. Following interviews a transcript will be given to the participants for them to validate the record, it will also afford them the opportunity to remove any information they want to at that stage. It is considered that any of the demographic data which readily identifies participants will be sufficiently altered to protect their anonymity without altering the content of interviews.

The research method is qualitative, and a grounded theory approach will be used. Within this method a point of "saturation" in information is reached which will be used by the researcher and supervisor, as an indicator of the numbers of participants needed to validate data. Strategies used in this method of inquiry include open-ended interviewing, participant observation, perusal of records and any other means considered necessary in order to obtain the maximum amount of information available. Health professionals and agencies providing support and care for the elderly will be asked to contribute to the data collected by the researcher. Given the nature of the research, a time frame has not been attached to this research project.

It is the researcher's intent to provide the Community nurses and the Illawarra Health Service with a summary of the findings once the data has been analyzed. I would appreciate your comments, criticism and support for this inquiry.

Yours sincerely

Judith A Davis
Table 1 - POPULATION PROJECTION FOR THREE AGE CATEGORIES: 1985 - 2000.

Table 2 - COMPRESSION OR EXTENSION OF MORBIDITY

Table 3 - REGIONAL COMPARISONS OF PROFESSIONAL AND NON-PROFESSIONAL EMPLOYEES: 1981.