

The partnership metaphor in Quebec health care policy:
The decision-making process with cognitively impaired
elderly clients in home care

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ABSTRACT

This research evaluates Quebec's health care policy by analyzing how the partnership metaphor is implemented in policy and practice. The partnership construction is identified in 4 interpretive communities within long-term community services to the elderly population. This analysis focuses on the placement decision for cognitively impaired clients in home care. Interpretive policy analysis is employed to examine 3 policy documents and 3 client files, while grounded theory serves to analyze 13 semi-structured interviews with 2 administrators and 3 open triads of client, caregiver, and case manager. The findings show partnership to be an egalitarian, collaborative ideal widely adopted but with little consensus on the pertinent objects and actors. Important differences emerge in how partnership is applied to the placement decision, indicating a too flexible application. Specific restrictions are recommended on the application of the partnership metaphor in order to improve community services and organizational structures in health care.

RESUMÉ

Ce projet de recherche évalue l'impact de la politique québécoise de la santé et des services sociaux sous l'angle d'une analyse de la métaphore du partenariat dans les documents officiels et la pratique des gestionnaires de cas en services de première ligne. Le projet dégage une typologie des formes de partenariat dans le secteur des services communautaires publics de soins de longue durée aux personnes âgées en perte d'autonomie. Cette étude s'inscrit dans le contexte particulier de la prise de décision concernant l'admission en centre d'hébergement des personnes âgées atteintes de pertes cognitives qui reçoivent des services de soutien à domicile. Trois documents politiques et trois dossiers clients sont analysés par le biais d'une analyse interprétative et 13 entretiens semi-directifs font l'objet d'une analyse s'appuyant sur la théorie ancrée. Ces derniers ont été réalisés auprès de 2 administrateurs et de 3 triades composées du client, de la personne-soutien et du gestionnaire de cas. Les résultats démontrent que le partenariat est perçu comme un idéal d'égalité et de collaboration endossé par tous bien qu'il y ait peu de consensus autour des acteurs et objets auxquels le partenariat doit s'appliquer. En effet, des différences importantes émergent entre les diverses manières d'appliquer la notion de partenariat à la décision d'hébergement, ce qui indique qu'il est actuellement appliqué avec trop de flexibilité. Cette recherche propose, en dernière analyse, une application plus restrictive du partenariat afin d'optimiser les services aux personnes âgées et d'améliorer la structure de l'organisation des soins de santé et des services sociaux au Québec.

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PREFACE

This research project is associated with a larger research project entitled “La décision du placement des personnes âgées en centre d’hébergement et de soins de longue durée (CHSLD) et la structuration du lien familial” [The decision regarding the placement of elderly people in nursing homes and the structuring of the family bond], which has recently received funding from the Quebec Council of Social Research (CQRS).

This thesis is dedicated to my CLSC colleagues in recognition of their great work in a largely invisible world.

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CHAPTER 1: INTRODUCTION

As Václav Havel remarked, when awarded the Peace Prize of the German Booksellers Association on 15 October 1989, “We have always believed in the power of words to change history, and rightly so ... In the part of the world I inhabit, the word ‘Solidarity’ was capable of shaking an entire power block” (1990: 5). Yet, it always pays to be suspicious of words and to be wary of them, the president of Czechoslovakia continued. “The selfsame word can, at one moment, radiate great hopes, at another, it can emit lethal rays. The selfsame word can be true at one moment and false the next, at one moment illuminating, at another deceptive” (1990: 6). (Boudreau, 1998, p. 497)

Words are powerful and their connotations can change over time. Sometimes a certain word comes to constitute truth to such an extent that questions are no longer asked about the potential difficulties that may inadvertently arise from its use. Partnership constitutes one such word in current policy. This thesis examines how this word is used in Quebec health care policy and how it translates into practice on the front line of health care. The aim is to shed light on how partnership, as a representation of current values, has affected the way the Quebec health care system operates.

Health care policy reflects in many ways the values that are dominant in a society at a given point in time. Prior to manifesting themselves in institutional structures, dominant values often manifest themselves in imaginative words, metaphors, which transfer meaning implicitly from one domain in society to another. In fostering new understandings and expectations, metaphors can impact significantly on the structure and practice of health care. For example, the relational metaphors in health care policy shape the relationship between users and providers. As indicated in Figure 1, the dominant

relational metaphors in health care policy have changed significantly over the past 30 years. In 1971, the relationship between the state and its citizens was cast as a healthy parent-child relationship, while the same relationship was considered pathologically overprotective 15 years later. In 1992, the state was an investor in its social resources, i.e. the population. Currently, the dominant relational metaphor is one of an egalitarian adult-to-adult relationship, that is, a partnership. Policy metaphors impact powerfully on the operation of health care and are therefore worthy of careful attention and analysis.

The partnership metaphor is associated with the world of business and transfers meaning, values and expectations from the business arena into the domain of health care. It carries connotations of equality, collaboration, win-win, and synergy, all of which are positive values. Partnership is a winning word with broad support and appeal. As an abstract concept, partnership is flawless and able to carry multidimensional meaning and inspire wide appeal. However, once applied in practice, partnership gives rise to different interpretations and potential disagreements. Much of the partnership metaphor's popularity derives from its positive connotations and the flexibility with which it can be applied in practice.

Partnership is popular in many sectors of society. Its application in health care policy is particularly interesting because this domain constitutes a primary battleground for ideological conflicts in Canadian and Quebec society. These conflicts, expressed in the debate about public or private financing of health care, carry far beyond the health system as such in that they embed a struggle about the social values that differentiate Canada, and Quebec in particular, from the United States. The popularity of partnership is reflected in the growing use of this term in health care research, policy, and public

1971: Metaphor of a healthy parent-child relationship

The objectives of economic development must be conceived in a perspective of social development, that is, with the preoccupation of giving everyone equal opportunity of access to goods and services. The raison d'être of development is to assure the well being of each citizen in his social milieu. To develop a society thus becomes synonymous with developing man: to develop means to take the means, accomplish the necessary action so that the citizens of a society flower fully. Effectiveness of the action sometimes requires profound transformation of the social system, the political system or the economic system. (Commission of Inquiry on Health and Social Welfare, 1971, p. 217)

1985: Metaphor of an overprotective parent-child relationship

The withdrawal of religious and charitable institutions from the health care system has contributed to giving the impression that only the state could answer to the needs of individuals, families and groups. This has resulted in the development of a dependency on the state, making it difficult to maintain a proper balance among individuals, local resources and the state.

The dependency on the state has extended to its health care personnel in that individuals and groups have been put in a situation of needing "experts" to solve their problems. This situation has had a "pathologizing" effect on the life of the elderly and has translated into a heavy use of health and social services as well as a strong tendency to medicalize needs and problems that are essentially of a psychosocial nature [translated from French]. (Ministry of Social Affairs, 1985, p. 18)

1992: Metaphor of an investor-social resource relationship

For the individual, health and well-being are important for satisfaction and fulfillment in life. For society, healthy citizens are a guarantee of vitality and progress.

The money and energy that society devotes to improving health and well-being must therefore be viewed first as an investment rather than an expense. But like any investment, it should be directed to the most effective solutions. (Ministry of Health and Social Services, 1992, p. 11)

2001: Metaphor of an adult-to-adult relationship, a partnership

To choose a strategy of integrating services is to take a unified perspective on service organization. This perspective relies on the collaboration between health care professionals, managers, elderly people and their family, and it manifests itself concretely in a different way of managing resources and clinical interventions. (Ministry of Health and Social services, 2001, pp. 23)

Figure 1. Relational metaphors in Quebec health care policies (1970-2001).

discourse (Beal, Grawford & O’Flaherty, 1997; Boudreau, 1998; Charles, Whelan & Gafni, 1999). For example, research funding in health care is increasingly dependent on the establishment of partnerships among various federal and provincial institutions. The federal funding agency for health research, *Canadian Institutes of Health Research* (CIHR) encourages partnership in the following words:

We envision partnerships to take on many forms, such as contributing to the identification of research priorities and relevant research questions, and/or contributing financially to a research initiative that may have been identified through the consultation process. Some initiatives will find expression in the form of a «Request for Proposal» which will be of interest to multiple health research stakeholders representing sectors such as federal/provincial/municipal governments, policy makers, voluntary organizations, associations, industry and health researchers. Collectively, as partners on these initiatives, we will invest in excellence and transfer the results of new found knowledge back to the constituencies that each partner serves. (CIHR, April 6, 2001)

This statement indicates that research funding will be tied closely to the development of collaborative partnerships. The Quebec funding agency for health research, *Fond de la recherche en santé du Québec* (FRSQ) follows the lead of CIHR in stating that it is collaborating with research funding agencies that are provincially or federally subsidized in order to develop a strategy for harmonizing and complementing programs and fostering synergy in research planning and promotion (April 6, 2001, p. 50). FRSQ writes: “Partnership that adds value to research merits supportive efforts. However, partnership without added value is a loss of time. For every potential partnership, the stated objective must be profitable for both parties [translated from French]” (p. 50). Hence, both the federal and provincial funding agencies adopt partnership as a general orientation to research.

In line with this orientation, partnership is the object of increasing health care research. This tendency is reflected in the research database *Medline*. A keyword search on *partnership* shows an exponential growth over the past 30 years in the number of health care articles that employ this term. Figure 2 indicates the frequency with which the term partnership has appeared in health care research. According to this graph, partnership started to gain momentum in the 1990s and has grown rapidly throughout the past decade. Although the graph indicates a clear growth, it is pertinent to take into consideration that there has been an overall growth in the total number of articles published in the field of health care over the last 30 years. In an attempt to control for this factor, a similar keyword search was performed on *social responsibility* as a representation of the welfare state discourse that emerged in the 1970s. Figure 3 shows the frequency pertaining to social responsibility for the same time period. According to this graph, the use of the term social responsibility has also increased in the past 30 years. However, the growth pattern is quite different from that of partnership. Of particular interest is the point at which acceleration took place, that is, when the percentage increase from one year to the next was the greatest. Social responsibility accelerated the most from 1976 to 1978, stabilizing at a relatively high level, while partnership was rarely used in the 1970s and 1980s and then took on momentum in the 1990s. The different growth pattern suggests that an increase in the total number of published articles is not the only factor accountable for a striking increase in the use of partnership terminology in health care research. This keyword search confirms that partnership is indeed a currently popular term in the academic field of health care.

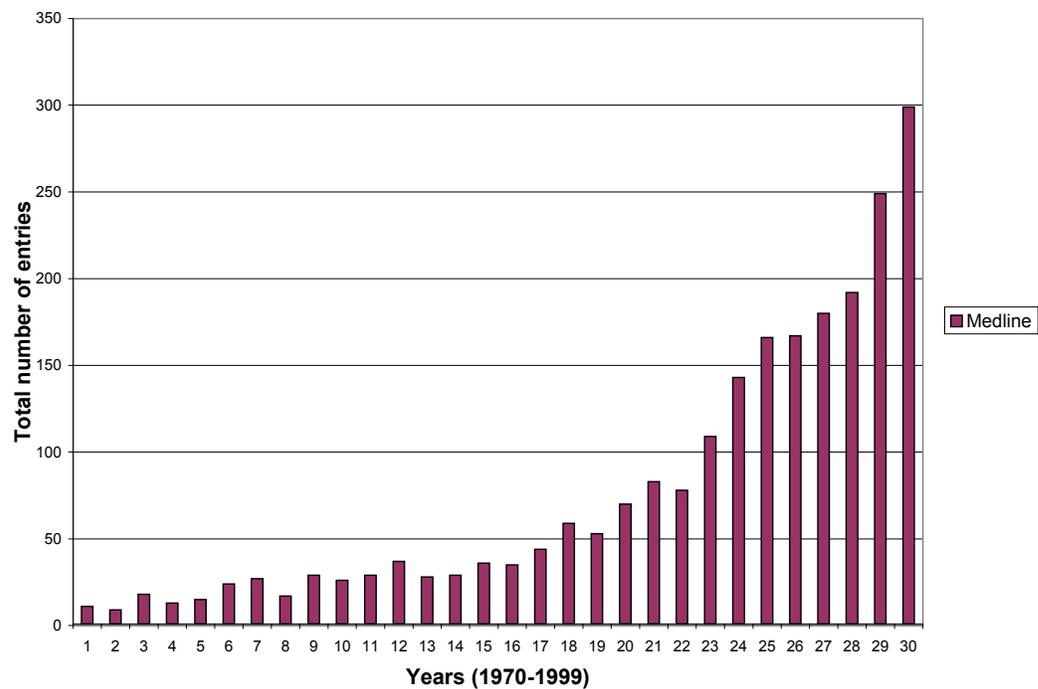


Figure 2. *Medline* entries on partnership (keyword search).

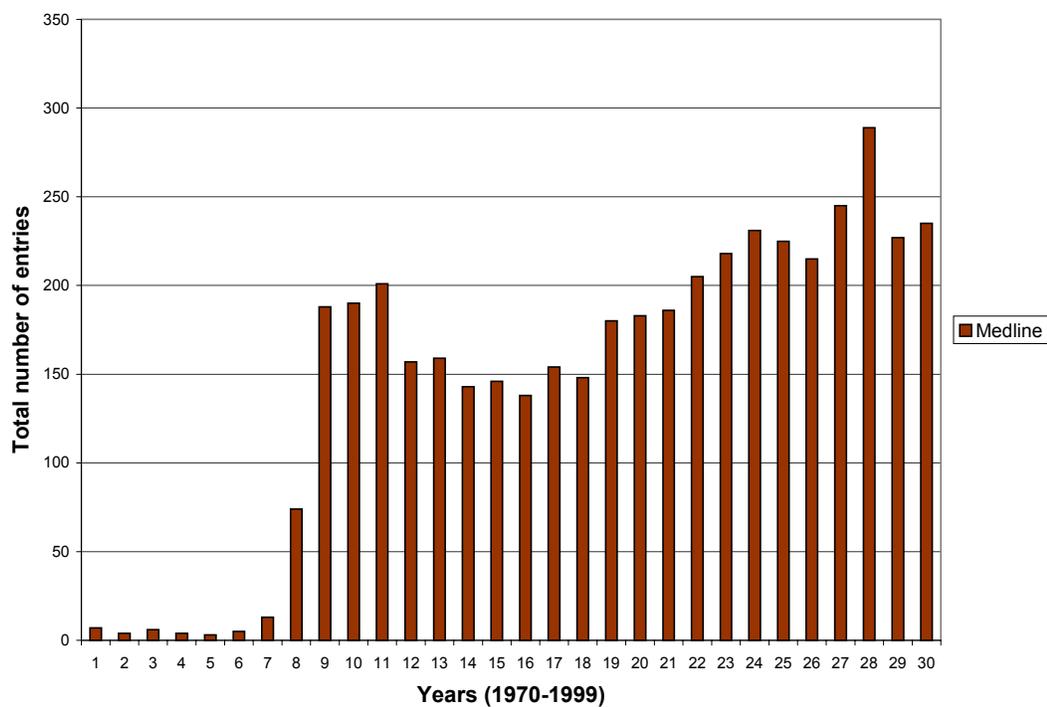


Figure 3. *Medline* entries on social responsibility (keyword search).

The partnership metaphor also manifests itself in health care policy. Policy is first and foremost expressed in formal documents. However, the wording of a policy can often give rise to multiple interpretations. The meaning of policy is often revealed in how it is interpreted and applied in practice. It is the *applied* policy, not the document itself, that is most significant, as explains Dwora Yanow (2000): “What implementors do, rather than what the policy ‘says’ in its explicit language, constitutes the ‘truth’ of policy (and thereby the state’s) intent” (p. 9). Accordingly, policy should be evaluated on how it is interpreted and implemented in practice. Policy evaluation is important because it is only in comprehending the social impact of policy that it becomes possible to reconsider its content and make appropriate, informed changes to it. Moreover, health care actors at all levels are better able to direct their actions appropriately if they are aware of how health care policy impacts on clinical practice.

This thesis examines the implementation of partnership as a policy metaphor in health care. It traces the implementation of partnership from policy to practice, analyzing its application at several institutional levels. These institutional levels are hierarchical in the sense that they receive a mandate from the level above. The institutional levels considered in this research are the Quebec Ministry of Health and Social Services, the Montreal Regional Board, the CLSC (local community service clinic) and finally case managers in home care. At the CLSC level, the analysis is carried out in the context of long-term public community services for the elderly population. This context is pertinent because of the current policy debate surrounding the provision and financing of long-term care for Quebec’s aging population (Comité pour la révision du cadre de référence sur les services à domicile, 2000; Commission d’étude sur les services de santé et les services

sociaux, 2000). Long-term services to the elderly population are offered both in nursing homes and in the community setting. The community setting is particularly pertinent for analysis because it constitutes the object of future policy orientations (Ministry of Health and Social Services, 2001). The public services offered in this setting are provided primarily by community clinics (CLSC), which deliver home care services to the population on its territory in collaboration with community organizations and other public health care institutions. Home care is well suited for an analysis of partnership, given its reliance on extensive collaboration among actors in the public, private and community sectors. Community organizations, although pertinent, are not given much attention in this study because of their extensive, individual autonomy, which makes it less likely that the findings can be applied beyond the specifics of one study.

Decision-making constitutes the specific object of analysis, because it has been highlighted as a particularly sensitive dimension of partnership (Bonney & Metrakos, 1999). One of the most significant clinical decisions made in home care is that of nursing home admission (McAuley & Travis, 1997). This decision is significant both to the clients and informal caregivers, who are personally affected by it, as well as to public administrators who aim for cost-effective management of scarce public resources. The decision regarding nursing home admission is particularly pertinent as an object for partnership when it involves clients who are still legally competent but who have lost some of their mental faculties. An ambiguous cognitive status can compromise the client's ability to make informed decisions. Although much literature has addressed nursing home decision-making, little is known about the application of partnership to this decision, particularly in the home care setting. This research aims to analyze how

partnership relates to decision-making regarding the placement of elderly persons with cognitive impairment.

In tracing the metaphor of partnership from policy to practice, this research project addresses the following questions: How is the policy metaphor of partnership interpreted and implemented at four institutional levels of the Quebec health care system? And how do these institutional levels apply the partnership metaphor to the placement decision for cognitively impaired elderly clients in home care? To answer these questions, the research employs the methodological framework of *interpretive policy analysis* to a textual examination of policies, reference guides and client files. This examination is complemented with a *grounded theory* analysis of the decision-making process in clinical practice. This latter analysis is carried out using triads of client, primary caregiver and case manager in home care. The analysis identifies incongruent and inappropriate applications of the partnership metaphor and discusses the implications for research, policy, and practice. Lastly, suggestions are made for how to prevent a diminution of the partnership metaphor's potential as a positive agent of change.

CHAPTER 2: LITERATURE REVIEW

The literature reviewed for this thesis fall within the domains of social work, gerontology, health care, and public policy. This chapter reviews the literature pertaining to (a) metaphors in policy and health care, (b) partnership in health care and community care, and (c) the decision regarding placement of elderly people. This literature review presents a partial review of the pertinent literature in these domains.

Metaphors in Health Care Policy

Metaphors play an important role in health care. They provide an overarching framework that defines health care and assigns meaning to health care interventions. Metaphors contribute to the social construction of phenomena. As writes George Lakoff and Mark Johnson (1980): “Metaphor is pervasive in everyday life, not just in language but in thought and action. Our ordinary conceptual system, in terms of which we both think and act, is fundamentally metaphorical in nature” (p. 3). Metaphors impose a frame of meaning on a given domain, shaping not only discourse but also action. The impact of metaphors has received attention in many related subfields, including psychotherapy (Lowe, 1990; Whynot, 1994), community development (Yanow, 1993), organizational conflict (Hamburger & Yitzchayak, 1998), everyday language (Lakoff & Johnson, 1980) and persuasion (Ottati & Graesser, 1999). These studies demonstrate how metaphors shape perception and action by transferring meaning from one domain to another. Other studies examine the social construction of specific terms, such as community (Mercier & White,

1995), informal carer (Heaton, 1999), mind and body (Kirmayer, 1988), medically necessary (Caulfield, 1996), and nation, community and all Canadians (Iannantuono & Eyles, 1997). These studies testify to the importance of examining the social construction of popular terms in health care.

The metaphors with most relevance to the domain of health care are the metaphors of war, ecosystem and economic market (Annas, 1995; Beisecker & Beisecker, 1993; Segal, 1997). The war metaphor draws attention to the perception of physicians as *battling aggressive* diseases and enhancing the *defence* mechanisms of the *immune* system. As an alternative framework, the ecosystem metaphor casts health care as a holistic, systemic balance of several dimensions of health and well being, both internally to the body and between the individual and the larger physical and social environment (Annas, 1995). The economic market metaphor, which is most relevant to the current study, cast health care as a business (Annas, 1995; Beisecker & Beisecker, 1993; Segal, 1997). This metaphor makes it pertinent to talk about health care in terms of (cost)-efficiency, profit maximization, consumer rights and satisfaction, ability to pay, entrepreneurship, financial incentives and competition. Applied primarily in the United States, the business metaphor is winning grounds in Canada as well, making it increasingly pertinent to use terms like cost-efficiency, performance indicators and consumers in the field of health care. However, the business metaphor applied to health care is the object of much controversy. Some researchers argue that health care is largely incongruent with the premise of the business metaphor (Annas, 1995; Segal, 1997). Segal argues, for instance, that health care and business are driven by fundamentally different motivational goals. She writes that

the “prime beneficiaries” of human service organizations . . . are those who use its services, whereas the prime beneficiaries of business organizations are understood to be their owners. We seem intuitively to know that health care is not *per se* a business, which is why we are uncomfortable, for example, with the physician who owns a share of the clinic to which he or she sends patients for x-rays; it is why “Root Canals and Retailing” strikes us as an odd title for an article in a professional journal; it is why we feel upset when an infertile woman is redesignated as a market opportunity.” (p. 226)

In this quote, Segal argues that the business metaphor is inappropriate as a framework for health care and suggests that the implicit features of a metaphor be given more attention in terms of its applicability to health care. The literature on metaphors in health care demonstrates that certain metaphors become so integrated in the health care discourse that they acquire a certain truth status. This status allows them to go almost unnoticed, while nevertheless exercising an important influence on health care policy, service organization and clinical practice.

Partnership constitutes a current metaphor that has its roots in the overarching metaphorical framework of the economic market. Boudreau (1998) explains this foundation in an analysis of the partnership concept in the field of mental health:

The language of partnership, as adopted by a growing number of social policy makers, is translated from a neo-corporatist conception of economic management into the world of human service management. Instead of speaking of representatives from capital, labour and government at the negotiating table, the “partners” invited are representatives from the public service network and various levels of community groups, providers, and consumers. (p. 510)

Accordingly, partnership constitutes a metaphorical frame that has been borrowed from business and superimposed on health care. In its application to health care, the partnership metaphor transfers a relational style (of equality) and a common goal (of concerting efforts to reach a shared objective), replacing simply the actors and objects to make it pertinent to health care. The underlying assumption is that partnership can create

synergy in the sense that several actors, working in collaboration, can achieve health care goals more effectively than can single actors (Lasker, Weiss & Miller, 2001). In this sense, partnership is a current health care metaphor.

Partnership in Health Care

The literature on partnership in health care has increased rapidly throughout the 1990s (see Figure 2). This pattern of increase is congruent with research stating that the partnership concept first emerged in Quebec health care policy in the middle or late 1980s (Boudreau, 1998; Vézina & Roy, 1996). These studies suggest that partnership was first applied to the field of community mental health, emerging later in the field of gerontology. The following section presents an overview of the current literature on partnership, subdividing it according to different actor perspectives.

Client Perspectives

A significant part of the literature on partnership in health care targets the relationship between clients and health care professionals. This literature presents partnership as an equitable and respectful way of empowering clients in their interaction with health care professionals (Bonney & Metrakos 1999; Boyce, 1998; Cegala, McClure, Marinelli & Post, 2000; Darling, 2000; Krogh, 1998; Lievrouw, 1994; Lord & Church, 1998; MacGillivray & Nelson, 1998). From this perspective, partnership in its ideal form has as a primary objective to shift the traditional power balance between clients and health care professionals in the direction of putting clients in greater charge of their own lives. Partnership is thus a form of client empowerment that aims to make clients equal partners in

decisions about their own care. Partnership is practiced when health care professionals share power, information and decision making with clients (Cegala et al., 2000; Krogh & La France, 1998; MacGillivray & Nelson, 1998.) The following definition of partnership illustrates the feature of power sharing:

[Partnership ... can be described as] a relationship involving two or more [partners] that have agreed to work cooperatively with the common goal of addressing a human/ community issue or set of issues. A partnership requires the sharing of power, work, support, and information with others. Through mutual agreement and shared values, a partnership confers benefits on each partners as well as the community, while fostering an achievement of ends that are acceptable to all participants. (Krogh & La France, 1998, p. 67)

This definition presents the objects of a partnership to be a shared goal, common values, power, work, support and information. These objects lend themselves well to a partnership between clients and professionals. Although this definition does not specify the partners, it does in no way exclude the client as a partner.

Many researchers within this tradition examine to what extent this notion of partnership, particularly the power-sharing dimension, takes place in clinical practice (Boyce, 1998; Krogh, 1998; Lord & Krogh, 1998; MacGillivray & Nelson, 1998; Opie, 1998). They frequently discover an insufficient level of client empowerment in health care practice. For instance, MacGillivray and Nelson found that

power-sharing emerged strongly as [a] value of partnership. All participants talked about issues related to power and power-sharing. One consumer/ survivor said “a relationship that one has power over the other . . . I wouldn’t even call it a partnership.” Participants advocated for a more balanced sharing of power between consumer/ survivors and professionals, which is consistent with what other consumer/ survivors have been saying for some time. (p. 75)

This quote indicates that partnership requires that attention be devoted to diminish power differentials between partners. Once it is clear that partnership is insufficiently implemented, researchers often turn to identifying the obstacles of fully implementing a partnership. Some of the identified obstacles are that health care professionals are sometimes unwilling to acknowledge the power inequality between themselves and their clients and to share power and decision-making more equitably with their clients (Opie, 1998; Krogh & La France, 1998). Several studies suggest further efforts on the part of health care professionals to establish true partnerships between clients and health care professionals (Darling, 2000; Lord & Church, 1998; MacGillivray & Nelson, 1998).

Family Caregiver Perspectives

A different subsection of the literature on partnership focuses on the role of family caregivers as partners in the health care system (Lavoie et al., 1998; Lesemann & Chaume, 1989; Saint-Charles, 1995; Vézina & Roy, 1996). These studies focus their attention on the nature and consequences of perceiving family caregivers as partners in providing care for the chronically disabled people in the community. As community care is rapidly taking the place of institutional care, much of the responsibilities for daily caregiving are transferred from the institutional setting (the state) to the home or community setting (the family). The concern is that this transfer of responsibilities falls primarily on one female family member, often a daughter or a wife, who ends up providing 70-90 % of the total caregiving work (Guberman, Maheu & Maillé, 1993; Lavoie et al., 1998; Lesemann & Chaume, 1989; Saint-Charles, 1995). These studies provide a critical analysis of this disproportionate division of labour and its larger social consequences and

call for a more balanced division of care-giving tasks between the family and the state. They suggest that there is more than sufficient focus on the “natural” role of informal caregivers in providing daily care for family members and recommend that family caregivers receive more recognition, services, financial compensation and influence in decision-making (Guberman et al., 1993). This literature suggests that family caregivers are possibly not partners in an equitable sense of the term but rather inexpensive resources who absorb public budget cuts at a risk to their own health and well-being and with little financial compensation. In this sense, partnership may serve as a rhetorical vehicle for passing silently over insufficient community services for persons in loss of autonomy and their informal caregivers.

Community Organization Perspectives

Another section of the literature on partnership focuses its attention on the role of community organizations as partners in health care (Austin, 1986; Panet-Raymond & Bourque, 1991; Secrétariat à l’action communautaire autonome du Québec, 2000). Panet-Raymond and Bourque analyze the partnership between community organizations and public health care in Quebec and show community organizations to be less-than-equal partners to the state. They deplore the state of affairs and call for more efforts to establish true partnerships, which they define in the following way:

A true partnership can be defined as an egalitarian and equitable relationship between two parties that differ in nature, mission, activities, resources and mode of operation. In this relationship, the two parties contribute differently, but their contributions are judged to be equally essential. Hence, a true partnership is based on respect and mutual recognition of the contributions and of the parties who engage in an interdependent relationship. The objective of this partnership is to exchange services and/or resources that are different by nature, but whose weight and value are comparable or

recognized as such by the involved parties. The objective of partnership can also be the joint creation of a project or a resource. Lastly, a true partnership makes room for negotiation whereby the parties can define their shared project [translated from French]. (pp. 9-10)

This definition of a partnership emphasizes interdependence between partners who contribute with different but equally valuable resources. Being limited to two actors, this definition makes service delivery and project creation the most obvious objects of a partnership. This definition of partnership is tailored more to the relationship between community organizations and the public sector than to the provider-user relationship because clients do not generally exchange services and resources with the organizations from which they receive help. Hence, from the perspective of community organizations, partnership is primarily construed as an ideal relationship between community organizations and public institutions.

The main conclusions emerging from this research are that the public sector tends to be rather dominating and paternalistic in its partnership with community organizations. Public institutions are perceived as imposing their own agenda and vision on community organizations, thereby overriding and sometimes even undermining the autonomy and organizational culture that constitute the very core of community organizations. To change this situation, Panet-Raymond and Bourque (1991) call for interventions to counter the power imbalance between the public sector and community organizations. They suggest (a) the creation of a more solid network among community organizations in order to increase their relative power in negotiations with the public sector, and (b) a sensitization of public home care workers to the needs and difficulties of community organizations with the aim of modifying paternalistic attitudes and behaviour in the public sector. Recent policy developments endorse this orientation and propose a more

important role for community organizations in the field of long-term community care (S cretariat   l' action communautaire autonome du Qu bec, 2000).

Government Perspectives

A quite different perspective on partnership emerges in the literature from the perspective of government. The focus of government is to manage its financial resources cost-effectively, that is, to use the available resources in a way that optimizes the health of the population (Bergman et al., 1998; Boyer, 1995; McBeth, 2000). Budgetary limitations in the public health care sector are of primary importance from this perspective. Public administrators, faced with the mandate of organizing health care services cost-effectively, have been looking for new ways to provide optimal, public services. Partnership has emerged in this context as a promising way of “doing more with less” (Boyer, 1995; Boyle, Gardner & Callaway, 1998; McBeth, 2000; Schmieg & Climko, 1998).

The *raison d'  tre* of partnership, from the perspective of government, is to work collaboratively with other actors to reach government objectives within a limited budget (Boyer, 1995). Accordingly, the primary objective of a partnership is to share the action and cost associated with meeting stated objectives. It is therefore not surprising that Boyer defines partnership in the following brief manner, using a dictionary entry: “Partnership, a key word in the government policy on mental health, refers to an ‘association of enterprises, of institutions with the aim of acting collectively’ (Le Petit Robert) [translated from French]” (p. 31). In this definition, action is the primary object of a partnership, and the actors are different institutions; clients cannot be included in this definition of partnership. The style of interaction between partners is primarily construed

as a means to an end, not an end in itself. From a government perspective, the main goal of promoting partnerships with other sectors of society is therefore to mobilize actors to share in the responsibility, cost and effort involved in solving a larger social problem, such as the long-term care of people with loss of autonomy. Research from this perspective tends to examine successful, cost-effective partnerships between different social sectors in order to identify successful elements of a partnership (Bergman et al., 1998; Boyle, Gardner & Callaway, 1998; Boyer, 1995; Lesser, 2000). This information helps the government evaluate and adjust its strategies for optimizing the use of limited financial resources.

Integration of Multiple Perspectives on Partnership

As a whole, the literature on partnership indicates that there are clear differences in how the term is defined once it is applied to practice. The definition and meaning fluctuate according to the perspectives and interests of those who employ the term. Although there is general agreement that partnership means equal or equitable sharing, there is little agreement on what partners should share and who should be partners. Health care research, as an entity, does not agree on who qualifies as a partner, nor does it provide any criteria for who can or should become a partner in what and with whom. For example, some research limits partnership to major organizations, while other research includes all involved individuals, including clients. There is also tremendous variation in the shared object of a partnership. For example, the client perspective favours decision-making as the shared object, while the state perspective emphasizes shared responsibility, service delivery and

cost. The examination of the health care literature on partnership suggests very important differences in the objects and actors that characterize a partnership.

The findings suggest that the least powerful partner in a partnership focuses on sharing power and influence, while the more powerful partner, generally the state, puts more emphasis on shared responsibility. It is interesting to note that the partnerships that receive most attention in the literature are those with large power differentials, such as clients or family caregivers in partnership with public actors. Little attention is devoted to partnerships between more equal players, such as between two community organizations or between a client and a family member. This disparate attention is perhaps related to the greater disillusionment and frustration experienced by those who attempt to implement an equitable relationship between partners of unequal power. The literature serves perhaps as an amplifier for voicing dissatisfaction with the current social order and as a way of calling for change. It is plausible that the most unequal situations inspire the most uproar and therefore give rise to more publications.

The literature on partnership in health care may have increased because of increasing uproar with the current state of affairs in health care. However, there is also another possible explanation for the increase of literature on partnership. Boudreau (1998) examines the partnership concept in Quebec mental health policy and proposes a socio-political explanation of its rising popularity. According to her findings, “[Quebec is] the province which has carried its faith in *partenariat* the farthest” (p. 498). She traces the emergence of the partnership concept back to a 1985 Canadian conference on mental health advocacy, *Empowerment through Partnership*, which seems to have inspired many Canadian policy makers. Partnership terminology emerged in various provincial mental health policies

shortly after this conference, suggesting that this conference served as a catalyst for introducing the partnership concept in Canadian health care policy.

Boudreau (1998) draws attention to partnership as a vehicle of social values. She argues that its connotations of fairness, equity, mutual help, respect, harmony, and dialogue have won broad support in Quebec society, hence propelling the term partnership to success. She writes that “while the concept of empowerment has shown itself to be too politically intimidating and remains a quasi exclusive, though influential, feature of grass-root and community support literature, the word *partnership* was destined for a much more glorious career” (p. 498). Boudreau argues that as a carrier of social values, partnership serves as a rhetorical policy tool with high strategic potential. With a sceptical eye to the underlying intentions of policymakers, Boudreau suggests that policymakers adopted partnership rapidly and with such enthusiasm because the government was encountering serious difficulties in dealing with the demands of multiple, opposing stakeholders, who were all striving for more recognition in health care. The introduction of partnership terminology, she argues, served perhaps as a temporary solution, a promise of rescue, for the government:

What is the meaning of [the frequent use of the term partnership]? Is it that our policymakers, in their avid search for paradigmatic consensus and for frictionless solutions, have seized on the notion of partnership because it annihilates, by definition, all adversaries, all contradictions? Is scepticism justified? Or is enthusiasm the more appropriate response? (p. 498)

In this quote, Boudreau raises the question of whether the adoption of the term partnership is a way for the government to avoid positioning itself in the controversy among opposing stakeholders. Through further analysis, she confirms her scepticism and concludes that the state is probably using the language of partnership to deal with the following strategic problems:

1) The exhaustion of resources and allocation of losses; 2) the loss of faith in government and the consequent need to redefine the role of the State; 3) the loss of faith in professional knowledge and the increasingly forceful voice of alternative and “psychiatric survivor” groups; 4) the problem of overload in pluralist and competitive democracy and related to this, the ubiquitous search for consensus and frictionless solution. (p. 503)

Boudreau’s analysis provides a strong and convincing argument for partnership as a strategic vehicle for dealing, or perhaps *not* dealing, with political issues in health care.

Boudreau’s research represents a social constructivist approach to policy analysis. This approach is reflected in her attention to how the meaning of words interacts with the social context in which they are used. Boudreau (1998) explains the social construction of policy metaphors in the following terms:

Policymaking, very crudely defined, is largely a search for politically powerful words, words which in and of themselves stand as “self-evident truths” which electrify, convince, and serve well. It is a search for words which have the power to rescue in times of crisis, which can influence attitudes, change behaviours and redirect action towards new goals, new ideals, and even towards the beginning of a new, “more progressive” era. (p. 497)

Boudreau indicates in this quote that the power of concepts and metaphors results from their status as self-evident truths, as unquestionable values in society at a given point in time. Metaphors are powerful when their connotations reflect social values, thereby allowing them to influence social interaction with an almost invisible hand.

Boudreau study is pertinent to the current research because it provides a social constructivist analysis of partnership as a policy metaphor in health care. Although Boudreau analyzes the context of mental health, Vézina and Roy (1996) demonstrate that the partnership concept is also widely applied in policies on community services to the elderly population. With regards to its emergence in gerontology, they write:

Seeking a partnership to support the frail elderly represents a central position in the Quebec government's discourse, particularly since the mid-1980s. Policy documents from the Ministry of Health and Social Services (MSSS) in 1985, the Rochon Commission's Report (1988), the report *Orientations* by the MSSS (1989), and more recently, reforms proposed by the government of Quebec for health and social services (*Une Réforme Axée sur le Citoyen*, 1990), all go in the same direction. In order to come to terms with the future for the frail elderly, all the people involved and especially the family have been invited *de facto* to form a partnership with the state even though this notion remains embryonic and not very operationally defined. (p. 150)

According to this quote, the partnership metaphor was first applied in Quebec health care policy about 15 years ago as a potential solution to the long-term care of the elderly. They highlight that partnership remained ambiguously defined ten years later. This ambiguity does not seem to have affected the popularity of the partnership metaphor, given its increasing frequency in both policy and research. The research findings of Boudreau (1998) and of Vézina and Roy (1996) testify to the pertinence of further examining the application of the partnership metaphor in community health care in Quebec.

Decision-Making Regarding Nursing Home Admission

Decision-Making Frameworks

Clinical decision-making in health care has received extensive attention in the literature. Two primary decision-making approaches can be identified, namely *evidence-based practice* and *client-centred practice*. Evidence-based practice seeks to provide decision-makers, traditionally physicians, with the tools and information they need to make the most effective treatment decisions for their patients (Jadad, Haynes, Hunt & Browman, 2000; Grol, 2000). In order to exercise rational decision-making, physicians and other health care professionals require data on the comparative effectiveness of

different treatment options, which they obtain from randomized controlled trials (RCT). This tradition seems to be most widely recognized within the field of medicine.

Client-centred practice, on the contrary, seeks to empower clients to make their own decisions (Bensing, 2000; Darling 2000). Health care professionals, physicians included, are cast as service providers who offer services and information to clients. Upon making decisions about which services to accept, clients provide informed consent for the desired interventions. This approach to decision-making is probably expressed the most strongly within health care law (An Act respecting health services and social services, 1999; Haddad & Kapp, 1991), but it is also well grounded in fields such as social work and psychology, which assign great value to client autonomy in decision-making (Healy, 1999; Schneider & Sar, 1998).

These two frameworks for decision-making co-exist in the clinical world, although not necessarily peacefully (Bensing, 2000; Grol, 2000). In fact, elements of both frameworks can be found in the reference guide on the organization of long-term community services for the elderly population with loss of autonomy (Regional Board of Health and Social Services Montreal-Centre, 1996). In this document, client-centred practice seems to be celebrated as the *raison-d'être* of community care in terms of offering clients a better opportunity for self-determination. At the same time, the decision-making authority appears to be assigned to one individual, the case manager, in line with the principles of evidence-based practice. The case manager is mandated to make rational decisions about how long a client can remain in the community and is hence assigned formal authority over decisions about nursing home admission. Although both decision-making frameworks seems to be supported in this reference guide, their

respective place is not integrated within a coherent framework. This incoherence suggests an ambivalent approach to clinical decision-making in service organization.

Decision-Making Processes

The fields of social work and gerontology provide a rich literature on the placement decision with regards to elderly people (Black, Rabins & German, 1999; Colerick & George, 1986; Cox, 1996; McAuley & Travis, 1997; Forbes, Hoffart & Redford, 1997; Minichiello, 1987; Parent, 1999; Schneider & Sar, 1998). These studies indicate that various factors and complex dynamics impact on the process of making this decision. Hence, these studies testify collectively to a complex decision-making process that is neither driven exclusively by client preferences, as suggested by client-centred practice, nor by one rational health care professional in line with evidence-based practice. One section of this literature examines various predictive factors that influence this decision (Black, Rabins & German, 1999; Colerick & George, 1986; Cox, 1996; Forbes, Hoffart & Redford, 1997). Another section examines the flow of events that precede a nursing home admission (Healy, 1999; McAuley & Travis, 1997). McAuley and Travis identify the following typical order of events preceding a nursing home admission:

- (1) Triggering mechanisms, such as a change in health, may be important initiators of the process of locating a nursing home;
- (2) once the triggers occur, the process may proceed quickly;
- (3) the family is likely to be heavily involved in the decision;
- (4) health professionals, especially physicians, may play significant roles under certain circumstances and for certain groups;
- (5) future nursing home residents are not apt to be significant players in the decision - especially if their functioning is diminished;
- and (6) the decision process may be influenced by the competing demands and resources of those responsible. (p. 30)

This framework is general but it serves as a starting point for further exploring the influence of different dynamics that impact on the decision-making process. The particular value of this framework is that it indicates that nursing home admission is not governed by *pull* factors. It suggests that elderly individuals are not attracted *per se* to a nursing home. Schneider and Sar (1998) confirm that the forces at play are primarily *push* factors in explaining that

it is only with great reluctance that an individual gives up voluntarily his or her residence and moves into an institutional setting. At other times, such relocations are involuntary and are the outcome of a crisis or major disruption in one's life such as death of a spouse, inability to care adequately or safely for oneself or financial contingencies. (p. 103)

This quote explains that nursing home admission is not an attractive or desirable option. Minichiello (1987) agree that nursing home admission is used as a last resort, as an action that can no longer be avoided, as a default decision that result from a lack of alternatives. Three important push factors are (a) concerns or events related to client health and safety (Cox, 1996; Forbes et al., 1997; McAuley & Travis, 1997; Schneider & Sar, 1998), (b) cognitive disorder (Black et al., 1999; Cohen et al., 1993; Colerick & George, 1986; Lieberman & Kramer, 1991), and (c) factors related to the caregiver (Colerick & George, 1986; Cox, 1996). These factors combined seem to account for much of the driving force behind nursing home admission.

The literature also suggests that there are *counter forces* that interact with, and constrain, the push factors. An important counter force is the refusal of an elderly individual to be admitted to a nursing home (Minichiello, 1987; Schneider & Sar, 1998). For example, an elderly person may decline nursing home admission, preferring to live in the community with a high risk to his or her health. According to these two studies,

another counter force is the shortage of long-term beds in hospitals and public nursing homes. For instance, a hospital may be pressured to discharge patients rapidly and are therefore more inclined to send the patient home, if at all possible, than to keep the patient in a long-term hospital bed while awaiting a place in a nursing home. The complex interaction of push factors and countering forces add a dynamic dimension to the decision regarding nursing home admission.

Actor Roles in the Decision-Making Process

The literature indicates that the dynamic process of nursing home decision-making involves several actors who may have different interests and concerns (McAuley & Travis, 1997; Minichiello, 1987; Schneider & Sar, 1998). Although the complex decision-making process is particular to each situational context, the literature suggests certain patterns and roles specific to each actor. Hence, a decision-making framework with multiple actors seems most pertinent to the decision regarding nursing home admission. The following section presents a review of the findings pertaining to the respective roles of the elderly person, the primary caregiver, and health care practitioners.

The elderly person.

The elderly person is rarely inclined toward nursing home admission, as discussed above. One reason is that most elderly individuals much prefer to avoid the stress of moving and another that nursing home admission is easily associated with little social value and loss of independence (McAuley & Travis, 1997). Research suggests that the elderly person rarely supports the decision to apply for nursing home admission (Cox,

1996; Minichiello, 1987; MacAuley & Travis, 1997). Rather, the decision tends to be made by others. For instance, Minichiello found in an empirical study that three-quarters of participating elderly persons expressed the sentiment that they had little or no say in the decision to move into a nursing home, sometimes not even being informed of the decision before arrangement. He deplores the minimal influence of the elderly person in making this decision. Cox (1996) agrees and argues that “all but the most severely confused patients have the potential to be involved in the discharge decision” (p. 102). Hence, the elderly person seems to have a marginal say in the placement decision.

There is a possibility, however, that elderly individuals may perceive the same events and dynamics differently than do their primary caregivers. To control for this factor, Minichiello (1987) compared the viewpoint of elderly persons with that of their primary caregivers and found a 92 percent congruency rate between their perceptions. Family members were slightly more likely than clients to perceive health professionals and the health status of the elderly person as important factors (p. 347). With this study as a control, there is some evidence to indicate that the elderly person plays a minor role in making the decision to proceed with a nursing home admission. It is important to take note, however, that these studies do not take into consideration that the elderly person, being likely to resist an admission, may have been influential in *postponing* an admission.

The literature indicates certain variations in the role played by elderly persons. Living arrangement has been identified as an influential factor (Healy, 1999; Minichiello, 1987). Minichiello (1987) found that elderly persons living alone played a more important role in the decision than did those who lived with the family caregiver. He found that “39 percent of those living alone nominated themselves as the person most

involved in the decision, [whereas] only 18 percent of those who lived with others mentioned themselves as the person most responsible for deciding” (p. 353). One reason for this difference may be that elderly people who live alone are more autonomous than those who live with others. Another reason could be that there is more pressure on an elderly person when the signs of danger are visible to others, such as to a live-in caregiver. Minichiello supports the second hypothesis in writing that

aged persons living with others run a higher risk of having a decision made for them by family members or friends. Perhaps this is the cost older people have to pay when they decide to live with their families. In return for sharing their privacy and altering their life styles, family members feel that they have the right to determine the fate of the older person. Under closer scrutiny, the family may find signs of disabilities that require long term care, which could have been kept “backstage” (Goffman 1971) if the aged person was living in a separate household (p. 352).

As indicates this quote, the role of the elderly person in making the decision regarding nursing home admission may be diminished in direct response to an increase in the role of a live-in caregiver.

The primary caregiver.

The literature indicates that the primary caregiver and other family members play an important role, directly or indirectly, in the decision regarding nursing home admission (Colerick & George, 1986; Cox, 1996; McAuley & Travis, 1997; Minichiello, 1987). The literature further indicates that the role of the family is often limited to one family member, often female, who acts as a primary caregiver in the community setting (Guberman et al., 1993; Lavoie et al., 1998; Lesemann & Chaume, 1989). This role gives caregivers an important say in the decision in as much as “social workers must include

informal caregivers in care planning because their labor is typically essential in community settings” (Kapp, 1995, in Healy, 1999, p. 30). Hence, the role of informal caregivers in the decision regarding nursing home admission is likely to increase as the caregiver assumes more responsibility for caregiving. Lesemann and Chaume (1989) confirm this hypothesis in a study on family caregiver perspectives on the placement decision. They found 90-95% of participating primary caregivers to consider it appropriate that they make the decision regarding placement of a family member in grave loss of autonomy. This study suggests that the more dependent an elderly person is on help from a family member, the more influential the family member may become in the decision regarding nursing home admission. Minichiello (1987) confirms this hypothesis in a study conducted in the hospital setting. He found elderly patients to perceive family members to be the most influential actors in the decision in almost half the cases studied. Physicians were perceived as occupying the second place of importance, followed by social workers and then nurses. This finding confirms that primary caregivers may play an important role in the placement decision, particularly so when the primary caregiver provides much of the care.

Colerick and George (1986) suggest that primary caregivers usually want to avoid a placement of the person for whom they care, but that they may face limitations that prevent them from pursuing their role as caregiver. Several factors have been identified as predictors of primary caregivers requesting placement. An important factor is stress, exhaustion or illness (Colerick & George, 1986; Guberman et al., 1993; Lavoie et al., 1998; Schneider & Sar, 1998). Another factor is the attitudes of the caregiver toward nursing homes. McAuley and Travis (1997) write that “caregiver characteristics,

including caregiver stress and attitudes toward institutionalization, are strong predictors of whether a move to a facility occurs” (p. 29). These attitudes may be deeply rooted in sociocultural and family values. Norms and ideals vary with regards to whom should care for the elderly people. Healy (1999) writes that “family members and social workers may have strong feelings and beliefs about the obligations of families to care for elders. In addition, ideas about reciprocity and justice within family systems and within society often arise in relation to decision making about care plans for frail elders” (p. 30). Hence, the caregiver’s attitudes and well being may impact on his or her motivation to request a nursing home admission of a family member with loss of autonomy

Health care professionals.

According to the literature, health care professionals also participate in the decision regarding nursing home admission (Cox, 1996; McAuley & Travis, 1997; Minichiello, 1987). These studies, all conducted in the hospital setting, suggest that physicians are very influential actors in the decision regarding nursing home admission. McAuley and Travis (1997) found social workers to play the second most important role among professionals. The studies suggest that the role of health care professionals is expressed through the advice they give patients and families. Cox (1996) found the strongest predictors of nursing home admission to be patients’ health condition, followed by the advice of physicians and social workers. This finding suggests that health care professionals in hospitals contribute in important ways to the decision regarding nursing home admission. Similar studies do not appear to be available for the community setting. However, two studies suggest that the role of health care professionals may be more

pronounced when nursing home admission follows a hospitalisation than if it occurs directly from the community setting (McAuley & Travis, 1997; Minichiello, 1987).

Several studies suggest that social workers play an active role in the decision regarding nursing home admissions (Cox, 1996; McAuley & Travis, 1997; Minichiello, 1987). Cox explains the role of the hospital social worker in the following words:

Balancing the discharge needs and concerns of elderly patients with those of their families and the hospital is a major challenge to hospital social workers. . . . This task is further complicated when the older patient is cognitively impaired and the primary responsibility for discharge rests with the family (p. 97).

Cox suggests in this quote that the hospital social worker influences decision-making by estimating the right balance between the respective needs and concerns of the elderly person and the family. In supporting this orientation, Minichiello (1987) examines how social workers behave when faced with opposing interests of multiple actors. He finds that health care professionals tend to assign more weight to caregiver stress than to the needs and fears of the elderly individual. This finding suggests that hospital social workers do indeed influence the decision regarding nursing home admission.

Among several factors identified as influencing the hospital social worker are (a) caregiver stress and (b) health and safety concerns for the elderly person (Cox, 1996; Healy, 1999; Minichiello, 1987; Schneider & Sar, 1998). Cox found health condition to be the strongest predictor of nursing home admission in the hospital setting. Safety is a concern not only in the hospital setting but also in the community setting. Healy cites a study showing that “86% of community case managers surveyed noted that safety issues create ethical dilemmas in their practice” (Kane et al., 1993, in Healy, 1999, p. 29). Conflicts between safety concerns and support for client autonomy appear to create

ethical dilemmas for community case managers and social workers. Opie (1998) writes that “working in an empowering way is likely to become the more difficult the more vulnerable or frail the user because professional concerns, such as those about safety, may well conflict with empowering a person to make significant life decisions” (p. 202). This quote suggests that concerns about client safety may conflict with support for client autonomy, and that the former may at times override the latter concern.

Safety concerns appear to take on particular importance when they pertain to cognitively impaired individuals. Cognitive impairment can render individuals unable to understand and recognize signs of danger and respond appropriately to them (Haddad & Kapp, 1991). Diminished cognitive functioning may affect the memory and increase the likelihood that affected individuals forget recent events and respond with disbelief when others raise cause for concern. Consequently, individuals suffering from cognitive impairment may not perceive risks and danger and therefore give rise to worry about their ability to protect their own health and safety. These concerns may interfere with social workers’ support for client self-determination (Healy, 1999). Many social workers aim to empower and support clients to make their own life decisions, even if those decisions seem unwise from the perspective of others. Clients’ ability to make autonomous decisions must generally be seriously compromised for social workers to override client autonomy. However, safety issues may take precedence over the support for autonomy in certain extreme situations (Clemens et al., 1994, in Healy, 1999, p. 29). In those situations, social workers must evaluate whether to support client autonomy or take steps to protect client safety. Healy (1999) suggests that social workers in home health care tend to first evaluate cognitive status and then safety (p. 30). She further suggests that

social workers are more likely to intervene in unsafe situations if the client's cognitive status is compromised. This finding suggests that the evaluation of client competency affects the motivation of social workers to support nursing home admission.

Competency is a medico-legal concept with significant implications for decision-making with cognitively impaired individuals. The following quotation describes the notion of competency and some of the implications of its absence:

Competency requires the ability to think, deliberate, and choose a course of action. It serves as the foundation for self-determining behaviour and informed consent. If a negative judgment is made about the capacity of an older person to decide freely and knowledgeably about his or her own care, basic decisions about the person's life will pass into the hands of another person (Collopy, 1988). When an older, incapacitated person makes harmful choices, there are defensible grounds for intervening in the choice and behavior of the person. Nevertheless, assessing competency is complex because it may be fluctuating, intermittent or of borderline quality (Dubler, 1988). (Schneider & Sar, 1998, p. 107)

This quote suggests that a lack of competency may diminish the client's ability to make the decision regarding nursing home admission and make it more likely that others intervene in this decision. The legal framework for health care services in Quebec makes it clear that users must consent to the care and services they receive (An Act respecting health services and social services, 1999). This document states, for instance, that "no person may be made to undergo care of any nature, whether for examination, specimen taking, treatment or any other intervention, except with his consent" (§9). However, user consent can be overridden if the user's life or bodily integrity is threatened and if the user's competency may be altered (§ 7). Under these circumstances, and if the user or a third party request it, the health care system must intervene (§ 7). Legal measures allow health care institutions to carry out this mandate (An Act respecting health services and social services, 1999; Association des CLSC et des CHSLD du Québec; Haddad & Kapp,

1991; Public Curator Act, 1999). The aim of these measures is to protect the rights and integrity of users who are not in a position to make informed decisions. A third party may replace the user in decision-making but must respect a user's repeated and categorical refusal of certain interventions, such as nursing home admission, unless the situation presents an immediate and serious danger (Public Curator Act, 1999).

The notion of competency provides the underpinnings for how health care professionals evaluate the ability of an elderly person to make an informed decision regarding nursing home admission (Healy, 1999). Healy finds that safety, caregiver burden, and diagnostic labels impact significantly on social workers' support for autonomy of elderly people with cognitive impairment. She finds, for instance, that a diagnosis of Alzheimer's disease tends to lead to less support for autonomy than does a diagnosis of stroke. This notion of support for autonomy becomes particularly pertinent, she argues, when the elderly person has mild to moderate cognitive impairment:

Future research is needed to address the manner in which social workers in home health care evaluate the decisional capacity of those who are experiencing mild to moderate cognitive impairment. It is these situations in which the degree of cognitive impairment is most ambiguous that social workers may find evaluation of decisional capacity particularly difficult and may be vulnerable to making decisions based on bias. (p. 43).

Besides recommending further research in this area, Healy suggests in this quote that social workers in home care may exercise an influence on decision-making in terms of their evaluation of client competency. This evaluation may affect the relational dynamics involved in the decision-making process regarding nursing home admission.

Integration of actor roles in nursing home decision-making.

The literature on the roles of different actors in the decision-making process suggests that the decision regarding nursing home admission is embedded in a complex network of relational interactions. Various factors impact on this interaction. The interaction appears to be particularly complex when the elderly person in loss of autonomy presents with light to moderate cognitive problems. Certain patterns emerge in terms of the respective roles of different actors in the decision regarding nursing home admission. Firstly, the role of the elderly individual seems to be marginal, particularly if admission takes place from hospital or if the elderly person lives with a family member. The influence that the elderly person exercises seems to consist primarily in a potential to resist an undesirable nursing home admission. Secondly, the role of the primary caregiver seems to increase in proportion to the level of responsibility for care-giving. The caregiver also appears to have more say if he or she lives with the elderly person or experiences much stress or illness in the role as caregiver. Thirdly, health care professionals, primarily physicians and social workers, exercise an important role in the decision, at least if nursing home admission takes place directly from the hospital setting. Little is known about the specific role of health care professionals in the home care setting, but the literature suggests that social workers in the community setting may be as preoccupied with client health and safety and with caregiver stress as are hospital social workers. Professionals appear to exercise an influence on decision-making through their evaluation of client and caregiver needs, safety concerns, and the client's ability to make autonomous decisions.

Identification of Current Gaps in Research

This literature review suggests that more social constructivist research is needed on the concept of partnership in health care (Boudreau, 1998). The use of partnership is growing (see Figure 2), yet its application in community gerontology remains rather vague (Vézina & Roy, 1996). The relatively few sources available on this topic indicate a gap in research. Although health care metaphors have received attention in the literature (Annas, 1995; Beisecker & Beisecker, 1993; Segal, 1997), little attention has as yet been devoted to studying the specific metaphor of partnership. Partnership is considered to be a fundamental pillar of current health care policy (Commission d'étude sur les services de santé et les services sociaux, 2000; Ministry of Health and Social Services, 2001; Secrétariat à l'action communautaire autonome du Québec, 2000). For this reason, it is important to carry out further research on partnership, not only on successes and failures but also on limits to its applicability in health care.

Decision-making has been identified as a dimension of partnership that is particularly sensitive (Bonney & Metrakos, 1999). The placement decision has received much attention in research. However, there is insufficient knowledge on the relational dynamics of placement decision-making (a) in the home care setting, (b) in case an elderly individual presents with mild to moderate cognitive impairment (Healy, 1999) and (c) in case a decision is made not to admit (McAuley & Travis, 1997). The present study aims to contribute to filling these gaps in the literature.

CHAPTER 3: METHOD

Theoretical Underpinnings: Social Constructivism

Social constructivism is a theoretical perspective that view phenomena as shaped, partly or fully, by social factors. The field of social constructivism is broad, incorporating theorists with various orientations to this general premise. Common to social constructivism is a broad commitment to *reality* and *truth* as at least partial social constructions, hence potentially variable from one social context to another. Michel Foucault, one of the fathers of constructivism, argues that “‘Truth’ is linked in a circular relation with systems of power which produce and sustain it” (Fairclough, 1992, p. 49). He claims that truth refers to the social lens through which reality is perceived, not to the objective notion of truth that characterizes the natural sciences. Social constructivists draw attention to the role of social relations in constructing truth and examine practices and social webs of meaning that underpin these constructions.

Social constructivism proposes a different dynamic to truth than that assumed in the natural sciences. Foucault argues that the construction of truth may change suddenly and asks, “how is it that at certain moments and in certain orders of knowledge, there are these sudden take-offs, these hastenings of evolution, these transformations which fail to correspond to the calm, continuist image that is normally accredited?” (Gordon, 1980, p. 112). Truth follows a historical path, he claims, which is characterized by relatively sudden and rapid shifts in webs of meaning. Power is an important dimension of truth. Foucault argues that individuals and groups do not actively control truth, nor do they directly create sudden shifts in meaning. However, they may use the power inherent to

truth for their own ends (Fairclough, 1992; Gordon, 1980). This notion of power is one of discursive strategy rather than domination. Foucault explains:

One should not assume a massive and primal condition of domination, a binary structure with “dominators” on one side and “dominated” on the other, but rather a multiform production of relations of domination which are partially susceptible of integration into overall strategies. (in Gordon, 1992, p. 142)

This quote suggests that power is located in discursive and relational strategy rather than in economic control. According to Foucault, power is fluid and circular, operating simultaneously at multiple levels of society in the form of discourse. This notion of power contrasts with traditional notions of power in as much as it is a positive, not a negative, force. Foucault explains this positive dimension in stating that,

What makes [power] accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression. (in Gordon, 1980, p. 119)

According to this quote, the positive dimension of power emerges in discourse. Power struggles are in a sense located in a strategic game over the use of positive forces in society. This perception of discourse and power is supported by multiple findings to the effect that social change corresponds to significant shifts in discourse (Gordon, 1980).

Discursive shifts can be identified through discourse analysis. Discourse analysis is a method often employed in social constructivist research. It is used to examine the language and images that serve as building blocks for the construction of social meaning. Norman Fairclough (1992) explains discourse analysis in the following words:

Discourses . . . are manifested in particular ways of using language and other symbolic forms such as visual images. . . . Discourses do not just reflect or represent social entities and relations, they construct or

“constitute” them; different discourses constitute key entities (be they “mental illness”, “citizenship” or “literacy”) in different ways, and position people in different ways as social subjects (e.g. as doctors or patients), and it is these social effects of discourse that are focused upon in discourse analysis. (Fairclough, 1992, pp.3-4)

According to this quote, meaning is created through the use of language and visual images.

Language and images serve to construct entities and social relations, while discourse analysis is employed to identify these constructions as well as the processes that lead to their creation.

This theoretical framework is relevant to the study of the partnership metaphor in the sense that it offers a theoretical explanation for the sudden popularity of the partnership metaphor in health care (see Figure 2). According to social constructivism, as represented by Michel Foucault’s notions of truth, power and discourse, the partnership metaphor constitutes a current carrier of positive power in society. In this capacity, partnership serves as a strategic vehicle for many different groups and individuals in society who employ it for their own gain. Social constructivism offers therefore a theoretical explanation for the current, collective popularity of the partnership metaphor.

Methodological Frameworks

Social constructivism offers more theoretical than methodological orientations. There is no “authoritative” methodological framework available for social constructivism. Rather, the researcher may adjust other methodological frameworks to the theoretical premises of social constructivism. For the purpose of this study, two methodological frameworks have been selected to complement social constructivism: *interpretive policy analysis* (Yanow, 2000) and *grounded theory* (Strauss & Corbin,

1998). The methodology of interpretive policy analysis is particularly pertinent as an overall framework for data collection and for analysis of textual material. Grounded theory is selected as a further complement because of its strengths in examining processes and practices through detailed interview analysis. The following section describes the features and theoretical underpinnings of each of these methodological frameworks, discussing also their pertinence and compatibility with the theoretical underpinnings of this study.

Interpretive Policy Analysis

Interpretive policy analysis, as developed by Dwora Yanow (2000), is a methodological framework that provides guidelines for a discourse analysis of policy. Interpretive policy analysis draws attention to how policy language is implemented in practice. This is important because “what implementors do, rather than what the policy ‘says’ in its explicit language, constitutes the ‘truth’ of policy (and thereby the state’s) intent” (Yanow, 2000, p. 9). This statement suggests that the meaning of policy emerges in its implementation. That is, meaning resides primarily in the interpretation of policy and in the action that follows from this interpretation.

Various actors interpret policy differently, that is, their understandings of it differ and they therefore respond differently in action. Although different individuals interpret the same policy somewhat differently, they tend to adjust their interpretation through interaction with other members of the group to which they belong. This adjustment gives rise to several *interpretive communities*, which are not, however, characterized by stability and clear boundaries, nor by internal homogeneity. Yanow (2000) explains that,

[there are] at least three communities of meaning in any policy situation: policymakers, implementing agency personnel, and affected citizens or clients. But we know from implementation and organizational studies that agencies may contain any number of internal communities of meaning: directors, managers or administrators, groups of professionals, lower-level employees, and street-level bureaucrats. And from community studies we know that communities and neighborhoods have internal divisions. (p. 10)

This quote highlights the lack of clear boundaries around interpretive communities and acknowledges the division within communities. It nevertheless identifies three primary interpretive communities in the policy context, namely policymakers, implementing agency personnel and affected citizens or clients. These interpretive communities are considered equally important to a policy analysis. Voicing several interpretations of the same policy is an essential feature of interpretive policy analysis. This approach serves to avoid the silencing of certain groups. The interpretive policy analyst has a certain moral obligation, claims Yanow, to uncover and convey the different interpretations held by different interpretive communities. She writes:

Policy analysts have a responsibility to make silenced stories and silenced communities speak: to bring them, their values, and their points of view to the conversation: it may be more difficult to identify unspoken stories and the interpretive communities whose meanings are not included in issue discourse, especially since these are typically the ones who lack the power (including organizing abilities) to get their views heard. (p. 92)

This quote suggests that there is a political dimension to policy analysis in the sense of recognizing and giving voice to all interpretive communities, particularly to the least powerful ones.

Interpretive policy analysis approaches policy discourse with a particular emphasis on symbolic language. Metaphors, one form of symbolic language, are important because “metaphor is not a harmless exercise in naming. It is one of the principal means by which we understand our experience and reason on the basis of that

understanding. To the extent that we act on our reasoning, metaphor plays a role in the creation of reality” (Lakoff & Johnson, 1987, in Yanow, 2000, p. 43). Lakoff and Johnson (1980) provide empirical support for the fact that metaphors shape perceptions in powerful ways by assigning meaning implicitly and allowing for multiple interpretations. Yanow explains that metaphor, with its etymological roots in the Greek word “*metapherein*”, meaning “moving van”, refers literally to the transportation of meaning from one domain to another. Metaphors contribute, in this sense, to framing an issue, to assigning meaning: “A ‘frame’ - with its metaphoric origins in a picture frame . . . sets up an interpretive framework within which policy-related artifacts make sense” (Yanow, 2000, p. 11). Yanow further explains that perceptions, expectations, and prior experiences are the main building blocks of such an interpretive framework. “The power of symbols lies in their potential to accommodate multiple meanings”, writes Yanow (p. 14) and explains that multiple meanings arise from metaphors not having fixed meanings; they are superimposed images that fit imperfectly.

The flexibility in meaning derives partly from the historical, social and cultural contexts within which symbolic language is used. This contextual dimension can give rise to multiple meanings of the same term, as explains Yanow (2000):

A symbol is something - usually concrete - that represents something else - usually an abstraction. For example, a dove is a symbol of peace. A symbol is a social convention: a group of people (a state, a society, a tribe, an organization, a community, a workgroup) agree on it as a stand-in for the meaning(s) it conveys. Policy, agency, and community analysis treat public, not private or personal, symbols and their meanings. And these are historically and culturally specific: at another time, in another place, for another group of people, a dove could be dinner or simply a grayish white bird. (p. 14)

Yanow explains in this quote that the flexibility in meaning derives from the sociocultural connotations of metaphors. The flexible meaning assigned to metaphors makes them important objects of analysis. This is true in policy because “policy frames use language, especially metaphoric language, and in so doing shape perceptions and understanding” (p.12). Hence, a policy metaphor may have a different meaning and inspire different actions in various interpretive communities. It is therefore important to study policy metaphors in an effort to capture the meaning and impact of policy.

In terms of methodology, interpretive policy analysis proposes certain procedures for data analysis. Yanow (2000, p. 20) suggests that the researcher identifies: (a) the significant carriers of meaning (such as policy metaphors), (b) the relevant interpretive communities, (3) the various discourses of the interpretive communities with respect to the policy issue, (4) the meanings that present a conflict, and (5) the implications of conflicting meanings. Data can be collected from documents, interviews or observation. This methodology allows the policy analyst to identify the architecture of a policy and analyze its implementation.

Pertinence and compatibility with social constructivism.

Interpretive policy analysis is both helpful and pertinent as a methodological framework. It offers a theoretical grounding for data collection and identifies appropriate objects and participants for policy analysis. These procedures are directly applicable to an examination of the partnership metaphor in health care policy. They are particularly helpful to an analysis of how the partnership metaphor is interpreted and implemented at different institutional levels.

In terms of ontological compatibility with social constructivism, interpretive policy analysis does not build on a theoretical foundation that is fully identical to the theoretical framework of Michel Foucault. However, the differences are relatively insignificant for the purpose of this study. The main differences pertain to the role of the individual in interpreting meaning and to the relevant sources for data collection. Foucault assigns a minimal role to individual interpretation, focusing on collective social and historical processes. Accordingly, empirical data is derived primarily from social discourse in a broad sense. Yanow, building on the theoretical work of Clifford Geertz, assigns primary importance to the subjective interpretation of discourse. This subjective interpretation, organized into interpretive communities, makes it pertinent to collect data from different interpretive communities, not from society as a collective.

Although Foucault and Yanow's premises differ in this regard, the frameworks are fundamentally compatible. Both portray discursive meaning as fluid and context-dependent, suggesting that power is primarily located in the skilful use of symbols and metaphors. The objects of analysis are very similar; they are simply derived from different data sources. This difference is not a problem as much as an asset to the present study. While Foucault's framework offers an explanation for the broad popularity of the partnership metaphor, Yanow's framework is pertinent to studying how different interpretive communities in the health care system interpret and implement the partnership metaphor. Thus, the two frameworks are both pertinent; they supplement rather than contradict each other for the purpose of this study.

Grounded Theory

Grounded theory, developed by Glaser and Strauss in 1967, is a qualitative research methodology (Strauss & Corbin, 1998). Its basic premise is inductive, i.e., it allows the data to speak for itself, grounding categories and concepts in the collected data rather than in theoretical hypotheses derived from the literature. The overall aim of grounded theory is to generate theory about a certain phenomenon. The grounded theory develops as the analyst explores which concepts and categories are relevant to the actors, and how these categories relate to each other. In principle, any micro or macro factor may be pertinent to the phenomenon under study, but it must be grounded in, i.e. derived from, the collected data. According to Strauss and Corbin the grounded theory develops progressively through data collection and analysis. New data is collected with the specific purpose of building and refining the emerging theory. Data collection is not complete until all relevant categories have been identified, fully explored, and well connected to other categories. The grounded theory is *saturated* when this process is complete. The development of a saturated, grounded theory does not exclude the possibility, however, that the grounded theory may be further elaborated, refined or adjusted when applied to a different situational context.

The methodological procedures require the use of *theoretical sampling*, that is, the selection of cases that carry a high potential to fill in gaps in the developing theory (Strauss & Corbin, 1998). Data collection is directly tied to data analysis in that the researcher continues to collect data until the grounded theory is saturated. Saturation means that an additional case does not add significant new information to the grounded theory. Data is analyzed using qualitative coding procedures. These procedures consist of

three levels of coding: open, axial and selective coding. Open coding identifies the relevant concepts and explores their nature and dimensions. Once concepts are identified, they are grouped into categories. Axial coding serves to establish the relationship between these categories. This process allows the researcher to construct the architecture of the grounded theory. Finally, selective coding identifies dimensions that require refinement, and it is employed to build full dimension, specificity, and variation into the grounded theory.

Pertinence and compatibility.

Grounded theory is compatible with social constructivism and interpretive policy analysis in the sense of addressing the relationship between meaning and action. It complements the other two frameworks by providing detailed techniques for analyzing social processes at a micro-level. This strength makes it particularly useful as a methodological approach to studying clinical decision-making processes. Moreover, its uncommitted theoretical stand toward data collection makes it well suited for examining an area characterized by little prior research, that is, how the partnership metaphor is interpreted and implemented in health care.

There are, however, some ontological concerns associated with using grounded theory as a methodological complement to the other two frameworks. The most important concern is that grounded theory is an inductive methodology, while social constructivism and interpretive policy analysis are deductive, theoretically informed frameworks. The inductive premise underlying grounded theory means that the researcher must have no prior theoretical commitment. This difference presents a concern regarding compatibility. In order

to minimize the risk of ontological incompatibility, grounded theory is applied exclusively to an area with no prior theoretical commitment, namely to the study of how the partnership metaphor applies to the clinical decision-making process regarding the placement of cognitively impaired elderly people. The only prior theoretical commitment consists in presuming that the partnership metaphor is somehow pertinent to this process. This application increases the compatibility of grounded theory with the other two frameworks, although it does not eradicate all ontological concerns.

Different units of analysis present another cause for concern regarding compatibility. Grounded theory requires that data be collected from the smallest unit of analysis, that is, from individuals. This requirement is tied to the inductive premise in the sense that data must first demonstrate the existence and pertinence of studying groups. No collective units should be presumed prior to data collection. Contrarily, the unit of analysis in interpretive policy analysis is groups (interpretive communities), while Foucault operates with the social collective (in a given time and place) as the unit of analysis. These differences in the targeted unit of analysis do not, however, present a fundamental incompatibility, given that grounded theory does not exclude the possibility of group formations. It simply requires that there is no prior commitment to group formations. To avoid potential problems related to the unit of analysis, grounded theory is applied exclusively to one institutional level, namely to case management practice. It is studied independently from the other three interpretive communities included in the research design. This limited application minimizes the potential for grounded theory being incompatible with interpretive policy analysis and social constructivism.

Research Design

This research examines how the partnership metaphor is interpreted and implemented by four different interpretive communities in Quebec's health care system. These interpretive communities are selected for their pertinence to the field of long-term community services for the elderly population with loss of autonomy. These four interpretive communities are the Ministry of Health and Social Services, the Montreal Regional Board, a CLSC in the Montreal area, and case managers in a different CLSC home care program. These four interpretive communities, represented by four institutional levels, constitute a direct hierarchical line in the organizational structure of the health care system. Each institutional level receives a mandate from the institutional level above it. Case managers in home care provide and organize community services to the elderly population. They receive this mandate from the administration of the CLSC (local community service clinic), which in turn is organized by the Regional Board. The Regional Board is responsible to the Ministry of Health and Social Services. The partnership metaphor, particularly as it applies to nursing home decision-making, is the object of interpretation in the four interpretive communities.

Data collection is divided into two stages. This division is done partly to avoid ontological problems, as mentioned in the previous section, and partly to separate the analytical procedures for textual data and interview data. The first methodological stage deals with the textual analysis, which is particularly pertinent to the three interpretive communities that do not provide clinical services. The primary data collection on the interpretive community of case managers is addressed in the second methodological step. This step employs grounded theory to study how the partnership metaphor applies to the

decision-making process regarding nursing home admission of cognitively impaired elderly clients in home care.

Data Sources (Stage One)

The sources from which data were collected consist in limited textual material from each of the four interpretive communities. This material is not exhaustive and is intended as an indication of the perspectives of the four interpretive communities. Firstly, at the level of case management practice, the source of data collection was three CLSC client files from CHSLD CLSC Bordeaux-Cartierville. Within the files, data were collected from case management entries and professional evaluations conducted at multiple public institutions and contained within the client file. Secondly, from the interpretive community of CLSC administrators, the data source was a home care reference guide (a working document), currently in use at CLSC Montréal-Nord (CLSC Montréal-Nord, 2000). Thirdly, at the Montreal Regional Board, the data were derived from the 1996 reference guide on the organization of long-term community services to the elderly population with a loss of autonomy, *Le Guichet Unique* (Regional Board of Health and Social Services Montreal-Centre, 1996). Finally, at the Ministry of Health and Social Services, data were collected from pertinent sections of its most recent, general policy on health and social services, *The Policy on Health and Well-being*, which was adopted in 1992 (Ministry of Health and Social Services, 1992). This policy appears to have initiated the partnership orientation, judging from a review of a range of ministerial health care policies published in the period from 1970 to 2001 (see Appendix A). The selected data sources are not published simultaneously; there is a time lag of four years

between the three policy documents. This time lag has allowed each institutional level an adequate amount of time to become familiar with new orientations at higher institutional levels and to form their own interpretations and take action. Although interpretation is a continuous and dynamic process, four years should be an appropriate amount of time for an interpretation to settle.

Procedure (Stage One)

Textual data, collected from these sources, serve to examine how the partnership metaphor is interpreted and implemented by the four interpretive communities. One procedure was employed for the analysis of the three administrative policy documents and another procedure for the file analysis. In the policy documents, all instances of the word *partnership* (or *partenariat* in French) and its derivatives were identified and copied from the text, accompanied by the actors and the objects (domains) to which they refer. This method allows for a portrait to emerge of whom the intended partners are and in which domain they are partners. While this data provide information on partnership, it does not indicate if certain domains of health care are specifically intended *not* to be an object of partnership. In order to also obtain this information, similar data were collected on the terms *responsibility* (or *responsabilité*) and *decision* (or *décision*). The data on these three words are used as indicators of role divisions and partnership in health care. This data serve to identify the intended division of responsibilities and decision-making powers in the health care system.

The collected data were then subjected to both an actor analysis and an object analysis (Appendixes B & C). In the actor analysis, the notion of *actor* was defined and

an approximate number of total actors determined. Divided by word, all entries were then subdivided into three categories, consisting of entries that had (a) one defined actor, (b) more than one defined actor, or (c) undefined actors. If all actors in an entry could not be defined because the actor was left open-ended (e.g., actor a, actor b, and others), the actor was considered to be undefined. The actor analysis serves to clarify the extent of role clarification in health care and to identify the construction of partnership. In the object analysis, the collected data were divided into different object categories, and the category of most relevance to the decision regarding nursing home admission was identified. The entries within this category were then subjected to two further selections: (a) entries that may potentially refer to the placement decision and (b) entries that specifically address the placement decision. The object analysis serves to identify which actors are included in service determination, particularly in the decision regarding nursing home admission.

The analysis of client files was conducted by identifying the actors of each case manager entry in the client file, including telephone conversations, home visits, case discussions, caregiver interviews at the CLSC, etc. Data were collected on the period from the first entry that mentioned nursing home to the file was closed following a nursing home admission. The clinical objects were identified in all entries and it was specified whether an entry pertained to potential nursing home admission. All entries that made reference to nursing home were considered pertinent to the placement decision. In terms of analysis, the entries were divided into two object categories: (a) all entries and (b) entries pertaining to the placement decision. Individual actors were grouped into five actor types: client, primary caregiver, other family members, CLSC actors, and external actors. Reporting separately for the two object categories, the number of entries in which

each actor participated was calculated and added to that of other actors of the same type. The total number of entries for each actor type was divided by the total number of case management entries within the category. These proportions, reported in percentage, constitute the participation rate of each actor type in each of the two object categories. Microsoft Excel software assisted in graphically presenting the participation rates of the five actor types in each object category.

Participants (Stage Two)

The second methodological stage consisted of interviews collected for a grounded theory analysis of how the partnership metaphor applies to case management practice. The object of analysis was the decision regarding the admission of cognitively impaired elderly clients to a nursing home. Participants were asked about a specific decision-making process in which they took part rather than inquired directly about partnership. This choice was made in order to obtain information that participants do not necessarily construe as a form of partnership. Moreover, there is a risk that a direct inquiry about partnership may lead participants to primarily select ideal or successful situations. Examining partnership implicitly minimized this potential for biased data. Thus, an abstract discussion about ideal decision-making and partnership was avoided by focusing on the relational dynamics surrounding specific instances of nursing home decision-making.

Triads of client, caregiver and case manager were used to study the decision-making process. The targeted triad was constructed based on the most likely actors to have participated in the decision. The primary caregiver refers to the individual, most

often a close family member, who provides daily care to a client with loss of autonomy. Given the primacy of this role in home care, the family caregiver is expected to play an important role in the decision regarding nursing home admission. The case manager/ social worker is the person who acts both as social worker and case manager for the client within the home care program. The role of the case manager, introduced in 1996, is to evaluate the client's needs, negotiate appropriate services for the client and the primary caregiver, coordinate a multitude of community services, and determine when a nursing home admission is required (Regional Board of Health and Social Services Montreal-Centre, 1996). Hence, the case manager is expected to play an important role in the decision regarding nursing home admission. Although the primary triad was predetermined, additional participants were also included if the data indicated that they had contributed significantly to the decision. This feature made it possible to respect the inductive premises of grounded theory.

The administrative participants were selected through a convenience sample. A request was addressed to an appropriate individual identified through referral or through minimal prior contact. Participants in the three clinical cases were selected among nine eligible clients referred by case managers/ social workers in a CLSC home care program (see Appendix D for a description of the study population and Appendix E for the participant recruitment letter). Based on the eligibility criteria, participants were selected through theoretical sampling seeking to obtain maximal variation in the level and type of cognitive impairment, age, gender, client-caregiver relationship, living arrangement, ethnic origin, and trajectory preceding nursing home admission. Following the selection of potential participants, the triad members (client, primary caregiver and case manager/

social worker) were contacted for consent to participate. Only if all three participants in the triad agreed to participate was the case retained for the study.

A total of 13 participants were interviewed for this study (see Appendix F for information letters and Appendix G for the consent form). Two participants were administrators close to clinical action, one being a coordinator of nursing home admissions at the Regional Board and the other an administrator of a CLSC home care program. The remaining 11 participants were actors in three cases in which an elderly person with cognitive impairment was admitted to a nursing home. Of these, 9 belonged to the target triad of client, primary caregiver, and case manager. The last two participants were a hospital social worker and an additional family member who both played a significant role in one of the three cases.

Procedure (Stage Two)

Data were collected using semi-structured interviews. The interviews on the management level sought general information about clinical policies and procedures related to nursing home admission, case management practice, and actor roles and interactions (see Appendixes H-1 & H-2 for the interview guides for the two administrative interviews). The case-based interviews on the front line were retrospective. They served to examine how a decision regarding nursing home admission was reached and which elements shaped the interpersonal dynamics of the decision-making process. The interviews explored role perceptions and development of events from the perspective of three to five different actors in the same case. The study of

interpersonal dynamics focused on, but was not limited to, the interactions within the main triad (see Appendix H-3 for the interview guide for the clinical triad interviews).

The interview data were coded according to the principles of grounded theory. Firstly, a separate analysis of each case served to identify points of congruence and incongruence in the perspectives of different actors. Secondly, the overall pattern of decision-making was identified for each case by triangulating and incorporating the perspective of each actor. Thirdly, the three cases were compared to each other by identifying similarities and variations from case to case. Finally, these findings were triangulated with the data from the administrative interviews and integrated into a conceptual framework describing the dynamic process of decision-making. This conceptual framework constitutes the grounded theory. Moreover, it represents the results on how the partnership metaphor applies to the decision regarding nursing home admission in case management practice. Lastly, the collective findings from stage two, i.e., the conceptual framework, were incorporated into the framework of stage one, thereby adding the component of how partnership applies to the placement decision in case management practice.

Scientific Merit and Limitations

Both interpretive policy analysis and grounded theory are qualitative research methodologies and should therefore be evaluated according to the specific evaluation criteria of qualitative research methods. A qualitative study has scientific merit when it is made transparent to the reader how the researcher obtained and analyzed the data that led to the conclusions (Strauss & Corbin, 1998, p. 266). Three evaluative concepts are

significant in this regard, namely validity, reproducibility, and generalizability. Although these concepts are applied somewhat differently in qualitative and quantitative research, the underlying purpose is identical. The following section discusses how these three concepts apply to the research design of this study.

Validity

Validity refers to whether the data reflect what they claim to reflect. The validity of certain types of data is more easily ensured than that of other kinds. Qualitative research is frequently used to obtain a type of data that is quite difficult, if not impossible, to obtain through quantitative methods. As opposed to quantitative methods, qualitative methods tend to avoid the use of highly structured measuring instruments to not impose a predetermined framework on the data. Qualitative methods rely instead on the researcher as a trained individual to ensure validity of the data. Strauss and Corbin (1998) explain:

In qualitative research, objectivity does not mean controlling the variables. Rather, it means openness, a willingness to listen and to “give voice” to respondents, be they individuals or organizations. It means hearing what others have to say, seeing what others do, and representing these as accurately as possible. It means having an understanding, while recognizing that researchers’ understandings often are based on the values, cultures, training, and experiences that they bring to the research situations and that these might be quite different from those of their respondents.
(p. 43)

This quote explains that the researcher aims to ensure validity by giving voice, as truthfully as possible, to the experience and perspective of participants. The greatest risk to validity is therefore that the researcher voices his or her personal experiences and perspectives rather than those of respondents.

Three techniques help ensure that the data reflect the experience of respondents, not that of the researcher (Strauss & Corbin, 1998, pp. 43-44). One technique to minimize bias, and hence to ensure validity, is to continuously and carefully compare one incident in the data to another. The potential for bias is minimized as the researcher develops a clearer understanding of how the properties and dimensions of different concepts vary from one incident to another. A second technique is to use triangulation, meaning that the researcher verifies the data by collecting information about the same phenomenon from different sources or individuals. Lastly, the third technique is that the researcher verifies the data by regularly checking out assumptions and hypotheses with respondents, thereby ensuring that the analysis fits with their experiences. These three techniques help ensure the validity of data obtained through qualitative methods.

The validity of the first methodological stage of this research refers both to the research design and to the data collection and analysis. Firstly, validity is a concern in terms of the indicators employed to represent role divisions in health care. The words *responsibility* and *decision* as well as their derivatives do not capture *all* instances pertaining to role division in as much as their synonyms are excluded. Likewise, *partnership* does not capture all instances in which a text refers to actor collaboration. The question is whether these indicators are sufficient, not whether they are necessary or pertinent. Secondly, the actors and objects identified for each entry allow some room for interpretation. Certain phrases and paragraphs are constructed in ambiguous ways, making it unclear which actors or object to include. Careful analysis, repeated again at a later point in time, served to ensure the best possible judgment in data collection. Thirdly, a judgment call was made when grouping entries into object categories in the analysis of

both policies and client files. A double verification served to minimize the risks to validity. To facilitate the evaluation of validity, the analytical procedures and associated findings of the policy analyses are made available in Appendixes B and C.

Validity was a particular concern to the second methodological stage of this study. While possibly contributing positively to the research design, prior clinical experience as a case manager in this domain increased the risk that personal clinical experiences may bias the findings. Similarly, knowing some of the participants (the case managers) beforehand may have increased data quality in terms of pre-existing trust. However, prior interaction may also have biased the responses of participants in subtle ways. Several steps were taken to minimize these risks to validity. Firstly, a period of several months with no clinical exposure and no contact to participating case managers preceded the collection of data. No clinical exposure continued throughout the period of conducting research. Secondly, extensive review of research literature and policies in this field served to counter-weight knowledge obtained through practice. Knowledge obtained from practice, policy and research were triangulated against each other to decrease the risk of bias. Thirdly, data were collecting from several participants who took part in the same process. This procedure served as a triangulation in the sense that multiple perspectives increased the validity of the findings. Data were also triangulated with the information contained in the client file. Fourthly, careful coding of the data, employed in accordance with the principles of grounded theory, helped to increase validity of the emerging grounded theory. Finally, the research results were validated in a clinical conference presentation attended by many case managers, several home care administrators, and other professionals in both home care and partner institutions. This

presentation ensured that the results reflect the experience of clinicians involved in this process. Although this presentation was open to the public, steps were not taken to specifically validate the results with caregiver groups and other clients. These multiple steps, while not fully exhaustive, minimized risks to validity in the second methodological step.

Reproducibility

Reproducibility of the findings is another dimension of scientific merit. This concept refers to whether the data can be reproduced, hence verified, if the study is repeated. Data is more easily reproduced if the data source is a constant. Hence, research on individual experiences and relational processes present more difficulties in terms of reproducibility than does textual analysis. The first methodological step presented little concern about reproducibility as the data sources were constant and the procedures allowed only little room for interpretation. An exception is the judgment calls made in (a) the identification of actors and objects associated with a word entry, (b) the creation of object categories and selection procedures, (c) the identification of a file entry as pertaining to nursing home admission (see the section on validity for a discussion).

Reproducibility presents more challenge in the second methodological step. Given the experiential and relational dimensions of a grounded theory study, it can be difficult, maybe even impossible, to reproduce the exact same findings. Given this dimension of much social research, reproducibility is applied with some flexibility in qualitative research. As explain Corbin and Strauss (1998),

Reproducing social phenomena can be difficult because it is nearly impossible to replicate the original conditions under which the data were

collected or to control all the variables that might possibly affect findings. That is the difference between doing research in a laboratory, where one can to some degree “control” variables, and conducting it out in the “real” world, where events and happenings follow a natural course. However, there are ways of rethinking reproducibility to extend its meaning. . . . Given the same theoretical perspective of the original researcher, following the same general rules for data gathering and analysis, and assuming a similar set of conditions, other researchers should be able to come up with either the same or a very similar theoretical explanation about the phenomenon under investigation. The same problems and issues should arise regardless of whether they are conceptualized and interpreted a little differently. (pp. 266-267)

This quote explains that certain variations should be expected if a qualitative study is reproduced. All variables cannot possibly be held constant and this variation will reflect in the findings of a reproduced study. Scientific merit can be evaluated by comparing the two different contexts, taking their differences into consideration. These difficulties regarding reproducibility fully apply to the second methodological step. In order to increase the reproducibility of this study, the second methodological step is explained in as much detail as possible, thereby facilitating a possible reproduction.

Generalizability

The third indicator of scientific merit is generalizability. This concept refers to whether the findings of a study are more broadly applicable. Generalizability is sometimes difficult to obtain in qualitative research as small sample sizes limit the ability of a study to be representative. Moreover, research is often characterized by simultaneous interaction of many different social variables; these context-dependent findings cannot automatically be transposed from one social context to another. In the first methodological stage, generalizability refers to whether the findings can be generalized to an entire interpretive community. In the second methodological step, generalizability

means that the conceptual framework has *explanatory power* beyond the specific context in which it was developed. According to Strauss and Corbin (1998),

The purpose of using a theory-building methodology is to build theory. Thus, we are talking more the language of explanatory power rather than that of generalizability. Explanatory power means “predictive ability”, that is, the ability to explain what might happen in given situations. . . . We are not suggesting that a substantive theory (one developed from the study of one small area of investigation and from one specific population) has the explanatory power of a larger, more general theory. It cannot because it does not build in the variation or include the broad propositions of a more general theory. (p. 267)

This quote suggests that the concept of generalizability, applied to the second methodological stage of this study, means that the conceptual framework is applicable in other contexts with small adaptations and adjustments to the original formulation. In this study, the concept of generalizability refers to how representative the collected data are of the interpretive communities under study. This small study has several limitations in this regard. Several steps were taken to increase the generalizability of this study, but the findings are not necessarily widely generalizable. The following discussion specifies these limitations with respect to each of the four interpretive communities.

The interpretive community of the Ministry of Health and Social Services is represented by its general 1992 policy. This policy is still in use, but there is a risk that it is no longer as representative as it might have been at the time of implementation. However, its orientations with regards to partnership seem to still hold true, judging from a review of recent policy documents (Commission d'étude sur les services de santé et les services sociaux, 2000; Ministry of Health and Social Services, 2001). These documents

suggest little overall change from 1992 with regards to the notion of partnership and its application to the field of health care. If anything, partnership has been expanded further.

The 1996 policy document, selected to represent the interpretive community of the Regional Board, may compromise generalizability in two areas. One concern is that this document may no longer represent the Montreal Regional Board in 2001. This is not likely given the fact that its general orientations are reflected in a recent ministerial policy document on community care to the elderly population (Ministry of Health and Social Services, 2001). The interview with an actor at the Montreal Regional Board, carried out as part of the second methodological step, also suggests that the orientations of the 1996 document are still pertinent and representative today and that little change has occurred that may affect this study. A second concern is that the Montreal Regional Board is not representative of all Regional Boards in Quebec. Since no steps were taken to verify this aspect, the findings are at most applicable to the interpretive community of the Montreal Regional Board.

The CLSC document, employed as an indicator of the interpretive community of CLSC administrators, carries similar limitations to generalizability. While currently representative of the CLSC to which it pertains, this document may not represent the entire interpretive community of CLSC administrators. However, this document stands a good chance of being somewhat representative of CLSCs in the Montreal area, judging from personal clinical experience at another CLSC and from interaction with case managers and social workers in yet other home care programs. While the findings *may* apply to the entire interpretive community of Montreal-area CLSCs, they are probably not generalizable to CLSCs outside the district of the Montreal Regional Board.

With regards to the interpretive community of case managers, the data is limited to three cases, which are represented by client files and multiple interviews. This limited data cannot necessarily be extrapolated to the entire interpretive community of case managers. At most, the data may be representative of case managers in Montreal-area CLSC home care programs. The results derived from the textual analysis of client files are indications of a pattern. A file review of a much larger scale would be required to make the findings generalizable beyond this study. Steps were taken, however, to confirm the generalizability, i.e. the applicability, of the conceptual framework (the second methodological step). During a conference presentation, case managers in two different home care programs (SAD and SIPA) fully validated the conceptual framework. This validation included the participating case managers and case managers from the professions of both social work and nursing. This validation increases the likelihood that the findings can be applied more widely.

In summary, this study offers limited findings on all four interpretive communities. Further study should be conducted on all four communities if the findings are to be applied as more than an indication of how each of the four interpretive communities interprets and implements the partnership metaphor. The preceding discussion explained to what extent the findings are valid, reproducible and applicable beyond this specific study. Validation is recommended in order to ensure the validity and generalizability of this research. Although the study has limitations in scientific merit, multiple measures were taken to optimize its scientific merit.

CHAPTER 4: RESULTS

The research findings emerge from an integrated analysis of the data collected through the two methodological stages mentioned in the preceding chapter. The first section presents a brief description of how partnership is conceptualized at the four different institutional levels, each representing an interpretive community. The second section provides a more detailed presentation of the findings that pertain specifically to the decision regarding nursing home admission of cognitively impaired, elderly clients. These findings indicate how the four different interpretive communities interpret and implement the partnership metaphor in relation to the decision regarding nursing home admission of cognitively impaired elderly people.

The Construction of Partnership

The findings pertaining broadly to the partnership construct indicate that it is adopted as an ideal at all four institutional levels. It represents collaborative, egalitarian efforts to reach a shared goal. Partnership is not only valued but is also actively implemented at all four institutional levels. The general implementation of partnership is reflected in the textual analysis of policies and reference guides (see Appendix B) and in the client file analysis (see Figure 4). These findings show that all four levels apply the partnership metaphor. The consensus on partnership is limited, however, to an agreement on its general applicability and merit as an egalitarian, collaborative style of interaction.

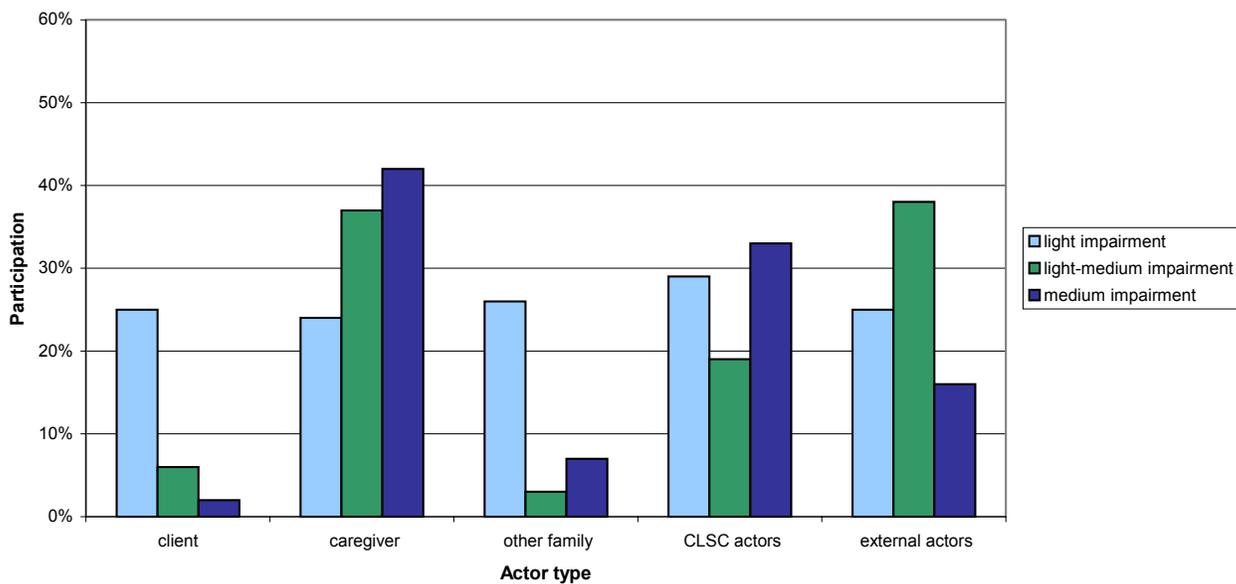


Figure 4. All case manager interactions.

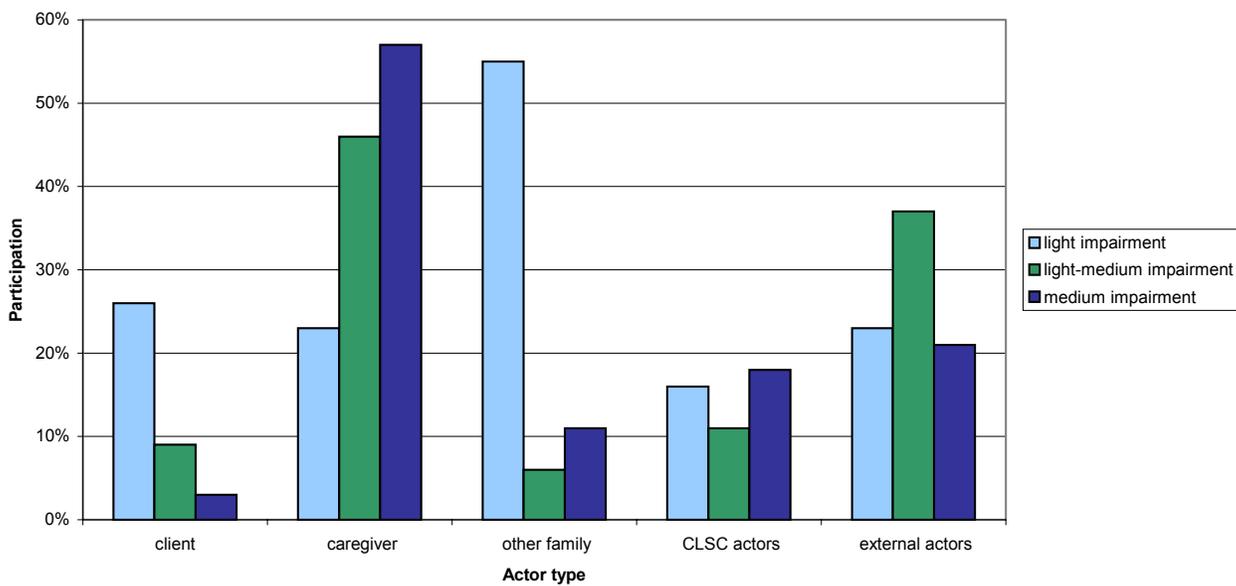


Figure 5. Case manager interactions regarding nursing home admission.

The findings show that once partnership is applied in practice, differences emerge in terms of how different institutional levels interpret and construct this concept. These differences manifest themselves in the selection of objects and actors to which partnership is applied, as indicated by the actor analyses of the three documents (see Appendix B). In the ministerial policy, partnership is constructed as an extensive collaboration between multiple public, private and community actors. The actor analysis of this document (Appendix B-1) shows that all partnership entries refer to the public system in collaboration with a potentially unlimited number of other actors. Moreover, the majority of the decision and responsibility entries leave the actors unbounded or unidentified. About a quarter have one actor, none of which are public sector agents. This actor analysis suggests that the ministerial policy does not clarify the role of the public sector in health care, but rather embeds the role of public health care actors within an extended partnership that includes a wide, unbounded range of external actors in the public, private and community sectors.

At the level of the Regional Board, partnership is constructed primarily as a collaborative organizational framework for the interaction among public health care institutions (see Appendix B-2). Community organizations, physicians, users and families constitute secondary actors. Most of the multiple additional actors mentioned in the ministerial policy are excluded completely from the Regional Board's partnership construction. All of the entries on partnership refer to a smaller circle of about 10 actors, most of which are public health care institutions. This finding shows that the Regional Board limits the partnership construction to a smaller number of actors, focusing its attention on elaborating the roles of public institutions within its mandate. The actor analysis also shows that over a third of the entries on responsibility and decision have

multiple, identifiable actors. This finding indicates that the Regional Board constructs partnership in a more bounded and defined way than does the Ministry of Health and Social Services. According to the actor analysis, the role of the CLSC is the object of special attention in as much as the majority of all responsibility and decision entries have only one actor. This single actor is almost without exception the CLSC. The Regional Board highlights the role of the CLSC and, in so doing, suggests that this actor is assigned a privileged role within the partnership of public institutions.

The CLSC document maintains essentially the same partnership orientation as the Regional Board but subdivides public institutions into smaller units, such as case managers, professional groups and multidisciplinary teams. The primary actors are users, families, case managers, professionals, multidisciplinary teams and community organizations. The actor analysis of the CLSC document (Appendix B-3) shows that half the partnership entries refers to all the actors mentioned in the document. The other half refers to these actors in potential collaboration with external actors. This finding indicates a less bounded approach to partnership than that used at the Regional Board, yet more bounded than that of the Ministry of Health and Social Services. In terms of role clarification, at least two thirds of the responsibility and decision entries have only one actor. This single actor is almost exclusively the case manager. This focus on the role of the case manager suggests that this actor is particularly important. Hence, the case manager may be assigned a privileged position within the partnership.

At the level of case management practice, partnership is reflected in the frequency with which the case manager interacts with different actor types. The actors that had contact with the case manager are recorded in the CLSC client files. The analysis of all case

manager entries shows that the case manager interacts with five actor categories, namely clients, primary caregivers, other family members, CLSC actors and external actors (see Figure 4). Figure 4 shows that when cognitive impairment increases, the case manager has less interaction with the client and more with the primary caregiver. The varying frequencies for the category of other family members can be explained by different family compositions. Differences in the frequency of CLSC actors and external actors may be accounted for by one client receiving most home care services from a sub-contracted private agency (external actor), while the other two received all home care services from the CLSC (CLSC actor). The file analysis suggests congruence between the CLSC document and case management practice with regards to the actors involved in clinical practice.

An integration of the four actor analyses indicates that partnership is a favourite mode of operation at all four institutional levels of the health care system. However, the actors of a partnership vary among the interpretive communities. The Ministry of Health and Social Services is all-inclusive and unbounded in its inclusion of actors, while the Regional Board focuses on public health care institutions, particularly on the CLSC. The CLSC administration subdivides the public actors further and focuses on the case manager as a privileged actor in the partnership. Finally, case managers construe clients, families and other health care professionals as their primary partners. This actor variation among different interpretive communities suggests that partnership is a very flexible, organizational concept. Partnership maintains its connotations of collaboration and equality no matter to which actors it is applied. It can also be applied selectively to different objects as indicates the following analysis.

Decision-Making Regarding Nursing Home Admission

Stage One: Textual Analysis

As previously discussed, the decision regarding nursing home admission is central to long-term community care of elderly persons in loss of autonomy. This decision carries great significance to elderly persons affected by it, to their caregivers who provide the majority of care in the community, and to public administrators responsible for managing scarce health care resources cost-effectively. Being an important object to many actors in the health care system, the decision regarding nursing home admission is worthy of special attention. It was therefore subjected to a textual object analysis (see Appendix C & Figure 5).

Firstly, the object analysis of the ministerial policy (Appendix C-1) indicates that the Ministry of Health and Social Services does not directly address the decision regarding nursing home admission. Rather, this decision is included more generally within the object category of service delivery. All the entries in this category have multiple, unbounded actors; this indicates that the ministerial policy provides little specification of whom should deliver health care services, including whom should make the decision regarding nursing home admission.

Secondly, the object analysis of the Regional Board's reference guide (Appendix C-2) shows a more specific orientation toward the placement decision. The majority of entries in the category of service orientation refers specifically to the decision regarding nursing home admission. These entries assign the decision almost exclusively to the CLSC. It is interesting to observe, however, that the other, more general entries on service orientation do

not restrict the actor role to the CLSC but include also users, other establishments and community organizations as relevant actors. This object analysis suggests that the Regional Board identifies the CLSC as the sole decision-maker of nursing home admission, while other actors can participate in other aspects of service orientation. Thus, the decision regarding nursing home admission is framed as an exception, as an exclusive domain within the overall partnership in service orientation.

Thirdly, the object analysis of the CLSC home care guide (Appendix C-3) reflects the general orientation of the Regional Board. However, the CLSC modifies certain aspects of the placement decision. Only a minority of entries in the object category of service orientation refers to the decision regarding nursing home admission. Of these entries, two thirds assign this decision to the case manager, while one third has multiple, unlimited actors. This finding indicates a certain ambivalence, confirming in part the position of the Regional Board and in part opening this decision up to a partnership. The actors in the general entries on service orientation, i.e., entries that do not specifically refer to the placement decision, include users, their family members and the case manager. These findings suggest that the CLSC takes a middle road between excluding the placement decision from a partnership and including it within a general partnership on service orientation. The CLSC document seems to respect the position of the Regional Board yet opens the door for including the placement decision within a partnership on service orientation.

Finally, at the level of case management practice, file data show an inclusion of all five types of actors in the decision regarding nursing home admission (see Figure 5). According to Figure 5, the relative participation of the client and the primary caregiver vary

with the client's level of cognitive impairment. Much interaction shifts from the client to the caregiver when the client's cognitive impairment increases. All informal caregivers combined constitute in all three cases the type of actor that most frequently interacts with the case manager on the topic of nursing home admission. A remarkable finding is that the overall interaction pattern on nursing home admission is essentially identical to the general pattern of case manager interaction (see Figure 4). The only exceptions are a greater participation of other informal caregivers in one case and the lesser participation of CLSC actors in all three cases. The similarity between the two graphs suggests that the decision regarding nursing home admission does not have an exclusive status in case management practices. This decision is not excluded from a partnership. Rather, it seems to be fully integrated and representative of a general partnership approach to case management practice.

A comparison of the four object analyses suggest that the Regional Board applies partnership quite differently to the placement decision than do case managers. The Regional Board largely excludes this decision from the partnership and assigns it to the CLSC; case managers fully include this decision in a partnership with clients, caregivers and other health care professionals. The CLSC seems to take a position somewhere in between these two constructions. The Ministry of Health and Social Services takes little stand besides promoting partnership widely, at least in this general document. To fully explore partnership in case management practice, the following section explains in detail the conceptual framework that emerged from the grounded theory analysis (step two).

Stage Two: Conceptual Model of Practice

The conceptual framework of case management practice is the result of the grounded theory analysis, i.e. the second methodological step. This conceptual framework provides a more detailed picture of how the decision is made in case management practice to admit cognitively impaired clients to a nursing home. The conceptual framework presents a decision-making process that is quite complex and potentially circular (see Figure 6). The process comprises three or four consecutive partnerships, each of which have certain actors making specific sub-decisions on the path to an eventual nursing home admission. The entire decision-making process can take place in the home care setting. However, several steps and partnerships may also be completed in the hospital setting, in which case the hospital social worker partially replaces the case manager; a hospital team also replaces the CLSC multidisciplinary team.

The following explanation of the conceptual framework is supplemented with illustrative quotes from the interviews. These quotes are intended as illustrations and do not represent all the material employed to develop the conceptual framework. The validity of the quotes are affected by three factors: (a) translation from French, (b) condensation of longer passages, and (c) alterations or omissions required to respect confidentiality. Figure 7 offers a brief description of the three cases; identifying information has been altered to respect the confidentiality of participants.

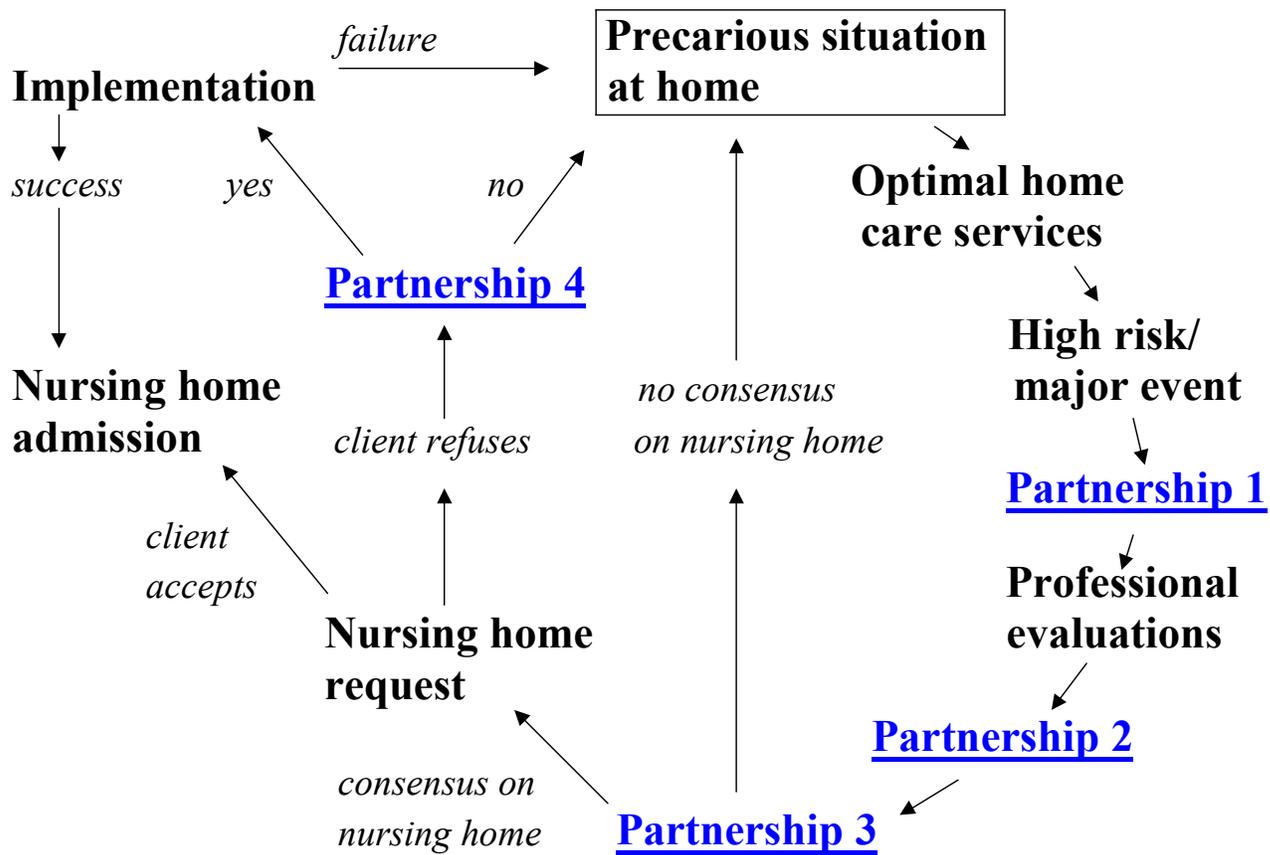


Figure 6. Conceptual model of nursing home decision-making process in case management practice.

The conceptual framework (Figure 6) starts with a precarious situation at home. Optimal home care and community services are then installed, taking into consideration the availability of services and the interests of the client and the caregiver in receiving these services. When the available services are no longer adequate in combination with the care provided by informal caregivers, the risk increases to client and caregiver health and well being. The risk itself or a major event triggers the entry into the first partnership.

Case A: Mrs. Jakobi, 84 years old. She suffers from degenerative, cognitive problems of medium severity (an average score of -2 on the SMAF scale of 0 to -3). She is of Eastern European origin but has spent most of her life in Quebec. Mrs. Jakobi has lived alone since her husband passed away 15 years ago. The primary caregiver is her son, Mr. Jakobi Jr., who lives close by with his family.

Case B: Mrs. Safa, 61 years old. She suffers from the early onset of degenerative, cognitive problems of light to medium severity (an average score of -1.5). Of Mediterranean origin, she has spent most of her life in Quebec. She lives with her husband, the primary caregiver, and one of their two children who has a physical handicap. Her husband, who is several years younger, works full time.

Case C: Mr. Tremblay, 93 years old. He has light cognitive problems, which has not yet been diagnosed (a score of about -1). He is French-Canadian and has lived all his life in Quebec. His wife is 89 years old and suffers from cardiovascular problems. She also receives home care services. One of their sons, Mr. Tremblay Jr., lives close by with his family and is quite involved.

Figure 7. Case descriptions to complement the conceptual model of nursing home decision-making in case management practice.

Partnership One: Setting the Stage

The first partnership is all-inclusive. It involves the client, the caregiver(s), the case manager and the multidisciplinary team. Their tasks are to negotiate three aspects of reality, namely (a) the rational and emotional dimensions of current and future reality, (b) the possible and acceptable solutions to the identified problems, and (c) the respective roles of each partner in the decision-making process. This preparatory step serves as a framework for an eventual decision on nursing home admission.

Negotiating reality.

The first step is a clarification of the rational dimension of reality, that is, a problem formulation. The case manager and the home care team gradually negotiate a shared view of the current situation with the client and the primary caregiver. This negotiation seems to be most difficult with clients, in part due to their cognitive problems. For instance, in the case with the lightest impairment, the case manager/social worker engaged the client and the family in a reality negotiation that served primarily to make the client more aware of the caregiver's exhaustion:

The caregiver did not say, "I cannot handle the situation any more, we need to make a nursing home request". Rather she said, "It is difficult, it is demanding" and expressed to me and to her son how difficult she found her role as a caregiver. She did not voice these feelings in the presence of her husband, but nodded when I voiced her sentiments to him. In fact, I met several times with the client and his wife to help reflect and reformulate what the wife was saying so that the client would hear and acknowledge the difficulties she experienced. This process permitted the client to realize the difficult reality for his wife and to slowly begin to accept a nursing home. (Ted, case manager for Mr. Tremblay, lines 73-98)

This quote illustrates a successful reality negotiation in which all actors came to a certain consensus on the rational dimension of reality, namely that the client was in loss of

autonomy and that his wife was becoming increasingly unable to pursue her role as primary caregiver. This negotiation became increasingly difficult as the level of cognitive impairment increased. It was more difficult for the client with medium impairment to perceive and acknowledge the problems and risks raised by others. The following three quotes show how the case manager, the caregiver, and the most impaired client perceived the same reality:

Case A

The client forgot a lot of things and her judgment was impaired. She was telling us that she did not need any help at home because she was doing everything just fine by herself. We realized after a while that this was not true. It was not true that she was eating, that she was cleaning, that she was doing the shopping, that she went to the bank by herself. In fact, I would say that she hardly left her apartment in the past year. Her son was doing a lot, because the client refused to open the door for the home care staff, or she hid in the bathroom if her son opened the door for the CLSC. (Martin, **case manager** for Mrs. Jakobi, lines 60-86)

My mother refused everything. She did not want the CLSC to come; she said, “they bother me too much”. I was saying, “look mama, they want to take you to the store, they will do the shopping with you, they will bring you back”. She just replied, “no, no, I can go myself, I want to go out to the store, I want to go to the bank myself”. But she could not do that alone. I tried to explain to her how to close the door with the keys and how to operate the elevator, but she really could not do these things alone. I had to do it for her. (Mr. Jakobi Jr., **caregiver**, lines 238-260)

Why do I stay here [in the nursing home]? I am not sick. I like to be free and go outside to see somebody, walk, go to the store, buy something, cook. I do everything myself at home; nobody helps me (Mrs. Jakobi, **client**, lines 7-37, 64-71).

In these quotes, the social worker and the primary caregiver voice similar visions of reality, i.e., that the client is not autonomous. The client disagrees strongly, insisting on her full autonomy. These visions of reality differ so much that negotiation with the client was made

more or less impossible. The case manager gave up on negotiation with the client, turning instead to the caregiver to negotiate reality.

Reality negotiations with caregivers were centred primarily on the reality of the near future. Caregivers and health care workers tended to have a similar view of the current reality, while caregivers expressed a stronger belief in future improvement. Caregivers hoped, or believed, for a longer time that current problems and difficulties would remain stable or get better, while health care professionals suggested that further decline was most likely. A hospital social worker voiced this difference in perspectives:

The wife did not agree with the multidisciplinary team that her husband needed nursing home care. She said, “the CLSC will give us services like before, I will do my part, my husband will do his. He will recuperate, just like my brother did.” I had to explain to her that her husband is in his nineties and that he cannot recuperate the way her brother did at the age of 50. Later on, she accepted the reality a little more. (Monica, hospital social worker, lines 49-72)

In this case, the caregiver stuck to her vision of the future reality for a relatively long period, eventually finding herself surrounded by health care staff and other family members all agreeing that home care was impossible. Her son, a secondary caregiver, explained the dynamic in this way:

My mother was hoping that my father would continue to stay at home, that he would recuperate and regain his autonomy. But given his physical condition and health, this was completely unrealistic. Between the social workers at the CLSC and the hospital, my brother, and myself, we managed to convince her that this was impossible, but she was very reluctant. My parents are inseparable and she did not want to live alone. (Mr. Tremblay Jr., son, lines 46-70)

This quote shows that the caregiver had emotional attachments that made it difficult for her to share a vision of the future reality with her son and health care personnel. Another

caregiver, in a different case, also gave voice to the difficult emotional experience associated with accepting the vision of reality as health care professionals presented it:

I was not doing well. I was becoming very nervous, very fatigued. I couldn't handle it; sometimes I was crying or acting out. I was denying everything, asking myself why this is happening to me. Then a specialized team evaluated my wife and explained her disease to me and the consequences of her staying home. They explained that there is no treatment, only medication to relieve some of the symptoms. When they explained all this to me, I realized that the situation is hopeless, that there is no cure, only deterioration. "Why do you deny reality?" I asked myself. "Accept it and that is it, you can live with it". I accepted it. Otherwise I would have ended up in hospital. (Mr. Safa, caregiver, lines 116-120, 258-264, 388-393)

The caregiver is voicing an emotional situation that makes it very difficult for him to acknowledge the likely future scenario. He expresses a sentiment of being almost forced to accept this reality in order to cope with the situation. The primary caregiver in all three cases expressed a feeling of not being able to fight reality any longer, of being more or less obliged by exhaustion to acknowledge their inability to continue in the role as caregiver. The third caregiver (Mr. Jakobi Jr.) said, "I have never cried so much in my life as I did in the six weeks before my mother was admitted to a nursing home". Hence, the emotional exhaustion obliged the caregivers to let go of their hopes for improvement and accept a nursing home admission of their family member.

Reality negotiations among health care professionals seemed to be relatively unproblematic compared to the reality negotiations with the client and the primary caregiver. This may be explained in part by the consequence of nursing home admission having less personal impact on health care professionals than it did on clients and caregivers. Consideration of nursing home admission was in all three cases associated with a defeat, a failure, or an abandonment of sorts, which gave rise to feelings of guilt for caregivers and

anger or disappointment for clients. One of the clients, who declined to express her sentiments directly, expressed nevertheless an implicit disappointment in the following statement:

My mother was sick for a long time. I looked after her alone at home, until the end. It was very difficult. You know, I could never have put her in a home or something. Never. And I am pleased with myself every day. (Mrs. Safa, client, lines 305-333)

In another case, the caregiver did not openly voice a sentiment of guilt, but instead removed herself from the placement decision. The case manager voiced his hypothesis on the caregiver's sentiments in these words:

I think that maybe the caregiver did not express her exhaustion in the presence of her husband because she felt guilty. I do not think she was quite at ease with the idea of a nursing home admission. Maybe she did not want to carry the burden of having made the decision to admit her husband to a nursing home. I think guilt may have played a role in the sense that she did not feel capable of continuing to care for her husband at home. (Ted, case manager for Mr. Tremblay, lines 59-72)

This emotional dimension of a nursing home admission seemed to give rise to deep sentiments of guilt, anger and abandonment. This dimension may have contributed to making it difficult for case managers to negotiate reality with the client and the primary caregiver.

Negotiating solutions.

Solutions are negotiated in the second part of the first partnership. Potential solutions to the identified problems need to be acceptable, pertinent and available. The case managers share information with client and caregiver on which services are available in the public, private and community sectors as well as the risks associated with inadequate services at home. The client and caregiver share in turn their willingness to (a)

consider the available options or (b) accept the risks associated with inadequate services in the home care setting. One case manager explains the negotiation of solutions:

I discussed several different possibilities with the client, the caregiver and the son. The wife would sometimes decline a certain service that she did not feel she needed. When we discussed the possibility of a nursing home, the client said he preferred a placement for the couple, not just for himself. We worked a lot with that in the first couple of weeks, because his wife was too autonomous to receive nursing home care. It was most appropriate that only he be admitted to a nursing home. (Ted, case manager for Mr. Tremblay, lines 45-50, 370-385)

Negotiating decision-making roles.

The last component of the first partnership is a negotiation of the respective roles of the partners in the decision-making process. This negotiation touches both on the family tradition for decision-making and on the developing relationship between the family and the health care system. In terms of the family pattern, each family has its own system for how decisions are made within the family. The client's cognitive impairment may have altered or undone an earlier pattern, in which case new family roles may be renegotiated. In one case, the client had been the primary decision-maker earlier on, but his authority had started to fade with the onset of light cognitive impairment. In the following three quotes, the three family members express their view of the decision-making mode in the family:

Case C

My husband used to make the decisions. He was the boss. He has always had his own business and is used to manage his employees. Sometimes he behaves as if this is still the case and tells his sons what to do. But they do not listen so much to him now, saying that he repeats himself, which is true. But he is still a very intelligent man. (Mrs. Tremblay, **caregiver**, lines 187-203)

My father always made decisions in our family. There has always been much consultation and discussion first. He is authoritative by nature and used to make the decisions, also for my mother. My father was capable

then of making decisions. Now he is less capable because his memory is not so good, he is a little confused. He has delegated most of the decision-making to my mother and my brother. I also participate because I am the oldest son, but my role has not changed much really. (Mr. Tremblay Jr., **son**, lines 174-219)

Well, you see, I started to be on a decline. I was working less. In fact, I did not make a living any more. That is kind of it. My son is younger than I and he knows a lot of people, so he is organizing things for me. (Mr. Tremblay, **client**, lines 148-157)

These quotes show an agreement among all three family members; the traditional decision-making mode in the family has shifted in response to a decline in the client's autonomy and the onset of cognitive impairment. The client indicates, vaguely, that he associates decision-making with being autonomous and working actively. He seems willing to let go of the decision-making role in as much as he may no longer qualify for this role now that he does not make a living. Although all three actors agree that the client was responsible for decision-making earlier on and is less so now, they do not seem to agree on the new decision-making roles. The client suggests that his oldest son is taking over, while the son perceives his mother and brother to have taken on the father's decision-making role. This role ambiguity suggests that the internal decision-making process in the family is currently being adjusted and restructured.

Besides the negotiations within the family, there is also a negotiation on the division of roles between the family and the case manager. Each actor in the partnership brings certain role expectations and decision-making ideals to the encounter. They then negotiate, mostly implicitly, their respective roles in the decision-making process. For instance, in the case mentioned above (case C), the case manager brings a different ideal of decision-making. The family is accustomed to extensive discussion and consultation

followed by one individual making an authoritative decision. The case manager, on the contrary, aims for decision-making in partnership, that is, a consensual decision-making mode. This ideal is transmitted in the following statement:

I really appreciated that things could be discussed so openly in this family. Things were named exactly the way they were. I could work with them without being in opposition to the client, to the wife or to the son. I provided them with the information they needed to help them make an informed decision. The information circulated nicely and everything went in the same direction; it was really quite harmonious. (Ted, case manager for Mr. Tremblay; lines 110-114, 410-416; 444-464)

In this quote, the case manager expresses a success in making decisions in a partnership. He shared information with all the actors with the goal of arriving at a consensual decision. This decision-making mode differs somewhat from that used traditionally in the family in terms of positioning actors as equals rather than as ranked. The case manager was not at ease with taking a role as authoritative or imposing but sought rather to obtain a consensus; he entered the family as a negotiator, a facilitator, a consensus seeker. Hence, the difference between the decision-making modes of the family and the case manager added another dimension to the role negotiations. The three types of negotiations in the first partnership were preparatory for the rest of the decision-making process.

Partnership Two: Professional Recommendation

After the first partnership, which sets the frame for the decision-making process, professional evaluations are carried out. These evaluations represent a more formal analysis of reality, that is, of the health, capacities and difficulties that the client and the caregiver have. This analysis is accompanied by a professional recommendation for intervention. One or more appropriate professionals carry out the evaluations; the evaluations can take place at

home, in an ambulatory setting, or in a hospital. Following this formal analysis, a second partnership takes place between the case manager and a group of professionals. Based on the multidisciplinary evaluations, the professional actors determine which services are available and appropriate for the client and provide a united recommendation for service orientation.

The hospital social worker in one case explained the professional partnership in these words:

All the team members are equal. We make a decision together; it is a consensus. First we each evaluate the patient in our respective discipline. Then we meet in the team to discuss the orientation. First we see if the patient is a candidate for rehabilitation. If rehabilitation is possible, we make a request for it. If not, then we evaluate if the patient can return home with CLSC services. In this case, we did not recommend that the patient return home, given his loss of autonomy and that his wife was exhausted. I contacted the case manager at the CLSC who agreed that the available home care services were inadequate. So the team recommended that the patient be admitted to a nursing home. (Monica, hospital social worker for Mr. Tremblay, lines 255-315, 370-380, 410-438)

This process took place at the hospital but reflects also the functioning in home care. The multidisciplinary team is a corner stone in home care as well. A home care administrator voices the important role of the home care multidisciplinary team in the following words:

We use interdisciplinary teams a lot. They are great as a way to validate interventions. One professional may say for example that it makes no sense for a person with a certain stage of Alzheimer's disease to live alone, but that depends, you know. The synergy of the multidisciplinary team is important, because different professions have different types of knowledge. Social workers may be less protectionist than nurses, but in sharing their knowledge, they find a certain equilibrium. (Jill, home care director; lines 140-143, 180-198)

This quote shows the importance assigned to multidisciplinary teams in home care. The team helps individual workers to validate or adjust their approach to intervention in a specific case. In this sense, the team forms a partnership that clarifies the appropriate service orientations and makes a united recommendation to the client and the family.

The second partnership has another important task to accomplish with regards to cognitively impaired clients. The actors in this partnership must make a professional judgment about the client's ability to make a decision about service orientation. This is particularly appropriate for clients who are in a grey zone of competency, that is, who are no longer fully lucid but who have not been declared legally incompetent either. Relying on professional judgment and cognitive evaluations from the previous stage, the partners in the second partnership determine to what extent the client is capable of making an informed decision regarding which services to receive. The home care administrator explains the difficulty associated with balancing the value of user self-determination with protection from harm when clients have cognitive impairment:

When users have cognitive problems, even if they have not yet received a diagnosis, things can get very complicated. The user's choice is always respected, but at the same time we have a duty to make sure that this choice will give the user a certain protection in his or her environment. The art of home care is exactly this dance around user choice and protection from danger. (Jill, home care director, lines 30-47)

The case manager in one case explains how a competency evaluation took place in practice:

The occupational therapist evaluated the client twice. This evaluation demonstrated cognitive problems in terms of poor short-term memory and diminished judgment. The client forgot explanations and claimed that she was autonomous. Then later on, I received a full geriatric evaluation stating that the client was incompetent for both finances and personal care. Her Folstein exam showed 13 on 30, I believe. That is when it became clear to me that nursing home admission was only a question of time. (Martin, case manager for Mrs. Jakobi; lines 73-86, 223-226)

Hence, the case manager evaluates in a partnership with other professionals whether the client is competent enough to participate in the placement decision. In this latter case, the client was considered to be incompetent. In the other two cases, the client was deemed competent enough to participate in the decision, that is, a partner in the third partnership.

Partnership Three: Service Orientation

In the third partnership, a decision is made on service orientation, meaning whether the client should be admitted to a nursing home or continue to receive services in the community. The client is included as an actor in this partnership if he or she was deemed competent in the second partnership. The main other actors are the primary caregiver and the case manager, the latter being replaced by the hospital social worker if this partnership takes place in the hospital. The partners choose between the pertinent and available service options identified in the second partnership and negotiate an orientation. If this negotiation does not result in a consensus on nursing home admission, home care continues and the decision-making process may start over (see Figure 6). However, if the partners agree on a nursing home admission, a formal request for admission is made.

Two clients participated in this partnership. Although these clients contributed to make the placement decision, their agreement was reluctant. Both clients voiced a sentiment of feeling unwanted and obliged to accept a nursing home admission. As indicate the following quotes, neither of the clients perceived themselves as partners in the nursing home decision, while other actors indicated the contrary:

Case B

A man [the case manager] came to the house and talked to me. He made me sign that I should go to the hospital. He said I should go and made me sign. I had no choice. (Mrs. Safa, **client**, lines 40-54)

I had a formal meeting with the client and her husband to finalize and sign the nursing home request. They had already discussed nursing home admission and I had met with the husband earlier on to discuss this. It was certainly collaborative because there had been a lot of discussion. I recall, though, that the husband seemed quite resolved at this meeting. The client asked her husband for his preference, and he said that he would prefer that she accept a nursing home. There was no argument. Her discourse was somewhat disorganized, but I think she perceived her husband's wish.

Then she said she would go. I think she understood what was going on, but I am not sure, though, that she understood all the implications of it. (Alex, **case manager** for Mrs. Safa, lines 162-178)

First my wife did not accept to go to a nursing home. Then the social worker came and persuaded her to go. I also persuaded her, because you know it was really bad at home. Finally she said, "Okay, I will go". She had to decide herself to go or not, because I am not forcing her. The law is like that, you cannot force somebody to go to a nursing home. She is free to decide for herself, but you know she has little judgment; you have to repeat everything three or four times to her (Mr. Safa, **caregiver**, lines 36-54).

Case C

The hospital sent me here. It must have been their decision. I did begin to question if I should find a place where they would accept me. You know, I was no longer autonomous. Then you need to go to a place where people are not autonomous and all this. I would like to return to the way I was before and go home to my wife. But at this age, you know, it is not easy. (Mr. Tremblay, **client**, lines 184-207)

The patient was more consenting than his wife to a placement. Rationally, he accepted and consented to a nursing home admission, but the emotional separation from his wife was very difficult. He had not yet dealt with that. (Monica, **hospital social worker** for Mr. Tremblay, lines 83-191)

The patient does not think he can return home. He is looking for a place with domestic services and help with bathing and a possibility that his wife may stay there as well. Orientation: permanent nursing home. (**Occupational therapy evaluation** from the hospital, Mr. Tremblay's client file)

Both clients express here that they accepted nursing home admission for a lack of real alternatives. The first client seemed to feel more resentment than the second one, possibly because of her much younger age, which may have made a nursing home admission less acceptable. The caregiver and professionals express a somewhat different viewpoint, suggesting that the decision was made in a partnership. The disparity in how the actors perceived the partnership testifies to the complexity of a partnership among essentially unequal actors. Although the decision on service orientation is made in a partnership, the negotiating positions of the actors differ. The client, not being autonomous, has less freedom

than do other actors to speak freely and push for an acceptable solution. In other words, there is an important power differential between a non-autonomous client and his or her caregiver. A home care administrator voices this power differential in the following words:

There are rarely open conflicts between clients and caregivers, because a person in loss of autonomy cannot afford really to be in conflict with the caregiver. One client I heard of said nothing but cried profoundly when she was admitted to a nursing home. She accepted admission, because in the end it was maybe best, given that she was not desired anywhere (Jill, home care director, lines 111-125).

This quote shows that the client has a disadvantaged position in the negotiation with the caregiver because of dependency on help. The caregiver, in turn, is dependent on the health care system for home care services. If community and home care services are very limited, caregivers are left to fend for themselves until they can no longer continue in their role as caregiver. The home care administrator explains in the following quote how inadequate home care services can limit the choices available to clients and caregivers:

It is clear that we have limited financial resources at our disposal. When we cannot offer the services mentioned in the reference guide because we do not have the required resources, then the person's choice is limited. She has a choice, yes, but few alternatives. If she wants to stay at home, a professional evaluates her needs and tries to find the least costly solutions. But obviously her choice is limited by the services we can offer her. (Jill, home care director, lines 67-76)

This quote illustrates how financial restraints can easily limit the negotiation on service orientation to a choice between inadequate home care or nursing home admission. If community services are inadequate, the only alternative to nursing home admission is a refusal of nursing home admission, no matter the consequences.

In one case, the client was excluded from the decision regarding service orientation (the third partnership) because of her level of cognitive impairment. Instead, the caregiver and case manager came to an agreement on the need for a nursing home admission and

made a formal request. The client categorically refused admission. When the client refuses to go along with the decision on nursing home admission, whether or not the client participated in making this decision, the decision-making process proceeds into the fourth, optional partnership.

Partnership Four: Alternative Admission Strategy

The fourth partnership brings together the caregiver, the case manager and the multidisciplinary team to decide whether to pursue nursing home admission in spite of client refusal. The client is not included in this partnership. The partners evaluate the risk associated with the client's remaining in the community against the risk of pursuing an involuntary nursing home admission. One client lived alone and refused available community services as well as nursing home admission. The caregiver explains the risks that she encountered at home:

My mother had a bad habit of opening the oven completely and putting her feet on the hot oven door. She would wear slippers. I told her it was dangerous, that some materials burn, but she would not listen. Sometimes she would also cook in her kimono with long sleeves. I told her she was too close, that her sleeves could catch fire. She just told me that she knew what she was doing, that she did not need a babysitter, a watchman. She would call me names and tell me to go home, but I could not leave her alone like that. The doctor also said that my mother could not live alone because something dangerous could happen to my mother and to all the people who live here in the apartment block. (Mr. Jakobi Jr., caregiver, lines 141-143, 171-173, 317-319, 418-428)

The case manager has a similar perception of the risks to the client but added the risk of caregiver burn-out. He said:

The son [caregiver] came to sleep at his mother's place every night, because he was worried for her. He did not want to leave her alone because of her cognitive problems. She would forget to close the tap in the kitchen sometimes and in the winter she would warm her feet on the open oven door,

putting tape around her slippers to protect against too much heat. The son did most of the cooking, cleaning and shopping for her, but she got very upset with him for helping her. The situation got worse and worse. It was really precarious. I doubt the son could have lasted much longer in the end. But I did not want to intervene before the son was ready to collaborate with me. (Martin, case manager for Mrs. Jakobi, lines 122-128, 159-180, 524-530)

The case manager expresses a concern about the high risks to the health and well being of both the client and the caregiver. Moreover, he voices a concern about intervening prematurely. He recognized the risks but evaluated when the timing was right for intervention.

After evaluating the risks, the partners in the fourth partnership decide to pursue or abandon the nursing home orientation. If the actors decide not to pursue nursing home admission, or if they do not reach a consensus, inadequate home care services continue with a high risk to the health and well being of both the client and the caregiver. The decision-making process may start all over again awaiting further deterioration before actors attempt an alternative admission plan (see Figure 6). Health care professionals may in an extreme situation exclude the caregiver from this partnership and proceed with protective interventions without consent from either the client or the caregiver. If the partners do reach a consensus on pursuing nursing home admission, a strategic admission plan is developed and later implemented. This plan can span from legal action to white lies or subtle misrepresentations that aim to increase the likelihood of an actual admission. In this one case, the actors decided to pursue nursing home admission when the caregiver became clearly unable emotionally to pursue his caregiver role under the difficult circumstances. The case manager presented different admission strategies to the caregiver and the multidisciplinary team, and the caregiver reacted to the different options. The caregiver explains his reactions in the following way:

[The case manager] was thinking about going to court to get a letter from the judge, so that my mother could be forced to go to a nursing home. I said “no stop that, we can work on that slowly”. He called me later when a place at the nursing home became available. Then he asked me not to say anything about it to my mother, to tell her that she needed to go to a doctor’s appointment. That is what I did. Then when we arrived at the nursing home, she complained that she never saw any doctor. Next day, they told me she was doing fine. (Mr. Jakobi Jr., caregiver, lines 146-165)

This quote suggests that the caregiver felt some ambivalence about not telling his mother the whole truth and an even stronger discomfort with legal action as a means to protect his mother. The case manager expresses a similar discomfort with intervening against the wishes of the client:

We tried all the different possibilities. We tried home care services for six months, which she refused; we sent her once to the hospital in an ambulance to be evaluated, but she left before seeing a doctor; we got her calming medication to diminish her aggressive behaviour with her son, but she stopped taking it. I was really worried that we had to take legal action. In the end it worked to tell her a white lie about going to a doctor’s appointment. But this strategy almost failed, because the son had told his mother about the whole thing when the nurse and I showed up to accompany them to the nursing home. He was very ambivalent about it all. It was like he had one foot on the accelerator and one on the brake, almost as if he wanted our strategies to fail. In the end, the client was delighted when she arrived at the nursing home because some staff spoke her native language. (Martin, case manager for Mrs. Jakobi, lines 222-242, 254-266)

This quote shows that the admission strategy eventually was successful. If the strategy had failed, home care would have continued and another strategy may have been attempted later. Alternatively the entire decision-making process might have repeated itself later when the situation deteriorated further. The quotes also indicate that the fourth partnership is used as a last resort when everything else has been tried.

The fourth partnership seems to represent an ethically delicate situation in which a decision must be made about whether it is justified to use “white lies” or legal measures to make a nursing home admission take place. The fourth partnership appears to constitute the

most ethically ambiguous and emotionally difficult part of the decision-making process for family members and health care professionals. A coordinator of nursing home admissions at the Regional Board confirms this ethical problem:

If the client refuses nursing home admission, we will not allow the placement process to take place. If the family member is able to persuade the person to accept a nursing home placement, we go along with it, just to the point where the client is willing to go. I mean we cannot drag somebody to a nursing home, because they are supposed to be voluntary unless it is a court order. If the client says, “no, I do not want to go”, then the family member has to take out a legal mandate, which of course can take a couple of years. So if the person is in dire straits at home and a family member cannot look after them, we are kind of stuck with the problem. The hospitals are already overloaded, so we continue in the grey zone. We do not get directly involved in the clinical aspect; this we leave to our partners wherever they are to work at, but we are aware. We may get a phone call from the nursing home, saying, “Listen, the client has not been informed, the social worker left, and here we are! We do not know what to do“. But I think the workers become quite adept at handling these situations (Mona, coordinator of nursing home admissions at the Regional Board, lines 22-41, 204-209).

In this quote, the admissions coordinator acknowledges the ethical and clinical dilemmas of the fourth partnership and describes the grey zone it represents in clinical practice. The caregiver and case manager in case A both voiced great discomfort with going behind the client’s back to plan a nursing home admission, although this protective measure was clearly required and all alternatives had been carefully considered and explored beforehand. The case manager expresses the ethical dilemma he faced in these words:

This case consumed a lot of my time and energy. At times I did not sleep well at night. I did not want to intervene too early, because if the strategy failed, we would be no further ahead. The client would still be at home at a high risk and the caregiver would still be exhausted. Yet it was getting more and more risky at home. I was worried about the son. You never know what might happen, always worrying about being blamed, about legal consequences, about a complaint to the professional order. I felt caught in an ethical dilemma and I had to rely on my professional judgment to decide how and when to intervene. On an ethical level, it was really tough. (Martin, case manager for Mrs. Jakobi, lines 431-465)

Like this statement indicates, the fourth partnership presented an ethical dilemma for the case manager. The same intensity of ethical preoccupation was not raised in the two other cases in which the fourth partnership did not come into play. This finding suggests that the fourth partnership is the most draining on case managers. It seems to contradict fundamentally with the value of respecting clients' right to self-determination and to present ethical dilemmas for which there are few guidelines for intervention.

Discussion of Actor Roles

As demonstrates this conceptual framework, many different actors play a role in the decision regarding nursing home admission. Different actors exercise their influence in different parts of the process. The client seems to have the greatest potential to influence the process by convincing other actors of a certain reality and solution (partnership one) and by refusing an undesired nursing home admission (partnership three and four). In refusing admission, the client may prolong the process by restarting the decision-making process. Thus, the client's influence in this decision is largely reflected in his or her ability to not terminate the decision-making process.

The primary caregiver and other informal caregivers seem to have much influence in terms of negotiating reality and solutions (partnership one). For example, caregivers may convince the case manager that the available help from family, home care and community services is insufficient to care for the client and sustain the primary caregiver. Caregivers also appear to have much potential influence on service orientation, that is, on the decision to make a nursing home request (partnership three) and in deciding whether to proceed with an involuntary nursing home admission (partnership four). While caregivers cannot

determine the outcome, they seem able to partly determine the speed of the decision-making process, at least as long as home care does not present a significant health risk. As one case manager (Martin) stated metaphorically, “the caregiver had one foot on the accelerator and one on the brake”. While caregivers may influence the process in terms of the speed of the decision-making process, caregivers also have emotional attachments and moral obligations that make it unlikely that they will accept the nursing home admission of the person they care for before feeling obliged, emotionally or physically, to do so.

The case manager, being involved in all steps, seems to have an ability to influence the decision throughout the process. The case manager influences service determination in important, although not unlimited, ways (partnerships one, two and three). The case manager may, for instance, mobilize other actors to extend the range of available service alternatives, both in the community and the institutional settings. The case manager also affects role negotiations through his or her orientation to decision-making and to client competency (partnerships one and two). In fact, the case manager seems to have an important say on whether the client is considered competent enough to participate in the partnership on service orientation (partnership three) and whether it is pertinent to initiate an alternative admission plan (partnership four).

The role of other health care professionals seems to be centralized in the first partnership and in the professional evaluations. Other professionals may participate at all levels of the process but seem to exert most formal influence in the professional evaluations and in the identification of pertinent service options (partnership two). The role of the hospital social worker is particularly important when the process, or parts of it, takes place in the hospital setting. In that case, the hospital social worker may almost completely replace

the case manager. The only exception is the determination of available home care services and the formal agreement to proceed with a public nursing home admission. A current research project (SIPA) suggests that changes may be made to increase the roles of the case manager during client hospitalization (Bergman et al., 1998).

Health care administrators at all levels also seem to influence the decision regarding nursing home admission. This influence is manifested in budget allocation and access to public services. The home care director voiced that when the budget for home care is insufficient to provide required services in the community, clients are left with few choices. Health care administrators affect the decision-making process in terms of making certain services available and limiting others. For instance, in limiting funding for hospitals, administrators contribute to shifting the decision-making process from the hospital setting to home care whenever possible. In limiting funding for home care and public nursing homes, they require elderly people with a loss of autonomy to rely more on informal caregivers and on community and private services. This administrative influence on the decision-making process is largely invisible, but its effects are quite real to those who compensate for it, primarily informal caregivers (Guberman et al., 1993). The role of budgeting is recognized in a recent policy evaluation that recommends an increase in resources to home care and nursing homes in order to optimize the quality of life for elderly persons with a loss of autonomy (Commission d'étude sur les services de santé et les services sociaux, 2000, p. 70).

The conceptual framework for the clinical decision-making process (Figure 6) suggests that this process is very complex indeed. Not only does it involve many more actors besides the case manager, it also subdivides the decision regarding nursing home

admission into many steps. The decision-making process include up to four partnerships with specific decision-making mandates. One difference noted between the home care and hospital settings is the change of actors. In the hospital setting, the hospital social worker largely replaces the CLSC case manager, and the hospital multidisciplinary team replaces that of the CLSC. Another difference is that the decision-making process seems to proceed more rapidly in the hospital setting. One reason for this appears to be the imperative to liberate hospital beds; another reason seems to be that clients are often hospitalized following a major event that triggers a significant drop in autonomy. The decision-making process spans over a longer period of time in home care. The file analysis shows that the first consideration of nursing home admission took place in home care one to three years prior to admission.

The conceptual framework suggests that the decision regarding nursing home admission is more complex in practice than suggested in policy. A clear discrepancy emerges in a comparison of the conceptual model of practice with the formal model presented in the Regional Board's reference guide (Regional Board of Health and Social Services Montreal-Centre, 1996). Figure 8 illustrates the Regional Board model superimposed on the conceptual framework of case management practice. This illustration shows that the Regional Board's view of the decision regarding nursing home admission is much simpler than the conceptual model of clinical practice. This diagram further indicates that the Regional Board model includes none of the four partnerships of the conceptual model of case management practice; it also does not include the option of clients refusing a nursing home admission. The discrepancy between the two frameworks suggests incongruence between policy and practice. This incongruence constitutes a very

CHAPTER 5: DISCUSSION

Summary of Research Findings

The grounded theory of case management practice shows that the partnership concept is applied extensively in clinical practice (see Figure 6). Case managers engage in several distinct partnerships with clients and primary caregivers, as well as with multiple other actors, in making the decision regarding nursing home admission. The decision-making process was found to include several steps and choices along a potentially circular path that eventually led to nursing home admission. Cognitively impaired clients participated in some partnerships but were excluded from the decision regarding service orientation (the third partnership) when case managers judged their cognitive impairment to be too advanced for informed decision-making. The clients who did take part in this partnership had a compromised status as partner; their dependence on others and lack of real alternatives put them in a disadvantaged negotiating position. Caregiver and other family members participated in most of the partnerships. They accepted nursing home admission as a last resort when they were no longer able to pursue their role as caregiver for physical or emotional reasons. Their wish to avoid nursing home admission conflicted with a harsh reality of having few other alternatives left. Case managers expressed a strong support for consensus-seeking and client self-determination. Much discomfort was voiced when a case manager had to pursue an involuntary admission of a cognitively impaired client (partnership four). This situation gave rise to ethical preoccupation for the case manager involved; the case manager voiced concerns about the proper way to intervene when negotiation proved insufficient.

The research results from the grounded theory analysis, combined with the textual analysis, show partnership to be adopted as the primary mode of operation in the health care system. The meaning of partnership, namely that all actors work together as equals to reach a shared goal, is clearly an ideal in all four interpretive communities. The four institutional levels of the Ministry of Health and Social Services, the Regional Board, the CLSC, and case management practice adopt partnership as a general framework for providing health care. The popularity of the partnership metaphor appears to be related to its connotations of synergy, win-win, collaboration, and equality. These connotations represent current social values and ideals and are therefore indispensable as principal corner stones of the health care system. This research confirmed that the partnership metaphor is indeed a vehicle of current values and that it constitutes a gold standard at all levels of the health care system.

The findings indicate, however, that the different institutional levels disagree on how to apply the partnership metaphor. This disagreement is manifested in the selection of objects and actors appropriate for a partnership. The actor and object analyses of the written material (policies, guidelines, and client files) show that there is little agreement among the four levels with regards to which actors are, or should be, participants in the decision regarding nursing home admission (see Appendixes B & C, Figures 4 & 5). The grounded theory analysis complements this finding by demonstrating how partnership applies to the placement decision within case management practice. This analysis indicates that case managers operate with up to four different partnerships in the decision-making process regarding placement. Each of the four consecutive partnerships unites a certain set of actors to make specific, subordinate decisions that may eventually

lead to a nursing home admission. The file analysis confirms that case managers consider the placement decision to be an appropriate object for a partnership; they include multiple actors within it: clients, primary caregivers, other family members, CLSC actors and external actors (see Figure 5). Case managers' application of the partnership metaphor contrasts most importantly with the Regional Board model, which excludes the placement decision from a partnership. The Regional Board assigns this decision primarily to the case manager, at most in collaboration with other health care professionals. Figure 8 visually represents the differences between these two interpretive communities with regards to the applicability of the partnership concept to the placement decision. This difference indicates incongruent applications of the partnership metaphor in policy and practice.

Implications for Research

Nursing Home Decision-Making

The research findings contribute to the extensive body of research on the decision regarding nursing home admission. One significant contribution of this research is the conceptual framework, the grounded theory, of case management practice. This conceptual framework has implications for the research design employed in studying the placement decision. The following section discusses the research contributions of the current study and suggests avenues for future research on the placement decision, particularly with cognitively impaired elderly clients.

Much research on the decision regarding nursing home admission conceptualizes this decision as a process, yet many studies operationalize this decision as a specific

event in time, as one action that precedes the nursing home application (Cox, 1996; McAuley & Travis, 1997; Minichiello, 1987). The current research suggests that this notion of *decision* is somewhat flawed in that it only represents the second and third partnerships in the conceptual model of practice (see Figure 6). According to this conceptual model, the decision-making process is comprised of many steps and several subordinate decisions that may both precede and follow an application for nursing home admission. Even if previous studies potentially conceptualize *decision* very broadly, they tend to merge all the different steps into one unit (Cox, 1996; McAuley & Travis, 1997; Minichiello, 1987; Schneider & Sar, 1998). In so doing, they obscure the dynamics of the decision-making process. Research on the relative influence of different actors in the placement decision could be much improved by incorporating current research findings. As actors change from one partnership to another in the decision-making process, it is important to specify which partnerships, or steps, are objects of study. If the entire process is studied as one unit, important aspects of actor influence are easily missed. The conceptual framework developed in this study can enhance research designs on the placement decision by allowing for more specification of different actor roles than has previously been possible. For example, this conceptual model makes it possible to examine how one actor may exert great influence in one of the four partnerships but have a marginal say in another. This specification provides more valuable information than a finding that one actor accounted for half the total influence in decision-making. Moreover, this model facilitates the study of elderly people who refuse nursing home admission. This dimension of the placement decision has received insufficient attention

in research (McAuley & Travis, 1997), possibly for a lack of appropriate conceptual models. Previous research (Cox, 1996; Minichiello, 1987) may have designed the study to examine only the second or third partnership or may have disallowed the recruitment of participants who successfully refused nursing home admission. Hence, previous research designs may have missed the role of resistance that clients can exercise throughout the decision-making process. Although resistance is not a desirable form of power and influence for clients, it is nevertheless a source of influence that should be included in the notion of decision-making. This is particularly important given that research testifies to nursing home admission being a rather unappealing orientation for most elderly persons (Minichiello, 1987; Schneider & Sar, 1998). The current research may facilitate the inclusion of this population in future studies on the placement decision. The conceptual model may, for instance, allow researchers to design a study that targets the dimension of the decision-making process that has particular relevance to this population, e.g., the fourth partnership. The existence of a pertinent conceptual framework is a necessary condition for recruiting participants who successfully resist nursing home admission.

Although future research may benefit from incorporating the findings from this study, precautions should be taken until this conceptual model has been validated. The conceptual model is grounded in practice and has been validated by case managers, but it nevertheless builds on a small amount of data. It is appropriate to validate this model through further research in order to ensure its validity and general applicability. For instance, it is appropriate to verify if this conceptual model is equally applicable in the community and the hospital setting, and whether there are variations from one home care

program to another. It is also appropriate to validate the four partnerships and their connections to one another, both with regards to cognitively impaired clients and with other client populations.

Following validation, this conceptual model may contribute to evaluative research on current practice and administration in home care. Applied as a theoretical framework for a large-scale analysis, this model can help to clarify the professional resources devoted to the placement decision. Such a clarification may be useful to health care administrators and professionals alike in terms of identifying how public resources, in terms of professional time, are distributed at different stages of the process. Currently, administrators only have access to statistical information on the time it takes professionals to fill out the formal nursing home application in the presence of the client or caregiver (Ministry of Health and Social Services, 2000). Given that the current research indicates that the total time span from the first partnership to nursing home admission covered one to three years, the act of completing the formal application is beyond doubt miniscule compared to the total amount of time that professionals devote to the placement decision. Information on the allocation of case management time is relevant for measuring and adjusting case manager caseloads, which is currently a preoccupation in home care. Moreover, information on case management time allocation is likely to be increasingly relevant in the short-term future, given that the Ministry of Health and Social Services (2001) has recently expressed a commitment to extending the application of case management in the field of long-term services to the elderly population. This document acknowledges a particular concern with the growing population of elderly people with cognitive impairment.

Policy Metaphors

The research findings also have implications for research on the social construction of policy, particularly on the role and impact of policy metaphors. The current research contributes to this field by offering suggestions for designing research according to the methodology of interpretive policy analysis (Yanow, 2000). It suggests ways in which the partnership metaphor may be subjected to a policy analysis. This study also contributes empirical data to the current body of social constructivist research on policy metaphors. More specifically, this study advances knowledge on how partnership as a policy metaphor affects clinical practice. Not only does the current study demonstrate this impact but it also identifies how a policy metaphor can be interpreted in multiple ways and how its inherent limitations in application can easily be overlooked and give rise to certain problems. These findings are important for advancing social constructivist research on policy language and increase the knowledge on the impact of metaphors in action.

Implications for Policy and Practice

Current Debates in Policy and Practice

This research has implications for several of the current debates in policy and practice. There is currently debate in case management practice about the potential conflict between the role of the case manager and that of a professional. Social workers who act as case managers often raise a concern about professional obligations and a divided loyalty between the individual client and multiple other stakeholders in the health care system. There is also debate about the risk of burn-out. Part of this debate is tied to

current problems in determining an appropriate caseload for case managers. Efforts are currently under way in several home care programs to validate and implement caseload measurements in order to facilitate the evaluation of real caseload charge as opposed to simply counting the total number of clients. Moreover, there is debate about the invisibility of much case management practice. The statistical system currently in use (Ministry of Health and Social Services, 2000) does not allow for the recording of much of the work done by case managers. This statistical system only measures specific service acts, not the time devoted to negotiation, collaboration, and coordination. Hence, there is little formal recognition of the time devoted to case management.

In the domain of policy, current debates are captured in a recent report on recommendations for improving the Quebec health care system (Commission d'étude sur les services de santé et les services sociaux, 2000). Requested by the Quebec government, this report is written by an expert panel referred to as the Clair Commission. Some of the issues raised in this report are (a) future amendments to the *Canada Health Act* to explicitly incorporate home care services and (b) the sub-standard financing of home care in Quebec as compared to other Canadian provinces. This report recommends structural changes to the organization and financing of both home care and family medicine. It proposes that case management be officially adopted and expanded as an organizational model of home care. Moreover, it suggests that important changes be made to the financial structures of delivering public services to the elderly population with a loss of autonomy. This orientation follows partly from the preliminary results of a large-scale, government-funded research project (SIPA) currently under way in two Montreal CLSC settings (Bergman et al., 1998).

The Ministry of Health and Social Services has endorsed the recommendations of the Clair Commission in a recent policy that expresses future ministerial orientations to long-term services for the elderly population (Ministry of Health and Social Services, 2001). These orientations build in much flexibility in the structure of health care delivery.

The Ministry of Health and Social services writes that

the most important changes [in ministerial policy] exceed, however, and in a substantial way, the sector of health and social services. They refer to the way in which Quebec as a society reacts to the new phenomena of its aging population. The proposed orientations invite more flexibility in the structures and the resources in the health and social services sector as in all spheres of public activity. It is only at this price that Quebec can take up the challenge of managing the total question of aging. [translated from French] (p. 47)

This quote indicates that the Ministry of Health and Social Services intends its future orientations to promote more flexibility in service delivery to the aging population. This flexibility is perceived as an optimal way of promoting collaboration between multiple actors and hence of improving services. In this sense, partnership is endorsed as a corner stone of future orientations to health care delivery. A review of current policy documents suggests that this policy orientation is widely endorsed. The Clair Commission recommends, for instance, that partnership with the private sector and the third sector be developed further (R-26) (Commission d'étude, 2000). A recent report on improving home care policy also suggests a consolidation and further development of partnerships between the private and the public sector (Comité pour la revision du cadre de reference sur les services a domicile, 2000). These two policy reports indicate a broad support for partnership and flexible service organization. Changes are proposed primarily to the financial structures with the aim of optimizing the potential for creating and consolidating partnerships in health care. Hence, recent policy recommendations fully endorse the

partnership concept and promote flexible service delivery and organization as a means to optimize partnership.

Although recent reports promote maximal flexibility in the partnership construct, they also recognize a need to clarify the roles of different institutions (Commission d'étude, 2000; Comité pour la revision, 2000). The report by the Clair commission recommends that the respective mandate, roles and responsibilities of the primary health care institutions be clarified (Commission d'étude, 2000). It states that the role of the CLSC needs clarification (R-3) as do the roles of the Regional Board (R-32) and the Ministry of Health and Social Services (R-31). The report on home care policy further recommends that the role of different actors in home care be clarified (Comité pour la revision, 2000). This report mentions that role clarification is needed because the latest reference guide (from 1994) allows for multiple interpretations and is unclear on how responsibilities are to be shared among actors (p. 1). Hence, these two reports both recommend a clarification of actor roles. As a suggestion for how to address this issue, the two reports propose more specification of actor collaboration. The Clair commission suggests that the Regional Board and clinical institutions develop shared objectives and state them clearly in triennial performance contracts for which they can be held accountable (R-36) (Commission d'étude, 2000). The report on home care policy suggests more specification of the type of collaboration that the Ministry of Health and Social Services intends to have with its partners. Hence, the two reports propose that the partnership concept should be developed further but also recommends that specific forms of collaboration be made more explicit.

Current policy debates suggest that policy makers hesitate to promote maximal flexibility in service delivery without clarifying the roles of different actors and institutions. Flexibility is considered an important dimension of partnership, yet there is concern about the notion of accountability if actor roles are left widely open for interpretation. Although policy debates draw attention to this problem, the partnership concept is not itself an object of concern. This research suggests that caution is appropriate. The current application of the partnership metaphor may have certain limitations that are being overlooked in both practice and policy debates. These limitations appear to result from an inappropriate use of the partnership metaphor. The research findings suggest that it may be worthwhile to recognize these limitations and adjust the application of the partnership metaphor accordingly. The following section presents six problematic dimensions of how the partnership metaphor is currently applied and suggests strategies for improvement in policy and practice.

Research Contributions to Current Debates

Incongruent applications in policy and practice.

The results showed an important discrepancy in how the decision-making regarding nursing home admission is constructed at the Regional Board (*Le Guichet Unique*) and in case management practice. The findings showed that the Regional Board excludes this decision from a partnership, while case managers treat it as a process that includes three or four consecutive partnerships (see Figure 8). The Regional Board considers actors in the public system to have some relevance, while case managers

consider a multitude of actors to be pertinent, including the client, primary caregiver, other family members, CLSC actors and external actors (see Figure 5). Hence, there is a disparity between these two institutional levels in terms of which actors are considered pertinent to the decision regarding nursing home admission. That is, different institutional levels assign different actors to the same task. This disparity is likely not coincidental but rather an indication of divergent interests, expressed in a subtle way through the specific construction of partnership.

The designation of an object for a partnership and the selection of partners are not neutral tasks. Actors have interests in how the partnership metaphor is applied, that is, actors are stakeholders. They may agree on the general values of equality and collaboration, but they are likely to disagree on which objects should be exclusive domains--to them--and which objects are appropriate for sharing. This research indicates that many actors feel an entitlement to make the decision regarding nursing home admission--often autonomously. Clients, for one, wish to decide for themselves where to live, and they are entitled, with few exceptions, to determine their own life course and decide themselves which public services to receive. Caregivers also feel an entitlement to make this decision, or at least to transfer their caregiver role to others if they can no longer cope with its demands. The only transfer possibility may be nursing home admission, for which reason caregivers may feel entitled to make this decision. Finally, health care administrators may also feel entitled to make this decision, or to transfer it to the case manager because of their responsibility for managing public resources cost-effectively. They also have a claim, an entitlement, an interest in making this decision. None of the three actor groups may consider it appropriate to apply partnership to the

placement decision, given that they each may think themselves more entitled than other actors to make this decision. They all have something at stake in how the partnership concept is applied to this decision and which actors are selected as pertinent. Their interests are not necessarily compatible at all times. A client may wish to remain home, while the public system considers this option inappropriate for the purpose of cost-effectiveness. When actors do not have a shared goal, partnership is used primarily as a synonym for compromise. Not only is this use inappropriate, but it also gives rise to problems.

It can have negative implications for clinical practice when different institutional levels apply partnership differently to the same situation, i.e. to nursing home decision-making. Case managers and hospital social workers may feel frustrated that the extensive negotiations involved in making this decision are not officially recognized. This work is made invisible in the formal model of the Regional Board as well as in the statistical system that measures clinical activity in the CLSC (Ministry of Health and Social Services, 2000). This invisibility arises from partnership not being applied to the placement decision at the Regional Board, or at the most to collaboration between public system actors. This invisibility can negatively affect the motivation of case managers and hospital social workers. They can easily come to feel unrecognized for the difficult work they accomplish in consensus seeking with multiple stakeholders. This discrepancy may also give rise to diminished collaboration between case managers and other health care actors. Other actors in health care, basing their expectations on the formal model of the Regional Board, may be frustrated that a nursing home admission does not always take place when health care professionals agree that it is clinically indicated. They may

inadvertently direct this frustration at case managers (or hospital social workers) who are easily perceived as the cause of *status quo*. These false expectations may result in frustration and give rise to mistrust among actors. Mistrust can lead to diminished collaboration, both within the home care program and between the CLSC and other public institutions. If actor collaboration suffers, it can impact negatively on the quality of care. Home care is fundamentally premised on an extensive collaboration among many actors. If this collaboration is undermined, the quality of care will suffer. Congruence between policy and practice is needed to optimize the quality of care and the working conditions for case managers.

For these reasons, different institutional levels may benefit from not applying the partnership concept differently to the same object. Case managers and pertinent Regional Board staff could maybe interact directly with each other to develop a model for nursing home decision-making that is both pertinent and feasible in practice. The first step in doing so may well be to recognize the importance of how partnership is interpreted and implemented, not simply of its merit as a concept. This research can facilitate the task of creating congruence between policy and practice by offering a representation of current incongruence in application.

Role flexibility.

Actor roles are currently very flexible. This flexibility is reflected in partnership being applied in multiple ways to the same object (see Appendixes B & C). Different interpretations of the partnership metaphor give rise to actor roles that are closely tied to how partnership is applied in practice. Actor roles change when there is a change in how

partnership is implemented. Changes in the partnership construct from one institutional level to another suggest that roles are indeed left very open and flexible. Role flexibility means that the responsibilities and decision-making powers of different actors are negotiable from one situation to another. Actors negotiate their own roles from context to context. Current case manager workshops offered by the Regional Board (Guérand, 2000) confirm that negotiation is considered increasingly pertinent for case management practice. Their availability suggests that case managers need these negotiation skills to negotiate roles and solutions. The idea is that role flexibility allows actors to unite their efforts to create partnership synergy.

Several policy documents endorse the flexibility of responsibilities and decision-making powers and construe role flexibility as a means to optimize partnership (Comité pour la révision, 2000; Commission d'étude, 2000; Ministry of Health and Social Services, 2001; Secrétariat à l'action communautaire autonome du Québec, 2000). The positive dimensions of role flexibility are also well recognized in the literature, although many obstacles are identified to its implementation in practice (Boyce, 1998; Courtney et al., 1996; Darling, 2000; Lord & Church, 1998; Panet-Raymond & Bourque, 1991). Applying partnership with its connotations of equality intact appears to be easier said than done. Role flexibility can certainly be an advantage in terms of increasing the ability to adapt actions to reach a shared goal. It can also incite multiple actors to engage in a partnership when they are considered to be equals from the point of departure. These positive dimensions of role flexibility are an important improvement in policy, yet role flexibility has certain risks that are not sufficiently acknowledged in current debates. Most importantly, there is a fine line between role flexibility and role evasion. When

roles are left flexible, it is very difficult to hold anyone accountable. Actor responsibilities that are negotiable from context to context leave only legal boundaries to prevent powerful actors from negotiating very favourable roles for themselves and leave less attractive tasks to the actors with little negotiation power. The state is often the most powerful actor in health care. Thus, role flexibility also means that the responsibilities of the state are flexible and context dependent. The state, having a good negotiation position, will have much flexibility in a partnership to determine its own role in health care. The state may pick its role first and leave other actors to choose theirs in order of respective negotiation power. Caregivers and clients, often having less power, are likely to be left with tasks and responsibilities that no one else is willing to take. This potential implication of role flexibility can have negative consequences for clients and caregivers. If the state slowly removes resources from health care, case managers will have less to offer and be obliged to pick a minimal role for public actors. Clients and caregivers will then have little recourse if they disagree with the outcome of role negotiations. The state cannot be held accountable to the public if its mandate is vague and context dependent.

It may be worth the effort to devote more attention to the risks associated with role flexibility as it may prevent current risks from turning to reality. It would be appropriate to define a set of minimal responsibilities for different actors, including the state, caregivers, and clients, leaving only *some* room open for role flexibility. This recommendation is relevant to the current debates surrounding an extension of the case management model. More clarification of actor roles can protect not only clients and caregivers but also case managers. It may prevent case managers from spending much time on basic role negotiation and hence avoid that excessive stakeholder conflicts

consume much of the case manager's time. Some pre-established role clarification can leave more time for fine-tuning collaborative relationships that facilitate service delivery.

All roles need not be set in stone, but it might be wise to restrain the application of the partnership metaphor. Partnership could be confined to a more restricted space by ensuring that there are minimal definitions of nonnegotiable actor responsibilities for which actors can be held accountable. Roles are currently specified in laws and policies, but it may be wise not to erode these specifications in an excessive effort to create partnership synergy. It may also facilitate case management practice if the role of the state is presented realistically to the public through policy. Clients and families are then more likely to have realistic expectations of the health care system. The conditions for case management practice may also improve if the responsibilities of the client and the caregiver are clarified. For instance, it may enable a clarification of the case manager's obligation for intervening rapidly when negative consequences arise from a client or a caregiver refusing recommended services.

Role flexibility also makes for a very ambiguous organizational structure. If actor roles of different public institutions are left too flexible, collaboration is rendered more difficult. Roles will need to be negotiated before collaboration can even take effect. If there is little time available to negotiate roles, actor collaboration will be compromised and the quality of care will suffer. Hence, predefined structure is not necessarily an obstacle to partnership; it can also facilitate collaboration between actors. Partnership, applied in its most flexible sense, can thus compromise the quality of care. The currently flexible application of partnership cannot be characterized as an organizational structure but constitutes rather a flexible mode of interaction. The partnership metaphor needs to

be applied consistently to the same objects and actors if it is to serve as the basic organizational framework in health care. To be most effective, partnership should be accompanied by a basic definition of actor roles and a clear indication of the flexible space left open for creating synergy.

Disconnection of Responsibility and Decision-Making

Another problematic application of the partnership metaphor is its application *only* to responsibility *or* to decision-making. Current use of partnership terminology in policy and practice tend to ignore this link and focus exclusively on either responsibility or decision-making as an object for partnership. The same holds true for much research (Boyce, 1998; Boyer, 1995; Charles, Whelan & Gafni, 1999; Lord & Church, 1998; Krogh, 1998; Minichiello, 1987). Insufficient attention has been devoted to looking at the link between responsibility and decision-making within a partnership. Most actors, of all types, are quite eager to obtain maximal decision-making powers while minimizing their responsibility for providing or funding long-term care. However, there is a connection between responsibility and decision-making powers in the sense that an actor who has much responsibility in an area might rightfully feel entitled to a large say in decision-making. This connection is confirmed in empirical studies showing that caregivers feel increasingly entitled to make the decision regarding placement when the person they care for lives with them or experiences increasing loss of autonomy (Lesemann & Chaume, 1989; Minichiello, 1987). Hence, when family members assume more responsibility for caregiving, they may also expect to have a more important role in decision-making. This

relationship between responsibility and decision-making is not surprising, but it is surprising how rarely it is acknowledged in both policy and research.

It is important to avoid separating responsibility and decision-making in the application of the partnership metaphor. For one, it is unsustainable to divide responsibility among actors without also dividing decision-making powers. Partnership is considered to be a voluntary association of actors who all benefit from uniting their efforts to reach a shared goal. Actors may withdraw from a partnership if they have more to lose than to gain. If an actor gains responsibility and loses autonomy in decision-making, this actor may have little incentive to engage in a partnership. This problem is demonstrated by community organizations, which frequently voice a sentiment of being imposed certain mandates of responsibility while losing autonomy in decision-making (Panet-Raymond & Bourque, 1991; Secrétariat à l'action communautaire autonome du Québec, 2000).

The separation of the two dimensions can also have negative consequences for clients and caregivers. There is a tendency for one section of the health care system to apply partnership to responsibility (advocates of cost-effectiveness) and another section to decision-making (client and caregiver advocates). If these discourses are not integrated, it may result in clients and caregivers ending up with few public services but all the decision-making powers they may desire. Client and caregiver advocates endorse partnership in terms of sharing decision-making powers with health care professionals, i.e., the state (Charles et al., 1999; Opie, 1998; Krogh, 1998), while advocates of cost-efficiency apply it primarily to mobilize other actors to participate in long-care community care (Boyle, Gardner & Callaway, 1998; Beal, Crawford & O'Flaherty,

1997). A transfer of responsibility may well mean that clients need to rely more on family and private resources. Partnership may then serve to facilitate state withdrawal from long-term care. Client and caregiver advocates may therefore want to exercise caution in their endorsement of the partnership metaphor. To not undermine their own cause, they may be well advised to strive for an integration of the divided partnership discourse on decision-making and responsibility.

Conflicting interests between clients and caregivers.

Partnership is problematic when actors do not have a shared goal, given that this is a key feature of the partnership metaphor. Actors do not always have a shared goal when they have different and opposing interests. The partnership metaphor is sometimes applied in any event, possibly as a remedy for conflicting interests. This was the case in the third partnership on service orientation (see Figure 6). The actors did not have a shared goal; rather their interests were in direct opposition to each other. The client wanted to remain home while the caregiver was no longer able to provide the care required. There were no alternatives available that might have been acceptable to both the caregiver and the client. The partnership metaphor may be applied to this situation of conflicting interests in order to encourage a compromise, a collaboration, a consensus. But when the interests of actors go in different directions, that is, when there is not a common goal, the chance of creating synergy is not there. Hence, partnership is not applicable as a metaphor. It seems to be expected of case managers that they *make* partnership applicable to situations of conflicting interests, that they *create* synergy, even when there is not a common goal among different actors.

The partnership metaphor is used as a miracle solution when it is applied to a situation of conflicting interests. This application carries certain risks. For instance, it risks sending case managers out on a mission impossible, considering them to be ineffective negotiators if they cannot turn a situation of conflicting interests into win-win synergy. This may leave case managers feeling ineffectiveness and disillusioned and possibly increase the risk of burn-out. If a conflict of interest results from lack of community services, insufficient resources may increase the risk of burn-out. When the partnership metaphor is used as a miracle solution, it removes attention from the bigger issue of funding. As stated by the home care director in this study (Jill, p.84), client choices are limited when home care budgets are minimal and insufficient to meet needs. This problem is further entrenched by Quebec providing sub-standard funding for home care (Commission d'étude, 2000). The conceptual model also indicates that health care professionals determine the alternative options from which clients and caregivers may choose. This determination is not only a matter of pertinence but also of availability of appropriate services. When the options are limited by insufficient funding, choices are few and there is an increased likelihood that client's interests may conflict with those of the caregiver. The application of partnership to this situation may cover up the source of the conflict, namely budget limitations. The partnership metaphor, superimposed on reality as a miracle solution, suggests that case managers are miracle workers. However, partnership is a metaphor with a certain potential, not a guaranteed recipe for creating miracles on a small budget.

Actor inequality.

According to the research findings, partnership is presently applied in its most flexible sense, relying first and foremost on its connotations of actor equality and collaboration. All actors are equal and there is no limitation, in principle, on which actors qualify as partners. Anyone can be a partner in any one domain of health care--within the legal boundaries. Equality is an ideal that should be promoted and strived for, and no actors should be excluded from a partnership because of power inequality. However, there is a risk that promoting equality may disadvantage the least powerful actors in a partnership. These actors, being equal, will have no special protection; they are left to negotiate on equal terms with more powerful actors. They risk losing out rather than gaining, possibly even being considered participants in making decisions that they do not endorse. This problem is illustrated in the decision regarding service orientation (Figure 6, third partnership). The cognitively impaired client was included in this partnership in two of the three cases. An important power differential existed, however. The clients had little negotiating power, because they were dependent on others and had few alternatives to relying on the primary caregiver or accepting nursing home admission. Having little power to negotiate, these clients expressed a feeling of being pressured to accept nursing home admission, of being an object more than a partner in this decision. Other actors considered the clients to be partners and treated them as equals. Equality may characterize this partnership on service orientation in an abstract sense, but equality soon vaporized when the client had little power to negotiate. Lievrouw (1994) explains the disadvantaged negotiation position of clients in writing that

“negotiation” and “collaboration” between patients and providers often favor the provider. In all but the most extraordinary clinical situations the

knowledge claim of the provider (i.e., the clinicians view of the case) takes precedence over that of the client . . . The provider's claim is privileged in the process of communication with the patient, since the provider almost always set the terms of the problem, the parameters for its management, and what behavior is needed for its resolution, before "negotiation" can even start. (p. 96)

This quote confirms the difficulties for clients in negotiating on equal terms with health care providers. Being treated as an equal can be difficult for actors who find themselves in the disadvantaged end of an important power differential.

The implication of presuming equality is that existing power differentials between actors are obscured. In largely ignoring power differentials, or simply wishing them away, the partnership metaphor may give a false impression of consensus. If it is applied to essentially unequal actors, partnership may result in the least powerful actors feeling disillusioned or frustrated. This research indicates that clients who took part in the third partnership did not consider themselves to have engaged in a partnership. Had the partnership approach been made explicit to them, they may have been left feeling angry about being considered a partner when they had few alternatives to choose from and hence little margin for negotiation. Egalitarian terminology like partnership cannot by itself eliminate fundamental power differentials in society. The metaphor's connotation of equality may incite more powerful actors to treat less powerful ones as equals, but being treated as equal is not always in clients' best interests. Being equal also means that protective treatment and special consideration are not made available to clients. They must negotiate on equal terms to everyone else, and doing so can be quite difficult for clients with loss of autonomy and cognitive problems, particularly if they depend on others for care. The partnership metaphor may, at times, be used to camouflage power differentials, but it is worrisome to use it as a magic wand in an attempt to erase existing

inequalities and power differentials. This application may simply serve to marginalize actors with little power in the name of consensus and equality. Caution may therefore be advised when the partnership metaphor is applied to interaction among unequal actors.

Involuntary admission to nursing home.

The last of the four partnerships in the conceptual framework concerns the decision to proceed with an involuntary nursing home admission. This partnership was identified as the most problematic part of decision-making. The case manager framed this problem as an ethical dilemma, feeling caught between an imperative to intervene and a wish to respect client self-determination (p. 90). Although this finding is limited in scope, it is supported by the research finding that “86% of community case managers surveyed noted that safety issues create ethical dilemmas in their practice” (Kane et al., 1993, in Healy, 1999, p. 29). This quote suggests that the experience of this one case manager is not unique. The case manager framed this problem as an ethical dilemma and voiced a lack of protection for the case manager. The nursing home coordinator at the Regional Board acknowledged this grey zone in the nursing home admission procedure, suggesting that workers become quite adept at handling difficult situations with experience and training. The coordinator suggests that increased clinical training may alleviate this problem:

Home care is very tough on workers, because I do not hear the same complaints from people in other areas. Maybe there is not enough time for team discussions, or not enough clinical supervision. Or maybe workers do not have sufficient control over their workload, or they might need more training in crisis management. Some new workers I see have absolutely no training; they are really green. You know, you need to invest in the personnel if you want them to be around for a while (Mona,

coordinator of nursing home admissions at the Regional Board, lines 419-455).

The coordinator suggests here that clinical training may be one of several solutions to the clinical difficulties experienced by workers in home care. This suggestion appears to reflect the general orientation of the Regional Board in that this institution offers clinical training in negotiation (Guérard, 2000). The Regional Board may offer these workshops as a support to case managers in the sense that better negotiation skills may enable case managers to create win-win synergy when they meet obstacles in practice. This orientation suggests that partnership is considered a solution to dealing with the clinical or ethical problem of involuntary nursing home admission.

The application of partnership to this situation may be problematic. If a shared goal is obtained by eliminating a key actor, partnership may be inappropriate. The application of partnership to this situation may also give the impression that the problem can be solved with a partnership approach, that a consensus can be attained if just the case manager has sufficient negotiation skills. This application eliminates the possibility that the client may have more to gain in withdrawing from a partnership than in striving for a consensus. It presumes that all actors are willing to engage in a partnership to solve their disagreements. The conceptual framework of case management practice suggests that this is not always the case. The fourth partnerships already represent a failure of consensus seeking at earlier stages of the process. Hence, further negotiation is not likely to be fruitful at this stage, no matter how good the negotiation skills of the case manager. Given that the partnership metaphor may have limitations in the domain of involuntary nursing home admissions, other means may be required to deal with this situation. It may greatly help case managers if clinical guidelines are developed. Guidelines for practice

may prevent the use of time-consuming and expensive legal means and instead assist case managers in navigating through the ethically ambiguous and emotionally draining domain of involuntary admissions. Guidelines are particularly relevant to clinical practice with cognitively impaired clients who refuse nursing home admission and who are not able to fully understand or recognize the consequences that this refusal may entail. Case management working conditions may be greatly enhanced if this dimension of clinical practice receives more attention at a clinical policy level.

Conclusion

This research evaluated how partnership as a policy metaphor is applied in both policy and practice. The findings showed that the partnership metaphor is widely applied at all levels of the health care system, but that there is much variation in how it is interpreted and implemented at different levels of the health care system. Policy and practice seem to be incongruent with regards to the applicability of the partnership metaphor to the decision regarding nursing home admission. This research suggests that certain limitations in application may be appropriate in order to optimize the organization and delivery of services to the elderly population with a loss of autonomy.

While partnership has certainly fostered a more collaborative spirit in the health care system, it might also have sustained a hope of finding a miracle cure to many organizational and budgetary problems in health care. The partnership metaphor is currently riding on its positive connotations of win-win synergy, collaboration, and equality. These connotations may have been just what the health care system needed when the partnership metaphor was first introduced in health care a little over a decade

ago. Having contributed greatly to creating flexibility and collaboration in health care, the partnership metaphor now appears to be applicable to almost all situations and actors. In a sense, partnership has been glorified and put on a policy pedestal. This research suggests that there are certain risks associated with unconditionally embracing this metaphor. Applied inappropriately, partnership can also lead to lower quality of care. It may, under certain circumstances, diminish actor collaboration, render service organization ineffective, marginalize actors with little negotiation power, and open the door for subtle state withdrawal in the field of long-term care. Partnership needs to be recognized for what it is, namely a policy metaphor, a superimposed image with limited applicability to health care. While this metaphor has a great potential for improving the health care system, it is not necessarily a magic wand. It may not have an unlimited potential to resolve budgetary problems or undo existing power differentials and conflicting interests among actors. It may be worthwhile to take these research findings into consideration when recent policy recommendations are soon to take effect. If precaution is not taken in the application of partnership, case managers may be requested to battle impossible consequences arising from a poor application of the partnership metaphor. Moreover, the partnership metaphor may eventually fall from glory and change status from being a positive agent of change to “radiating lethal rays” (see below). While this status change is not likely to take place in the immediate future, this research highlights certain risk factors that merit attention.

As Václav Havel remarked, when awarded the Peace Prize of the German Booksellers Association on 15 October 1989, “We have always believed in the power of words to change history, and rightly so ... In the part of the world I inhabit, the word ‘Solidarity’ was capable of shaking an entire power block” (1990: 5). Yet, it always pays to be suspicious of words and to be wary of them, the president of Czechoslovakia continued. “The selfsame word can, at one moment, radiate great hopes, at another, it can emit lethal rays. The selfsame word can be true at one moment and false the next, at one moment illuminating, at another deceptive” (1990: 6). (Boudreau, 1998, p. 497)

APPENDIX A
Quebec Policies on Health and Social Services (1970-2001)

- Comité ministériel permanent du développement social [Ministère des Affaires sociales, Ministère de la main-d'oeuvre et de la sécurité du revenu, & Ministère de l'habitation et de la protection du consommateur]. (1985). *Mieux vieillir, Mieux vivre. Trois politiques à l'égard de la personne âgée. Le logement, la sécurité du revenu et la santé et les services sociaux.*
- Commission of Inquiry on Health and Social Welfare (1970). *Health. Report of the Commission of Inquiry on Health and Social Welfare.*
- Commission of Inquiry on Health and Social Welfare (1971). *Development. Report of the Commission of Inquiry on Health and Social Welfare.*
- Ministry of Health and Social Services. (2001). *Orientations ministérielles sur les services offerts aux personnes âgées en perte d'autonomie.*
- Ministry of Health and Social Services. (1994). *Cadre de référence sur les services à domicile de première ligne.*
- Ministry of Health and Social Services. (1992). *La politique de la santé et du bien-être, Résumé-synthèse.*
- Ministry of Health and Social Services. (1992). *The Policy on Health and Well-being.*
- Ministry of Health and Social Services. (1992). *Projet de politique. Politique de services à domicile pour les personnes qui présentent des limitations d'activités et leur milieu respectif.*
- Ministry of Health and Social Services. (1990). *Une Réforme Axée sur le Citoyen.*
- Ministry of Health and Social Services. (1989). *Pour Améliorer la Santé et le Bien-Être au Québec. Orientations.*
- Ministry of Social Affairs. (1985). *Un nouvel âge à partager. Politique du Ministère des Affaires sociales à l'égard des personnes âgées.*
- Ministry of Social Affairs. (1985). *Un nouvel âge à partager. Résumé de la politique du Ministère des Affaires sociales à l'égard des personnes âgées.*
- Ministry of Social Affairs. (1981). *Le réseau des CLSC au Québec: un parachèvement qui s'impose. Politique du Ministère des Affaires sociales.*
- Ministry of Social Affairs. (1979). *Les services à domicile. Politique du Ministère des Affaires sociales.*
- Ministry of Social Affairs (1973). *Orientations générales en santé communautaire.*
- Sécretariat à l'action communautaire autonome du Québec [Ministère de la Solidarité sociale]. (2000). *Proposition de politique. Le milieu communautaire: un acteur essentiel au développement du Québec.*

APPENDIX B-1

Actor Analysis (Ministry)

Source: Ministry of Health and Social Services (1992). *The policy on health and well-being* (pp. 3-28, 96-99, 106-165). Quebec: Official Editor of Quebec.

Actor definition

An actor is defined as one institutional level of the public health and social services system or as one bounded actor external to this system. An actor is considered defined if it is clearly distinguishable from other actors, although actors may overlap, like “local population” with “user”. Broad categories like “society” and “public system” are not considered defined.

How many actors are included in this document?

There are at least 25 different identified actors in this document (regional board, users, community organizations, municipalities, the Ministry, professional groups, local population, etc.).

How many PARTNERSHIP entries refer:

- | | |
|--|-----|
| (a) only to certain public health and social service actors? | 0/5 |
| (b) to all public health and social service actors and no others? | 0/5 |
| (c) to public system actors in potential collaboration with external actors? | 5/5 |

How many RESPONSIBILITY entries have:

- | | |
|--|------|
| (a) only one actor?
[individuals (1), women (1), single mothers in poverty (1)] | 3/14 |
| (b) more than one defined actor? | 3/14 |
| (c) unidentified actors? | 8/14 |

How many DECISION entries have:

- | | |
|--|------|
| (a) only one actor?
[users (1), individuals (1), workers (2), local population (1)] | 5/17 |
| (b) more than one defined actor? | 3/17 |
| (c) undefined actors? | 9/17 |

APPENDIX B-2

Actor Analysis (Regional Board)

Source: Regional Board of Health and Social Services Montreal-Centre (1996). *Cadre de référence. Continuum de services aux personnes âgées. Le CLSC: Guichet unique d'accès aux services de longue durée* (pp.6-29). Montreal: Services aux personnes âgées, author.

Actor definition

An actor is defined as one type of institution or organization. Different programs within the same public institution are considered to be the same actor.

How many actors are included in this document?

There are at least 10 different actors included (ex: user, family, physician, regional board, CLSC, CR, CHR, CHSLD, CHSGS, community organization).

How many PARTNERSHIP entries refer:

- | | |
|--|-----|
| (a) only to certain actors in the document? | 0/8 |
| (b) to all actors in the document and no others? | 8/8 |
| (c) to all actors in the document in potential collaboration with external actors? | 0/8 |

How many RESPONSIBILITY entries have:

- | | |
|-----------------------------------|------|
| (a) only one actor?
[CLSC (8)] | 8/15 |
| (b) more than one defined actor? | 6/15 |
| (c) undefined actors? | 1/15 |

How many DECISION entries have:

- | | |
|---|------|
| (a) only one actor?
[user (1), CLSC (5)] | 6/10 |
| (b) more than one defined actor? | 3/10 |
| (c) undefined actors? | 1/10 |

APPENDIX B-3

Actor Analysis (CLSC)

Source: CLSC Montréal-Nord (2000). *Guide d'intervention, Maintien-à-domicile, document de travail* (pp. 2-41 & appendix 1). Montreal: author.

Actor definition

An actor is defined as a type of individual or a group of professionals within one institution.

How many types of actors are included in this document?

There are at least 10 different actors without counting each profession (user, family, CLSC multidisciplinary team, rehabilitation professionals, case manager, hospital staff, nursing home staff, community organizations, etc.).

How many PARTNERSHIP entries refer:

- | | |
|--|-----|
| (a) only to certain actors in the document? | 0/2 |
| (b) to all actors in the document and no others? | 1/2 |
| (c) to all actors in the document in potential collaboration with external actors? | 1/2 |

How many RESPONSABILITY entries have:

- | | |
|--|-----|
| (a) only one actor?
[the designated professional/ case manager (6)] | 6/7 |
| (b) more than one defined actor? | 1/7 |
| (c) undefined actors? | 0/7 |

How many DECISION entries have:

- | | |
|---|-----|
| (a) only one actor?
[case manager (3), user (1)] | 4/6 |
| (b) more than one defined actor? | 1/6 |
| (c) undefined actors? | 1/6 |

APPENDIX C-1

Object Analysis (Ministry)

The Decision Regarding Nursing Home Admission

Source: Ministry of Health and Social Services (1992). *The policy on health and well-being* (pp. 3-28, 96-99, 106-165). Quebec: Official Editor of Quebec.

Object Categories

Public health, service types, service organization, service delivery, undefined object.

<u>Selection Criteria</u>	Selected/Total
1. Most relevant object category (service delivery)	5/36
2. Entries that may include nursing home admission	5/5
3. Entries that explicitly regard nursing home admission	0/5

Second selection.

partners	p. 3	all (their respective responsibilities under the 1991 legislative framework of health and social services)
partnerships	p. 3	everyone involved in directing, organizing delivering health and social services (operating in a decentralized framework)
decision-making	p. 3	users (the health and social services they receive)
decision	p. 144	actors not defined (acting for and with groups at risk, using these groups' own perspectives and values, language, strength and creative energy)
responsibilities	p. 3	all partners (their mandate within the health and social services in accordance with the 1991 legislative framework)

APPENDIX C-2

Object Analysis (Regional Board)

The Decision Regarding Nursing Home Admission

Source: Regional Board of Health and Social Services Montreal-Centre (1996). *Cadre de référence. Continuum de services aux personnes âgées. Le CLSC: Guichet unique d'accès aux services de longue durée* (pp.6-29). Montreal: Services aux personnes âgées, author.

Object categories

Client identification, service type, service orientation, service organization, interaction style, other object, undefined object.

<u>Selection criteria</u>	Selected/Total
1. Most relevant object category (service orientation)	12/33
2. Entries that may include nursing home admission	12/12
3. Entries that specifically regard nursing home admission	7/12

Third selection.

Responsabilité	p. 8	le CLSC (la planification des services, la coordination des divers services de maintien dans la communauté, la décision du recours à l'hébergement)
responsabilité	p. 11	le CLSC (représenter les intervenants du réseau face à la décision de recourir à l'hébergement, améliorer la planification et l'organisation des services)
décision	p. 8	le CLSC (le recours à l'hébergement)
décision	p. 11	le CLSC (recourir à l'hébergement)
décision	p. 19	un intervenant du CHSGS, appuyé par le CLSC (orienter la clientèle à l'hébergement)
décision	p. 27	le CLSC (maintenir à domicile ou orienter en hébergement)
décision	p. 28	non identifié ici (le recours ultime de l'hébergement)

Excluded from third selection.

responsabilité	p. 6	chaque établissement (élaborer un PII)
décision	p. 6	tout usager (les interventions affectant son état de santé ou de bien-être)
décision	p. 11	le CLSC (statuer sur l'impossibilité de maintien dans la communauté)
décision	p. 14	l'accueil centralisé du CLSC (l'orientation de la demande d'aide)
décision	p. 27	le CLSC et l'organisme communautaire (continuer ou cesser la dispensation des services communautaires suite à une réévaluation des besoins)

APPENDIX C-3

Object Analysis (CLSC)

The Decision Regarding Nursing Home Admission

Source: CLSC Montréal-Nord (2000). *Guide d'intervention, Maintien-à-domicile, document de travail* (pp. 2-41 & appendix 1). Montreal: author.

Object Categories

Needs assessment, service orientation, service delivery, undefined object

<u>Selection criteria</u>	Selected/Total
1. Most relevant object category (service orientation)	8/15
2. Entries that may include nursing home admission	8/8
3. Entries that specifically refer to nursing home admission	3/8

Third selection.

décision	p. 21	le gestionnaire de cas (mettre fin au maintien à domicile)
décision	p. 40	le gestionnaire de cas (décision finale d'héberger)
décision	p. 40	toutes les personnes concernées (décision d'héberger)

Excluded from third selection.

décision	p. 30	tout usager (participer à toute décision affectant son état de santé ou de bien-être)
décision	annexe 1	la personne et ses proches (participer au processus de décision)
responsable	p. 20	le gestionnaire de cas (l'orientation de l'usager, avec le consentement de l'usager et de ses proches)
responsable	p. 30	l'individu désigné (élaborer, appliquer et réviser le plan d'intervention)
responsable	p. 32	le gestionnaire de cas (orienter le dossier de l'usager avec la participation de ce dernier et de ses proches)

APPENDIX D

Study Population

Inclusion Criteria

- (a) The client must have a geriatric profile and have light or medium cognitive impairment (as indicated by the formal home care evaluation form). This criterion allows for an ambiguity of the client's capacity to make autonomous decisions.
- (b) The cognitive impairment must affect the client's autonomy as indicated by the formal home care evaluation form. This indicator suggests a loss of autonomy.
- (c) The CLSC case manager must have been involved in the case for at least six months prior to nursing home admission. This indicator increases the chance that the case manager is familiar with the family dynamics and has participated in the decision-making process.
- (d) The case manager must be a social worker by profession. This criterion increases the likelihood that the case manager has intervened in the relational family system during the decision-making process.
- (e) A decision regarding nursing home admission is made prior to the interview. Either a formal nursing home request has been made with the client's consent or an actual nursing home admission has occurred within the past six months. This criterion is the most reliable indicator of permanent nursing home admission and avoids the situation of a client not being aware of a nursing home request.

Exclusion Criteria

- (a) The client is declared legally incompetent and has been assigned a legal representative for personal decision-making. This exclusion criterion allows for some room for interpretation in terms of decision-making roles.
- (b) One actor in the triad declines participation or does not speak either English or French. This exclusion criterion avoids the collection of data that may be incomplete for the purpose of analysis.

APPENDIX E-1

Information Letter for Recruitment of Participants

Research Participants

Dear case manager (social worker),

I am conducting a research project as part of my Master of Social Work degree. This project is about the decision regarding nursing home admission of elderly clients who are cognitively impaired, but who have not been declared legally incompetent. I will be studying specific cases to understand how the decision was reached. I will interview the client, the primary caregiver and the case manager (social worker) in the same case as well as any other individual who might have played an important role in making the decision regarding nursing home admission.

I would very much appreciate your help in recruiting a small number of participants for this study. Attached you will find a detailed description of the type of clients I am looking for. I would appreciate if you would fill out one of the attached referral sheets for each client who meets these criteria and return it to me. Please include clients in your current caseload as well as clients whose file you have closed within the past six months. Please eliminate any client that I might know. If one of your clients is selected, I will ask you to call the client and the family caregiver to request if I can contact them to set up an individual interview of about one hour, conducted at a place and a time convenient to them.

Thank you for your help.

Eva Boxenbaum, Social Worker
M.S.W. candidate, School of Social Work, McGill University.
Telephone: (514) 288-2378

APPENDIX E-2

Description of Participants

Inclusion Criteria (all the criteria must be met):

- (a) The client has a geriatric profile and light to medium cognitive impairment (a SMAF score between -1 and -2 in the home care evaluation form).
- (b) The client is in loss of autonomy and has a primary caregiver who is known to you.
- (c) You are the case manager for the client and have known the client for several months. You must have discussed nursing home admission with the client and caregiver prior to admission.
- (d) A decision of nursing home admission is already made. Either a CTMSP form has been completed with the consent of both the client and the family caregiver, or the client has been admitted to a nursing home (public or private) within the past six months. Please include clients who have been admitted from the hospital.

Exclusion Criteria (either one or the other):

- (a) The client has been declared legally incompetent and another person acts as legal representative for personal decision-making. The client can participate if a request has been made but the legal process has not been completed.
- (b) The client or the family caregiver does not speak functional English or French or either one of them refuses to participate.

APPENDIX E-3

Participant Referral Sheet

1. First name: _____ Last name initial : _____
2. Age: _____ Gender: M___ F___
3. Diagnosis (cognitive impairment): _____
4. Current residence:
- a) community _____
 - b) nursing home _____ (since: _____)
 - c) other (specify) _____
5. Living arrangement in community setting:
- a) alone _____
 - b) with caregiver _____
6. Family caregiver's relationship to client:
- a) spouse _____
 - b) child _____ Gender: M___ F___
 - c) other (specify) _____
7. Client's spoken language(s):
- a) French _____
 - b) English _____
 - c) other (specify) _____
7. Family caregiver's spoken language(s):
- a) French _____
 - b) English _____
 - c) other (specify) _____
8. Name of case manager: _____
9. Length of follow-up: _____

APPENDIX F-1

Information Letter for Interview (case manager)

Research Participation

I am conducting this research as part of a Master of Social Work degree from McGill University. The research project is concerned with the decision-making process regarding nursing home admission of elderly clients with cognitive impairment. In this interview, I will ask you about the decision-making process that took place in one of your cases. I am interested in understanding the interaction you had with the client, the primary caregiver and any other individual who played an important role in making the decision regarding nursing home admission. I am interested in your perspective on this decision-making process. I will also interview the client, the caregiver and any additional individual identified during the interviews. However, the information you provide will be kept confidential as will the information I receive from other participants. Your participation is entirely voluntary and you may withdraw at any time. The interview will be audio-taped and it takes about one hour.

Thank you for your participation.

Eva Boxenbaum
M.S.W. candidate, School of Social Work, McGill University.
Telephone: (514) 288-2378

APPENDIX F-2

Information Letter for Interview (primary caregiver)

Research Participation

I am conducting this research as part of a Master of Social Work degree from McGill University. The research project is concerned with the decision-making process regarding nursing home admission of elderly clients with cognitive impairment. In this interview, I will ask you about the decision-making process in which you took part recently. I am interested in understanding the interaction you had with the person who was recently admitted to a nursing home, the case manager at the CLSC and any other individual who played an important role in making the decision regarding nursing home admission. I am interested in your perspective on this decision-making process. I will also interview the client, the case manager and any additional person that may be identified during the interviews. However, the information you provide will be kept confidential as will the information I receive from other participants. Your participation is entirely voluntary and you may withdraw at any time. The interview will be audio-taped and it takes about one hour.

Thank you for your participation.

Eva Boxenbaum
M.S.W. candidate, School of Social Work, McGill University.
Telephone: (514) 288-2378

APPENDIX F-3

Information Letter for Interview (client)

Research Participation

I am conducting this research as part of a Master of Social Work degree from McGill University. The research project is concerned with the decision to move into a nursing home. In this interview, I will ask you about your experiences. I am particularly interested in understanding which role you and others had in making this decision. I will also interview the person who helped you at home, the case manager at the CLSC, and any additional individual identified during the interviews. However, the information you provide will be kept confidential as will the information I receive from other participants. Your participation is entirely voluntary and you may withdraw at any time. The interview will be audio-taped and it takes about one hour.

Thank you for your participation.

Eva Boxenbaum
M.S.W. candidate, School of Social Work, McGill University.
Telephone: (514) 288-2378

APPENDIX F-4

Information Letter for Interview (additional participant in triad)

Research Participation

I am conducting this research as part of a Master of Social Work degree from McGill University. The research project is concerned with the decision-making process regarding nursing home admission of elderly clients with cognitive impairment. In this interview, I will ask you about a decision-making process in which you took part recently. I am interested in understanding the interaction you had with the person who was recently admitted to a nursing home, the primary caregiver and the case manager at the CLSC. I am interested in your perspective on this decision-making process. I will also interview the client, the primary caregiver and the case manager as well as any additional person that may be identified during the interviews. However, the information you provide will be kept confidential as will the information I receive from other participants. Your participation is entirely voluntary and you may withdraw at any time. The interview will be audio-taped and it takes about one hour.

Thank you for your participation.

Eva Boxenbaum
M.S.W. candidate, School of Social Work, McGill University.
Telephone: (514) 288-2378

APPENDIX F-5

Information Letter for Interview (administrator)

Research Participation

I am conducting this research as part of a Master of Social Work degree from McGill University. The research project is concerned with the decision-making process regarding nursing home admission of elderly clients with cognitive impairment. The primary focus of this project is the interaction among the client, the primary caregiver and the case manager in home care. However, I wish to increase my understanding of the administrative context surrounding nursing home admission. In this interview, I will ask you about your perspective on the admission of cognitively impaired individuals to a nursing home. Participation in this interview is entirely voluntary and you may withdraw at any time. The interview takes about one hour. It will be audio-taped and the information you provide will be kept confidential.

Thank you for your participation.

Eva Boxenbaum
M.S.W. Candidate, School of Social Work, McGill University.

Telephone: (514) 288-2378

APPENDIX G

Consent Form

I acknowledge that the research procedures have been explained to me, that I understand the study, and that any questions I had were answered to my satisfaction. I know that I may ask any questions that I have about the study procedures now and in the future. I have been assured that information about me will be kept confidential and that no information that would disclose my personal identity will be released or printed.

I agree that my individual interview will be audio-taped for the purpose of analysis. I understand that my participation in this interview is entirely voluntary, and that my decision to participate will not affect the services available to me (if applicable). I further understand that I am free to withdraw from the interview at any time and/or to have part or all of my tape erased. I have been given a copy of the information letter.

I hereby consent to participate in one individual interview. If I am or was a client of the CLSC home care program, I also agree that the researcher confidentially consults my client file at the CLSC for analytical purposes.

Signature: _____

Date: _____

Name (please print): _____

Researcher: I have carefully explained the nature of the research. I certify that, to the best of my knowledge, the participant understands the nature of the research.

Signature: _____

Date: _____

Name (please print): _____

APPENDIX H-1

Interview Guide (coordinator of nursing home admissions)Theme One

What is the current situation regarding nursing home requests for cognitively impaired elderly clients?

This theme explores the frequency of nursing home applications received for cognitively impaired clients. The theme explores general tendencies and procedures involved in processing nursing home applications for this population.

Theme Two

How does the Regional Board respond to complex clinical situations involving cognitively impaired clients?

This theme explores the reaction of the evaluation committee when a nursing home application indicates that a cognitively impaired client, who is still legally competent, has not been informed of the request made by the primary caregiver.

Theme Three

How does the Regional Board perceive current problems with regards to the nursing home admission of cognitively impaired clients and are there any initiatives taken to address identified problems?

This section attempts to clarify the perspective of the Regional Board with regards to the nursing home admission of cognitively impaired clients who are legally competent. The theme explores the orientation of the Regional Board and looks at which problems and possible solutions receive attention at this level. It also inquires about any existing clinical, ethical or legal guidelines with regards to the nursing home admission of this population.

APPENDIX H-2

Interview Guide (CLSC administrator)Theme One

How does the CLSC perceive its mandate in relation to cognitively impaired clients?

This theme explores problems and issues the CLSC faces in providing adequate community services to cognitively impaired elderly clients. It asks about the limits of the home care program with regards to this clientele and explores whether the limits differ for clients who are lucid, somewhat cognitively impaired, or legally incompetent. This theme inquires about the extent to which the CLSC receives a specific mandate from higher levels, specifies its own mandate in relation to the targeted clientele, or leaves its mandate broad and general.

Theme Two

What is the orientation of the CLSC home care program toward the nursing home admission of cognitively impaired clients?

This theme looks at the extent to which home care managers direct or orient case management practice. It asks whether the CLSC has developed any internal policies on this clinical issue or whether it delegates its orientations to a supervisor or to individual case managers. This theme also explores the perspective of management on the relevant actors in the decision regarding nursing home admission of cognitively impaired clients.

Theme Three

What happens if a cognitively impaired client who is still legally competent wishes to remain in the community but the primary caregiver is no longer able to provide the required care?

This theme explores the decision-making process regarding nursing home admission of cognitively impaired clients. It asks specifically about situations in which there is a conflict of interest between the client and the family caregiver, seeking to identify how management perceives current case management practice.

APPENDIX H-3

Interview Guide (actors in triad)Theme One

Which events led to the request for nursing home admission or to actual nursing home admission?

This theme seeks to reconstruct the trajectory leading up to the final decision regarding nursing home admission. Questions within this theme explore the context surrounding the client's loss of autonomy, such as indications of the client requiring help in daily living, the level of implication of the family caregiver, the request for CLSC services, and possible hospitalizations, etc. This theme aims to establish a frame of reference for discussing relational dynamics and the decision-making process.

Theme Two

How did the relationships among the primary actors develop during the time of CLSC involvement?

This theme attempts to explore the type of contact these primary actors had with each other during the period of case manager involvement in the community setting. This theme looks at how the relationships among actors developed and which factors influenced this development. The emphasis is on the delivery and coordination of services in the community, not on the decision regarding nursing home admission

Theme Three

How was a decision reached regarding nursing home admission, and which roles did each of the actors play in the decision-making process?

This theme constitutes the central part of the interview. It explores the perception each participant holds about his or her own role and that of the other actors in making the decision regarding nursing home admission. Circular questioning is employed to explore how each participant thinks that the other actors perceived his or her role. The theme explores the reactions the participant had to the unfolding of the decision-making process and inquires about the "ideal scenario" of the decision-making process. This theme also explores whether any additional actors (besides the client, the family caregiver, and the case manager) played an important role in the decision making process. If so, attempts are made to include these individuals as participants.

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