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Tailoring Elderly Patients' Identities through Healthcare Service Relationships: Toward a Guardian Conception of Vulnerable Publics' Identities

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INTRODUCTION

Population aging has become an unprecedented global phenomenon, impacting most countries across the globe; in France, seniors aged 65 and over will become the largest age group in 2050, accounting for nearly 30% of the total population (Cetelem Observatory 2016). This trend has a tremendous impact on the management of public hospitals, which are facing new challenges with the admission of elderly patients.

Patients' medical and social care can be viewed through the prism of the healthcare service relationship. It refers to the mutual implication of patients and healthcare providers, as well as to the potential mobilization of their respective resources to nurture and develop the care relationship; however, in the case of vulnerable groups, such as elderly patients, the service relationship tends to develop in an asymmetrical manner: healthcare providers can claim a legitimacy in the provision of care derived from their competences and status. As hospitalized elderly patients can be considered fragile subjects facing an alteration of their physical and/or cognitive resources, healthcare providers have a natural tendency to make decisions on their behalf and tailor their identities. The healthcare service relationship in hospitals can thus be analyzed through the prism of care providers' representations of old-patient figures, as well as through the identities they project on the elderly, which are impacting their healthcare practices.

Identity configuration does not only depend on one's personal resources but also develops through social interactions. It can be read in others' eyes and enacted in their actions (Tesser, Millar and Moore 1988). The role played by social interactions in identity configuration is even greater when an individual is old and vulnerable. To define their identities, the elderly will use their remaining personal (cognitive, physical and emotional) resources, the social resources provided by the group of people assisting them in their everyday activities, and the social and cultural imaginary at work in the representations of the elderly.

The theoretical framework of the *elderly consumption ensemble (ECE)*, defined by Barnhart and Peñaloza (2013), identifies family and paid caregivers as central members of a nuclear network within which the elderly's identities are negotiated in relation with consumption activities. In line with Drolet-Rossi, Kelleher and Peñaloza (2015), we propose to broaden the perspective to health service consumption contexts, and explore the role of healthcare providers' practices in the preservation, restoration or alteration of the elderly's identities. This paper introduces a *guardian conception* of elderly patients' identities, viewed as a process through which healthcare providers substitute them in making decisions on their behalf, and thus tailor their identities.

ELDERLY PATIENTS' VULNERABILITY AND IDENTITY CONSTRUCTION

Elderly patients are confronted with vulnerability (Baker, Gentry and Rittenburg 2005), as they experience chronic illness, pluri-pathology, functional decline, loss of autonomy and decline in their social role. These combined disabilities increase the tendency to perceive them as impaired people, which potentially affects their feelings of dignity and integrity

(Monod and Sautebin 2009). Perception of the elderly as vulnerable may influence healthcare providers' mental representations of senior patients. These representations will be embedded in their care practices as representations perform reality. Vulnerability can be considered as the result of several internal and external factors affecting elderly patients, health decline being a central catalyst (Mason and Pavia 2006; Pavia and Mason 2012).

Perception of their altered body and representations conveyed by others are central in elderly patients' identity construction. Physical, psychological and/or emotional vulnerability favor the alteration of their identities. Furthermore, the context in which interactions with others take place plays an important role in the definition of seniors' identities: uncomfortable situations, perceived negatively, and negative attitudes or criticism from others can alter self-esteem and even lead to a negative *self* (Banister and Hogg 2001). The inability to perform everyday tasks without help and interactions with others placing the elderly in a state of discomfort are perceived as stigmatizing as they remind them of their physical and/or cognitive impairments. These experiences exacerbate the negative perception of the *self*, and may even generate a kind of dissolution of *self* constituents (Mason and Pavia 2014).

Though social interactions can project stigmatized identities on seniors, they are neither prepared nor ready to accept them (Barnhart and Peñaloza 2013; Pavia and Mason 2012). When they have the resources to do so, they tend to deploy strategies to preserve or reconfigure their identities to counter the institutionalization of negative stereotypes, in particular when central elements of their identities are at risk. They engage in an attempt to build a resilient identity (Mason and Pavia 2014) that allows them to focus on the restoration of the positive and rewarding aspects of their *self*.

ELDERLY PATIENTS' VULNERABILITY AND THE GUARDIAN CONCEPTION OF THEIR IDENTITIES

Recent research (Mason and Pavia 2014; Pavia and Mason 2012; Stone, Brownlie and Hewer 2011) has focused on the study of the processes in action during the transformation of seniors' self, without providing a complete understanding of the mechanisms leading to the reconfiguration of their identities however. Indeed, these studies reveal the role played by seniors' personal resources in this process but do not analyze how resources deployed by members of their network (family, friends and paid caregivers) (Barnhart and Peñaloza 2013) may play a role in this identity preservation process. To the nuclear network of actors already identified in the literature, it is possible to add healthcare givers working in medical institutions as they have frequent interactions with hospitalized elderly patients and can be included in what we call the *extended elderly network*. Depending on the role they play, the legitimacy that they give themselves and the contexts in which social interactions with elderly patients take place, we propose that these actors elaborate representations that also contribute to the identity (re)configuration of the elderly.

This research contributes to the field of service relationships with vulnerable publics. We focus on the role of healthcare givers with authority in the provision of health services, in building, preserving or altering elderly patients' identities. We reveal the existence of a *guardian conception of elderly* patients' identities, embedded and enacted in healthcare practices. This conception relates to two different visions: deficient elderly patients, dependent on others, requiring an adaptation of professional norms to their specificities; and elderly patients as individuals with remaining resources, actors of their healthcare path and needing to be preserved to respect the ideal type of autonomous patients.

METHOD

This exploratory qualitative research[1] was conducted in the geriatric ward of a French hospital group admitting elderly patients aged 75 and over in the suburbs of Paris (France). Data was collected from June to October 2016. Eighteen healthcare providers (doctors, nurses, nursing assistants, a nutritionist and a physiotherapist) were interviewed at their workplace. Informants were contacted by hospital executives and volunteered for the research. Semi-structured interviews lasted one hour on average. Interviews were registered, transcribed entirely and content-analyzed through a process consisting in going back and forth between data and existing literature (Miles and Huberman 1994). The authors double coded the data to increase the reliability of their findings. Categories emerged from the coding process – they consist of representations and figures of elderly patients' identities, perceived, elaborated and enacted by healthcare providers during service relationships.

BRICOLAGE AND RUSE AS LEVERS TO PRESERVE, RESTORE OR ALTER ELDERLY PATIENTS' IDENTITIES

Our findings show that healthcare providers use *bricolage* and *ruse* as strategies to deliver healthcare and that these practices shape elderly patients' identities. This tendency to (re)configure senior patients' identity is a way for hospital staff to legitimate their role in their treatment. On the one hand, it can help elderly patients recognize their own capabilities and be active in their care, and can thus contribute to rebuild or rehabilitate their desired positive *self*. On the other hand, it may convey to the elderly the image of a dependent person and thus contribute to build or confirm their negative, undesired *self*.
As a result, healthcare practices can be viewed as coping strategies developed by care providers confronted with elderly patients' various situations. These strategies reveal a *guardian conception of patients' identities*, which is two-fold; it can take the form of fragile and dependent figures to which hospital staff needs to adapt even if it requires derogating from professional norms or take the form of enabling, resilient and autonomous figures, which favor the expression of patients' power to act.

Bricolage as a way to adapt to elderly patients perceived as limited in their capabilities

Daily healthcare provision and the variety of interaction contexts in which they take place create interstices to which standardized processes cannot fully be applied. This creates possibilities to imagine and tinker other methods that impact elderly patients' identities directly. Hospital staff creates hybrid and modified practices; they tap into their own history and cultural values to find the resources needed to accomplish their care mission. This hybridization of practices can be viewed as *"a contribution to sociology of the in-between, sociology from the interstices. This involves merging endogenous/exogenous understandings of culture"* (Pieterse 1995, 64). Healthcare providers thus have to arbitrate between the obligation to respect patients' power to act and the perception of their physical and cognitive deficiencies. The progressive alteration of senior patients' abilities, which can occur when hospitalized or during their stay in the medical institution, leads to practical questions on the possibility to involve them in the care relationship. It raises questions about the best way to do so, by trying to articulate goals that are not always compatible: "respect the patients' will" without actually putting them in danger and "making them comfortable" without undermining their autonomy.

[1] This research received funding from the French National Center for Scientific Research (CNRS) and the authors' university.

Bricolage practices show that elderly patients' guardian conception of identity is expressed through deficient and weak figures such as the dependent patient, patient with dementia, child patient, soiled patient, patient from the past and deviant patient (*cf.* Table 1).

Ruse as a way to protect or rehabilitate the autonomy of senior patients perceived as having residual resources

Besides *bricolage*, we identify *ruse* as a *coping* strategy deployed by caregivers confronted with patients' potential refusal of care. We borrow *ruse* from Hennion and Vidal-Naquet's (2012) ethnographic research of home care relationships. Drawing on Goffman's theoretical frameworks (in particular his usage of fiction, 1973) and those of Paul Ricoeur on narrative (1983), the authors consider home care as bearing a *fictional paradox*: *"it is precisely to preserve an autonomy whose very meaning is eroding, and to provide protection that individuals may no longer see as an opportunity, that, depending on the practical issues to be resolved, one has to encroach on autonomy, or accept some risk-taking to "save" what is essential, for instance to maintain a possible form of autonomy and protection given the situation"* (Hennion and Vidal-Naquet 2012, 329). Authors call *ruse* this risk-taking contributing to the recognition and self-worth development of individuals - ruse *"viewed not as a deception but as an art of making do"* (326), or even "do with". This is what we mean here: a series of tricks embedded in healthcare micro-practices allowing for the preservation of the ideal-type of autonomous patients and as such, getting them to do and cooperate.

Ruse practices allow the guardian conception of elderly patients' identities to be expressed through the projection of positive images of the self, embedded in the healthcare providers' attitudes and practices, as shown by the following figures: the person patient, wise patient, active patient and equipped patient (*cf.* Table 1).

Guardian conception of elderly patients	Description	Bricolage practices	Types of related identity configurations
Dependent patient	Elderly patients are perceived as dependent subjects. Healthcare professionals wonder whether the dependency is real and caused by their polypathology or exaggerated by them to get more attention from hospital personnel.	**Slow down the pace of care.** "One day, a doctor said to me: "You see, you take two hours to round up patients". I told him: "OK, now you come with me and you tell me where I'm being slow (…) Because taking a pill, putting it there and telling the patient: "take this" and then go away, I can do that… and it'll save time. But at the end of the day, I don't know whether the pill was taken." (nurse B.L.)	Elderly patients' identity alteration – portrayed as ill and dependent.
Patient with dementia	Elderly patients' dementia is frequently evoked by informants. It crystallizes individuals' own projections into old age. In its soft version, it relates to anxiety and confusion exacerbated by the hospital's sanitized environment.	**Take time to reassure.** "They wander. Sometimes it creates problems but then, well, you have to go with them …and tell them what to do and why. Always reassure them. It's a little bit like a psychological support." (nurse E.L.)	Elderly patients' identity alteration – portrayed as psychologically fragile.
"Child" patient	Elderly patients are frequently compared to children with no critical judgment capacities, sometimes unable to verbalize their pain, and who are under the supervision of their parents.	**Take the time to explain and reformulate.** "The old patient, sometimes, he does not understand you see. We explain again, we reformulate, and try to adjust." (nurse B.L.).	Elderly patients' identity alteration - portrayed as not capable of thinking critically.
Soiled patient	Elderly patients' bodies are marked by decline, degeneration, uncontrolled soiling whose tracks must be covered by healthcare givers.	**Delegate healthcare to third parties.** "Her daughter finally took over and said: "Well, I'm going to clean her. I will go with her." It happened like this but we had to take her clothes because they were completely soaked [*with urine*]. We were running after	Elderly patients' identity alteration – portrayed as not capable of controlling their bodies.

		clothes afterwards." (nurse S.F.)	
Patient from the past	Elderly patients are locked in the past and use words and expressions and cultural references that are old-fashioned.	**Avoid certain types of care to adjust to patients' old habits.** "There are certain types of care that…well you know, (they say)"I don't want now…I'm tired…". It's not a problem. We go on. Finally, we come back. (…) there are people who do not want to wash every day. You know…they were born… before the war…and…you have to take this into account." (nursing assistant J.M.)	Elderly patients' identity alteration – portrayed as belonging to a bygone era.
Deviant patient	Elderly patients refuse care and/or treatments, or even engage in deviant behaviors; informants evoke numerous *translation* conflicts. This figure differs from the representation of the vulnerable patient.	**Physically coerce the patient to protect him / oneself.** "Well…for example, if there are violent patients (…) we constrain their lower and upper extremities, but it's on prescription. This means that doctors decide if it needs to be done. (…). It looks…It looks a bit barbaric but…sometimes you have no choice." (nursing assistant C.B.)	Elderly patients' identity alteration through usage of physical coercion.
Guardian conception of elderly patients	**Description**	**Ruse and trick practices**	**Types of related identity configurations**
Person patient	Elderly patients are primarily seen as persons, individuals with whom it is possible to develop a relationship of equals, to discuss, exchange and laugh.	**Create a common language to establish a symmetrical relationship.** "As she did not speak French, I looked at her. I put myself at her level. I looked at her and I told her: "Don't worry. We're not here to harm you". I told her this, with my words. I tried to convey this through my eyes…to try to calm down." (nurse C.B.).	Elderly patients' identity preservation through the recognition of their identity.
Wise patient	Elderly patients are wise elders who share their knowledge and life experiences, which are of value to the current generation.	**Use past cultural references to establish communication** "You know, sometimes, there are old, elderly people who are very interesting, they tell you their old stories and it is enriching: I would say about war, about their private life when they were young:" I was doing that. At that time (…) it was good » (nursing assistant G.M.).	Elderly patients' identity preservation through the recognition of their valuable past experience.
Active patient	Elderly patients are individuals with their own rights, having residual resources that they can mobilize to express their self.	**Sensitize elderly patients about their rights to decide, to get them to exercise their power to act.** "It's…the patient has the right not to know; it means that if he doesn't want to know what disease he has, we need to respect that. We need to try to understand why he does not want to know […]. It's really the patient who…who is the owner…of his disease." (doctor SK).	Elderly patients' identity restoration through the recognition of their rights.
Equipped patient	Elderly patients are not vulnerable, a "normal" relationship with them is possible provided that we use objects that extend their bodies or substitute for deficient physical functionalities.	**Use (patients) objects as levers enabling the activation of their capabilities.** "If, for example, your patient needs glasses to read, I need to know that I will find them in the room, because if he does not have his glasses, it means that he will not be able, of course, to read the documents I will give him." (nurse S.F.).	Autonomous elderly patients' identity restoration through the recognition of material resources enabling them to exercise their power to act.

Table 1. Guardian conceptions of elderly patients, healthcare practices and types of related identity configurations

DISCUSSION AND CONCLUDING REMARKS

A first contribution of this research consists in proposing a *guardian conception of elderly patients' identities*, which enriches the notion of senior subject positioning (Barnhart and Peñaloza 2013). Our findings suggest that, as a vulnerable public, elderly patients experience an alteration of their physical and/or cognitive resources, allowing actors belonging to their resource network to substitute for them, making decisions on their behalf and configuring their identity. This *guardian conception of identity* thus goes beyond a representation or a projection that the elderly would receive from others and try to articulate with their own vision of their self. We uncover two types of guardian identities elaborated by healthcare providers: the first relating to a dependent and stigmatized vision of the elderly and the second, contrary to the first, conveying the image of an old patient capable of doing and resilient, and favoring the expression of the patient's power to act. In the first case, the identity projected on the patient can be destructive and acts as a factor of identity dissolution (Mason and Pavia 2014), contributing to the creation or exacerbation of a negative identity. In the second case, the projected identity is rewarding and helps to create, restore or preserve a positive, desired self.

This *guardian conception of identity* has an impact that goes beyond the context of elderly patients and can apply to vulnerable populations (*e.g.* precarious consumers or individuals with physical or mental disabilities) more generally. It deems that when individuals experience a temporary or durable deficit of their internal abilities and become vulnerable, resource persons give themselves the right to confiscate the decision-making on their behalf and the definition of their identity. This situation can lead to the preservation or valuation of vulnerable publics' identities, or on the contrary, result in its deterioration or dissolution. This *guardian conception of identity* is based on resources mobilized by a third party having or claiming to have supervisory authority over senior, fragile or vulnerable individuals who are permeable to representations conveyed in others' discourses and practices. This *by proxy* intervention of a third party in someone else's identity configuration represents a significant theoretical contribution to the area of *self*-concept (Sirgy 1982; Belk 1988). Indeed, it challenges the view that individuals are themselves the repositories of the arrangement of internal and external resources constituent of their identity.

The second contribution of this research is to enrich the concept of the *elderly consumption ensemble* (Barnhart and Peñaloza 2013) through the proposal of the *extended elderly consumption ensemble*. We show that the network of resource persons committed to the elderly is changing depending on places and contexts where consumption or service activities take place. We thus identify the existence of an extended network in the hospital, consisting of healthcare providers whose representations of old age challenge elderly patients' own identities. In this perspective, we propose a dynamic view of the elderly network, viewed as a field of power relationships between healthcare providers and patients.

This research draws on healthcare providers' discourses, ignoring other members of the elderly network's perspectives. An interesting direction for future research would be to study the impact of tensions between members of the *extended ensemble* on the elderly's identity configuration. These resource members (such as family and healthcare providers) may develop different tutelary figures of the elderly and compete to tailor elderly patients' identities. Such conflicts create the risk of generating and projecting a tense and fragmented identity on the elderly.

REFERENCES

Baker, Stacey M., Gentry James W. and Rittenburg Terri L. (2005), "Building understanding in the domain of consumer vulnerability", Journal of Macromarketing, 25 (2), 128–139.

Banister, Emma N. and Hogg Margaret K. (2001),"Mapping the Negative Self: From 'so Not Me'...To 'Just Not Me'", in Advances in Consumer Research, Vol.28, ed. Gilly Mary C. and Meyers-Levy Joan, GA: Association for Consumer Research, 242-248.

Barnhart, Michelle and Peñaloza Lisa (2013), "Who Are You Calling Old? Negotiating Old Age Identity in the Elderly Consumption Ensemble", Journal of Consumer Research, 39 (April), 1133-1153.

Belk, Russel W. (1988), "Possessions and the Extended Self", Journal of Consumer Research, 15, (2), 139-168.

Drolet Rossi, Aimée, Kelleher, C. and Peñaloza Lisa (2015), "Advancing Connections Between Consumption and the Elderly: Consumer Research Issues, Opportunities and Challenges", in Advances in Consumer Research, Vol.43, ed. Diehl K. and Yoon C., MN: Association for Consumer Research, 765-765.

Hennion, Antoine and Vidal-Naquet Pierre (Dir.) (2012), « Une ethnographie de la relation d'aide : de la ruse à la fiction ou comment concilier protection et autonomie » [An etnography of care relationship: from ruse to fiction or how to reconcile protection and autonomy], Paris/Lyon: CSI/Cerpe, Mire.

Mason, Marlys and Pavia Teresa (2006), "When the Family System Includes Disability: Adaptation in the Marketplace, Roles and Identity", Journal of Marketing Management, 22 (9-10), 1009-1030.

Mason, Marlys and Pavia Teresa (2014), "Health Challenges and Consumer Vulnerability: Identity Dissolution and Resiliency Behaviors", in Advances in Consumer Research, Vol. 42, MI: Association for Consumer Research, 9-11.

Miles, Matthew B. and Huberman A. Michael (1994), *Qualitative Data Analysis: An Expanded Sourcebook*, 2nd ed. Thousand Oaks, Sage.

Monod, Stéfanie and Sautebin Annelore (2009), "Vieillir et devenir vulnérable [Ageing and Becoming Vulnerable] ", Revue Médicale Suisse, 5 (November), 2353-2357.

Pavia, Teresa and Mason Marlys (2012), "Inclusion, Exclusion and Identity in the Consumption of Families Living with Childhood Disability", Consumption, Markets and Culture, 15 (1), 87-115.

Pieterse, Jan Nederveen (1995), "Globalization as hybridization", in *Global modernities*, ed. Featherstone M., Lash S. and Robertson R., London: Sage, 45-68.

Sirgy, M. Joseph (1982), "Self-Concept in Consumer Behavior: A Critical Review", Journal of Consumer Research, 9 (3), 287-300.

Stone, Tim, Brownlie Douglas and Hewer Paul (2011), "Constructing cultures of caring consumption: An exploratory study of embodiment within an elderly care environment", in European Advances in Consumer Research, Vol.9, ed. Bradshaw A., Hackley C., and Maclaran Pauline, MI: Association for Consumer Research, 269-274.

Tesser, Abraham, Millar Murray and Moore Janet (1988), "Some affective consequences of social comparison and reflection processes: The pain and pleasure of being close", Journal of Personality and Social Psychology, 54, 49-61.