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Daily Life in a Quebec Public Nursing Home

Sylvie Marie Héroux

A Thesis
in
The Department
of
Sociology and Anthropology

Presented in Partial Fulfilment of the Requirements
for the Degree of Master of Arts at
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Abstract

Daily Life in a Quebec Public Nursing Home: A Study of Interaction in an Institutional Setting

Sylvie Marie Héroux

This study is an ethnographic exploration of several aspects of daily life in a Québec public nursing home. The emphasis is placed on political determinants of the structure of nursing home life. Some of the issues to be addressed are: the appropriateness of institutionalization as a solution to some of the problems encountered by the elderly, the nature of the nursing home as a living environment, and the role of the family with respect to the institutional situation. Due to the exploratory nature of the study, conclusions are formulated in terms of further work to be accomplished in order to better understand the situation.

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In memory of Cecile P.

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CHAPTER 1 INTRODUCTION

... with the onset of severe physical and mental impairment, a time may finally arrive when it is best for the individual and the family that extended-care institutionalization occur. Until this time arrives, however, premature institutionalization should be avoided if at all possible. For both humanitarian and economic reasons, institutionalization is a costly step that could be avoided or delayed in many situations if viable alternatives were available in the community. (McPherson, 1983: 304)

The pattern of life afforded is most difficult for the mentally intact but infirm patient who is surrounded by peers incapable of meaningful communication. In such settings it is extraordinarily difficult to maintain one's personal integrity; despair is a frequent mood. (Clausen, 1986: 186)

In spite of considerable investigation, our understanding of nursing homes as residential environments remains quite limited. (George and Maddox, 1989: 127)

While middle-aged women particularly will be actively carrying on with their traditional roles of nurturing and caretaking in helping aged parents, new tasks will also confront mid-life and older sons and daughters. They will be intervening in the bureaucracy that now surrounds family life and aging to ensure that their elders receive their old-age security benefits, Canada and Quebec pensions and supplements, and other entitlements; they will be dealing with the red tape of hospitals and other service organizations which can confuse an older person. They will also be helping to make decisions, often in conflict with siblings and other relatives, regarding institutionalization, terminal illness and death. (Nett, 1984: 158)

The four quotes presented above serve to underline some of the issues that will be addressed in this thesis: that of the appropriateness of institutionalization as a solution to some of the problems encountered by the elderly, that of the nature of the nursing home as a living environment, and that of the role of the family with respect to the institutional situation. Another major issue examined is that of the influence of governmental policies at the level of the delivery of institutional services.

Human aging is more than a biological process. It is also a socio-cultural process. Social inequalities affecting the elderly stem from their disadvantageous position within the age stratification system (Massé and Brault, 1984). The elderly are often considered less powerful, in part due to their disadvantaged socio-economic status, lower levels of education, and physical frailty: all factors which may influence how they are perceived in society. However, older people themselves do not necessarily see themselves as sick, dependent, isolated and unhappy as it is often assumed as part of the predominant stereotypes of aging (Connidis, 1989a).

Not only do individuals age, but so do populations. The degree of aging of a population is indicated by the proportion of elderly people in the total population. Population aging may result in changes in the attitude towards the elderly. Positive changes would include raising their status, thereby increasing the level of attention given to their particular

needs. Negative changes would result in increasing social inequality, leading to poverty, poor living conditions, lower levels of health care provision and so on. With the current emphasis on individual rights, changes seem to more likely be for the best, at least as far as official policies directed towards the elderly are concerned. On the other hand, exaggerations in that direction lead to "compassionate ageism" (Binstock and Post, 1991: 1).

Precisely because of the variety of changes occurring in modern society (including population aging), it is a fallacy to transpose the aging experience of the elderly of today to those of yesterday or tomorrow (McDaniel, 1989: 148). Nevertheless, a careful examination of current living conditions, current needs, and current demands of the elderly may lead to a better understanding of the interplay of the various factors affecting them.

Several factors (social, economic, and political) affect living conditions of the elderly. Social factors include the consequences of age stratification in modern society, the presence of primary support networks, and the interaction of other variables such as sex or social class with age. Economic factors include the personal economic position of the elderly and the economic burden that assistance given to them in terms of financial support, health care and other social services, represent for society as a whole. Political factors includes the weight that issues related to aging and the

elderly have on the agenda of those who are in a position to effect changes, and their relative importance with respect to other issues holding the attention of policy makers.

We must pay particular attention to issues having to do with elderly women. The differences between the experience of aging of men and women must be taken into account because the intensity, frequency, and duration of many of the problems related to aging are frequently more severe for women than for men (Rosenmayr, 1991: 37). Among other things, women have fewer financial resources than men in old age due to their different employment history (McDaniel, 1989).

Middle-aged women are often called upon to take care of an elderly family member, more so than other members of the family (Novak, 1988: 285). In addition, the amount of help required of any family member may increase in the future. With the decrease in the fertility rate in the Western world, there is a much smaller potential number of family members available to provide help to elderly family members. In addition, with the extension of life expectancy, those providing help can expect to do so for longer periods of time. According to Rosenmayr (1991), we must reject the myth according to which families do not concern themselves with, and take care of, their elderly relatives. There are however more tensions and problems associated with providing such help, since women of mature age (who are often the ones providing care) are frequently caught between the values of

the family and those of the society, which emphasize individualism, professional success, and independence. They may also be sandwiched in between two generations needing their help: their parents and their children.

In any case, it is recognized that the elderly rely on institutions when all other avenues have been explored: when they have too much difficulty taking care of themselves, when no family member can provide the help they need, and when no other outside help is available.

Binstock and Post (1991) fear the rationing of health care for the elderly. In their opinion, the calls for the rationing of health care are due to the fact that the elderly are seen as the source of increase in global health care costs in the United States and that they may be blamed for something which has quite complex causes. This attitude may cause a backlash directed at the elderly through the setting of an arbitrary chronological age as a "natural life span" and beyond which health care provision would be restricted. Such calls for rationing, however, rely on stereotypes and myths of aging whereby the elderly are assumed to not benefit as much from certain medical procedures as younger patients, and that older people have lost their "usefulness" to society. It would in effect create a category of second class citizens.

It is not to be said, however, that a universal approach to health care provision cannot produce such categorizations of individuals. Whereas nursing homes are generally

considered a humane and considerate approach to care of the very old, it could also be seen as an "old age ghetto" where the sick and the very old are isolated from the mainstream. How does life go on in the nursing home? What services are provided there? How do nursing home residents maintain ties with the outside and especially with their family? This thesis attempts to answer these questions through the examination of everyday life in a nursing home.

An outline of the thesis

This project looks at these questions through an ethnographic exploration of several aspects of daily life in the nursing home, through a case study done at Maison Bon Accueil (a fictitious name for the Montreal-area institution where fieldwork was conducted). The greatest emphasis is placed on political determinants of the structure of nursing home life.

Chapter 2 introduces some facts and figures about aging in Canada and Québec, and discusses population projections, sex ratios, life expectancy, and health status of the elderly. It provides a basis for comparison between nursing home beneficiaries and the aged in general, especially in terms of the differences in age and sex composition of the general aged population and the nursing home population. These differences are likely to be a factor in the orientation of social policies affecting these populations, and the fact they are

not taken into consideration, to a certain extent, may point to the nearsightedness of such policies.

In Chapter 3, we look at the evolution of policies affecting nursing homes in Québec, in particular the shift from private to public ownership in the 1960s, and the intermittent calls for community-based care. I will particularly point out some of the assumptions that are made about population aging and about the role of the family and the community that have some bearing on the nursing home situation.

Chapter 4 presents the theoretical framework of the thesis. It defines the particular aspects of daily life in the nursing home that will be discussed later in the thesis, such as the use of space within the institution (especially the distinction between public and private space), the behaviour of beneficiaries in formal and informal social activities, and their relationship with other people with whom they come into contact, especially staff members and relatives. The chapter also describes how analysis will be carried out using many concepts drawn from Erving Goffman's work.

The literature pertaining to institutionalization and nursing home life is reviewed in Chapter 5. The chapter also contains a review of the literature on relationships between nursing home beneficiaries and staff members, and between residents and their relatives.

Chapter 6 presents the research methodology used for gathering data on nursing home daily life. It defines the approach to participant observation which was used for this study. The chapter also describes how the research setting was selected, how access to it was gained, how first contact with the research subjects was made, as well as some of the difficulties encountered during the fieldwork period and the limitations of the study.

Chapter 7 describes the data gathered through fieldwork, organized according to the framework set by Chapter 4. It is followed by Chapter 8, which discusses the data presented in Chapter 7 with respect to the theoretical framework, and attempts to link this data with the information given by Chapters 3 and 5. The discussion is concluded by raising some questions and suggesting some paths for further research on aging and the provision of health and social services to the elderly.

CHAPTER 2

AGING AND HEALTH IN CANADA AND QUEBEC

Who is old in Canada and Quebec? How is old age defined? What characterizes the older strata of the population? How sick are the elderly? These questions touch upon several aspects related to aging for which this chapter presents statistics that will be used to compare the composition of the older population with that of the nursing home population.

Aging refers to two different processes: individual aging and population aging. Individual aging is the process whereby an individual goes through his life, reaching a more or less advanced age. The time at which one is considered aged (or old, or elderly) is generally arbitrarily determined. Age 65 is most generally used by public and private pension plans, official statistics, and where it is legal, mandatory retirement policies. Population aging is the process whereby the proportion of older people in the total population increases. It may result from a decrease in adult mortality, an increase in life expectancy, or a decrease of the fertility rate. It is most likely the result of combination of some of those factor, decrease in fertility being the most influential. If people tend to die at an older age and thus

to live longer, and there are less babies being born, then the relative number of older individuals in the population will increase.

Such a process has generated concern with respect to several issues. One is income maintenance for the elderly population. Another is the possible increase in demands put on health services. The chapter presents facts and figures about population aging in Canada and Quebec, as well as about the state of health of older people.

Patterns in Population Aging

What determines that a population is aging is that the relative composition of the population changes, with the result that the 65+ group constitute a greater proportion of the total population. According to the United Nations, a population is considered aged when at least 7 percent of it is over 65 (McDaniel, 1986: 2; McPherson, 1983: 84). This is certainly the case with the population of Canada, and this situation is expected to persist. According to some projections made by Statistics Canada in the mid-1970s, this proportion could increase to 20.2 percent by 2031 (Powell and Martin, 1980: 205). This is one of many such projections, as they can be made according to different assumptions regarding fertility, mortality and migration patterns and are frequently revised.

Crichton and Hsu (1990: 123) note that whereas the 65+

age group constituted 7.6 percent of the Canadian population in 1961, this proportion had increased to 9.7 percent in 1981 (a higher percentage than the projection mentioned above). Statistics Canada's 1990 estimates show further increases in population aging (see Table I). The proportion of the population over 65 was at that time 11.47% for Canada and 10.93% for Québec. We can see that approximately two-thirds of the age group is comprised of people above 70, and that a higher proportion of women than men are aged.

The sex composition of an aging population is also of importance. While the total population is almost evenly split among males and females, it is not so among older age groups.

According to Statistics Canada..., the sex ratio¹ in Canada at present [1979] is .89 at 65 to 69 years of age; it decreases to .83 (70 to 74 years), .71 (75 to 79 years) and .54 (90+ years). (McPherson, 1980: 82)

The 1990 estimated sex ratios (from Table I) are .74 for Canada and .70 for Québec in the 65+ age group. They are, however, much higher if we consider only individuals aged from 65 to 69: .86 for Canada and .84 for Québec. They are lower for older individuals (70+), at .68 for Canada, and .63 for Québec.

¹The sex ratio gives the number of men per woman in the population. For example a sex ratio of .89 indicates .89 men per woman, or 89 men per 100 women.

Table I Canadian population proportions by age group and sex (1990 estimates, %).

<u>Overall - 65 + age group</u>			
Québec		10.93	
Canada		11.47	
<u>65 + age group</u>			
	<u>M</u>	<u>F</u>	<u>Sex ratio</u>
Québec	8.98	12.80	0.70
Canada	9.71	13.18	0.74
<u>65 - 69 age group</u>			
	<u>M</u>	<u>F</u>	<u>Sex ratio</u>
Québec	3.52	4.18	0.84
Canada	3.62	4.20	0.86
<u>70 + age group</u>			
	<u>M</u>	<u>F</u>	<u>Sex ratio</u>
Québec	5.46	8.61	0.63
Canada	6.08	8.98	0.68

Source: Statistics Canada, 1991: 85.

This is probably a result of the greater life expectancy of women. The overall life expectancy for Canada in 1981 was 75.4 years (71.9 for males, 79.1 for females) (Crichton and Hsu, 1990: 15). This measure, however, does not take into account quality of life, which takes great importance for older people who generally experience higher rates of morbidity (for example, suffering from debilitating diseases).

Health and Aging

Demographers have developed calculations for determining expectancy of life in good health, using qualitative data on functional incapacity, institutionalization rates, and restriction of normal activities (Desjardins and Légaré, 1984).

Table II Life expectancy and life expectancy in good health at birth, Canada and Quebec

	<u>Life Expectancy</u>		<u>Life Expectancy in Good Health</u>	
	<u>M</u>	<u>F</u>	<u>M</u>	<u>F</u>
Canada (1978)	70.8	78.3	59.2	62.8
Quebec (1980)	70.3	78.2	59.0	60.2

Taken from (Desjardins and Légaré, 1984: 46)

We can see from Table II that men can expect approximately 11 years of ill health at the end of their life. Whereas women can expect to live much longer than men, there is little difference in expectancy of healthy life. Women can therefore expect 15.5 years of ill health in Canada as a whole, and 18.0 years in Quebec, much longer than men. We can also look at this state of affairs by looking at the percentage of the population experiencing difficulties with carrying out various activities.

The older population experiences more limitations than does the population in general. Whereas 88.4% of the Canadian population experiences no limitations in activities of daily life, only 61.8% of the 65+ group claims to have no limitations (Crichton and Hsu, 1990: 17). As is shown in Table III, physical limitations are more likely as one advances in age. However, the percentage of people with "some limitations" does not vary very much from one group to the other, but the interesting fact is that the percentage is higher for women than for men. Higher percentages among women can also be found in "major activity limited". The situation is, however, reversed in the case of the most severely limited category.

On the other hand, a large majority of non-institutionalized elderly in the province of Quebec rate their health as being at least good (see table IV). Whereas the average subjective rating of health by the elderly is lower

than for the whole Quebec population, few people rate their health "bad".

Table III Sick Role Behaviour, Males and Females, aged 50 and over, 1978-79

Age 50-59		
<u>Major Activity</u>	<u>Male</u>	<u>Female</u>
No limitation	78.6	77.4
Some limitation	1.3	4.7
Major activity limited	11.1	15.2
Cannot do major activity	7.7	1.9

Age 60-69		
<u>Major Activity</u>	<u>Male</u>	<u>Female</u>
No limitation	64.6	68.3
Some limitation	2.7	4.0
Major activity limited	15.7	24.1
Cannot do major activity	16.9	3.8

Age 70+		
<u>Major Activity</u>	<u>Male</u>	<u>Female</u>
No limitation	61.1	59.8
Some limitation	1.7	4.0
Major activity limited	24.8	30.0
Cannot do major activity	12.3	5.9

Source: Gee and Kimball, 1987: 32.

Table IV Subjective Perception of Health, Quebec, 1987.

Age 65 - 74			
	<u>Male</u>	<u>Female</u>	<u>All</u>
Excellent	8.8	11.0	10.1
Very Good	30.5	22.5	25.9
Good	32.9	41.5	37.9
Average	23.1	21.0	21.9
Bad	4.7	4.0	4.3
Age 75+			
	<u>Male</u>	<u>Female</u>	<u>All</u>
Excellent	13.5	9.8	11.4
Very Good	26.8	29.2	22.9
Good	33.8	37.0	35.7
Average	18.7	27.0	23.5
Bad	7.2	6.1	6.6
All Age Groups			
	<u>Male</u>	<u>Female</u>	<u>All</u>
Excellent	21.4	16.2	18.7
Very Good	41.0	40.8	40.8
Good	27.3	30.8	29.1
Average	8.5	10.3	9.4
Bad	1.9	2.0	2.0

Source: Lapierre and Adams, 1989: 48-50.

Table V Subjective Perception of Happiness, Quebec, 1987.

	Age 65-74		
	<u>Male</u>	<u>Female</u>	<u>All</u>
Very Happy	37.7	33.5	35.3
Somewhat Happy	54.8	58.1	56.7
Not Very Happy	7.5	8.4	8.0

	Age 75+		
	<u>Male</u>	<u>Female</u>	<u>All</u>
Very Happy	33.9	30.2	31.7
Somewhat Happy	54.1	59.5	57.3
Not Very Happy	12.0	10.4	11.1

	All Age Groups		
	<u>Male</u>	<u>Female</u>	<u>All</u>
Very Happy	40.4	38.8	39.6
Somewhat Happy	55.0	55.7	55.4
Not Very Happy	4.6	5.6	5.1

Source: Lapierre and Adams, 1989: 66-68.

In addition, when asked whether they were very happy, somewhat happy, or not very happy, the non-institutionalized elderly do not rate themselves much lower than the population of Quebec as a whole (see table V). The percentage of people claiming to be very happy decreases as age increases, but the percentage of people claiming to be somewhat happy is fairly

constant across age groups above 25 (Lapierre and Adams, 1989: 66-68).

Putting the information on health status together with that on life expectancy, we can suspect that while women live longer than men, they suffer limitations to their activities for a longer period of time, although they may not be as severely affected as men of the same age. Since women are more numerous than men in older age groups, their particular situation should be taken into account in any study of the elderly, especially as far as health and social services used by them are concerned. On the other hand, elderly people of both sexes may consider themselves relatively healthy, and think of themselves as being happy, regardless of the actual limitations with which they are faced.

Implications

The signification that the trends identified in this chapter have for aged individuals, and especially for those living in institutions, as well as for their entourage, is by no means obvious. We can postulate that these trends have implications at a political level, by serving as the background information on which a host of government policies are built. They can also influence, through their diffusion in the popular media, the perceptions that individuals have of old age and the expectations that they form with respect to their own situation and that of loved ones.

In particular, in the case of health and social services, institutions can be given a specific function within a network of available services, and the resources that can be devoted to particular services will be apportioned on the basis of fair and equal distribution (and, as we will see in the following chapter, as rationally as possible). The variety of conflicting perceptions that can exist as far as the application of these principles are concerned can greatly influence the structure of daily life in the public nursing home.

CHAPTER 3

HEALTH AND SOCIAL SERVICES POLICIES

C. Wright Mills said that "the sociological imagination enables us to grasp history and biography and the relations between the two within society" (1959: 6). It also enables us to grasp the relations between the political and the world of everyday life. Very little in our lives is exempt from the influence of political events and political decisions leading to the application of government policies, whether national or local, to the most minute details of our everyday existence.

To trace these influences and their implications, as well as to develop an understanding of the perceptions of 'ordinary' actors with respect to the influence of the political in their own life is a titanic enterprise. What complicates it is the lack of conscious realization, on the part of many, of these influences. In addition, the intrinsic conflict that exist between many of these political influences and actors' values lead to feelings of tension, inadequacy, insecurity, and at best, diffuse anxiety and uncertainty in the face of decisions that must be made in one's life.

The study of everyday life in public nursing homes in the province of Québec can be set in such a political context.

Many aspects of the nursing home as an institution and a residential milieu are decided upon by the political and administrative levels of the provincial government. Many of their decisions are likely to influence the way in which the elderly live their life, the role of the family in caring for the elderly, and the role of the nursing home as one of the elements of the system of health care and social services available to the elderly. Walker (1991) points out that welfare states have an important role in the social construction of caring relationships and that many of these social constructions are issued from assumptions and prescriptions within social policies and from the influence of the latter on the organization of everyday life.

Therefore, the study of interaction in everyday life in the nursing home should be done within the political and policy context in which it exists. What is understood as 'the political' in this project is any statement made on behalf of political bodies, and administrative disposition issued from actual government policy such as the administrative structure of the nursing home, and any study commissioned and used by the government in its definition of policy issues.

In a society which in the past thirty years has seen state involvement in people's everyday life increase considerably, it is necessary to investigate the various facets of this involvement and its consequences. A case in point is that of social and health services for the elderly in

the province of Québec.¹

Before the 1960s and the Quiet Revolution, the elderly were mostly cared for by their own family, as well as by church organizations. This was certainly the case for the French-speaking Catholic population. The elderly were taken in charge by their own family in the cases where family members could bear this burden, or by religious organizations and their hospices in the case where the elderly person had no other resources to turn to. Some elderly people ended up in asylums for the insane if they seemed "sufficiently" disturbed or senile. Most of the French institutions were also owned and operated by religious orders (D'Allaire, 1984: 232; Boudreau, 1984) even though they could be, in the case of mental institutions, supported by the state on a per diem basis.

The period from the beginning of the 1960s to the mid-1970s saw many changes occur, some of them based on reports of various parliamentary commissions mandated to investigate the state of social and health care services in the province of Québec. We can give as examples the Bédard Commission², which examined the situation of the mental health care network, and

¹This overview of the situation, while attempting to describe some aspects of the evolution of the health system, does not strive to be exhaustive.

²Commission d'étude des hôpitaux psychiatriques (1962).

the Castonguay-Nepveu Commission³, which examined social services as a whole. A complete reorganization of health and social services resulted from recommendations made by these commissions, with a transfer of control from the private sector to the public sector. This created a concentration of power and a uniformity of services as well as the establishment of province-wide standards.

The Castonguay reform in particular led to the creation of a network of public nursing homes as part of the complete transformation of the network of health and social services in the province. These public nursing homes provide a range of medical services to the residents, as well as providing what should be an appropriate living environment.

The Quiet Revolution and the Reforms

As stated in the introduction, the Quiet Revolution brought on many changes in Québec society, and the reorganization of many sectors of activity, including health and social services. According to D'Allaire (1984), the Quiet Revolution period was characterized by two distinct, but related, processes. The first one was that of the secularization of Québec society, that is, of changes in value orientations. The second one was that of a declericalization of many spheres of activities. This resulted in a

³Commission d'enquête sur la santé et le bien-être social (1970).

transformation of institutions and a change in locus of power.

The 1971 law on health and social services gave power of organization and management to the Ministry of Social Affairs⁴, and other legislative changes resulted in integrated planning of health services, and put into place policies of regionalization to permit equal access, following principles of social justice, as recommended by the report of the Castonguay-Nepveu Commission. The period from the beginning of the Castonguay-Nepveu Commission in 1966 to passage of legislative measures in the early 1970s saw a transition from family-type organization in health and social services to a complex and modern state-controlled organization.

Some economic influences can also be examined. Grenier (1985) points out that as economic conditions improve in a society, its members put a greater emphasis on health and especially on equal access to health services. These changes are therefore changes on the demand side of the health care market. On the supply side, we find improved technology and advances in knowledge which may cause increased reliance on health professionals and which may foster greater government involvement. In particular, it is assumed that "health care expenditures could be reduced by better resource planning, particularly in terms of care for the aged" (Grenier, 1985: 277). Thus, "the evolution of the Canadian health care

⁴Presently called the Ministry of Health and Social Services.

services sector is characterized by a gradual shift from personal and private to collective and governmental responsibility for the allocation of resources" (Grenier, 1985: 252).

We can also look at the level of expenditures on health care services in Canada. Health Care expenditures as a percentage of the GNP for the whole of Canada were 5.62%, 7.30% and 7.48% for 1960, 1970, and 1980 respectively. These expenditures include personal health care as well as other costs, such as administration, research and prevention. Expenditure for "homes for special care" (which include nursing homes for the elderly) as a percentage of the GNP were of 0.29%, 0.52%, and 0.91% for 1960, 1970, and 1980 respectively. The rate of increase of expenditures on homes for special care, which almost doubled two decades in a row, show much higher rates of increase than overall expenditures (Grenier, 1985: 254). Grenier states that "the share of institutional care expenditures in the GNP rose during that period because of the increase in institutions offering special care, mainly for the aged" (Grenier, 1985: 255).

The situation in Québec parallels that of Canada as a whole. In the 1970s, social programs were given solid support and the involvement of the state continued at a great pace until the early 1980s, when funding diminished in all areas of social and health services, although not for public nursing

homes, where funding was still increasing⁵. This continued the trend of transition from the private to the public sphere in special nursing care for the elderly. At the end of the 1960s, there were approximately 160 private nursing residences for the elderly and other adults which, with a total of 13700 beds, constituted about 67.6% of total capacity in the province. But in 1976-77, the public sector was controlling the majority of beds (79.5%), with 13392 beds (Vaillancourt, 1988)⁶. While the provincial government was building new nursing homes, it was also acquiring institutions formerly owned by religious organizations (Gouvernement du Québec, 1988: 222). This easily contributes to an explanation of the rapidity of change in the situation. Among the approximately 60000 beds available in 1987, 53.6 percent were in public nursing homes and pavilions, 28.8 percent in public long-term care or acute care hospitals, and 17.6 percent in the private sector (Gouvernement du Québec, 1988: 218).

However, some questioned the relevance of public involvement in the nursing home situation and the extent of

⁵In 1984-85, 7.6 percent of the health budget went to public nursing homes compared to 6.2 percent in 1980-81. At the same time, the percentage budgeted for hospitals decreased slightly (Desrosiers, 1987: 35).

⁶In 1989-1990, total Québec expenditures on shelter and home maintenance services for the elderly were of 93.5 millions (compared to a total budget of over 8 billions for the Ministry of Health and Social Services). In 1990-1991, 121.5 millions were earmarked for that purpose (MSSS, 1989-90: 13). We must take into account when looking at these figures that beneficiaries of institutions do pay a certain amount for room and board.

reliance on institutional care. In the 1980s, after a long interlude of emphasis on the comprehensiveness and quality of public services, a resurgence of the emphasis on community care and on the limitations of nursing home care made its appearance. This is what Vaillancourt (1988: 155) calls the "communitarist line".

Against the limits of the welfare state - the weight of bureaucracy, the confines of paternalism and its ensuing dependency - it proposes boundless possibilities of aid and solidarity rooted in natural and primary support systems. (Vaillancourt, 1988: 154)

An example of this is a document published by the Ministry of Social Affairs called "Un nouvel âge à partager" (Gouvernement du Québec, 1985). This document's underlying theme is that of moving away from institutionalization.

The argument can be summarized in the following fashion. From the point of view of policy orientations, the government of Quebec has been increasingly concerned with the very high level of dependency of the elderly population on public services to solve their problems. Before the 1960s, the family, the community (in a general sense), and religious institutions were assuming the greatest part of the care required by the elderly. Following the implementation of public health care services, religious institutions withdrew their services, while the family and the community continued to assume little known services. The withdrawal of religious institutions from the health care field gave the impression that only the State could provide the width and breadth of

services required by the population. The increasing reliance on "experts" to solve problems of even a psycho-social nature has led to an over-medicalization of the response to such problems.

The document continues by stating that we need to de-medicalize aging. In the past decade, the accent has been put on passing from an ideology of institutionalization arising from the previously mentioned developments, to a philosophy of intervention aiming at keeping people in their "natural" communities as long as possible. Besides institutional resources, there exists such intermediary resources as help available at home (whether material, physical, or nursing services), day centres (where people can also obtain medical care and rehabilitation services such as physiotherapy and ergotherapy). Institutional care ranges from long-term care hospitals, to nursing homes, to group homes for the elderly experiencing a light loss of autonomy (Gouvernement du Québec, 1985). After one swing of the pendulum from the private to the public sphere, we are experiencing a return of the pendulum towards the private, although not necessarily towards private nursing homes, but towards maintaining the elderly in their natural environment.

In fact, the idea of de-institutionalization was proposed by the Castonguay-Nepveu Commission. The report of the commission stated that there were insufficient options to care for patients requiring long-term care and that we could not

rely on hospitals to fill the void. In addition, it was difficult to return these patients to their families without support. The suggested alternatives to hospital care were: day centres, special institutions for long-term care, home services (Gouvernement du Québec, 1970: 108). The report, in addition, states that it is regrettable that policies of shelter provision have not been developed in parallel with home care programs which would have permitted elderly individuals to stay in their natural environment as long as possible. It often happens that people request admission into a public institution, not necessarily because they cannot do without that level of care, but because there are, in fact, no available alternative resources (Gouvernement du Québec, 1972). Indeed, Roy (1990) states that social and environmental factors may be more influential than health factors in the desire of elderly individuals to move to an institutional setting.

The Nursing Home Population

A study whose goal was the evaluation of the elderly population of nursing homes and long-term care hospitals in Québec (Sicotte, 1982), done at the beginning of the 1980s, drew the following conclusions. There was a certain amount of overlap in the needs of beneficiaries of both levels of care, although the heavier cases were more likely to be found in long-term care hospitals. In spite of this, there is clearly

a certain specificity to the clientele of both types of establishments. For example, the average level of direct nursing care required per beneficiary was 1 hour and 20 minutes per day for nursing home residents compared to 2 hours and 41 minutes per day for long-term care hospital patients. At the same time, study of the available resources for nursing care, physiotherapy, ergotherapy and social workers show that they are below requirements per beneficiary. The lack of services was similar for both levels of care as far as physiotherapy and ergotherapy were concerned. However, the lack in nursing care and social work requirements were much more severe in the case of nursing homes. According to Sicotte, a large proportion of nursing home residents (30.8%) could eventually be better served by alternative resources and do not require the more advanced level of care provided in that type of establishment. However, to encourage de-institutionalization of the elderly does not necessarily mean that those who are presently living in nursing homes should be sent back home, and for various reasons: they may not have a home to go to, their close relatives may not be able to assume the burden their care may constitute, and external resources to home maintenance should be better developed (Sicotte, 1982).

Another study conducted at the beginning of the 1980s gives us descriptive data on the characteristics of the

nursing home population⁷ (Bouchard and Therrien, 1982). According to this study, 70.9 percent of nursing home residents are women and more than 75 percent are above 75 years-old. In addition 60.6 percent are widowed and 19.4, single. More than 50 percent of the residents surveyed had been living in the institution they were currently in for more than 4 years (49.9 percent for men and 57.2 percent for women). Among the autonomous respondents⁸, 39 percent state that their health is good. Seventy-nine percent of autonomous residents are mobile (54.2 for non-autonomous). At least 50 percent of all residents do not need help to walk (no cane, wheelchair, etc.). However, 33.6 percent of autonomous residents require constant care (60.9 for non-autonomous).

We can suspect, however, that the characteristics of the nursing home population has changed in the last ten years. Given the increasing emphasis on home maintenance for those elderly persons who do not absolutely need institutional care, it is probable that the ones who are in better health are kept off the institutional network and that therefore the overall state of health in nursing homes is lower than the study presented above shows.

⁷In this study, nursing home was understood to include public nursing homes, private but publicly funded nursing homes, as well as nursing homes integrated to hospitals.

⁸Autonomous respondents are those who could answer the survey questions themselves. Questions regarding non-autonomous residents were obtained by staff members, with the help of the resident's file.

The Rochon Commission

We can now turn my attention to the Rochon Commission, the commission of inquiry into health and social services which published its report in 1988.

the commission was appointed by the Parti Québécois in 1984 and reappointed by the Liberals in 1985. Both political parties thought it was time to review the principles and implementation of the Castonguay-Nepveu reports and investigate how the model for the provincial health and social services system was working out. In its general recommendations, the commission reaffirmed the fundamental importance of the existing approach of the health and social services system for improving health and welfare. (Gouvernement du Québec, 1988: 238-9)

The Rochon report does not propose any major changes to the principles of the health care system, but suggests that the ideas put forward by the Castonguay-Nepveu Commission be applied in a more "efficient" or "rational" way (Crichton and Hsu, 1990: 240; Bergeron, 1990).

The report says of nursing homes that their main function is to provide shelter for people whose loss of autonomy prevents from being able to live alone. There are some handicapped adults or severely ill ones below 65 living in nursing homes, but most residents are elderly (Gouvernement du Québec, 1988: 218).

During the 1970s, each nursing home was in charge of its own admission policies and criteria, although many admissions were referred by other public agencies. There was therefore two parallel admission systems. At the time, criteria varied from today's in terms of the severity of the cases being

admitted. Senile or confused beneficiaries were generally sent to other categories of facilities. Nursing homes were not necessarily meant for non-autonomous elderly individuals, which are more likely to compose today's clientele (Gouvernement du Québec, 1988: 219).

According to the report, elderly people do look to some form of assistance in a residential setting and expect to have access to such services when they feel they need it. However, some studies have shown that "objectively" only 6% of individuals should need institutionalization. Consequences are assumed to be negative. Therefore, attitudes towards institutionalization need to be changed, in order to foster the maintenance of the elderly in their natural environments (Gouvernement du Québec, 1988: 221).

The progressive change to much heavier cases being admitted to nursing homes occurred from the 1970s on. Starting in 1975, the Ministry reserved the use of nursing home beds to those people experiencing severe deterioration and loss of autonomy. The average required number of hours of nursing care per day for the nursing home population was at the time of the Rochon report of 2 hours, versus three and a half hours in long term care hospitals (Gouvernement du Québec, 1988: 221). Whereas these figures have greatly increased compared to the figures given in the 1982 evaluation, the gap between the two levels have been reducing. This leads to questions about whether the nursing home

represents a distinct level of care in the Quebec health care system.

An interesting point is that the Rochon Report makes several statements on population aging and on the health status and health care needs of an aging population, which serve as assumptions in the examination of the health care delivery system. The Report states that population aging will increase in the future, but that population projections indicate that this will occur at a rate which is neither catastrophic, nor exceptional (Gouvernement du Québec, 1988: 14).

Two other phenomena must however be taken into account: the increase of the number of elderly women with respect to the number of elderly men of the same age, and increase of the population proportion of the very old (or old old) (Gouvernement du Québec, 1988: 15).

We have to expect an increase of public expenses for health care of the elderly as the aged population increases, unless the state of health of the elderly in the future tends to be better than it was in the past. Therefore, society will have to encourage autonomy of the elderly and try to prevent that loss of autonomy transforms into a handicap. At the same time, appropriate services must be available to those who require them. It is understood that in this context, "active generations" will have to take care of their own elderly relatives more and more (Gouvernement du Québec, 1988: 17).

The section on the influence of population aging is concluded with the remark that in years to come, public institutions will have to show some imagination in the support to bring primary support networks of the elderly. There will be strong pressure on them to do so, as there will be pressure to require help from people close to the elderly and this is likely to occur at very high personal costs (Gouvernement du Québec, 1988: 18).

I will later comment on some of the statements made by the report of the Rochon Commission, based on the situation observed during fieldwork.

CHAPTER 4

THEORETICAL FRAMEWORK

In this research project, the analytical emphasis is placed on behavior analyzed in a symbolic interactionist fashion. Community is used as a heuristic device, in order to provide categories to analyze interaction. Policy is used as background information, in order to understand the place of the nursing home in the network of health and social services in the province of Québec, and in order to understand the place of the aging individual in such a context. Marshall and Tindale (1978-79: 167) state that

any understanding of the process of aging as experienced by individuals must include an awareness of the historical context in which they have grown old... the historical context includes social, political, and economic realities which both shape the lives of individuals and are shaped by individual and collective action...

Interaction within the nursing home walls is not only determined by the communal organization of life in it nor by the policies shaping the major characteristics of the nursing home as a formal organization and a product of bureaucratic structures, but also by the interactive decisions of the people in the home.

Nursing homes bear a resemblance to what Goffman has called "total institutions". Goffman (1961) characterizes total institutions by the fact that some people associated with the institutions (the "inmates") sleep, work, and play in the same location, and that activities are conducted in "batch" with a tight schedule of activities. It is a residential community coupled to a formal organization. Several of the characteristics of total institutions can be briefly listed: there is less possibility for inmates to hold on to personal possessions, inmates are thrown into "forced personal contact" (Goffman, 1961: 28), there exist house rules, and solidarity does not necessarily form among inmates. These characteristics seem to apply to some degree to nursing homes.

Whereas total institutions can be highly hierarchical, communities have traditionally often been considered as egalitarian, as Redfield's "folk society". Some authors have stated that community is not possible in a nursing home setting because of the dependency on staff created by the institutional regimen and lack of autonomy. In particular, Hochschild (1973) assumes that community is not possible in nursing homes because residents do not develop the type of interdependency required (based on similarity and reciprocity) due to the asymmetrical nature of their relationships with staff members. According to Ross (1977: 183):

There is a general hypothesis that the degree to which special settings for older people are

institutions with social control over their residents has a negative relationship to social activity. Spontaneous social activity is the least likely in the most institutional settings. If community formation is to take place among older people, the setting in which they are brought together should not be too institutional.

However these authors do not take into account that independent action by nursing home residents is possible outside of the framework provided by the institution. Not all action is determined by the structures of the nursing home, even though a large part of it may be considered to be. Action carried out by residents within the limitations of organized activities is individualized by the residents which bring to it a unique background.

The theoretical framework embodies several different considerations, namely the nursing home as organization and community, social interaction, and government policy. This chapter will describe each of the elements of the framework and how they relate to each other.

The notion of community is used as a heuristic device to categorize the circumstances in which different types of behavior occur. The aspects of community selected provide the categories to be used in the analysis of behavior of the nursing home residents and other people found in the setting.

Policies affecting members of the nursing home community will affect behavior of community members and their interaction, as well as some structural aspects of the community. By policies, I mean laws such as the one

legislating health and social services as well as some internal administrative rules particular to the nursing home. Some of these policies do not affect only people connected to the nursing home but also other elderly people. It can affect their behavior and interaction as well as other aspects of their life.

Elements of Community

The concept of community is one which has defied consistent definition. According to Cohen (1985), community implies two things: one is that members of the community have something in common, and the other, that they can be seen by opposition to other groups or social entities. What defines the difference is the boundary. Boundaries are marked at the point of interaction of members of different groups. They may be statutory, physical, racial, linguistic, or religious, but they are not necessarily obvious, explicit, or visible. Cohen does not see community as a "structure of institutions".

However, other definitions do include some structural aspects. Bell and Newby (1971) report on an inventory of 94 definitions of community done by George Hillery from which they abstract the characteristics which are most often present in definitions of community. Some of them are: social interaction within the group, sharing of a geographic area, common life, possession of common ends, norms, and means. They state that "a majority of definitions include, in

increasing importance for each element, the following components of community: area, common ties and social interaction." (Bell and Newby, 1971: 29)

According to Arensberg and Kimball (1965), the three main aspects of community are: (1) the territorial aspect, (2) the social organization within the territory, and (3) the environment. As far as (2) is concerned, they claim that the characteristics of the social organization of the community are related to the characteristics of the territory itself. For example, since the nursing home is a hospital-like setting, it elicits some hospital-like behaviour from residents and staff. By environment, they mean the surrounding society, with its values and activities, from which the community is not completely independent. The three factors are considered to be interdependent. Indeed, "community should be viewed as systems comprising interactional regularities and cultural behaviour in an environmental context" (Arensberg and Kimball, 1965: 4).

For Ross (1977), the main aspects of community are social organization, "we-feelings" or feelings of belongingness, and territory (although this is the least interesting aspect). This is very similar to Bell and Newby's characterization of community. However, like Cohen, Ross gives a lot of importance to the symbolic aspects of community.

As people live together, they may develop shared responses to certain symbols of their life together: events or individuals may become new symbols, or symbols from common past experiences

may be translated into terms relevant to the present. Affective symbols uniquely associated with the emerging community will be a source of the sense of shared fate and distinctiveness that I have labelled we-feelings. (Ross, 1977: 15)

In studying "community", therefore, I will look at territoriality, formal social organization, informal social organization, and interaction across boundaries.

We can define each of these elements one by one. The territorial aspect manifests itself in several ways. One is the physical separation of the community from its surroundings. Another is delimitation of space within it. Some areas are marked for group activities, some, for personal occupation. Formal social organization denotes those organized activities where definition and control is out of the residents' hands, with the purpose and form of the activity being defined from the outside. Some of these may be defined by administrative rules. An example of this would be the way in which meal times are structured. Others may apparently originate from within the home, such as social activities organized by the recreation staff, but are really instigated at the administration level through the use of money earmarked for that purpose. Some outings which are organized by the residents' committee can also be seen as formal, since very few community members have a say in their organization. Informal social activity is that which occurs within the bounds offered by the nursing home organization, but which has a more spontaneous nature. It may occur

spontaneously as a result of fortuitous sharing of physical space, or it may occur by choice of individuals. An examination of conflict within the community, for example overt disagreements or exchanges of harsh words, can point to divisions within the community. One can also try to infer how conflict within the community can lead to greater solidarity with respect to threats from the outside. To locate symbolic markers of community boundaries in nursing homes, we can look at the following dichotomies: resident/non-resident, or in particular, resident/staff, resident/out-patient, resident/family, and look at the set of symbols for the different sets of dichotomies that are used, as a whole, in defining the community boundaries.

Social Interaction

Patterns of behavior which recur in various circumstances tend to be ritualized responses to the actor's surroundings, some acquired over time and in various circumstances, some acquired in a specific setting as a response to a specific needs. In many of his essays, Goffman explores these ritualized responses which are to him necessary elements of interaction, and which he refers to as "elements of behavior which must be built into the person if practical use is to be made of him as an interactant" (Goffman, 1967).

Goffman's dramaturgical approach can be used in the study of day-to-day interaction in nursing homes. A strong emphasis

is given to keeping up appearances of normality in many areas of nursing home life, both on the part of residents, who show pity to those who cannot, and on the part of the staff. The comment that the nursing home is a home and that people should feel at home there is very often heard, despite evidence to the contrary, such as fixed meal times and fixed seating arrangements for meals. Recreational activities are organized with the goal of keeping people active¹, and to organize activities which are "normal" for people to engage in. The Friday afternoon sing-along party (called "la boîte à chansons") is one example of this. Paid animators or volunteers bring people together from two to three o'clock in the afternoon, and make them listen to music and sing along, or sing songs from booklets which they hand around. While such activities may occur spontaneously in family environments, the fact that this is a scheduled activity organized for residents and day-centre users gives this activity a very contrived appearance. In many ways, "'homes' for the aged try to reconstitute the family-kin domain, but in

¹A great example of the influence of activity theory. This theory, the first one to be formulated with respect to the specific behavior of aging individuals (in the early 1950s), advocates an image of successful aging whereby the elderly will experience higher life satisfaction if they maintain a high level of activity and substitute new roles for old ones that may have been lost as a result of the aging process. This theory became a basis for programming of services for the elderly even though subsequent research does not consistently support the assumption of a positive correlation between levels of activity and life satisfaction (McPherson, 1983: 136-137).

a separate way, detached from the rest of society" (Ostör, 1984: 296). A detailed examination of participants behaviour permits inference of their attitudes towards this type of activity. A resident recently told me that "Doing that or something else, it's all the same. We have to pass the time in some way." Most of the singing is rather unenthusiastic.

By using Goffman's dramaturgical approach, particular attention can be given to individual gatherings and encounters in the context of nursing home life. In Goffman's language, gatherings occur when two or more people are in "co-presence". They may be fleeting occasions (such as a brief meeting in a corridor) or can occur in formal activities (called social occasions). Social occasions "are typically rather clearly bounded in time and space and often employ special forms of fixed equipment - formalized arrangement of tables and chairs and so on" (Giddens, 1984: 71). Social occasions are contexts for gatherings occurring within them. Many routinized parts of daily life are of this kind, and so is most of nursing home life. We can therefore examine behavior occurring in these circumstances.

In addition, people can act in such ways to influence the impression others have of them, using "techniques of impression management" (Goffman, 1959: 208). In particular, we can look at how people carry out "face-work". Face-work basically consists of avoidance processes and corrective

processes, including redefinition of incidents² (Goffman, 1967). In his discussion of the use of face-work in interaction, Goffman says that

... the person's face clearly is something that is not lodged in or on his body, but rather something that is diffusely located in the flow of events in the encounter and becomes manifest only when those events are read and interpreted for the appraisals expressed in them. (Goffman, 1967: 7)

Face-work may be used by staff members, for example, to mask the level of dependency residents have on their help, thereby preserving a semblance of autonomy, even though the possibilities of this may be in fact very limited.

We can also look at the apparent rules of conducts and propriety which govern face-to-face interaction (Goffman, 1963). Many of Goffman's observations were based on work he did on mental hospitals, so his examples frequently refer specifically to behavior of mentally ill persons. A parallel can be drawn for the study of some older people, obvious in the case of senile dementia, perhaps less so in the case of very mild confusion and disorientation. As Goffman states that mental illness can be diagnosed on the basis of "inappropriate behavior" attached to many mental illnesses - that he also calls "situational improprieties" (Goffman, 1963:3) - many actions of older people are labelled inappropriate in relation to the situations in which they are

²Goffman calls incidents those "unmeant gestures, inopportune intrusions, faux pas, and scenes" that disturb the prevailing definition of the situation (1959: 212).

carried out. The roles that people assume can also be examined³ since "it is through roles that tasks in society are allocated and arrangements made to enforce their performance" (Goffman, 1961: 87).

Each of these aspects of interaction can be looked at in the context of the aspects of community I have chosen to investigate. It is important to notice that interaction in everyday life in the nursing home cannot be considered to limit itself to the aspects described in this study. To make the link to the aspects of community which are to be considered in this study, we can point to specific types of behavior which are more likely to occur in various circumstances. As far as territoriality is concerned, references made to the difference between private and public space can be examined. Goffman (1963: 9) defines public places as "any regions of a community freely accessible to members of that community" and private places as "soundproof regions where only members or invitees gather". Gubrium (1975) has discussed this aspect of nursing home life. In particular, he pointed out that perceptions of public/private place within the nursing home will vary among the various subgroups of community members (clientele, administrative staff, caregiving staff). In particular, from the residents' point of view, one's room is private space, which obviously can be

³The sick role is a role which is assumed in many circumstances and which points to the dependency of residents on staff members.

a problem for those sharing rooms. In the nursing home I studied, one resident made comments to the effect that she was not "at home" and that she had no space of her own, and was greatly distressed by this state of affairs. While corridors are generally considered public space, some other areas, such as the dining room and the T.V. room, that are officially public space, can be invested with "private" properties by their usual users. These appropriations of public space for private use can be made on an habitual basis ("this is my chair") or on a temporary basis, as when relatives come for visits and wish to have some privacy without resorting to visiting in bedrooms. Some ritualized forms of behavior expressing wishes for privacy, such as arranging chairs in a closed circle, can be used for this purpose, expressing implicitly that others are not welcome.⁴ We can also look at the difference in spatial use inside and outside the nursing home. Although the outside (mostly the backyard) is only used in the summer, some specific behavioral patterns of staff and residents in that setting warrants separate consideration.

Impression management, of which face-work is a part, is used in many instances of contact through formal and informal social interaction. Formal social interaction provokes the

⁴There are often attempts made by other residents to "share visitors" in order to have contact with people from the outside. The attempts can be considered overly intrusive by residents being visited, although some of them do not feel annoyed and readily include in the circle any persons wishing to join them.

occurrence of social occasions, sometimes purposely to avoid isolation of beneficiaries. Since these social occasions force the gathering of beneficiaries at pre-arranged times, settings, and circumstances, it may elicit a considerable amount of face-work, for example to put up an air of competence and self-sufficiency in occasions, such as arts and crafts classes, which require active participation. It may also elicit a considerable amount of impression management, in order to look interested in the activities going on, or at least not to look downright bored.

As stated before, boundary definition can be studied by considering the following dichotomies: resident/staff, resident/out-patient, resident/family. The resident/staff boundary is often expressed through "rules of deference" (Goffman, 1967). Residents usually treat staff members as authority figures while residents are often treated in a very paternalistic manner, or talk to them in the same tone of voice that is used for children. There is relatively little interaction between residents and day centre users. Residents sometimes consider day centre users as intruders, especially where they cause a crowding of the facilities. Relationships of residents with members of their family is rather difficult to observe and more difficult to interpret. The present relationship, having developed and evolved over a long period of time, is probably rather complex and many-faceted. The detachment of family observed in certain cases could be

explained by the difficulty in dealing with the loss of autonomy of own's parents or spouse.

Conclusion

The purpose of this discussion was the elaboration of a theoretical framework to study daily life in a nursing home setting. An attempt is made to take into account the socio-historical context in which public nursing homes have developed, as this context is also indicative of the perceptions of the elderly by those who can determine the form and shape of services to be offered to them. This socio-historical is described in chapters 2 and 3. The main goal of the study is not only to develop an understanding of nursing homes as institutions, but an understanding of nursing homes as indicative of the place of the elderly in our society. A second aspect is to study how nursing homes are used by their beneficiaries.

Marshall states in his discussion of the scope of theorizing in aging that

The social study of aging deals properly with the ways in which age and changes in age become consequential for social life and, conversely, with the ways in which aspects of social life become consequential for aging. (Marshall, 1987: 43)

We can take into account that there are two separate processes of aging: individual aging and population aging. The two are not wholly unrelated. Population aging results in a population containing a larger proportion of elderly

individuals. Individual aging refers to the

physical, psychological, and social change and adaptation throughout the life cycle. These structural and behavioral changes and adaptations over the years within and between individuals and cohorts constitute the process of aging. (McPherson, 1983: 5)

The proportion of elderly in the population is increasing in Canada and in Québec, and this is likely to bring about changes in attitudes and perceptions of the elderly. It will also surely necessitate changes in services offered to the elderly. In order to be able to plan for such services, so that they will correspond to the needs of their beneficiaries, it is important to study present services, their nature and effects on those who use them.

In the case of nursing homes, George and Maddox (1989: 117) "urge the development of what... [they] call a behavioral ethnography of nursing home life - an endeavour that we believe will highlight the fundamental social processes that underlie the organization and effects of nursing homes". They also urge the examination of the social factors that lead to entry in a nursing home, the study of the composition of the nursing home population, the study of the nature and effects of nursing homes as residential environment, and the study of the "relationships among family involvement, residents outcomes, and the attitudes and behaviors of nursing home personnel" (George and Maddox, 1989: 117). According to them, "social and behavioral scientists must pay greater attention to the clinical and policy

realities of institutional life" (George and Maddox, 1989:
118).

CHAPTER 5

A REVIEW OF THE LITERATURE ON NURSING HOME LIFE

This chapter aims at reviewing literature than can be found on various aspects of nursing home life. Some of the issues that are discussed are factors affecting conditions of life in the nursing home.

As mentioned in chapter 3, Roy (1990) contends that, in Quebec, the desire to move to an institution is more often motivated by social and environmental factors. This clashes with the health care network's emphasis on factors relating to health itself. Therefore, we must put into question selection criteria which underestimate social and environmental dimensions in the determination of needs and the determination of resources to be mobilized to respond to these needs. Vicente, Wiley, and Carrington (1980-81) state that people who are alone (no spouse or close relative who can take care of them) are more likely to be institutionalized.

In addition, nursing homes are usually organized on the model of the hospital (Diamond, 1986) and are administrated following the medical model, not following a holistic approach to care and well-being (Johnson and Grant, 1985).

Admission into a nursing home is often perceived by residents as moving into their last home (Carrier, 1984). This may be a frightening prospect (Gubrium, 1975). Entry into a nursing home signals closeness to the end of life, that is, it can foster a sense of social death which occurs before physical death (Gustafson, 1972). In fact, relatively few people return to independent living after first admission. A stay in a nursing home often end in death or transfer to hospital, especially shortly before death (Vicente, Wiley, and Carrington, 1980-81).

Privacy has been an issue for many authors. Safeguarding privacy is seen by some as important, while others claim there are also negative aspects to it. Myles (1979) states that privacy must be problematic to nursing home residents since there is a constant search for it. Opportunities for privacy are reduced in an institutional setting. Compensation is often used, for example by the redefinition of public space as private space, or by "turning off" interaction in public (Lawton, Patnaik, and Kleban, 1976). Gubrium (1975) discusses this as well. Firestone, Lichtman and Evans (1980) discuss preference of nursing home residents for privacy and solidarity. They state that residents with private rooms are more concerned with maintaining their privacy than ward residents. The conclusion they draw from their study is that "privacy-sociability preferences were primarily determined by their current type of accommodation within the nursing home"

(Fireston, Lichtman and Evans, 1980: 239). On the other hand, physical features of an institutional setting that encourages privacy may have both positive and negative effects. Increased privacy may lead to a greater sense of freedom for some residents, but other will withdraw more due to a lack of opportunity for interaction (Bonardi, Pencer, and Tourigny-Rivard, 1989).

The question is not, however, whether the nursing home as an institution should encourage privacy or be indifferent to the privacy needs of its beneficiaries. The question lies, rather, with the need for a certain degree of flexibility in order to accommodate changing needs and to a respect of elderly individuals in their choice for privacy or sociability. It may be difficult, or at least less efficient from an administrative point of view, to do so. The nursing home possesses many characteristics of a total institution, one of which being a tendency for "batch processing", or for treating everybody in the same way.

Brent, Brent, and Mauksch (1984) report on a study of behavior in public areas (dining room, lounge, corridor) of a nursing home. Systematic observation of behavior in specific areas was done. The chart of activity codes include a classification of "active" and "passive" activities. Active resident activities include: watching television, reading, eating, drinking, helping self, manipulating environment, performance of assigned duty, helping others, roving about,

personal maintenance, talking on the phone, and interaction with other residents, staff members, or others. Passive activities in which the resident is alert include: smoking, chewing tobacco, focused observing, thinking, meditating, having something done to them (for example, being wheeled about)¹. Passive activity in which the resident is not alert include sleeping, talking to self, backstage behavior, singing to self, daydreaming, or fidgeting. The authors seem to use the term "passive activity" to signify non-instrumental activity.

The authors state that "residents who were immobile and/or mentally disabled displayed less diversity of behavior in their use of space than mobile and/or mentally able residents" (Brent, Brent, and Mauksch, 1984: 190). Moreover, they concluded that patterns of behavior ranged from more active and sociable to passive and isolated, and that these patterns of behavior are related to "mobility and mental status, but not to physical disability or time in residence" (Brent, Brent, and Mauksch, 1984: 191). In addition, residents with better health status have a wider range of activities and engage in more complex ones. Lastly, "residents who were immobile and/or mentally disabled more often slept or displayed backstage behaviors in the three public areas" (Brent, Brent, and Mauksch, 1984: 192).

¹This leaves out praying, which could be mistaken for thinking or meditating, but which would have a different significance for residents.

Most of Brent et. al.'s conclusions seem plausible in the light of behavior observed at Maison Bon Accueil. Immobile residents, especially those who are also mentally disabled, tend to display more backstage behaviors in public. Some attempt to take off their clothes, pick their nose, clean their dentures, or sleep. Mentally disabled residents may do so because they are less conscious of the circumstances in which they carry out their actions. In the case of lucid but immobile residents, it may simply reflect the impossibility to return to a more private area on their own. The most healthy residents should normally be the most active, out of personal interest and to kill boredom, and also maybe to show off their better health status.

According to Fontana (1977), most of nursing home life consists of waiting between scheduled events. People pass time by sitting around (which includes talking, dozing, reading, doing "hand-work", watching) or walking around (Gubrium, 1975). There is relatively little interaction between residents. While the elderly may be perceived at large as an homogeneous group, they are not and a certain lack of commonality in background may lead to a situation where they feel they have nothing to say to each other (Gustafson, 1972). Another factor which could be considered in this case is that even if some residents has something in common, their constant proximity in the institutional setting may result in a level of interaction which, while being disconcertingly

rarefied to the outside observer, is still meaningful to residents.

Those who go to staff because they have nothing to do are considered trouble makers (Gubrium, 1975). Patients often turn to staff for interaction, but staff members are often too busy to respond (Fontana, 1977).

They approach nurses and aides anxiously, eager to fill their time with anything. They may ask for something that, as one patient put it, 'you really don't need, just to see a face and chat a bit'. This might mean calling an aide for things such as 'unnecessary' toileting, which produces no urine or stool, or 'help' in climbing into bed when everyone concerned knows that it can be accomplished without aid. Some clientele follow aides about or loiter at the nurses' station, either conversing or watching or both in order to calm themselves down. Clientele who anxiously 'make trouble' for the floor staff in order to avoid just sitting are usually described by nurses and aides as 'agitated today'. Those who often feel nervous about just sitting become known as the 'agitated patients'. (Gubrium, 1975: 159)

Nursing home residents can use the sick role to gain advantages within the setting. It may seem better to look "legitimately" sick than to be merely old and incapable, and this may lead to the gain of some advantages in interaction with staff (Hanson, 1985). Dependent behavior of the elderly produces "dependence-supportive" behavior in staff. Independent behavior often does not elicit reaction from staff members, or elicits an incongruent response, that is, a response which does not encourage or support independent behavior. In addition, elderly persons can manipulate their environment in order to produce dependence-supporting

responses from staff (Baltes et. al., 1983).

Staff members are generally considered only for the tasks they accomplish in the nursing home. In particular, from an administrative point of view, all that counts as work in nursing homes is what can be recorded (or charted). Caring work (patience with beneficiaries, listening to them, and so on) does not come into it. It is, however, a very difficult part of the job. Work in a nursing home is not merely a series of tasks, but a set of social relations, i.e. social relations are established between staff members and residents and tasks must be accomplished within this context (Diamond, 1986). Diamond gives this example of conflict between caring and organizational goals in the carrying out of daily activities:

After the patients were awakened, those who were able to leave their beds were transported to the day room for breakfast. Some residents could not perform all the complex tasks of eating, and had to be helped. The rush was on to finish breakfast by 8:30, so there was pressure when one had to help several people eat. The luck of the bad draw was noted in the question, "How many feeders you got today?" 'Feeders' referred to a patient who needed help eating. The one who is doing the eating becomes an object in this term, the object of feeding, and under the pressure of time, an object of scorn. Buried underneath this pressured moment, however, was the act of feeding a frail, sick person - a delicate process, requiring much skill. To learn the extremely slow pace of an old person's eating, or how to vary portions and tastes, how to communicate non-verbally while feeding - these are refined skills, but unnamed, indeed suppressed, by the dictates of the organization. (Diamond, 1986: 1290)

In addition, "the confused-nonconfused distinction is an

important organizing principle in nursing homes" (Morgan, 1985: 103). Many social factors have an influence on perceptions of mental confusion: limitations in activities of daily living have an impact, and so does age (Morgan, 1985). However, dementia and depression are often not distinguished by those working with the elderly (Haug, Belgrave, and Gratton, 1984).

The potential effects of life in nursing homes include: de-individuation (and increased dependency), disculturation (break with the past and previous social environment), emotional, social, and physical damage, estrangement (from the outside world), isolation, and stimulus deprivation. (Johnson and Grant, 1985).

Nursing homes may turn out to be decision-free environments. To be given opportunities for decision-making and taking responsibilities may result in an increase in "mental alertness and increased behavioral involvement in many different kinds of activities" (Langer and Rodin, 1976: 197). A higher degree of self-determination (higher control over activities of daily life) may lead to higher life satisfaction. Residents of nursing homes which allow for self-determination experience as much satisfaction as elderly living in the community (Vallerand, O Connor, and Blais, 1989). This could, however, be due to another cause: according to Myles, "institutionalization indirectly increases the level of life satisfaction among residents of

institutions for the aged by lowering their level of perceived disability" (Myles, 1978: 518) since the reference group to which they can readily compare themselves is likely to be in worse physical shape than the population to be found in an age-integrated environment.

Social ties are important to nursing home residents. Gubrium states in relation to the situation he reports in Living and Dying at Murray Manor, that "ties with the outside world take precedence over any ties that clientele have in the Manor" (1975: 91). Feelings of abandonment may beset the elderly person after placement without any real abandonment taking place. It is however likely that there will be less strain in parent-children interaction after institutionalization, due to the reduced burden of children as caregivers (Connidis, 1989b).

Lack of involvement of families with nursing home residents is a myth (York and Calsyn, 1977). However, while there may be continuing involvement between the institutionalized elderly and relatives, this involvement could have both positive and negative effects. Some researchers (such as Hook, Sobal, and Oak, 1982, and Greene and Monahan, 1982) assume that visiting by family is beneficial, which is not necessarily the case, since in some cases there may be frequent visitation, but such visits are not enjoyed by the visitors themselves (York and Calsyn, 1977), and presumably not always by residents either. Many

myths surround family visitation. Besides the idyllic images of children happily visiting their parents who are also happy to see them, there are occasionally fights and arguments where old, bitter memories resurface. Whereas I did not witness any overt family arguments at Maison Bon Accueil, I was recounted several incidents.

Carrier (1984) looks at the difficulties encountered by families in the context of the institutionalization of an elderly family member. Some of these difficulties relate to various aspects of taking the decision to institutionalize, the act of leaving a familiar living environment for the nursing home, and the follow-up to institutionalization. Taking the decision to enter an institution is difficult for elderly persons. They may at first deny the need to take this step, by refusing to admit their functional limitations and the lack of material and/or social resources in their natural environment.

Carrier states that children may also have a tendency to underestimate their parents capacities to cope in their old age, and this may lead to feelings of rejection for the old person. On the other hand, children often have very ambivalent feelings themselves with regard to institutionalization of their parents. Rationalizations concerning entry into an institution, some of them emphasizing positive aspects, are used to justify entry into an institution to their parents. Leaving the decision to the

elderly person may facilitate adaptation to the institution. Following institutionalization, the elderly person must create his or her own "life space" within the institution. In addition, the family must figure out what its own space and role become in the new situation.

According to Smith and Bengston (1979), following institutionalization, 45% of families experience a renewal or discovery of emotional ties and 25% a continuation of an existing close relationship. Twenty percent experience the continuation of a "lack of meaningful involvement" (p.443) and 10% admit that there is quantity, but not quality of interaction. Strengthening of ties may be due to a larger sense of freedom of the relatives who do not bear the burden of technical aspects of the well-being of the elderly relative.

Other researchers have also seen this distinction between technical and non-technical aspects of care. In another American study (Shuttlesworth, Rubin, Duffy, 1982), nursing home administrators and relatives of residents were asked to rate an inventory of tasks as being the responsibility of the home or the family or both. They found that "... the housekeeping, dietary, patient care, counselling/emotional, security, and clerical/professional [tasks].. are viewed by both groups as mainly the nursing home's responsibility."

²What is meant by counselling/emotional tasks are professional counselling, not regular emotional support normally provided by significant others.

Both groups see transportation to appointments and the provision of extras (such as special foods and plants in bedrooms) as the responsibility of families. In cases where there was disagreement on responsibility for a particular task, each group was more likely to assign it to itself, not to the other.

A replication of the above study done with nursing home staff instead of only nursing home administrators had similar results (Rubin and Shuttlesworth, 1983). Tasks assigned to families included reading to the resident, paying bills, giving the resident spending money, running errands for residents, selecting a doctor, encouraging friends to visit. Five categories of tasks showed less agreement from both groups: personalizing care, monitoring and ensuring the provision of care, clothing needs, grooming, providing reading material. The authors state that "meaningful family involvement depends upon agreement in task assignments and must be systematically reviewed and reinforced with family and staff" (Rubin and Shuttlesworth, 1983: 636). At Maison Bon Accueil, this is done through the distribution to residents and family members of the "Residents' Manual", which describes the services given by the home and suggests some areas in which family get involved.

Hook, Sobal, and Oak (1982) look at the factors which help determine how often visitors will come to the nursing home. They are distance travelled, visiting alone, length of

residence, and marital status. The further away the visitors lives, the less often they will come. Visiting alone is also associated with higher frequency of visitation. The longer a resident has been at the home, the less frequent is visitation. And finally, married residents receive more frequent visitation. The authors of this study expected to find a relationship between sex and status employment of the visitor and the frequency of visitation, but they did not. From their data, they conclude that women do not visit more often than men, which is often assumed to be the case. The authors take this to be an indicator of changing attitudes. Also, those who do not work were expected to visit more often than those who do, but this was not confirmed by the study. However, this may be an artifact produced by the method of data gathering. All data was collected on Sundays. Patterns of visitation may be considerably different on weekdays. For example more women and unemployed persons (especially with the possible association of sex and employment status) visiting more often on weekdays, in effect leaving Sunday for those not available during the week. The study does not take that into account.

Another study investigates the relationship between visitation and resident well-being (Greene and Monahan, 1982). They conclude that an increase in the degree of psychosocial impairment, or in the degree of impairment with respect to activities of daily living, does not necessarily reduce the

frequency of visitation. Psychosocial impairment refers to "confusion, agitation, depression, regression, verbal hostility, and physical hostility" (Greene and Monahan, 1982: 421). The hypotheses that were supported include: (1) the closer the relative lives to the home, the more often he or she visits, (2) the longer the resident has been in the home, the less frequent the visitation, and (3) married residents are more likely to have visitors. If we look at the determinants of psychosocial impairment (used as a measure of well-being), it was found that married residents are likely to have a lower degree of psychosocial impairment, and that visitation frequency is negatively related to psychosocial impairment of the resident.

Some authors state that family counselling for families of nursing home residents should be more widely available, as well as information programs on physical and mental problems more likely to be found among the elderly (York and Calsyn, 1977, Smith and Bengston, 1979).

Some of the concerns unearthed by this brief review of literature concerning nursing home life are the causes of use of institutional care, privacy in the nursing home, behavior and social activities, interaction between staff members and residents, as well as issues relating to the ties that the elderly maintain with their family. Many other issues are raised by the authors whose work was reviewed here. The above selection was determined by the topics to be discussed in

Chapter 7 as outlined in Chapter 4. These statements will provide comparisons for an ensuing discussion of the quality of life in the nursing home.

CHAPTER 6

FIELD RESEARCH METHODOLOGY

The data for the ethnographic part of this study of daily life in a nursing home has been gathered mostly through participant observation. Other data was used as well, such as available documents gathered at the research site. This chapter will describe in detail the process of data gathering and discuss the appropriateness of the methods chosen for this project. The way in which access to the setting was gained and contact with research subjects was made, the various difficulties that arose in the course of data gathering, and the limitations of the data thus obtained will be discussed. The first part of this chapter will review some statements on the basic principles of participant observation. This will help determine its appropriateness in the case at hand.

The Methodology of Participant Observation

Spradley describes ethnographic research in terms of a cycle where the researcher goes through the following activities: asking questions, collecting data, recording data, analyzing data. The cycle can be repeated several times. It is entered after selecting a topic of research and

can lead to the production of an ethnography of the setting in question. As stated by Singleton et. al. (1988: 318):

... there is a constant interplay in field research between data collection and data analysis. Observation guides the creation of analytical categories and coding schemes. And whatever codes, tentative hypotheses, and theories you develop constantly are checked against and modified according to your observations.

According to Spradley, the ethnographic process does not fit a linear model of research with definite steps and procedures because of the frequent 'back-tracking' required in the field and the cyclic nature of data gathering and analysis (1980: 29).

Becker and Geer define participant observation in the following way:

By participant observation we mean that method in which the observer participates in the daily life of the people under study, either openly in the role of researcher or covertly in some disguised role, observing things that happen, listening to what is said, and questioning people, over some length of time. (1972: 102)

Bruyn delineates the methodology of participant observation through the following axioms of fieldwork and their corollaries:

Axiom 1: The participant observer shares in the life activities and sentiments of people in face-to-face relationships.

Corollary: The role of the participant observer requires both detachment and personal involvement.

Axiom 2: The participant observer is a normal part of the culture and the life of the people under observation.

Corollary: The scientific role of the participant

observer is interdependent with his social role in the culture of the observed.

Axiom 3: The role of the participant observer reflect the social process of living in society. (Bruyn, 1966: 13-20)

That the participant observer deals with his research subjects on a face-to-face basis, for an extended time period, and as part of their normal activities has consequences and can cause some problems. In the introduction to Junker (1960: xii), Everett C. Hughes says of field work that

The outstanding peculiarity of this method is that the observer, in greater or less degree, is caught up in the very web of social interaction which he observes, analyses, and reports.

And this peculiar position of the researcher with respect to his research subjects also raises some ethical issues.

According to Spradley (1980: 20-25), some of the ethical principles to be followed are: consider informants first; safeguard informants' rights, interests and sensitivities; communicate research objectives; protect privacy of informants; don't exploit informants; make reports available to informants. This assumes that one is doing research overtly, since covert work would have to involve some degree of deception (which may be done on purpose, by assuming an identity one does not possess or by misrepresentation, or by omitting to disclose the purpose of one's presence).

Many difficulties occur in the course of field work that can affect the ability of the researcher to collect data and to analyze it. These difficulties can even jeopardize the

continuation of the project.

The most common learning experiences, mistakes, and dilemmas of fieldworkers... can be classified in these groups: the rebuff; using cues, insights, and social perceptiveness; blocking (on the part of the informant); status problems; problems of role choice; handling emotional involvement; and ethical problems of reporting. (Junker, 1960: 106)

Status problems can arise when the researcher's mandate is ambiguous. In some cases, the researcher's status may change depending on the different kinds of environments in which research is carried out. The informant may attribute a different status (and act accordingly) depending on his/her opinion of the researcher and the project itself. This may lead to a disparity in perception of the field work and the informant and produce feelings of resentment or condescension towards one party or the other (Junker, 1960: 116-120).

Problems of role choice are often related to status problems. Generally roles can be found on the continuum from "complete participant" to "complete observer". Assuming a given role may cause problems when the researcher assumes an identity with which he or she may not completely comfortable. In some cases, using one's identity without any disguises may also cause problems when some characteristics clash either with the project or with the setting. For example, a lapsed Catholic studying a strongly religious community may need to appear religious enough not to shock his/her subjects. Problems of role choice also arise when, in order to establish rapport, the researcher must become a "whole person" for the

informant and therefore depart from the more objective stance of the researcher. Other problems can be caused by role changes occurring in the course of the field work (Junker, 1960: 120-133).

Emotional involvement problems can also occur. However, personal feelings should be subordinated to the field worker role. In some cases, over-identification with the informant can cause low morale induced by the perceived difficult situation of the other (Junker, 1960: 133). Participant observation research can cause emotional stress in cases where one does not like research subjects. The impulse to help research subjects and fighting the tendency to go native can also cause stress (Lofland and Lofland, 1984). In addition, researcher can also suffer from "overload", if they try to input and process too much information from the research setting (Spradley, 1980: 55).

Selection of the Research Setting

The research setting selected for this project is the Maison Bon Accueil (a fictitious name), in the Montreal area. It is a 57-bed institution located on a quiet street near a commercial area of the town. It was selected on the basis of convenience. Several conditions were taken into consideration: the site had to be easily accessible by public transit, it had to be small enough so that I could know everybody by name in a relatively short time, and it had to be

in an area I knew well enough. Easy access by public transit was necessary so that I would not be spending too much time commuting. Part of the field work period overlapped with a term in which I still had some course work to complete and all activities had to be rather tightly scheduled. A small size was more convenient to keep track of changes in population composition and patterns of relationships. To know the area in which the research setting was located was convenient in the sense that since most people in the home were likely either to have lived in that area or to have relatives in it¹, it made it easier to situate the beneficiaries with respect to the immediate environment of the research setting. That most of the beneficiaries and staff members were French-Canadian (as I am) was an advantage since we had common backgrounds and customs, making it easier to establish comfortable relationships. Many of the residents had lived through the same historical periods and in similar living conditions as my older relatives, which gave a frame of references when being told about "the good old days" or the not so good ones.

I make no claim that the nursing home I chose is representative in any way of public nursing homes in the province of Québec. It most probably is not. In fact, I was told several times by various staff members that conditions found there were very different from other places. It offered

¹As a result of standard admission policies for public nursing homes for the elderly in Québec.

services and programs not found in many other homes. It had an uncommonly large amount of support from the community (individual volunteers and community groups). It also had its very specific labor management problems (a daily topic of conversation among staff members, it seems). It is generally considered a good nursing home, but people also complain about many aspects of its services and management.²

Gaining Access

Gaining access to the setting was relatively easy. I had already interviewed the director of recreational services for an undergraduate paper and a member of my family had done some volunteer work at the home in the past. This home also had a history of accepting to supervise work terms for social work students as well as serving as a training setting for nursing home personnel. In addition, since I had offered my services as a volunteer, which they are constantly looking for, there was no problem on their part. I was given extra privileges as far as dining room use was concerned, by being permitted to use the employees' meal plan.

Even though I already knew somebody working at the home,

²One woman whose mother had been a resident for 6 years once told me: "There is no way anybody will ever convince me that it is a normal living environment. It's another world." This was said in a rather indignant tone of voice. However, after her mother's death, the same person commented that the staff had been extremely good, understanding, supportive, competent and professional, and that they had taken very good care of her mother.

I chose to first find out what was officially the appropriate channel to gain access to the setting. In an initial phone call, I was told to address my query to the personnel coordinator, who asked for a written statement of the goals of the project. I sent a letter to the personnel coordinator, the director of recreational services and the director general, along with a copy of the thesis proposal I had prepared for the department³. These initial steps were undertaken in May 1991. Several weeks later, I received a phone call from the social worker attached to the home, who showed some interest in the project. We set up a meeting to discuss it in more detail. We met at the beginning of June. It was then established that I would start fieldwork at the beginning of July, on a fixed schedule at first, with changes to be made later if needed. The field work was expected to terminate at the beginning of November, but eventually continued until the beginning of December. The initial schedule was as follows:

Thursday	9 am to 4 pm
Friday	2 pm to 9 pm
Saturday	7:30 am to 2:30 pm

This permitted me to cover all three daily meals, get-up time, bed-time, church services, as well as many recreational activities. There was actually very little deviation from the original schedule, although I made a point of going to

³A model of this letter (in French), along with an English translation of it can be found in Appendix A.

activities on other week days.

The social worker suggested that I publish a note signalling my future presence and its purpose to beneficiaries, their families, and the staff in the internal monthly newsletter⁴. Nobody ever made comments on the note and my presence in the home was never questioned by anybody, apart from friendly inquiries. However, I usually downplayed my presence as a researcher (without concealing it completely) and the fact that I was a university student. I did not want to create some additional distance between myself and my research subjects, whose level of education was likely to be much lower than mine, by impressing them.

First Contact

The first day at the home was rather confusing. I came in at nine sharp that morning and sat down in the reception area to wait for the social worker, who had not come in yet. When she came in, she told me I was free to move around as I wished in the home and to introduce myself to people. The first people I approached were nice without being overly warm. I made a point of remembering names. I did not walk around very much in the beginning. I felt very much out of place.

The director of recreational services (Mrs. ST) gave me the list of residents along with their room numbers. Another

⁴A copy of this note, along with its English translation can be found in Appendix A.

list gave indications as to people's physical condition (blind, deaf, lucid or not, and so on). Finally, I had a list of when people were ready, in the morning or after afternoon naps, to go outside. Mrs. ST also told me that there was a person who was on a special project (we will call her Antoinette), doing individual activities (mostly reading, as I saw) with residents. She took me up to Mrs. QP's room, where Antoinette was, to introduce me. Mrs. QP knew a member of my family, who used to do visits with her as a volunteer worker. Antoinette showed me how people were taken down from the first floor to the ground floor for lunch, and how to go pick up food at the kitchen counter to bring to the person I was feeding. Spoon feeding somebody was not a problem in itself since I had done it before.

It took me a few weeks to learn the routine (meal times, seats in the dining room, who I could feed, what foods the people I fed liked best, and so on). I only noticed that I had really learned it when some women who were in for a hands-on training session started asking me questions about how to do some things. I then reminded myself that I had asked the same questions: How many wheelchairs can be put in the elevator at one time? Can Mr. MO⁵ find his own seat in the dining room? Where does Mr. HM sit? Where do we put empty wheelchairs after people have been transferred to regular

⁵All beneficiaries are given a 2-letter code as fictitious name. A short description of all those mentioned by name appears in Appendix B.

chairs? So many details that are part of the "normal" way of doing things in the nursing home.

Difficulties

I encountered several difficulties in the course of fieldwork, some of them emotional, "people-related" problems, and others more technical. Technical problems often had to do with the sheer amount of work required by fieldwork. After spending a large amount of time in the field, I had trouble disciplining myself to commit my most important observations to paper. The quality of the data may have suffered as a result of this. One of the causes of what could be seen as lack of discipline could have been what Spradley calls "overload": wanting to do too much and being overwhelmed by it. Another cause could have been a certain lack of direction at the beginning of the project, when I did not yet know what I was looking for within the setting.

Another technical problem has to do with the issue of consent. In the case of staff or lucid beneficiaries, there was no problem with getting consent, explicitly or implicitly. I was rather open about the work I was trying to accomplish and people who wanted to avoid me were free to do so. In any case, I never felt challenged or rejected. The problem lay rather with people who were not lucid and could not understand the primary motivation for my presence at the home. They were not capable of giving consent nor of expressing disapproval.

The only safeguards I have to offer in this case were the note in the internal newsletter, mentioned before, as well as the promise I made to home administrators that under no circumstance would my work permit identification of the home, its beneficiaries, or its staff, in order to maintain confidentiality.

My presence in the setting could also be problematic. It would be difficult to assess its impact on the appearances put up by all actors involved during the course of field work. It may be possible to assume that my presence in the home over a period of five months would have given me a chance to see people interact in the way they usually would. In addition, I deliberately avoided putting myself right in the middle of the action, often standing on the sidelines to quietly observe.

My role changed in two respects over the course of field work: in the range of activities I got involved with and the extent to which I physically helped beneficiaries. At the beginning of the field work period, I volunteered to help out with various recreational activities, to take walks with residents, to do some reading, to help feed people at meal times. In a rather short time, I realized that if I kept myself too busy, I was less open to perceiving the action around me. As a result, I took the habit of mostly hanging around and talking to people. I never stopped helping out at meal times, however. With respect to the second point, it was

mostly out of concern for my personal well-being that I restricted my activities. There were some unresolved questions about my rights if I hurt myself while helping an elderly person and as to my responsibilities if somebody got hurt as a result of my actions. I was also advised by many staff members not to get involved in such things as transferring beneficiaries from their wheelchair to regular chairs, for meals, especially since I had suffered a back injury a few years ago.

That field work involves dealing frequently with people, on a face-to-face basis, creates situations where the researcher becomes quite attached to some of the research subjects. This was certainly my experience. The death of one of my "friends" at the end of the fieldwork period affected me greatly. In my position as a volunteer, I was often tempted to relinquish the last bit of emotional detachment I usually tried to retain, to throw myself body and soul into the "helping" role. I could see so much loneliness and need for friendship and affection in some cases. A feeling of helplessness on my part came along with this realization. No matter how hard I would have tried to help, there were some needs I could not have fulfilled. In any case, the idea that research could also be ultimately useful to people in this kind of situation, by helping to understand the overall situation and going beyond the particular case, kept me hard at work. On the other hand, there were also people I did not

like and situations I deliberately tried to avoid. Some days, I did face going to the home with some reluctance.

Limitations of the study

The usefulness of the study is limited in a certain sense. There is the question of the time at which field work was conducted and the amount of time spent on the project. There is also the question of the limitations of the data itself, since many techniques could not be used in the nursing home.

Field work was carried out from July to November. From July to September, most people were free to go outside. As a result, interaction was much less "dense" or constricted in space. The thing that struck me when the weather became colder was how cramped the home seemed to be with everybody being inside the building most of the time. There was a definite change of atmosphere. I suppose that it would change again (along with the quality of interaction) as people feel the stress from the increased density. Continuing field work through the winter would have enabled me to test this hypothesis, but time constraints did not permit this.

Most of the actual data gathering was done through observation. Informal interviews were carried out through what should have looked as a casual conversation for the other party. I could not use a tape recorder in the home, nor take notes in front of beneficiaries (with the exception of two

beneficiaries committee meeting I attended, in the case of written notes). I was also very careful not to ask questions too insistently so as not to get people upset. The social worker had told me in the beginning that they had had problems with another graduate student doing research in the past, and that under absolutely no circumstances should I upset beneficiaries. I usually sneaked down to an unused part of the basement to jot down notes and tried to expand them upon my return home. I had to rely on my memory for many details. More interviewing (and more structured interviewing) would have helped clarify some points and check on some insights and hypotheses. For the reasons mentioned above, as well as external time constraints, interviewing was not possible.

The Analysis

Ethnography as utilized in this project corresponds to the first stage of the ethnographic research process as presented by Eckert (1988). He says of the first stage that it

is typically descriptive and exploratory, i.e., the researcher is not testing precisely defined hypotheses. Instead, data collection is aimed at generation insightful propositions relevant to the general problem under study. (Eckert, 1988: 246-7)

The second stage consists of hypothesis testing and explanation, whereas the third concerns long-term processes of change.

Thus, this study seeks to uncover how everyday life in

the nursing home is affected by policies issues which provides some of its structure. It is meant as a point of departure for further work. The concluding chapter will present some of the insights issued from the project and make suggestions for investigation of some specific aspects of everyday life in such settings, especially as they may have some relevance for future policy development.

CHAPTER 7

DAILY LIFE IN A QUEBEC PUBLIC NURSING HOME

Daily life in the nursing home may seem to follow fixed patterns and to rarely deviate from them. Life tends to be centered around the daily schedule of meals and activities scheduled. There is also the weekly schedule with its round of regular activities. This fixed scheduling is administratively determined and structures both the use of time and space for beneficiaries and staff members.

The fixed markers provided by this scheduling are frequently referred to in everyday life in the nursing home, often as signs of time passing and as reference points to situate oneself in time. But nursing home life is more than that. Every single one of its occupants, staff members, day centre users, volunteers and visitors brings to the setting their unique outlook on life, their attitudes, demands, needs, as well as their own contributions to making the home a place they can call their own. A wide range of events and incidents take place within the walls of the home. These events and incidents can bring small pleasures and great joys, or sadness and pain.

This chapter will describe various aspects of daily life in the nursing home, as determined in Chapter 4. A short description of the physical set-up of the nursing home is provided as well as a delineation of the various groups of people that can be found in the setting. An account of how space is used in the home follows a sketch of the typical day and typical week at Maison Bon Accueil. The last three sections in the chapter discuss participation to formal and informal social activities, as well as interaction across boundaries, especially resident/staff interaction and resident/family interaction.

The Setting

Maison Bon Accueil, when approached from the front looks rather small; that the front building is only one-story high, and that the two wings at the back are not readily visible, accentuates the effect. It is, however, rather spacious. The first floor houses the administrative offices, the kitchen, a large dining room/living room, twenty-nine bedrooms, and other facilities. The second floor is a bit smaller, with a small dining room/living room and twenty-eight bedrooms. The basement houses the chapel, the pool room, a small convenience store, offices, activity rooms, storage space, and a small sitting area called the "Bistro".

The greatest part of the backyard is located between the two back wings, which meet at a ninety degree angle. There is

a large patio just outside the dining room. A paved walkway leads from the patio to the backyard. The grounds are enclosed by a tall metal fence.

The Players

The people that can be met at Maison Bon Accueil are by no means a homogeneous group. There are beneficiaries and staff members, as well as occasional visitors. The staff can be subdivided by function: administrative, nursing care, professional, janitorial and food services. The administrative staff includes the director, people in charge of accounting and human resources and office staff. The director of nursing care can also be included in this group. These people do not generally come into contact with beneficiaries. They work in the front offices, except for the director of nursing care, whose office faces the first-floor nursing station.

The nursing care staff comprises nurses, orderlies and educators. They do the "bed and body" work⁶. They wash people, help them move around, get dressed, and eat. The nurses distribute and administer medication and are responsible for calling the doctor should somebody require his presence. Orderlies are the people with whom residents interact the most on a daily basis. Some are liked, some are not. One young black orderly has a reputation for being

⁶As Gubrium (1975) calls it.

thorough in the accomplishment of the tasks assigned to her, and is also known to be very gently and considerate. An elderly female resident, who feels so comfortable and secure during her favourite orderly's shift, gets very anxious when she is about to leave. One male orderly is considered careless by several residents, who think he is constantly dragging his feet and is always trying to cut corners to save himself some work.

The professional staff is listed in the discussion concerning the Residents' Manual. I did not generally witness interaction between professionals and beneficiaries, because it usually took place in the professionals' offices.

The janitorial staff is composed of two men and two women. The women do the daily cleaning of the rooms and washrooms. The men do the heavier work such as washing floors, as well as various repair work. The food services team is composed of cooks and kitchen helpers. The cleaning ladies frequently chat with residents as they dust and clean the rooms, commenting on the weather or on some in-house events. The janitors, who also serve as handy men, are two of the few men among the staff, most of them being women.

The beneficiaries group can be broken down into several subgroups: lucid residents, non-lucid residents, and day centre users. There are approximately 6 to 20 day centre users depending on the day. While some people spend the whole day there, some come only for specific activities or

physiotherapy.

There were 57 residents at Maison Bon Accueil in 1990⁷. Two-thirds of them were women. The overall average age was 79.38. The age distribution is presented in table VII. Over 60 percent of residents require over three hours of nursing care per day, and the average amount of nursing care required is 2.9 hours per day. Other services were used in the proportions indicated in parentheses: physiotherapy (60%), zootherapy (54%), and musicotherapy (35%).

Table VI Age distribution of residents at Maison Bon Accueil

<u>Age</u>	<u>% of residents</u>
45-64	7%
65-74	15%
75-84	50%
85 or more	<u>28%</u>
	100%

A brief description of some of the characteristics of residents is given in Appendix B. The main purpose of these descriptions is to apprise the reader of the amount of physical and mental limitations experienced by the Maison's residents.

⁷From the 1989-90 Annual Report.

The Residents' Manual

The Residents' Manual, a small booklet given to new residents upon their arrival (or to their family if needed), contains information about the various services offered by the home, as well as short introductory comments on the philosophy of the home. It states that

The Maison Bon Accueil responds to every person's needs without discrimination. Residents have a right to dignity, autonomy, and respect with regards to their uniqueness as human beings.

The Maison Bon Accueil fulfils its mission by maintaining, developing and organizing competent staff teams and by offering quality services adapted to the needs which are expressed by its residents.

The Maison Bon Accueil has a philosophy of intervention which has the goal of maintaining the residents' autonomy, as well as to foster an active life-style, while seeking to maintain a high level of well-being and by maximizing the existing potential. Programs are developed to facilitate the expression of individuality and creativity, while respecting individual limitations. As far as possible, we do not act for the residents, but they do know that we are there to accompany and assist them with those activities that they can no longer undertake by themselves. [my translation]

With respect to the services having to do with residential services, the manual gives many pointers to new residents. Residents can decorate their room as they wish. It is advisable not to keep valuables and money in bedrooms as the home is not responsible for the personal belongings of residents. Living rooms exist where one can watch television, participate in various activities or have a snack. There is a nursing station on each floor. Meals are served at 8:00,

12:00 and 17:15. Table service is provided but residents who can pick up their plates at the service counter themselves are encouraged to do so. Two snacks are given everyday, one in the afternoon and one at night. Visitors can eat with residents, but must pay for their own meals. Housekeeping is also provided, but again, residents are encouraged to clean their own rooms if they are able to do so. A washer and dryer are available on each floor. Family members can help with laundry if the resident is unable to take care of it. It is advisable to mark all clothing articles.

Residents can have individual phone lines at their own expense. Mail is distributed daily. Residents can mail their own letters by leaving them at the nursing station. Family members will be contacted if a resident needs transportation for a medical visit or other purposes⁸. Several bulletin boards are available in various locations and can be used freely. The centre's activity schedule is posted on these bulletin boards, as well as other announcement about in-house or outside activities.

The Manual also contains security regulations and tips. Smoking is prohibited except in the smoking lounge, the pool room and the Bistro. Electrical appliances should not be used in bedrooms. Preventive measures include smoke detectors and fire extinguishers, and the home conducts evacuation drills on

⁸However, it is provided if no one is available, or done through volunteer services.

occasion. It is advised not to lock bedroom doors at night. However, it is preferable to do so during the day. Each bedroom and washroom has a bell connected to the nursing station. They can be used at anytime of the day or night. Residents who are planning to go outside should advise the nurse of their absence.

A community life coordinator (in charge of social activities) is present four days, from Monday to Thursday. She meets with new residents on an individual basis, in order to build individual activity schedules. There is a chapel in the basement and services are held each Friday. Communion is distributed throughout the home to those who are unable to attend.

The financial contribution of the resident is established by the home, based on earnings of the resident and subject to revision by the Ministry of Health and Social Services. It is payable the first week of each month. In some cases, glasses, dental prostheses, and hearing aids can be paid, as determined by the Ministry. Tips to staff members are prohibited.

Volunteers take part in many activities at the home. In the basement, various articles are available at the store, as well as snack foods. The bistro is located close to it. A hair dresser is present once a week and a barber, once a month. These services must be paid directly by residents. Rooms can be reserved for family meetings or to celebrate anniversaries. There is a beneficiaries' committee, whose

role is to inform residents of the various policies of the home, to forward complaints to the administration and to defend the collective and individual interests of residents. Visitors are welcome at any time.

The Residents' Manual gives an image of the nursing home being a community of lively elderly, living in a worry-free environment, and where autonomy and creativity are strongly encouraged. Through the terms used in its philosophy statement, with its emphasis on dignity, autonomy, and respect for uniqueness, it gives little sense of the apparent uniformity and monotony which strike the first-time visitor.

Scheduling of Daily and Weekly Activities

As the residents' manual states, meals are taken at 8:00, 12:00, and 17:15. The rest of the daily activities are scheduled around these times. Many of the activities of the beneficiaries centre around waiting for meals. In actuality, breakfast starts at 8:00 but sometimes continues until 9:30 since some residents get up later than others. This is mostly due to the scheduling of the orderlies' work. Some beneficiaries are more difficult to get out of bed and relatively few require no help at all.

In addition to meals, a snack is served in mid-afternoon and in the evening. It generally consists of juice, coffee, cookies. Fruits are usually available, and ice cream on occasion.

Many people are put back to bed between meals, mostly the confused and the very sick.

The standard weekly activities⁹ are usually scheduled in the following way:

	<u>Summer</u>	<u>Winter</u>
Sunday	10:00 Mass on TV	10:10 Mass on TV
Monday	10:15 Singing 14:00 Sandbag activity	9:30 Painting 10:15 Singing 14:00 Sandbag activity
Tuesday	9:30 Gardening 14:00 Games	9:30 Beauty care 10:00 Dancing 14:00 Gardening
Wednesday	10:15 Exercise 14:00 Various activities	10:00 Exercise 10:00 Ceramics
Thursday	9:00 Hairdresser and manicure 14:00 Ice cream	9:00 Hairdresser and manicure 13:30 Knitting 14:00 Movie
Friday	9:30 Gardening 14:00 Boite à chansons 16:00 Mass at the chapel	9:30 Gardening and woodworking 9:30 Cooking 14:00 Boite à chansons 16:00 Mass at the chapel

⁹The activity labelled "sandbag activity" consists of throwing little pouches filled with sand at a board where round holes have been cut out. The points awarded for each hole are written above it. The person who gets the highest score wins.

Saturday	Individual activities	Individual activities
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Use of Space

In considering use of space in the nursing home, we must first of all make a difference between private and public space. We can designate as public space that which is generally used by various people and which is not generally considered to be "assigned" to a specific individual. On the other hand, private space is that which is reserved for the use of a specific individual and where one would expect that his or her privacy be respected.

In a nursing home, bedrooms are the only places generally recognized as private. At Maison Bon Accueil, most residents have their own room. Only three of the rooms are shared rooms, one of them being a guest room for short-term stays. Therefore, only four residents live in a double room. Bedrooms contain one hospital bed, a bureau, a small desk and chair, and a bedside table. Most residents bring their own comfortable chair to sit and most place it next to the window. Residents can have their room painted and decorated to their own taste. The administration asks of families that they do the painting and decorating themselves. Many residents have their own colorful curtains and bedspreads and hang paintings and family pictures on their bedroom walls.

There are occasionally transgressions on private space.

Some of the confused residents wander around and pace the corridors, and will occasionally close an open door or enter a room to the great displeasure of its occupant. Another way by which private space is invaded is noise. Some of the residents have a tendency to scream, to complain loudly, or to call out from their rooms to staff members passing by in the corridor. This can bother people in neighboring rooms, by keeping them from sleeping or resting.

Staff can also transgress on residents' private space. Due to space shortages, bedrooms are used by the nursing care staff for team meetings. Some care is taken to use rooms of confused and disoriented patients (and often additionally not mobile) for these meetings in order not to disturb residents who do come and go as they wish. Such meetings are held when residents are attending some activity.

Some staff members on the second floor have the habit of going to the bathroom in one of the confused residents' room. In this way, they save time since the staff washroom is on the first floor. One of the orderlies said it will be annoying to have to go downstairs when the elderly woman whose washroom they are using leaves. However, the staff is conscious they are infringing on her private space. They do have to go downstairs when some of her relatives are present at the home.

Whereas staff members do not necessarily act in such a way as to actively infringe upon residents' privacy, they do not always promote it. A confused and disoriented patient

lifted above a bed pan by a hoist was once left in this position unattended, with her bedroom door opened wide enough for her exposed buttocks to be visible from the corridor.

The use of many public areas in the nursing home can be described: the TV room and smoking lounge, the dining room, the corridors, the upstairs dining room, the basement and the grounds (especially the backyard). The TV room and smoking lounge is used for a variety of activities, mostly informal ones. Its location near the main entrance and across the dining room's main entrance (as well as one of the home's general access washrooms) makes it an obvious point of convergence for residents, staff members, and visitors. It is one of the few places where people are officially permitted to smoke. It also has a color television with cable which can be watched at any time of the day. People often gather here, or are taken there by staff, to wait for meals. Staff members often sit here during their breaks. It is less heavily used during the summer months. During this period, the patio just outside the dining room can be used as an alternative. During meals, some residents are transferred from their wheelchairs to regular chairs. Empty wheelchairs are left either in the lounge section of the dining room or in the TV room.

The dining room can be separated in two sections. The dining area proper has small square tables around which four people can sit. This area is used almost exclusively for meals. It is cleaned immediately after meals and tables are

often set quite a long time before meal times. The lounge section is used throughout the day. Many people sit here regularly. It is also used for Friday afternoon's "Boîte à Chansons", as well as for other activities. A larger part of the dining room is used for occasional bingos.

People often gather in the lounge part of the dining room before meals. Those most likely to gather there are those whose place is closest to this side of the room. They come in through a small door at the opposite end of the dining room (with respect to the main doors). Others will gather close to the main doors. Confused and disoriented residents whose room is on the first floor are brought to the lounge by staff members which line them up against the wall. Residents in wheelchairs, who are not mobile and have their room upstairs, are lined up in the corridor leading to the elevator shortly before meal time and taken downstairs by staff members or volunteers.

The corridors are in general rather wide, wide enough for two wheelchairs to cross each other. Very few residents spend time in the corridors, with the exception of Mrs. NG and two day centre users who all have a tendency to wander around compulsively, and Miss DO who often sits at the window which is at the end of her corridor to look outside. The portion of corridor along the nursing stations are busier. Downstairs, Mr. GM often stays in front of the nursing station for long periods of time and Mr. NB often uses the phone there as he

does not have one in his room. Many people also drop by to talk to the nurse or orderlies when they are close to the desk, and staff members and the general practitioner attached to the home sit there to update beneficiaries' files. The upstairs nursing station is much smaller and not used as much. There are several rocking chairs in front of it and they are used most of the day. Mr. OM's room directly faces the nursing station. His television set is usually put in the entrance of his room so as to be seen from the corridor. Mr. OM usually spends most of the day sitting in one of the rocking chairs.

The basement being the location of several offices and many activities, there are generally quite a few people there on week days. However, the Bistro (or cafe) is not used very much as a drop-in area, except on Thursdays when the hairdresser comes. The hairdresser's "salon" is right across the corridor from it. Also, very few people go to the chapel, apart from attending the Friday afternoon service. I have seen one of the cooks napping there on a very hot summer day. The convenience store is located right in front of the elevator. It is a tiny room. The service counter is a small counter atop a half-door. People sometimes stay for a few minutes to chat with Miss QP, the resident who usually tends the store unless she is away, sick, or has other commitments.

The outside grounds are more or less accessible to beneficiaries. The backyard is surrounded by a fence so that

mobile confused beneficiaries will not wander away. There is a patio with tables and parasols just outside the dining room. People frequently sit there in the shade in the summer. A path leads from the patio to the backyard by going around one of the wings where bedrooms are located. Part of the backyard is paved to provide a more stable surface. People will sometimes gather in the backyard instead of the patio as there may be more shade there depending on the time of day. The "Boîte à Chansons" has been held in both areas. Work to construct the path finished sometimes in July so that the backyard was not accessible all summer.

Whereas most beneficiaries always eat in the dining room, staff members often ate outside during the summer. They would sit either on the patio tables or on garden tables in the backyard. Beneficiaries rarely joined them at these times. Tables occupied by staff members were considered as private space by beneficiaries who conceded meal times as real "off times" to staff. These times were dissociated from work tasks, one of which is interaction with beneficiaries.

Participation to Formal Social Activities

Formal social activities at Maison Bon Accueil fall within three broad categories: ceremonial activities, occupational activities, and leisure activities. Mass and anniversary celebrations are ceremonials.

Mass is celebrated every Friday at four in the afternoon.

Mass goers needing assistance are taken to the chapel by staff members, volunteers, or family members who are present. The service is announced on the public announcement system to remind beneficiaries who wish to go. The chapel fills up quickly. Twenty to twenty-five people are usually present. In addition to residents, some day centre users, staff and relatives of residents attend mass at the home. For example, Mrs. VP's daughter and son-in-law come almost every Friday to spend the afternoon with her and also attend mass. Mrs. ML, one of the cleaning women, also comes to the chapel. Mrs. NP, who lives nearby, comes to mass at the home.

The celebrant is a priest from the parish in which the home is located. Prior to the celebration, his ceremonial robes are laid out for him over the pool table in the pool room across the corridor from the chapel. The celebration is a shortened one that lasts approximately twenty minutes. Sermons are kept very short. One that come to mind was on selective listening, where it was given as an example that an old person can pretend to be more hearing-impaired than he or she is really when he or she does not want to respond. This brought a few chuckles from the audience.

Mass goers usually sit in the same place every week, except for those who depend on volunteers and staff to come to the chapel. Their place in the chapel depends on the order in which they come in, especially if they are in a wheelchair. However, Mrs. VP always sits in the front row, next to the

bench on which her daughter takes place. Her son-in-law usually sits in a chair at the back of the room. Mrs. VP's voice can also be heard above all of the others in songs and prayers. Mrs. TD, who has a much more reserved temperament than Mrs. VP, resents her for putting herself forward in this way. It is to be noted that they sit together for meals but that they do not seem to get along very well.¹⁰

Many volunteers help with various aspect of Roman Catholic ritual: readings, distributing communion, musical accompaniment and so on. During part of the year, volunteers come sing for mass, usually three people. Volunteers also distribute communion to residents unable to attend the celebration.

Anniversary celebrations are another form of ceremonial found in the home. In contrast to religious ones, they do not occur on a regular basis and involve fewer people. I am referring mostly to residents' birthdays. They are announced monthly on a large bulletin board in the dining room. The kitchen staff makes a birthday cake and it is brought to the resident's table by a group of staff members singing "Happy Birthday". Other residents do not generally sing along with staff members. Birthday cards and wishes are not exchanged by beneficiaries. When family members get involved, they usually invite the resident outside the home for a special meal and do

¹⁰Places in the dining room are generally assigned by staff and change very little over time.

not celebrate at the home. Mrs. LP is one of the exceptions to this. It must however be said that her state of health precluded her going out. Her daughter brought a birthday cake to the home and they celebrated. She had the remains of the cake on her desk and was inviting people that were coming into her room (mostly staff members) to have a slice of cake.

Occupational activities include gardening, ceramics, wood working, knitting, cooking, and painting. Relatively few people take part in these activities. Many of these activities are run by volunteers. However, gardening is taken care of by the home's horticulture specialist, who also takes care of the grounds and flower beds in the summer. None of the residents attend the knitting workshop. Only day centre users do.

As far as woodworking is concerned, it is exclusively attended by men. One session at which I dropped by, the participants were sanding bread knife handles. Some of the men who were not able to do much sanding (in particular Mr. TF and Mr. RT) nevertheless had a few pieces of wood and sand paper in front of them. There was quite a lot of talking and teasing going on. They were comparing the number of handles they had managed to sand to satisfaction. Mr. TF, being an easy target for teasing since he laughs easily, bore the brunt of the teasing. Mr. RM, a day centre user who spends five days a week at the home and occasionally stays overnight on weekends, was making faces at Mr. FN who was pulling his

tongue and grunting at him (he cannot talk). There was a certain atmosphere of camaraderie in this group.

The cooking workshop is attended by Mr. DB, Mr. DG, Mrs. KB, Miss QP, Mrs. LR and Mrs. VL. It takes place every Friday in a tiny kitchen in the basement and is directed on a voluntary basis by a professional caterer. The menu is decided in advance and the food is ordered by the home. Every Friday, some people eating in the dining room will ask where the cooking workshop participants are and wonder if they are late for lunch. They then remind each other that it is Friday and that they are eating downstairs.

The most active member of the cooking workshop seems to be Miss QP. Mr. DB often complains that Mrs. LR and Mrs. KB do not do much in the workshop, especially Mrs. LR who apparently openly says that she goes to the workshop because she finds the dining room food uninteresting. She can also use this occasion to cheat on her very strict diet. She does not always go, since on days where her arthritis pains her too much, she does eat in the dining room. Mr. DG often talks about how much he enjoys this activity, without complaining about any aspects of it.

Oil painting takes place in the large all-purpose room in the basement. The workshop is run by volunteers and it attended by many people, although not all of them are able to do the work by themselves. During one of the beneficiaries' committee meeting, it was suggested by one of the volunteers

who runs the activity (who is also a committee member) that there could be two solutions to the problems that come up during the workshop: (1) that they have more "directed" activities such that everybody would work on a similar piece of work instead of the present system which consists of letting everybody chose what they do, or (2) to exclude those who cannot seem to be able to handle the activity. Option (2) was ruled to be too drastic a measure, in fact deciding for others what they should be doing. In addition, it would be against the philosophy of the home. Option (1) was also judged to be unacceptable. Miss QP, who sits on the committee and also participates in the painting workshop, thought that this option would discriminate against those residents who find in this activity an outlet for their creativity and a good means of expressing themselves. For example, Mr. DB shows his paintings with a lot of pride and likes describing how he got the idea for the painting and discussing what he plans to do for the next ones. Changing the format of the workshop would deprive long-time participants of one of their favorite activities.

With respect to the problems in the workshop, Mrs. BK's case in particular was discussed. With her failing eyesight, she has an increasing amount of difficulty participating in the workshop. It seems that volunteers end up doing most of her paintings with her. It shocks them that she manages to sell them claiming they are her work. Mrs. BK often talks

about how she sold her paintings and that people are amazed that a 92-year-old woman can produce such paintings. It may be an indication of attempt to affirm that she still has some amount of autonomy she can preserve. She seems to have some trouble accepting her limitations.

In contrast to occupational activities, whose obvious purpose is to maintain a certain level of autonomy and to practice some skills for the beneficiaries, leisure activities are purely recreational in nature. They range from the presentation of videos at the home to spending the week end at an inn in the Laurentians. As with other activities, confused and disoriented beneficiaries are often left out. However, many people are brought to the Friday afternoon "Boîte à chansons" and seem to enjoy listening to music despite a certain degree of confusion.

Special activities are held for holidays such as national holidays, Fathers' Day, Mothers' Day, as well as religious holidays. Recreational activities include picnics, going out for ice cream, cruises on the river, a trip to a resident's hometown, playing cards, listening to music, playing bingo, watching movies.

Leisure activities do not meet with everybody's approval. Many beneficiaries do not like some of the activities available and may feel somewhat forced to participate. For example, Mrs. CM does not like playing bingo but she is still brought to play. However, since her partial paralysis makes

her speech very difficult to comprehend, the volunteers helping with this activity may not understand that she does not want to go (or does not always want to go).

On a Sunday in August, there was to be a special day with a barbecue and a show by a local singer and band. Mr. CD and Mrs. DH were looking forward to it, welcoming the diversion from routine activities. On the other hand, Mrs. LP was rather worried about the possible noise and chaos so much activity could cause. She gets tired easily and prefers a peaceful and quiet environment. However, she said the week after that she went to the show for a while and enjoyed it. The activity was not as disruptive as she had feared.

One day, Mrs. TD left the lounge in the middle of the presentation of a movie and seemed to be quite upset about it. I had not gone to see the movie and did not know about its contents. I sat down with her and asked what made her so upset. She was making comments about sinning and immoral behavior. It turns out that the movie showed two people kissing and this is what upset her. I asked another resident, Mrs. KR, about her impressions on the movie and she said it was boring but nothing more.

The "Boîte à chansons" is held on Friday afternoon and is the leisure activity that involves the greatest number of beneficiaries. It was held outside in the summer and in the lounge portion of the dining room when the weather did not permit sitting outside. People generally sit in a large

circle, with the animators standing in the middle, trying to make people participate in the action. Sometimes they sing, sometime they listen to music, but participation is never very enthusiastic. A snack is always distributed in the afternoon, but the Friday afternoon one is often special. There is sometimes a theme to it, such as a wine and cheese tasting.

One Friday in the summer, it was held in the dining room because it was a rainy day. At one point, one of the animators decided to go around the circle and to make each person state his or her name in case some people did not know each other's name, although on that day there were few day centre beneficiaries and in spite of the fact that residents do know each other by name. In the case of women, the animator asked that they state both their married and maiden names. After each person, the whole group was applauding.

On a sunny September day, the whole group was sitting on the patio near the dining room. Most people were sitting in the shade. The animator asked Mrs. VL to start a song, which she did, singing a bit off key. Mr. DB, next to whom I was sitting, said that this activity was so boring, as usual. They used to go to a small park nearby instead of staying on the home grounds all the time and that this was a nice diversion, but they don't do that any longer.

Informal Social Interaction

Formal social activities are only a small part of the action occurring at the nursing home. While they are one of the major theatres for interaction in this setting, there are also many opportunities for informal interaction to occur, and for informal social activities to spring up in the course of a day. Many spontaneous gatherings take place in the TV room, in the basement cafe, in the dining room, on the patio or in front of the nursing stations. There are impromptu games of cards, Mr. TF's wife plays music for the beneficiaries, and some people will have a chat over their evening herb tea before going to bed.

Mr. RM, Mr. CD, Mr. TF, Mr. TB, and Mr. HR often sit in the TV room, where all of them except Mr. CD smoke cigarettes. They occasionally watch television. Most of the time, they chat. Mr. RM, a 55 year-old day centre beneficiary with multiple sclerosis, calls out to everybody who walks by. He also frequently asks people about their sex life.

Some of the women will occasionally sit there after they finish their meal, but this is infrequent. Once, Mrs. KR had not been taken upstairs and was sitting in front of the television. She usually does not talk to other residents but, on that day, she turned sideways, looked at Mr. TB sitting next to her, saluted him and smiled. Mr. TB responded in the same manner. Such incidents often look like interaction between remote acquaintances who seldom see each other, rather

than that which one would expect to see between two people who have been living in the same home for years.

The television room is a gathering place for a variety of people before meals. A frequent topic of conversation is the menu for the next meal, or whether it is time to go into the dining room yet. However, a more common occurrence is a complete lack of conversation between beneficiaries. People will sit side by side without any of them initiating any kind of conversation or other forms of interaction. There seems to be a greater level of interaction between staff member and beneficiaries than among beneficiaries themselves.

On Thursday mornings, the Bistro is the site of the weekly manicure session. It is done by volunteers who clean and shape nails, and apply nail polish. It is also an occasion for other people to come sit in this area, since this is where the action is. One of the volunteers takes out the tape player. A special morning snack is served. The hairdresser works in a small room just between the Bistro and the store. The Bistro is therefore also used as a waiting room for hairdresser appointments. The volunteer manicurists are very careful to remember what their "customers" like. For example, it is known that Mrs. TD likes having her nails painted bright red. She is very disappointed when they do not have her favorite color. Several men also take advantage of this service and they are teased about it. Mr. DE, brother of Mrs. NP and a day centre user, likes to have his nails in a

pointed shape; he says in jest that he can scratch better this way. This comment, as well as his usual harangues about beautiful women and crooked politicians or lawyers, brings a smile to people's faces. Some day centre women also take advantage of the hairdresser service. The price charged at the home is much lower than in neighboring salons.

Impromptu card games often occur in the evening. Usually the participants are Mr. DG, Miss QP, Mrs. DH, Mrs. VL, and Mr. CS when he visits his wife in the home. Mrs. CS usually sits next to her husband and watches the game. The game usually goes rather slow and they talk about many things, reminisce or discuss problems occurring within the home. They play in the dining room or outside on the upstairs patio. The game usually breaks up early, when someone decides to bed or to go shower.

People often sit in the lounge part of the dining room. Unless it is used for some formal social activity, people will drop by and sit there without interacting much with other beneficiaries present. Mrs. TG is usually brought to this area by staff members. She is partially blind and somewhat confused, and is not independently mobile. If someone sits on her right side, she grabs their hand. Miss DO once sat down next to her and got up to change places immediately when Mrs. TG grabbed her hand. She feels insecure when she is left alone and often calls out her favorite orderly's name.

When confused wheelchair-bound residents are brought to

the dining before meals, they are lined up against the wall in the lounge section. While some merely continue sleeping in their wheelchair, others are quite alert and eagerly observe people around them. Miss BH, while she does not move much and cannot talk, has a very expressive face. When she sees someone she recognizes, her eyes widen and she smiles. She often starts laughing if that person goes towards her to take her hand and talk to her. Mrs. CM, who is half paralysed, waves at people passing by with her good hand and likes shaking people's hands when they come to her. She does not talk very clearly but is quite lucid and enjoys having company.

Mrs. MD usually sit at her table in the dining when she is not in her room or participating in some activity. Staff members walking back frequently ask her why she is there so early because she can often be seen sitting there quite a while before meals are to be served. Since very few other people go into this area between meals, she is usually alone. Her visitors sit there with her as well.

A line-up similar to the one downstairs is formed in the upstairs dining room before meals. At the same time, mobile residents wander around. One day, Mrs. TD kept walking back and forth between the elevator and the dining room, and walking past Mrs. CB who is wheelchair-bound. Mrs. CB who is quite confused was saying, every time Mrs. TD was going towards the elevator, that she was going to the basement. Her

constant comments were annoying Mrs. TD who eventually told her to shut up. A loud argument ensued in which each woman told the other that she was a crazy old woman. However, whereas Mrs. TD can understand what is said to her despite being slightly disoriented, Mrs. CB does not usually understand. The whole conversation sounded slightly out of phase to the outsider, each sentence not being a direct reply to any of the previous utterances.

On a Friday evening in September, I was sitting next to Miss BH in the lounge portion of the dining room. I was sitting on the couch and talking to her while holding her hand. After a short while, I noticed Miss NM coming toward us slowly with her wheelchair. She almost never moves when she sits in her wheelchair, so I was rather surprised to see her come across the room. I asked her if she was bored sitting by herself. She bobbed her head up and down, I asked her if she was coming to see us and she said yes again. She never actually talks but will answer yes/no questions by moving her head. This is the only effort I have ever seen her make to establish contact with somebody.

Some residents will occasionally provide help to others. This does not happen all that frequently because of the obvious physical limitations of many beneficiaries. Mr. DG, who participates in the gardening workshop and keeps an eye on the garden, once brought a ripe tomato for Mrs. SG who likes fresh vegetables, but who is blind and does not go outside

very often. Mr. CD often helps people by opening doors for them and pushing wheelchairs.

Residents who cannot offer help themselves will go get help for other who need it. When the paved pathway to the backyard was first done, it was not completely flat and wheelchairs would tend to lean to one side and come to rest again the guard rail. Mrs. MD was in the position once and did not have the strength to straighten the chair sufficiently to continue her "stroll" in the backyard. Mr. DB, who was sitting in his usual corner of the backyard came back to the dining room to fetch someone who could push Mrs. MD back to the patio. She never went back to the backyard by herself. The home subsequently had the pathway redone.

Conflict is always present at Maison Bon Accueil. Disapproval is often expressed with respect to lack of propriety of behavior, in particular dining room manners and sexual behavior. Any expression of sexuality is usually disapproved of. Mrs. KB, a 92-year-old widow who has a male friend outside the home, often talks about how proper he is but other people contend that he has been seen touching her in public (grabbing her knees) and they strongly disapprove of that.

Dining room manners are another cause of tension. Gluttony, bad table manners, spilling food and openly cheating on one's diet also meet with disapproval. Incidents also occur with non-lucid beneficiaries. For example, Mrs. KR and

Mrs. NG share a table but must be seated at opposite ends of the table, since Mrs. NG (who has Alzheimer's disease) will pick up food in Mrs. KR's plate. Mrs. BA once ate her paper napkin. She was laboriously chewing it while repeating "Mmmmm, that's really good". When we noticed this, we tried to figure what she was chewing since all she had before that was a bowl of soup. When we realized it was her paper napkin, we tried to convince her to spit it out, but she kept saying that it was really good. During this time, Miss HB was staring at her and laughing. They then started making faces at each other. Many of the conflicts and tensions occurring in the nursing home have something to do with maintaining some appearance of normalcy. Lucid beneficiaries are quick to point out that they are neither confused nor disoriented. Those who are only slightly so will try to camouflage it as forgetfulness and "temporary" confusion by, for example, agreeing with their lucid interlocutor on whatever topic was being discussed.

Residents could also deny that an incident occurred. Mrs. VP sometimes mistakes Mrs. LR's wheelchair for her own and will deny it categorically, despite the chairs being of a different make and appearance. Mrs. VP sometimes walks from her room to the dining room instead of using her chair. After her meal she will either forget she did not bring her wheelchair and take Mrs. LR's by mistake or be too tired to walk back and take it on purpose. When she gets to her room,

she either leaves the extra chair outside (if she realizes it is not hers) or brings it into her room and denies having made a mistake in spite of her having two different wheelchairs in her room.

Interaction Along Group Boundaries

In this section, we look at the way in which people interact across boundaries. The boundaries to be discussed here are defined as follows: a boundary will mark the difference between groups that possess notably different characteristics. The people found in the nursing home can be divided in the following categories: residents, day centre users, staff members (nursing care and non-nursing care), and visitors (generally relatives). The relationships that will be discussed in the most detail are resident/nursing care staff, and resident/relatives relationships. However, relationships between other groups will be briefly reviewed as well.

Delimitation of such groupings, besides the obvious "functional" division in this case, is facilitated by observation of patterns of conflict between groups. For example, the line can be drawn between residents and day centre users in terms of the rights of individuals of both groups. Residents, by the very fact that they live in the building, have more rights than day centre users and a greater access to services. They try to preserve this higher status

by making sure that certain rules are observed, for example that residents will be served before day centre users in the dining room. Transgression of this rule will bring protest from certain residents. In addition, for some specific activities, different staff members are assigned to deal with residents and day centre beneficiaries.

There is a clear boundary between nursing care staff and administrative staff. Orderlies and nurses often feel that the goals of the administration are not compatible with competent and diligent provision of care. Even the official philosophy of providing a real home seems to them to be taken too far sometimes. One of the orderlies made a comment about the physical organization of the upstairs dining room, which is used for several beneficiaries who are too disorderly to be taken downstairs for meals. The administration wants the staff to set the table in the standard manner, and to put dried flowers decorations, as is done downstairs, in order to reproduce a "real home" environment as much as possible. She did not agree with that way of doing things with deeply confused and disoriented residents or with people with behavioral problems, such as is the case with the people they keep upstairs for meals. Putting too many things on the table gives residents more things to throw around. She did not see the benefits this could bring to beneficiaries.

The relationship between nursing care staff and residents is worthy of a more lengthy discussion. It is characterized

mainly by its greater frequency and by the fact that the locus of control seems to be in the hands of staff members. While the amount and type of interaction is largely determined by administrative rules and work schedules, some variation in several aspects of these relationships are possible. Tone of voice, form of address, and degree of affection expressed to the beneficiary will vary. While not all staff members address beneficiaries in a patronizing way, there exists a tendency among some of them to call some female beneficiaries "grand-mother" or "aunt". A similar tendency was not observed for male beneficiaries. First names are also sometimes used when addressing beneficiaries. Using first names is preferred by some beneficiaries who give their first name when asked how they like to be called. However, the official policy of the home is to address people by their last name. In addition, there are great differences in how lucid and disoriented and confused residents are treated.

Needs expressed by non-lucid residents are more likely to be disregarded. For example, one day just before lunch, I was bringing Mrs. CL to her table and she said she had to go to the bathroom because she had a bladder infection and really had to go. Since she is rather confused usually, I doubt she had any ailment but her need to go to the bathroom may have been real. I asked one of the orderlies about it, and she told me that Mrs. CL did not need to go since she had gone two hours before.

A certain disregard with respect to residents needs also occurs with spoon feeding. The amount of time and care given to spoon feeding of residents who cannot eat alone is more often a function of how much time an orderly has to feed someone, rather than of the rhythm proper to the beneficiary. From the point of view of the administration, twenty minutes are sufficient to give a meal. Some orderlies will try to feed a person in ten minutes in order not to be late for their own lunch break, or because they have too many people to take care of at once.

Some orderlies are also rather careless about the amount of food a beneficiary consumes. Some will spit back food or some of it may fall on the table or the floor, so that an empty plate is not synonymous with a full stomach. The fact that some confused residents are manifestly irritable after a meal may have something to do with being hungry. Mr. DG reported an incident in which a trainee working at the home forgot to feed his wife who is bedridden. He went to see her after taking his meal in the downstairs dining room, and her meal was sitting on the desk, cold.

There is also less care given to what food is served to those who eat pureed food. Unsavoury, bland food that has no consistency is much less appetizing. Most of these residents are not lucid, but there are exceptions. This may show a certain assimilation of physical incapacities to mental limitations on the part of staff members.

On the other hand, some orderlies will sit patiently with beneficiaries, feed them without pushing them, and will talk to them throughout the meal, often naming the food they are given, to remind them of what it is they are eating. Talking to beneficiaries while they are being fed often has a soothing effect on them.

Another circumstance where physical deficiencies are assimilated by staff members to mental deficiencies is when information about a beneficiary must be obtained. For example, an orderly guiding a female resident who had recently been admitted to the home to her table in the dining room may ask another staff member where she must sit and what she should eat and will never ask the woman herself. I am referring here to a particular incident where the resident, while being slightly confused and speaking very slowly and hesitantly, could sustain a short, coherent conversation. She could have been able to tell the orderly herself where she usually sat in the dining room. This talking "over residents' heads" is very frequent.

Working with confused and disoriented elderly people, or with sick ones, requires an uncommon amount of patience. They make many demands on the staff and what may seem to be a very important thing to an overanxious beneficiary may have very low priority for staff members. Anxiety tends to go up towards the end of a work shift. It is also the time at which staff members try to "wrap up" their day. Nurses have

activity reports to produce. Orderlies must carry out their tasks according to a tight schedule.

Beneficiaries will ring the bedroom bells or go in search of a staff member on their floor for a variety of reasons: to get information, to ask for medicine, cigarettes, or a glass of water, to ask for assistance to go to the bathroom, or will want to signal a real medical problem. If no staff member is near the nursing station, the bell will not be heard and the call for help will go unanswered. Of course, some beneficiaries are known to make non-priority demands on a regular basis. Others will complain about real conditions (for example, pain or shortness of breath) to which the staff has no remedy, and will do so on a regular basis. This may also be considered a use of the sick role in order get attention, as discussed by Hanson (1985). Some orderlies will answer any call with a patient and caring attitude. Others will abruptly dismiss those which are not considered important. Beneficiaries complain about this frequently, but do not seem to take into account that staff members are caught between the demands of the administration (as effected in work schedules) and their own demands. During the field work period, at least one orderly was on sick leave due to burn-out, while another was being treated for anxiety problems.

Some of the most important relationships for nursing home residents are those which they maintain with their close relatives. While there may be some perception that

institutionalization is synonymous with abandonment on the part of the family, this is frequently not the case. The elderly person living in a nursing home frequently receives support from relatives (more or less depending on the case), and very few have no contact with any of their relatives. Even though the nursing home can be considered a "total institution" (following Goffman's formulation), there is still quite a strong emphasis given to relationships residents maintain with the rest of the world. As was mentioned in the section discussing the Residents' Manual at Maison Bon Accueil, relatives are strongly encouraged to take part in the care of the elderly.

Patterns of relationships will differ depending on whether residents have a spouse and children or not. Elderly childless widows or single women are more likely to have fewer visitors and less familial support. Mrs. KR is a childless widow. Her most frequent visitor is a nephew who lives nearby, receives her mail at his home and seems to take care of her affairs. Many other older women do not get visitors, although the director of nursing care says there are relatives they can call upon when certain items the home does not provide are needed and that these relatives will respond to such calls.

In general, the most frequent visitors are spouses. Mrs. CS's husband, Mrs. BP's husband, Mr. GM's wife, Mrs. MD's husband, Mr. TF's wife, Mr. RT's wife, and Mr. NM's wife are

frequently seen at the home. Mrs. NM practically spends her whole time there. She participates in her husband's care (he's an advanced Alzheimer's sufferer) and helps the staff with a variety of chores. Her son comes as well once in a while and sits down with his mother for a chat. She knows quite a few of the residents and will sometimes have her lunch in the downstairs dining room with some of these residents, or staff members and volunteers. Mrs. RT often sits with her husband, who is rather confused and disoriented, whether in the upstairs dining room or in front of the nursing station watching television. Mrs. TF helps take care of her husband's things and plays music for all beneficiaries in the dining room lounge. Mrs. MD's husband takes her out to their home, about a mile from Maison Bon Accueil, once in a while.

Mrs. GM comes about every two days to spend some time with her husband. In the summer, she and her husband can often be seen sitting side by side on the front lawn of the home, she on a bench, he in his wheelchair. She does not come every day because she finds it too tiring. She is not young either and has other activities that she participates in (like the Golden Agers). She lives only about a mile from the home but because of the lack of direct bus routes, she has to walk most of the way to the home. She also says that it is not always very interesting to come visit her husband because he is sometimes grumpy, never feels like doing anything and does not talk much. She is generally there for the church service

in the home chapel on Friday afternoon and sits next to her husband. She occasionally gives a hand and does some of the readings for the service. She also occasionally stays to eat with him in the home dining room. Mr. BP drops by almost everyday. He takes the bus from his daughter's house where he lives. He and his wife usually sit in her room when he comes over.

Mr. CS comes see his wife often and takes her out frequently, either to their home or to their children's. Mrs. CS is not very old; she is in her early 60's. She is sometimes confused but not all the time. According to some staff members, she adores her husband and eagerly awaits his daily visits.

On the other hand, some spouses are never seen. It is the case for two residents suffering from Alzheimer's disease. It is rumored that Mrs. TC's husband lives with another woman. Mr. PL's wife never comes to the home. His son comes once in a while, but according to staff, finds it difficult to come see a father who cannot recognize him anymore.

Relationships with children are very important to residents. Those who perform most of the help for their parents are women: bringing clothes and other needed articles, driving their parent to dentists' or doctors' appointments, setting hair.

Mrs. LP is a 79 year old women who is very sick. She is in bed most of the time, but she is able to get up and sit in

her wheelchair by herself even though her left side is paralysed. She has an only daughter who comes visit her almost every day. Her daughter always brings her little things like cut flowers, special foods such as ice cream. She usually decorates her room for special occasions like Halloween. She cleans her mother's drawers and puts things in order on a regular basis. She brings her mother cassettes with new age or classical music since it calms her down when she feels anxious. She goes with her mother for things like dentist appointments. Once, I went to visit Mrs. LP and both her and her daughter were lying down side by side on the bed eating an apple and talking. They had a very close relationship. Mrs. LP died at the end of November and her daughter told me that one of the thing her mother told her shortly before dying is that she was not afraid to die but was worried about leaving her alone.

Mr. LR is in her 80's. She is a widow; her husband died fifteen years ago. She still misses him very much and frequently talks about him. She has two daughters, both in their 40's. They both live rather close to the home and each have a teenage son. They take their mother out regularly.

Mrs. RD moved into the home towards the end of my field work period. She is 98 years old, short and very frail. She needs help to walk (she loses her balance easily) and fell frequently in her first few weeks at the home. Her two middle aged daughters went to the hospital with her for tests after

one such fall. Prior to her admission at Maison Bon Accueil, she had been living with one of her daughters. It is my understanding that she had lived there for a long time. She seemed to resent the move to the home, but it seems to be one of those cases where institutionalization was postponed to the last possible moment. She needs fairly constant supervision due to her frailty and slight confusion.

Mrs. KB was widowed young and lived with one of her daughters for many years. Her daughter visits frequently. She takes her mother to church on Sundays and to the camping where they spend a lot of time in the summer. She says she would come every day if she could, but she unfortunately does not have the time to do that.

One of the staff members told me that one of Mrs. CS's sons once took her out for trip lasting a few days, to go visit out-of-town relatives. He took a stock of her medication and diapers and took care of her during the trip (she needs help to get dressed, to get around, for her bath and so on). Many of the staff members feel she is very lucky to get so much support from her family.

It may be rather difficult for relatives, especially children of the elderly, to see elderly family members deteriorate both physically and mentally. I have mentioned before the case of Mr. PL's son. Another incident which comes to mind is one which occurred in relation to one of the short-term residents at the home. Although this man sleeps in the

short-term bedroom downstairs, he spends most of his day upstairs where he is free to wander around. As I was coming out of Mrs. LP's room to leave, his daughter who was visiting with her children, asked me if I knew where she could find a staff member who could change her father's diaper because he was very smelly. She seemed to be terribly embarrassed by the situation. The fact that she could not find any available orderlies on the floor probably made the incident even more disconcerting to her.

In general, visitors from the outside are relatives. Very few friends come. This may be due to the fact that they are themselves old, sick or even deceased. In general, residents who have few visitors are those who are confused and/or aggressive. Alzheimer's patients have fewer visitors. We have seen above the difference between committed and uncommitted spouses.

We can say that the residents' relationship to the exterior world is mediated through their family. Family members will often take of financial and legal matters, and even act as mediators in situation requiring medical attention.

Conclusion

While life in the nursing home is a matter of routine and is indeed centred around the daily schedule, it is lived in a different way by every person involved. The very sameness

apparent to the outside observer seems to also be perceived at first by the insider, who then proceeds to justify that he or she is really different from the others. All lucid beneficiaries make a point of stating that they are definitely not like the disoriented and confused. Those who ostentatiously receive many visitors make it felt that they are loved and cared for, unlike those whom they perceive as being abandoned by their loved ones. The sameness is therefore not produced by an inherent similarity of behavior, perception, and reaction of the elderly beneficiaries to the institutional environment, but by the superimposed organizational structure of the nursing home as institution.

It must be noted that while the observational data presented in this chapter is presented in a rather compartmentalized fashion, it does not necessarily appear in this way in the setting. The distinction between informal and formal interaction as made here is indeed not very clear in the field. In addition, there is a constant overlap of situations and incidents which makes the setting a very rich environment for data gathering. The investigator must therefore be rather selective in the aspects of daily life reported. The complexity of the actual situation is very difficult to show in writing. All this chapter can hope to do is to present a series of snapshots of nursing home life.

CHAPTER 8

DISCUSSION

The Rochon Commission report makes the point that population aging is neither catastrophic nor exceptional (Gouvernement du Québec, 1988: 14). Since it is also possible to forecast it to some extent, some planning can take place of the kinds and amounts of services that will be required at some future time. Whether this kind of planning is taking place in Québec is questionable.

Among the services offered to the elderly population, many of the changes taking place are ones which consists in curtailing access through more stringent admission criteria or in reducing coverage. For example, the free medication program covers a narrower range of products than it did at the time of widest application in 1977 (Gouvernement du Québec, 1988: 154), and nursing homes now only admit elderly people who require a fair amount of assistance whereas they used to serve a much wider range of population ten years ago.

A number of commentators, along with the Rochon Report, assume that an aging population automatically creates a rise in public expenditures for health care (see Brooks, 1989, for example). However, it is conceivable that this rise in

expenditures is due to the misutilisation of facilities or to the lack of appropriate facilities and services. According to Johnson and Grant (1985), misutilisation occurs when individuals are placed in the wrong level of care. In addition, they state that some elderly are placed in nursing homes not because they are impaired but because they are alone and have nowhere else to go, which constitutes overutilization.

The Nursing Home: A Distinct Level of Care?

The nursing home, as a residential environment which also provides health care, serves two functions. The first, which is also the most costly to the State, is the health care component. This aspect, in itself, does not necessarily require the type of environment offered by the nursing home. As we have seen in Chapter 3, the relative lack of differentiation between long-term care hospitals and nursing homes on the level of physical care provided by both attests to this fact.

The second function, which consists of offering an appropriate residential environment to the frail elderly, is the one under investigation in this project. Given the change in admission criteria favoring more severely limited individuals in the last few years, it is likely that a relatively small number of nursing home residents can actively participate in the home's social life. In fact, at Maison Bon

Accueil, only about a quarter of the residents were lucid and active.

That is not to say that confused and disoriented residents (as well as day centre users) do not benefit from the stimulation provided by these activities. Some obviously do. Mrs. TG sings along with the music at the Friday afternoon "Boîte à chansons", for example. Many residents can feel the "party atmosphere" of some activities, such as the home anniversary, without understanding the purpose of the activity.

On the other hand, some lucid residents complain about the presence of the non-lucid ones, and about the "damping effect" they are perceived to have on some of the activities. The specific needs and desires of confused and disoriented residents often seem to be ignored, or at best their importance discounted, when demands of residents are taken into account. They also interfere with the maintenance of "normal" appearances at the home.

"Normal" Appearances in the Nursing Home

The major part of the organization of everyday life in the nursing home has the purpose of preserving some degree of normality to the life of the very old and sick who live there. Of course, the limitations of the beneficiaries must be taken into consideration. Many of the activities offered at the home are adapted for the elderly or at least to some notion of

what should be appropriate for the elderly¹. The overall structure of nursing home life, as defined by the administration, must reproduce life on the outside: going to mass, going to the hairdresser, eating regular balanced meals, going out, getting treats, going to the store (even though the basement store is mainly used by the staff), participation in enjoyable leisure or occupational activities.

There are also many unofficial rules that are enforced to this effect. People must get dressed in the morning. Only those who do not leave their rooms at all and are bed-ridden are left in night gowns or pyjamas. Others are dressed and take their morning or afternoon naps in their day clothing. Hair is brushed, faces washed. In some cases, jewelry and make-up are worn. Those who still care about such details perceive themselves as having an advantage. They are still able to make the effort to look good. Of course, in keeping with societal trends, looking good is much more important for women than for men. The barber comes once a month; the women's hairdresser, once a week. Volunteers run a manicure

¹These supposedly "normal" activities sometimes take a strange face. Once asked to participate to the sandbag activity, Mr. RM, a day centre beneficiary, replied "Do I really have to do this? I don't want to play? I don't want to do this. I'm no good at this." The implication is that games which are aimed at maintaining coordination also force a certain amount of social display of one's inabilities, which may be humiliating for the beneficiary. In addition, the competitive nature of the game - tallying scores - further enhances perceptions of disability. Thus, what is supposed to be a game becomes a test one might prefer to avoid by withdrawing, physically or mentally, by leaving the room or pretending to be asleep.

clinic. Although most of the customers are women, some men also avail themselves of this service, but are copiously teased about it.

The institution strives to make life normal. This normality, which exists in a very institutional sense, is forced upon the nursing home residents with a regularity and rigidity that "normal" everyday life on the outside does not exhibit. In this radically different environment, individuals are not always able to respond in the ways they are accustomed to, as the ritualized responses they had learned in the past may not be appropriate in the new setting, decreasing their efficiency as interactants (Goffman, 1967).

Of course, this forced normality is superimposed to the hospital-like qualities of the nursing home. It is hospital-like in its design and organization. Medical apparatus can be seen everywhere. Many staff members wear hospital-like uniforms. The head nurse systematically distributes medicine at meal times and the doctor is frequently present.

In addition to the institutional enforcement of normality, beneficiaries try to maintain "normal appearances" in their everyday behavior. This is why many improper forms of behavior are disapproved of. Table manners, dress, personal cleanliness, and signs of incontinence are carefully scrutinized. Those who still have control over their bodily functions and can take care of their personal appearance pity those who cannot, and at the same time seem to dread the day

when they will no longer be able to keep up appearances. This can be considered a form of face-work, along with the examples of attempts to camouflage confusion and forgetfulness given in Chapter 7.

For the most part, routine aspects of everyday life and regular activities were discussed throughout the presentation of the data in Chapter 7. On the other hand, special events and planned disruptions of the daily schedule of the nursing home are generally welcome by residents, even though the daily round of usual, "normal" activities are important. It is, however, preferable to them that the daily rituals of meal times, snacks and the usual times at which they rise or go to bed be left undisrupted. For example, afternoon outings are appreciated, as long as the group is back in time for supper. "Over-disruptions" are too stressful.

One such outing was delayed by a small accident on the highway with the result that the group arrived at the home late for supper. The group had gone for a small cruise on the river. Some people complained of excessive tiredness in the evening, while others were annoyed by the incident. Mrs. KB, who had wanted to go to the bathroom before making the trip back to the home, had been told they would be home in no time, and had decided she could wait until her return. Because of the delay, she could not help but pee in her clothes, which means she had to be rushed to her room, cleaned up and changed before she could eat supper. In addition, even when special

activities take place, people expect that the basic routine and activities will serve as a "normalizing" frame or grid, or as a reference point.

Social occasions and gatherings are frequently occurring in the nursing home. They are also frequently forced upon beneficiaries. So much pressure is put on participation that it may be extremely difficult to refuse to do so. On the other hand, many gatherings occur where beneficiaries are merely "co-present", and where very little actual interaction between them is taking place.

When there is interaction, behavior tends to be formal. For the aged living in institutions, proximity does not breed familiarity. They tend to address each other as little known neighbors. Whereas such an institution as the nursing home may at the limit be considered a community, it is certainly not a "big family" as was claimed by Maison Bon Accueil's social worker.

I am left with the discussion of front and back regions. What is frontal in the nursing home is public space behavior, or what is normally considered by people to be public space behavior. Ceremonials, recreation, occupational activities, or social life in general are front region things. On the other hand, body care, disease, helplessness and other signs of aging are back region things. The peculiarity of the nursing home is the lack of clear demarcation in practice between front and back regions. Some of it has to do with the

design of the facilities. People have to be taken from their bedroom to the whirlpool for a bath through long corridors. Everybody knows it is bath time, whereas for non-institutionalized individuals, such activities are of the realm of private life and are certainly not displayed in public. The shady region between front and back regions widens when it is crossed by an insensitive nursing care staff member who does not take personal sensibilities into account.

The face of normality which is found in the nursing home is therefore quite different from what people may have known at other periods of their life. It is more normality-under-the-circumstances than normality-period. In this sense, it is a deviant form of normality, if one may say so. The deviations are also often excused in those terms by people in the setting. They also frequently create conflict between residents, their relatives, and the home (both administration and staff) because of the differences in outlook created by this shift in the meaning of normality.

Looking Back at the Literature

A peculiar feature of the literature on nursing homes is the predominance of American studies. Relatively few Canadian sources can be found. There are also few studies conducted using participant observation. This leaves us with the difficult task of comparing disparate statements on this topic. Some studies used systematic observation with rigid

recording charts to examine resident or staff behavior; others used structured questionnaires. The only monograph on nursing home life is Gubrium's Living and Dying at Murray Manor. More recent material on nursing homes tends to focus on causal relationships of specific variables, structural modelling, or statements of "educated intuition" on the state of health care for the very old in North America (see for example, Binstock and Post, eds., 1991, for the last point). Still, a look at a range of such statements provides some comparable material that can be discussed in the light of the project I carried out.

Several points can be made. First, what is said in the American literature about the financial situation of the sick elderly who have to rely on care offered by nursing homes (see, for example, Diamond, 1986) does not correspond in any way to the Canadian and Quebec situation. Universality of access to care² and state ownership of health care institution somewhat softens the financial blow. While the elderly must pay for residential services given by the nursing home (the equivalent of rent), they are not paying for health services as such. This gives the impression to some beneficiaries that they are "given" what comes to them.

The second point that can be made is the following: for

²There is universality of access to the extent that one fulfils the requirements for entry, which can be quite restrictive. In addition, the administrative agency which examines application for institutional care also has some discretionary powers (Lavoie, Grandmaison, and Ostoj, 1988).

many aspects of daily life in the nursing home, the predominantly American literature on this topic seems to describe a similar situation to that observed at Maison Bon Accueil. The nursing home is indeed perceived as the elderly person's last home, both by residents and staff. Privacy is an important issue to residents, as is self-determination. However, self-determination in principle and self-determination in practice are two different things. For individuals, self-determination may have something to do with getting up later if they feel like, eating foods they like, or participating in activities when it is convenient to them and not necessarily at regular, pre-determined times. In short, it may mean having some control over normal activities of everyday life. This is what tends to be rigidly scheduled in the nursing home. However, whereas complaints about this are indeed voiced, they are not voiced very strongly. Beneficiaries see many of these things as immutable. "That's the way things are here".

Formal self-determination from an administrative point of view is that there exists a beneficiaries' committee, which will organize some activities for beneficiaries, and will serve as the official channel for complaints. What happens with the committee is that it tends to worry about what concerns lucid residents mostly. Needs of confused and disoriented residents tend to be disregarded. The committee formally involves two representatives for the residents

themselves. Other residents are not touched by the activities of the committee for the most part. In other words, to have a residents' committee does not guarantee participation for the whole of the nursing home population. This issue is discussed by McDermott (1989).

Relationships with families seems to not differ very much when comparing the situation at Maison Bon Accueil with issues discussed in published materials. It is plausible that residents will be visited and helped more frequently if they have a spouse, if they relatives live close by, and if they are lucid. But causal relationships cannot be assessed with the research design of this project.

The situation may differ slightly in the case of relationships with staff. Nursing home staff members in Quebec are unionized. They may be less at the mercy of their employers than in the predominantly privatized American situation, where many nursing aides (or orderlies) are poor and of foreign origin, and have little recourse against their employers. In addition, there is no systematic difference in terms of class, ethnic origin, and other variables describing social background between residents and staff at Maison Bon Accueil. This may facilitate the establishment of relationships between residents and their formal caregivers.

More Comments on Policy

Institutionalization was at some time believed to be a panacea for the problems of the elderly. However, over time, it was realized that it is an extremely expensive remedy and governments do not have unlimited funds. The return to community advocated currently, as described in Chapter 3, relies on a myth of the family as an integrated caring unit. It hardly takes into account that when elderly family members are cared for by family members, the burden frequently falls on mature daughters. They have been called the "sandwich" generation, having to care for both children and parents, in addition to having to continue a career in many cases.

This return to community assumes the existence of alternative, lighter resources to assist in times of need: day centres, home care, group homes, and so on. The network for such services in Quebec is severely underdeveloped.

It also ignores that many elderly are institutionalized as a last resort. All other avenues are explored before considering what is still considered by many as admitting defeat in the face of old age. For many mature children, "putting mom (or dad) in the home" results in feelings of guilt and remorse. But they may have no choice. There are few services available to support family caregivers. As Miller and McFall (1991) point out, public policies should support access to formal services as backup for family caregivers.

In addition, the return to community stance ignores the continuing role of the family in the care of elderly persons living in nursing homes. While nursing homes assume many aspects of the care of the elderly, they do not completely take over the role of the family. Connidis states that "ample evidence that families, especially spouses, children, and, in their absence, siblings, are providing extensive, longterm support to their older members. Therefore, more help from families is not a viable alternative for increasing support to older individuals" (1989b: 94).

The importance of the role of the State in the social construction of caring relationships, emphasized by Walker (1991), which I mentioned earlier, is not to be discounted. What Walker calls "familist" arguments³ assume that care by family is "natural", whereas he considers them as socially constructed. The "familist" arguments have a normative content which encourages women to fulfill nurturing roles vis-à-vis elder family members.

These arguments are also based on very little information of empirical nature. George and Maddox (1989) point out the lack of research done on nursing homes as residential and clinical environments. Gubrium and Sankar (1990) point out that little is known about the home care situation. For policymakers to make decisions favoring one option over the other, without the benefit of possessing enough information on

³Vaillancourt's "communitarist line" (1988: 155).

either, borders on irresponsibility. There is still much to investigate in this area, one aspect of which is the inherent conflictual nature of the nursing home situation.

Conflict in the Nursing Home

I pointed out one area of conflict in the discussion of the search for normality towards the beginning of this chapter. Conflict also exists in the consideration of the role of the nursing home as such. Whereas the Ministry of Health and Social Services considers the nursing home a health care institution, there may be conflicting perception by some elderly themselves, as stated by Roy (1990), in that the latter see the nursing home as a residential milieu where health care also happens to be provided. However, others still see entry into the nursing home as taking their place in the antechamber of death, their last home.

While the obvious clash in perceived purpose may be fully grasp by the lucid elderly and family caregivers and other relatives who turn to institutionalization as the most reasonable option to fulfil the needs faced by elderly individuals with reduced capabilities, it is much less clear what effect it can have on the confused and disoriented individuals who form a large proportion of the nursing home population.

Entry into a nursing home can also cause problems when it is not desired by the elderly person. The transition to the

institutional regime is difficult enough in any case, but it is likely to be much worse for a bewildered and confused elderly person. For example, Mrs. PT keeps asking everybody to take her home. She keeps saying she is not home and that she is not happy. While the sister with whom she used to live may have thought she could not take care of her anymore and that the nursing home was the best solution, Mrs. PT obviously felt otherwise.

We can also wonder about the influence of labor problems the staff are experiencing on the everyday life of the beneficiaries. All staff are unionized. Work problems are dealt with through the rules set by the collective agreement. However, most of the root of conflict between staff rests on a more subtle basis than infringing upon the collective agreement. It has to do with private vision of "good" care for the elderly, and with the difficulty of coping with demanding work schedules and human need at the same time⁴.

A wider view of the nursing home situation also shows disparate positions with respect to the range of services to be provided by such institutions. The majority of beds are reserved for long-term elderly residents. There are several long-term beds for younger adults suffering from incapacitating diseases such as multiple sclerosis. There are also several short-term beds used by chronically ill, handicapped or very old individuals being cared for in the

⁴Diamond (1986) also points this out.

community, usually by close relatives, for short stays which provide relief to their usual caregivers. In addition, there is also the day centre, which provides activities and services throughout the week to community-dwelling elderly. This leads to the question of whether the nursing home is being used as a catch-all solution for a wide range of problems which may be difficult to categorize and deal with. On the one hand, offering such a range of services does maximize the use that can be made of the facilities. This is one face of the administrative rationality of health care and social services in Quebec. On the other hand, one wonders what or who is better served by this organization: the elderly individuals who have to be put on waiting lists before acceding to much needed services or the system itself?

Further Work

Since I have claimed in the introductory chapter that this study was exploratory in nature, it is fitting to comment in the concluding chapter on various aspects of this project which could be extended. Deeper probes into several aspects of everyday life could be conducted. In addition, more work could be done in the area of policy analysis, with a wider angle that has been used in this study.

While in this report, I have concentrated mostly on the confused/non-confused distinction made between nursing home beneficiaries, since it is the major distinction around which

is built the organization of work and the perception of the elderly as individuals needing care, it would also be interesting to extend the examination of the dynamics of relationships between beneficiaries, family members, and staff members by looking at the different subcategories found in the confused and in the non-confused groups. This would entail the development of a typology of behaviors and problems of beneficiaries. It would also entail the development of a typology of behaviors of relatives with respect to the nursing home situation, as well as an examination of the various levels of involvement of family members. We can hypothesize that the behavior of staff members and the way in which beneficiaries are treated depends to some degree on the complex array of factors which also affect the behaviors of beneficiaries and relatives, as well as the behaviors of the latter.

Especially in the case of confused beneficiaries, this situation is similar to that discussed by Sanders (1992) with respect to veterinary practice, where the service to be rendered by the veterinarian is received directly by the pet, but is negotiated through a third party, the pet owner. The service rendered is thus shaped by the veterinarian's perception of the pet, the owner, and the relationship between the two. The same could be said of the services rendered by the staff members in the nursing home situation.

In addition, the life history of the various actors

involved can be taken into account, since the events individuals live through in their life shape their attitudes and expectation. Habits developed throughout a lifetime can also influence the way individuals adapt to the institutional regime of the nursing home.

Whereas the spatial dimensions of social relations in the nursing home are discussed in this report - especially with respect to the question of privacy - the time dimension has been ignored. This is in part a consequence of the short time spent in the field, which did not make possible the observation of change in relationships over time. If I had been able to consider behavioral changes over time, I might have been able to see the combined influence of aging, role change, and change in structure.

To look at change in the nursing home over time might reveal different aspects of everyday life. Mr. DB's complaint that activities are not as interesting as they used to be, other residents' reminiscing about what life in the nursing home used to be like when the population was younger and healthier (the change in population characteristics was mostly due to changes in admitting policies) might point to real change in living conditions and social organization. However, it might only be a sign that long-term memory glosses over details, especially unpleasant ones, so that all that is

remembered is what one would like things to have been.⁵

I have looked, however, at the time dimensions as far as the change in policy orientations are concerned. By not looking at concurrent changes in everyday aspects of nursing home life, we lose the full force of the impact of the changes in policies on people's everyday life in such settings. Therefore, we can only at the cumulative effect the changes have had on expectations of beneficiaries. And, of course, we cannot assume that observable features of interaction in the setting have remained constant over time.

Lastly, we can look at the role of the welfare state in general in the care of the elderly. I did not examine, in this study, the various theories concerning the responsibilities and obligations of the welfare state with respect to its citizens. This could add to the depth of the analysis, especially with respect to the examination of "familist" or "communitarist" arguments.

Conclusion

Many questions are unresolved. I stated before that this project only gave a snapshot of some aspects of what happens in ordinary circumstances in a nursing home. What is discussed in this report are some of the residential characteristics of the home and interaction of people within

⁵This can also be a sign of what one would like things to be in the present.

it. To get the whole picture would require an examination of the medical aspects of the nursing home and of the interaction of those with residential aspects. Only then could the very particular position of actors within the setting (be they beneficiaries or staff members) be understood fully.

The questions this study examined, as stated in the introduction (Chapter 1), were that of the appropriateness of institutionalization as a solution to some of the problems encountered by the elderly, that of the nature of the nursing home as a living environment, that of the role of the family with respect to the institutional situation, and that of the influence of governmental policies at the level of the delivery of institutional services.

The influence of governmental policies can be seen in its involvement in the field of care for the elderly around the Quiet Revolution and the extensive reforms that followed it. The almost complete control that the government has over nursing homes insures a certain degree of universality of access as well as certain standards in terms of quality of care. The major disadvantage is increased bureaucratization and an apparent inflexibility in service provision.

The nature of nursing home life and the role of the family in it have been discussed at length. The major question remaining is that of the appropriateness of institutionalization for the elderly. It is in many ways a moral question, not a technical one. Who should be

responsible for the elderly? Is their well-being an individual or collective responsibility? In the United States, an individualist stance is taken. Quebec has gone the collective route. But whereas, in principle, health care and social services are considered a collective responsibility - a stance which has led to the reforms of the 1970s - the more recent stands taken tend to assign as many responsibilities as possible back to individuals. These have been rationalized in terms of the need to cut expenses in the health and social services. However, considering that the population continues to age, that is, that the proportion of elderly in the population keeps increasing, we can wonder who will be left, as an individual, with the wherewithal to care for the elderly.

APPENDIX A
SUPPORTING DOCUMENTS

This is a model of the letter sent. The original French is presented on this page and the English translation on the following page. This is not the original letter, as some information was omitted in order to preserve confidentiality.

Mai 1991

Directeur/trice
Maison Bon Accueil
Une Ville, PQ

Monsieur, Madame,

Je suis étudiante de maîtrise en sociologie à l'université Concordia et je suis présentement à la recherche d'un endroit où je pourrais effectuer la recherche que j'ai prévu faire afin de compléter mon mémoire de maîtrise. Vous trouverez ci-joint une courte description du projet tel qu'il a été accepté par le comité du programme de maîtrise.

La description du projet comprend une description des méthodes d'observation et d'interview qu'il sera nécessaire d'utiliser au cours du travail de recherche. Du point de vue du centre d'accueil, la plus grande partie de mon travail consisterait à tenir compagnie ou aider des personnes qui en aurait besoin. Je serais heureuse d'en discuter plus amplement avec vous (dates, horaire, etc.).

Vous pouvez me rejoindre au ###-####, ainsi que par courrier à l'adresse indiquée ci-dessous. J'aimerais avoir une réponse le plus tôt possible afin de pouvoir poursuivre mes démarches auprès d'autres établissements si elle s'avérait négative.

Vous pouvez confirmer les informations ci-incluse auprès de mon superviseur, ou du directeur du programme de maîtrise en sociologie.

May 1991

Director General
Maison Bon Accueil
Some Town, PQ

Dear Sir, or Madam,

I am a student, presently pursuing graduate studies in sociology at Concordia University. I am presently looking for a place to carry out the research project I have planned to do for my master's thesis. You will find attached a short description of the project as it was accepted by the program committee.

The description of the project includes a description of observation and interview methods to be used in the course of the field work. From the point of view of the nursing home, the greatest part of my work would consist of keeping company to some beneficiaries. I would be happy to discuss the project with you.

I can be reached at ###-#### as well as at the address indicated below. I would like an answer as soon as possible so that I can have time to approach other institutions if it was not possible to do research at the Maison Bon Accueil.

You can also confirm the above information with my thesis supervisor and the Sociology Graduate Program Director at Concordia.

This is a copy of the note published in Maison Bon Accueil's internal newsletter. Its English translation can be found on the next page.

UNE ETUDIANTE EN SOCIOLOGIE A LA MAISON BON ACCUEIL

J'ai commencé une maîtrise en sociologie depuis un peu moins d'un an. La sociologie étudie en partie le fonctionnement des différents groupes de personnes dans la société. Tout de suite, je me suis intéressée à la vie en centre d'accueil. Les journaux et la télévision les présentent souvent comme des endroits où personne ne voudrait aller vivre. Il existe de nombreux préjugés négatifs sur les centres d'accueil, de même que sur les personnes âgées. C'est pourquoi j'ai décidé de faire un projet de recherche sur la vie de tous les jours en centre d'accueil. On peut supposer qu'avec l'augmentation du nombre de personnes âgées au Québec, il y aura de plus en plus de demandes pour ce genre de service.

Ce projet de recherche est obligatoire pour l'obtention d'une maîtrise. J'ai l'aide de trois professeurs de l'université pour le faire. Ils m'ont d'abord donné des conseils sur sa conception et devront plus tard corriger et approuver la thèse que j'écirai. Une thèse est un rapport de recherche de longueur variable, 100 à 200 pages en général.

Pour me familiariser avec la vie de tous les jours au centre, je travaillerai comme bénévole trois jours par semaine à partir du début de juillet jusqu'au mois de novembre. Je serai là pour donner un coup de main pour des ateliers ainsi que pour tenir compagnie à ceux qui en auront besoin. Ce sera un très grand plaisir d'être parmi vous pour ces quelques mois.

A Sociology Student at Maison Bon Accueil

I started a master's degree in sociology since a bit less than a year. Sociology studies in part the functioning of different groups of people in society. I soon became fascinated with the living situation in nursing homes. The news media often show them as place where surely nobody would want to live. There are many negative pre-conceived ideas on nursing homes, as well as on the elderly themselves. This is the reason why I decided to carry out a researcher project on everyday life in nursing homes. We can suspect that with the increasing number of aged people in Quebec, there will be greater number of requests for such services.

This research project is a compulsory part of the master's degree. I can count on the help of three professors from the university in my work. They first gave me advice on its preparation and will later have to correct and approve the thesis I will write. A thesis is a large research report of variable length, generally 100 to 200 pages.

To become acquainted with daily life in the home, I will do volunteer work three days a week starting at the beginning of July, until November. I will be there to help out for activities as well as to keep company to those who need it. It will be a great pleasure to be among you for these few months.

APPENDIX B
DESCRIPTION OF RESIDENTS

Ground floor residents:

Miss BH	Used to be a nurse. Sometimes responds to what we say. Has a temper. Loves eating. Wheelchair-bound.
Mrs. CA	Has a speech problem. Wheelchair-bound. Stays in her room most of the day, but participates in some activities.
Mr. CD	Has Alzheimer's disease. Loves singing. Adores his grand-children. Used to be a car salesman.
Mrs. CM	Partially paralysed and has heart problems. Loves getting attention. Waves at people who walk by with her good arm. Wheelchair-bound. Prefers to be called by her first name.
Mrs. CR	Screams frequently to attract attention and has a very high-pitched voice. Staff members get very annoyed with her. Also very affectionate. Wheelchair-bound.
Mr. DB	Was a farmer and a mechanic. Loves the outdoors. Wheelchair-bound. His legs are paralysed. Is known to have a bad temper, but can be quite congenial.
Mr. DG	Has pacemaker. does his own thing but participates in a lot of activities. Great sense of humor. Sits on beneficiaries' committee.

Mrs. DJ Very thin and fragile-looking. In bed all day, except for meals, complains all the time but hard to understand. I don't know how much of what we say she can understand.

Mr. DM Cannot communicate. Does not move. Is in that state following an accident he had when he ran away from the home.

Miss DO Walks with a cane. Constantly complains of stomach pains. Does not talk much. Often seen walking around.

Mrs. GB Was very thin and deaf. Died in July.

Mr. GM Paralysed on one side. His wife lives in municipal low-cost housing. Very lucid. Complains all the time. Wheelchair-bound.

Mr. FN In his 40s. Cerebral Palsy. Arrived at the end of the summer. Does not talk and must use a wheelchair. Very sociable.

Mrs. KB Is 92 years old. Wheelchair-bound. Lucid. Loves talking about herself. Stays in her room much of the day. Goes out with her daughter most weekends.

Mr. LB Short, fat man with bad eyesight and hearing. Wheelchair-bound.

Mr. LF Lucid. Stays in his room, and eats there. Could walk when I started fieldwork, but broke one hip later on.

Mrs. LR Born in the U.S. Lived in many places in Canada. Her husband used to be a cook in the army. Wheelchair-bound. Walks with great difficulty.

Mrs. MD	A bit lost but can converse a bit. Her husband takes her out regularly. Wheelchair-bound.
Mrs. MS	Completely confused. Does respond to questions though. In bed most of the day.
Mr. NB	Has Parkinson's disease. Can walk but has a wheelchair. Talks very low. His wife has a heart operation while I was doing field work and he was very worried about her.
Miss NM	Never wants to eat. Doesn't talk. Uses wheelchair but can walk with some assistance.
Mr. PL	Has Alzheimer's disease. In his early 60s. Used to be an engineer. His wife does not come to see him anymore.
Mrs. RP	Confused and disoriented. Does not eat alone, never talks. I could not communicate with her. Wheelchair-bound
Mr. RS	Wheelchair-bound. Arrived at the end of the summer. Partially paralysed. It's his second stay at the home.
Mr. TF	Mid-40s. Has multiple sclerosis. Is lucid but has no short-term memory. Wheelchair-bound.
Mrs. TG	Always sits in dining room lounge. A bit lost, almost blind. Talks a lot. Used to run a restaurant. Likes having company. Only walks with assistance, is very hesitant.
Mr. TQ	I was told he was quite aggressive. Died in July before I had a chance to know him.
Mr. VE	Was early 40s. Had multiple sclerosis. Died in July.

Mr. YP Does not talk much. Never moves. I think he can understand what is said to him well. Wheelchair-bound.

Mrs. VP Is 98 years old. Uses wheelchair but occasionally walks by herself. Often has visitors. Lucid, but always says the same things.

Second floor residents:

Mrs. BA Confused and disoriented. Talks all the time. Has a bad temper but can also be very affectionate and sweet. Often makes noise banging her cup on the table at meal times. Wheelchair-bound.

Mrs. BP Stays in her room most of the time. Her husband comes everyday. Very quiet and hard of hearing. Wheelchair-bound.

Mrs. CB Completely confused and disoriented. Often talks very loudly. Does not like to be touched. Wheelchair-bound.

Mrs. CL Confused and disoriented. Blind. Loves eating. Wears a wig but always pulls on it on one side so that it is always crooked.

Mrs. CS Slightly disoriented. Her husband often comes and she goes out with family members regularly. Can walk but frequently uses a wheelchair.

Mrs. DC Wheelchair-bound. Confused and disoriented, does not respond.

Mrs. DG Mr. DG's wife. Has Alzheimer's disease. Bed-ridden. Does not communicate anymore.

Mrs. DH Is in her late 90s. Relatively autonomous. Can do some shopping by herself in the summer. Bad hearing.

Mrs. DP	Is always in her room.
Mr. HM	Lucid. In his room most of the day except for meals. Wheelchair-bound. Watches TV a lot. His son often goes for short visits, for example, on his way to work in the morning.
Mrs. KR	Is in her 80s. Was a nurse. Prays very loudly and cried when left alone in her room. Very religious. Has a nephew who visits regularly. Has no children. Wheelchair-bound.
Mrs. LD	Always in bed. Does not talk. According to staff, took care of her husband for many years before becoming ill herself.
Mrs. LP	Was 79 years old. Very sick, but lucid. Had a speech problem. Stayed in her room most of the time. Had an only daughter who took very good care of her. Died in November.
Mrs. LG	Confused and disoriented. In bed most of the day. Does not talk much. Seems to understand what we say sometimes.
Mrs. NG	Has Alzheimer's disease. Used to walk around constantly until she fell and broke her arm. Is now very hesitant.
Mr. NM	Has Alzheimer's disease. Does not communicate. His wife is always at the home
Mr. OM	Very old and a bit disoriented. Must be led by the hand to go to the dining room. Always plays with his dentures. Very sociable.
Mrs. PC	Confused and disoriented. Always gathers what she can get of her dress on her lap. Does the same thing to table cloths. Always whimpering.
Mrs. PT	Can walk with some help. Slightly confused but can talk. Moved into

the home during fieldwork. Use to live with her sister.

Miss QC Bed-ridden but eats in downstairs dining room. Does not talk. Must be spoonfed but barely opens her mouth for food.

Miss QP Lucid. Walks with a cane. Helps run the basement store. Used to have her own home for the elderly and mentally handicapped. Sits on beneficiaries' committee.

Mrs. RL Died in July. Was wheelchair-bound.

Mr. RT Used to be a blacksmith. Confused and disoriented. His wife often sits with him. Wheelchair-bound.

Mrs. SG Comes from New Brunswick. Has a very large family and frequent visitors. Went blind a few years ago. Uses a wheelchair but is able to walk when somebody guides her.

Mr. TB Confused and disoriented. Heavy smoker. Sits in his room most of the day, but also sits in TV room a lot.

Mrs. TC Has Alzheimer's disease. Is very roody. Her husband never comes to see her. Hangs around with Mr. OM most of the time.

Mrs. TD Is approximately 84 years old. Is rather confused. Rarely gets visitors. Lost her husband in an accident when the children were quite young. Is very prudish.

Mrs. TP Wheelchair-bound. Does not talk. Never goes downstairs.

Mrs. VB Is of Polish origin. Does not talk much. Confused. Very aggressive. Never misses a chance to slap or scratch.

Mr. VG

Slightly disoriented. Used to be a fireman. Wheelchair-bound. Eats in large quantities.

Mrs. VL

Uses wheelchair, but according to staff, should be able to walk. Lucid. Wears a wig. Participates in many activities.

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