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Institutional Mealtimes and Family Caregiving for Chinese Nursing Home Residents

by

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Institutional Mealtimes and Family Caregiving for Chinese Nursing Home Residents

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Shirley Wu

To my parents and grandparents

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I thought really old people did nothing, *had nothing to learn or contribute or yearn for. They just smelled like old leather and pipe tobacco, or potpourri and too much face powder.* ***I thought nursing homes were repositories for suspended animation of the living dead.*** *This shallow stereotype took all the life and dimension out of my elders.* ***What I found instead was a gallery of fascinating people gathered at a pivotal point in life's journey.***

– From *Nobody's Home: Candid Reflections of a Nursing Home Aide* by Thomas Edward Gass

Well, this isn't home! This is an institution!... They're wonderful to you and the surroundings are nice. They're good to you, but it's still an institution. It isn't my home regardless of how nice it is. They ring a bell when you come in. They ring a bell and you sit down. You haven't got a home.

Just take yourself being in my place. How would you feel? Think about it. Just think of yourself to be in a place like this. How would you feel? It's very hard to take. Very hard. It can almost [make your] heart break. 'Cause you got your own home. You got everything in it. You do what you please. You buy what you want ... what you want to eat, what you want to drink. ... What they give you, you gotta eat. If you don't eat, you go hungry. Lots of times, I walk away hungry.

– Quotes from *Living and Dying at Murray Manor* by Jaber Gubrium

Life in the nursing home is about "eating and excreting."

– From *Limbo* by Carobeth Laird

Food symbolizes care, concern, love, and life itself.

– Jeanie Kayser-Jones

CHAPTER 1: LITERATURE REVIEW

Section I: Overview of Research Questions

What are the mealtime experiences of Chinese elders[1] in an American nursing home?

Specifically, which foods are served to Chinese elders, and what do they eat? Which foods, served in which ways, do they like? Do they receive special foods from family or friends, from other residents or from staff? Do they eat too little, enough, or too much, for physical health? What are the meanings of institutional food and special foods for Chinese nursing home residents?

What are the mealtime and snacktime practices of giving, sharing, and receiving foods among residents, their families, and staff? What are the meanings ascribed to these practices?

What roles do the meanings of food and of the giving of food play in professional and family caregiving at mealtimes? Which cultural values, such as American and Chinese values, are important to Chinese elders in making meaning of food and of how they are cared for at mealtimes? How important are food and meals in Chinese elders' evaluation of nursing home life? How are these cultural values interpreted in the particular institutional environments of American nursing homes?

Section II: Introduction

---

[1] The use of the term "Chinese elder" or "elderly Chinese resident" is not unproblematic. The term suggests that all Chinese, even within one particular institution, share a particular cultural and social orientation. Additionally, this use of "Chinese" refers to *Han*-Chinese, a larger ethnic group that accounts for the vast majority of Chinese.

What can answers to these questions tell us about the meanings of meals and food? How are these meanings related to larger questions of ethnicity and "Chinese-ness," "American-ness," aging and the aged, nursing and medicine, institutionalization and caregiving? Can a better understanding of the role of these meanings in Chinese residents' mealtime experiences help nursing homes provide better care?

The meanings of food and meals for Chinese residents in a nursing home in the United States is a topic that falls within three areas in the literature which, based on empirical studies, have contributed to general theories on culture, biomedicine, and aging. Within general theories of culture are discussions of the relationship between race, ethnicity, and culture, and from these are drawn theories of cultural or ethnic identity. Theories of biomedicine share common values with so-called Western and, specifically, American beliefs. These common values underlie the cultures of medicine and nursing, which include the institution of the nursing home. Aging is a multidisciplinary, fragmented field that encompasses a range of theories in biomedicine and the social sciences.

In an effort to address the call for generation or examination of theory (Bengtson and Schaie 1999), this paper will briefly discuss the major salient theories in the three theoretical areas of culture, biomedicine, and aging, and discuss their implications on three empirical areas addressed in the main research question. The discussion will also include empirical findings on the specific area of Chinese cultural studies related to family structure, family caregiving, and their underlying cultural values. Chinese cultural values related to food and meals will be discussed in Chapter Two.

Three largely empirical areas addressed in the research question are: nursing homes in the literature on institutionalization; the meaning and practices of food in nursing homes; and institutional caregiving. As in research in the fields of aging, biomedicine, and culture, empirical findings about institutionalization, food in nursing homes, and institutional caregiving have

given rise to specific theories. This paper will review the empirical knowledge in these three areas in some depth, and apply the derivative theories to the research question.

Few attempts have been made to explicitly connect general theories of aging, biomedicine, and culture, with the literatures on nursing homes, particularly ethnographic work. In the summary, discussion, and conclusion of this paper, the findings and implications of both parts of the literature review on the general research question will be discussed, and specific potential research questions will be generated.

Section III: Three Theoretical Areas

This section seeks to place the specific research question within larger, primarily anthropological theoretical discourses, and to show that this study makes a contribution toward answering how larger theories apply in a specific context that has not been previously examined using this theoretical background. As researchers in aging have argued, theory provides explanations for empirical findings and serves as groundwork for both explaining aging heterogeneity and informing policy, yet has been widely neglected in gerontological work (Bengtson and Schaie 1999). Are general theories about aging, medicine, and ethnicity, applicable in the experiences of particular nursing home residents? The intent of the research question is to examine the particular in an attempt to gain insight on larger theories.

Theories of Aging

One characteristic of the population of interest in the research question is that it is elderly. But what is meant by "elderly"? What are the cultural meanings of being old, and what are the implications of those meanings? Which values or meanings about aging underlie the formation and practices of modern nursing homes? Which theoretical orientations do academic fields in aging offer to researchers?

The study of aging in Western academia is multidisciplinary and fragmented, and for those who study aging, there has been a struggle for legitimacy as a "science." According to Vern Bengtson, the way that "aging" has been approached theoretically has taken three general orientations within different disciplines (emphasis added, below):

> (1) the aged as a population, with a focus on the *functional problems* of the aged
>
> (2) aging as a *developmental process* occurring over time, rather than a defined period of life; biology, psychology, and the social sciences use this orientation
>
> (3) the study of age as a *dimension of structure and behavior*; as a study of primarily "social" phenomena, this is the domain of social scientists, zoologists, primate anthropologists, and evolutionary biologists.

In this section, two types of research approaches are discussed, biological or biomedical sciences and social sciences, for the following reasons: Biological approaches inform theories that may underlie beliefs and practices in nursing homes, while social science approaches illustrate how aging and the study of aging may be defined differently than how it is defined in biology and biomedicine.[2]

Biological and Biomedical Concepts and Theories in Aging

A biological approach constitutes a world view that is perpetuated at multiple levels of studying aging and old age. A key argument in the medical anthropology literature is that biological and biomedical views tend to pathologize or make abnormal processes of aging (i.e., the "normal" standard is the idealized young, white male). Furthermore, as will be discussed later, social science and health policy literature support the supposition that biological and biomedical approaches to health and disease were fundamental in the formation and organization of modern nursing homes. This section will examine these two key arguments in

[2] This research was a qualitative, anthropological study within the third orientation of aging research; further discussion of methods in this study follows in Chapter Two.

more detail. Further implications of how old age and aging are valued within a biomedical paradigm will be addressed below.

Biological approaches are "reductionist" in that they examine cellular and genetic aging; biomedical approaches use such biological approaches to understand aging at the level of organ systems and individual bodies.[3] Aging is generally not considered pathological; instead, aging consists of processes that predispose to pathology. Environmental and "psychosocial factors" are considered "potentially modifiable" influences on the processes of aging and thus on the production or prevention of pathology, creating the opportunity for individual autonomous action to modify the body, and prevent and manage disease. Such opportunity suggests that individuals may be deemed responsible for failure to modify such external, non-somatic factors, and thus, taken to its extreme, responsibility for disease.[4]

Biological approaches also place aging within a context of evolutionary pressures, where "fitness" is defined by reproductive capacity and species survival. Thus, within the biological sciences and biomedical sciences, wisdom derived from experience (old age)[5] and traditional cultural values and practices, are not explicitly valued except as to how they may contribute to reproductive fitness.

We are confronted with a major question in aging studies: *What is normal aging?* Can aging be normal or is it a manifestation or continuum of inherently pathological processes? Does the insidious onset of chronic diseases that are associated with increasing age show that normal aging is a precursor to disease (Solomon 1999)? That is, to what extent can aging be defined as an

---

[3] Epidemiological approaches are similarly interested in individuals, in so far as they may be arranged into homogenous populations from which random samples can be drawn. Epidemiological studies and evidence-based medicine rely on this kind of impersonal individualism.

[4] Obesity is an example. Obesity is a risk factor for diabetes mellitus and cardiovascular disease. Both patients and physicians *tend* to treat the failure to prevent or correct obesity as an individual problem. This tendency is probably partly due to a sense of futility in changing social structures but also reflects fundamental beliefs derived from reductionist biological approaches to health and disease. In other discourses, such as in academia and in the media, social structural factors, such as poverty and unequal access to healthy foods, are also believed to contribute to obesity.

[5] This simplification applies to the objects or subjects of study rather than the researchers and clinicians. Experienced scientists and physicians who use their cumulative knowledge and judgment are highly valued, particularly if they incorporate the latest research and techniques into their research or practice.

inherently disease-causing process (i.e., a process of biological failure), and thus a medical "problem" (Estes and Binney 1989)? Others, notably John Rowe, a physician, and Robert Kahn, a psychologist, have pointed to other biomedical and scientific literature to argue that the medical and lay focus on the "negative" aspects of aging do not accurately represent the true experience of aging for most people (Rowe and Kahn 1998). Societal "myths of aging" include the axioms "to be old is to be sick" and "the secret to successful aging is to choose your parents wisely"; arguing against these "myths," Rowe and Kahn dispute the equation of old age and inevitable pathology, challenging the (reductionist) view that genetics determines longevity. The argument of "successful aging" is thus an almost neo-liberal stance that with self-determination one can overcome one's genetic heritage and socioeconomic circumstances through self-monitoring and education about the proper behavior to preserve health and thus prolong (a healthy) life. Yet, this attempt at bringing "context" into evaluating medically-based "myths" can be interpreted as another kind of reductionism: In this view, disease results from the individual's failure to take responsibility for prevention via education and lifestyle modifications, thus de-emphasizing or ignoring the contribution of sociocultural and life course factors.

The fact that biomedicine has not come to a consensus on the "true nature" of aging leaves us with an ambiguity surrounding the value of aging. Such ambiguity about whether aging is normal or pathological (and thus abnormal, bad, undesirable, and a target for medical intervention) is perhaps reflected in the devaluation of aging studies as an imperfect, even pseudo, science(Estes and Binney 1989).

In summary, fundamental biological approaches to aging are unclear on whether aging is normal or pathological. Biological fitness is based on an evolutionary model in which perpetuation of the species is paramount; in this context, the sexually unreproductive elder is generally considered unfit. Thus, a focus on defining aging in biological terms tends to devalue aging and the aged.

Biological and Biomedical Approaches in Aging Studies and American Society

Anthropologists and others have contended that biomedicine's theories of aging are the dominant cultural constructs defining aging in academic disciplines and in American society, not just in its hospitals and clinics. Carroll Estes suggests that "aging" as an interdisciplinary subject has been dominated by the biomedical model (which is individualistic and reductionist, as described below) (Estes and Binney 1989). Estes argues that the medical model, instead of social and behavioral frameworks, has become the "institutionalized thought structure" to examine problems associated with aging. The financial and intellectual prestige of the biomedical model (e.g., in published journals and funding) gives it power to provide incentives for gerontologists and others who study aging to legitimate and fund their research by focusing on health implications; problems become legitimate, fundable problems of "aging" by defining them as "problems of disease of old age." By framing problems associated with aging as health or disease-related, Estes argues that the lay public is led to believe that "these problems can only be solved by increased purchase/consumption of high cost medical services and technology."

Furthermore, Vern Bengston argues that gerontologists have focused on empirical studies to the detriment of theory-building in an effort to address functional problems of old age (i.e., the first research orientation listed above) and thus legitimize gerontology as a worthwhile field. Ironically, the building of theory—so fundamental to science—has been neglected; indeed, it is the difficulty of generating "universal" theory on aging that devalues gerontology as a true science.

Estes further argues that in biomedicine, individualism is a mode of reductionism, not contextualization.[6] Michel Foucault defined the "clinical gaze" as a distinct, objectifying way of seeing and conceptualizing reality that objectifies the patient, and is thus consistent with the reductionist scientific model (Foucault 1975). By ignoring "macrostructural" etiologies of ill

[6] The use of narrative analysis and narratives in medical practice, touted as a humanizing method, is, in Estes' view, another manifestation of individualism in biomedicine because it ignores larger social and environmental structures and factors (for example, see Kleinman, Arthur. 1988. The illness narratives: suffering, healing, and the human condition. New York: Basic Books).

health, medicine has "focused attention on individual health behaviors and lifestyles, making the individual responsible for illness" (Estes and Binney 1989).

Estes saw chronic illness (i.e., biomedically uncurable) or diseases of old age, and the focus on preventive or management modalities like nutrition, exercise, and lifestyle and home modifications,[7] as crises or sources of resistance to the preeminence of the biomedical model in curing human disease. Instead, chronic illness and lifestyle modifications, rather than remaining in a separate domain, have (arguably) been folded into "geriatric" medicine. This implies that the reach and scope of medicine's interventions into daily life and behavior has increased, particularly for the elderly with multiple chronic diseases.

Elders are admitted to nursing homes based (at least in part) on medical diagnoses. Nursing homes are hospital-like institutions for patients for whom even the latest and best biomedical treatment cannot provide a cure. Taken to its extreme, this means that nursing homes, and the patients within them, represent failures of modern biomedicine.[8] Correspondingly, unlike in acute hospitals, physicians are largely absent from residents' daily lives. Simultaneously, to "manage" residents' chronic diseases, physicians, nursing staff, and other staff, recommend and, to varying degrees, enforce, medically appropriate lifestyle interventions that limit residents' autonomy and touch nearly every facet of their daily lives. This tension between home and a health care institution is evidenced in the very terms used to describe people confined to nursing homes; staff may try to call the inhabitants "residents" but the word "patients" also appears in much discourse. Limitations to autonomy in a nursing home include what, when, and with whom, residents may eat. The home, the one place that represents almost unlimited autonomy, choice, and privacy, in Western values and society, thus becomes a site of

---

[7] For example, placing grab bars in bathrooms and eliminating throw rugs. Furthermore, such home modifications may be seen as more structural or environmental than individual in nature, and thus more amenable to policy intervention (e.g., building codes that make grab bars mandatory in all bathrooms).
[8] Nursing home residents often are admitted following a hospitalization, rather than voluntarily from the community (e.g., as an autonomous choice by a senior who believes it is time for her to make this life transition). While nursing homes may have a rehabilitative component, from which many residents return to the community, many residents stay for years, and die within the nursing home.

daily medical intervention. Residents in nursing homes live in the most highly regulated health care institution in contemporary American society. While nursing home institutionalization has been studied in the literature, focus has not been paid on how the biomedical model functions in specific contexts within nursing homes, such as during mealtimes; in particular, researchers have not studied how residents of non-Western cultural backgrounds experience immersion in an institution based on a Western biomedical model.

Social Science Concepts and Theories in Aging

The purpose of this section is to illustrate how social sciences have defined age and aging differently than the biomedical sciences.

Unlike biomedicine, social science approaches have tended to examine societal structures to explain aging related phenomena, and have tended to ignore the body as a "universal" experience and factor. In particular, anthropologists have focused on individuals' complex experiences in socioeconomic and cultural contexts.

Some key theories of aging are based in anthropology, social constructionism, life course studies, the aging and society paradigm, and a political economy perspective.

Anthropology in general is interested in the "entirety of human experience," in its historical, social, and ecological context resulting in "complexity and specificity rather than generalizations" (Fry 1999). In the broad genre of work denoted as social constructionist, subjectivity constructs reality; in ethnomethodology, one such approach within this genre, social interactions construct reality. Meanings in context, rather than things, define and organize the world. The heart of constructionist perspectives is an orientation toward everyday life that addresses the question of how social categories and social forms develop and enter into experience and so create meaningful behaviors and ideas.

Anthropologists have found that theories of age differ across cultures. In modern Western societies, as in biomedicine, age is by definition a chronological measure, and age (e.g.

life stage) defines appropriate behavior, at least in large part. In contrast, in some other societies (e.g., tribal societies), generations are the main system for "organizing the life course," and age in years may not even be tracked. Generations are "based on relative time," such that generational relations define age and structure social relationships. "Seniors" may include parents and people related to them by generation, "juniors" may be children, nieces, and nephews, while "peers" are "equals" (siblings, cousins) (Fry 1999).

While anthropology focuses on culture in lived contexts, sociology examines how a "human organism becomes a human being," and recognizes that "social interaction" is key for both becoming and maintaining "human status" (Dannefer and Uhlenberg 1999; Gubrium and Holstein 1999). Sociological approaches, such as life course studies and the aging and society paradigm, have recognized the role of social structures and historical context in shaping lives (Dannefer and Uhlenberg 1999; Riley, et al. 1999). A political economy perspective accounts for how political and economic structures stratify people by age and thus shape and organize different experiences of old age (Quadagno and Reid 1999).

In summary, most social sciences approaches have looked at structural and contextual sources of aging problems, rather than focusing on how individual world views are experienced and expressed in daily life, an orientation which anthropology takes and which will be used in this study. These approaches define problems of aging differently than biomedical approaches. Therefore, application of social science theories may offer alternative solutions to problems of aging.

Theories of Biomedicine

An anthropological approach to the research question may help address a gap in the literature—understanding how biomedical values are used in a nursing home, and how these are experienced and understood by residents, family, and staff.

Anthropologists use the term "world view" to capture the structure and totality of the beliefs, logics and practices that form a way of understanding reality. An attempt will be made in this paper to connect larger beliefs that constitute world views with the specific research question about lived experience; the premise is that lived experience and world views affect each other reciprocally.

The research question reflects several motivations beyond theoretical issues, such as my desire to treat elders with respect and compassion and to make nursing homes more humane places to live. Nursing homes, however, are health care institutions, and many practices that take place in nursing homes are motivated by health outcomes, which are defined in biomedical terms; the research question's relevance, in terms of health outcomes, touches on malnutrition (e.g., as manifested by weight loss) and mental health. Understandings of disease and disability, however, are manifestations of world view. The health concerns that the research question raises, such as malnutrition and mental health, have multiple, even contradictory, meanings attached to them, only some of which may be explicitly biomedical. That is, the biomedical meanings of health-related experiences in nursing homes may not be the most important meanings for residents or for staff. Margaret Lock argues that a medical anthropological approach to a health-related question must extend well beyond the clinical encounter because "analyzing the medical system just within the sick body-healer relationship does not reveal the complexity of disease within the world view" (Lock and Gordon 1988).

In this study, asking, "What does an institutionalized Chinese elder experience?" entails examining what is intended, implied, and assumed, by the labels of "Chinese," "elder," and "institutionalized." In other words, what are the (cultural) constructs at play in the experiences of interest?

The institution of the nursing home is built, in part, on the authority and epistemological dominance of a medical view of health and disease in the aged. Such world views inform behavior and derivative beliefs, shaping both larger policy and administrative decisions and the decisions

played out in daily life. The general ways in which a biomedical worldview is and is not manifested in daily nursing home life will be discussed in Section IV, along with competing and contradictory frameworks. However, the specific ways in which residents use or understand biomedical perception and values is lacking in the literature.

According to many anthropologists, biomedical values and perception are components of larger, more general world views which value and assume the preeminence of medical and scientific truths and the individual autonomy. This particular study attempts to address how such values are used among nursing home residents in their experience of food and meals. Like many medical anthropologists, Margaret Lock believes that there are "culture[s] of contemporary medicine," where "facets" are derived from a "value system characteristic of an industrial-capitalistic view of the world in which the idea that science represents an objective and value free body of knowledge is dominant" (Lock and Gordon 1988). Thus, Lock argues that the temptation to examine the "clinical encounter" out of context derives from a Western construct of a "reasonably autonomous," objective medical system that is "distinct from other social institutions" (Lock and Gordon 1988).

Deborah Gordon describes the fundamental beliefs that underlie biomedical ways of thinking, highlighting what she calls "tenacious assumptions" in the natural science and biomedical paradigms. Gordon argues that there are parallels between the assumed autonomy of nature in these paradigms and the "assumed autonomy of the individual in Western understanding of personhood, society, morality, and religion" (Gordon 1988). Naturalism, Gordon writes, is assumed to be autonomous from the supernatural, cultural, social, psychological, moral, and particular time and place. Furthermore, naturalism values truth above other criteria (e.g. goodness, creativity), and sees truth as universal.

This naturalism is the foundation of the reductionism found in the physical sciences; the individual, like the atom, is inherently natural and autonomous. The individual's true self is "restrained" by culture and society. Analogously, the Western ideal is the "free individual in

society," who "discovers one's true self" (Gordon 1988). The true self is independent of the body; when ill, the separation of the "psyche and the soma" preserves the "ideal self" as separate from the sick body (Kirmayer 1988).

An implication of the "free individual" ideal in society is that social institutions are meant to "provide means for realizing the ends of individuals," yet they are simultaneously a "potential threat to freedom" (Kirmayer 1988). The social institution, such as the nursing home or hospital, should serve the individual, even as its organizational structure constrains individual freedom.

The assumptions about the fundamental nature of the self and society manifests in Western morality and ethics, which "defend the sovereignty of the individual." The language of "rights" and "justice" seeks to ensure freedom from interference, equal treatment, and opportunity for development. In modern medicine, bioethics mandates that (competent) individuals have the right to be fully informed to make autonomous choices.

What are the implications of the "tenacious assumptions" described by Gordon? Values about self and society are derived from the basic assumption that there is an autonomous natural "truth." The ideal individual—and the ideal scientist—is one who seeks the truth about larger nature or about the individual's true self by setting aside culture, and acting independently. Similarly, as anthropologists argue, the biomedical model of disease causation works to "depoliticize" the medical encounter (Gordon 1988). Ideally, the value-neutral physician observes or sees the truth (i.e., diagnosis of pathology) in the patient's body, while the patient's true self (mind or psyche) is separate from the sick body (soma). The mixing of body and mind, for example in "psychosomatic illness" or somatization, or the mixing of the body and culture, is devalued. Despite ideals of value-neutral truth, anthropologists point out that there is "moral evaluation" involved in "explaining the why" of getting sick. Furthermore, medical sociologists have argued explicitly that because medicine in capitalist societies reflects the values of larger society, medicine "acts as an institution of social control."

Patient autonomy is the goal of patient rehabilitation in modern biomedicine. Patients who cannot set aside culture (i.e., "alternative" ethnic views or religious beliefs and practices) when addressing the needs of the sick body may be seen as unreasonable and irrational because they are devaluing the preeminence of the truth of the natural body, as diagnosed through physicians' ideally objective eye. "Ethnic" persons are those whose values and culture do not coincide with biomedical assumptions; their inability to act autonomously over the natural, true body due to the restraints of irrational "culture" suggests that they may be devalued within this paradigm.

To discipline the individual through autonomy means to become objective in observations of the (external to the individual) physical world, and thus to be able to discover the (highly coveted) truth.[9] Society and culture serve the individual, but also restrain the individual. At its extremes, Western individualism is anti-authority and anti-tradition; adherence to bounds of tradition limits the truth that can be observed.

Yet, despite biomedical emphasis on individualism and autonomy, in nursing homes, residents' safety is prioritized over autonomy. Why would this be so? Biomedical values and societal values define competent adulthood as a period marked by independence, including "normally developed" physical and cognitive capabilities. The ideal in medicine is the patient who gets back to his "old self" and thus is not altered by illness; this implies that one who is changed by illness is somehow weak.[10] Nursing home residents are generally frail; lacking physical and/or cognitive independence (i.e., body and intellect), they are not treated as fully competent to make their own autonomous decisions. Furthermore, they are changed by their often incurably disordered bodies and minds; for example, a significant proportion is afflicted with dementia, which "steals" the self. Thus, the biomedically appropriate way to help nursing home residents is to make them more independent, autonomous, and rational (i.e., for example,

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[9] Contrast this with spiritual traditions in which truth is sought through internally and individually focused meditation.

[10] Interestingly, the ideal contemporary cancer survivor is changed by illness for the better; s/he triumphed over the body and the "outside" antagonist, the cancer, yet the mental change has spiritual overtones.

rather than guiding them through social rituals that impart meaning to old age and dying, and reintegrating them into the community on social, emotionally meaningful grounds). However, because residents' chronic illnesses are often incurable this goal is not fully realized, and instead staff work to protect residents' safety. Furthermore, a political economic approach may suggest that residents' lack of full competence may also serve to justify staff's attention to their own self-interest—a desire not to be punished for poor results (i.e., to have their autonomy compromised)—by focusing on "patient safety" rather than patient autonomy.

Aihwa Ong highlights how political interests and values lie beneath the emphasis on individual choice and autonomy. Ong argues that the practices of medicine "govern through freedom"; good patients are good citizens, independent and self-reliant (Ong 2003). The patient's free will is to choose between a circumscribed set of "rational" choices.

Furthermore, as we will see in aging studies, science is a tradition based on objectivity; medicine is based on a tradition of practice, and so may be less highly valued than pure scientists. Nurses provide hands-on care to patients, while doctors diagnose. Even further removed than doctors from the objective eye of the true scientist, nurses are firmly entrenched in biomedical values even as their work is relatively devalued within biomedicine. As Evelyn Nakano Glenn observed, nursing home and hospital staff with the least patient contact had the highest prestige and the highest pay; furthermore, they were more likely to be white, i.e., non-ethnic (Glenn 2000).

The cultures of naturalism, science, and biomedicine, are fundamental to nursing homes. The American nursing home as an institution is based on particular Western world views in both its initial design and perpetuation, as will be discussed more detail in Section IV. Isolated within nursing homes, people from a variety of cultural backgrounds live as both residents in their homes and patients in hospitals. Within a social institution justified on medical terms, medical diagnoses may be given higher priority than sociocultural meanings. The particular formulations of Western values and the way they are practiced may not be compatible with

residents' views, and for ethnic minorities, such as Chinese elders, these differences may be stark. Elderly Chinese come to nursing homes with different, although likely overlapping, sets of perceived options for daily life and health care choices, and differing sets of values and priorities on which to base decisions.

Theories of Culture & Chinese Cultural Values

Anthropological Theories of Culture

Anthropologists have long argued that Western constructs of culture define culture as static, bounded monoliths, which I would call an assumption of "cultural constancy." Such reductionism and atomism in defining culture is consistent with science and biomedicine. In contrast, anthropologists tend to think of culture as dynamic phenomena created "on the ground" in social interactions and constantly influencing and being influenced by larger trends of politics and social change.

In contemporary biomedicine, a call for incorporating patients' personal experience into medical practice has led to the concept of "biopsychosocial medicine" (Engel 1977). However, the problem with biopsychosocial medicine is that it still rests on the fundamental "tenacious assumptions" described by Gordon, in particular, individualism. Sociologists argue that larger sociopolitical institutions structure unequal experience in aging. Within biopsychosocial medicine, the influence of these institutions on individual opportunities is seen as the background setting within which autonomous individuals are expected to carve their own paths. Narratives of personal experiences of illness are centered around the individual as the actor, and the impact of social institutions is both downplayed and devalued. Such narratives within biopsychosocial medicine thus tend to remove institutional structures as mutable actors in discourses about shifting power and social change.

Chinese Culture

Cultural Constancy

Chinese culture has its own constructions of cultural constancy. Since early Chinese colonization of other places in the 1500s, the idea of the "sojourner" or "overseas Chinese" has been a predominant model for the Chinese migrant (Skeldon 2003; Tu 1994; Woon 1983). Sojourners were usually men who traveled to other regions to take advantage of economic opportunity. The ideal sojourner would return home to China with his fortune, although in reality, the majority did not (Skeldon 2003). This cultural constancy is inseparable from Chinese colonial power and financial dominance; such cultural "preservation" was possible because of colonial power and also a means of maintaining and justifying differential relations of power and thus financial dominance over the "locals." In Chinese history, then, cultural constancy is tied to a history of cultural superiority, "cultural difference," and pride. The dispersal of Chinese throughout many countries, including the U.S., has been called the Chinese diaspora (Skeldon 2003; Tu 1994). However, the term "diaspora" (e.g., the Jewish diaspora, which describes the Jewish exile from their "homeland") implies an involuntary "break-up" and "scattering" of a people from their ancestral land, and thus masks the cultural pride and the financial and colonial motivations for much of this Chinese migration (Skeldon 2003).

Family & Aging

The primacy of the patrilineal, multigenerational family household in traditional Chinese culture is well documented, although the extent to which actual pre-modern and contemporary Chinese families have lived up to this ideal has been debated over time (Jacobs 1975; Lee 1949; Osborne 1948; Tsui 1989). Notions of family, "kinship" in anthropological research, shed light on the way the individual is conceived in Chinese cultures. The individual is defined persistently in relation to others, particularly family members, in hierarchical, generational patterns. In Chinese households today, family members are often called by their family relational role rather than their first name (e.g., big sister, little sister); children call adult friends of their parents' generation,

"aunt" or "uncle" to label, respect, and behave according to the generational differences and social norms appropriate to those relationships.

Of particular salience to this paper is the value of "filial piety" (Dai and Dimond 1998). Filial piety is a cultural and moral norm in many Asian cultures that relies on the family relational structure and which has "governed intergenerational relationships" in Chinese families (Lan 2002). The concept of the ideal family varies by culture, although features of the Chinese ideal family are not unique to Chinese culture. The ideal Chinese family was patriarchal, three-generational, defined by patrilineal inheritance, and resided together (Ebrey 1984; Jacobs 1975). There was a "moral contract" in which "childrearing [was] viewed as a social investment, with an expectation of delayed repayment, in the Chinese term *bao-da* (payback) [...] Children, especially sons, [were] thus obligated to return the debts through filial care to their aging parents"; a Chinese proverb states, "To raise a son, to protect yourself in old age." (Lan 2002).

Family caregiving is framed within a traditional Chinese model that emphasizes a "hierarchical concept of serving," which differs from a more "egalitarian" concept of "caring"(Lan 2002). Daughters-in-law illustrate the concepts of dutiful service based on, arguably, a primarily cultural rather than biological concept of family. Filial piety dictates that daughters-in-law are "expected" to care for her husband's parents because the traditional patrilineal family line incorporates women into the husband's family (Chao and Roth 2000). Daughters-in-law who care for frail elders have explained that "maintaining filial piety" is a "primary duty" and a "lifelong commitment," and is the "desired outcome" of their care (Chao and Roth 2000). While daughters-in-law were "willing" caregivers, they expressed a theme of "holding up" as they struggled with many hardships related to caregiving. Because rates of nursing home usage among Chinese elders in the United States are disproportionately low, the burden on families may go unrecognized.

Dementia is a common factor in institutional placement in the United States. The role of family dementia caregiving for ethnic elders has been explored in the literature, with emphases

on understanding intraethnic diversity, caregiver help-seeking processes and barriers to care, and how dementia is handled in primary care settings (Hinton 2002). Most caregiving for elders with dementia is provided within families, regardless of ethnicity (Hinton 2002; Hinton, et al. 1999). It has been suggested, however, that the "extended" kin and non-kin networks and the availability of "valued social roles" in old age in ethnic families may ease both caregiver burden and the experience of frailty and dementia for the elders (Connell and Gibson 1997 and Holzberg 1982, cited in Hinton, et al. 1999).

Even when elders exhibit dementia, the Chinese family model does not provide an outlet for relinquishing in-home family care, in part because personhood is defined within family relationships more than as autonomous individualism (Ikels 1997; Ikels 2002). Historically, dementia has not been biomedicalized in China. Rather than viewing dementia as a stigmatized mental disorder, "Ordinary Chinese" view dementia as a "natural aspect of aging" in which "childish" behavior is seen as normal for old age; as a result, elderly are "less fearful" and family members are "less appalled" by behaviors associated with dementia compared to Chinese elders and their families in the U.S. (Ikels 1997; Ikels 2002). Most importantly, there is a greater cultural value placed on "heart" or moral abilities; appropriate role affect as a family member has greater salience than cognitive abilities (Ikels 1997). Such cognitive abilities define the "self" in American culture, and intellect makes possible autonomous independence (and furthermore, the pursuit of truth and objectivity). In Chinese families, elders' physical disability is perceived to be a greater burden on family members than mild cognitive deficits. For example, Charlotte Ikels found that hemiparesis following a stroke is more feared than dementia. While nursing home placement rates may be lower in China than the U.S. because there are fewer nursing homes in China, Ikels' findings suggest that lower usage may be in part a result of cultural perceptions of aging (e.g., that dementia is not a pathological process) that do not frame the hardships of caregiving as problems that require outside intervention (Ikels 2002). Ladson Hinton has studied Chinese family caregiving for elders with dementia in a Chinese ethnic enclave in the U.S., and found

similar attitudes toward dementia as part of "normal aging" rather than a pathological condition, as Ikels found in her work in China (Hinton, et al. 2000).

Reinterpretation of Values

In modern China and in countries of the "Chinese diaspora," changes in household structure and financial demands have made the traditional expectations of filial piety difficult to uphold. Transnational migration, nuclear families, and two-income households, have limited immigrants' abilities and desire to care for frail elders at home. Daughters-in-law may be caught between caring for their husband's parents and caring for their own parents. Some qualitative studies have examined how filial piety is reinterpreted in such modern contexts, such as when families have hired "fictive kin" to fulfill the duties of filial piety (Lan 2002). Such reinterpretation of kinship and the practice of filial piety exhibits both cultural constancy and dynamic change over time.

Studies suggest that Chinese residents' experiences in nursing homes in the U.S. may be more positive and less difficult than those of non-Asian residents because of Chinese cultural values of collectivism and harmony. Most of the few studies of Chinese elders in nursing homes were conducted in Hong Kong, and there is no literature on the experience of immigrant or ethnic Chinese in nursing homes in the U.S. As an example of the former group of studies, Diana Lee used grounded theory to study the cultural context of adjustment to nursing home life for Chinese elders in Hong Kong (Lee, et al. 2002). Although non-Asian studies have found that new residents typically respond to "nursing home placement with a great deal of emotional distress, feelings of loss, and fear," Lee found that Chinese elders in her study generally "made the transition with ease" (Lee, et al. 2002). She found that the values and practices of "collectivism" over "individuality," "harmony and balance," and "protecting the face," are fundamental to understanding elders' experiences. Collectivism is a "conception of the person as deeply embedded in the group *without legitimate autonomous interests*" (Schwartz 1994, cited in Lee, et al.

2002, emphasis added). Collectivism is manifested in the lived experiences of Chinese elders who are used to "sharing common facilities and eat[ing] together as a big family" in the patrilineal family household (Lee, et al. 2002). Lee thus argues that the "problems of rules and regulations and communal living" that, in Western studies, have been "major blocks to nursing home adjustment" are not a major factor for Chinese elders.

However, the greatest difficulties for the elders in Lee's study arose when trying to "protect the face," a belief and practice which refers to the "preserv[ation] of honor for oneself or one's family" (Wong 1999, cited in Lee 2002). Coupled with a priority placed on "harmony and balance," elders were hesitant to engage in overt conflict with other residents, due to the threat of "loss of face"; such social tensions meant that inter-resident relationships were often "tenuous" and insubstantial (Lee, et al. 2002).

Given that Chinese-American elders have low rates of nursing home use, a gap in the literature is research on whether Chinese nursing home residents in the United States have similar experiences and evaluations of nursing home life as the elders in studies of Hong Kong nursing home residents.

That cultural values can be applied in different ways with different results in a new setting, like a nursing home, is not surprising. Ethnicity and culture are not, as Jay Sokolovsky points out, static categories; ethnicity is a "creative act, meshing ancestral 'native' patterns with restraints imposed by the broader society and the demands of the local environment" (Sokolovsky 1997). In addition to restraints and demands, the appeal of alternative beliefs, values, and practices, also influences thought and behavior. Sokolovsky warns that ethnicity has too often been thought of as a "positive resource," a form of compensation for the problems associated with aging, in which an "overly optimistic" emphasis has been placed on informal social supports and ethnic family networks as the "saviors" of ethnic elderly. He asks researchers to consider the "impact of context on culture," with the main question of, "do ethnic distinctions

make real differences in the experience of aging?" This study is an attempt to help address this question.

Research on Elderly Immigrants

Overseas Chinese are migrants, specifically, immigrants (a term with legal status). What can be useful from the literature on migration in an anthropological examination of the experience of elderly Chinese? First, I will review the history of documented Chinese immigration to the U.S. as discussed in law and policy literature, then review theoretical approaches to the study of migration in sociology, demography, and anthropology, with an eye towards what these literatures may contribute to a better understanding of the lived experiences of institutionalized Chinese elders in the U.S.

Historically, U.S. immigration policy has reflected a desire to exclude Chinese, as well as other Asians, from migration to the U.S., until 1965, when a key policy change made possible large-scale migration from Asian nations, and thus changed the demographics of Chinese in the U.S. These policies on migration have been based on a variety of metaphors about immigration. The "melting pot ideology" was based on the ideal and expectation of assimilation, one based on the historical circumstances that have led to the amorphous "mixed European" ancestry of white Americans today (Hutchinson 1949; Massey 1995). However, Americans' beliefs about whether non-Northern or Western Europeans could, would, or should be allowed to immigrate and assimilate have changed over time. During the late 19th and early 20th centuries, Chinese, as well as other Asians (and non-Northern or Western Europeans), were considered undesirable immigrants in the American nativist point of view, and immigration policies were enacted to support this "restrictionist" attitude toward the "immigration problem,"[11] beginning most explicitly with the 1882 Chinese Exclusion Act, which denied permanent residence to Chinese

[11] See, for example, Smith, J. Allen. 1911 "The relation of Oriental immigration to the general immigration problem." *In* The American Economic Review 1 (2, Papers and Discussions of the Twenty-third Annual Meeting): 237-242.

migrants. (Hutchinson 1949; Massey 1995; Salyer 1995). Although additional acts sought to exclude Chinese migrants in the intervening years, the restrictionist view really "triumphed" in the 1920s, with the 1921 and 1924 Quota Acts, which instituted "national origin quotas" which favored Northern and Western European immigration, with the "stated purpose" of "maintain[ing] the cultural and racial homogeneity of the U.S." (Hutchinson 1949). It was not until World War II, when legislators became convinced that American exclusion of "Asiatics" was fodder for "damaging propaganda" abroad, that the Chinese Exclusion Acts were repealed in 1943, and Chinese were then allowed citizenship via naturalization. National origin quotas continued to limit legal migration until the 1965 amendments to the Immigration and Naturalization Act, which lifted the prohibition on Asian entry (with some legislators' explicit intent of facilitating "large-scale immigration from Asia"), removed the national origins quotas, and sought to encourage immigration of professionals and family reunification (Massey 1995; Reimers 1981). This led to "unprecedented" migration from Asian nations; in the 1960s, about 35,000 documented Chinese immigrants came to the U.S., while in the 1970s, the number grew to 347,000 (Massey 1995). Of course, these numbers do not reflect the (also increasing) numbers of undocumented migrants, although, understandably, statistics on undocumented migration are unreliable and probably underestimates (Massey 1995). This large-scale migration from Asia, including China, Taiwan, and Hong Kong, has shaped the demographic structure of Chinese communities in the U.S. Also during the 1970s and 1980s, much Asian migration to the U.S. came as a result of the Vietnam conflict, which led to U.S. resettlement of Southeast Asian refugees. Furthermore, as Douglas Massey points out, the unabating migration from Asia (and Latin America) has led to "new fears" among European-Americans that the "melting pot ideology" will not hold for these new non-European migrants, and that European-Americans' dominance of American culture and society is threatened. Thus, despite high levels of Asian immigration to the U.S., positive attitudes towards migrants or positive experiences among migrants should not be assumed.

As this brief summary of the history of immigration policy of Chinese and other Asian migration to the U.S. should suggest, attempts to formulate theories to explain migration is a daunting one. As such, migration has been studied in many disciplines in the social and behavioral sciences, most extensively in sociology, but also in public policy or political science, geography, demography, economics, psychology, and anthropology. Each discipline has tended to focus on different problems and used different data and theories; to explain migration, theories of migration have drawn on "asymmetrical dyads," such as individual vs. contextual reasons to migrate, economic migrant vs. political refugee, and push vs. pull factors (Cohen 1996). These dyads can be placed within three general levels of migration analysis which tend to emphasize the importance of certain factors over others (e.g., individual rational choice over structural barriers), which Thomas Faist identifies as micro ("individual values and expectancies"), meso ("collectives and social networks," which attempt to link micro and macro levels), and macro ("macro-level opportunity structures") (Faist 2000). Thus, although immigration studies has been multidisciplinary and is becoming more interdisciplinary, there is no one definitive theory of migration (Cohen 1996; Foner 2003).

The "conventional" view of the migrant has been, according to sociologist William Peterson in his review of the migration literature, that of a "young man of modest background" (Petersen 1978). As Peterson describes, until 1925, less than 1% of immigrants to the U.S. were professionals, and subsequently mostly constituted refugees; in more recent decades, however, there has been an increasing proportion of professionals. Sociologists have sought to explain migration (which may be defined, for example, as the crossing of a cultural or societal boundary), using such theoretical tools as push and pull, migration streams, and urbanization, which are more economic, geographic, and demographic in discipline than sociological; furthermore, these fields have also contributed significantly to migration studies (Petersen 1978). Peterson states that this led to sociologists' "relative neglect" of the role of "social institutions, group coherence, and collective behavior" in understanding migration. Meanwhile, geographers have used "spatial

models" to theorize as to how "forces" impel movement of people; economists have used labor force models to explain the "movement of workers," for example, temporary migration; and demographers have been concerned with population growth and how to measure (and define) migration (e.g., undocumented migration) (Petersen 1978). While capturing the complexity of the migration literature is beyond the scope of this paper, it should be clear that the study of migration has been extensive.

Compared to sociologists, anthropologists' interest in migration is relatively recent, although extending back at least sixty years. Michael Kearny has described how, during the 1950s and 1960s, "modernization theory" was the dominant sociological "paradigm" to understand "economic and social change" (including migration); based on the (Victorian) ideal and assumption of civilizing "development," modernization theory emphasized the "psychologistic, individualistic, microeconomistic, and ahistoric." Anthropologists used the basic ideas of modernization theory in their "community studies" but began to suspect that these suffered from a "terminal myopia" in that they did not relate to macro levels of study, i.e., historical-structural factors (Kearney 1986). By following their subjects from the (typically) "countryside" to the cities (and thus creating "urban anthropology") anthropologists focused on internal migration as "forced" or "pushed" by the (undeveloped) countryside towards urban areas (Foner 2000; Kearney 1986). At this time, anthropologists' focus in international migration was primarily on refugees and asylees, despite the massive increase in voluntary migrants from Asia for educational or economic benefits in the 1970s subsequent to the 1965 amendments (which came into effect in 1968). Eventually, urban anthropology came to focus on "migrants' links to their home societies, culture, community, and identity," and, since the 1990s, has been integral to "transnational" studies, while continuing to pay special attention to both continuity and change in cultural meanings and social practices (Foner 2000; Foner, et al. 2000).

In response to increasing migration and dual citizenship in a context of globalization, anthropological studies in transnationalism have challenged notions of bounded, territorial

nations and corresponding cultural constancy. Transnationalism represents an attempt to reconcile the modern discrepancies between melting pot assimilation theory and multiculturalism (e.g., "salad bowl"), in which atomistic immigrants retain bounded cultures, e.g., "overseas Chinese." A transnational perspective conceptualizes immigration as part of a pattern of transnational connections which foster familial, economic, social, organizational, religious, and political relations that span nation-state borders, and are motivated by both financial and political factors (Foner 2003). "Transnationals" in this formulation are young or middle-aged professionals, sometimes "satellite dads" who, unlike sojourners, travel back and forth repeatedly between multiple locations (a practice also called "circular migration"), such that "home" becomes unclear (Ong 1999).

The elderly have been generally absent from immigration studies because host countries' immigration policies excluded the elderly because they were not "economic migrants"; rather than supplying labor (resources), elderly immigrants would require the host countries' resources. Thus, the elderly are not included among the new transnationals. Elders appear, not as the subject transnationals, but as the aging parents of the subjects. Elders may arrive in one of the landing places to be cared for and managed, but they are largely missing from this reformulation of the international migrant. Furthermore, transnationalism does not provide a framework for understanding how elder immigrants may interact with medical and other institutions.

Gay Becker has examined the nexus of aging and migration in her work among Cambodian refugees, in which sociocultural "liminality" may be more a result of unwilling migration than cultural difference. She found Cambodian refugees' experience of migration to be a "creating [of] continuity after disruption," where "cultural adjustment" would be a lifelong process (Becker and Beyene 1999). The notion of "liminality" has been applied to disabled persons, as well as institutionalized elders (Shield 1988). Becker applies liminality to refugees because they have been "declassified," but not yet "reclassified." She differentiates refugees from immigrants because the former migrate "involuntarily and without preparation and planning,"

while immigrants are "willing" economic migrants. However, while immigration may be willing, there are often push factors that make the choice to migrate the only perceived viable option (Guest 2003).

Leo Chavez has argued for the study of immigration in medical anthropology (Chavez 2003). He discusses citizens' perceived "right" to health care, which are not necessarily extended to immigrants. Immigration policy defined by nation-states and territorial political entities (e.g., as a xenophobic "immigration problem" that focused on both the causes and consequences of undesirable immigration), links migration studies with discourse on citizenship rights (Foner, et al. 2000). American citizenship is value-laden with particular assumptions, values, and expectations (Lowe 1996); the self-governing individual is an ideal that is underpinned, like biomedicine, with assumptions of the inherent value of independence and individualism (Ong 1999). Like political economists, Chavez sees immigrants as "disadvantageously embedded in a political economy of health care characterized by pervasive structural inequalities." Access to care, particularly for non-emergencies, depends on ability to pay out of pocket, and the 1996 welfare reform law denies some legal and undocumented immigrants access to many medical and social services. Furthermore, elders who migrate may not have access to long-term care because they are not eligible Medicare or Medicaid, tax-based programs to which they did not contribute.

In summary, the "tenacious assumptions" behind the biomedical model have also infused theories of aging and culture, devaluing aging and culture and defining the problems in old age as fundamentally biomedical in origin (Gordon 1988). The role of culture in ethnic elders' experiences is unclear; theories about culture (as well as popular lay notions) tend to suggest a cultural constancy among elders, especially ethnic Chinese migrants (overseas Chinese). Studies of institutionalized Chinese in Hong Kong and community-dwelling Chinese elders in the U.S. suggest, not surprisingly, that certain cultural values, such as filial piety within the traditional patrilineal household, are interpreted differently in changing societal circumstances. However, there is a dearth in the literature on the experience of Chinese elders in American nursing homes

or other long-term care. The literature on migration shows a history of American restrictionist attitudes and U.S. policy that have excluded Asian immigration, despite trends toward continuing and growing migration from Asia. Explanations for Asian migration have tended to address migration in terms of labor and economics, largely because most migrants (not just Asians) have been young men. As such, the migration of elders or the current situation of aging migrants lacks a theoretical paradigm for understanding the experience of such elders, a situation that is not alleviated by recent transnational studies. Such work as Becker's on ethnic refugees suggests, however, that ethnic migrants experience social "liminality," similar to the liminality that Shield described in her work with nursing home residents. The status of Chinese migrants should be considered in the context of the meaning of American citizenship—the rights and responsibilities to be self-governing and independent and individualistic—and what kind of access legal and undocumented migrants may have, or should have, to long-term care services, such as through Medicaid or Medicare. As Chavez states, however, the interaction of immigrants with the receiving society is medically important; there is the confrontation between immigrants' cultural beliefs and practices and those of health care providers and the larger society, the stigma of disease associated with particular groups, structural obstacles to seeking care, and limitations of interventions at the individual instead of societal level (Chavez 2003). These issues should not be separated from the perception of the "deserving" migrant in the historical context of immigration as inextricably intertwined with racial or ethnic issues (e.g., xenophobia) and the (young) migrant as a source of labor.

Section IV: Three Empirical Areas

This section seeks to place the specific research question within the discourses of empirical studies in the literatures on aging. Some of these studies have yielded theories about the phenomena described, and those theories will be discussed. The intent of the research question is to examine whether findings and theories from past empirical studies of

institutionalization, food and meals, and institutional caregiving, are applicable in the experiences of particular nursing home residents.

Nursing Homes

History & Public Policy

The peculiar blend of medical and nursing care and residential living that is found in nursing homes is a result of historical circumstances and the resulting public policy. Bruce Vladeck argued that the "unloving care" and brutal conditions found in many nursing homes in the mid- to late-twentieth century was a manifestation of poor public policy decisions governing the formation and regulation of nursing homes (Vladeck 1980).

Vladeck described how early public welfare programs for poor elderly consisted solely of institutions supported by local county funds. Historically, early American hospitals were modeled on seventeenth-century English hospitals, which functioned primarily as shelters rather than medical institutions (Shield 1988). The "aged and indigent" lived in poorhouses supported by charity, rather than hospitals, and work was required of the inmates. Poorhouses' "unsavory reputation" was largely deemed acceptable because most of the poor were not considered "deserving"; a "Puritan suspicion that moral degeneracy was the cause of poverty often held sway" (Vladeck 1980).

However, by the early 1900s, multiple factors led to an increase in the number of older people and demand for alternative housing; such factors included "weakening of family ties," industrialization, urbanization, residential mobility, and single-family housing (Farmer 1996). By 1923, more than half of all almshouse residents were over age 65, resulting "in the words of the Department of Labor, [in] 'insanity, feeble-mindedness, depravity, and respectable old age [...] mingled in haphazard unconcern'" (Vladeck 1980). According to a 1925 Department of Labor report cited by Vladeck, small almshouses and many city facilities were characterized by "dilapidation, [...] even indecency," and "ignorance," along with a "complete lack of

comprehension [among managing personnel] of the social element involved in the conduct of a public institution" (Vladeck 1980).

Such poorhouses were common until the 1930s, but public demand for reform was overshadowed by the call for an "old age pension." The resulting Social Security legislation lacked any form of health insurance, and in an effort to prevent support of almshouses, benefits would be paid "only [to] those patients receiving temporary care in hospitals [who] were eligible for state support," thus effectively excluding inmates of public institutions and rewarding noninstitutional, proprietary care (Shield 1988; Vladeck 1980). The provision of care to the poor and indigent was no longer seen as the domain of charity (or an obligation of local governments) but instead an opportunity for government reimbursement at the federal level; as a result, the number of public nursing home beds barely increased, while the number of proprietary beds increased dramatically, since elderly could receive benefits and now afford to live in institutional care (Shield 1988). This was the seed of the contemporary proprietary nursing home industry.

Following World War II, increased demand for health care meant that hospital investment became an increasingly important priority (Vladeck 1980). In 1946, Congress passed the Hospital Survey and Construction Act (known as Hill-Burton) which "subsidized private, voluntary hospitals." Almost ten years later, Hill-Burton was amended to provide grants for construction of nursing homes; in so doing, Hill-Burton placed nursing homes into the "ideology of "progressive patient care" which is still prevalent today, in which patients are "moved from one level of service intensity to another as their condition changed." In this health care model, nursing homes became the "final stage of institutionalization for the chronically ill requiring long-term convalescence." By incorporating nursing homes into the medical model of care provision, nursing homes were designed and constructed according to (minimally modified) hospital standards. For example, the open wards of older nursing homes, were modeled on the hospital Nightingale-style wards where each patient had an individualized hygienic space and, from a central nursing station, just a few nurses could observe the whole ward.

In 1965, Social Security legislation was amended to include Medicare and Medicaid; Medicare coverage of nursing home care is limited to one hundred days following an acute hospitalization of at least three days, while Medicaid remains an important source of funding of long term institutional care (Shield 1988). Thus, as Farmer points out, the financial strain of the Depression eventually led to "the linkage of old age, health care, and federal intervention" (Farmer 1996).

Through the mid-1950s, nursing homes remained largely custodial in nature. However, as the definition of institutions for the elderly changed from poorhouses to nursing homes, staffing requirements also changed over time, reflecting the increasing medicalization of nursing home care as well as nursing homes' dependence on federal reimbursement (Shield 1988). By 1969, a full-time registered nurse (RN) was required at nursing homes that received federal reimbursement. Because most nursing homes did not meet Medicaid requirements for "skilled nursing facilities" (SNFs), in 1970, the Miller Amendment created a system of Intermediate Care Facilities, in which "lower staffing standards were considered appropriate" because "custodial care," rather than nursing care, was provided (Shield 1988; Stafford 2003). However, such custodial care facilities are not the focus of this literature review and my study.

In summary, prior to the Depression, poorhouses, public facilities, and boarding homes, which were often "found to be unfit for habitation," were the primary source of institutional care for poor elderly (Farmer 1996). Yet, despite policy that created nursing homes for those in "respectable old age" who found themselves destitute, nursing homes became well known for tragic incidents and incomplete standards enforcement (Shield 1988). Erving Goffman's 1961 study, *Asylums*, was one of the first major academic studies of institutionalization.

Themes in Anthropological Studies of Nursing Homes

The Total Institution

Using the prison as the prototypical total institution, but including "mental hospitals" and "nursing homes," *Asylums* defines the characteristics of a "total institution" that shape the experience of living or working in such an institution (Goffman 1961). Goffman's work has informed much of the academic literature on nursing homes. In total institutions, Goffman argued that individuals were stripped of their outside identities, and the physical domains of work and home (public and private) were collapsed.

A review of the nursing home ethnography literature reveals interrelated themes that can be set within larger frameworks, often pinned at the foundation by Goffman's work on total institutions.

Worlds in Conflict

> *In a somewhat wounded tone, [the Head Nurse] demanded specifics. What, exactly, was making me unhappy? [...]* ***I didn't want to break out into accusations about the dreadful food, [..] the dehumanizing effect of treating everyone as senile, [...] the absence of any sort of medical care*** *except for a patient obviously in extremis.* ***I felt cowed and timid,*** *as Florence and I had felt when we slavishly assured the dietitian we were satisfied with the food. [...]* ***If I said too much, there could be reprisals.*** *[...] I merely thanked her and said that in the future I would do as she suggested.*
>
> --*Carobeth Laird,* Limbo

Gubrium's ethnography *Living and Dying at Murray Manor* is a foundational work in nursing home ethnography (Gubrium 1975). As in Goffman's work on total institutions, Gubrium finds explanatory meaning in connecting physical place and social worlds. Gubrium describes how certain areas of the nursing home, which he calls Murray Manor, are designated private or public, and within these physical spaces, inhabitants use particular worlds with their own "logics" (e.g., ideals, sense of justice, duties). Gubrium extends Goffman's work in arguing that changing physical places can change the meaning or effect of social logics; for example, he found that "top staff" (e.g. administrators, top staff nurses, physicians) and residents had similar attitudes towards death, but when these social logics met on the ward floors, they conflicted in practice.

Gubrium found three meaningful social worlds, that of the top staff, the nurse's aides (today, certified nursing assistants), and the residents. Top staff in Murray Manor, as in nursing homes today, are rarely found on the wards, and have little resident contact compared to the CNAs. The more power or prestige a person held in the nursing home, the less patient contact he or she had. As is legally mandated, physicians are to visit their patients in nursing homes once monthly; most nursing home ethnographies report that this is rarely complied with (Gubrium 1975; Kayser-Jones 1981). Bruce Vladeck called this phenomenon simply, "the Missing Physician" in his analysis of how public policy has structured nursing home organization (Vladeck 1980). As Laird wrote, "as a rule, in Golden Mesa [the nursing home] only doctors were harder to contact than nurses." Physicians' brief visits result in "momentary impressions" captured in brief and "stylized" notes in the residents' chart (e.g. "cheerful today," or "appears depressed").

The physicians' and the CNAs' conflicting points of view were illustrated by these notes in the medical charts. The reduction of complexity to simplified medical language is not simply a summary, but a way of conceptualizing what is observed. Gubrium observed that top staff, including physicians, saw residents' motivations in terms of individual behavior, and addressed problems as individual interventions (e.g. changing medications). Significantly, CNAs approached the same difficulties with situational strategies; they changed the situation to minimize the effects of individual behaviors on their work. For example, their primary method was "sequencing," in which they carefully choreographed the sequence in which they managed their residents, for example, bringing "complainers" last to meals to minimize their wait times.

Bed-and-Body Work

Another key manifestation of the conflict between social worlds is in direct care. CNAs gave "lip service to ideals that approximate top staff's conception of total patient care"—ideals that focused on providing individualized, holistic care. However, in practice, CNAs were most concerned with what Gubrium calls "bed-and-body work." Such work focused on keeping the

body clean, groomed, and fed, and the beds made. As Nancy Foner found, the tension between demands for efficiency from top staff and the personal, individual needs of the residents, results in a "caregiving dilemma" that often is pushed towards efficiency (Foner 1995)[12] and "bed and body work." Like Carobeth Laird in *Limbo*, Gubrium describes a daily life overwhelmed with the details of tending to the failing body. This focus on appearance was critical to maintaining the minimum required for the top staff to claim that total patient care was achieved. However, the focus on bed-and-body work was effectively depersonalizing. Furthermore, depersonalizing bed-and-body work has been one of the factors that other ethnographers have identified as one of the defining aspects of nursing home life (Gass and Vladeck 2004; Kayser-Jones 1981).

Stripping Identity/Dehumanization/Lack of Choice

Jeanie Kayser-Jones compared two nursing homes, one in the U.S. and one in Scotland, to examine structural differences and the effect of structural characteristics on patient care, in her book *Old, Alone, and Neglected* (Kayser-Jones 1981). She was interested in the first hand experiences of those who were "old, disabled, and institutionalized." Her goal was to identify criteria for quality care that could be institutionally arranged to maintain a high standard of care. She found that care in the American nursing home—which was considered quite reputable—was "dehumanizing, without amenities giving humaneness, warmth, and meaning to life." As in Gubrium's study, the focus on bed-and-body work did not care for the "human side," and thus did not, to Kayser-Jones, constitute a high standard of care.

Kayser-Jones found that care at the Scottish nursing home was far superior to that in the American nursing home. In the Scottish home, certain reproductions of outside activities were truly "comparable to services in the community." Resident modesty was respected. Significantly, in multiple arenas, residents were allowed more choice, freedom, and independence. For example, residents were given a choice of entrees at every meal. Furthermore, as Kayser-Jones

[12] A more complete discussion of caregiving in institutions follows in Section IVc: Institutional Caregiving.

points out, food has nutritional, religious, and symbolic significance, and is a social and recreational activity from which pleasure is derived and care from others is expressed. As another example, certain activities constituted work that had "meaning"—which, as in Goffman's discussion, is the critical difference between work inside and outside the institution.

In contrast, Kayser-Jones found that in the American nursing home, four patterns of staff and patient interactions served to degrade residents' quality of care: infantilization, depersonalization, dehumanization, and victimization. In these characteristics, Kayser-Jones found that they "undermined dignity and self-worth, increased dependency," "deprived" individuals of "the factors that attach him to the social system" leading to a "loss of personality, or sense of identity," as well as "depriving [the resident] of human attributes." Kayser-Jones found that "routinized care and deprivation of individual choice" fostered and was a manifestation of these types of interactions.

The frameworks of the total institution and its separate social worlds with differing and conflicting priorities, which tend to objectify residents as receivers of care, foster what other ethnographers have characterized as a ritual-less, timeless limbo or liminal social space.

A Ritual-less, Timeless Limbo

Time plays different roles in different nursing home ethnographies. Goffman described the prison inmates as being a timeless place where achievements were unmarked and work did not contribute toward changes in status outside the institution (i.e. "work without meaning").

As in Goffman's *Asylums*, in Jay Gubrium's ethnography, time is not significant in the same way as it outside the nursing home. While markers of time are important for dividing up the day, there is a sameness, or timelessness, day-to-day. As Laird wrote about her experience of institutionalization, "Because of the timeless monotony of institutional life, I have forgotten how long I was in The Ward. One week? Ten days? Two weeks?" (Laird 1979). The importance of time is the problem of how to "fill" it, or finding ways of "passing time"; each day is divided into three

parts, defined by the three meals of the day: morning, afternoon, and evening (Gubrium 1975). Gubrium found that residents felt most comfortable in the mornings and evenings because they were most analogous to the way time was divided and used outside the nursing home; afternoons, however, were long, and residents found little to do. The reproduction or approximation of life outside the nursing home, and the inability to achieve this in the afternoons, is an interesting finding, because it points to the fact that life in the institution, despite being called a home, is deeply segregated from life in the community, and that the nursing home is unable to successfully reproduce life outside the nursing home within the nursing home. How this may be due to a change in the meaning of "outside" things within the nursing home will be discussed below.

Renee Rose Shield, in her ethnography *Uneasy Endings*, found that the nursing home was a place where people's social roles changed, yet they remained in a liminal, undefined, and timeless space (Shield 1988). Shield's ethnography is based on three theories: Goffman's "total institutions," reciprocity theory, and rites of passage theory. In the nursing home, Shield found that the inability of residents to reciprocate care degraded their status as adults, because adults' ability to give and receive is related to power, choice, and control. Without these, an adult in age cannot be an adult as a social role. Shield relates this socially liminal state to rites of passage theory; nursing home residents are removed from the community and are caught in the transition between the adult social role and death (i.e., the social role of the dead). Usually, transitions between social roles are accompanied by "rites of passage"—socially constructed rituals that provide support and meaning to these life changes, and simultaneously construct "communitas," a feeling of community and social interconnection. Shield found that in the nursing home, such rites of passage were absent, and the imminence of death was ignored in favor of a particular timelessness marked by institutional routine.

Carobeth Laird, quoted above, was an anthropologist and, for a time, a nursing home resident. She wrote about her experiences in *Limbo*, which provides examples of the phenomena

that Shield described in her ethnography (Laird 1979). Laird describes an existence overwhelmed by the details of "eating and excreting," in which daily life is defined by the struggles of tending to the physical body. In the nursing home, Laird describes a "limbo" state in which there is a disjunction between the staff and residents' views of her, and her own view of herself. She finds herself effectively isolated from the outside world, caused by a synergy between her physical limitations and the power dynamics in the nursing home. In the nursing home, she feels "helpless" and thus powerless; the CNAs dictate quality of life, not the nurses or the administrators, and she finds herself incapable to articulate her dissatisfaction to those "with authority." Laird found some reprieve from the demands of the body in religious ritual during the nursing home's regular Mass; such rituals, according to Shield's analysis, provide a means for making sense of the resident's new social role.

Making Gray Gold

Since the early 1990s, there have been efforts to account for the proprietary dimension of nursing home organizations, in part because the majority of nursing home beds today are proprietary, and because proprietary homes are accused of the some of the worst grievances leveled at nursing homes. Timothy Diamond and Bonnie Cashin Farmer have both examined the organizational framework of nursing homes as profit-driven enterprises (Diamond 1992; Farmer 1996). However, Diamond's work is based on his participant-observation fieldwork working as a CNA in multiple nursing homes, while Farmer's ethnography is based on observations.

Diamond connects residents and CNAs' daily experiences to larger structures that produce wealth—"making gray gold." He sees the regulation of caregiving as manifestations of labor economics, where minimizing labor costs to maximize profits is the underlying logic of regulatory practices. In this model, CNAs are cheap labor and the residents are "objects" that are worked upon. The relationship between technology and labor is reciprocal; "the use of one

mitigates the need for the other," thus encouraging the use of restraints and medications to prevent bad outcomes, rather than more caregivers.

Diamond thus emphasizes the "organizational context and set of rules" which defined caregiving as a commodity and turned caregiving into a capitalist industry. Such commodification, Diamond argues, was realized through "specific regulations of power" that removed power in decision-making and wish-fulfillment from the residents by "making people into things" upon whom caregiving was enacted, routinized, regulated, and made "efficient." Physicians, not just administrators, are complicit in the commodification of residents. The (bio)medical model legitimates the practice of redefining people as frail, physical bodies that need to be worked upon (i.e., cared for). As in Gubrium's Murray Manor, complex personal experience is simplified into "stylized" phrases that internalize problems to the individual, rather than seeking structural explanations—and thus structural interventions (Gubrium 1975).

The processing of complex reality into documents was controlled and defined by administrators and physicians, and it was the documents—not direct observations—that served as the reality to be inspected by the Department of Health.

As in Gubrium's ethnography, Farmer found an incredible attention to appearances (via bed-and-body work, which she calls "maintaining the body") in the nursing home she studied, which she calls the Meadows of Madison. Unlike in Gubrium's "Murray Manor," however, the attention to appearances was less explicitly about giving the appearance of total patient care but instead about the appearance and metaphor of a "hotel." The underlying "core value" is a "business model of service," in which the nursing home is run like hotel—customer service is key, not patient care per se. The administrator's guide is a book called, evocatively, *Service America!*, whose key lesson is that service that is customer-driven will result in financial success (Albrecht and Zemke 1985).

In this business model, Farmer found three "core values": appearances, customer service, and residents' rights. Residents' "choices" were emphasized; in meals, personal preferences are carefully attended to because the nursing home was likened to a restaurant.

Farmer points out that stated "core values" (i.e. the hotel or business model of service) can be and often are incongruous with "dominant processes," in this case, "maintaining the body." Farmer states that, "such a model does not reflect the unique needs of this particular organization called a nursing home." The emotional health of residents was neglected; Farmer found an "absence of resources to comfort." Furthermore, like Gubrium's social worlds, Farmer found that, despite administrators' focus on the business model, nursing and other staff would frequently dissent by saying, "but we *are* a *nursing home*."

Interestingly, the Meadows of Madison addresses two aspects of nursing home life that drew much criticism in earlier ethnographies, such as Kayser-Jones' *Old, alone, and neglected*: first, the focus on residents' rights in making daily life choices, and second, the maintenance of individual appearances, which is one aspect of identity maintenance and adult dignity. Farmer's work invites the question: despite its apparent weaknesses, is a hotel or business model of service an improvement over the traditional medical model of institutional care?

Resisting Bio-Power

Athena McLean provides a more recent conceptualization of power in the nursing home (McLean 2001). She also saw residents treated as "dehumanized objects," acted upon by "overworked, underpaid," working-class minority CNAs. Based on the literature, she points out ways that residents do assert some control; for example, they may exchange services, food, mimic staff behavior, limit indebtedness to staff, and "act out." With these strategies, however, they "risk being labeled 'difficult.'" Moreover, McLean argues that such individual strategies don't address the effects of "diffuse disciplinary power," that is, power that arises from larger structures rather than individual interactions. The "power structure" of the nursing home creates

an asymmetry between the power "available" to residents and to staff; within the nursing home, residents' autonomy is restricted because there is a reduced "range of choice." One aspect of this choice is the inability to *not* be observed; the spatiality of the institution is designed to "ensure ease of surveillance," resulting in "exposed bodies in power relations." This power over and by bodies is what Michel Foucault called "bio-power"; such power was achieved via "disciplinary technologies" derived from the authority of science and the law (Foucault 1975). In the nursing home, the paternalistic value of "protecting residents" authorizes the use of technologies to achieve power over residents' bodies.

Nursing Homes & the Biomedical Model

Although modern American nursing homes are based on a medical model of health care, the literature reviewed thus far has not explored the salience of the medical model in the nursing home. Stafford has argued that the "medical design" of the nursing home is a source of conflict with the "true dominance of nurses" (Stafford 2003). However, it could be argued that nursing homes are not dominated by a nursing framework either. Although they are called nursing homes, only a small proportion of hands-on care is provided by licensed or registered nurses because nurses spend a great deal of time managing paperwork and preparing medications. Kayser-Jones, a nurse, admonishes her field for, at times, neglecting to give "personal, humane, respectful care" to nursing home residents, which is a violation of "professional nursing ethics"; she quotes a fellow nurse, who wrote, "Have nurses indeed discarded the humanistic, caring approach to helpless patients in favor of impersonal technical services that may repair the body but crush the soul?" (Kayser-Jones 2000). In the discussion, the implications of the theoretical analysis on biomedical culture will be discussed in an examination of the cultures of nursing homes.

The Meaning of Food & Meals

"You eat, sleep, and sit around." –Jay Gubrium, Living and Dying at Murray Manor

In the nursing home ethnography literature, food has been discussed within the context of larger themes or theoretical frameworks, in particular, within organizational structures. Guided by Gubrium's framework of the three social worlds he found in a nursing home: the residents, the nurse's aides, and the top staff (Gubrium 1975), this section will begin with a review of findings within the general category of the meaning of food for residents. Then, the role of food within nursing home organizational structures will be discussed.[13]

As Joel Savinshky wrote, for residents, food "carries emotional and symbolic weight inside the institution" (Savinshky 2003). Savinshky found that food was a particularly potent symbol of "domesticity." Renee Rose Shield places the "domesticity" of food within a rites-of-passage theoretical context (Shield 1988). Shield found that one of the early stages of adjustment to nursing home life was "giving up the outside," a process which included "breaking up" the previous home, giving up driving, and giving up the refrigerator and food. She found that for many residents—in particular, women, since women predominate in nursing homes—food was a symbol of past nurturing, childhood, mothering, and hosting guests. Having one's own refrigerator, with the ability to control one's own food sources, including the ability to offer food or drinks to guests, or cook for family and guests, was sorely missed. Shield also found that giving up the kitchen table was also symbolic and filled with meaning, because kitchen tables were sites of meal-sharing with family. Thus, Shield highlights the connection between institutional food and the experience of institutionalization, in particular the processes of "role-stripping" (Goffman 1961).

Despite the emotionally symbolic meaning of domesticity, including family and social connections through food, Shield and others have found that mealtimes in the nursing home were not consistently social (Shield 1988). The nursing homes that Shield studied mixed

[13] Some relevant nutritional and medical considerations will be discussed in Section C: Institutional Caregiving. This paper is focusing on the social and cultural meanings of fffoodfood and meals and the manifestations of such meanings in institutional life. The literatures on nutrition in aging, oral health, dysphagias, and other causes of malnutrition, are extensive are beyond the scope of this discussion.

residents of varying cognitive and physical ability in the dining setting. She found that "alert" residents would avoid talking, even with other alert residents, to avoid unpleasant interactions with "confused residents." An examination of social interaction at mealtimes is likely not complete, however, without considering the importance of non-verbal communication. In Carobeth Laird's personal experience as a nursing home resident, she describes a wordless relationship with a silent resident based on sharing of food that she claims "emotionally sustained" both her and the other resident (Laird 1979). Food plays an emotionally visceral role in *Limbo*; Laird cannot complain enough about the consistently bad, poor quality, and unvarying food.

Kayser-Jones and Farmer have described the not uncommon arrangement where meals are served in separate dining areas based on overall disability and in particular separating "feeders" (residents requiring total assistance with eating) from those who can eat independently (Farmer 1996; Kayser-Jones 1981). In the nursing homes they described, the institutions made explicit efforts to make the mealtime experience for independent eaters appear non-institutional, for example, by providing choice of entrée, flowers on tables, and tablecloths. In these homes, Kayser-Jones and Farmer found more social interaction during mealtimes.

Beyond mealtimes as a time for potential social interaction, the significance of food in social interaction is also a form of social reciprocity (Shield 1988). Residents use food as "social currency," in which the giving and receiving of food establishes and maintains social relationships (Savinshky 2003). However, Shield found that such food-sharing among residents was generally lacking (due to institutional living restrictions, as discussed above), and cited this as an example of how residents are organizationally prevented from social reciprocity in general that in earlier adult life works to maintain meaningful social roles. Shield thus argues that such lack of opportunity for social reciprocity, one example being food-sharing as social currency, places residents in a socially liminal state.

Food in social reciprocity with staff has also been addressed, usually as a manifestation of how residents are unable to reciprocate with staff using methods that are socially acceptable outside the nursing home (e.g., giving of food or other items as gifts).

As Savinshky noted, food structured experience in the nursing home on multiple levels. Time is structured around meals and because meals are a social opportunity, food also structures "sociability." Rules around food-sharing also shape opportunities for social reciprocity. Perhaps because of its important role in structuring nursing home life, Savinshky ultimately found that food served as a proxy for residents to express the totality of their satisfaction and dissatisfaction with nursing home life. At mealtime, Savinshky found that the social opportunity was often devoted to discussion of the food; residents "displace[d] their pleasures and displeasures with life onto the quality and quantity of institutional food" (Savinshky 2003).

In summary, food has been found to be a meaningful symbol and manifestation of past domesticity and social life for nursing home residents. Yet, in many studies, opportunities around food to engage in social reciprocity among residents and with staff were lacking, often due to organizational structure (e.g., rules or regulations). Food structures daily nursing home life in a way that perhaps contributes to residents' use of food evaluation as a socially acceptable way to express feelings about institutional life.

This discussion of the residents' perspective can now be extended to include a review of the meaning and role of food in formal organizational structures. Many of the findings are based on the theme of resident objectification, in particular as recipients of care, a theme described by Goffman.

Diamond and Farmer evaluate the significance of food as an example of institutional organization and control over residents. In Diamond's study, food was nutrition, another aspect of formal care that was heavily regulated and inspected by outside agencies. Diamond discusses how food was placed outside the power of residents to control and evaluate it; food was turned into an abstraction, where the reality of food was labeled, measured, and documented in

nutritional terms (Diamond 1992). For example, residents complained of a "tomato soup" that was, by their experience, actually "water soup." Nevertheless, when the Department of Health inspected the facility, they spent little time with residents or looking at the food itself, but instead examined the records documenting adequate nutrition. The residents, thus, possessed little power in their evaluation of the food to affect their choice.

The official policies that are supposed to prevent residents from giving or sharing food (or other gifts) with staff has been cited as an example of how the objectification of residents as recipients of care is formally achieved. However, personal stories have provided examples of how rules are broken or social boundaries are reworked in practice. For example, Thomas Gass worked as a nurse's aide and describes how some residents would secretly share treats brought by family with favorite aides (Gass and Vladeck 2004).

As noted earlier, Farmer, like Kayser-Jones in a Scottish nursing home, found an unusual case in which residents were given meal choices, personal preferences were carefully attended to, and even pureed foods were made visually appealing (Farmer 1996; Kayser-Jones 1981). As described above, in Farmer's study, the attention to attractive food, good service, and residents' rights (i.e., choice) was explicitly about maintaining a business strategy based on a hotel or restaurant model of service, rather than about preserving residents' dignity, autonomy, and sociocultural beliefs and practices. While these latter goals are not necessarily in conflict with the goal of a hotel model of service, one could argue that the methods in which goals are achieved may color the value or meaning ascribed to those practices, specifically, attention to residents' rights.

Jeanie Kayser-Jones is the only researcher who has done extensive qualitative, as well as mixed-method, research on residents' mealtime experiences. However, a detailed review of her research is included in the next section on institutional caregiving, because her focus has largely been on mealtime experiences within the context of nursing care.

Institutional Caregiving

> *I was concerned about my blood pressure and had other problems I wished to discuss with a physician. I was told soothingly, 'Dr. Hawke usually comes in around the first of the month.' [...] **Dr. Hawke never saw me.** [...] **RNs were very exalted beings.** If you needed something, you told your nurses' aide (if she saw fit to answer your light) [...] **The most important persons in our lives,** the real arbiters of our daily destinies, **were the nurses' aides**, the 'girls.'*
>
> --*Carobeth Laird*, Limbo

An examination of nursing home cultures is incomplete without examining the particular ways in which caregiving is defined and practiced in nursing homes. This section will discuss the findings from studies on the work of certified nurse aides (CNAs) and then provide a focused review of the literature on institutional caregiving, which is typically provided during mealtimes by CNAs. Discussion of the role of family caregiving in institutions will also be included.

CNAs are responsible for the physically intimate work of hands-on care in nursing homes, which shapes the daily life experience of residents far more than nurses and certainly physicians (Vladeck 1980). Numerous authors have pointed out that the staff with the most contact with residents—the staff who know the residents best—are also the least trained and most poorly paid in the pay and prestige hierarchy. In Carobeth Laird's words, quality of life was "dictated" by the "girls" (the CNAs), and she scoffed at the notion put forward by administrators and nurses that she could affect the CNAs' decisions by complaining to top staff (Laird 1979).

Timothy Diamond's *Making Gray Gold*, discussed earlier, focused on the structures of labor rather than the complexity of CNAs' daily work (Diamond 1992). In his view, CNAs and residents are two aspects (the actors and the acted upon) of a "pauperized" group that are simultaneously exploited to make money for the administrators and the physicians. More recently, in his ethnography about his work as a nurse's aide in a for-profit nursing home, Thomas Gass makes a similar argument; he found that administrative, state, and federal regulations ruled his and his fellow CNAs' work such that the meaning of caregiving was defined

as maintenance of the physical body (Gass and Vladeck 2004). Gass argues that the "undoab[ility]" of the long "list of job tasks" fostered the arbitrary and irrational application of select regulations that resulted in a depersonalized body maintenance rather than care of the person.

In contrast, Nancy Foner's ethnography, *The Caregiving Dilemma*, focuses on the conflicts within CNAs' work from their perspective, rather than residents' or top staff perspectives (Foner 1995). The dilemma she articulates is the conflict between structural aspects of the institution (e.g., "bureaucratic demands for efficiency") and residents' individual emotional and physical care needs. Foner examines the contradictions and ambiguities that CNAs face daily. Residents are both a source of pressures and frustrations—in part because the institution focuses on "patient's rights" over "worker's rights"—and of emotional satisfactions. Like "mother's wit" in Diamond's *Making Gray Gold*, Foner found that the "mother role" provided a skill base and patterns of behavior for CNAs to draw upon in their paid labor, while also giving meaning to their work, as manifested in their use of fictive kin terms in referring to their residents as either children or parents. Furthermore, shared mothering experiences and shared gender and ethnicity provided a basis for solidarity and bonding among CNAs. Nevertheless, the administration, physicians, and nurses, did not recognize the contribution of the "mother role," and such skills were not well rewarded in wages.

In addition to institutional culture, ethnic or cultural diversity among staff and residents may also explain values and behaviors, in particular contributing to objectification of residents as "other" or, to return to Goffman, objects to be worked upon. Reed-Danahay points out that nursing home studies have focused on "institutional culture" rather than cultural diversity as explanations for observed phenomena (Reed-Danahay 1997). Most nursing home residents are white (96%), while CNAs are 40% non-white, and mostly women (90%). Registered nurses, in contrast, are 95% white. Reed-Danahay argues that such cultural and ethnic dimensions, societal power discrepancies, and "we-they" distinctions are important because care is related to the

"recognition of a common human bond." In her review of literature, Reed-Danahay found that there was much more staff-patient interaction when residents and staff were ethically and racially homogenous, although quality of care was more difficult to measure.

Mealtime Caregiving

> *One of Mrs. Sariano's two daughters visits daily. They bring food for themselves and their mother, eating their lunch and dinner at her bedside. [...]The daughters feed Mrs. Sariano slowly and patiently. [...] 'When she eats, I feel happy,' one daughter explained. [...] Each day the daughters bring some of her favorite: an omelet, a Filipino stew (with fresh vegetables) or a nutritious homemade Filipino dessert.*
>
> *--Jeanie Kayser-Jones, "Mealtime in Nursing Homes"*

Both Jeanie Kayser-Jones and Nancy Foner have examined food within caregiver-resident relationships. Foner's focus on the CNA-resident relationship framed food within the "caregiving dilemma," a balance between caring for residents (e.g., preventing weight loss), and the demands for efficiency coming from the administration (e.g;, strict time limits for feeding) (Foner 1995). Foner found that feeding was an example of an arena in which CNAs' work is not unskilled work, as is perhaps commonly assumed—the skills required in feeding and in feeding efficiently were significant. Foner found that because skill was necessary, feeding was also an arena in which abuse occurred, where CNAs and residents were both perpetrators and recipients.

Jeanie Kayser-Jones, a nurse, has used qualitative methods to examine food, feeding, and mealtimes, in a practical context of observing and preventing malnutrition, starvation, and dehydration in nursing homes; like Foner, she emphasizes that skill and training are necessary for good mealtime caregiving. Kayser-Jones is perhaps the only anthropologist or sociologist who has focused on food and mealtimes in the nursing home (Kayser-Jones 1996; Kayser-Jones 1997; Kayser-Jones 2001; Kayser-Jones 2002; Kayser-Jones and Schell 1997; Kayser-Jones and Schell 1997; Kayser-Jones, et al. 1999).

Elderly nursing home residents are at risk of inadequate dietary intake and protein-calorie malnutrition; malnutrition is "common, serious, and undertreated" with

prevalence of protein-calorie malnutrition ranging from 17 to 65% (Kayser-Jones, et al. 1998; Schell and Kayser-Jones 1999). The common causes of malnutrition make up a "constellation of interacting factors," including lack of "provision of attractive food in a pleasant dining environment," lack of "remediation of swallowing and oral health problems," "sufficient staffing to assist residents," the "interactional skills and abilities of the caregivers" when residents are "eating-dependent," medications, and general "lack of attention to individual needs" (Kayser-Jones 1996; Schell and Kayser-Jones 1999).

Nursing staff are certainly aware that malnutrition is a risk, and regulations require that nutritional status be monitored. This is typically achieved by serial weight measurements—i.e., not necessarily by monitoring food intake; when a specified amount of weight loss is found, nurses must notify the resident's physician (Kayser-Jones, et al. 1998).

Based on her findings, Kayser-Jones has framed the goal and the problem of institutional mealtime caregiving in terms of "individualized care" (Kayser-Jones 1996). Such individualized care consists of "providing food that residents like and enjoy" and "providing help to those who need assistance with eating in a manner that is safe and preserves their dignity" (Kayser-Jones 1996).

Perhaps the prime reason of such neglect is "inadequate" staffing at mealtime, a problem that, Kayser-Jones notes, has been around for "decades." In 1990, 88% of American nursing homes needed more CNAs (Kayser-Jones 1997). Understaffing, Kayser-Jones argues, is a "major factor that contributes to weight loss" (Kayser-Jones 1997).

Kayser-Jones has given many examples of how CNAs used multiple strategies to accomplish "feeding" efficiently given their heavy workload (Kayser-Jones, et al. 1998). A not uncommon consequence of weight loss is that a physician will order a liquid oral dietary supplement, which the CNAs are then responsible for providing to the resident. Kayser-Jones found that liquid supplements were often used as a substitute for food, particularly during understaffed shifts (Kayser-Jones, et al. 1998). As Kayser-Jones points out, this is unfortunate

because food is often one of the few remaining pleasures for frail nursing home residents. Furthermore, because CNAs were typically not well-trained, and were often unsupervised, their strategies often resulted in poor quality of care. On evening and weekend shifts when staffing levels were lowest, CNAs were generally unsupervised (e.g., by nurses or dietitians).

Ellen Schell, also a nurse, emphasizes one particular aspect in lack of training in a symbolic interactionist approach to the problem of poor mealtime care by CNAs. Symbolic interaction is a "sociological theory that stresses the role of face-to-face interchanges in shaping behavior"; role-taking refers to the "ability to see the world from another's perspective" and is therefore central to "compassion" and is necessary in the "provision of sensitive, humane care" (Schell and Kayser-Jones 1999). A requirement of role-taking skill is knowledge of the other person (e.g., food preferences, past experience); therefore, the ability of CNAs to imagine the resident's perspective depends on the quality of their relationship.

Schell found that "task-driven, mechanistic care" was defined by ineffective role taking, manifested in behaviors such as not addressing the resident or failing to "support autonomy" (e.g., offering choice). Schell wrote that these behaviors showed CNAs' "tendency to control and infantalize residents." CNAs' treatment of meals as work rather than as a potentially meaningful and pleasurable social event is most evident when they are feeding residents who need total assistance; the CNA may stand, feed multiple residents simultaneously, not addressing residents by name, and allowing food to drop on clothes and the floor indiscriminately. Schell and Kayser-Jones argue that such practices do not help orient residents to the event as a "meal" and furthermore such disorienting and insensitive care puts residents with swallowing disorders or oral health problems potentially at risk for aspiration. In contrast, "creative," "empathetic" care required knowledge and observation of the resident, to make sense of patterns of behaviors and to foster the "social value" of mealtimes (Schell and Kayser-Jones 1999).

Understaffing may foster such task-driven, mechanistic care as a way for CNAs to meet demands expected of them. Schell's work contributes a simple but important framework for

understanding how "efficient" but impersonal care makes sense of CNAs; through a combination of time pressures and inadequate training, CNAs fail to envision the resident's perspective, and treat the residents as the objects of formalized tasks.

Ethnic diversity in nursing homes leads to a need for "ethnic food" and cultural considerations in institutional food planning. Kayser-Jones notes that in urban areas, nursing home residents are no longer mostly Caucasian; for example, in one of her studies, "20 to 25% of the residents were Asian, Latino, African-American, and Russian" (Kayser-Jones 1996). She points out that "the *choice* of food and its *preparation* are culturally specific"; furthermore, "food likes, dislikes, and habits are established early in life and are difficult to change" (emphasis added). As others have pointed out, she notes that food has multiple and "varied meanings," including as an "expression of respect, care, and love," and is associated with "family celebrations, social activities and festivities, health, well-being and survival." Thus, "the absence of ethnic food was especially problematic" (Kayser-Jones 1996).

Family caregiving at mealtimes is not unheard of, and has been noted to be highly valued by residents (Kayser-Jones 1996). Family members' caregiving roles change with institutionalization. Institutionalization is not only a major life transition for the new resident, but also a significant transition for the caregiver; with institutionalization, a family or other nonprofessional caregiver does *not* simply give up the caregiving role, but instead must learn to modify that role (Perkinson 2003). Margaret Perkinson identifies one of the major sources of conflict between family caregivers and institutions that, she argues, hinders the productive ongoing use of family as a resource—that institutional care is more intensive than family caregiving because it is necessary when family caregiving is insufficient. In fact, Perkinson points out, residents may actually receive *less* care in a nursing home compared to that provided by home health aides and other in-home care.

One effect of mealtime understaffing is to highlight the role that family members can play in improving mealtime care for residents. As other researchers have indicated, Kayser-Jones

found that some family members brought preferred foods, fed, and in other ways served as advocates for residents (Kayser-Jones 1997). Kayser-Jones found that the lack of "ethnic food" was a major contributor to eating problems, as well as an area in which family members can significantly aid in good care (Kayser-Jones 1996).

In summary, the demands for "efficient" caregiving and lack of training create a situation where CNAs tend not to give individualized care to residents at mealtimes, treating meals as another task to be accomplished and thus ignoring the emotional and social meanings of food and meals for residents. When residents require assistance at meals, this problem becomes most evident. Ethnic food is one example of individualized care that may be lacking, and in which family members can potentially offer assistance at mealtimes.

Section V: Summary, Discussion & Research Questions

What are the mealtime experiences of Chinese elders in an American nursing home? How does the preceding review of literature on biomedicine, aging, culture, institutionalization, the meaning of food, and caregiving, apply to this general question?

The following sections will summarize thematic findings from the literature and the resulting research questions.

Theoretical Areas

Theories of Aging & Biomedicine

Because I have argued earlier that theories of aging and biomedicine are linked, I will summarize these theoretical areas together.

Summary:

Fundamental Western ways of thinking are reductionist, and highly value objective truths and individual autonomy. These ways of thinking underlie science and biomedical values and practices, which are thus high in cultural and social prestige in Western societies. Biological

and biomedical theories of aging tend to pathologize or make abnormal the aged, in part by focusing on the (patho)physiological processes of the aging or diseased body. In this way, biomedical perception is a mode of reductionism, not contextualization, that places responsibility for health and disease on individual patients rather than on larger social structures. Because of the prestige accorded to science and medicine, biomedical views of aging dominate how we define and solve problems associated with aging. Social sciences, like anthropology, offer theories of aging that may define problems associated with aging differently and thus offer different solutions. Despite biomedicine's dominance, the medical problems associated with aging, like chronic or degenerative diseases, resist reductionist biomedical categorization and treatment. Medical therapy in chronic illness often requires lifestyle changes; within a nursing home, lifestyle changes are an integral part of therapeutic care. In part due to the "messiness" of chronic disease and aging processes, treating the problems of aging is low status in medical practice and even within nursing.

Because medicine is based on fundamental attitudes that privilege science and medicine because they purportedly seek objective truths, the impact of medical care and nursing homes as dominant cultural practices and institutions on ethnic minorities has not been adequately explored. Furthermore, the cultural emphasis on cognition to determine autonomy means that many nursing home residents' ability to make their own choices is limited. We should recognize, however, that the basis of limiting residents' autonomy is Western cultural attitudes about the self.

An emphasis on individuality in Western cultures and in biomedicine means that social institutions, such as nursing homes, have two goals that are seen to conflict: serving the individual, and serving society. Anthropologists have recognized that, because social institutions are value-laden, they serve as normative methods of "social control."

Questions:

Theories of aging and biomedicine are important in assessing the cultural context in which nursing home residents live, because nursing homes are based on the biomedical model. Are nursing home residents treated or viewed by themselves, staff, or family, as diseased, or abnormal? Do residents define their problems and living situation in biomedical terms? Is caregiving in the nursing home defined in individual terms? How do the staff view their work with the elderly residents? Do biomedical priorities dominate staff priorities and the meaning they ascribe to their work? Do staff consider their work as low status or devalued, and why? Overall, how do values and practices of aging and medicine shape the context in which residents live? How are alternative medical beliefs (i.e., beliefs that are not legitimized by a foundation in "objective" scientific truths) and practices treated in the nursing home? Do Chinese residents perceive cultural difference between themselves and the staff, and on which values are difference or similarity based? Lastly, do biomedical approaches to problems adequately define the problems that residents perceive in nursing home life? What other approaches to defining problems do they, staff, or family, use? How do residents, family, and staff define the purpose of the nursing home? Is it to serve individuals and/or serve society? Which goals take priority? Are therapeutic goals guided by making the resident more independent, autonomous, and rational? Do residents and family share these goals? Is patient autonomy overridden by "safety" regulations?

Theories of aging and biomedicine are also relevant to evaluating how food and meals are experienced and valued in the nursing home. Several of the questions detailed above can be applied to the particular issue of food and meals for Chinese residents. Are food and meals considered part of medical therapy, and if so, how and by whom? How are the non-nutritional aspects of food attended to, such as social and cultural meaning of food as a symbol of caring, friendship, and sociality? How are individual preferences met? Are food and meals tailored to individuals and/or to groups? How is individual choice exercised in food and meals?

Theories of Culture & Chinese Cultural Values

Summary:

Western attitudes towards culture reflect atomistic understandings of truth. In Western thinking, culture tends to be conceptually bounded as purely "cultural" or ethnic, unchanging, apolitical, and inherently not scientific. Historically, Chinese have also conceived as their culture being unchanging, but this cultural constancy is based on an acknowledged pride in China's long history of technological progress, colonial power, and economic domination.

Family is a culturally specific concept that is particularly relevant to this study's research questions. In Chinese culture, individuals are defined by hierarchical relations to others, particularly within a patrilineal family structure, in which a "collectivist," rather than an "individualistic" orientation leads individuals to value the needs of the group over individual needs. The value of filial piety requires that children "pay back" parents for care given early in life. However, changes in society lead to reinterpretation of cultural values. Contemporary studies in nursing homes in Hong Kong have found that residents made a "smooth transition" and adapted well to nursing home life due to use of traditional collectivist values in this new context while other cultural values did not lead to positive adjustment (Lee, et al. 2002; Leung 1992). Concern about "loss of face" to members outside one's family led to tenuous relationships with other residents.

The ways in which elderly immigrants use cultural values, in particular, how different sociocultural contexts encourage different applications and interpretations of values and attitudes, has not been well studied, in part because the elderly have not been the usual subjects of immigration, refugee, or ethnic studies.[14] Immigration studies have differentiated between studies of refugees and immigrants based on perceived differences (differences in push-pull factors for migration) that assume that refugees have a more socially and politically liminal status

[14] The fact that the elderly are not commonly objects of studies in these and other fields may reflect a Western academic bias towards studying middle-aged adults and children (e.g., socialization studies). Viewed another way, the elderly are seen in a social continuum in which being aged is not seen as separate from the experience of the society, which is, I believe, a valuable orientation to studies of the aged.

compared to immigrants, and perhaps therefore more worthy of study. A more activist point of view has been posited in medical anthropology, which argues that immigration should be studied because immigrants have poor access to care due to structural inequality, and a dominant perception that immigrants do not have a citizen's right to health care. In these types of academic orientations, the lived experience of elderly immigrants has not been a focus of study.

Questions:

The broader question in which the research question sits asks how elderly Chinese residents value and make meaning of their experiences living in a nursing home, and how do Chinese, biomedical, and other values, interact and how are they interpreted in this setting by residents, their family members, and staff.

How do residents relate to Chinese culture? Are residents proud of this culture? Are they resistant to Western culture, and if so, does it reflect a conflict of Chinese and Western cultural dominance? How do residents define family and their role within the family? Given that Chinese families traditionally lived in multigenerational households, how do Chinese residents define home? Do residents acknowledge changes in society and what meaning do they make of these changes in their current situation? Are values reinterpreted to fit these changes? Which values are of salience in evaluating their lived experience? Are the experiences and values of Hong Kong elders in nursing homes similar to Chinese elders in a nursing home in California, the site of my study? Specifically, how are values of collectivism, "loss of face," and filial piety interpreted among these Chinese residents? Additionally, the residents' social experience of being immigrants may affect how they, their families, or staff, interpret their rights to health care, particularly within a public institution.[15]

In data collection, these questions were targeted specifically to the context of eating, food, and meals.

[15] The research site is a public institution; details regarding the research site and methodology will be discussed in Chapter Two.

Empirical Areas

Nursing Homes

Summary:

A historical perspective shows that nursing homes began as charitable poorhouses which provided only custodial care. The social milieu characterized these residents as "undeserving poor." One of the goals of funding nursing homes was to separate "respectable old age" from the undeserving poor, and to restrict funding from almshouses. Funding was justified by folding care for the elderly into hospital construction legislation, thus institutionalizing nursing homes into an explicitly biomedical model, and simultaneously creating the incentive for a for-profit nursing home industry to flourish. Even today, biomedical values and medicine's dominance in defining the problems of the aged—providing diagnoses—legitimates admission to and continued care planning in nursing homes. The legislation required that nursing home buildings were constructed on a hospital model, which sacrifices privacy in favor of surveillance, and required that they must be staffed by registered nurses. At the same time, the majority of nursing homes are for-profit, so the priorities of efficiency and economic or business models have also come to interact with the medical model of care in nursing homes, resulting in a focus on labor-saving technologies and increasingly routinized, impersonal care to increase efficiency and thus maximize profits.

That nursing homes are institutional rather than home-like in nature has been explored in the academic literature; nursing homes were characterized as "total institutions" along with prisons and mental hospitals, because they isolated residents ("inmates") within an institutional environment that stripped residents of their outside identities and collapsed the meaningful social spheres of public and private. The institutional environment circumscribes residents' ability to make choices, a theme that arose frequently in the literature, particularly in how structural aspects of nursing homes resulted in routinized care that objectified residents as

infantilized, depersonalized, dehumanized, and victimized, receivers of care, and thus limited their choice, freedom, and independence.

Researchers have looked at social aspects that result from institutional structures to explain how such practices that reduce choice and independence come to be. They have found that administrative and top clinical staff, caregiving staff, and residents, occupy different social worlds in which values, priorities, and practices, differed and at times clashed. Within these contexts, top staff, such as physicians and administrators, were largely absent from residents' and the CNAs' daily lives, yet their decisions and state and federal Medicare and Medicaid regulations dictated how residents were treated and how CNAs should work. Such conflicts resulted in impersonal, dehumanizing care that was primarily attendant to the body, not to emotional, social, and cultural concerns.

Researchers have also compared institutional life to community life to understand what makes nursing home life dehumanizing. Nursing homes have a timeless, ritual-less quality, in which residents are isolated from the outside community. While the nursing homes attempt to reproduce community life within the institution, this is unsuccessful, largely because these approximations of outside life lack the social meaning they possess in the community. The inability of residents to reciprocate socially with staff, and to some extent, with each other, tends to strip them of meaningful social roles as adults, rendering them in a socially liminal status. The timeless quality was in part due to a lack of meaningful rituals that both mark the passage of time and make sense of life change, institutionalization, aging, and death. In this context, meals lacked their previous social and emotional meanings and became, instead, primarily markers of time in the nursing home.

Questions:

Initial questions address the underlying models, goals, and values, of nursing home life. Do medical values define nursing home life? What importance and meaning do residents and staff ascribe to the medical model? What is the goal of the nursing home? What are the social worlds

in the nursing home? How do staff and residents see for-profit vs. public institutions' goals; are they similar or different? Would a business model based on "customer service" improve Chinese residents' evaluations of the nursing home? Do the values of customer service, or medical or business models, reflect a Chinese conception of home?

Further questions are about how the models, goals, and values, or nursing home life shape residents' care. How applicable is the model of the total institution? Are there characteristics of total institutions that are relevant to residents? Are efforts made to address these characteristics? Is the care seen as individual, personal, or holistic? Do residents conceptualize problems as individual or situational? How are interventions formulated? Does bed-and-body work dominate care given to residents? Why? Are residents objectified, and if so, how? Are they infantilized, depersonalized, dehumanized, and victimized, through routinized care?

How do structures based on these models of care result in limitation of choice and independence? What tools are used to keep an eye on and restrict choice? How are these justified (e.g., as medical interventions)? How do structures in the nursing home define what can be done in the nursing home to increase choice, freedom, and independence, and make activities meaningful within the larger community?

Are there meaningful rituals? How is the passage of time marked? What is the significance of the timing of meals? Are there socially constructed rituals to make sense of death or life changes? Do residents share and engage in social reciprocity with other residents? If residents could engage in reciprocity, would this improve their connection to the community?

Meaning of Food & Meals

Summary:

The meaning of food and meals has been found to differ between residents, and staff and administration. For residents, food is a meaningful symbol of domesticity, part of a process of

"giving up the outside," and past and present social relationships. Institutional food and mealtimes are a manifestation of the process of "role-stripping" that is essential to Goffman's definition of total institutions. Sharing of food among residents and with staff is limited, and is another example of how food-related rules and practices tend to strip residents of meaningful adult social roles.

In institutional structures, the meaning of food perpetuates the objectification of residents as receivers of care. Role-stripping and changes in the meaning of food and mealtimes within the nursing home are part of the process that turns community-dwelling adults into socially liminal "objects" (bodies) on which caregiving work is performed. For example, regulations restrict how food may be shared among residents and staff.

In the nursing home, the meaning of food is as nutrition. Because the purpose of food is to be nutrition, the power to choose, evaluate, and regulate, food is owned by outside agencies. In one study, even practices that were meant to encourage residents' choice of food are not primarily about resident autonomy or attention to cultural practices or beliefs, but instead about sound business practices.

Questions:

For residents, what are the meanings of outside food or meals eaten in the past, before institutionalization? What are the meanings ascribed to institutional food and mealtimes? How do residents interact at mealtimes? Do they share food with other residents? Do they share food with staff?

Do food practices governed by the institution perpetuate residents as objects or receivers of care? Is food primarily "nutrition"? How does the meaning of food shape (or is shaped by) institutional structures that manage food and meals? What meaning is ascribed to choice or lack of choice and attendance to personal preferences? What meaning is ascribed to the visual appearance or attractiveness of food? Are these meanings the same among residents, family members, and staff?

Institutional Caregiving

Summary:

Consideration of the CNAs'point of view constitutes an examination of their "social world" within the institution, both as viewed amongst CNAs and by residents and other staff. CNAs are the primary caregivers in the nursing home. They dictate residents' daily quality of life. They also tend to be racial minorities, and such differences in race or ethnicity between them and residents (and top staff) may contribute to resident "objectification." Despite the importance of CNAs' work and the (often "feminine") skills required—i.e., "mother's wit"—they are not well compensated in pay or prestige.[16] CNAs are often exploited by the top staff as cheap labor. Health care regulations and profit demands create an environment in which CNAs adapt by defining caregiving as efficient care of the body (object). Such institutional demands create a caregiving dilemma for CNAs, because adherence to these demands conflict with residents' individual, emotional, and physical care needs. Furthermore, the satisfaction, the meaning, which CNAs draw from their work is often as mothers caring for children or parents.

Questions:

Who provides the most care to residents? What is the social role of CNAs within the institutional hierarchy? How do staff and residents perceive CNAs' social roles? Are CNAs seen to be exploited in residents' evaluation? Among other staff, are CNAs seen as exploited? Do CNAs express a caregiving dilemma, as described by Foner? How do CNAs define their work, and what meanings do they employ to make sense of their work? Do they conceptualize residents as parents or children, and themselves in a "mother" role, and if so, what meaning does this have for them?

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[16] Those with autonomous decision making (choice) power are most highly paid; e.g., physicians, top staff (Farmer 1996; Kayser-Jones 1981).

Mealtime Caregiving

Summary:

Past qualitative studies of mealtime caregiving are limited in number and scope.

One of the primary concerns among the staff is that nursing home residents are at risk for malnutrition. While several factors affect food intake, regulations to prevent and treat malnutrition measure weight loss as a means to monitor intake (as compared to, for example, resident satisfaction).

Simultaneously, CNAs continue to be under the demand for efficiency at mealtimes. Furthermore, inadequate staffing levels contribute to malnutrition and/or inadequate intake. Staff also lacked adequate training and at times were unsupervised, especially in the evenings and weekends. Strategies to increase or maintain intake include liquid supplements, which were often used a substitute for food. The use of nutritionally "complete" liquid supplements are an example of a technology that is used to save labor in the nursing home. Thus, within the caregiving dilemma, food is another arena in which skilled labor is underappreciated and care for residents conflicts with demands for efficiency.

Kayser-Jones argues that the goal of institutional mealtime caregiving should be "individualized care." CNAs' ability to give good care depends on their "role-taking ability." CNAs treated meals as another task, and failed to adequately orient confused residents to the social aspect of meals. Furthermore, Kayser-Jones points out that food has multiple and varied meanings, such that the "absence of ethnic food was especially problematic." The choice and preparation of food is culturally specific, and preferences are established early in life and are difficult to change. Kayser-Jones recommends more "individualized care" at mealtimes, a suggestion that reflects individualistic biomedical values.

Family caregivers' roles change with institutionalization, but family caregiving does occur at mealtimes. Mealtime understaffing means that family members can significantly aid in

good care. Family members advocate for residents, and bring preferred foods and do other essential caregiving for residents.

Questions:

The perspectives of CNAs, registered and licensed vocational nurses, and other staff who provide direct care during meals, are important to understand because fundamental values (e.g., regarding medical, nursing, and nutritional concerns) and how these are put in practice shape caregiving at mealtimes. What goals do CNAs have at mealtimes? Do CNAs express a demand for efficiency and conflict with care? How important is "risk of malnutrition" to CNAs, and to residents? What are the regulations to prevent malnutrition that CNAs cite? Are mealtimes understaffed? Do residents or staff mention understaffing as a problem at meals or regarding food? Are the CNAs supervised at meals? Are residents, especially confused residents, cued to a meal as social practice in order to help them eat? How are liquid supplements used and why?

It is important to understand how mealtime caregivers believe the residents think and feel about food and mealtimes. Do CNAs express thinking of the residents' point of view, and does this affect their caregiving values or practices? How do staff think residents value food and meals?

Cultural or ethnic food is an important aspect of this study. What do residents cite as cultural food? What do staff cite as cultural food? What preferences are expressed? Are they considered "cultural" in nature? What meanings and values are ascribed to food and to meals?

Family caregiving reflects sociocultural values. What do family do when they visit residents? What kind of caregiving do they give in general and specifically at mealtimes? Is there caregiving provided because they perceive understaffing at meals? Do family members act as advocates?

Section VI: Conclusions

The structural features, both organizational and in biomedical and other cultural value systems, described in this review of the literature outline daunting obstacles to any change that this study could recommend. However, the intention of the study is to highlight how medical values may play a role in everyday life among elderly Chinese residents in a particular nursing home during their mealtimes, in order to understand whether and how medical and other values interact with Chinese cultural values and meanings. Sociological and anthropological analytical approaches, unlike medical approaches, investigate how structures and individuals and society interact, but they do not assume that structures are immutable or absolutely restrictive or prescriptive. People make up these structures and work with and within them, and even anthropology, in the field's interest in specificity, is forced to simplify the complexity of lived experience. Just as "elderly Chinese resident" is an artificial category that hides intra-group differences, biomedicine is not as monolithic as depicted here, and nursing homes will not remain the entities that they are today. Movements like the Green House Project are addressing widespread distrust and dissatisfaction with contemporary nursing homes (Hamilton 2005). The more we may understand about what works and does not work, from the experience of those who live and work in nursing homes, the better chance we have of improving our models for what we now call "long-term care for the elderly."

CHAPTER 2: A QUALITATIVE STUDY

Section I: Introduction

Summary of Literature Review

As reviewed in Chapter One, significant work has been done in understanding the institutional culture of nursing home life and the processes of institutionalization in the United States. Nursing homes have been characterized as "total" institutions in which residents are isolated, stripped of outside identities and meaningful rituals that maintain social roles through time, and objectified as receivers of care (Diamond 1992; Foner 1995; Goffman 1961; Gubrium 1975; Kayser-Jones 1981; Shield 1988).

However, researchers have largely neglected to explore the effects of residents' cultural backgrounds in the experience of institutionalization. What happens when one is immersed in a culture profoundly different from one's own? Such questions have been asked in immigration studies, but not in the context of ethnic Chinese living in a nursing home based in Western or American biomedical values and practices.

However, the experience of institutionalization is a broad, complex topic. In this study, I had two perspectives: a broad view that asked how cultural values and medical values interact in a nursing home setting and with what consequences, and a narrow, in-depth, view that asked specifically to understand how specific cultural values and practices are at work in the experience of elderly Chinese residents at mealtimes.

Why did I choose to study mealtime experiences over other facets of nursing home life? Jeanie Kayser-Jones wrote, "Food symbolizes care, concern, love, and life itself." That food has meaning beyond nutritional characteristics is inarguable. However, the specificities of the meaning of food vary widely across cultures, in part because social context shapes the ways in which people eat—their "food practices." The meanings of food cannot be separated from the contexts in which eating takes place, from snacking, to daily meals, to special events and community rituals.

Thus, how do ethnic Chinese elders in nursing homes in the United States make meaning of their food practices and mealtime experiences within the hospital-based institution of

American nursing homes, which were founded on the Western biomedical model of disease and the American healthcare system?

Within nursing homes, researchers have found food and meals to have social and emotional meaning tied both to residents' past experiences and current experience within the institution. In some studies, for higher-functioning residents who ate independently, mealtimes were meaningful social contexts in which to forge connections with fellow residents and make sense of institutionalization. For residents who needed assistance with feeding, however, institutional mealtimes were found to lack sociability with other residents or staff.

At the same time as food and meals have social and cultural meaning, they are also among many tasks for professional caregivers. Furthermore, these tasks are biomedically oriented such that adequacy of care is measured by outcomes within the biomedical model (e.g., decubitus ulcers, weight loss). Although addressing sociocultural aspects of food and meals may improve certain biomedical outcomes, professional caregivers have not adequately attended to the social and emotional meanings attached to food and the mealtime experiences, particularly for those residents who need assistance with feeding. Jeanie Kayser-Jones, the major researcher to have conducted qualitative studies of food and meals within nursing homes, found that low staffing levels and inadequate training at times led to insensitive and even inhumane feeding practices that resulted in inadequate intake and resulting health consequences. Kayser-Jones argues for "individualized care" that consists of "providing food that residents like and enjoy," including ethnic foods, and mealtime feeding assistance "in a manner that is safe and preserves their dignity" (Kayser-Jones 1996). As a registered nurse, Kayser-Jones emphasizes the role of training nursing staff, particularly CNAs, and adequate staffing levels, including supervision of CNAs. As such, her analyses and recommendations work within the biomedical model; her recommendations frame the fundamental problem as inadequate individualization.

Thus, both the problems and solutions of institutionalization have been defined primarily using Western or American cultural values and practices. In contrast, in this study, I

sought to understand the experience of institutionalization for Chinese residents by looking specifically at which of their and the institution's cultural values and practices about food interacted at mealtimes, and with what consequences. By learning how these residents experienced meals, and thus any problems they saw in their food and mealtimes, I aimed to understand how they used particular Chinese cultural values or practices to define problems. How problematic experiences are defined on different terms than the biomedical may suggest different solutions—or, at least, different recommendations. Thus, the primary contribution of this study is to illustrate how, in this particular setting, culture affected how food and meals are understood in institutions.

Given that the interaction of different cultural values is at the heart of this study, core theories about Western biomedical perception and values, in general and as a foundation of theories of aging, and theories about culture, were reviewed in Chapter One. Although Chapter Two does not present findings from this study regarding this background literature, data analysis on these theories informs the background context as described in Section III: Findings: Description of the Setting.

Research Questions

Potential research questions that arose from the literature review were narrowed to three basic questions regarding cultural values, the meaning of food and meals, and the meaning of mealtime caregiving.

The first research question is, how do elderly Chinese residents value and make meaning of their experiences living in a nursing home? In other words, which values (Chinese, biomedical, etc.) are important in understanding the elders' experiences? Specifically, which Chinese cultural values are important, if any, and how are they interpreted? Even more specifically, how do residents view the meaning of family and of home? Are the cultural values of collectivism, "loss of face," and filial piety, important to elders in this context?

The second research question is, how do elderly Chinese residents value and make meaning of food and meals in the nursing home? Background information includes asking Chinese residents valued food and meals prior to nursing home placement. Specific questions are, what is the meaning of food according to the institution, as expressed by its staff? What are the meanings of institutional food for the Chinese residents? What are mealtime food practices for the Chinese residents, and which values about food do these practices reflect? What are Chinese residents' food preferences, and why? What is the meaning and value attached to food from outside sources, such as family members? What kind of food is considered cultural food?

The third research question is, what are the meanings of mealtime caregiving? What are the values that are important to caregivers at mealtimes and how do these shape mealtime practices? How are these values different or the same among different caregivers (i.e., nursing staff, family members, and activity therapists). How does the meaning of mealtime caregiving shape residents' mealtime experience?

Findings are presented in Section IV by type of participant, beginning with residents, then family members, and staff members (dietetic, kitchen, and nursing staff). Discussion of the findings in relation to the three main research questions will follow in Section V, as well as conclusions and recommendations.

Section II: Methodology

This section begins with an overview of methodological theory, then provides a profile of the research site, an overview of the participant sample and a description of the data collection and analysis methods, and ends with a discussion of limitations.

Methodological Theory

The choice of a qualitative research design was based on "what information is sought" (Miller and Crabtree 1999). Because there is a gap in the literature on ethnic Chinese elders'

experiences of nursing home institutionalization, the important analytical categories were not entirely known, therefore, qualitative rather than quantitative methods were more suited to an open-ended inquiry. A qualitative approach is particularly suited for research which seeks to understand meaning derived from detailed larger contexts, as in anthropological theoretical approaches. As Howard Becker maintains, both qualitative and quantitative methods try to get at "the actor's point of view"; however, qualitative research emphasizes the everyday world and tries to show the "web of mutual influence" occurring in everyday life, rather than the limited, reconstructed world of set variables in quantitative research (Becker Forthcoming).

Using Valerie Janesick's metaphor of dance and choreography for qualitative methods, the research design included "fixed movements," such as depth interview guides and scheduled fieldwork participant-observation periods during meals (Janesick 2000). In addition to such planned components, the research design also required "improvisation," where concurrent analysis with data collection promoted ongoing revision of interview question guides and subsequent iterative re-analysis of data.

Observations and interviews with participants were sampled in a nonrandom fashion. I sought "maximum variation" sampling in an attempt to observe and talk with a representative range of residents and caregivers (family members and staff) (Kuzel 1999).

Field Site

The field site is a government, county institution with over five hundred beds, in an ethnically diverse urban setting.[17] It is an acute-care licensed facility with Medicare and Medi-Cal certification. As such, the nursing home must meet five levels of regulations: federal, state, county, city, and internal.

[17] Facility and resident demographic information is from the California HealthCare Foundation, which gathers information from state and federal government sources and accrediting agencies.

The facility provides skilled nursing, rehabilitation services and long-term care as needed; it does not provide intermediate or residential care. There are also special units for AIDS and hospice. As a county facility, this nursing home serves people with limited resources.

The patient population is younger than the state average for similar facilities (see Table 1); 60% of patients are age 65 or older compared to the state average of 84%. The gender gap is less pronounced than the state average, with women comprising 53%. Overall, while over one-half of patients stay for less than 3 months, 20% stay for more than two years.

There are at least three patient populations; a younger population that is homeless or indigent,[18] a shorter-stay population in rehabilitation, and a chronic care population of the elderly that is more typical of the average California nursing home. These differences in demographics help explain why the patient population at this nursing home tends to have shorter stays and is younger than the state average.

The racial or ethnic demographics reflect urban diversity. According the United States Census 2000, 30.8% of the population in the research site's county is of only-Asian descent, with 19.6% of the population in the research site's county of specifically Chinese-only descent (not including Taiwanese). Of the total population of those 65 years of age or older in the county, 25.7% are of Chinese-only ethnicity. In the research site, Caucasians comprise 41% and Asians comprise 16% of the patient population, reflecting disproportionately low rates of nursing home use in the Asian population in California. While Asians are a minority within the nursing home,

[18] Many staff reported that this population has a higher prevalence of psychiatric illness, and that this patient population should not be mixed with "the elderly," a sentiment that echoes the public outcry against 19th century almshouses and poorhouses that eventually led to modern nursing homes.

Table 1: Research Site Resident Characteristics

Demographics	Facility	State Average
Age		
‹ 45	10%	4%
45-64	30%	11%
65-84	43%	45%
85 & Older	17%	39%
Gender		
Male	47%	33%
Female	53%	67%
Race/Ethnicity		
African American	25%	9%
Asian	16%	5%
Caucasian	41%	72%
Filipino	4%	1%
Hispanic	10%	11%
Native American	0%	0%
Pacific Islander	0%	0%
Other	2%	1%

Source: California HealthCare Foundation

Care Needs	Facility	State Average
Length of Residency		
0 to Less Than 3 Months	55%	66%
3 Months to 2 Years	26%	13%
More Than 2 Years	20%	21%
Special Care Needs		
Rehabilitation	8%	22%
Extensive, Special Care or Complex	49%	38%
Impaired Cognition	13%	9%
Behavioral Problems	1%	2%
Reduced Physical Functions	29%	29%
Resident Need for Assistance		
Eating	29%	25%
Mobility	46%	32%
Toileting	52%	41%
Average of the Three	43%	33%

African-Americans are better represented, comprising 25% of the patient population, while Hispanics constitute a smaller group, at 10%.

Overall, 49% of patients at the research site required complex or extensive care, compared to 38% for the state average. An average of 43% required assistance with eating, mobility, and/or toileting, which are considered fundamental activities of daily living (ADLs) (Katz 1983).[19] Furthermore, the average requiring assistance with eating, mobility, or toileting, and the rate of impaired cognition, is higher at this facility than the state average. To the extent that ADLs fit a hierarchical Guttman scale,[20] this suggests that those who require assistance with eating most likely also require assistance with most other ADLs (Lazaridis, et al. 1994; Travis and McAuley 1990). Thus, impaired cognition combined with need for assistance with multiple ADLs suggests that a higher proportion of residents are considered "heavy care" than in the average California nursing home.

I provide this study sample's demographics for comparison below in Section IV. While this research site is not representative of most nursing homes in California because of its greater patient load of younger residents and residents in rehabilitation, it was selected for its relatively high proportion of Asians and its large patient population.

Sample

The research protocol design called for ten nursing home resident participants of either gender and without regard to immigration status (refer to Table 2).

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[19] Katz developed a scale commonly referred to as the "Katz Index" to "measure functional health" by assessing the ability to perform independently the "activities of daily living" (ADLs): bathing, dressing, toileting, transferring, continence, and feeding. In general, people do not qualify for institutionalization unless they need assistance with at least one or more ADLs.

[20] A Guttman scale is "a measurement scale that ranks response categories to a question with each unit representing an increasingly strong expression of an attribute such as pain or disability" (*Stedman's Medical Dictionary*, 27th ed., s.v. "Guttman scale").

Table 2: Resident Participant Criteria

	Criteria
1	Resident at the Research Site
2	Self-identified ethnic Chinese
3	Age 55 or older
4	Cognitively competent to consent OR Surrogate Consent

Family members and staff members were recruited if they were involved with Chinese residents' mealtime care; there were no other inclusion or exclusion criteria. Family member participants were self-identified relatives who were present during meals and/or provided mealtime care. The provision of outside food was *not* a criterion for inclusion as a family member participant. However, all family members participants did bring food; on general observation, family members who were present at mealtimes almost invariably brought outside food. Staff participants were involved in eating and mealtime care, ranging from supervision of other mealtime staff, observation of residents during meals, administration of medications with food, food preparation at mealtimes, provision of snacks or recreational food activities, and feeding. Key informant staff members were individuals involved in food or meal preparation, planning, or dietetic clinical care who did not provide residents' mealtime care.

During data collection for this study, seven residents and twenty-six non-resident participants were enrolled (refer to Table 3). Because the research involved human subjects, a research protocol was submitted to the University of California at Berkeley's Committee for the Protection of Human Subjects (CPHS #2004-11-42) and the research site's Data Governance Committee and was subsequently approved by both parties.

Table 3: Research Participants	
Participant Type	
Resident	7
Family Members	9
Staff Members	17
Total*	33

* Select family member participants also served as surrogates for residents; therefore, total participants exceeds number of unique individuals involved. Refer to Table 8: Resident Participants.

Data Collection Methods

Mixed methods were employed in data collection procedures. Contextual setting information was obtained through observations at breakfast, lunch, dinner, snacks, and other food-related activities, and key informant interviews. Formal interviews with residents or their surrogates, family members, and clinical staff provided data on the experiences and beliefs of Chinese residents and their caregivers.

Table 4: Mealtime Observations	
Breakfast	2
Lunch	10
Dinner	8
Total	20

I collected data over three contiguous months during the summer of 2005. Observations were documented by dictation and in field notes. In addition to twenty meal observations on-site (see Table 4), I also observed scheduled snacktimes on some units and food-related activities coordinated by activity therapists (ATs). These activities included an AT providing Chinese *dim*

sum[21] on-site and a restaurant bus trip, in which an AT, eight residents, and a CNA, took a facility bus to a local Chinese restaurant for lunch. I only conducted two breakfast observations because I found that residents did not attribute much significance to breakfasts. When asked about breakfasts, residents were not interested in discussing breakfasts compared to other mealtimes; this may be because, as will be discussed below, breakfasts were usually eaten in bed and were not a time of potential social interaction. Family members did not visit at this time or express a desire to; furthermore, official visiting hours begin at 9 o'clock, after most residents have had breakfast.

In-depth interviews were semi-structured. I used interview guides with a series of open-ended questions and additional subquestions called probes. Interviews were documented either in written notes or audio recordings. Participants interviewed included residents or their surrogates, family members, and staff members (refer to Table 3).

Many interviews and observations were conducted in English. However, many participants' preferred language was the Cantonese dialect of the Chinese language. Therefore, a trained Cantonese-speaking interpreter was hired for observations and interviews that were not conducted in English.

Data Analysis

I used a qualitative, grounded hermeneutic approach with an immersion/crystallization organizing style to analyze the data. The hermeneutic approach is an interpretive style that "talks about the coconstititution of foreground and background, parts and whole, interpreter and interpreted, researcher and research participants, data and theory in a circular or spiral form" (Addison 1999). Thus, this approach works to reconstruct the "web of influence" occurring in

[21] *Dim sum*, a Cantonese specialty which literally means "a little bit of heart" or "dot the heart" are typically rice flour dumplings with pork, shrimp, beef, sweet paste, or preserves, that are steamed or deep-fried; *dim sum* also more loosely refers to a way of eating these foods in which there is "morning or noon snack-type eating of many small dishes" (Lau 1998; Newman 2004). *Dim sum* is also known as *dianxin* (in Mandarin) or *yum cha*, in Guangdong Province and in the city of Guangzhou (formerly Canton) (Newman 2004).

daily life using the iterative or circular process that is characteristic of qualitative methods. Furthermore, a fundamental aspect of qualitative analysis is that it is *interpretation* of data, i.e., texts (Crabtree and Miller 1999). Because "all texts are derivative"—all texts are interpretations (e.g., field notes are an interpretation of a researcher's field observations)—analysis was carried out in a reflexive manner, paying attention to bias introduced by my and the hired interpreter's roles and personal perspectives in the data collection and analysis processes (Crabtree and Miller 1999).

An immersion/crystallization organizing style for the data was selected because it is a creative organizing style that makes use of a researcher's imagination and reflexive awareness (Borkan 1999). Initial theoretical categories were then used in a hybrid template organizing style, supporting the re-analysis of field notes and interview audio recordings or notes (Crabtree and Miller 1999).

Validity

Triangulation of methods enhanced validity through observations, informal and formal interviews with residents, family members, clinical staff, and key informants. Field notes and multiple in-depth interviews were used to confirm or disconfirm initial and subsequent findings. I consulted with experienced advisors to strengthen analysis. Moreover, my results were not greatly different with many previously reported in the literature, which suggest I tapped into a widespread, stable pattern of belief and behavior.

Limitations

This was a small study that would be suitable as a pilot project. As such, my aim in this study was not to produce a quantitatively rigorous catalog of elderly Chinese residents' mealtime experiences, food preferences, and relevant cultural values. Rather, my intent was to use qualitative research methods to provide a picture of the "web of influence" of multiple factors in

how Chinese residents interpret and act in and around their mealtimes and food experiences. Because the study aimed at depth rather than quantity of data collected from individual participants, the sample size was small for all participant groups.

The small sample size (e.g., seven resident participants, see Table 8) means that I did not have enough data to support any observed differences based on gender, socioeconomic status, or other demographic characteristics. Thus, I am aware that the effects of social class are not addressed in this study. Furthermore, I did not include a comparison group (e.g., "American" residents). Although my findings were particular to the elderly Chinese residents, their family, and staff members, this does not imply or suggest that similar findings, particularly regarding satisfaction with food and meals, would not be found among non-Asian residents. I suggest, however, that the particularities of cultural values and practices likely do differ from those of other groups. Furthermore, my hope is that this study provides new data on this ethnic population that will help guide further qualitative and/or quantitative research in similar settings.

Selection bias in the study population should be considered. Although I informed residents and other participants that participating in this research project would not benefit them, it is possible that participants nevertheless believed that I might be able to intercede in some capacity to positive or negative effect. This may have made them more or less willing to share their experiences and express their opinions. For example, if they thought I could make a change, they may have over-emphasized their dissatisfaction in hopes of creating a strong argument for change. Alternatively, if they believed that I would share what they said with the administration (despite assurances of confidentiality), they may have censored strong negative experiences and opinions in order to avoid retribution. It is also possible that residents and family members who were unhappy with the food service were more likely to participate than those who were content because they felt that this was an opportunity to express their opinions in a confidential setting.

As a government institution, the research site is not typical of most existing nursing homes nor of those reported in the literature, such as in Gubrium's and Farmer's ethnographies of private facilities (Farmer 1996; Gubrium 1975). In proprietary homes, the goal of "making gray gold" tended to result in impersonal care in large part because CNAs, the main labor force, were poorly paid and under intense pressure to be efficient in order to reduce costs and so maximize profits; as such, CNAs were low status, which often resulted in high turnover (Foner 1995; Gubrium 1975). In contrast, the research site, while also under intense economic pressures, was not proprietary but funded through taxation and fiscally accountable to civil service agencies. Furthermore, CNAs were well-paid compared to the regional average; many were employed at the research site for many years, citing the excellent benefits and relatively high pay. Thus, unlike in earlier studies, where an official ethos of residents' or patients' rights often clearly overrode staff rights and concerns, in this research site, staff rights were not as clearly overlooked.[22]

Importantly, I was the sole researcher in the field, which made awareness of bias especially important. Sources of bias were linguistic, cultural, socioeconomic, and may have manifested in selection bias and interactions with participants as well as in observations and data analysis.

My linguistic, cultural, and socioeconomic background was a source of potential bias. I am a native English speaker, and have limited Chinese language ability in Mandarin and no experience with Cantonese, the most common Chinese dialect spoken among the residents and staff. While I hired a Cantonese-speaking interpreter, interpreting does not provide a transparent medium of communication. Additionally, my Chinese cultural background differs from the majority of the residents, and staff, in that, while I am considered ethnic Chinese by most residents, I am not an immigrant and I consider myself Taiwanese-American, not Chinese-American. My parents are native Taiwanese who immigrated to the U.S. in the wave of immigration in the 1960s and 1970s of highly-educated ethnic Chinese from Taiwan.

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[22] A strong local union presence may also contribute to difficulties of making change in the nursing home.

Additionally, it is difficult to ascertain the degree to which political tensions between Taiwan and China may have affected my interactions with residents and staff.

The hierarchical quality that has traditionally defined relationships in China may also have affected how participants and I interacted, particularly among elderly residents, because respect for elders is an important traditional value that shapes appropriate behavior. While being a young person and a woman in some cases seemed to encourage residents to take a role of elder-as-teacher, for the most part, I suspected that my perceived relative youth and cultural differences may have discouraged elders from fully disclosing their personal feelings, opinions, and values.

At the same time, the nature of participant-observation and depth-interview methods is such that a particular kind of familiarity develops between the researcher and participants. I grew to care for the participants as people, some of whom became, as one participant said, "a kind of friend." Furthermore, I identified with the staff members in some ways because they were professional caregivers; as a medical student, I am being educated and trained in the biomedical approach to health and disease. As such, at times, I noticed that I was viewing residents with a biomedical, objectifying, reductionist "eye." Simultaneously, I also identified with the ethnic Chinese residents and the ethnic Chinese staff for cultural reasons, viewing elders with a culturally-based respect. I strove to always clarify the nature of the research relationship (i.e., as distinct from a medical student- or physician-patient relationship, or a friendship, or an elder teaching a younger person). Methodologically, I treated my responses as a researcher, and the biases which they manifested, as a kind of data. As such, my responses, my biases, and the ways in which they manifested in my relationships with participants, were subject to analysis along with the rest of the "hard" data.

Furthermore, as a medical student, I may have been particularly sensitive to manifestations of biomedical culture and values in such a way as to overrepresent their salience in the residents' and staffs' daily lives. However, I made every effort in data collection and

analysis to be aware of such biases and how they may have affected what I observed and the interpretation and subsequent analyses. Furthermore, while one of my advisors, William Jagust, is a biomedical researcher with training as a medical doctor, my other advisors were Judith Barker, faculty in Medical Anthropology and Andrew Scharlach, in Social Welfare.

Section III: Findings: The Nursing Home

After providing a general description of nursing home life that highlights themes relevant to the research questions and providing an overview of food and meals within the institution, I will present findings about Chinese residents' cultural values within the nursing home. Then, in Section IV, I will provide some background on food and meals in Chinese culture and society before exploring the perspectives of residents, family members, and staff members, on Chinese residents' food and meals.

Description of the Setting

Nursing Home Life

This nursing home is a public institution that is large and bureaucratic, much like the city in which it is located, as well as much like a hospital. Within this setting, staff attempt to replicate aspects of life outside the nursing home, in particular, the cultural ideal of independence, as well as home and family. However, the extensive bureaucracy laid by multiple levels of regulations and biomedical practice limits the expression of independence and leads residents, family members, and staff, to feel unable to make change. Furthermore, many Chinese residents feared causing trouble to themselves or staff by complaining. In this context, many Chinese residents, their family members, and staff, sought to "just take care of my business."

The nursing home is like a city.

In many ways, the nursing home is like a city.[23] As a staff member said, "It is like a small city in here." It is a large facility, with hundreds of residents and many departments. As one staff participant said, "you're just a little [grain of] rice, you sort of get lost in it. If you knew the right people, if you asked the right questions, you start finding out what [this place] is." The ethnic diversity reflects the diversity of the city in which it is located. As a large, public institution, it can offer a vaster array of resources than a small nursing home; as a staff participant said, "It's a big facility, very resourceful. The equipment, supplies—it's just affluent." However, as the city and state in which it is located has been limited with a reduced budget, the nursing home has had to respond to reduced funding, which has meant cuts in staffing levels and resources.

The nursing home is like a hospital.

The nursing home design is based on a hospital layout, with beds arranged in multiple "units" or wards. Approximately thirty to forty residents live in a unit. Each unit has beds arranged in an open-ward style, with beds lining a long hallway, separated by hospital-style curtains, which are usually left open. Each unit has one or more dining rooms, of variable size, as well as one or two break rooms for staff. The dining rooms seat a small fraction of the total unit population.

Residents in wheelchairs and with walkers often line the hallways, sometimes in pairs, but often alone. Some practice walking using parallel bars set up for physical therapy in the halls. Groups of residents and ATs may do activities in the hallways, often with loud music that fills the air. The people who stride down the halls with purpose are usually staff; wearing identification tags, they are sometimes in uniforms, often in business casual clothing, and many wear clinical white coats. Often, though, the halls are quiet, and a soft breeze moves through the

[23] Staff articulated this metaphor; supported by elements of the physical layout, resources, décor, and in particular, the ways in which local politics and priorities shaped institutional life. While family members and residents did not use this metaphor, the ways in which they talked about and moved within the built environment and their place within the bureaucratic hierarchy reflect aspects of the "city" metaphor.

open windows, clearing the air of a musty odor. Occasionally, in the halls or on the units, a brisk voice comes over the intercom, like in a hospital.

To us they are patients, but to them they are residents. This is their home, so quality of life is important.

The influence of the biomedical model is apparent in how residents' care is defined. Furthermore, the nursing and dietetic staff typically referred to residents as "patients" while other staff, the residents, and their families, often used both "patients" and "residents." Residents and family expect that residents' care is based on health and disease, as determined by their physicians; for example, a resident said of the nursing staff, "They care about us from [i.e., based on] our physicians' diagnosis. They would not go over [the physicians'] decisions."[24]

Because the look of the nursing home is, as some staff said, "institutional," staff have made some effort to make the units "homelike." Each unit is decorated somewhat differently. In the main hallway, there may be small framed photographs, usually of staff, or residents' or professional artwork, in addition to a variety of signs and notices, such as "We thank you for not smoking," "Thinking about quitting smoking? When you're ready, we're here to help," and the AT's activity calendar. Decorations are limited by safety concerns, even though they may help create a "sense of family." An AT said,

> We could display so many pictures, ... [of] residents who came in and left, or went back home, and got better. ... Because of the fire marshal, they were taken down. It was like, trips that we'd gone to, we'd take pictures. They would stroll by and say, 'Oh, I remember this, so-and-so!' We tried to give them a sense of family, that they haven't lost that just because we're an institution.

[24] Residents and families frequently said that the nursing home was a good place; generally, they believed it to provide good healthcare, i.e., they evaluated the facility based on its primary intent, to provide certain types of healthcare. However, many also simultaneously expressed dissatisfaction with the emotional and cultural aspects of care.

This quote illustrates an example in which a staff member, an AT, made an effort to create a sense of history and so of family or belonging,[25] but the priority of physical health and safety took precedence. The quality of time is another important element that contributes to a lack of home-like feeling. As in other studies of institutionalization, in this study, each day formed a cycle that repeated, but there was a lack of rituals to recognize significant life events (e.g., deaths) that created a quality of timelessness (Shield 1988). The photos that the AT wanted to post may have functioned to give the unit and its residents a connection that created a sense of history.

On this ward, we are like family.

According to many staff members, the staff, family members, and residents, form a kind of family. This metaphor comes about partially by the nature of long-term care, and as a means of helping residents. As a nurse said, the residents "see you everyday, not like in acute care, [where] you work this, and you done, and you go home. But in here, you contact, and you build up more relationship. Just like getting to be a family." Many nursing staff, particularly Chinese CNAs, think of their work metaphorically as children helping older relatives; a CNA said, "I like to help the participants [the residents]. They are like my uncle, grandpa, [or] grandma. We are like family together. I like to talk to them. If they need something, I help them. [...] We talk like I'm their daughter." An AT said that residents and staff are "sort of like family. We make them feel at home, that it's okay to share their feelings, their thoughts. They don't have to feel intimidated because we're staff. 'We know everything, what do you know? Be quiet and eat your food.' No, we're not like that." A nurse said, "The family [members] trust you, they know you're taking care of their family. Hopefully they think we're part of the family. I have that feeling, because some of them think of us as their family, that's why they put their fathers or mothers here."

[25] See Section V for a discussion of the timeless, ahistorical quality of nursing home life and related recommendations.

The metaphor of family helps some staff explain the emotional connection that they have with residents. One nurse said, "Especially if somebody dies, you say, oh, they've been working with us for a long time, singing with me every day. [...] When there is [a] loss [of a patient], I feel loss. I feel so sad. All of a sudden, it's losing one of the family." A CNA said, "I will treat them as a family member. I will try my best. If I did something wrong at work, I would feel bad, I would feel sorry in my heart."

Yet, while the metaphor of "family" is often cited, staff acknowledge that it is not "true" family; "The feeling and the relationship are so different. They love to have their family to be concerned about them. Even though we love them, but it's a different love," one nurse said.

The idea of family goes together with a notion of home. An AT said, "They live here. This is their home. We try to make them feel they're in a home environment. We'll accommodate TV, 'What do you want?'" The staff's metaphor of family is particularly important for those residents without families; "The team, we are their family. So, we tell them, 'What else do you need? Are we doing okay? Do you have any complaints about anything?' We remind them that we're their family."

I treat them like my family because maybe someday I will need to be cared for.

Some staff treat the residents "like family" because they believe that will be how they wish to be treated if they are institutionalized in old age. A few staff members, particularly Chinese staff, see an equality between their current role as family-like caregivers and the possibility of a future role as a nursing home resident. A CNA said, "Someday I will be older. I may need to come here. I wish to be treated like a family member. I hope this will happen. So, I treat them like family, and I hope to be treated the same when I'm old. See, so it's equal." Such attitudes gave these staff meaning to their work; as this CNA added, "That's why I'm happy, even though this is hard work, physically and emotionally." Further exploration of how ethnic Chinese professional caregivers relate to elderly Chinese nursing home residents or other elderly

long-term care patients may provide insight into how concepts of intergenerational family roles shape meanings of institutionalization.

We try to make them independent, like they were outside the nursing home.

More than recreating family or home, independence is an important goal in approximating life in the community within the nursing home. A constellation of physical and cognitive abilities are necessary for independence. As conceived in a medicalized framework, independence is defined by the extent of functional impairment. Basic measures include the ADLs and instrumental ADLs,[26] and, as noted above, the degree of assistance required with ADLs directly impacts on the level of care needed; i.e., functional impairment is a very important determinant of the extent of care provided as defined within the nursing home.

However, beyond this "functional" definition, independence in the nursing home reflects ideas about patient autonomy that are based on ideals of individualistic independence that are articulated in American society. There are connections among functional "independence," the perceived ability to make independent choices, the ability to reciprocate in social relationships, and life outside the nursing home. Circumscribed by a priority on safety as manifested in Medicare and Medicaid (Medi-Cal) regulations, institutional rules, and medical diagnoses and care plans, residents are encouraged to be independent. However, beyond the kind of functional independence defined by ADLs, the way that independence is conceptualized is limited to the expression of individual preference of choices dictated by the myriad regulations and medical concerns alluded to above.

Nevertheless, independence, as it was thought to have been realized in the community, remains an ideal. In particular, the ATs that I interviewed often expressed the goal of independence, with the implicit dichotomy that within the nursing home, residents are

[26] Instrumental ADLs are more complex tasks needed for independent living (i.e., in the community) and include shopping, food preparation, and, of course, taking medications.

dependent, and those outside are independent. For example, in describing a resident who became a United States citizen, an AT commented, "It's a sort of independence for them. We proved it to everybody; there's still life after being hospitalized."

The ATs strategically encouraged residents to participate in reciprocal relationships with each other and with staff. An AT described encouraging a resident to participate; "He knew what I was doing, trying to get him involved, keep him from being isolated. I said, how can I help you? [He said,] 'I don't know. What do you need help with?' I said, 'Well, I have some plants, I need help watering them, I always forget.'" She was successful when she asked him to "help" her with activities. Such reciprocity mimicked social exchange that takes place in the community.

I cannot make changes to the nursing home; I just take care of my business.[27]

The large, city-like bureaucracy combined with the hospital-like setting are daunting obstacles to those within the institution who desire change. Many residents, staff, and family, said that they do not believe they can initiate change in the nursing home. For example, there is sometimes tension between the food services department and clinical dietetics, which historically had been under different supervisory departments. A dietitian spoke of wanting to offer additional cultural foods to the regularly available items on meal trays, but, "[Food Services said that] there would be too many things on the line.[28] If there are too many items, there would be more errors. The print [on the individual tray menu] isn't that big. [The tray line workers] have to read it fast and pick the right items." Dietetic staff had to dedicate many months of effort to get Chinese rice porridge[29] (*juk*) available for residents on tray line.

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[27] Several food-related issues are mentioned in this section as examples but will be discussed in more detail in the sections on participant perspectives, below.

[28] As will be described below, meals are served on trays that allow kitchen staff to provide individualized, therapeutically appropriate meals as designed by dietitians using physicians' dietary orders (e.g., restrictions). The meal trays are prepared on an assembly line called the "tray line."

[29] Rice porridge is called *juk* (or *zhuk*) in Cantonese; this is the term most commonly used among study participants. In the literature, *juk* is also referred to as *congee*.

Patient requests cannot always be accommodated, and the dietitians serve as a go-between; "We are the link between the clinical and the food service. The patients talk to us and we tell the food service. Sometimes we can't do anything, and we have to tell the patients. We can't accommodate everybody."

While the food services and dietetics staff work to provide culturally appropriate foods, the nursing home is limited in its ability to provide cultural foods to specific ethnic groups; "We can categorize by Asian food, kosher food, or something, but we don't really differentiate what nationality. So if they have their unique tastes, they have to get it on their own. But we understand." Because the nursing home serves a diverse population, serving a general majority often takes precedence; a dietitian said, "I've asked for some stable food on the line, like fried rice. But they [the administration] says that isn't fair. 'What about the Hispanics? How about soul food?'"

While some family members complained or made suggestions to clinical and/or upper level staff, they also expressed a futility in making complaints or suggestions because of "rules" that cannot be changed and staff who are unwilling or unable to make a change to the rules. For example, staffing levels, both understaffing in general and, in particular, of Chinese-speaking staff, is a common concern. A family member said, "I say, please have one Chinese work on this shift for my mom. [But] the rule cannot be changed. So, what can I do? They say, we cannot change for your mom." Instead, family focus on their individual concerns. A family member said,

> I understand my mom won't live here forever. I'm going to lose her. I'm just trying to make her happy. I give her a little [salty food] even though she has a risk of high blood pressure. I cannot request [Chinese food], but I think you [the researcher] can make a change.

Another family member mentioned the problem of understaffing, but said, "It's not my business. I just take off after feeding [my parent]."

Among family and residents, that Chinese residents are in the minority and cannot be catered to specifically bears almost no comment, but is implied; "When you ask for them to

improve by feeding the Chinese cultural food, I don't think they'll respect only for the Chinese residents. I don't think so. I don't have such a request." Yet, family and residents know that without making suggestions or complaints change will not happen; a family member said, "[There is] no family to complain. If nobody takes the idea [to administration], why should the hospital change?"

The residents often refused to comment to me on what could be changed or improved. Even if they did make comments, they usually expressed that their opinions would not lead to change. Furthermore, they feared causing trouble, both to staff members and to themselves. A resident said, "The jello is cold. The Chinese, we don't like cold food. But, this is talking only. Even if you speak up, there's no improvement. I just want to get out of here. I don't want to complain, so I won't get in trouble. ... I just take care of myself." As this quote illustrates, residents, like family, focused on their own individual concerns because they felt that they could not initiate change from the administration.

Food & Meals

The provision of food and meals is highly specialized in the nursing home such that multiple departments are responsible for each aspect of how food is chosen, purchased, prepared, prescribed, and served to residents. There are also some foods available on-site for residents, family members, staff, and visitors, to purchase. Additionally, residents can occasionally participate in food-related activities led by ATs. At such a large institution, a wide variety of foods are available, yet simultaneously, meals are scheduled and routinized such that on any given day there is little surprise and few choices.

In this section, I will discuss background information on how food is handled in multiple departments. Then, I will give a general description of breakfast, lunch, dinner, snacks, foods available for purchase, and food-related activities.

Background

Food and meals are planned at the institutional level in a recurring cycle and individualized in diet orders. The regular diet is the default.

Long before meals are served, the food services manager and the top dietetic staff have designed and continually revised a regularly recurring menu called a "cycle menu," with which dietitians design individualized meal plans for residents that are guided by physicians' prescribed dietary orders. The default "regular" diet offers the widest variety of foods and thus maximizes choice. The regular diet is modified according to therapeutic dietary restrictions and/or residents' food preferences. Certain health conditions limit specific nutrient intake (e.g., the "renal diet" restricts sodium, potassium, protein, and fluids) or total caloric intake. Other restrictions are due to physical difficulty with eating, such as difficulty swallowing (dysphagia) or poor dentition; in these cases, certain foods may be chopped or pureed, and in some cases residents are placed on a liquid diet, or tube feeding (i.e., via nasogastric or gastrointestinal route). All of these deviations from the regular diet progressively limit meal options (See Tables 5, 6, and 7). Furthermore, residents may request certain changes to their diet based on personal preferences. For example, residents may request "no beef," and the dietitian will input into a database that all entrees with beef be automatically replaced with that day's substitute entrée.

A selection of "ethnic" entrees is offered in the recurring menu, usually as the substitute entrée, but occasionally as the regular entrée.[30] The Chinese entrees are tofu stir-fry, *dim sum* platter, Chicken Cantonese[31], and sweet and sour pork. Staff also report that Chinese like the fried chicken, which, although American, resembles Chinese-style fried chicken. As a nurse noted, "They like the fried chicken very much, they think it's very tasty."

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[30] The Asian food items available in the institution will be discussed in more detail in the section on Key Informants.

[31] Chicken Cantonese consists of chicken pieces and chopped vegetables; this is not a Chinese dish per se (e.g., unlike *dim sum*).

Table 5: 28-day Cycle Menu Sample Week. This sample menu of a typical week includes the entrée and substitute entrée for the regular diet only. Notice the wide variety of entrees offered. During this week, three Chinese entrées (out of twenty-eight total entrées) are offered: sweet and sour pork, tofu stir-fry, and fried rice / pot stickers. Two Chinese entrées in the complete 28-day cycle menu used during the study period were offered as the regular (i.e., not substitute) entrée during lunch or dinner: "Chicken Cantonese" and sweet and sour pork.

Seasonal Entrée Menu					
DAY	NUMBER*	LUNCH ENTRÉE	LUNCH SUB	DINNER ENTRÉE	DINNER SUB
Mon	8	Sweet & Sour Pork	Garden Quiche	Fried Catfish	Chicken Piccata
Tues	9	Corned Beef	Roast Turkey	Chicken Adobo	Beef Stew
Wed	10	Cottage Cheese & Fruit Plate	Beef Rice Casserole	Fried Fish Fillet	Fried Rice/Pot Stickers
Thurs	11	Italian Spaghetti	Tofu Stir-fry	Roast Turkey	Veggie Burger on Bun
Fri	12	Fried Chicken	Hamburger on Bun	Greek Lamb Ragout	Cheese Strata
Sat	13	Salisbury Steak	Baked Ham	BBQ Ribletts	Sirloin Beef Tips
Sun	14	Linguine & Clam Sauce	Roast Beef	Tamale Pie	Fried Chicken Legs
* Cycle Menu Day Number. This number is not the date; it is the numbered day of the 28-day cycle menu.					

Table 6: Sample Menu. (Page 90) In this example, for lunch, the entrée is "Beef Tamale"; the substitute entrée is "Chinese Dim Sum with Rice" (See Table 5). Notice that the quantities of food are highly detailed and that the diets are adjusted according to dietary restrictions.

Table 7: Meal Substitutes. (Page 91) This sample corresponds to the menu in Table 6. Notice that the "Chinese Dim Sum with Rice" substitute entrée is only available for residents on a "Regular" diet. For example, a resident with hypertension (low sodium diet) or diabetes mellitus cannot receive the Chinese entrée. Note also that substitutions are limited by the resident's "prescribed diet order" and that the staff is under regulations to provide substitutions "within 15 minutes."

<table>
<tr><th></th><th>BREAKFAST</th><th>LUNCH</th><th>DINNER</th></tr>
<tr><td>REGULAR</td><td>Dry Cereal, 1 pkg.
Cream of Rice, 6 oz/Oatmeal
Cheddar Cheese Omelet, 1 ea.
Glazed Doughnut, 1 ea.
Margarine, 1 pat
Stewed Prunes, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td><td>Tangy Chilled Coleslaw, 4 oz.
Beef Tamale, 1 each
With Spanish Sauce, 2 oz
Spanish Rice, #12 scoop
Buttered Zucchini, 3 oz.
Margarine, 1 ea.
Summer Sunset Fruit Medley, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td><td>English Batter Dip Fish, 2 ea.
Tartar Sauce & Lemon Wedge, 1 ea.
Hot German Potato Salad, 3 oz.
Buttered Leaf Spinach, 3 oz.
Wheat Roll & Margarine, 1 ea.
Peach Halves, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td></tr>
<tr><td>MECHANICAL SOFT</td><td>Dry Cereal, 1 pkg.
Cream of Rice, 6 oz/Oatmeal
Cheddar Cheese Omelet, 1 ea.
Glazed Doughnut, 1 ea.
Margarine, 1 pat
Puree Prunes, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td><td>Lemon Gelatin, 3 oz.
Beef Tamale, 1 each
With Spanish Sauce, 2 oz
Spanish Rice, #12 scoop
Buttered Zucchini, 3 oz.
Margarine, 1 ea.
Light Fruit Compote, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td><td>Baked Cod, 1 ea.
L.S. Cream Sauce, 2 oz.
Hot German Potato Salad, 3 oz.
Spinach Souffle, 4 oz
Wheat Roll & Margarine, 1 ea.
Peach Halves, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td></tr>
<tr><td>SEMI-PUREE</td><td>Cream of Rice, 6 oz.
or Oatmeal, 6 oz.
Scrambled Egg, #16 sc.
Whole Wheat Toast, 1 slice
Margarine, 1 pat
Puree Prunes, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td><td>Lemon Gelatin, 3 oz.
Spanish Beef Puree, 4 oz.
with Strained Tamale Sauce, 2 oz.
Spiced Cream of Rice, 3 oz
Zucchini Puree, 3 oz.
Margarine, 1 ea.
Fruit Cocktail Puree, 4 oz.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td><td>Seafood Puree, 4 oz.
with Cream Sauce, 2 oz.
Spiced Polenta, #12 scoop
Spinach Souffle, 4 oz.
Tea Roll & Margarine, 1 ea.
Peach Puree, 4 oz
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td></tr>
<tr><td>DIABETIC</td><td>Dry Cereal, 1 pkg.
Cream of Rice, 6 oz/Oatmeal
Scrambled Egg, #16 sc.
Whole Wheat Toast, 1 slice
Margarine, 1 pat

Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td><td>Tangy Chilled Coleslaw, 4 oz.
Hearty Beef Noodle Casserole, 8 oz.
Zucchini Squash, 3 oz.
Summer Sunset Fruit Medley, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td><td>Baked Cod, 3 oz.
Lemon Wedge, 1 ea.
Leaf Spinach, 3 oz.
Tea Roll, 1 ea.
Margarine, 1 pat
Light Peach Halves, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td></tr>
<tr><td>LOW SODIUM</td><td>Dry Cereal, 1 pkg.
Cream of Rice, 6 oz/Oatmeal
Scrambled Egg, #16 sc.
Whole Wheat Toast, 1 slice
Margarine, 1 pat
Stewed Prunes, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td><td>Green Salad with Ranch, 4 oz.
Hearty Beef Noodle Casserole, 8 oz.
Zucchini Squash, 3 oz.
Whole Wheat Bread, 1 slice
Margarine, 1 ea.
Summer Sunset Fruit Medley, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td><td>Baked Cod, 3 oz.
L.S. Cream Sauce, 2 oz.
Leaf Spinach, 3 oz.
Mashed Potatoes, #12 scoop
Wheat Roll, 1 ea
Margarine, 1 pat
Peach Halves, ½ c.
Low Fat Milk, 8 oz.
Coffee, Tea, Decaf 8 oz.</td></tr>
</table>

<table>
<tr><td>BREAKFAST till 9:15am</td><td>LUNCH till 1:15pm</td><td>DINNER till 6:45pm</td></tr>
<tr><td colspan="3">DAILY SUBSTITUTION ITEMS</td></tr>
<tr><td colspan="3"><u>Items available from Ward Stock</u>
Nursing staff is encouraged to use ward supplies to accommodate resident requests
White & Wheat Bread, Sandwich spread for sandwiches, Peanut Margarine & Jelly
Cookies, Applesauce; Whole & Chocolate Milk; Apple, Orange, Cranberry Juice
Low Fat Fruit Yogurt, America Cheese Slices
Individual - Custard, Sugar Free Pudding, Regular & Sugar Free Gelatin, Graham Crackers</td></tr>
<tr><td>Corn Flakes, Frosted Flakes, Wheaties
Bran Flakes, Cheerios, Rice Krispies
Trix, Raisin Bran
Orange, Apple, Banana, Grapefruit
<u>Items available from Ward Stock</u>
White & Wheat Bread
For toasting by nursing staff
Apple, Orange, & Cranberry Juice</td><td colspan="2">Grilled Beef Patty, Chopped & Puree Beef, Regular & Low Sodium Gravy
Mashed Potatoes, Steamed Rice, Rice Porridge (Juk), Pureed Soup
<u>Sandwich of the day:</u>
Lunch - Bologna on Hi-Fiber Wheat, Egg Salad on Wheat
Dinner - Turkey on Wheat, Turkey Salad on White
Note: Hamburgers are available only with advanced Dietitian approval
<u>Items available from Ward Stock</u>
White & Wheat Bread, Sandwich spread for sandwiches. Peanut Butter & Jelly
Nursing staff is encouraged to use ward supplies to prepare sandwiches
Cookies, Applesauce, Whole, Low-Fat, Non-Fat, & Chocolate Milk</td></tr>
<tr><td colspan="3">REGULAR</td></tr>
<tr><td>Hard Boiled Egg
Soft Cooked Egg
Scrambled Egg
Sausage Links</td><td>Chinese Dim Sum with Rice
Hearty Beef Noodle Casserole
Sweet Corn
Chopped Chicken Salad
Green Salad w/ Diet Ranch Drsg</td><td>Quiche Florentine
Sliced Roast Beef with Sauce
Cut Green Beans
Tomato Juice</td></tr>
<tr><td colspan="3">MECHANICAL SOFT</td></tr>
<tr><td>Hard Boiled Egg
Soft Cooked Egg
Scrambled Egg</td><td>Green Salad w/ Diet Ranch Drsg
Hearty Beef Noodle Casserole
Chopped Chicken Salad
Pineapple Juice</td><td>Quiche Florentine
Green Bean Puree
Tomato Juice</td></tr>
<tr><td colspan="3">SEMI-PUREE</td></tr>
<tr><td>Soft Cooked Egg
Scrambled Egg</td><td>Cranberry Juice
Fruit Cocktail Puree
Pineapple Juice</td><td>Green Bean Puree
Tomato Juice</td></tr>
<tr><td colspan="3">DIABETIC</td></tr>
<tr><td>Hard Boiled Egg
Soft Cooked Egg
Scrambled Egg</td><td>Green Salad w/ Diet Ranch Drsg
Chopped Chicken Salad
Sweet Corn
Tomato Juice</td><td>Quiche Florentine
Sliced Roast Beef
Cut Green Beans
Light Peach Halves</td></tr>
<tr><td colspan="3">LOW SODIUM</td></tr>
<tr><td>Hard Boiled Egg
Soft Cooked Egg
Scrambled Egg</td><td>Green Salad w/ Diet Ranch Drsg
Fresh Orange
Pineapple Juice
Sweet Corn</td><td>Cut Green Beans
Light Peach Halves</td></tr>
<tr><td colspan="3">SUBSTITUTIONS MUST COMPLY WITH RESIDENT'S PRESCRIBED DIET ORDER
Regulations require that whole-food substitution be received within 15 minutes.</td></tr>
</table>

Dietitians may order and residents may request what is called the "Asian diet," which consists of a serving of *juk*, a breakfast food, with all three meals, steamed rice with lunch and dinner, and hot tea or hot water. The Chinese entrees are not automatically included in the Asian diet; they must be inputted for each day they are offered as the resident's preference. In other words, the regular entrée is the default unless requested otherwise. As a dietetic staff member said, "Like, baked chicken [on the cycle menu], they won't get tofu stir fry unless we put it in the computer: 'no baked chicken, sub tofu stir-fry.' If I go up and see the patient eating baked chicken, it's like, 'If things aren't broke, don't fix it.'"

Meals are delivered on a schedule, served on individualized "trays."

Figure 1: Sample Tray Menu

SLICED PINEAPPLE RINGS
HOT TEA
WHOLE WHEAT BREAD WITH MARGARINE
SKIM MILK
STEAMED RICE
SAVORY BEEF VEGETABLE STEW
* ONE SERVING OF GRAVY IN A DISH
ITALIAN GREENS WITH FRENCH DRESSING
* SALAD W/ CARROTS&DIET 1000 ISLES DRESSING
* TOMATO SLICES IN A BOWL

ORANGE PACK (NO SUGAR-NO SALT)

LOW SODIUM P

**** ORANGE DIET KIT ****
DINNER
* EARLY B'FAST DAILY **
NO ADDED SALT, NORMAL CONSISTENCY

[RESIDENT'S NAME, BED #, UNIT #, DATE]

Source: Courtesy of family member participant.

Meals are served on pod-like rectangular, covered meal trays. Due to the range of medical conditions requiring restrictions, the incredible variety of food offered, and the range of individual preferences, meal tray preparation is complex and highly orchestrated. The extreme demands on the "tray line" (assembly line) for speed and accuracy with high volume means that the administration, kitchen staff, dietetic staff, and clinical staff, express that there are significant limitations on what changes can be made.

Figure 1 is a sample menu from a dinner meal tray. The main entrée is served on a round dinner plate along with the steamed rice. Side dishes like vegetables (e.g., green beans, salad) and fruit (e.g., pineapple rings), are served in small, shallow, and rectangular disposable plastic

containers that fit into depressions in the tray. *Juk* is also served in the plastic containers. The tray is also designed to leave space for cups, such as a plastic mug for the hot tea, coffee, or water, and single-serving cartons of milk or juice. Metal flatware is sealed in a plastic bag along with a paper napkin and seasoning packets (e.g., salt, pepper, sugar). Desserts also come in the plastic containers (e.g., a slice of cake) or in individual sealed plastic cups (e.g., sherbet, ice cream). To encourage residents to eat the tray food, liquid supplements (Ensure or Glucerna) are not served with meals. The end result is a highly self-contained, complete and individualized meal tray.

Once the meal trays are prepared, with individual "menus" attached (See Figure 1), they are stacked on rolling carts. Kitchen staff deliver the trays to the units at precisely scheduled mealtimes. Times are staggered throughout the facility, so that some units receive breakfast before 7:30AM, while others have breakfast through 9AM. Lunch also varies from approximately 11:30AM until 1PM. Dinner is as early as 5:30PM until 6:45PM. The time that residents eat is somewhat more flexible; some meal trays are delivered early to allow staff more time for feeding, nursing staff may not deliver meal trays to individual residents at the same time, and residents may choose to eat more or less quickly, or wait to eat.

Nevertheless, the institution is conscientious about scheduling; if the trays will be late by a few minutes, dietetic staff call the units. Furthermore, if residents refuse to eat, regulations require that a substitute food must be provided within fifteen minutes.

When the meals arrive on the units, CNAs or nurses call out to one another, "Trays are here!" They look at the tray menus and deliver the trays to residents. Where and when residents eat is also routinized, determined by an array of factors, including the size and accessibility of the unit's dining room(s), the residents' mobility and independence, and the demands of preparing trays, feeding residents, and observation. Because residents cannot be gathered centrally, staff group residents according to caregiving needs, to ensure that those who need to be fed can be fed and those who need monitoring can be monitored, chiefly for choking but also intake. Photographs on the wall illustrate what a tray looks like when served and at various levels of

consumption, from "100% consumed" to "25% consumed." Nursing staff document how much residents "consume" in the residents' charts.

Earlier studies have found that meals structure time within a nursing home, thus structuring "sociability," and providing the normality that work and family life usually provides outside the institution (Farmer 1996; Kayser-Jones 1981; Savinshky 2003). While mealtimes in nursing homes have not been found to be consistently social, situations in which alert, high-functioning residents ate together separately from "feeders" were more likely to have social interaction (Kayser-Jones 1981; Shield 1988). While participants in this study did not describe meals in this manner, and did not complain or attach any significance to the timing or strict scheduling of mealtimes, it is possible that the ways in which meals structure time may be subconsciously meaningful to these residents. For example, perhaps among residents who ate at times different from their meals in the nursing home, the lack of control in choosing mealtimes diminishes a sense of mealtime that might otherwise be shared with their past experiences.

Furthermore, in some studies, residents were not allowed to share food amongst themselves or with staff, thus preventing them from engaging in meaningful social reciprocity by sharing food (Savinshky 2003; Shield 1988). Similarly, at this research site, tray food was generally not shared,[32] and sanitary concerns do not allow family-style meals among residents. Because monitoring intake is a component of care, if residents ate from others' trays or gave away their food, it would be more difficult for nursing staff to determine how much the resident consumed.

Breakfast

[32] Further discussion on this topic is below. Additionally, in one incident, a resident wished to share the tray food with the interpreter and me, using separate bowls, but the staff could not allow it, citing both sanitary reasons and that the food was the resident's meal tray (i.e., it was the resident's meal). However, the resident said that it was entirely her decision what was done with her food. Ultimately, we did not share her meal.

For breakfast, many residents eat in bed because they are not yet up for the day. CNAs go from bed to bed, preparing trays, putting disposable bibs on some residents, and feeding some residents. Breakfasts are relatively quiet, although some residents have their televisions turned on, with the volume down low.

Snacks

Some units serve a "snack" at scheduled times in the morning and/or afternoon. A CNA pushes a cart through the unit and delivers a choice of beverages, and some kind of small snack, sometimes cookies, small sandwiches, a meat salad, or cake. Liquid supplements (Ensure or Glucerna) are also available.

Lunch and Dinner

As with other meals, lunch and dinner are on a precise schedule, although the trays are not always on time. When the trays arrive, the CNAs look at the menus and deliver the trays. People sitting next to one another may get their trays at different times, although not by more than a few minutes. Those who can begin eating do so without waiting for others. Many wait for a CNA to "prepare the tray," which entails opening cartons and removing lids, opening the plastic bag of utensils, opening packets of salt and/or pepper and sprinkling them on certain foods as requested, steeping tea bags, and cutting up food. The CNAs do this quickly and efficiently while standing; once done, they hurry away to attend to another resident.

Because the food and meals are predictable, as a staff member said, the residents "eat *fast*, and then they're out of there [...] They know exactly what time to come in. It's like, 'Gotta show up, gotta eat, gotta go.'" According to a clinical staff member,

> Standard menu, standard dishes, sauce, and they know exactly what they want when they eat their meals here. 'Can you please put the sauce on the rice and the chicken and the vegetable? Can you put the mustard with the chicken only?' Setting up for them,

> I get the same thing over and over. Very specific. It's not surprising, they don't get surprised.

Residents' few conversations about the food are often centered on how the dish compares to how it was prepared in the past. A staff member said, "They say, 'This time it's kind of hard,' or, 'more saucy this time.'"

Most residents eat at the bedside.

Most residents eat at the bedside either on their own wheelchair tray table or a rolling side table that extends across the lap. Arranged in this way, they sit alone next to their beds, facing the central aisle of the open wards.

Some residents sit together for "social dining," but there is little social interaction.

As further discussion below will make more clear, meals were generally not treated as social events. What staff call "social dining" is limited in part because of inadequate dining room space. The dining rooms resemble kitchens or bathrooms in that they are small rooms with ceramic tile halfway up the walls, linoleum floors, and, frequently, refrigerators or other appliances and a sink. Some have a television. The most independent and mobile residents are often the ones who eat in the dining rooms, or those who are grouped together to be fed. However, there is little talking during meals. Residents often do not speak the same language, and so can communicate only minimally, through stereotyped phrases and simple gestures. Residents get up and leave when they are done without waiting for others. Or, they may sit and read a newspaper, watch the television, or sit or doze quietly in their seats or wheelchairs.

Visitors arrive around lunch time. They bring plastic bags full of plastic containers of food, usually home-prepared food, but sometimes take-out. They sit or stand with their family member, opening containers and often feeding the resident. It is very unusual for them to eat with the residents.

Most units do not have social dining at dinner, because many residents are in bed at that time. Eating is mostly at the bedside.

Although not articulated by participants, the typical lack of sociality at meals may possibly reflect a reversal of privacy and sociality found in nursing homes (and in the community) in which residents live in single or double rooms and meals represent important social events. Residents at this nursing home live on the open wards where the typically private is made public. Meals in this situation may be an opportunity to be alone when unavoidable sociality is otherwise the norm.

Foods Available for Purchase

Other foods are available for purchase in the nursing home, which seems to reflect attempts at providing access to non-nutritionally prescribed foods within the institution. The available foods, however, are not culturally appropriate for Chinese residents (or other ethnic minorities).

Vending machines are available in the hallways between wards, offering soft drinks, individual packages of brand-name snacks (e.g., chips, pretzels, cookies, candy), and in some cases, packages of ready-made foods like burritos and hot beverages such as coffee and hot chocolate. These snack foods are typical of processed snack foods available at large American grocery stores or convenience stores. There is also a "General Store" in the nursing home which sells a wider variety of packaged snack foods and beverages as well as other small items such as tissues and other toiletries. Fresh foods or fruit are not for sale. The vending machines and the General Store do not offer any Chinese or Asian snacks, foods, or beverages.

Although I saw many non-Asian residents use the vending machines and the General Store, none of the resident participants or their families reported purchasing from either. While some residents were physically unable to go to a vending machine or the General Store

independently, they expressed disinterest in those resources because they did not offer anything that they wished to purchase (e.g., salty Chinese crackers or sweet Chinese "biscuits").

There is also a cafeteria on-site open for breakfast and lunch that primarily serves staff and visitors; on my numerous visits to the frequently crowded cafeteria, residents were rarely present, and if so, they were invariably alone. While the food is often similar to that served on the trays, certain foods are only offered in the cafeteria, as well as fresh fruits, yogurts or other chilled snacks, and a salad and deli bar. However, ethnic foods were not more available at the cafeteria than on the meal trays. While the cafeteria could have been another source for additional options, only one resident participant reported buying food at the cafeteria, primarily to increase variety but also to obtain sweet or salty foods that were not available on the resident's therapeutic diet.[33] Other residents either denied awareness that there was a cafeteria or felt that the food offered there would not be essentially different from the tray food and so was not particularly desired.

Food-related Activities

Units are each assigned an AT who schedules food-related activities, along with many other types of activities. Food activities range from individual snacks given at the bedside, social events with snacks (e.g., ice cream social, tea party), multiple-unit or interest group-specific meals on-site (e.g., every few months, all Chinese residents who are able to attend are offered Chinese food as a multiple-unit activity), to off-site bus trips to restaurants.

Culture

Certain values had particular salience in how Chinese residents made sense of institutionalization—what kind of place the nursing home is, and what their expectations and

[33] This participant also procured free packets of soy sauce in the cafeteria, which he used on his meal tray foods quite liberally. On one occasion, a staff member gently chided him for wanting so much soy sauce on his food, telling him that if he added more it would "kill" him.

attitudes were towards residing within one. Cultural values tightly link home, family, and the individual. Values that dictate caregiving practices within the family were adapted to the economic demands of living in American society. Yet, throughout, residents demonstrated but did not articulate the notion of "protecting the face." Within this context, residents emphasized a collectivist expectation about nursing home life such that the needs of the group superceded individual preferences and individuals rarely complained, particularly to upper-level staff. Simultaneously, the biomedical demands of residents' individual health conditions also took precedence over individual preferences. The biomedical and "American" values and practices within the nursing home tended to separate past meaningful social events like mealtimes from their current manifestations in the institution. Thus, activities that provided a culturally meaningful context facilitated residents' engaging in social interaction with other residents and staff.

Home is family.

The Chinese residents describe their families, and their role within the family, when asked to describe themselves. For example, a resident replied, "My life is filled with family. I raised my children. I tried my best." Another resident said about himself, "The worst part is my physical limitations. Otherwise, I'm a lucky man. Even though I am disabled, I care about my family, my son, and my grandchildren, especially my daughter." When asked about how they feel about living in a nursing home, the most common complaint was that they were separated from their families, rather than, for example, lack of independence, personal belongings or space, or privacy, as would be suggested from the literature. As a nurse observed, "Sometimes they are emotional because they know their family are not here."

I have no friends here. I would not tell my private things to others.

The residents say that they do not have friends here. A resident said, "We're getting along. We're living here together. Our relationship is we are residents. But we're not friends." The other Chinese with whom they speak and eat meals are "people who live here," but not friends. Another resident summed up her relationship with Chinese residents as, "We can communicate, because we all speak Chinese." An AT observed, "It's just this generation, they want to be on their own. They only talk to their family members, their loved ones. They don't talk to each other."

One resident[34] offered an explanation for the lack of friendship among Chinese residents as a matter of privacy;

> When we [resident and researcher] are talking, you are trying to understand me. I think this is a kind of friendship. But if it's general [conversation], I don't think it's friends. I support your project, so I talk freely about myself, otherwise this is my privacy, my private matters.

This explanation would suggest that residents may define friendship as an attempt at understanding personal matters. However, further research is needed to better understand how Chinese residents relate to one another within the nursing home context.

Most staff say that the residents "don't talk" during meals and many activities, and that they "just fight" during *Mahjong*.[35] Several factors account for this general trend. Language differences among residents make communication difficult because residents speak different Chinese dialects and other Asian languages. Differences in cognitive capacity also contribute. ATs recognize that social differences can be quite profound; "I try to do [therapeutic activities] in a group sense, but it usually doesn't work. The patients are different in their education, language, socioeconomic status, and many can't read, so I have to make it simple." For example, an AT said about a former resident, "He would isolate himself; he thought he was better than everyone else,

[34] Other residents, who did not enroll in the study, expressed a concern about privacy, i.e., not sharing one's private matters with others, as primary reason why they did not want to officially consent to participate.

[35] *Mahjong* is "a game of Chinese origin usually played by four persons with 144 tiles that are drawn and discarded until one player secures a winning hand" (*Merriam-Webster Collegiate Dictionary*, 10th ed., s.v. "Mahjong").

'I don't belong here. I'm just here because no one takes care of me.' So, he tries to isolate himself by his bedside." The AT had him attend an activity, but, "He was honest. [..., he said], 'I don't like the people.'"

When you are young, you care for your children, so that in old age, they will care for you. But it's different here. That's why I'm in the nursing home.

While residents articulated that, traditionally, the children take care of parents in old age, they did not complain about their children. They say that the children are too busy, that living here, in the United States, their children have to work too hard, so they cannot take care of the parents at home. The residents characterize their reasons for institutionalization as "disability" or physical problems, not old age, although many residents said that in old age, you become like a child. However, old age itself is not a reason for institutionalization. They are in the nursing home because they are "sick."

It may be that residents are unwilling to speak ill of their family to outsiders, such as myself. For example, a staff member said of a resident, "His children weren't around for him because they had work. He went into a depression, 'Nobody cares.'"

This is a group home; it can't cater to one person.

The residents emphasized that the nursing home is a "group home" which cannot cater to Chinese residents in general or themselves, as individuals. They emphasized that everything is "standard." A resident said, "It is difficult, because this is a public[36] place—it's not only for myself, it's for a group of people. They give us general food, because they give out food as a group." Simultaneously, certain aspects are highly individualized. A resident said, "Chinese cultural, is not that appropriate, because everyone has an individual need. [For example,] people

[36] Although the translated word here is "public," when asked to clarify, it was clear that the participant was referring to the group nature of the nursing home, not to its status as a government (publically-supported) facility.

have diabetes... They did not particularly design it for us [Chinese]. Like, they don't have stir-fry. I guess they just provide every individual's needs." This quote illustrates the fundamental tension between group needs—the majority of residents, who are non-Chinese, and the needs of the ethnic Chinese group, who are in the minority—and individual needs: individual diagnoses (e.g., diabetes) and "individual" cultural differences and preferences. Chinese cultural preferences become "individualized" and thus do not constitute a just cause to push for change in a "group home" that serves a majority of "Americans."

I will not say bad things about others. I don't want to complain because I will get in trouble. It is best to accept things because you cannot change them.

Most of the Chinese residents generally refrain from complaining to staff, especially upper-level clinical and administrative staff. Because the nursing home is a group home, the residents say that changes cannot be made. Some residents express fear of "getting in trouble" with unit staff and upper-level staff if they complain; a resident said,

> If I complain, they [the staff] will get fired, so I have to be very careful what I say. This incident [with a staff member], I don't want to report it, to say it again. I just swallow it [emotional hurt] by myself. I don't want to make it serious. I just don't want to talk about it because I only talk about it if it's the very worst case.

This attitude extends to food and meals. A resident said, "The jello is cold. The Chinese, we don't like cold food. But, this is talking only. Even if you speak up, there's no improvement." A nurse said, "All of them, they don't complain. They say, 'Oh, I don't have a choice, so I just don't eat, because it's already like that.'"

It appears that residents do not complain because they believe that this is not a bad place; it meets certain basic healthcare needs, and that is what the residents can expect. As a result, they only complain if they perceive that there was a particularly grievous problem or

mistake within the domain of the nursing home's expertise and responsibility—health-related or biomedical—such as the administration of medications.

The Chinese residents are polite.

Because Chinese residents generally refrain from complaining about the institution, the staff, and other residents, from the staff's perspective, Chinese residents are often considered to be "polite." For example, a non-Chinese staff member said, "They're very nice and they cooperate." A staff member at a restaurant bus trip observed, "I notice every time serving them they say, 'Oh sit down and eat. Take care of yourself first, it's okay, we still have food on the plate.' They're very polite."

However, many Chinese staff recognize that politeness does not necessarily reflect true feelings. An AT spoke of trying to convince a resident to participate in an activity; "He [said], 'I don't care for it. Thank you.' He was very polite." Such polite behavior may extend to mealtimes; another staff member said, "Sometimes patients refuse to eat. Some patients may not complain about food, especially Chinese patients." This example also illustrates that many staff observed that Chinese residents were less apt to complain, or complain as persistently, as non-Chinese or non-Asian residents.

These cultural things are what they've done their whole lives.

The ATs provide some cultural activities, primarily Chinese language media (e.g., newspapers, video), Chinese instrumental music, Chinese snacks and/or meals, and *Mahjong*. The ATs plan the activity calendars for specific unit(s), based in part on the unit's residents' characteristics and preferences. In general, the ATs and the other staff said that the Chinese residents will do what they had done their whole lives, and are not open to trying new activities; one AT said, "A lot of the older generation, [reading the Chinese newspaper or playing *Mahjong*] is

what they're used to doing. To teach them new things, they laugh at you sometimes. If you sit them down to do arts and crafts, oh, you'll never hear the end of it. Their eyes are just rolling and rolling."

Chinese food is the residents' favorite activity.

The ATs all try to provide some Chinese food, either as snacks or meals, such as in a bus trip to a restaurant. Chinese food is a favorite activity; an AT said, "They love to eat Chinese food, that's the main thing [that they like. They say,] 'We're going to an art museum? Okay, are we going to eat Chinese food?'"

Residents prioritize so-called cultural activities. One AT said, "Food, *Mahjong*, Chinese newspaper—those are the three main things that they look forward to daily, that they would just give up everything else and do."

While the residents generally do not interact, staff describe how they interact during certain activities or behaviors that they participated in before they lived in the nursing home. An AT said, "They'll fight for the [Chinese] newspaper, but they don't mind sharing. 'Give me that page, I'll read that first.'" The residents prefer drinking hot tea or water. A nurse said, "Everyone uses the same container now [for hot tea or water]. They learn from each other. They see somebody get better, they want to have that one. They're kind of peers, they learn from each other." In traditional Chinese thought, warm beverages like tea are believed to better for elders, who may have excessive *yin*.[37]

Residents are elders; they're like my parents or grandparents.

Many staff describe a special attachment to working with seniors characterized by respect for one's elders (parents, grandparents) and their experience. A staff member said, "I

[37] See section below on "Residents' Specific Food Preferences" for a discussion of *yin-yang* theory.

think it's just with this population, this senior group. I have such great respect, there's so much to learn from the older generation that it's so easy for me."

Some food activities provide an opportunity for residents to take on age-appropriate roles with the staff. An AT described this occurring during a restaurant trip; "When I'm serving and I haven't sat down, they'll say, 'Sit down, sit down, and enjoy yourself first. Try some food, don't wait until it gets cold.' It's like your parents. They really take on a role, like your elders or your grandparents."

Section IV: Findings: Perspectives on Food & Meals

Chinese Food & Meals

Food in Chinese Culture

In general, food has had an important place in Chinese society and culture. Frederick Simoons wrote, "Food plays such an important role in Chinese life as to lead many to characterize the Chinese as having a food-centered culture. [...] Concern with the excellence of food is found in all segments of society" (Simoons 1991).

Southern Chinese Cuisine

As described below, most of the residents are from the southern regions. There is a great variety of culinary styles in China, which is primarily regional.[38] The cuisine of southern China, which includes the southern coast "emphasize foods of the sea and include a wide combination of flavors" with a special "attention to freshness of ingredients, lightness, crispness in cooking, texture, taste of each ingredient, and eating foods in season" while also "car[ing] about the color of each food and its presentation" (Newman 2004).

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[38] According to Newman, "some" say that there are "eight popular and different styles of cuisine," each associated with a different province in China (2004).

Chinese Meals

A Chinese meal "must have a staple or grain food as its principle component," both as a principle source of calories and also culturally, if the staple is a minor component or absent, the food is considered a "snack" (Newman 2004). In Southern China, from which most resident participants originated, rice is the staple.[39] In Mandarin, the word for rice, as well as meal, is *fan*. *Fan* is "the basic, essential element of a meal" (Simoons 1991). Vegetable and meat dishes are called "cai" and these are used to "accompany and flavor" a large amount of *fan* (Newman 2004; Simoons 1991). *Cai* is literally means vegetables, which reflects that, traditionally, Chinese ate little meat, so the second most important food category after *fan* was vegetables (Newman 2004; Simoons 1991). A traditional southern Chinese lunch and dinner most typically consist of "soup, rice, and mixed dishes consisting of vegetables and fish, meat, or poultry" (Lau 1998). The focal point is not the (often meat) entrée, as in American meals, where complex carbohydrates are side dishes. Instead, the rice is the staple around which the meal is built. The centrality of rice is reflected in the phrase for eating a meal, which uses the characters (words) for "to eat" and "rice" or "meal" (*chi fan* in Mandarin).[40] Nutritionally, this is reflected in the traditional diet, which derives about 80%[41] of its calories from "grains, legumes, and vegetables" (Lau 1998).

Differences between Chinese and Western meals include "the food itself, how individual food items are cut and cooked, and how dishes and meals are served" (Newman 2004). Food is almost always cut in small pieces so that knives are not needed at the table, which means that preparation time is long but cooking time is short, in contrast to many Western meals (Newman 2004). Meals are served "family-style," which means that each dish (*cai*) is served separately rather than in the individual's bowl. Rice is eaten out of a bowl with chopsticks such that the

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[39] In contrast, noodles, dumplings, and buns, made from wheat flour are common in northern China (Lau 1998).

[40] The centrality of food and meals is also implied by the observation that many Chinese say *chi fan* as a greeting (Newman 2004).

[41] Today, as the more affluent consume a greater proportion of calories from meats, as well as other factors, the proportion ranges from about 60 to 90% of calories from the staple grain (Newman 2004).

dishes (*cai*) are added in approximately bite-size amounts, as the meal progresses, which means that determining how much any one person has had of a dish is difficult. The *fan* is usually served in a bowl and a larger bowl of additional *fan* is available on the table. Beverages are typically soup, although in southern China, hot tea is frequently had at meals.

Table manners are highly oriented towards noticing the needs of others over oneself and showing respect. Traditionally, elders are served first with the best morsels. Tea is "served," such that if one wants tea, one should serve it to others first before serving oneself. Left-handed individuals are taught to use chopsticks right-handed, to avoid interference with the person sitting to the left (Newman 2004; Simoons 1991).

Food & Meal Perspectives

Residents

Resident participants were mostly female and the average age was 81 (See Table 8). All were immigrants, coming from mainland China, particularly the southern regions, Hong Kong, and other Asian nations. Even those from other Asian nations (i.e., overseas Chinese) were originally from southern China. They have been in the U.S. for many years, over one decade at minimum, with an average of twenty-five years. Yet, only two spoke any English, and this was minimal (i.e., not conversant). The majority spoke Cantonese, some with other dialects or another Asian language, Vietnamese. There were no significant differences in findings between genders or among residents of different socioeconomic factors, however, because the sample size was small, this is by no means conclusive.

Table 8: Resident Participants	
<u>Gender</u>	
Female	5
Male	2
Total	7
<u>Age</u>	
Range	60-91
Average	81
<u>Consent</u>	
Self	4
Surrogate	3
Total	7
<u>Immigrant or Refugee</u>	
Yes	7
No	0
Total	7
<u>Country of Origin</u>	
China/Hong Kong	4
Other*	3
Total	7
* Ethnic Chinese from Malaysia, Vietnam, or the Philippines	
<u>Years in U.S.</u>	
Range	13-40
Average	25
<u>Years in Facility</u>	
Range	0.5-5.5
Average	2.7
<u>Language</u>	
Cantonese alone	3
Cantonese with Mandarin	1
Cantonese with Toisanese	1
Cantonese with Vietnamese	2
Total	7
Fluent English	0
Chinese with minimal English**	2
Total	2
** Some basic phrases but not conversant.	
<u>Feeding</u>	
Independent	2
Tray preparation	3
Feeding	2
Total	7
<u>Family Visitors</u>	
Mealtime(s)	7
Weekday(s)	4
Weekend	5
Total***	16
*** Total exceeds number of unique participants.	

Residents ranged in their ability to feed themselves. To provide a general assessment of residents' independence and thus control of their eating, I categorized residents into three groups: 1) Independent, in which residents, after tray delivery, can "prep" the tray themselves (i.e., open juice cartons and ice cream cups, uncover containers, open tea bags, unwrap utensils, tear open salt and pepper packets, cut meat into bite-size pieces, as well as put on the disposable paper bib) and eat independently; 2) Tray Preparation, in which staff, usually a CNA, preps the tray for the resident, but the resident then eats independently; 3) Feeding, in which the staff preps the tray and feeds the resident. As noted in Table 8, each category was represented by two to three residents in this study.

Most of the elderly Chinese residents did not like the institutional food, and several particular patterns of preferences emerged. However, the residents emphasized that because the nursing home is a "group home" tailored toward white Americans (literally, "foreigners") they could not expect that their individual preferences would be catered to, and so they must accept what they are given.

The nursing home is a group home, so the nursing home cannot cater to one person.

This theme was widely expressed, with the emphasis on the nature of the institution having to care for many, that those in the minority (literally, not specifically ethnic) and individual preferences could not and would not be expected to change. There was little anger, mostly resignation, and the explicit expression of "accepting." Many residents pointed out that there was no use discussing, much less complaining to staff, that they did not like the food. What they were given was fixed; they could not change it by asking, so they would eat what they could.

Meals are individualized.

The residents describe very "individual" meals, pointing out that each individual gets a particular meal tray based on individual problems. They are highly aware that the meals are based on individual medical diagnoses, so "everyone's tray is different." Everything, they say, is packaged individually in single servings. They treat the meal as a time to eat, not a social event.

The food has no taste and no seasoning.

Residents will often say that the food is "not bad," but this usually means that the food is "nutritious." Nevertheless, the majority interviewed disliked the food. Several, but not the majority, said that the food is like "what you feed to dogs." Explanations of why they dislike the food centers around two main themes: that the food has no taste, and that it is American food. Additionally, there are foods that they would like more of, in particular, chicken and fish.

The residents complain that the food has, "No taste. No sweet. No salt." They attribute this to the cooking style more than a therapeutic diet, although they also mention "health problems" as a factor limiting how the food can be prepared.

This is cooked in the American style. If you like American food, the food is pretty good, but Chinese food has more variety.

The residents mostly attribute their dislike of the food to the fact that it is mostly "American" food. The residents believed that the American residents would like the food; they did not base this belief on conversations with "American" residents, because of limited communication with non-Chinese speakers. The cooking styles are simply different, and, where residents would give value judgments, they think that American cooking styles are inferior to Chinese cooking, which has "more variety" and "looks better". Indeed, Cantonese cuisine is known for its extensive range of cooking methods and "enormous variety" of ingredients, combined with an emphasis on appearance (Simoons 1991). Unlike the key informant and clinical staff, few residents mentioned inherent institutional structures as the reason for the cooking

style; e.g., the demands of the tray line, or mass production. Rather, many believed that there were no Chinese cooks, and the institution should hire a Chinese cook, to provide cultural food; a resident said, "If they could have a special Chinese cook, and some cultural food, that would be nice, so we don't have a longing for the home-cooked food."

Residents' Specific Food Preferences

There's no Chinese food here.

The residents like the rice and *juk*, and hot tea. However, these are limited components of a meal, foundational and basic, but not complete. The residents say that there is no Chinese food served, while some say that they get a Chinese dish once or twice a month. The residents who do get the Chinese entrees vary in their recognition of the food as "Chinese"; some say it is not really Chinese food, others will say that it is Chinese because of a specific ingredient, such as "tofu." Although the residents do not particularly like the institutional Chinese food, they prefer it to the other entrees served.

The staff see the Chinese food as both limited and not particularly good;

> Maybe twice a month they serve *dim sum* to the Chinese residents. The patients, they order the *dim sum* plate. Usually, pot stickers, deep fried shrimp, barbecue pork bun, and sometimes we serve shrimp fried rice. That's all we have. That's only [what kind of] lousy Chinese food [that] we can provide. We cannot provide the dishes like what the restaurant does.

Implicit in this ethnic Chinese staff member's assessment of the Chinese food offered is that, although it is called the "Dim Sum Platter," the offering is limited, and does not compare well to what a restaurant may offer,[42] which emphasizes that the range, choice, and serving style all matter in determining to what extent the food is "Chinese." As another staff member observed, "The way they [the kitchen staff] cook, I know they [the residents] don't like it. They still don't

[42] Restaurants may offer from twenty to sixty different *dim sum* dishes (Newman 2004), and Guangdong (Canton) province is "reputed" to have over one thousand different types of *dim sum* dishes (Simoons 1991).

eat it. It's only the tofu that's the Chinese way. Sometimes they have small dumpling with the shrimp. That's what I see. I don't see other Chinese food. Not everybody gets it."

However, although the staff notice these preferences and express their empathy, they do not feel that this is something they can change;

> They like to have the rice and *juk*. They also like the noodle very much, like the spaghetti noodle. But other than that, [such as] the Spanish food, they don't like it. I feel so sad they cannot serve that kind of food [that they like] every day. It's very hard. They say they don't want to eat.

There isn't enough fish or chicken.

While some residents like beef, most residents would like more "meat," meaning, specifically, fish, and to a lesser extent chicken, especially if prepared in a Chinese style. This preference for fish may reflect regional southern origins, which emphasize seafoods, especially fish (Newman 2004; Simoons 1991). This includes "fried chicken," which was not designed as a specifically Chinese entrée, but resembles Chinese-style fried chicken.

As one staff member observed, "I think mostly they like meat, like chicken, fish, beef, or some kind of meat. [...] They are very happy to see it. [...] They like the fried chicken very much, they think it's very tasty."

I don't like sour or cold food.

The preference for warm foods reflects the historical concept of *yin* and *yang*. *Yin-yang* theory is the fundamental philosophical "logic" of traditional Chinese medical theory in which the parts of a whole are seen to be "dialectically" related. *Yin* and *yang* constitutes "a system of thought" in which "all things are seen as parts of a whole" and so "no thing can exist in and of itself" (Kaptchuk 2000). *Yin* and *yang* describe how parts of a whole "interact with one another to maintain balance and harmony"; *yin* represents the "dark, cold, and feminine aspect," as well as

downwardness, decrease and completion, while *yang* represents beginning, dynamic potential, the "bright, hot, and masculine aspect" (Kaptchuk 2000; Lau 1998).

Health reflects the balance of *yin* and *yang* forces in the body. Health conditions can be considered *yin* or *yang*.[43] *Yin* illnesses are "characterized by weakness, slowness, coldness, and underactivity," while *yang* illnesses "manifest strength, forceful movements, heat, and overactivity" (Kaptchuk 2000). For example, muscle wasting is considered *yin*, while hypertension, diabetes mellitus, and infections, are *yang* conditions (Lau 1998). Clinical symptoms of excess *yin* (e.g., "dry cough, dizziness, and muscle cramps") or *yang* are treated by consuming foods of the opposite force, because many foods are considered either *yin* or *yang*, while others are neutral (e.g., soft rice, noodles) (Lau 1998). Metaphorically, *yin* is thought of as "water," while *yang* is "fire" (Kaptchuk 2000). With excess *yin*, which is often seen in old age, "hot tonic soups" (i.e., hot is like "fire") are commonly consumed; they are often made with "chicken, pork liver, pig feet, or oxtail" (Lau 1998). Thus, food is thought to affect health based on *yin* and *yang* concepts, rather than a biomedical understanding of nutrition.

While food is "thought to play a vital role in preventing and treating diseases," specific practices vary among people of Chinese ancestry in the U.S. for many reasons, including regional differences, specific family customs, cultural adherence, economic factors, and availability of ingredients (Lau 1998).

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[43] This discussion of *yin-yang* theory within traditional Chinese medicine (TCM) and its implications to dietary habits is simplified to the level relevant to the findings presented. Please refer to Kaptchuk for a more comprehensive, practitioner-based of TCM thought.

Table 9: Examples of *Yin*, Neutral, and *Yang* Foods
Modified from Lau 1998

Yin (cold)	Neutral	*Yang* (hot)
Bean curd	Noodles	Beef
Bean sprouts	Soft rice	Broiled meat
Bland foods	Sugar	Catfish
Boiled foods	Sweets	Chicken
Broccoli		Chicken soup
Cabbage		Chinese dates
Carrots		Eggs
Cold foods		Fatty meat
Congee (J)		Fried foods
Cucumber		Garlic
Duck		Ginger
Fish (some)		
Fruits (some)		Glutinous rice
Ginseng, American		Hot foods
Greens (most)		Liquor
Honey		Mushrooms
Melon		Onions
Milk		Peanuts
Pears		Pig knuckles
Potatoes		Pork liver
Pork		Red beans
Seaweed		Red foods
Soybean		Sesame oil
Spinach		Shellfish
Water		Sour foods
		Spicy foods
		Tangerines
		Tomatoes
		Vinegar

Original Reference: Siu P. The oriental client—cultural considerations in dietary counseling. Beta Release. 1987;2:23-27

Many cold foods are cold because the food is raw. Chinese of various ages, not just the elderly, have tended to be "wary of uncooked food and drink," both because cooking "tenderizes" food and also because cooked foods and drinks may be "healthier" (Newman 2004). Residents or their families framed the aversion to cold foods as "habit" or preference common among the elderly, rather than articulating specific cultural concepts of *yin* and *yang*; previous research has also found that, while Chinese "commonly" apply these concepts in their food practices, that this "does not necessarily imply knowledge of *yin-yang* philosophy" (Lau 1998).[44] A family member said about her mother's preferences, "No yogurt or ice cream. She doesn't like cold foods. She is afraid of cold food. The box milk she doesn't like [milk carton given on the tray, because it is cold]. I think it's a habit. The elderly Chinese people, they don't like cold. Mom will spit it out."

It was not clear why residents disliked sour foods. Because western (Sichuan province), rather than southern cuisine, is more associated with sour or highly vinegared foods,[45] it is possible that the residents' dislike of sour foods reflects regional differences. Also, foods with tomato sauce were "too sour," which may reflect an unfamiliarity with Italian and other cuisines that use tomatoes or other sour ingredients. Additionally, sour foods, like the other five tastes, have their role in TCM (Newman 2004).

Many residents also dislike salad and orange juice because it is cold and sour. I rarely saw any resident eat the salad; vegetables are almost categorically never eaten raw in Chinese food (Lau 1998). A family member said about her mother, "She doesn't like sour. She doesn't eat the salad here. There's no taste. They just put a little bit sour, so no taste. Mostly the Americans, they like the vinegar, because it's a little bit sour." However, temperature is even more important. The residents preferred hot tea or hot water to cold beverages, although some would drink milk or the liquid supplements Ensure or Glucerna.[46] For example, a family member said, "She don't

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[44] Some Chinese staff also expressed a similar dislike of cold foods or beverages.
[45] For example, "hot and sour soup" (Simoons 1991).
[46] One family member's strategy was to mix hot water with the Ensure so that her family member would drink it, making it both warm and less sweet.

like cold food. Drinking—all the time it must be heated up for her." Staff members are aware of the preference for hot beverages; "They most like hot tea, because it's warm."

I should emphasize the underlying importance of *yin-yang* theory in the residents' preference for hot beverages. It is significant that the residents did not complain about the type of tea; certainly there is an extensive range of type and quality of Chinese tea, and American teas can be quite different to a discerning palate.[47] I suggest that for the Chinese residents, the hot tea provided at the nursing home was not a cultural food per se; instead, it accommodated their culturally-acquired preference aversion to cold drinks by giving them something to drink that was warm. Hot water or hot tea both accomplish this goal. Similarly, Chinese typically avoid raw or uncooked foods; traditionally and "still common[ly] today," many Chinese "boil all water before drinking it hot or at room temperature" (Newman 2004).

Furthermore, I suggest that hot tea in the nursing home is an almost fundamentally different entity from the hot tea that Chinese residents drank at meals or social events in the community. Residents did not mention the social aspects of tea drinking (i.e., how it is served according to rules of etiquette at the "family-style" table). They did not comment on the fact that tea is not served in a traditional Chinese tea pot with small, handleless cups. The use of a personal mug with a tea bag is, in contrast to Chinese practices, highly individualized; the hot tea is American, in type, serving style, and social meaning. Removed from the appropriate social context, hot tea for the Chinese residents is not the hot tea they drank in their homes, their friends' homes, or at restaurants. Thus, the fact that it is not Chinese tea is irrelevant.

The problem is lack of options.

While residents mostly said that they disliked the food, a subtheme was that the "lack of options," more than the type, was a fundamental problem. The residents contrasted the lack of

[47] For example, American- or English-style teas often contain tea leaf blends designed in such a way as to be balanced by the addition of milk and sugar, while Chinese teas are invariably drunk plain.

options with their food and meal choices before institutionalization. A resident compared going to a restaurant as he used to with the meal trays, highlighting the difference of choice; "I usually went to a teahouse in Chinatown. Whatever I like, I can just raise my hand, and they give me the food I like." Another resident said, "When we're eating at home, there are two differences. You can buy whatever you like, and we cook together. [...] We can eat whatever we like." A staff member said, "All of them, they don't complain. They say, 'Oh, I don't have a choice, so I just don't eat. If I don't eat, I get hungry, who gonna give me extra food?' So he has to force himself to eat. 'If I'm hungry, I have to eat, I don't have a choice.'"

I used to eat with my family.

The majority of residents described past meals as events which began with food shopping and/or preparation and then eating as a family. The social meaning of meals as family events and as events in which the residents took care of family members was a common theme. A resident said, "When I'm eating with my wife, there is happiness, a two-way communication."

Family Members

Family member participants included almost equal numbers of male and females with most being adult children to the residents. On observations, while women were more frequently present than men, men were certainly not uncommon. Two husbands were interviewed but no wives; although wives certainly were frequent family caregivers. In recruitment, female family members in general were more likely than male family members to decline participation, most typically citing lack of time and not wishing to be "on the record."[48] However, I did not find any suggestive differences between genders or spouses and children in this limited sample.

[48] Because these individuals were not study participants, I did not explore these reasons not to participate in depth. If the common anthropological observation that women tend to be "keepers of culture" applies here, I speculate that women family members were more likely to take a collectivist orientation not to complain (i.e., promote harmonious relations with the larger group), and that women may be more conscious than men of the responsibility of "protecting the face"—i.e., the family's privacy.

Table 10: Family Member Participants	
Gender	
Female	5
Male	4
Total	9
Relation to Resident	
Wife	0
Husband	2
Daughter	3
Son	2
Daughter-in-law	1
Son-in-law	0
Sister	1
Brother	0
Total	9
Usual Number of Visits per Week	
1 visit	2
2 visits	2
3 visits	1
4 visits	0
5 visits	2
6 visits	0
7 visits	2
Total	9
Average Number of Visits per Week	4
Mealtimes Present	
Breakfast	0
Lunch	4
Dinner	5
Snack	0
Total	9
Language	
Cantonese without other Asian language	4
Cantonese with Mandarin	0
Cantonese with Toisanese	0
Cantonese and Vietnamese	3
Other Asian language	2
Total	9
Minimal English**	1
Fluent English	3
Total	4

** Some basic phrases but not conversant.

Many residents have family members who visit regularly, with most visitors coming at least once a week (see Table 10). Family members are a common sight during mealtimes.

My family member doesn't like or won't eat the food, so I have to bring food.

Family members typically expressed that their relative did not like the food because it was "American" and that the resident was unused to eating such food that was not Chinese. Most said that the institutional food is not bad, that it is "nutritious," but that their relative would not eat it. For some, the residents would eat the institutional food, but the family members wanted to bring outside food for other reasons: increased variety, foods the resident used to like, and because home-cooked food is "better."

Family members play an important role for the Chinese residents because of the lack of food that Chinese residents will eat. As a nurse said, "If the family can participate with us, and come see whether he would like family to come visit, bring some food, if they come, that would be very good. Some of them come every day, because they know the resident doesn't eat this food." Moreover, the staff rely on family to provide food when residents will not eat institutional food; a nurse said, "If they really don't want it, they don't eat for one or two days, then we have to talk to the family, 'can you bring some of his favorite food?' We cannot ignore, let them not eat."

I come here because s/he is family. I have to. This is my burden.

Family members do not feel they have a choice, but they do not feel pressured by staff. Instead, they believe that because the relative is family, they simply have no choice; "I have not much choice [whether to bring food], because I am her son. I don't want to give up on my mom." In some cases, family bring food, and the residents eat independently, and staff warm up the food for residents at mealtimes. In many other cases, however, family feed the residents. Their mealtime caregiving substitutes for professional caregiving. A few family members described how busy the staff were, and suggested that they, as family, were therefore able to spend more

time than staff in feeding; "Also the staffing here, if you feed her, she'll spit it out. It makes it hard for the person feeding her, so they give up. But for me, a family member, I have to take up this burden." Many family members who feed or provide food come regularly, several times a week; "Every day, this is my routine," said one family member.

Many family members cook specifically for the residents, rather than, for example, providing family leftovers or buying take-out. Like the food services and dietetics, family members try to accommodate residents' dietary restrictions and their preferences, while providing nutritious food. A family member said,

> I make very simple food, but it takes me three hours. ... The very worst is that my mom has trouble in swallowing, so I cannot buy outside food from the restaurant. If she could eat regular food, I could just buy the outside food, it would be easy.

Providing food and mealtime caregiving is particularly burdensome, even though it is inspired by love; "After I come here and see her, I feel better, but I'm just exhausted." Another family member said, "I was raised by her, so I just return her love to me. [But] The truth is, if my mom lives longer, the longer that I suffer."

I could not interview most residents who received home-cooked or outside food because they were not cognitively competent. Among those I did interview, receiving food from family was not only preferable to eating tray food, but also had additional meaning. Such meanings were not uniform, but often pivoted around improving health. One resident said, "Without the money, the doctors, [my spouse's] support, and the homemade food, I would have already died."

I come here because my relative cannot speak to the staff.

Many residents and family members stated that communication was the most important problem. This problem arises for family members who either have relatives who have dementia or are otherwise unable to communicate, or for relatives who may or may not be able to

communicate in the native language, but who do not have access to staff who speak that language.

Residents without access to Chinese-speaking staff express frustration at being unable to communicate with staff. An alert resident said,

> When a sick person is sick, he is annoyed and moody, and the language barrier is not helpful. There's no way out and no way to get assistance. You cannot be understood. It's like adding oil to the fire. They don't understand us, and we don't understand them. The patients are helpless and sick, and plus there's a language barrier.

The following quote illustrates a family member's perception of the language barrier, as well as the biomedicalized orientation to problem-solving (i.e., "is it pain?") that is pervasive in the nursing home as a healthcare institution.

> My mom, they don't understand. When I go home, nobody changes the sheets for her when they get wet, and she calls. They don't understand what she's talking [about]. So my mom calls louder and louder, thinking they cannot hear. After that, they say, maybe she has pain. They talk to the doctor, to ask me, does she have pain? I said no, because she is [prefers to be] very clean. When she gets wet, she says 'pee-pee.'

Many staff do the best they can to communicate despite language differences. For daily activities, they believe that how they communicate is sufficient, although not ideal. A staff member said, "Language is not even a problem, believe me. I understand [a Chinese resident]. When she's mad, or when she doesn't want to do something she'll gesture." A CNA said, "I say [to them], lie down, go to sleep, eat. They gesture, if they want to drink, or eat. [But, I need an interpreter] if they want to talk to the doctor, go to the eye doctor, the clinic. I don't know what's wrong."

Families with residents in the wards with Chinese-speaking staff express satisfaction and comfort in knowing that these staff are available. As one family member said,

> This is easier for my mom to communicate with them. If she doesn't feel well, like a headache, or pain, she could talk to the staff, and then the staff could respond right away, like take her

> temperature, or take her blood pressure. I feel that when she stays in this ward, it's better than other wards.

Family members of residents on the Chinese-speaking wards consistently cited the Chinese-speaking staff as an important part of why they believed that the care their family members (residents) was good, while residents and family from the non-Chinese-speaking wards consistently cited communication as their biggest problem.

I come here because the CNAs are busy. They don't have time.

Family members say that the staff try their best, but that, because of multiple factors, the CNAs are too busy to give the extent of care that the family members wants for the relative. Some reasons include understaffing and the rigid staffing schedule. A family member said, "You know, there are three or four staff to forty [residents]." Another said, "You cannot count on the nurses to all the time check one by one, to check for you. They have their own job, you know. They are not your family member [with] all the time to check."

While family members say that they visit to show they care, this was rarely the first cited reason. However, staff observe the positive effect that family visits have on the residents. A nurse said,

> Mostly, they enjoy the family to bring the food because it's not just the food, it's the family come to see them, that makes them happy. So that's very important, because the food, whatever the food, it's just whether you eat or not, but the family support, and they come to see you, that's the touch they need.

Table II: Staff Member Participants

<u>Gender</u>	
Female	12
Male	5
Total	17
<u>Race/Ethnicity</u>	
Chinese	11
Filipino/Filipina	2
Other	4
Total	17
<u>Participant Type</u>	
Certified Nurse Aide (CNA)	6
Registered Nurse (RN)	4
Activity Therapist (AT)	3
Key Informants (Dietetics/Food Services)	4
Total	17
<u>Shift (Nursing Staff Only)</u>	
Day	12
Evening	4
Night	0
Total*	16

* Staff may work more than one shift, resulting in a total that differs from the total number of participants.

Staff Members: Key Informants

Key informant staff emphasized five main themes which center on the role of food and meals within the overall goal and institutional structure of the nursing home.

Food is nutrition; this is a therapeutic diet.

The nutritional aspects of food are fundamental to the participants' work because, as one informant said, "nutritional care is fundamental to the residents' well-being." A dietitian meets with and evaluates a "patient,"[49] and carefully designs a diet to achieve a "balance" among the doctor's orders and medically relevant diagnoses, clinical parameters (e.g., weight, appetite, and meal intake), the patient's and/or family members' preferences, and the options available in the institution. A dietitian said,

> I work closely with my doctors and my residents in an effort to provide foods that residents would enjoy eating, and benefit from the nutritional care. So, hopefully they will comply with the diet without seeking unhealthy food on their own. [...] Some doctors [...] understand that dietitians know how to design menu and give patients what benefits them.

Proper nutrition is necessary for both health maintenance and improvement. Dietitians assess residents' nutritional status by monitoring residents' weight, biomedical parameters, and food requests and preferences. Dietitians adjust the menus to improve or correct health problems—i.e., the diet is therapeutic. For example, a dietitian said, "If the lab value is abnormal, what does that tell you? And if there is the skin break, like injury, infection, or pressure ulcer, then what do we do nutrition-wise to help mitigate the problem? [...] Nutrition is therapy."

In designing therapeutic diets, as described earlier, the "regular" diet is the basic house diet, with the widest variety of foods available, and alterations are made from this baseline in

[49] As noted earlier, staff members (including key informants) used both the terms "patients" and "residents"; among key informants, the term "patients" was used more frequently, although not exclusively.

both nutritional content and mechanical preparation.[50] With each layer of dietary nutrient restriction in response to medical diagnoses, preferences, or other factors, the range of options narrows by eliminating a group of foods; "The more restrictions there are, the less food choices are available, thus the more monotonous the meals will be. The less they eat, the more problems will develop."

In order to promote dietary compliance, meal satisfaction, and health, the dietitian may recommend a more "liberalized" diet, then tailor the meal pattern on item-by-item to suit the particular individual's needs. The American Dietetic Association supports the use of liberalized diets for elderly residents (Womack and Breeding 1998); a "liberalized diet" is intended to "balance medical needs and individual desires" to maintain "quality of life." A dietitian explained,

> What would the three meals turn out to be on a two gram sodium, two gram potassium, sixty gram protein, 1500 calories, 1200 cc fluid restriction? [...] Would you be surprised to see they complain about the food or even refuse to eat them? For this kind of restricted diet, I would recommend liberalizing; [for example,] change this [no sodium order] to 'no added salt,' no concentrated sweets instead of 1200 calorie. It gives room for the dietitian to work with resident to tailor the meal planning to suit the individual's nutritional needs. [...] Give patients what they want to eat, not what we think patients should eat. If they don't eat, they don't benefit.

There are occasions where residents desire food non-compliant with the diet. However, dietitians cannot provide foods that are not allowed in a specific restricted diet listed in the "Diet Manual." Ultimately, dietitians must work within the physicians' dietary orders. One dietitian said,

> Some doctors think all these nutrients need to be restricted, without knowing that the severely restricted diet may deprive residents of a variety of food choices and will affect their meal enjoyment. Some can seek food elsewhere on their own to satisfy their appetite. For others, they cannot control what foods they receive, but they can still gain control and autonomy by rejecting the foods they don't want to eat. But if they don't eat, they might

[50] Based on various factors that determine mechanics of eating, certain foods may be chopped or pureed, and liquids thickened. These diets introduce restrictions because not all foods are considered appropriate for these preparation methods.

> lose weight, develop decubitus ulcers, or end up on tube feeding [to meet caloric needs] unnecessarily.

The Chinese don't like the food. If they don't like it, they won't eat it.

The dietetic staff were aware that the many ethnic minorities within the nursing home would prefer culturally appropriate foods. As such, while Chinese residents desired more Asian foods on the menus, like other ethnic groups, their specific ethnic food preferences could be met only to a limited extent.

Staff members expressed that observing residents was extremely important to understanding what residents' preferences were, due to several factors (e.g., residents' cognitive competence, language differences), and thus whether residents were eating what they were given. Said one staff member,

> The Chinese residents' voices often were not being heard because of the language barrier. If they're not being visited, if you don't hear them, you don't watch them eat, you don't know how well they like the food we give to them. We assume they eat whatever we put on the tray. But it's not the case. If they don't like it, what [do] they do? They don't eat it. [This is why] mealtime observing and patient visits are extremely important. [...] We need to hear their feedback and see how well they eat.

Knowing preferences by observing residents is important because if residents do not eat what is on the meal trays, they do not reap the benefits of the prescribed, carefully designed, balanced meals, putting them at risk for the two main outcomes which dietitians monitor for: skin ulcers (e.g., decubitus ulcers) and weight loss; if residents are not eating enough, "that's when sometimes they start to lose weight, and then have skin ulcers." The staff then give liquid supplements. In some cases, however, "Some Chinese patients don't like Ensure that much because they say it's too sweet or it gives them diarrhea."

We monitor for skin breaks and weight loss.

As alluded to earlier, the quality of nutrition is primarily assessed through two outcomes: skin breaks and weight loss. A staff member said, "Our biggest issue that's strictly monitored by [the] quality assurance committee is weight loss and skin breaks. [...] Skin breaks and weight loss are warning signs of improper or inadequate nutritional care." Thus, outcomes are defined in biomedical terms.

The so-called, limited "Asian diet" is preferred over the regular diet.[51]

As outlined briefly earlier, the Asian diet consists of *juk* (the Cantonese term for rice porridge) at all three meals, rice at lunch or dinner, and hot tea with all meals. Other Chinese food items, such as tofu stir-fry, *bok choy*, and sweet and sour pork, are offered sporadically.[52] *Juk* is a highly regional, even village-specific food, often containing small pieces of meat like pork and salty or preserved eggs (*pi dan* or "skin egg") which are nutritionally considered high-fat and high sodium (Lau 1998). Moreover, *juk* is traditionally a breakfast food that, like rice at lunch and dinner, is served in a bowl and serves as focal point around which the dishes are added. In contrast, the *juk* served at the nursing home is "plain"; it contains no meats or vegetables and is seasoned primarily with chicken broth. Furthermore, the *juk* is served at all three meals and in small disposable plastic container along with other side dishes. Although rice preferences can also be very particular, key informants and other participants (including residents) rarely mentioned this issue. Rice is served on the main plate alongside the entrée and possibly an additional side dish.

Hot tea is part of the "Asian diet" for two main reasons identified by staff: Chinese prefer to drink hot tea over other beverages, particularly cold ones, and among hot beverages, hot tea is preferable to coffee, because Chinese do not traditionally drink coffee. When asked, the residents

[51] The "regular diet" is also understood as the "house" or standard diet.
[52] Refer to the discussion of Food and Meals in the Background section for further details.

identify the hot tea (inaccurately) as *bo lay*[53] or as "American" tea. Hot water is served in a plastic mug with a disposable plastic lid, and a separate tea bag, which is labeled in English. Some residents drink plain hot water. As Lau notes, "Elderly Chinese seldom drink cold beverages such as soda, water, juice, or iced tea. They will accept hot water in place of hot tea" (1998).

Thus, the "Asian diet" is not tailored to specific regions, beyond a focus on rice (rather than wheat flour products), but instead generically Asian and thus inclusive of most Chinese or East Asian residents. Furthermore, the few Chinese entrees that are available are *not* automatically part of the Asian diet when the dietetic staff input the order into the computer system. The Asian diet does two main things: it provides forms of rice (*fan*) for the residents, and it provides a hot beverage other than coffee. However, the ways in which these foods are served removes them their previously meaningful social contexts such that the residents typically fail to see these hard-fought accommodations[54] as "Chinese food." A dietitian said,

> I found out that the Asian diet is just rice, *juk*, and tea instead of coffee. They don't automatically substitute the Chinese entrée. Like, baked chicken [on the cycle menu], they won't get tofu stir fry unless we put in the computer: 'no baked chicken, sub tofu stir-fry.'

Thus, the attitude is that, "If [the dietitian] go up and see the patient eating baked chicken, it's like, 'If things aren't broke, don't fix it.'" The regular diet is the default option, and the system's design tends to discourage changes by making changes categorically or requiring that changes are made on a day-by-day basis on according to the cycle menu. Thus, to order the Chinese entrees for a resident requires making the preference change on each day of the cycle menu for which there is a Chinese entrée available. Furthermore, changes must be made to individual records, such that the changes cannot be made to a group of patients without modifying each record individually. Thus, the system effectively treats each patient in a highly

[53] *Bo lay* is the name of the tea in the Cantonese dialect (*pu erh* in the Mandarin dialect). *Bo lay* is a type of fermented tea named after a region in China.
[54] As noted earlier, for example, the *juk*.

individual manner and makes deviations from the regular diet a time-consuming task, which is an issue for the staff, who describe severe understaffing.

Because of institutional limitations, some people say that the Chinese food here is not "real" Chinese food.

Besides the task of entering changes into a system that discourages the extremes of highly individualized or group changes, the dietetic staff understand and must consider the kitchen staff's workload, the structural and financial limitations of the institution itself. The kitchen staff include ethnic Chinese employees who, despite knowledge of Chinese cooking styles, are limited by the prepared nature of the food, the style of the kitchen equipment, and the logistics of cooking and delivering food to hundreds of residents in a large facility, e.g., food stays in warmers before being sent upstairs to the residents, in some cases causing foods to get overcooked or dry. Rather than using fresh vegetables that are chopped on site and then cooked in a particular order, as is typical of Chinese cooking, the vegetables are cooked simultaneously. For example, a staff member said,

> The Canton Chicken [Chicken Cantonese, see Table 5: 28-Day Cycle Menu Sample Week], the vegetable already comes mixed by itself, the carrot stick this big, and bean sprouts so little, already combined together. When the carrot sticks cooked, the bean sprouts are already melted, disappeared.

For example, a staff member said, "The vegetables are alright, but they're not the way they [the Chinese residents] want them. To do it right [Chinese style] is very labor intensive. There is a lot of chopping, there is too much cutting up. It takes time. They are short on staff, too." The limited budget[55] and resulting understaffing means that the time-consuming, labor-intensive Chinese cooking style is not thought to be feasible. Furthermore, although there are cooks trained in the

[55] Furthermore, both key informant and clinical staff express that the funding limitations that shape the perceived possibilities and staffing levels are inherently political, and tied to societal and local political views about what is worth funding; for example, is a large scale nursing home where the larger, non-institutionalized population wants to spend its tax dollars?

Chinese-style,[56] some of the appropriate kitchen equipment is not available (e.g., a large wok); "We can cook Chinese food here because there are two Chinese cooks here. But they don't have the Chinese cooking equipment here, so even though we cook Chinese food, it's not quite up to the standard." Yet, as described above, staff, like residents and family members, describe an inability to instigate change.

Staff Members: Clinical Staff

The clinical staff involved in mealtime care have role-specific orientations toward their work in general and food and mealtimes, in specific. The CNAs and RNs have a biomedically-oriented focus on safety.

Activity therapists are focused on the cultural and social aspects of nursing home life; as an AT said, "My work here is to make them feel at home, that they can always come to us with anything." The ATs have a different relationship with the residents than other clinical staff; "We're more in touch with them. We have the goodies for them, we're the fun part. They like food, we'll give them the best we can. [...] It's a big difference between the other staff who work here. ... We got the tools to be liked." ATs approach food and meals activities with an understanding of how meals and snacks are opportunities for social interaction and building relationships among residents and staff. An AT said, "Food is very interesting to interact with people, to have a good relationship."

For the nurses, long-term care is clearly within a biomedical orientation. For example, one nurse compared acute and long-term care, describing them as opposites along a continuum of healthcare[57]; "They see you everyday, not like in acute care, you work this, and you done, and

[56] None of the residents with whom I spoke were aware that there are Chinese cooks employed in the kitchen.

[57] As describe in Chapter One, the contemporary health care model places nursing homes within the medical system (in order to draw funding) of "progressive patient care" in which patients were "moved from one level of service intensity to another as their condition changed" (Vladeck 1980).

you go home. But in here, you contact, and you build up more relationship. Just like getting to be a family."

Observing patients is necessary for their safety. I have to watch for choking.

The nurses are concerned about the residents' safety—meaning, their health. One major threat to life is infection. Both nursing staff and ATs emphasize that it is important to observe the residents; a nurse said,

> Our experience is that, if you don't look at them, maybe they are sick, so if you don't treat them right away, for them, the old people are very fragile [...] they can die very quickly. [...] If you just ignore, they can just go in one or two days, very quick. So that's why we observe the residents.

Food and drink are nourishment and hydration.

For the nursing staff, food, eating, and meals, are important as they relate to safety—the protection of health and life. As a nurse said,

> So if you find out the problem, they have infection, and you treat them. You know they are not eating, so you have to find out why they're not eating. Maybe they got infection, they got very poor appetite. So if you treat the infection, in one week they're getting better, then they're getting strong.

Because of the importance of food and drink to health, the nursing staff use medicalized terms like "nourishment" and "hydration"; "We know the elderly, they easily get dehydrated, that's why we pass a lot of nourishment and water for them. Because that's the most important thing."

For staff, keeping the residents healthy and "stable" with nourishment and hydration impacts upon their own work; "If you say, 'ah, they old, they don't need to take care, then the next day you find another resident. That's a lot of work for you. That's a very hard job. That's why we want to make sure they're safe here."

The RNs generally do not feed the residents; that is the CNAs task. An RN said,

> We only observe, we make sure they are safe, not choking. And, we make sure their meal is what they want. Sometimes they don't want to eat [...] So when we observe them at mealtime, we know what kind of food they like, what we can give more support, to give them nutrition.

I have to give out medications at meals, so I'm busy.

In addition to observing residents during meals, nurses must "pass medications" that are prescribed to be taken at meals or with food. The nurses have a medications cart parked near the tables on the hallway and prepare individual doses of medications, giving them to residents one at a time in small paper cups, either whole or ground into a small amount of food in the cup, such as pudding. The nurses stand by the resident's side to make sure he or she takes the medication, or, if necessary, feed the resident.

Residents don't want to eat for many reasons.

When residents do not eat, the nursing staff see many possible causes, all of which locate the cause in the individual body, mind, or habits. For example, a nurse said, "Maybe their metabolism is low [in old age], they don't have the interest in eating." There is a constellation of possible causes, including slow metabolism, the therapeutic diet is not "tasty," depression, past habits of not eating much, medications, psychology, and cooking styles; "This whole picture you have to figure out, why they don't want to eat."

The food is a never a surprise for the patients.

The nursing staff observe that the "fixed" meal schedule limits choice; without choice, there is no "surprise"; "There's not a lot of variety to choose, it's fixed. So there's no interest. ... The alert people can memorize. They don't have any choice. They don't have surprise. It's not interesting, 'Oh, I might have something special.' Oh no, 'I eat something today I know already.' It's very sad."

Because they lived in Chinatown most of their lives, they cannot accept new food.

As with cultural activities like *Mahjong*, the staff observed that residents were typically preferred the foods they are used to, especially *fan*. A staff member said, "I think it's what they grew up with. You grew up eating rice everyday, and then you're in an institution, and they feed you beans. 'No, I need rice.' They would starve themselves just to get the rice back."

They may not eat the food, but they will be polite.

A staff member said, "To be in an institution where they serve Americanized, Western meals, they would just push the tray away. 'I don't want it, I'd rather wait for my family to bring food in,' or, 'I'll just starve,' or, 'I'm okay, I'm full.'" The family are an important resource for nursing staff if residents do not eat, while the dietitians provide additional help; "If there's a family, we get them involved immediately. If not, we work with the dietitian to provide an Asian meal for them."

As with other aspects of nursing home life, Chinese residents were typically thought of as "polite." So, although the residents may not like or eat the food, the staff say that they rarely complain; "They won't tell you [that they do not like the food], they'll be very polite about it."

Ethnic food makes the residents happy.

Because the ethnic food offered on the meal trays is both limited and "just not the same" as "real" Chinese food, the ATs provide ethnic food activities, ranging from snacks once or twice a month, food preparation activities on the units, to a bus trip to a local Chinese restaurant. Because most meals are eaten at home, meals at restaurants "emphasize food and sociability" to an even greater extent than meals in general (Newman 2004). Every few months, there is also a

nursing home-wide "Chinese luncheon" to which all Chinese residents are invited during which staff order Chinese take-out and residents receive a plate of food.

Choice of food provides independence and surprise.

The ATs emphasize the sociocultural aspects of food rather than the nutritional qualities; "They love Chinese food, soups, and noodles. These little details make a person happy." Furthermore, the ATs try to provide choice; "We ask them, 'What kind of menu would you like to have?' In the case of ethnic special groups, it becomes something special for them." Choice is meaningful because it approximates the independence that residents had before institutionalization. An AT said, "That's my goal for them, to be independent like they were before they come in. No one will go, here's your set menu, here's what you're going to eat."

At the restaurant trips, the meals are served family style as in a traditional Chinese meal, with a central lazy Susan, rice bowls and plates, and both chopsticks and forks available. While not all residents are able or wish to use chopsticks instead of forks, which are used at the nursing home, "some say, 'I just want to use chopsticks,'" because "it's easier" to use than forks.

It is considered typical of Chinese to discuss the menus extensively and talk about the food and previous meals at a restaurant (Newman 2004). In general, "some have noted that food is not only a common topic of conversation, but often the dominant one" (Simoons 1991). Because residents choose what to order, and their choices are shared with the other residents, individual choice provides meaningful social interaction among residents, as well as staff. An AT said, "Everyone has their own specific dishes that they love, and this is their way of sharing it with others. 'This is what I ordered. How is it? Do you guys like it?' They'll go, 'The fish was good, but I didn't like it fried. Next time let's not order it fried.'"

The meal event provides opportunities for social interaction that are culturally appropriate for the Chinese residents. For example, "there's always someone who wanted to take over pouring tea, making sure everybody is okay and the tea is filled." The residents behave as

they would if they were going to a restaurant on their own, "ask[ing] for things from the waiter," including "ask[ing] for the bill, and mak[ing] sure it's correct, making sure I [the AT] don't get ripped off."

They also take on a social role that is age-appropriate, in which they take care of the staff, who are of a younger generation. A staff member said, "They're very watchful of us [the staff]. 'You're not eating enough, why aren't you eating? Have some more vegetable, you need more vegetable.' 'Well, okay, what about you?' We take care of each other." As a social event, unlike at institutional meals, according to staff, "we all take our time" to eat.

The residents also interact across cognitive abilities more during the restaurant meals than during "social dining" at the nursing home, according to staff. An AT said,

> There's a few who are very alert and they know how to take care of the rest. If one of them is sitting there and he doesn't like the food on the table, they'll say, 'What's wrong? Why aren't you eating?' They'll say, 'I don't have an appetite today.' 'Well, what do you want? We can order something else. Come on!' And they'll get them involved. ... A lot of excitement, lots of talk when they're going to the restaurant. 'Oh, Mr. such-and-such, you need to try this dish, it's the best dish I've ever had in my life!'

According to an AT, besides eating itself, the residents most enjoy, "ordering something that they don't really know what it will turn out to be. I see a lot of excitement in their eyes from observing them. They always looked surprised to see items brought out. It's like taking a little kid to a candy store or a toy store." Thus, in contrast to the institutional meals, the restaurant trips provide not only choice, but, as a result of choice, surprise.

Section V: Discussion

Summary & Discussion

First, I will discuss which Chinese cultural values were important in how residents made sense of institutionalization, also discussing how tensions between nursing home-specific interpretations of Chinese values and biomedical values, based in Western Enlightenment ideals,

may explain why residents usually did not complain. I will review how the individualized, biomedical approach to food within the nursing home results in Chinese residents and staff narrowly defining the problem of mealtime experience as a problem of food rather than a lack of appropriate social context, such that institutional mealtimes lack sociability and past, familiar cultural meaning. Then, I will discuss how the specialization of food-related tasks leaves the cultural aspects of food to the ATs, while family members come to act as mealtime caregivers and thus reinforce the lack of sociability at mealtimes and residents' separation from family.

Chinese Cultural Values

Although translation made precise interpretation of terminology difficult, I found that Chinese cultural values, such as "filial piety," collectivism, and perhaps to a lesser extent, "protecting the face," were important in residents' evaluation of nursing home life.

The intimate connections among the place and concept of home, the family, and the self, appear to illustrate a Chinese concept of the self in relation to others (i.e., a socially rather than individualistically defined self), in particular, the family. The way that Chinese residents tied the ideas of family and of home reflects the concept of the traditional multigenerational Chinese household, in which adult children (and their families) reside with parents (Chao and Roth 2000; Ikels 2002; Lan 2002; Lee 2001; Lee, et al. 2002).

Resident participants were, of course, not residing at home with their children (and grandchildren), a separation from home and family that was quite poignant. Residents attributed their children's inability to care for them at home to American society that requires "having to work." They understand that society changes and that American society frequently requires their adult children, both men and women, to work hard to support themselves and their own families (an economic situation that reflects lower socioeconomic status, although residents did not comment on this specifically). As a resident said, "Everyone has a burden. I don't expect too much from my children. They have burdens, too." Another resident said, "A long time [at home]

is not possible. Because [my children] go to work, they're taking care of family. They don't have time to take care of me. So I just accept what it is. This is the reality."

With institutionalization, direct caregiving is mostly taken up by professional caregivers. Staff, particularly ethnic Asians, call on Chinese cultural ideas of family to make meaning of their caregiving work. They frequently described the idea of, "how I would like to be treated," namely, that they treat the residents like elders or grandparents, because that is how they would wish to be treated if they were institutionalized. Anthropologists, such as Foner, in her work with CNAs, have called this type of family-role-taking the creation of "fictive kin" (Foner 1995). The idea of seeing the roles of oneself and others within a traditional, repeating cycle of parent/elder and child/caregiver may reflect the idea of *bao-da* (payback), in which the staff act as "fictive kin" to the residents (Lan 2002). In contrast, non-Asian staff were less likely to refer to their own future as elderly persons and more likely to discuss the caregiver-patient relationship as "us" and "them."

Yet, despite the staff taking on the child/caregiver role, Chinese residents in this study were dissatisfied with nursing home life. As discussed in Chapter One, in studies in Hong Kong nursing homes, residents called on the values of collectivism and "protecting the face," in their evaluation, and expression of satisfaction, with nursing home life, although it is possible that "protecting the face" may have blunted expression of any dissatisfaction among participants in Lee's study (Lee, et al. 2002).[58] Despite the resident participants' dissatisfaction in my study, they stressed that they "accepted" their situation and did not wish to complain to staff or administration. In contrast, according to many staff, white-American residents were more likely

[58] Further research could explore to what extent, how, and why Chinese residents in the U.S. differ from both residents in nursing homes in China (Hong Kong being the best studied) and non-Asian residents in American nursing homes. While I speculate that these differences could be explained by some degree of what may be called acculturation among ethnic Chinese in American nursing homes, I would suggest that "diffuse disciplinary (bio)-power" over residents' bodies, in part a manifestation of what Ong called "governing through freedom" in an American nursing home setting with predominantly American residents, provides a different context in which to interpret collectivist values, such that, instead of finding similarity between a (multigenerational) home living situation and nursing home life, collectivist values were interpreted such that Chinese were not seen as part of the majority group.

than Chinese residents to complain to the administration and thus have their complaints addressed. However, as hinted at by some staff, the residents may have been concealing their own unhappiness about institutionalization, and their children's inability to care for them, in order to "protect the face."

Furthermore, the Chinese cultural value of collectivism and the Western cultural or biomedical value of individualism interact to further encourage Chinese residents to suppress their complaints. The care at the nursing home is highly individualistic in a particular Western, biomedical orientation in which a patient's problems are defined in terms of individual disease and individual preferences. Meanwhile, residents emphasized the collectivist aspect of nursing home life, i.e., that the nursing home is a "group home" that has to attend to the needs of the majority, i.e., native-born "Americans."[59] Because ethnic Chinese traditionally define the self in relational terms with others, especially family, for a Chinese to complain within the nursing home is to overemphasize the self in relation to the needs of the larger whole (the majority group in the nursing home); such individualistic complaints may have felt inappropriate and even overly selfish. Thus, despite (and because of) staff's emphasis and work ethos of individualized care, to the residents, everyone is an individual in the nursing home, so they do not see their needs as any more important and worthy of attention than anyone else's. Furthermore, they understand that the "individualized" care in the nursing home mostly pertains to individual medical problems (e.g., diabetes requiring a diabetic diet). Additionally, inappropriate behavior through expressing selfishness violates the cultural value of "protecting the face," and potentially reflects poorly not only on the resident, but the resident's family. In sum, residents did not expect that their individual preferences could be met, because catering to an individual is not in the majority's best interest, and so they did complain to the administration.

[59] Furthermore, as a public institution, issues of rights, particularly immigrant/non-citizen rights to government-funded services, may have shaped the residents' and family members' evaluation of their right to demand change. However, residents and family members did not identify these issues as relevant.

The ethnic Chinese could potentially constitute a collective entity; Asians make up 16% of the patient population, most of them Chinese. As a group, they could potentially justify the administration making changes to cater to their preferences.[60] Yet, despite Chinese identity as a potential source of deep cultural pride, even "cultural chauvinism" (Tu 1994), few residents cited China's long history or one's "Chinese-ness" as a basis of personal identity or justification for making change in the nursing home. The Chinese residents do not express a sense of meaningful connection with other Chinese residents. Even the Chinese living on the "Chinese wards" said they did not have friends among the residents, much less family among the staff. It may be that what McLean called the "diffuse disciplinary power" of staff and administration relative to residents within the institution tends to suppress Chinese identity as a source of pride and thus activism (McLean 2001). However, I suggest that the lack of group connection is at least partly explained by the Chinese patient population's heterogeneity (i.e., in language, socioeconomic background, and education), combined with the timeless quality of nursing home life, as described in the literature. For Chinese residents used to living among other Chinese (i.e., in ethnic enclaves), shared cultural values alone are not a cause for friendship; a meaningful shared experience and history within the nursing home, rather than a call to shared Chinese values or "Chinese-ness," may be necessary to forge links among Chinese residents and thus justify administrative change.

In summary, for the residents, the concepts of "home" and self are intimately tied to family. However, because of the demands of American society, the residents are institutionalized instead of cared for at home. Within the nursing home, despite staff's intentions, they consider themselves without family and friends. A collectivist orientation toward nursing home living means that residents not only believe that the nursing home, as a group home, simply cannot cater to personal or small group concerns, but moreover that it is most appropriate to "accept" what is best for the majority group. Furthermore, residents understand that individualized care

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[60] Dietitians advocated to get *juk* and rice for the Chinese residents.

within the nursing home is primarily defined in medical terms. A consequence of combining a collectivist attitude and "protecting the face" is to be unfailingly polite. Complaints, by their nature, violate an attention to politeness, so they are usually avoided. Furthermore, some residents feared "getting in trouble" if they complained.

Meaning of Food & Meals

The Chinese residents' past experiences with food were intimately associated with social interaction, especially the preparation and eating of meals with family. Residents were interested in discussing how and why they bought and prepared certain foods at home, often with another family member. They described eating together with family with "shared" dishes in the center of the table and each person having a rice bowl and chopsticks. Chinese food was also associated with past experiences of going out to eat; the meanings in these cases were most associated with choice of good or favorite foods and the opportunity to socialize with friends.

In the ethnographic nursing home literature, the extent of social interaction centering around institutional meals mostly depended upon whether alert, independent residents ate separately from "feeders" and others with lower function. In such studies, meals functioned to structure time and provide a setting in which residents could express their feelings about institutionalization.

However, for Chinese residents, the meaning of institutional meals is defined by meals as food, where food is individualized, medically-appropriate nutrition, rather than as socially meaningful mealtimes. The meaning of institutional food is highly individualized in a way that sublimates choice; the staff determine what residents can eat based on individual problems. The food is then served in a highly individual way that implicitly discourages sharing through its use of covered meal trays and individual packages and serving sizes. Explicitly, staff do not allow

residents to share food from plates for "sanitary" reasons.[61] Furthermore, the individual meal trays enable staff to observe and document how much each resident consumes—a task that would be nearly impossible with traditional family-style shared meals.

Further separating meals from Chinese residents' past experiences of food is that the food is American. The reductionist emphasis on meals as individualized food or nutrition led, I suggest, to Chinese residents' complaints (to me, not the staff) about a lack of Chinese food, rather than a lack of Chinese meals. So, they emphasize that the institutional food is not Chinese, not even the few Chinese entrees, because of different cooking styles. Residents do not complain about the way the food is served; to them, the meal experience is so fundamentally different from the notion of a "meal" in the Chinese sense—i.e., their lifelong experience of mealtime—that comparison is pointless. Food is no longer a meal; it is only the food itself, and the meaning of the food is inextricably the institution's view of the food.

Many times, I saw Chinese residents use only a fork or a spoon on every part of the meal, even when a combination of utensils would have been both more proper and more effective. For example, residents would stab a large piece of meat and lean over and try to bite off a piece. Or, they might use a fork when eating their *juk*, which in a Chinese serving style would be eaten with a large spoon. I suggest this reflects their unfamiliarity with how to use flatware, an implicit understanding that American food is eaten with flatware. Most importantly, however, this reflects that the way *juk* is served (i.e., *juk* is a staple breakfast food that in the nursing home is served as a side dish at lunch and dinner) separates *juk* from a recognizable Chinese mealtime experience, such that *juk* is hardly recognizable as a cultural food which should be eaten with a

[61] While the individualized sealed packages (including whole fruit) allow (sanitary) sharing, I never saw or heard of anyone sharing food at institutional mealtimes without the food item passing first to a staff member as a go-between. It is possible that this staff involvement ensured that the swap complied with each resident's therapeutic diet.

spoon.[62] It may also be a way for residents to appear willing to try to eat the food served without actually having to succeed in doing so.

Another example of the separation of foods from their familiar social context is hot tea or hot water. Removed from the appropriate social setting, hot tea for the Chinese residents is not the hot tea they drank in their homes, their friends' homes, or at restaurants. Thus, to them, the fact that it is not Chinese tea is irrelevant. They prefer hot tea to other drinks because it is hot, not because it is hot Chinese tea. As noted above, according to *yin-yang* theory, elderly tend to be in a relatively *yin* state, therefore, hot water and hot tea both help to balance an excess of *yin*. So, although hot tea is provided as part of the Asian diet, it does not provide the social meaning of shared tea at family-style meals.

The institutional approach to food so pervades the experience of Chinese residents that their perception of meals as a socially meaningful event is severely stunted. Most residents say that they do not enjoy mealtimes and do not look forward to them. Even the alert residents who ate together did not view meals as social events. The way in which meals are served—the unchanging schedule, the cycle menu, the meal trays, eating at the bedside, the plates and the flatware, and the lack of sharing, all contribute to the change in meaning of meals into individualized nutritionally-appropriate food. The individualistic, solitary qualities of mealtimes was especially apparent when compared to restaurant bus trips, where familiar social cues (e.g., family-style dining, waiters, shared tea) led to greater social interaction among residents and staff.

In summary, among the Chinese residents, institutional food is both group-oriented and highly individualistic in medical terms. The food is chosen for them based on their individual problems, such as illness and disability. This individuality is emphasized in the individual servings and packaging on the meal trays. The pervasive approach to meals as individualized

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[62] Further exploration of the meaning of serving style and utensils and perception of food would be helpful. Subtle differences can have meaning. For example, the length, the material, and the cut, of chopsticks vary among Asian cultures.

nutrition works to separate an already foreign food and food practices (e.g., flatware, individual plates rather than bowls) from culturally meaningful and recognizable past mealtime practices with family. Thus, institutional practices as regards to meal design, preparation, and service function to separate food and meals from Chinese residents' past meaningful sociocultural practices.

Meaning of Mealtime Caregiving

Based on the findings, mealtime caregivers are most meaningfully divided into three categories: nursing staff, activity therapists, and family members. The specialization of food and meals in the medicalized nursing home context shortchanges the social aspects of food and meals. Within this model of care, ATs become the only staff explicitly responsible for and capable of addressing the cultural aspects of food and meals.

Nursing staff are responsible for their patients' health and safety in biomedical terms, and enforced by Medicaid and Medicare regulations that determine reimbursement. During meals, nurses' attention must be focused on giving medications and monitoring for choking. CNAs are responsible for preparing trays and feeding, and they are also concerned about choking. Thus, the nursing staff's mealtime care is dominated by a biomedicalized orientation to mealtimes that focuses on a very narrow definition of maintaining health: the basics of life by preventing choking and administering the tools of modern biomedicine—medication. While most staff recognized that there was a lack of culturally appropriate food service for the Chinese residents, they chiefly framed this insufficiency as "no Chinese food" or a lack of ethnic food (reflecting a reductionist approach to the problem) and generally did not mention the mealtime sociocultural context.

In contrast to the nursing staff, activity therapists' food or mealtime tasks are less dominated by the concerns about choking. The ATs' role is less that of caregiver than social "leader," as one AT called it. Chinese cultural activities provide contexts in which previous social

roles make sense; e.g., playing *Mahjong* with others. As noted earlier, the Chinese restaurant provides ritualized social cues that stimulate social behaviors appropriate to the setting in ways fundamentally different than the mealtime setting in the institution.

Researchers have found that family members of non-ethnic nursing home residents performed "bed-and-body work," including feeding and providing homemade or "special" foods for residents (Foner 1995; Shield 1988). In such studies, care provided by family members benefited residents psychologically, helped them get better care through advocacy and "monitoring." However, as long-term family caregiving has been found to strain family relationships, family caregiving within the nursing home also detracts from family visits as times to continue and build family relationships apart from the tasks of basic caregiving. Furthermore, ethnicity has too often been thought of as a "positive resource"; there has been an "overly optimistic" emphasis placed on ethnic family networks as the "saviors" of ethnic elderly (Sokolovsky 1997).[63]

These themes from the literature were confirmed in this study. Family members visited primarily to bring food because residents did not eat and/or disliked the institutional food. For the family members, the institutional food is "good" because it is "nutritious," but it is not as good as home-cooked food. This reflects their understanding that the meals are designed to be balanced and to accommodate the resident's medical conditions, including dysphagia or other difficulties with the mechanics of eating. That family members came regularly and primarily brought the main entrée for the resident is significant because it means that they typically were not bringing special treats or favorite snacks; this reflects their role in providing basic care—meals—to residents, rather than fulfilling a more socially meaningful role oriented around family relationships. Further supporting the reorientation of family members as surrogate institutional caregivers is that family almost never ate with the residents. The staff came to rely on the family

[63] Although ethnic minority family caregivers may cite cultural values to care for elders, and bigger families may decrease burden on any one individual, the proximal reason for lower rates of institutionalization among ethnic elders may be that low-income minority families simply cannot afford nursing home care.

members to bring food rather than forcing the administration to provide food and mealtime experiences that would successfully encourage residents to eat. Thus, the "ethnic" family network did provide essential care in this study, but at social and cultural costs to both the family members and the residents.

Thus, family members became mealtime caregivers to replace CNAs' work within the nursing home context. That some family cite the "busy CNAs" as another reason for their visits further supports this analysis. As suggested in the literature, family did not visit to enjoy time spent with the resident and to provide the emotional aspects of relationships that the institution does not explicitly provide. Instead, family members often described their visits as a responsibility to provide caregiving that became "my burden." Family members also inadvertently reinforced the lack of sociability and separation from family at mealtimes by feeding residents and not eating with them.[64]

Rather than the resident choosing what she is going to cook, and then buying, preparing, and serving it, within the nursing home, it is clear that responsibility for food and meals is divided amongst multiple departments. Within this institutional paradigm, the only staff whose sole responsibility was to attend to the sociocultural aspects of life were the activity therapists. However, their time and resources to attend to the socially meaningful practices and values surrounding food and mealtimes was severely limited. While other staff expressed caring and attention to these aspects, their specialized responsibilities precluded them from devoting their full attention to these problems. Family visits, while important to residents, are not a panacea. Rather than maintaining family interactions that occurred prior to institutionalization, family caregiving at meals is centered around providing basic care that otherwise would (or should) be provided by the institutional staff. It may be that the nursing staff model "appropriate caregiving" for the institutionalized elder such that family members believe that these types of

[64] This is not to suggest that residents were indifferent to family caregiving; such visits clearly had emotional importance. However, I am suggesting that the type of family caregiving found here did not realize the full potential of such visits to foster culturally meaningful family relationships through mealtime practices.

tasks (i.e., bed-and-body-work) constitute what caregiving should be within the institution. While individual staff members see the problems and, to a limited extent, the burden on family members, like the residents, they feel unable to make change. Instead, the institution has come to rely on families to provide food; due to near silence from residents and family members, and the avoidance of weight loss and skin breaks, the facility has not been forced to make changes.

Conclusions & Recommendations

Elderly Chinese residents' mealtime experiences in this nursing home were profoundly guided by institutional understandings of the meaning of food that biomedicalize food as a therapeutic diet that is fundamentally nutritional rather than cultural in nature. The regularity of food, both in type and when it is served, the visual appearance of the "American"-style food, the way food is served in individualized meal trays using American-style settings and flatware, staff priorities that emphasize an essentially biomedical notion of "safety" and meals as food and nutrition—such practices contribute to a peculiarly institutional understanding of the meaning of food and meals that is disconnected from Chinese residents' strong association among the meanings and practices of meals, family, and home.

The specialization of food and meals in the nursing home context creates the need and importance of the ATs' role, because they are the only staff whose priority is to attend to sociocultural needs. Such cultural activities as Chinese restaurant meal trips place residents in a culturally meaningful setting with long-understood cues that encourage social interaction that is otherwise conspicuously absent in the nursing home.

Although residents disliked the American food, regularly available "Chinese food" is limited to staples such as *juk*, rice, and hot tea or hot water. Chinese entrees, when available, are limited to those who will not eat the regular entrée, because of widely-reported understaffing

and other institutional limitations.[65] Because the residents disliked the American food to the extent of not eating, many family members feel obligated to bring home-cooked or store-bought foods regularly, although this was frequently a heavy burden. Family members were effectively providing essential mealtime caregiving and reinforcing residents' social isolation, instead of visiting primarily for the sake of maintaining meaningful family relationships with the residents. Meanwhile, the nursing home is not forced to address the problem of Chinese residents not eating the institutional food.

Because residents value collectivist harmony over individual preferences and the importance of "protecting the face," residents are unlikely to complain. Chinese-speaking staff members have the greatest awareness of the Chinese residents' views because they can communicate with these residents. Yet, according to some staff, most Chinese-speaking staff, like the elderly Chinese residents, were also reluctant to protest for change, possibly for similar culturally based reasons.

The timeless quality of nursing home life described in the literature was also found in this study and contributed to a lack of meaningful family-like connection or recognized social roles among residents and staff through social reciprocity and culturally meaningful ritual. Multiple factors contributed to the ahistorical quality in the institution. As in hospitals or other healthcare settings, where infection control and "sanitary" conditions are important, the nursing home uses many disposable items, such as paper cups for medications or beverages, plastic containers for *juk* and other side dishes, and paper bibs. While residents or their families may make temporary changes (e.g., decorations) to their bed area, my impression was that residents do not usually leave a physical, tangible mark on the institution. In that way, they did seem to be in, as Shield called it, a liminal space within the nursing home. Without a sense of history that is

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[65] Institutional barriers are not entirely "upper-level" administrative but also come from labor—powerful unions also restrict the changes that can be made to staffing.

marked and recorded, and when what one uses daily is frequently disposed of (due to contamination), it seems to me that it would be difficult to call someplace home.

The ahistorical quality of life, contributed to by a lack of socially meaningful mealtimes, may have shaped residents' personal and cultural identity. However, the ways in which this may have occurred is a difficult question, largely because residents do not readily articulate the concept of identity in descriptive, narrative forms. I believe this may be in part because, as noted above, the ways in which residents think about themselves seems to be predominantly in terms of their family members' and their role within the family. In this context, identity is a highly individualistic category that requires a kind of self-introspection that, I suggest, may be somewhat foreign to the residents. Moreover, it is possible that talking about oneself in those terms may seem inappropriate or even immodest and selfish. Further research would be helpful in exploring the category of identity among ethnic Chinese immigrants, and how the concepts of self and identity may change with immigration.

My recommendations begin within the existing biomedical, hospital-based nursing home model. I will start with the food itself, because it is the problem most readily identified by the residents and staff, which reflects the institution's reduction of the complexity of mealtimes to a problem of "food." The first recommendation is simply to offer the existing Chinese entrees to all Chinese residents, rather than offering them only when the residents refuse the regular entrée. Offering low sodium versions, or making all the Chinese entrees low sodium, would also expand the number of residents who can have the Chinese entrees; this may require administrators to purchase fewer prepared foods, which are often high in sodium.

"Simply" offering more Chinese food, however, does have institutional barriers that, to some extent, pit departments against one another. Cooking in a Chinese style requires some special kitchen equipment (e.g., a large wok). Furthermore, Chinese food tends to be labor-intensive in preparation, particularly chopping vegetables, but quick in cooking and in eating (i.e., no knives are required at the table). In contrast, American cuisine tends to rely on longer

cooking times to tenderize foods, in combination with individual preparation at the table (e.g., cutting food in bite-size pieces). Thus, it should be acknowledged that an approach to food services that relies on prepared foods to cut down on labor costs, as found as this research site, makes it difficult to cook food in a Chinese style. Furthermore, in an institutional model that specializes the tasks related to food and meals, a shift toward increasing kitchen labor (away from the table, or the CNAs), potentially runs up against institutional barriers and labor demands.

My second recommendation is to make the way that food is served more culturally recognizable as a meal to Chinese residents, beginning with the serving utensils and dinnerware. Only one staff member recommended this, but as I suggested earlier, this may reflect the influence of the institutional approach to meals, such that meals are reduced to food as nutrition. As this staff member said,

> Even [if] the food is not very good, but the visual—but if you see the Chinese setting, the bowl, small rice. [...] Maybe it would make the difference. If [like] me, they are used to seeing the family eating with the bowl. Maybe I have the same feeling as them, but for me, oh, I just see a whole tray there, it's not so interesting. If they can serve in a Chinese style, I think it would make them feel more like it's home.

The role of ATs in food and mealtimes should ideally be expanded from special activities to all mealtimes and snacks, in consultation with nursing staff, physicians, and other staff. I suggest hiring additional ATs with an increase in budget so that more time and resources may be devoted to food, eating, and meal activities, or, given any budget constraints, advising ATs of the particular importance of food and meals within appropriate social contexts in providing opportunities for elderly Chinese to interact socially in a culturally meaningful way. Because this study was not based on paradigms within activity therapy, and is meant for an anthropological, medical, nursing, or dietetic audience, I trust that ATs may be able to apply this general finding to their design and approach to activity therapy for elderly Chinese residents.

However, a specific recommendation is to plan an activity in which residents invite their families to join them for a meal at the nursing home. The staff would coordinate ordering Chinese food from an outside source and a table would be made available at which the resident and family could sit together and eat, using Chinese-style bowls, chopsticks (if the resident is able), and a shared teapot. If funds are not available, the family may pay for their own food.

So, how can these changes be made? Who will advocate for change, given that residents are reluctant to complain? Fostering a sense of a collective Chinese group identity within the nursing home may encourage residents to express their preferences to staff, especially administrative staff. Despite shared cultural values, as illustrated in the findings, given the socioeconomic heterogeneity in this population, fostering collectivity has been difficult for staff. However, as some staff expressed, it is important to encourage a sense of a shared group by emphasizing the residents *current* shared experience as residents within the nursing home, rather than their unshared past outside in the community. Thus, rather than trying to duplicate community or family life (to which it will inevitably fall short), the goal is to foster a shared experience of institutionalization that is itself meaningful, in part by fostering a sense of historical connection to the nursing home itself and the individual wards, the other ethnic Chinese residents currently residing there, as well as past residents. Specific ways in which to foster increased connection may be to include more cultural activities which provide familiar contextual cues for previous social behaviors with other ethnic Chinese. These activities can include *Mahjong*, Chinese newspapers, and, not least, Chinese food and meals. Then, posting photographs of these activities and sharing stories about shared experiences, may help create a sense of a shared history and connection among residents, staff, and location.

By fostering a sense of lasting connection with the nursing home, a sense of meaningful shared experience may encourage ethnic Chinese residents to see their connection as a larger group, a collective, which is justified in expressing its needs and preferences and advocating for change at the institutional level. Staff may lead groups in formulating group comments (both

positive and negative) to present to upper-level staff, such that it is not an individual who complains, but rather a collective voice.

Any discussion on how to improve Chinese residents' experience of institutionalization would be incomplete without mentioning how profoundly the residents feel isolated because of language barriers.[66] Although this was not a major factor in how residents' made meaning of food and meals on a daily basis, the overall context in which they lived was indelibly shaped by their inability to communicate easily with staff. More adequately addressing this problem is vital, especially for the residents without ready access to Chinese-speaking staff.

My further recommendations are to support a re-modeling of the nursing home paradigm. That biomedical approaches have value is without much doubt, but the extent to which they should guide priorities in a place where people are living with disability or nearing the end of life is debatable. The ways in which food and nutrition are evaluated within the home are, understandably, guided by who funds the institution—federal health insurance programs and the state, county, and local governments—which emphasize food and meals within a healthcare paradigm such that staff perceive the two main outcomes related to food to be skin breaks and weight loss, with cultural food preferences a concern that is defined insofar as they affect these outcomes. I suggest that these outcomes, while not unimportant, are not the outcomes that assess the cultural appropriateness of food and meals, and that it is not enough to measure how well an institution meets preferences via the proxy of whether residents suffer the consequences of inadequate nutrition to an extent that creates clinical manifestations. Certainly it is not unreasonable to suggest that a person who is satisfied with their food and meals will have better mental health than one who does not, controlling for other factors; better mental health supports better physical health, measured in outcomes which the biomedical system can measure and appreciate. Thus, from a health policy standpoint, I suggest that researchers

[66] As quoted earlier, one resident said, "When a sick person is sick, he is annoyed and moody, and the language barrier is not helpful. There's no way out and no way to get assistance. You cannot be understood. It's like adding oil to the fire."

consider which outcomes should be measured to assess residents' satisfaction in cultural terms with their food and meals; in essence, which outcomes assess quality of life as affected by the cultural aspects of food and meals?

More radical programmatic and structural changes certainly would provide opportunities to experiment with restoring traditional meanings of food and family. For example, the Green House Project attempts to make mealtime a more shared experience both among residents and residents with staff (Hamilton 2005). Making family-style meals a possibility, if not at every meal, but occasionally, would be worth attempting. This includes, as suggested above, providing a place for such family-style meals with family members on-site; such a place could include a large round table, a shared teapot, and traditional bowls, chopsticks, and spoons, all within a private room so that family can have a meal together without interference with others, except nursing staff, who can observe, provide assistance, and administer medications.

The power of activism should not be underestimated; budgets are never limitless, but priorities must be determined. The goal would then be to make the values and opinions of Chinese residents, family members, and staff, heard and truly understood by those who have some capacity to make changes.

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