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Title: Hospital experiences/liminal spaces/ambiguous boundaries: A discursive ethnography

Original Abstract:

A cultural ethnographic approach is used to gain insight into the life worlds of nurses and patients, to interpret what they are doing and trying to accomplish, how they talk about, characterize, make meaning of, understand what is going on (Emerson, et al., 2011); problematizing assumptions and notions of what is observed and heard. The intent is to gain deeper understanding of how it is hospitalized older adults often get worse rather than better, a danger that brings huge social and economic costs (Graf, 2006). Ethnographic methods with discourse analytic strategies explicate how societal and organizational constructs, as constituted by discourses of care within the liminal space of hospitalization, can profoundly affect the care of hospitalized older adults.

I used interviews, document reviews, fieldnotes, and observations of nurse/patient interactions on a surgical and acute rehabilitation unit over a period of several months focussing on following seven patients, 75 to 92 years old, from admission to discharge, to see their trajectory of care and healing. Hospital is a liminal space as participants were unexpectedly thrust (unscheduled surgery) into "patient roles", strange experiences full of anxiety, ambiguity, and uncertainty except for one thing, determination to resume independence, to go home. By following the patients the episode is explored from their perspective as they experienced nursing care as chaotic, uncertain, postponed, disrupted, exacerbated by lack of continuity; nurses came and went, covered for one another on breaks, changed workload in relation to changing acuity/intensity of patients, worked casual, off sick, etc. Fractured moments, precious commodities of time for care usually focused on mobilization, a sacred ritual for circumventing functional decline which is thought to be the major problem for these patients. Patients who complied got out faster as the system wants self-motivated patients who are easy to enrol into the idea of "just tell me what to do to get out of here and I'll do it". Others became disadvantaged and problematic as they resisted and/or simply needed more care, longer hospital time which became difficult as the system is predicated on getting people "through" to make way for more surgeries, a throughput model of care.

Examination of contextual factors of workplace environment/culture in relation to how nurses practice revealed influences of imposed boundaries, time constraints beyond nurses' control, societal/organizational expectations, structures, policies, hospital documents (e.g., flow sheets, clinical order sets, electronic records). A newly

imposed care model brought grievous disagreements between staff and administration as RNs were replaced with LPNs replaced with care aides. I explore the impact, how this reflects conditions of neoliberalism (Lemke, 2001), everything viewed via an economic lens, that underpins the reengineering of health care, do more with less (Shannon & French, 2005), and managerialism, governing what nurses do and how to be (Chauviere & Mick, 2011).

Ethnography “rests more on a logic of discovery and happenstance than a logic of verification and plan” (van Maanen, 2010, p.220). For verification I use Foucault’s (1981) genealogical methods to map out how such conditions/events promote production/operation of a biomedical discourse integral to nurses’ care. Critique reveals how literature frames the debates, discussions, and health care issues and how discursive structures of nursing practice are influenced by neoliberalism imbricated with the managerialism of reengineered health care. I show how biomedical discourse pathologizes aging, constituting and marginalizing older adults as diminishing, beholden supplicants of care, their personhood rendered invisible. Further, as a discourse it can marginalize older adults as dependent non-productive members of society, a “grey tsunami” swallowing up health care dollars.

The paper:

This paper draws from a discursive ethnography that uses discourse analytic strategies for comparing reviewed literature with ethnographic findings; a PhD study focused on dynamics and politics of acute hospital care for older adults. The purpose is to gain deeper understanding of how discourses of care do what they do and to what effect on the provision of care in the case of hospitalised older adults. Ethnographic findings are from document reviews, fieldnotes, interviews, and observations of nurse/patient interactions on a surgical and acute rehabilitation unit over several months, following seven patients, who were 75 to 92 years old, from admission to discharge. They were admitted to hospital for surgical repair of a fractured hip due to a fall.

Discursive Ethnography with discourse analytic strategies

Discursive ethnography offered insight into the life worlds of nurses and patients, to interpret what they were doing and trying to accomplish, how they talked about, characterized, made meaning in effort to understand what is going on (Emerson, et al., 2011). Hospital is considered a liminal space as participants were unexpectedly thrust (unscheduled surgery) into “patient roles”, strange experiences full of anxiety, ambiguity, and uncertainty except for one thing, determination to resume independence, to go home.

Findings from such experiences are compared to findings from reviewed literature to gain insight into how contextual, theoretical, practical, and political factors interconnect with, influence, and shape actual hospital experiences and conduct of care. This paper focuses on mapping out dynamics of nurse/patient interactions as liminal experiences in the context of a care modality that is biomedical, a “reductionist approach, privileging physiological and pathological perspectives” (Phelan, 2011, p.896) in an environment of budgetary constraints reflected in neo-liberal discourse, a re-engineering of health care and managerialism. Discourse analytic strategies are used for discerning discourse, what makes it recognisable as it is disseminated in language, in effort to reveal the appearances, characteristics, dynamics and power of discourse.

Comparing theory data with practice data: using critique

Reviewed literature used as data for discursive analysis came from a search using Web of Science (covers the sciences, social sciences, arts, and humanities), CINAHL (*Cumulative Index to Nursing and Allied Health Literature*) and PubMed (biomedical literature from MEDLINE, life science journals, and online books) that focused on the topic gerontology health care using keywords functional decline, hospitalisation and older adults. Further literature findings came from reference lists and bibliographies of relevant print and electronic materials generated by the literature search. Reviewed literature (theory domain) and ethnography (practice arena) data illustrated how such liminal hospital experiences are predominantly constituted by a biomedicalised language of care, more specifically a biomedical discourse of functional decline that represents and positions patients and nurses accordingly. Discourse is identified as both processes and social practices, informed by knowledge and ideologies embedded in language, that constitute the objects of which they speak (Foucault, 1972). As such data analysis engaged discourse analytic strategies wherein research outcomes offered a radical critique of this biomedicalised discursive formation of care for hospitalised older adults. A kind of critique that

is not a matter of saying that things are not right as they are. It is a matter of pointing out on what kinds of assumptions, what kinds of familiar, unchallenged, unconsidered modes of thought the practices that we accept rest... (Foucault, 1988, p. 155).

By comparing reviewed literature (theory) with actual everyday care (practice) using such critique this paper will illustrate how a biomedical discourse of functional decline does what it does. It will reveal the paradox of discourse constituting that of which it speaks (Foucault, 1972) alongside its enunciative fragility, as its emergence and operation is contingent on interrelated multifarious circumstances and conditions from the micro-dynamics of the everyday to spheres of health care systems. Further, such critique seeks to interrogate how social relations within nurse/patient interactions contain differently privileged discourses that can position and represent nurses and patients in particular ways (Foucault, 1972; Phelan, 2010) and paradoxically how participants can as “individuals take up, negotiate or resist discourse, and [illustrate] how resistance is generated and sustained (Lupton, 1995, p. 304). To this end, critique using discourse analytic strategies helps to reveal how a biomedical discourse of functional decline insinuated in written, spoken and performed aspects of care contributes to the constitution of hospitalisation as a biomedicalised and liminal experience. In this study, a co-existing discourse structured within contextual and political constraints of an Activity Based Funding model wherein the hospital observed is influenced and paid by economic policy and funding practices “based on the volume and mix of patients actually treated” (Cohen, et al., 2012, p. 25), hence how a patient is languaged and represented becomes important.

Liminality: a biomedical discursive formation

The term liminal draws from van Gennep’s and Turner’s sense of the liminal as ritualised experiences involving isolation from community-as-known into a transitory ambiguous space of changing status, an initiation into something different from one’s usual life world, and “regarded as profound human milestones” (Bigger, 2009, p. 209). For example, one patient participant exclaimed, “I thought fractured hips were for old people, I guess I am an old person” as she struggled with how she could now regain her mobility and independence, a circumstance reflective of an initiation or rite of passage into the position of elderliness. Another example of hospital experience as liminal are rituals of nursing practice structured by prescribed models of care, clinical pathways, guidelines, standards, and competencies informed and discursively shaped by biomedical discourse; closely followed and shown to create constraints of institutional conformity. What makes this discourse of care biomedical? And what are the contingencies or conditions of hospital care

that make it conducive for such discourse to have the power it does to pervade the language of care?

Functional decline in reviewed literature is framed as a potential inevitability that can result in further functional impairment; “consequences of physiological changes that result in inability to perform activities that ensure a person’s independence” (Graf, 2006, p.60). Further findings indicated that functional decline can result in prolonged hospital stays, poor outcomes at discharge, increased dependence, and mortality (Chong, Savige, & Lim, 2009; Graf, 2006; Hoogerduijn, et al., 2006) and is a profound marker of morbidity and mortality (Thomas, 2002). This discourse of functional decline is biomedical because it “focuses on the molecular, physiological and pathological mechanisms believed to form the basis of biological process” (Eskinazi in Willard, 2005, p.116) as something readily measurable and “generally places an emphasis on interventions that treat biological pathologies” (Willard, 2005, p.116). Rubenstein et al. (1984) provide an excellent example of the power of this biomedicalisation in geriatrics by determining that “assessing functional status is now common geriatric practice...a cornerstone of geriatric assessment (p. 686)”. Commonly these assessments are levelled scales or measures for predicting and/or assessing function, tools that represent older adults in terms of their potential/eventual diminishing bio-capacity with loss of independence measured according to pre-established norms for performing Activities of Daily Living (ADL)¹ (Boltz, et al., 2010; Chong, Savige, & Lim, 2009; Cochran, 2005; Graf, 2006; Hoogerduijn, et al., 2006; King, 2006; Inouye, et al., 1998). It is a powerful discursive objectified structuring of subjectivity through dividing practices, vis-à-vis categorisation and normalisation built on various binaries of a static divisive nature, i.e., functional/dysfunctional, dependent/independent, normal/pathological, objectivising the older adult as a “body” of concern under the control of the medical gaze (Foucault, 1982). And as such biomedical discourse of functional decline represents patients in a language of characteristics hospitals can readily offer to translate and account for according to number and complexities of activities/interventions required in an Activity Based Funding system (Cohen, et al., 2011, p. 25).

¹ Activities of daily living according to Katz, S. et al. (1963) include bathing, dressing, going to toilet, transferring, continence, and feeding.

The power of discourse: analysing the data

This discourse is also powerful and dangerous because in its dominance it elides other discourses of care. This study and others found it dominates in health care, serving to produce objective authoritative knowledge of prediction and assessment, organising tools validated as effective/efficient health care practices, standardized via use of enumerated values that categorise and level patients' functional status accordingly (Hoogerduijn, et al., 2012). Inouye et al. (1993) claimed to provide a risk stratification predictive index via "a systematic, validated method to target elderly patients at high risk for functional decline during hospitalization" (p. 651) using four measurable risk factors. McCusker, et al., (2002) found in their systematic review of predictors for functional decline in hospitalised older adults that "indices...have moderate short-term predictive ability" (p.569). However, in their conclusion they restrict the discussion to alternatives based on biomedical discourse, obscuring other discourses. In this study a similar mode of restriction and constraint also became apparent.

Observations of nurses' work and documentation of care affirmed such pervasive biomedicalised health care practices as they followed prescribed biomedical clinical pathways institutionally organised, requiring bio-measurable tools for determining patient "progress" according to levelled physical capacity for ADLs, e.g., categorizing patients' mobility as a 2-person or 1-person lift or independent. When observing nurses interacting with patients most every encounter focused on tasks such as mobilising the patient, providing items to self-bathe, medication administration, dressings, wound treatments, intravenous care, and so forth; rarely for a purpose outside what would have to be recorded on the patient record. Documentation according to clinical pathways it seems almost exclusively organised and determined care provided. As one charge nurse noted, "we chart by exception still so we chart if [there are] any adverse events. We also chart how they move and how many people it takes to get them up, if there are 2 people or a lift". These kinds of depersonalisations are exacerbated by consistent reference to older adults both in reviewed literature and hospital documents using the 3rd person, objectifying them as bio-physiological objects of study and care respectively; rarely including older adults' personal views about hospitalisation in research studies (IA CIHR, 2007) or in hospital records. These practices constituted objectified subjectivities that privilege perceptions of older adults in

measurable biomedical terms that contributed to their sense of liminality, the ambiguity of who they are, a loss of identity as-they-knew-it; exacerbated by hospital practices of wearing androgynous shapeless gowns, using shared bathrooms, and commonly housed in two or four bed wards alongside strangers. The boundaries between self and others seemed blurred or effaced as their sense of identity shifted ambiguously into unknown spheres of liminal hospital spaces.

Contributing to this sense of liminality were observed rituals of nursing care informed and guided by care documents structured with biomedicalised scales, measures and norms that privileged ascertaining patients' capacity to mobilise over other markers of healing. Quality of care for patients with hip fractures spans "a variety of clinical issues...evaluation of surgical risk and stability, prevention of common complications, pain control, mobilization and physical therapy among them" (Siu, et al., 2006, p. 862) a finding reiterated in Malmgren et al.'s study (2014).

Bio-measurements as objective visuals are ubiquitous on patient charts, e.g., flow sheets comprised of tick boxes to record enumerated levels of performance, numbers of minutes sitting up in a chair, distances walked, percentage of meals taken, cc's of urine output, laboratory values, pain scales 0-10; all scientific, computable, and verifiable. As one nurse explains she does a full assessment wherein you "go by the numbers according to the categories". Overall, there was a ritualised mantra of "mobilise"; a symbol of functional status that was repeated throughout fieldnotes and found pervasive in interview conversations. A patient could not be discharged until achieving a minimum 'level' of mobility, as one nurse says, "back to normal" and a study states "regain optimal mobility" (Malmgren et al., 2014, p.145). A nurse commented "things went well. She mobilised and that was our goal". One explains her "priorities in care are to get them vitally and haemodynamically stable and then mobility because there are so many side effects to not moving when elderly". As one nurse explained with an air of familiarity and assumption, "we have hip care pathways that list what the ideal person looks like, voiding, mobility, those kinds of things, ...if there's one or two person lift" pausing then adding "we try to keep the patient safe, the nurse safe" – this the aim of setting lifts and person requirements to avoid injury.

However, one nurse resisted this biomedical discourse of care in how she talked about her nursing practice saying: “a lot of what nurses do is not documented, not spoken out loud [pause] that is not qualified in any way and I don’t know how you would actually search for it and I don’t know how you would recognise it”. Yet, when asked about her documentation of care she indicated it focused on the value of the clinical pathways despite “they are generic”, providing little re patients’ idiosyncrasies. And as others, said due to time constraints we chart by exception, which was noted when reviewing charts. What seems contradictory is one nurse who likes the tick boxes as they give details, e.g. bathed at bedside or shower and details, did own teeth, et cetera so you know how capable the person is, their unique status if you will. Care plans, she says, are great for passing on patient information but they are not effective as often there is no certainty re currency so can be misleading. She likes “to chart everything for the day... always anticipating discharge, that’s always our goal...I try to legally [chart] in pen but really if something hearsay...it is a challenge until it actually becomes something...it’s very hard to find where to put what on the charts and only as good as person using the chart.” In her practice I observed such charting and her taking time with a 92-year-old patient participant as she worked to engage the woman and her daughter in lively fun but serious conversation with sensitivity indicating how she understood this woman could be stubborn and uncooperative if crossed, but respected that as tenacity and coping mechanisms were located within anxiety of wondering if she [the patient] could ever be ‘the same’ again.

There was not always opportunity to observe whether or not a nurse conducted care congruent with how she said she conducted care, as often they were not reassigned to a patient participant. This situation was not uncommon because despite nurses working several shifts in a row they were not likely to keep the same patients as part of their daily assignment. This circumstance of changing assignments was not only disruptive to continuity in the study but also brought uncertainty to patient care as patients often didn’t know who their nurse was that day or “clear which nurse was their nurse today” and the “white board” at their bedside was inconsistently updated so more confusing than helpful. At the same time, nurses had to scramble to get to know yet again another group of patients.

Political/organisational/contextual constraints of nursing care

Intersecting political, organizational and contextual constraints compounded such uncertainty and disruption for both patients and staff. For example, when nurses had education and work commitments that took them off unit for a period of time due to political/organisational demands to attend staff meetings and education sessions on the new “care delivery model”. This model was brought in around the time the provincial Ministry of Health brought in Activity Based Funding. On such mornings it was observed that patients went with a warm washcloth at the bedside instead of a basin of hot water or taken up to the bathroom to wash-up. Further, this new care model is about having the right type of nurse for the right patient for more efficient/effective care that assumes cost savings along with greater accountability for services provided. This meant that each shift the different levels of nurses would be assigned according to changes or differing levels of patients’ acuity and intensity, constantly changing patient assignments; a possibility likely due to increases in patient acuity/intensity related to the kind of Activity Based Funding model brought in “because hospitals funded under ABF...are paid based on the number and complexity of activities/interventions, there is incentive...to increase volume” (Cohen, et al., 2011, p. 25). What is an unintended consequence is less continuity of care in contrast to a fluidity of nursing presence, as patients commented on not likely knowing who their nurse would be. Other compounding contextual and practical factors are as one nurse noted: “this morning is a gong show, we are short one nurse and the medication carts are being ‘serviced’ and another morning “we are very crazy busy with one physiotherapist off and not replaced”. In any event, such discursive circumstances of uncertainty were contingent on what came up, who was in need of what in the moment whether pain medication, readying for an x-ray/procedure, a person developing delirium and/or falling, all needing ‘extra attention’.

Patients experienced these intersecting constraints with their talk of experiencing nursing care as chaotic, uncertain, postponed, disrupted, exacerbated by lack of continuity as nurses came and went; scenarios usually caused by how nurses are organised to provide care with changes in assignment due to patient acuity, off unit for breaks or education seminars or staff meetings, nurses off sick and not replaced, and so forth. As each patient at

some time or other would comment on nurses not coming back when promised, offering the excuse, the nurse must be really busy or have more important things to attend to.

Nursing care is further complicated by fractured moments/loss of precious commodities of time for care, interruptions/disruptions due to unavailable or broken equipment, no assistance when needed, unexpected emergencies without recourse to 'extra staff', lack of time when assigned heavy patient loads, challenges when chronically short staffed, demands of long term disruptive patients assigned off-load, meaning there was no other place for them, and so forth. As one nurse lamented in regard to time constraints, "I think sometimes we just ask [the patient] what have you had done and do our care accordingly, not by who they are". This illustrates the power of organizational discourse about accomplishing measured tasks according to biomedicalised documents of care such as clinical pathways. It is about performing as many prescribed tasks as possible to meet funding targets, to get the job done of patients progressing on track for expected date of discharge, priorities that leave little to no space for other forms of conversations about care.

Intersections of Activity Based Funding and biomedical discourse of care

Patients who complied with regimes of care and kept on prescribed clinical pathways got out faster as a system such as Activity Based Funding wants self-motivated patients who are easy to enrol into the idea of "just tell me what to do to get out of here and I'll do it". Others became disadvantaged and problematic as they resisted and/or simply needed more care, longer hospital time which became difficult as the system is predicated on getting people "through" to make way for more surgeries. A systems approach often referred to as a throughput model is assumed to work best "on the basis of 'lean thinking' principles derived from commercial industry" (Scott, 2010, p. 319). As one administrator exclaimed "it can be the worst thing in the world if I cancel a surgery...as surgeries are monies to the hospital...if the unit is full and no discharges than surgeries are cancelled". This angst clearly reflects the hospital's Activity Based Funding that is in addition to a base block grant wherein "a portion of hospital funding will flow based on the number of cases, with remuneration adjusted for the mix of patient diagnoses and the services and procedures to those patients (Sutherland, et al., 2011, p. 3)". A kind of funding's success that is "critically linked to the ability to measure 'weighted' hospital output accurately" (p. 3) hence the

administrator's worry with needing to get patients 'out' to keep remuneration flowing and the system on track. It is a through put model involving case mix adjustments that adds to the complexities as each "case" admitted has to be coded as to estimated length of stay. This is a method or system intended to inform how many surgeries may be accommodated on any day based on potential discharges based on knowing the unit's current patients' clinical conditions in relation to surgical interventions made. And a biomedical discourse of measurable capacities for stratifying patients' functional status, levelling their independence in activities of daily living as language on to a clinical pathway, is the perfect match for such a system to offer efficiency in accountability.

As such, however, a patient becomes problematic if not ready for discharge as planned. For example, the participant who at 80 years old considered himself the 1% of hospitalised older people, "more active in lifestyle than 99% of others in hospital and they treat me like the other 99%. I don't like being classified as just another person especially wrongly". Following his surgical repair of hip fracture he actively resisted and refused to follow 'orders', the physiotherapist had said to no longer use the looped leg strap as he needed to use his own muscles but it was observed he continued to use it when she left the room. He did not progress as fast as 'others' but suffered in large part due to what seemed to be pain and anxiety issues. On his 3rd day post operative the nurse related that he may be discharged by day 5. However, the next day a different nurse noted he only walks to the bathroom and not into the hallway as would be expected on the clinical pathway. So his discharge date is delayed by two days. He is observed complaining to the nurses and physiotherapist on several occasions from the first day post operative about his knee pain but it was not until his 4th day post operative that a call is put in for his knee to be assessed by the surgeon. By day 6 the surgeon orders an injection but postpones coming until the next day due to his schedule of surgeries and when arrives on day 7 the nurse cannot find the ordered injection so it is postponed to the following day, as of course she was not the nurse that had put the medication away or had done his care before. In the meantime the nurses are encouraging him to be up as much as possible to regain his strength and as one nurse said "get back up to speed". The patient expressed frustration and exasperation as he was not clear what staff were telling him about what was happening for him over the next days re discharge and the cortisone injection. Further, he wanted to be active and keep

going; yet he says it is so painful. On day 8 he says his knee is feeling better. On day 10 it's a long weekend and an on-call surgeon came to give the cortisone injection but the patient is confused and thinks she is a nurse "I don't know who is who between the doctors and the nurses". The surgeon, according to the nurse, "apparently heard the patient was not sure he was ready or certain he wanted the injection so she left and would come again the next day but only if they called her to say the patient requested the injection". He got the injection day 12 and the next day up walking with his walker with little effort and said his "knee gave little problem". He was hospitalised several days beyond the usual or expected 5 days of a clinical pathway for surgical repair of a fractured hip due to a fall. The nurses were observed to be compassionate and concerned albeit always encouraging him to keep on the clinical pathway saying, "it's because you are nervous you feel like wood, you got to remember to breathe, everyday a little bit and you get some confidence back", "did you hear you are going to the rehab unit, it'll be good for you, to show you are on the mend". There is little explicit talk of functional decline; it is what the nurses choose to focus on, his getting up and getting mobile and what is not talked about; his exasperation, frustration and confusion in wondering what would be happening to him in the next days.

Discursive formation and ordering of functional decline discourse

Reviewed literature revealed how this biomedical discourse of functional decline emerged in health care in the early 1990s contingent on political conditions of the times and persists in structuring hospital documentation as illustrated in this study. It emerged at a time of economic downslides and increasing political talk of health care restraint. A time when neoliberal politics came to significantly affect how health care operates, influenced by a

consistent expansion of the economic form to apply to the social sphere, thus eliding any difference between the economy and the social.... they transpose economic analytical schemata and criteria for economic decision-making onto spheres which are not, or certainly not exclusively, economic areas, or indeed stand out for differing from any economic rationality (Lemke, 2001, p. 197).

Consequently modalities of care came to be based on such neoliberal economics (2001) that underpin the reengineering of health care, that is to do more with less (Shannon & French, 2005), and managerialism, a panoptic mode of closely governing what nurses do

and how to be (Chauviere & Mick, 2011). For example, hospitals became focused on finding researchers who offered more efficient/effective health care to gain cost savings, e.g., re-aggregating patients according to similar resources and skills required for their care (Kimberly & Walston, 1997; Shannon & French, 2005), indexes of independence in activities of daily living and generic severity illness measures to assure adequate care of older adults with minimum economic cost (Kelleher, 1992). Literature shows how the discourse of functional decline underpinned these modalities of care, promising and continuing to promise to be a cost effective way to address the problem of hospitalised older adults getting worse not better (Boltz, et al., 2012). It is a biomedical mode of care that is assumed to be how it needs to be, unchallenged and unquestioned as in the following study on functional decline that claims: “Developing valid measures of quality is important given the increasing focus on measuring and rewarding adherence to quality measures through the increasing use of pay-for-performance and public reporting programs” (Arora, Plein, Chen, et al., 2009, p. 895). As important it has come to be of great benefit for offering measurable progress of patients in an Activity Based Funding (ABF) system that demands accountability of funding discursively provided in strictly measurable terms because “ABF pays hospitals per episode of care for each patient served” (Palmer, et. al., 2013, p. 1). This is a fundamental policy change from what has been prevalent in Canadian hospital funding, i.e., a global budget method, which provided “an annual lump sum transfer to an individual hospital for treatment of its patients based on historical spending” (Sutherland, 2011, p. 3). The intent of this discursive ethnography is to reveal the dynamics of such discursive formations, showing how in their pervasiveness and objectivity they can efface personhood and contribute to older adults’ sense of ambiguity and uncertainty within the liminality of hospitalisation. As important, the aim is to reveal the danger and power of such discourses to elide other discourses of care.

What this study does

This study uses an ethnography that “rests more on a logic of discovery and happenstance than a logic of verification and plan” (van Maanen, 2010, p.220). For verification Foucault’s (1981) genealogical methods were employed to map out how political/social conditions/events promoted emergence, production and operation of functional decline discourse as imbricated in current nurses’ care and insinuated in research

initiatives. A modality structuring care according to numbers, levels, and categories: dividing practices made of such dichotomies as normal/abnormal, functional/dysfunctional. A radical critique reveals how literature frames and renders enduring this biomedical discourse of functional decline that is assumed and taken for granted as efficient and effective with little question to what effect on patients' hospital experiences. What is rarely said is how such discourse can pathologise ageing, constituting and marginalizing older adults as diminishing, beholden supplicants of care, rendering their personhood invisible. As observed in this study, thrusting them into the liminal space of hospitalisation, a place of transition, ambiguity and uncertainty and for many an initiation into elderliness, an experience of decline. Further, as a discourse it can marginalize older adults as dependent non-productive members of society, a "grey tsunami" with the potential to swallow up health care dollars.

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