

Globethics Repository

The logo for Globethics, featuring the word "Globethics" in white, sans-serif font centered within a solid blue rectangular background.

Elders' Impressions of Ethicolegal Issues in Healthcare

This page was generated automatically upon download from the Globethics Repository. More information on Globethics see <https://www.globethics.net>. Data and content policy of Globethics Repository see <https://repository.globethics.net/pages/policy>.

Item Type	Article
Authors	Cooper, Gabriella H;Buckner, Ellen B
Publisher	University of Mississippi Medical Center
Rights	With permission of the license/copyright holder
Download date	2026-04-17 11:52:37
Link to Item	http://hdl.handle.net/20.500.12424/171768

Elders' Impressions of Ethicolegal Issues in Health Care
Gabriella H. Cooper, BSN, RN
Ellen Buckner, DSN, RN

Abstract

Ethicolegal issues are those that involve ethical and legal considerations when one is deciding on a course of action. They include topics in advance directives, basic human needs, general nursing care, and health care decision-making. The purpose of this study was to investigate the perspectives of elders regarding geriatric care. Seniors ages 65 and older were interviewed using the Seniors' Perspectives Regarding Elder Care Issues (SPRECI) questionnaire to obtain qualitative responses. Eight open-ended questions developed by the investigator comprised the SPRECI. The questionnaire was reviewed for content validity by a CNS with cardiovascular and administrative experience, a faculty member with experience in geriatric nursing, a faculty member with experience in ethicolegal issues, and another with experience in research methods. Emergent themes: (a) general nursing care, (b) basic needs, (c) advance directives, (d) decision making, and 5) understanding, intimate that elders commend hospitals for effectively providing for the geriatric patient, yet they identify deficits in trust, communication, and frustration with that care. The implication is that nurses should become more active in eliciting information from elders which accurately document their experiences in health care settings. This information is needed in order to address elders' ethicolegal needs.

Key words: Ethicolegal Issues, Geriatrics, Advance Directives, Imogene King

Elders' Impressions of Ethicolegal Issues in Health Care

Gabriella H. Cooper, BSN, RN

2004 graduate of the Honors in Nursing Program of The University of Alabama School of Nursing, University of Alabama at Birmingham

Ellen Buckner, DSN, RN – Associate Professor

Coordinator of the Honors in Nursing Program at The University of Alabama School of Nursing, University of Alabama at Birmingham

Background

Competent geriatric care is required of U.S. hospitals. As the elderly population burgeons, the care of hospitalized elders should receive increasing consideration in research. By neglecting to maintain and improve upon the high standards of care for senior citizens, we would be ignoring the needs of the elderly, which is quickly becoming the majority of this country's population.

An investigation into elderly patients' opinions regarding geriatric care in general was posited to create a more thorough understanding of the image of the care hospitals provide. These institutions, regardless of the quality of care they currently provide to seniors, were thought to benefit from the views of their patients. While care given may be

of the highest standard, geriatric patients may interpret certain actions or methods of care differently than intended by hospitals' staff. Also, hospital administrators may believe more improvements are necessary in areas that, when viewed by the care recipient, may be perceived as superior.

To provide the subjective viewpoints of geriatric patients in general, care issues involving ethicolegal concepts encountered during hospitalization were studied. These issues pertain to a crucial element of geriatric care: providing ethically and legally acceptable health care to patients. The ethicolegal issues that will be confronted in this study include decision-making, basic needs fulfillment, and advance care planning.

Imogene King's theory of goal attainment relates to the successful management of ethicolegal issues in geriatric care. Essentially, if collaboration and interaction between the patient and health care personnel exist in geriatric ethicolegal issues, transactions are possible. According to King, transactions represent the valuation component of human interactions and involve bargaining, negotiating, and social exchange. When effective transactions occur between nurses and clients, goals are attained. However, deciding patient treatment without patient or caregiver collaboration is antithetical to King's transaction concept and is cited as possibly leading to discontent with care (Frey, Sieloff, & Norris, 2002; George, 1995).

Huckstadt (2002) found that patients generally had more positive than negative perceptions of care during her interviews of eight geriatric adults receiving inpatient care. On the other hand, the majority of care received was described negatively during the interviews conducted by Phillips (1987). Both Phillips' (1987) and Huckstadt's (2002) study participants expressed discomfort in their loss of autonomy while hospitalized. One participant expressed a resounding distaste for hospitalization when he stated, "Everybody loses their independence when they come into the hospital. It's a very demeaning experience to be hospitalized" (p.27).

During an interview with caregivers and elderly patients, Phillips (1987) documented concerns regarding perceptions of ethicolegal issues related to health care. Paternalism - the practice of health care personnel making decisions for a patient without consideration of the patient's wishes - was the primary issue of concern among interviewees. With decreased or nonexistent collaboration regarding care issues, the hospitalized individual may experience less autonomy and more dissatisfaction with care. "Not being believed and not being listened to is so much apart [sic] of the aging condition that elders interviewed indicated that they no longer expected that anyone would listen" (p. 37).

Phillips (1987) relates specifically that paternalism was problematic when elders and caregivers attempted to gather information about their condition or necessary treatment. They reported asking nurses direct questions and these questions being ignored completely. Many of the informants also experienced occasions of "pseudo-sharing" (Phillips, 1987). This included an explanation of treatment that was presented with terminology requiring medical training to understand, thereby leaving the patient with no more knowledge of his condition than when he arrived for the session. Additionally, caregivers described instances in which their questions were addressed while the elder was not acknowledged. In this situation, the caregiver was left "to share his or her limited

understanding with the elderly person after the health care provider had left the room" (Phillips, 1987).

By refusing to interact with the elder and caregiver—a spouse, adult child or sibling—in a way that provides them with complete knowledge of treatment, the nurse excludes them from the decision-making process, thus denying them an ethicolegal right. To resolve this problem, nurses always should provide information the patient requests. If nurses cannot determine the answer to the questions, they should tell the patient that they will secure an answer to his or her question as quickly as possible. By communicating with the patient and caregiver, the nurse positively influences their perception of her intent to help them. This will facilitate further interactions and positively influence future transactions, which will lead to goal attainment.

By collaborating with patients and their caregivers, health care personnel allow patients to become involved in treatment decisions. Although this may mean taking more time to explain details to the patients, this partnership creates a positive response to the chosen course of action because the patients feel that their opinions count and that they have not lost their autonomy. With the perception of a healthy relationship between health care personnel and patients, the established goal becomes attainable, and effective care becomes possible. This chain of events should lead to the patient's satisfaction with the care received and a higher likelihood that the patient will return to a hospital promptly when future care needs arise.

Another common ethicolegal issue in geriatric care is the disregard for basic needs, such as nourishment, pain management, and comfort (Mallory & Hadjustravropoulos, 2004). Many geriatric patients may wait for nurses to offer assistance. This is evident in a remark made by a participant interviewed by Huckstadt (2002): "I'm not used to being helpless and dependent on other people...I'd do anything to avoid asking somebody to do something for me" (p.27). For this reason, when patients receive food, nurses should assess whether they need assistance with eating. If patients are experiencing pain, nurses should strive to assess their needs and provide immediate relief. Soon after realizing that patients have soiled their beds, nurses should change the linens and clean the patients to promote comfort. When nurses fail to perform these tasks promptly, they deny patients their ethicolegal rights related to fulfillment of basic human needs.

The individuals interviewed by Phillips (1987) were white, middle-class, articulate and well-educated elders and caregivers, who had no communication impairments. Regardless of these factors, each person listed multiple occasions of nurses disregarding the elders' basic needs. Because the patients and caregivers in these instances were capable of communication, the nurse-patient transaction could have resulted in patient goal attainment (Frey, Sieloff, & Norris, 2002). It is important to address factors, according to geriatric patients, that may be causing the poor communication and how to change them.

Another ethicolegal issue is advance care planning, or advance directives (ADs). Advance directives include do-not-resuscitate orders, durable power of attorney, and directives to physicians, otherwise known as living wills (O'Keefe, 2001). Because the focus of the interaction between the nurse and patient consists of mutual goal setting and goal attainment, geriatric nurses are ideal persons to address advance care planning.

However, others relate that a lack of knowledge related to advance directives and lack of encouragement from nurses and other health care professionals contribute to the low use of advance directive documents (Inman, 2002).

Health care personnel should counsel patients by providing them with the knowledge and encouragement necessary to ensure that each plans for the time when they may become unable to verbalize whether they would like treatment to continue. By empowering the patient to structure his or her advance directives, the hospital staff improves the ability of patients to participate in their treatment up to the final moments of their lives. In fact, Ali (1995) states that the “most frequent reason cited for not executing ADs was the physician’s failure to discuss the issue.”

Inman’s (2002) study revealed that “the majority (37 percent) chose a doctor, 29 percent had no preference...and 8 percent chose a nurse” when determining from whom they would feel most comfortable learning about advance directives. In the opinion of the researcher, these numbers are low considering ADs pertain to medical care. Health care personnel should have the highest percentages of those polled when asking about advance directives. Could this unusual response indicate that elderly patients do not have confidence in the advice they would be given by health care personnel? Finding out the patient’s preferences for ADs before the patient reaches a state in which he cannot communicate his wishes will save the patient, the family, and everyone else involved the difficulty of trying to guess what that person’s final wishes would have been. This is an important ethicolegal issue to address in this study because knowledge of ADs would provide societal benefits, and knowledge of why patients do not plan for them may help hospital personnel revise their approach, thus leading to better informed and prepared patients.

Huckstadt (2002) explained in her study of hospitalized seniors that despite the fact that for more than 20 years, authors emphasized the need for further study of an elderly individual’s subjective response to hospitalization, to date, relatively few researchers investigate patients’ perspectives. Perceptions of ethicolegal issues in geriatric health care are important to the continuing development of health care provided in hospitals. This is true because the perceptions seniors have regarding the quality of care given to them affects their comfort while hospitalized and the likelihood that they will revisit the hospital when it becomes necessary in the future.

In light of identified ethicolegal issues in care of geriatric patients, it is important to investigate the needs of elders from the perspective of the elders. Therefore, the purpose of this study was to determine the perspectives of geriatric patients regarding ethicolegal issues involved in the care they receive. The perspectives gathered in this study provide health care personnel with insights regarding the image of geriatric care as seen by elders. By accumulating the opinions of patients currently hospitalized, it is hoped that these ethicolegal issues can be addressed for further improvements in the health care programs of hospitals. Additionally, it was hoped that this study would find that the geriatric population has an overall satisfactory view of their hospital experiences and the care they receive.

Methodology

Study participants consisted of a convenience sample of patients that met the inclusion criteria of being hospital inpatients receiving care in a for-profit hospital located in the southeastern United States, English speaking, mentally and physiologically stable, alert, oriented, competent, and willing to discuss the study. The nurse manager on duty determined patients' eligibility based on these criteria. The research was approved by the Institutional Review Board (IRB) of the University of Alabama at Birmingham (UAB) and the private hospital where the study was conducted.

After patients that met the selection criteria were identified, an explanation of the purpose of the study was presented to each. Written, informed consent for participation in the study was obtained from each participant, including permission to audio record each interview. In preparation, 30-45 minutes was allotted to each interview; however, none exceeded 15 minutes.

Interviews were conducted in each participant's hospital room. All interviews were conducted and analyzed by the primary investigator. Participants could have a family member present, if desired, but this occurred in only one interview. Each participant was interviewed on only one occasion and interviews were audio recorded. These recorded interviews are identified by number only, for example, Participant A, Participant B, etc., to protect the confidentiality of the participants. Participation was voluntary and specific assurance given that individual information would not be shared with providers. Participants were allowed to skip any question they did not wish to answer. The interviews were transcribed, and transcribed data was analyzed alongside the recordings to discern audible characteristics of participants' responses that might provide different implications to their answers than those gained by investigating merely the words used.

The investigator-designed tool, Seniors' Perspectives Regarding Elder Care Issues (SPRECI), was used as the basis for each interview. The SPRECI was designed to elicit general perceptions about elder care. This tool was reviewed for content validity by a CNS with cardiovascular and administrative experience, a faculty member with experience in geriatric nursing, and another with experience in research methods. The SPRECI is presented in full in Table 1.

Table 1. Questions in the Senior's Perceptions of Elder Care Issues (SPRECI) interview guide.

<p>Tell me about the general nursing care that seniors receive while in the hospital. What basic needs do seniors require assistance with during hospital stays? Advance directives are choices for care. You make them in case one day you become unable to give informed consent (voluntary agreement) for your care. They include do-not-resuscitate orders, durable power of attorney, and living wills. Are advance directives usually discussed with seniors during hospital visits? Who, in the hospital, talks with seniors about advance directives? While in the hospital, what people are involved in care and treatment decisions for seniors? Who should be involved in these decisions? Do health care personnel tend to understand the needs of seniors? What would you recommend to improve senior care in hospitals?</p>

Nine participants were interviewed. The participants, seven females and two males, were all retired, Caucasian and between the ages of 67 and 95 years. Educational backgrounds varied from the completion of 10th grade to the completion of a four-year college degree. Participants stated that they had between one and 25 family members living in the state currently, with the majority of participants having over 10 relatives in the state.

The theme that was initially visible among all interviews was the method of response. All participants were asked the questions of the SPRECI; however, each participant responded by referencing his or her own personal experience in this particular hospital. Reiteration of the question and specifically asking how other people 65 and older felt about each question did not lead to more information from the participants. For example, when questioning participants regarding the quality of general nursing care received by seniors, seven out of nine denied they had any information from other individuals aged 65 and older.

When answering each question, the participants appeared wary of being critical in their responses. This resulted in a majority of positive answers for each question. For example, when asked about general nursing care provided to seniors, eight participants were complimentary of it. While these responses may have been factual, certain instances of hesitations indicated that they may have been uncomfortable sharing certain incidents because of the setting in which these interviews were conducted. One such occurrence was during Participant E's response to the question about general nursing care that seniors receive. He started to explain about his son's "embarrassing" incident with some doctors and nurses in a southwestern hospital, and he paused a few times before stopping himself, telling me that the health care personnel there were "good and efficient."

General nursing care

Overall, participants were pleased with general nursing care provided to geriatric patients. Their responses varied from "fair" (Participant C) to "wonderful" (Participant H), as they referenced their personal experience with geriatric care. Participant G related an instance of being "ignored all day" a couple of weeks earlier. She attributed this to her advanced age because she recently had read about "them ignoring people that are older."

Basic needs

When asked about what basic needs were required by seniors, the definition of the term "basic needs" was initially unclear to most participants. Once defined, four answered from personal experience and five participants answered generally. None indicated an inadequacy of care in the meeting of such needs.

Advance directives

The majority of participants related their own personal experiences when asked whether advance directives were discussed during hospital visits. Seven specifically responded according to their personal accounts, while the other two simply responded "yes," without indicating personal experience. Four of the nine participants related that advance directives were discussed during their hospital visits. Two participants (Participants C and E) that had been admitted via the emergency room were uncertain about whether advance directives were discussed; however, both participants' children

indicated that they had been discussed during admission. One participant that was unaware of advance directives being discussed during hospital visits said they “probably” were (Participant I).

Participant B related that other than the living will and DNR orders, “I don’t think they delve into that [advance directives] in hospitals, and I don’t think they should.” She felt that other advance directives were the business of the family and their lawyers.

Overall, participants seemed unaware that doctors and nurses are ideal persons with whom to discuss advance directives. When asked who in hospitals discusses advance directives with seniors, five participants indicated that they were discussed upon admission to the hospital, but did not indicate with whom they were discussed. Three participants did not know who was supposed to discuss advance directives in hospitals. One participant said that no one outside of his family had discussed advance directives with him, but after being asked specifically whether the doctors and nurses had discussed them with him, he indicated that they had.

Decision-making

The initial response of five participants was that doctors and nurses are involved in decision-making. Only after prompting did eight of the nine participants indicate that their families and they themselves were involved in decision-making regarding their own care. This relates that geriatric patients do not consider themselves and their families to be the integral part of the decision-making process, and instead, consider the health care professional to be the primary decision-maker in their care.

Participant C did not indicate that doctors, nurses, or any others are involved in care. She directly and angrily responded, “I try to [make those decisions]. They don’t like it, but I try to.” When I inquired as to who didn’t like it, she exclaimed, “The nurses. And I don’t see the doctors, so I don’t know.” I asked if she felt that everyone worked together to make the decisions and she said, “No. The nurses do what the doctors tell them to do. And if I don’t want to do it, I have the right to say I don’t want it.” Her experience shows the necessity of involving patients in care decision and making them feel that they have a right to be a part of those decisions.

A statement by one participant highlights this need for collaboration in health care. “It’s a combined effort of all your facilities that makes a difference” (Participant D). However, even this statement indicates the collaboration of “facilities” instead of all of the individuals involved, indicating that he may not consider himself or his family in this recommendation of collaboration. Undoubtedly, partnership with patients and families is beneficial to the success of a chosen course of action and should be more visible to patients as they receive care. If patients are included in health care decisions, they are more apt to feel that their opinions count. This provides a retained sense of autonomy and more satisfaction with care.

Understanding

Six participants felt that generally health care personnel understand the needs of geriatric patients. None of these participants expanded on their views. Participant A said they probably do not understand but then went on to say that she did not know of geriatrics having any needs different than other patients. Participant C remarked that they do not understand because they are “too busy.” Participant B stated

that not all of them do understand and that nurses tended to understand seniors better than doctors. Specifically, she stated, “I don’t think that the general doctor (she starts to say “cares” & stops herself) *considers* [italics mine] them that much,” in reference to geriatric patients.

Recommendations for care

Overall, patients had few recommendations for improvements in care. Most recommendations centered on the need for additional money and a larger work force in hospitals.

Participant C was most vocal in her concerns. Regarding the limitations of hospital staff she stated, “They have to go by the doctors’ orders, and other than that, they cannot give you any kind of help.” When discussing the lack of money available for hospitals (except what doctors receive), she expressed frustration, stating that “there’s no answer to it [getting the money needed], so you have to stay out of hospitals.” She added that hospitals are “too big,” and related that there was a time in her life when, “you felt you trusted them. You felt like you were getting the right care but not anymore.”

Participant C’s last comments were, “the world’s in a rush.” After a brief pause she continued, “And there are just not enough of them [health care workers].” She paused. “Right now there’s no answer. Maybe you can do research, but I don’t think that’s going to do anything.” She paused once again, “Because you can’t do what’s necessary.” Before I left her room, Participant C added one more bit of knowledge, which relates to the need for holistic patient care: “If you don’t know the overall picture of one person, you can’t help them.”

In all of the topics investigated by the SPRECI, the most important aspect of geriatric care is that it be holistic. Through further research and concentration on bettering the care provided to patients, care can be improved to satisfy even patients such as Participant C.

Discussion

According to King, transactions represent the valuation component of human interactions and involve bargaining, negotiating, and social exchange. When transactions occur between nurses and clients, goals are attained (George, 1995). Health care personnel must aim for comfortable and honest patient interactions. Positive perceptions of interactions aid transactions, thus increasing the opportunity for mutual goal attainment, as defined by King. Goal attainment then will increase patient satisfaction with health care services, in turn, increasing the probability that seniors will seek care as needed. These events coincide to support better health for the elderly.

Collaboration with patients and with their families is essential. Including the patient in care decisions allows patients to retain autonomy at a time when they have forfeited many of their personal routines because they require assistance and care. Without such collaboration, paternalism ensues. Paternalism occurs when decisions are made for someone without their input or consent. This is congruent with findings of

Mallory and Hadjustravropoulos (2004) that consideration for the elder's "personhood" affects adequacy of pain-management.

Participants in this study reported generally satisfactory impressions of hospital care, with respect to basic needs being met. This contrasts the study by Phillips (1987) in which "white, middle-class, articulate and well-educated elders and caregivers," recalled multiple occasions of nurses disregarding basic needs. In the 1987 study, Phillips reported results from "informal interviews" in which elders and caregivers identified numerous examples of care omissions, mainly in hospital settings. The elders interviewed for the current study were still hospitalized, which may have limited their willingness to report omissions. In several responses, participants seemed wary of being critical or actually changed answers in the middle of the sentence. Phillips describes elders' specific fears of retaliation if their comments were shared with providers. This is a significant limitation of the current study but also presents an opportunity to "hear" elders in differing settings. Some of those interviewed still implied or directly spoke of breakdown of trust with providers. If they were able to report those realities, even when still in a care-recipient role, the veracity of the data is even stronger.

Phillips (1987) reveals that paternalism was the issue most frequently mentioned as a concern of elders and their caregivers. As stated above, elders felt "not being believed and not being listened to is so much apart [sic] of the aging condition they indicated that they no longer expected that anyone would listen". In a recently published study of older adults' perspectives of ethical issues, Smith (2005) found similar themes identified including needs for attentiveness, respect and care. These concerns were mirrored in several responses reported here including those who felt profound deficits in trust and caring. It is worthy to note that concerns raised by Phillips (1987) over 15 years ago were still found to be occurring. Participants in this study reported nurses were too busy to do what was needed, were only able to do what the doctor ordered or did not assist elders through sharing of information or assisting with decision-making. These findings are the same as those described by Phillips more than a decade ago.

King theorizes that role expectations and role performance, as perceived by nurse and client, must be congruent for transaction to occur and goals, in this case understanding, to be attained (Frey, Sieloff, & Norris, 2002). Additionally, perceptual accuracy plays a part in goal attainment. Therefore, if a nurse listens to patients intently and with an open mind, the patient is more likely to perceive the nurse as caring and helpful.

Because of the increased need for assistance in patients of the geriatric population, basic needs are a major factor of their care. Continuing to provide basic needs in a timely, caring manner enhances comfort and health of geriatric patients. Health care personnel should reassure all patients that they are available to assist them with these needs. A recent study by Rankin, Butzlaff, Carroll and Reedy (2005) suggests a role for advanced practice nurses, such as clinical nurse specialists in providing this care. Attention to the needs of a multicultural population is needed and listening is repeatedly listed as the primary means of recognizing the dignity of the elders (Jacelon, 2003; Shellman, 2004; Stewart, 2003; Woolhead, Calnan, Dieppe, and Tadd, 2004).

Nursing and other pre-professional education programs could provide leadership in these changes. For students entering professional programs, the role of the patient in

decision-making and care is repeatedly emphasized. Creating the balance between care and communication is needed. Valuing communication with nurses and other health care practitioners and preserving the opportunity for dialog should be a mandate as well. Health care personnel should be knowledgeable about advance directives. Nurses in particular should discuss all forms of advance directives with patients and doctors. Nurses are ideal persons to address advance directives because of the interpersonal relationship with patients. Nurses are focused on mutual goal setting, goal attainment, and support of patient autonomy. The most frequent reason cited for not executing advance directives was the physician's failure to discuss the issue (Ali, 1999). For this reason, Ali suggests that geriatrics nurses counsel older adults and physicians to ensure both are aware of the need for advance directive establishment while the patient is competent.

Implications for nursing practice, especially the everyday practice of nurses who come into contact with elders, are profound. Elders continue to look to nurses for protection and to provide for their basic human needs and rights. There is still a gap in the provision of those supports, however. Nurses can feel confident that if they function as advocates for the elderly that their patients will notice. In a health care setting characterized by fragmentation and loss of autonomy, nurses can be invaluable in restoring humanistic and holistic values, characterized by respect for the person and his or her dignity. Phillips (1987) and the current authors recognize the important responsibility nurses hold in practice with elders.

Limitations of this study include the small number of participants, the setting of the hospital and newly developed SPRECI. Future research is planned to increase participant number through inclusion of community-dwelling elders. Future research intentions include interviewing additional participants in alternate settings outside of the hospital. Interviews conducted in community settings or via telephone while the participants remain in their homes may increase the prevalence of candid responses, thus countering the tendency toward socially acceptable responses. This also may extinguish the participants' very real fears of retaliation by health care personnel who overhear negative remarks.

For future studies, the SPRECI should be clarified using definitions of basic needs and adding items to clarify the roles of differing practitioners. Studies that continue to develop the technique of audio-taping should be developed further to capture the real tendency for elders to convey their real needs and concerns through tone, style of language and words. Audiotapes could also be used as an educational tool to develop novice nurses' abilities to listen to elders; only then will nurses really develop the ability to "hear" them effectively.

Implications for nursing education include developing ways to better teach students how to give essential information to elders and to facilitate transactions that would allow them greater involvement in their own care decisions. Setting mutual goals as described in King's conceptual system for nursing can be an appropriate mechanism for conveying information in a nursing context. Nurses in all educational programs should consistently learn that listening to the patient, checking out possible discrepancies and providing for participation, not isolation, are essential requisites for health care. Implications for the relationship between nursing practice and education are significant. If the values we teach and instill cannot be communicated in the day-to-day settings of

health care then our worth as a profession is compromised. Staff nurses and faculty are called upon to model these values to new nurses. Like the call by Phillips (1987), nurses today must translate their values to the practice setting in ways that make them real for all recipients of care.

Acknowledgements

The authors would like to thank Mary Grace Umlauf, RN, PhD, and Carolyn B. Chalkley, RN, MSN, for their support of the project. The study was supported in part by a grant from the UAB Center for Aging Honors Scholarship program.

References

- Ali, N. S. (1999). Promotion of Advance Care Planning in the Nonhospitalized Elderly. *Geriatric Nursing, 20*, 260-262.
- Frey, M.A., Sieloff, C.L., Norris, D.M. (2002). King's conceptual system and theory of goal attainment: Past, present, and future. *Nursing Science Quarterly, 15*(2), 107-112.
- George, J. B. (1995). Imogene M. King. In J. B. George (Ed.), *Nursing Theories: The Base for Professional Nursing Practice* (4th ed., pp. 209-228). Norwalk, CT: Appleton & Lange.
- Huckstadt, A.A. (2002). The Experience of Hospitalized Elderly Patients. *Journal of Gerontological Nursing, 28*, 24-29.
- Inman, L. (2002). Advance Directives: Why Community-based Older Adults do not Discuss Their Wishes. *Journal of Gerontological Nursing, 28*, 40-46.
- Jacelon, C. S. (2003). The dignity of elders in an acute care hospital. *Qualitative Health Research, 13*(4), 543-56.
- Malloy, D.C., & Hadjustravropoulos, T. (2004). The problem of pain management among persons with dementia, personhood, and the ontology of relationships. *Nursing Philosophy, 5*(2), 147-59.
- O'Keefe, M. E. (2001). *Nursing Practice and The Law: Avoiding Malpractice and Other Legal Risks*. Philadelphia: F.A. Davis Company.
- Phillips, L. R. (1987). Respect Basic Human Rights. *Journal of Gerontological Nursing, 13*, 36-39.
- Rankin, S.H., Butzlaff, A., Carroll, D.L., & Reedy, I. (2005) Famished for support: recovering elders after cardiac events. *Clinical Nurse Specialist, 9*(3), 142-9.
- Shellman, J. (2004). "Nobody ever asked me before": understanding life experiences of African American elders. *Journal of Transcultural Nursing, 15*(4), 308-16.
- Smith, K.V. (2005). Ethical issues related to health care: the older adult's perspective. *Journal of Gerontological Nursing, 31*(2), 32-9.
- Stewart, S. (2003). "A tapestry of voices": using elder focus groups to guide applied research practice. *Journal of Gerontological Social Work, 42*(1), 77-88.

Woolhead, G., Calnan, M., Dieppe, P., & Tadd, W. (2004). Dignity in older age: what do older people in the United Kingdom think? *Age and Ageing*, 33(2), 165-70.