A Phenomenological Study of Hospital Readmissions of Chinese Older People with Chronic Obstructive Pulmonary Disease

TANG, Wing Ki

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Thesis Assessment Committee

Professor YU Sau Fung (Chair)

Professor Lee Tze Fan Diana (Thesis Supervisor)

Professor CHAN Yue Lai (Committee Member)

Professor CHAN Angela Engle (External Examiner)

PREFACE

ABSTRACT

Hospital readmission is prevalent among people with chronic obstructive pulmonary disease (COPD), particularly among older people in Hong Kong. Evidence shows that hospital readmissions exert a considerable impact on patients. Studies in this area primarily identify various associative factors based on the perspectives of health professionals. However, these factors are inadequate in illustrating the needs of older people and in illuminating the phenomenon of hospital readmissions. A thorough understanding of the issue can be achieved if the related experiences are interpreted from the perspective of the patients and in terms of their context. Understanding of their experiences has paramount significance in uncovering the unmet needs of patients and in informing the provision of healthcare services. Yet, there is a dearth of studies unfolding the experiences of Chinese older people.

This study aimed to explore and describe the lived experience of hospital readmissions of Chinese older people with COPD and to identify Chinese socio-cultural influences on the experience. Understanding was acquired through descriptive phenomenology. Twenty-two Chinese older people aged 62 to 89 were recruited by purposive sampling. They had been readmitted 4 to 14 times in the previous year. The older people were interviewed once during their hospitalization, and their readmission experiences were elicited from these unstructured interviews. Narrative descriptions were analyzed using the phenomenological method described by Giorgi (1985).

The general structure of the lived experience of hospital readmissions of Chinese older people with COPD reveals that older people refrain from unnecessary readmissions because they regard hospital care as the last resort in relieving breathlessness. When their breathlessness becomes intolerable, they perceive the urgency of surviving the distress. Craving for survival, they seek hospital readmission, which provides them immediate relief from the imminent threat. After being readmitted to a hospital, they feel powerless when their need for hospital care is disregarded

by their doctors. Considering themselves as demanding to their families in daily lives, older people remain conscious of relieving their burden during their periods of hospital readmission because they regard this as the only opportunity to relieve their burden. Older people come to realize hospital readmissions are unavoidable after they put every effort to refrain from it but hospital care remains necessary. They further rationalize hospital readmissions as inevitable and resign themselves to it because of their perception of aging, doctors' accounts of COPD, experience with and knowledge of the disease, and belief in fate. This acceptance of the inevitability of hospital readmissions precipitates an attitudinal shift toward the belief of living for the moment. Their past experiences inspire them to be satisfied with the current state of living and engage the present. This positive outlook enables them to embrace the experiences of hospital readmissions into their lives. Six invariant constituents emerged from the lived experience. The constituent "refraining from unnecessary readmissions" describes how older people manage their diseases in relation to hospital readmissions. "Craving for survival" explains why they seek hospital readmissions. "Feeling being disregarded and powerless" and "being conscious of relieving burden to families" characterize their experience of hospital readmissions. "Resigning to hospital readmissions" illustrates how they understand the recurrence of this phenomenon and "living for the moment" illuminates how they live with their experiences.

A deep understanding of hospital readmissions is embodied in the experiences of older people. The findings emphasize that hospital readmissions among Chinese older people are complex experiences shaped by their sociocultural context. The meanings of hospital readmissions to older people are influenced by their assumption of a submissive patient role, collectivism, external attribution style, and past life experiences. Although older people appear to accept and cope well with hospital readmissions, this study uncovers their needs as they move to and fro the hospital and home. The findings of this study offer implications in promoting the wellness of Chinese older people as they go through this revolving door.

論文摘要

再次住院在患有慢性阻塞性肺病人士中相當普遍，尤其是在中國老年患者。研究證據顯示再次住院對病人有很大的影響。現有的研究偏重於從醫務人員角度尋找不同的關聯因素，但該些因素並不足以反映老年人的需要以及解釋再次住院的現象。只有透過病人的觀點以及結合他們的背景來闡釋這些相關經驗，才能作出深入了解。了解病人的再次住院經驗有助於找出病人的需要以及指引醫療服務的提供。然而，有關中國老年人再次住院經驗的探討相當缺乏。

是次研究目的是探討和描述患有慢性阻塞性肺病的中國老年人再次住院的體驗，以及認識中國社會文化對再次住院經驗的影響。研究採用描述現象學方法。研究以立意抽樣方式選取了 22 名 62 至 89 歲的中國老年人。他們在去年入院次數為 4 至 14 次。這些老年人在住院期間均接受一次非結構式訪談以了解他們的再次住院經驗。這些敘述性描寫再按 Giorgi (1985) 的現象學方法作出分析。

患有慢性阻塞性肺病中國老年人再次住院的體驗的通用結構顯示他們避免不必要的再次住院，因為他們將住院護理視為紓緩呼吸困難的最後方法。當他們的呼吸困難惡化至無法忍受，他們會感受到從危病中活下來的迫切性。因著渴望生存的意識，他們尋求再次住院以即時消除緊迫的生命威脅。再次入院後，對於醫生漠視其住院護理的需要，他們感到無力。由於考慮到他們在日常生活中對家人的需求頗多，老年人以再次住院其間來減輕家庭負擔，因他們視這其間為唯一能減輕家庭負擔的機會。儘管老年人盡能力以避免再次入院，但他們依然需要住院護理，老年人逐漸意識到再次住院為無可避免。由於老年人對於老化的感知、醫生對慢性阻塞性肺病的解明、患病經驗和對疾病的相關知識以及相信命運的看法，他們更將再次住院合理化為無可避免並順從。接受再次住院為無可避免促成他們的態度轉變為活在當下。過去的經驗令他

們對目前的生活感到滿意並希望活在當下。這個正面想法令他們將再次住院接納為生活的一部份。六個不變組成要素呈現於老年人的再次住院體驗當中。組成要素「避免不必要的再次住院」描述老年人如何管理慢性阻塞性肺病以避免再次住院。「渴望生存」解釋了他們尋求再次住院的原因。「感到被忽略和無力」以及「減輕家庭負擔的意識」敘述了他們再次住院的經驗。「順從再次住院」說明了他們對再次住院現象發生的理解，*而*「活在當下」說明了他們如何接納再次住院經驗。

對於再次住院的深入了解具體表現於老年人的經驗當中。是次研究結果強調，老年人再次住院是由他們的社會文化背景塑造而成的複雜經驗。對於老年人而言，再次住院的意義受到他們對順從性病人角色的假設、集體主義觀念、外部歸因以及過往的生活經驗所影響。雖然老年人似乎接受並適應再次住院，是次研究發現了他們在這現象中的需要。研究結果對於促進再次住院的中國老年人的健康帶來新的啟示。

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PUBLICATIONS AND PRESENTATIONS

The following conference presentation arose from the study reported in this thesis:

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LIST OF ABBREVIATIONS

COPD	Chronic obstructive pulmonary disease
GOLD	Global Initiative for Chronic Obstructive Lung Disease
FEV_1	Forced expiratory volume in one second
FVC	Forced vital capacity
HADS	Hospital Anxiety and Depression Scale
HR	Hazard ratio
HRQOL	Health-related quality of life
OR	Odd ratio
PaO_2	Arterial pressure of oxygen
$PaCO_2$	Arterial pressure of carbon dioxide
RR	Relative risk
SGRQ	St George's Respiratory Questionnaire
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

The aging population is growing rapidly in Hong Kong. The prevalence of chronic diseases is also noticeably increasing (Department of Health, 2013). Chronic obstructive pulmonary disease (COPD) is a predominant chronic disease affecting older people. Hospital readmission is also common among older people with COPD. In the literature, a vast amount of studies have been conducted to understand this occurrence through identifying its associated factors. However, the existing body of knowledge is insufficient in illuminating hospital readmission without understanding from the patients' perspectives. A thorough understanding can be achieved if the experiences of patients can be interpreted. This phenomenological study explored and described the lived experience of hospital readmissions of Chinese older people with COPD. In this chapter, the nature of COPD and inquiry regarding hospital readmission are delineated. The problems of hospital readmissions are discussed. It is followed by an introduction of the Hong Kong context and the provision of healthcare services to COPD patients. The purposes and significance of this study are then highlighted.

Prevalence and Disease Progression of COPD

COPD is a global public health problem with heavy disease burden. It is the major

leading cause of morbidity and mortality worldwide. According to the World Health Organization (WHO), COPD is projected to be the fourth leading cause of death in 2030 (Mathers & Loncar, 2006). The morbidity and mortality are anticipated to increase drastically in Asian countries because of the increasing smoking population (Chan-Yeung, Ai-Khaled, White, Ip, & Tan, 2004). The estimated prevalence among developed countries ranges from 4.1% in Norway to 11% in Italy (WHO, 2007). In Hong Kong, the prevalence was estimated to be 8.5% (Ko et al., 2008) and it was as high as 9% among people over 70 years old (Ko et al., 2006). As aging is widely recognized as a risk factor for COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) (2014) indicates that its disease burden is expected to increase in the coming decades. However, the disease burden is suggested to be greatly underestimated because the disease is usually diagnosed when it becomes clinically apparent or develops to a moderate stage (Pauwels & Rabe, 2004).

COPD is a chronic illness with great impact on patients. As defined by GOLD (2014), COPD is "characterized by persistent airflow limitation that is usually progressive and associate with an enhanced chronic inflammatory response in the airways and the lung to noxious particles or gases" (p. 2). The diagnostic methods of COPD vary. The most commonly adopted method is recommended by GOLD, in which a patient should have a ratio of forced expiratory volume in one second (FEV_1) to forced vital capacity (FVC) less than 70%. Symptoms of the disease include dyspnea, cough, and sputum production. The disease

is usually controlled by medications, including bronchodilators, steroids, and expectorant. Patients with inadequate oxygenation are prescribed with long-term oxygen therapy. With its progressive nature, the lungs are gradually impaired and people with COPD frequently suffer from symptoms of the disease more. The symptoms, particularly dyspnea, limit patients' physical capabilities in performing daily activities. Patients gradually become housebound. In addition to the fear associated with dyspneic attack, this chronic disorder not only impairs pulmonary function physically, but also renders COPD patients to suffer psychologically and socially. Patients become more dependent as the disease advances, and they may require hospitalization to manage the disease. It is observed that patients progressively seek hospital readmission more often.

Inquiry of Hospital Readmission

Studies related to hospital readmissions emerged in the 1960s. The regular occurrence of hospital readmissions and high readmission rate were observed among psychiatric patients. Therefore, a vast amount of related studies were conducted in psychiatric settings. Those studies found that psychiatric patients not only have a single episode of hospital readmission after an index admission, but the frequent and multiple readmissions form a pattern (Ødegård, 1968). This pattern is described as "revolving door", which denotes the regular admission to and discharge of the patient from the hospital.

This pattern of repeated readmission for the same clinical reason was also observed at a later time in patients with medical problems. Subsequently, studies about hospital readmission were extended beyond psychiatric settings. Generally, these studies examined the characteristics of readmitted patients and the outcomes of hospital readmission on them (Anderson & Steinberg, 1984; Anderson & Steinberg, 1985; Smith, Norton, & McDonald, 1985). COPD has been found to be a common diagnosis among readmitted patients. In some studies, the diagnosis of COPD is associated with hospital readmission within 30 to 180 days (Brand, Sundararajan, Jones, Hutchinson, & Campbell, 2005; Cakir & Grmmon, 2010). In a comparative analysis of the hospital readmission rates for COPD among Finland, Scotland, Netherlands, New York, California, and Washington, the readmission rates were reported between 4.1% and 13.4% (Westert, Lagoe, Keskimäki, Leyland, & Murphy, 2002).

Older people have also become an interested group for researchers in view of their high readmission rate (Fethke, Smith, & Johnson, 1986; Gautam, Macduff, Brown, & Squair, 1996; Haines-Wood, Gilmore, & Beringer, 1996). Reed, Pearlman, and Buchner (1991) investigated the prevalence of early readmission to hospitals among older people, and found that almost 14% of the older patients were readmitted within 14 days from previous discharge. Empirical evidence also indicates that older age and a diagnosis of COPD are associative factors for hospital readmission (Gorman, Vellinga, & Gilmartin, 2010; Kirby, Dennis, Jayasinghe, & Harris, 2011). Various studies further indicate that COPD is the major

diagnosis for hospital readmission among older people (Burns & Nichols, 1991; Chu & Pei, 1999).

Problems with Hospital Readmission

The disease burden of COPD is exacerbated when patients are repeatedly readmitted to hospitals. Hospital readmission has been observed to have significant effects on COPD patients and it also reflects the quality of healthcare services. As for COPD patients, the disease has an undeniable impact in terms of mortality and quality of life. Glynn, Bennett, and Silke (2011) reported that hospital readmission was significantly associated with a mortality of 30-day, with an odd ratio (OR) of 1.12 (95% CI: 1.09-1.14). They explained that readmitted patients have poor health status, which inadvertently increases the mortality. Almagro, Calbo, and de Echagüen (2002) further indicated that hospital readmission is an independent predictor of mortality in COPD patients (OR=1.85, 95%CI: 1.26-3.84, $p < .03$). History of hospital admission for COPD is also indicative to hospital readmission (Coventry, Gemmell, & Todd, 2011; Garcia-Aymerich et al., 2003). Thus, the empirical evidence suggests that readmitted COPD patients have higher risk of subsequent readmission.

Readmitted COPD patients also possess poor quality of life. As measured by St George's Respiratory Questionnaire (SGRQ), COPD patients who were readmitted within a year had significantly poor quality of life than non-readmitted patients (Osman, Godden,

Fried, Legge, & Douglas, 1997). A positive correlation between quality of life and the number of hospital readmissions of COPD patients has been demonstrated in previous studies (Carneiro et al., 2010; Wang & Bourbeau, 2005).

Hospital readmission possibly reflects the quality of healthcare services. It is regarded as an adverse outcome of previous hospitalization, particularly for patients who are readmitted to a hospital early. Early readmission is presumed to be a result of the premature discharging of patients, which can be characterized by incompletion of necessary treatment, and inadequate discharge planning (Thomas & Holloway, 1991). Such negligence prompts patients to seek medical management at the hospital shortly after being discharged. Other reasons for hospital readmission include patient's and caregiver's lack of readiness for hospital discharge, inadequate coordination in the transition from the hospital to other clinical settings or home, and failure in self-management of the disease (Minott, 2008; Mistiane, Francke, & Poot, 2007; Vinson, Rich, Sperry, Shah, & McNamara, 1990). These attributes definitely are preventable. The meta-analysis of Ashton, Del Junco, Souchek, Wray, and Mansyur (1997) also showed that substandard care increases the risk of early hospital readmission by 55%. Therefore, hospital readmission is suggested to be an indicator for the quality of care (Ashton et al. 1997; Ashton, Kuykendall, Johnson, Wray, & Wu, 1995; Polanczyk, Newton, Dec, & Di Salvo, 2001; Thomas & Holloway, 1991). Among COPD patients, poor quality of care has also been shown to increase the risk of subsequent hospital

admissions (Ashton et al., 1995).

Hong Kong Context and Provision of Care to COPD Patients

Hong Kong is a city situated in the southern China coast. About 93% of its population is Chinese. According to the Population Census in 2011, 941 312 people were over 65 years old in Hong Kong, which accounted for 22.7% of the population (Census and Statistics Department, 2012). The aging population is increasing, and its growth rate is 1.6% faster than the whole population. Regarding the living arrangement, approximately 29.7% of older people lived with spouses and children, 23.6% lived with spouses only and 12.7% lived alone.

Traditionally, Chinese people regard family as a fundamental social unit (Ward & Lin, 2010). Taking care of older people is cultivated to be a responsibility of every family member. As COPD progresses, patients experience more physical restrictions and become more dependent on their caregivers. Children are supposed to take care of the older people. However, they are heavily engaged in their work because of the financial strains and highly competitive social environment in Hong Kong. In addition, children commonly move away from their parents and form their nuclear families after marriage. Therefore, the spouses usually become the primary caregiver of the older people with COPD.

The Hospital Authority, a statutory body, manages 42 public hospitals and institutions

in Hong Kong. According to the Hospital Authority, hospital readmission is defined as unplanned readmission within 28 days of the previous discharge. Based on this criterion, 6166 episodes of hospital readmission for COPD were reported in 2012, which accounted for 7% of all types of readmissions (Hospital Authority, 2012). The readmission rate of COPD patients was as high as 17%. Among the readmitted COPD patients, the ratio between male to female was three to one and 94% of them were over 60 years old.

COPD patients usually have regular follow-ups at specialist out-patient clinics. Patients normally attend the Accident and Emergency Department when the disease exacerbates. In-patient services are provided when the disease cannot be stabilized at the Accident and Emergency Department and patients require further management. After hospital discharge, some hospitals provide follow-up to COPD patients, who are identified to be frequently readmitted to hospital, through community nursing services. COPD patients can receive pulmonary rehabilitation, which is a programme provided by a multi-disciplinary team. The team involves doctors, nurses, physiotherapists, occupational therapists, and dieticians. Pulmonary rehabilitation aims to enhance COPD patients' efficacy in self-management of the disease and reduce hospitalization. The rehabilitation programme focuses on teaching patients about breathing and coughing exercises, physical exercise, energy conservation methods, and medication knowledge. In recent years, nurse-led clinics supporting patients with pulmonary disorders have been established. Nurses who received

specialty training provides health counselling and monitor patient's condition and compliance with treatment. In the community, a number of self-help groups are coordinated by non-government organizations.

Research Problem

Hospital readmission is prevalent among COPD patients. The hospital readmission rate is strikingly high among older people. As abovementioned, readmitted COPD patients have poor clinical outcomes, including high mortality rate (Almagro et al., 2002; Glynn et al., 2011), poor quality of life (Carneiro et al., 2010; Osman et al., 1997; Wang & Bourbeau, 2005), and higher risk of subsequent hospital readmission (Garcia-Aymerich et al., 2003). The high hospital readmission rate also suggests the poor quality of healthcare services, which is especially indicative to early hospital readmission.

The problem of hospital readmission among COPD patients has attracted the attention of healthcare professionals. Evidence from the literature only indicates the associated factors and clinical outcomes of hospital readmission concluded from the perspectives of healthcare professionals. However, a lack of understanding about hospital readmissions exists from patients' perspectives. In the literature, little has been done to explore the experiences of hospital readmissions of COPD patients. Little is known about how they perceive hospital readmissions and it is unclear about their sense of wellness as they undergo hospital

readmissions.

In Hong Kong, the provision of healthcare services provided to CODP patients cover primary healthcare to tertiary healthcare. Despite support is provided at various levels and in different settings, hospital readmission rate is noticeably high in Hong Kong, particularly among older people. In view of the aging population and older age as a risk factor for subsequent admission, the problem of hospital readmission is expected to worsen. Notwithstanding a number of studies has been conducted pertaining to hospital readmission, wherein its related experiences remain unclear among Chinese older people with COPD. Indeed, understanding of the experiences would have paramount significance to older people and healthcare professionals. The experiences can reveal what Chinese older people with COPD encounter in hospital readmissions, any socio-cultural issues that shape their experiences, the meanings of hospital readmissions to them, and how they undergo this revolving door. These understanding can uncover any unmet needs of Chinese older people and suggest ways to promote their wellness. The findings can also provide a more comprehensive understanding to healthcare professionals regarding hospital readmissions, and may serve as a basis to review the provision of healthcare services. In view of the knowledge gap, this study primarily aimed to explore and describe the experiences of hospital readmissions of Chinese older people with COPD. Phenomenology, which is an inquiry of lived experience, was employed to bridge this knowledge gap.

Conclusion

The aging population escalates the demands on healthcare provision. As shown by the hospital readmission rate, it is persistently high in Chinese older people with COPD. Although hospital readmissions have a considerable impact on COPD patients, a lack of understanding exists from patients' perspectives. Understanding about the experience of hospital readmissions of Chinese older people is of paramount significance to promote their wellness as they undergo this revolving door and to improve the quality of healthcare provision.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter reviews literature related to hospital readmissions of individuals with chronic obstructive pulmonary disease (COPD). It also provides an overview of the current knowledge, which engenders the conceptualization of hospital readmissions as an experience. In the literature, only a few studies have described the experiences of hospitalisation and hospital readmissions from the perspective of patients with COPD. Studies have mainly examined the factors associated with COPD hospital readmission and the effectiveness of different disease management programmes. In this chapter, the first section describes patients' experiences of living with COPD to provide a context to understand hospital readmissions. The second section reviews studies pertaining to hospital readmissions of patients with COPD. The last section synthesizes the existing body of knowledge and discusses the need for the exploration of the experiences of hospital readmissions among Chinese older people with COPD.

Experiences of Living with COPD

People with chronic illnesses lead their lives differently from others. Furthermore,

patients with COPD encounter multiple difficulties in their daily lives. For instance, individuals living with COPD struggle with shortness of breath that sometimes requires hospitalization. This disease also changes their lives and dynamics with their caregivers. Recognizing their experiences can provide a context to understand their struggle and the self-adjustment made to live with the disease, as well as hospital readmissions. The following sections describe the perspectives and experiences of patients with COPD and their caregivers.

Struggling with the Impact of Breathlessness

Breathlessness is a predominant symptom commonly identified by patients with COPD. They describe living with COPD as similar to living with breathlessness (Fraser, Kee, & Minick, 2006; Hall, Legault, & Côté, 2010). COPD patients often describe the feeling of breathlessness as air hunger (Mahler et al., 1996; Simon et al., 1990). This progressive symptom affects patients in various aspects of their daily lives. The lack of physical strength limits their daily activities. The intense feeling of air hunger also induces anxiety and fear. Increasing dependency impinges on their relationships with other people, and physical weakness curtails their social activities. Therefore, difficulty in breathing not only impairs their physical function but also elicits intense psychological distress and imposes social restrictions. With these impacts of breathlessness, some COPD patients perceive themselves

to be living in a “shrinking world” (Gullick & Stainton, 2008).

Physical restriction

Patients with COPD describe their daily activities as extremely draining. They carry out activities such as eating, walking, and recreational activities with much exertion (Barnett, 2005; Gullick & Stainton, 2008; Jonsdottir, 1998). In the study of Ek and Ternestedt (2008), patients with severe COPD experienced failure, shame and humiliation because of the lack of physical strength to manage basic daily activities, which they took for granted previously. To catch their breath and adjust to physical limitations, COPD patients are required to postpone some activities, pace their bodies, plan their activities in advance, and change their lifestyles (Avşar & Kaşikçi, 2011; Barnett, 2005; Cicutto, Brooks, & Henderson, 2004; Gullick & Stainton, 2008). Breathlessness is also associated with fatigue. COPD patients are, therefore, forced to restrict their activity levels and give up their previous interests because of physical limitations (Chan, 2004; Ek & Ternestedt, 2008; Seamark, Blake, Seamark, & Halpin, 2004). Some COPD patients even consider ending their lives to halt their struggle with breathlessness and physical weakness (Barnett, 2005; Ek & Ternestedt, 2008).

Physical restriction inevitably leads to dependence of COPD patients. The loss of physical strength limits their ability to take care of themselves and live independently (Frasar, Kee, & Minick, 2006; Gullick & Stainton, 2008; Hasson et al., 2008). Patients gradually

become more dependent on their caregivers (Avşar & Kaşikçi, 2011; Ek & Terrenstedt, 2008; Seamark et al., 2004). The COPD patients in the study of Barrnett (2005) explained how dependence is resulted from breathlessness. In order to avoid exertion and subsequent breathlessness, the patients unconsciously reduced their activity levels; thus they required assistance from others. This fear of breathlessness gradually leads to a vicious cycle of activity restriction and dependence. Participants in the study of Robinson (2005) were concerned about the effects of increasing dependency on their relationships with caregivers. Some COPD patients even perceived themselves as a burden (Barnett, 2005). Patients with COPD were also scared and experienced the lack of confidence to leave the houses by themselves, thereby affecting their sense of self-worth because leaving their houses on their own imparts a sense of independence and freedom (Habraken, Pols, Bindels, & Wilems, 2008).

For older people, struggling with breathlessness in daily activities is particularly arduous. In a phenomenological study exploring the lived experience of older patients with COPD, Elofsson and Öhlén (2004) described patients, who perceived their lives as “hard work”, performed housework and leisure activities with more difficulty. Despite the physical limitations, some older people maintain certain level of physical activities. Through interviews with COPD patients, Williams, Bruton, Ellis-Hills, and McPherson (2007) explored what patients perceive as the most important activities. The older participants

perceived walking as their most enjoyable activity and they preferred to participate in household activities. They regarded walking as a leisure activity and considered relying on others when leaving the house reinforces the sense of being housebound. These findings resemble the feelings expressed by COPD patients in the study of Habraken et al. (2008). The older patients considered participation in household activities as allowing them to be more involved in their families and maintained their roles in their families. Thus the patients' experiences described in these studies reveal that the significance of independence and engagement outweighs the functional purpose of physical abilities in carrying out daily activities.

Social restriction

The social lives of COPD patients are hampered by their concerns of breathlessness and impaired physical strength. They avoid stimuli and crowded places that may trigger respiratory distress (Avşar & Kaşikçi, 2011; Jonsdottir, 1998). Patients also remark that they are forced to refrain from social activities because of their physical limitations (Ek & Ternestedt, 2008; Elofsson & Öhlén, 2004; Gullick & Stainton, 2008). In the phenomenological study of Barnett (2005), COPD patients explained how physical inactivity leads to social loss. They were unable to plan outings in advance because these activities would depend on their physical condition on those particular days. These patients were also

concerned about physical limitations may result in loss of family and social relationships, as well as loss of intimacy with their spouses. As described, COPD patients gradually become housebound due to their fear of breathlessness. Chan (2004) interviewed a group of male Chinese older COPD patients about their experiences with the disease. The older people expressed that they would rather stay at home to avoid situations that might trigger breathlessness. Moreover, communication with other people was affected because of poor self-image. Eventually, they became less sociable and more isolated.

A decline in physical function also hinders patients from fulfilling their family roles as husbands, wives or grandparents (Avşar & Kaşikçi, 2011; Chan, 2004; Gullick & Stainton, 2008). The significance of fulfilling one's role for older people was highlighted by Williams et al. (2007). In spite of the support from their respective spouses, the older patients still felt socially isolated and lonely. They expected social support from others, but they also expected themselves to participate in physical and social activities because these are meaningful in maintaining their roles in their families and establishing their sense of normality. Such kind of participation facilitates social integration and promotes independence of older people. However, the fear of breathlessness and physical weakness restrain them from participating in activities. Concern about fulfilling family roles was also expressed by the Chinese older people with COPD (Chan, 2004). The older people felt hard to take care of their spouses and children with their deteriorating physical condition. They gradually became depressed

because they considered themselves as being limited to have contribution in their respective families. Although older patients are incapable of fulfilling their former roles, they try hard to protect their families and relieve their families' worries by showing that they are capable of managing the disease and by concealing their negative emotions (Barnett, 2005; Ek & Ternestedt, 2008; Hasson et al., 2008).

Social restriction also attenuates the sense of connectedness to the totality of their lives. Ek and Ternestedt (2008) described COPD patients in their study as "being socially and existentially alone." The patients avoided relationships and they felt other people avoided them as well. This sense of loneliness came from the lack of engagement in activities and lack of a meaningful life. The patients did not feel connected to the entirety of their lives; instead, they felt as if they live merely to exist. For the older people with COPD, Elofsson and Öhlén (2004) delineated that their sense of connectedness comes from their relationship with their family and their ability to maintain their interests and hobbies. Their lives were deemed as lacking in meaningful content if they were alone or unable to maintain activities they formerly enjoyed.

Psychological distress

Breathlessness also gives rise to psychological distress. Its impact on psychological distress may be even greater than that on physical and social restrictions. Patients with COPD

experience various negative emotions and feelings, such as anxiety, fear, frustration, depression, guilt, and helplessness (Barnett, 2005; Clancy, Hallet, & Caress, 2009; Hall et al., 2010; Hasson et al., 2008; Kessler et al., 2006; Robinson, 2005; Semark et al., 2004; Sheridan et al., 2011; Willgoss, Yohannes, Goldbart, & Fatoye, 2012). Anxiety can be resulted from dyspneic attack or misplacing medications (Ek & Ternestedt, 2008; Willgoss et al., 2012). Patients fear losing breath, failing to receive medications during breathlessness, and feel uncertain to the future (Clancy et al., 2009; Wortz et al., 2012). In addition, patients become frustrated about their incapability to perform a simple task, the complexity of treatment and not being understood by others including healthcare professionals (Barnett, 2005; Habraken et al., 2008; Josdottir, 1998; Robinson, 2005; Semark et al., 2004).

The subjective nature of breathlessness further increases their psychological distress. The feelings and difficulties in struggling with breathlessness are not easily understood by others including their spouses and friends (Apps et al., 2014; Gysels, 2008). Indeed, dyspneic attack contributes to intense fear and anxiety (Avşar & Kaşikçi, 2011; Barnett, 2005; Semark et al., 2004). The disease exacerbation is perceived by COPD patients as a crisis to their lives (Kvangarsnes, Torehein, Hole & Öhlund, 2013; Oliver, 2001). The COPD patients in the study of Hasson et al. (2008) expressed that they live in a constant fear of dyspneic attack when they are alone. Bailey (2004) observed the anxiety experienced by COPD patients resulted in health-seeking behaviour such as emergency hospital admission. Willgoss et al.

(2012) also found that patients would needlessly require hospital readmission when they confuse panic attack with the exacerbation they feel. The patients also become housebound because of their anxiety and fear of being unable to obtain help during breathlessness. In the study of Fraser et al. (2006), which described the experiences of older people living with COPD, the patients felt helpless when they failed to relieve breathlessness with their usual methods.

Self-adjustment Made to Live with COPD

Patients with COPD experience various losses in life because of the sufferings caused by a devastating symptom. They struggle with the impact from breathlessness but they gradually adjust themselves to live with the disease. Patients reduce their activity levels and change their lifestyles as a manner of physical adjustment to meet the bodily demands.

As COPD is a chronic disease, which takes time to progress, it allows patients to adapt to the losses and adjust their attitudes to live with the disease. These attitudes range from passive acceptance of the disease to active redirection of the focus of their lives. In the study of Jonsdottir (1998), COPD patients found resignation as the most effortless way to live with the disease. Being aware of their physical limitations, some COPD patients accepted their limitations and appreciated the idea of still "being here" (Gullick & Stainton, 2008). The unstable nature of COPD causes daily fluctuation of the physical condition. Some patients

feel lack of control over their bodies when breathlessness is severe (Ek, Sahlberg-Blom, Andershed, & Terntedt, 2011). It is difficult for them to anticipate how they feel from one day to the next. Therefore, some COPD patients hold on the belief of "taking one day at a time" because they are unsure about their capabilities in terms of their physical strength to cope with the disease (Ek & Ternestedt, 2008; Ek et al., 2011; Kanervisto, Kaistila, & Paavilainen, 2007).

Some positive ways to live with the disease are drawn from the memories of previous life experiences and the will to share these good memories with others (Ek et al., 2011; Seamark et al., 2004). Other COPD patients also compare their situations with people of their age to remind them that they are better off than others and that their limitations are inevitable with aging; thus these should not be considered as undesirable (Habraken et al., 2008). In addition, the participants in the study of Cicutto et al. (2004) depicted the use of self-talk and laughter to maintain a positive outlook. The patient's resolution to stay alive and live for the sake of their families also motivated them to survive COPD.

With respect to older people, Elofsson and Öhlén (2004) found older patients with COPD as devoid of high expectations from their lives, but they reviewed their good memories to alleviate the present strain. In the study of Fraser et al. (2006), the older people presented the most proactive ways to live with COPD. They positively accepted the limitations caused by their disease and employed strategies to compensate for functional

incompetence. They relieved themselves from psychological distress by focusing on the things they enjoy and the tasks that they could accomplish. These approaches enabled the older people to regain control of their lives.

Chinese older people with COPD show relatively passive attitudes. Chan (2004) revealed that these older people believe that having an incurable disease is fate. These patients further thought that they are incapable of improving or changing their conditions, so they chose to live with the disease. Leung, Molassiotis, and Chau (2002) investigated the correlations between perceived effectiveness of coping strategies and psychosocial adjustment of Chinese patients with COPD. The results indicated that the patients commonly rely on supportive, palliative and fatalistic coping styles. Among these styles adopted, the most effective were evasive, palliative and supportive strategies. For these coping styles identified, supportive style is considered problem-focused, whereas palliative, fatalistic and evasive styles are considered emotion-focused. Leung et al. (2002) also indicated that age is negatively correlated with the use of coping strategies. They further observed that older patients use less variety of coping styles and old age is a predictor of poor psychological adjustment.

Differences in Gender Roles in Illness Experience

Previous studies have examined how gender roles shape chronic illness experience.

Males and females with the same illness would have different experiences. Solimeo (2008) explored the gendered experiences of older people with Parkinson's disease and discovered that females were more concerned with the symptoms affecting activities that involved domestic duties and social connection with others. Males, on the other hand, were more concerned with the emasculating effect of the symptoms that would impair their sense of competence. Gender differences in the meanings of people living with heart failure have also been described in literature. Evangelista, Kagawa-Singer and Dracup (2011) reported that females ascribed more positive meanings to their disease and viewed it as a challenge as compared with males who ascribed more negative meanings to their disease and viewed it as an enemy. Mårtensson, Karlsson and Fridlund (1997, 1998) described how male and female patients conceived their life situations with congestive heart failure. Both males and females experienced physical and social restrictions from their diseases. However, they conceived their situations differently in that males felt the lack of physical and mental energy whereas females perceived a sense of worthlessness and being a burden to others. Hence, males appeared to suffer from a reduction of power whereas females were concerned of their inability to fulfil their expected role at home.

Several studies have also explored gender roles in the experience of people living with COPD. O'Neil (2002) described the illness perceptions of females with COPD. Females complained of the loss of family and social relationships. O'Neil suggested that the loss of

social interactions coupled with physical restriction could result in depression among patients. This inference is supported by the findings in the study of DiMarco et al. (2006) that female patients had higher levels of depression and anxiety compared with male patients. In the study of Ninot et al. (2006), they found that male COPD patients utilized more problem-focused coping strategies whereas female patients relied more on emotion-focused strategies. The authors suggested that the use of such coping styles conformed to masculine and feminine behaviours. As illustrated in previous studies, gender difference plays a role in influencing how COPD patients live with their disease.

Experiences of COPD Patients' Caregivers

The experiences of COPD patients have revealed that their physical limitations render dependence on others. Their daily activities require assistance from a caregiver, who usually is the spouse. The caregivers in the study of Semark et al. (2004) expressed that they experienced losses similar to those of COPD patients. They were overwhelmed by taking up multiple roles without any breaks and by the absence of someone who can share the burdens of caregiving. In the study of Simpson, Young, Donahue, and Rocker (2010), which explored caregiving for patients with advanced COPD, the caregivers described their experience as a series of "ups-and-downs." They became confused about their identity when they had to bear the roles previously taken by the care recipients. The caregivers found that they are being

housebound and socially isolated because of anxiety and guilt borne out of leaving patients on their own. The unstable nature of COPD also caused anxiety on these caregivers. They became hypervigilant to the patient's condition. Under the stress that caregiving causes, some caregivers regarded hospital admission of the care recipient as their respite. In the study of Bailey (2004), a similar sense of relief was experienced by caregivers that they were allayed after they had made the decision to seek medical care or during the arrival of the care recipient at a hospital.

Since males account for the majority of COPD patients, some studies have focused on describing the experiences of wives taking care of their husbands with COPD. Boyle (2009) used "riding the roller coaster" as a metaphor to portray the experience of living with a spouse having ever-changing condition. Similar to the experience described in other studies, the wives in the study of Bergs (2002) experienced burnout and isolation. They remained alert at night because of the fear of dyspneic attack. Communication with the care recipient was hindered by shortness of breath and the marital relationship gradually weakened. Despite the tension of caregiving, the wives were determined to fulfil their duties until their husbands would leave them at the very end. The wives gave priority to their husbands' health and they felt positive about being capable of alleviating their husbands' sufferings.

Experiences Related to Hospitalization of COPD Patients

Experiences from COPD patients and caregivers reveal hospitalization is required because of the disease. Generally, patients have negative views regarding hospitalization. In the study of Hasson et al. (2008), which explored COPD patients' needs in palliative care, the patients experienced considerable emotional stress from making decision of seeking emergency hospitalization. Although they realized that exacerbation would lead to death without prompt and appropriate treatment, they avoided hospitalization for as long as possible. Believing that hospital staff members are busy, they would not seek hospital care unless the situation has become an emergency. Most importantly, they were exhausted and demoralized because of the frequent admissions to the hospital.

A similar perception towards hospital staff was illustrated in the study of Schofield, Knussen, and Tolson (2006). The patients found most hospital staff to be pleasant and kind, but some were inconsiderate and busy, and thus getting their attention was difficult. In order to avoid bothering busy hospital staff members and believing that only severely ill patients warranted medical care, the COPD patients delayed seeking hospital care. Other negative experiences with hospital staff have also been presented in some studies that highlight doctors disregard patients' subjective feelings because they are only concerned about the objective clinical data (Bailey, 2004; Oliver, 2001).

In the study of Small and Graydon (1993) which explored the uncertainty encountered

by hospitalized patients, the uncertainty of self-management of COPD upon hospital discharge was recognized as the major concern. The patients considered themselves as incompetent in managing the disease and their daily activities independently. Even the patients who had managed the disease properly before admission were also concerned about the likelihood of regaining sufficient physical strength to be able to function as before. The patients were also doubtful about the future and the unpredictable course of the disease. Despite encountering these uncertainties, they adhered to coping strategies resembling those adjustment made to live with COPD, which have been previously cited. The patients focused on living one day at a time, accepted the disease and lived with the limitations and made positive comparisons to perceive that they were better off than others. Similar sentiments were also encountered by COPD patients after hospital discharge in the study of Gruffydd-Jones et al. (2007). They were frightened of the next dyspneic attack and became uncertain about disease management and when to seek hospital care again. In addition, they were concerned about the provision of medical care and social support after hospital discharge. Among the studies, only the COPD patients in the study of Kanervisto et al. (2007) perceived the benefit of hospitalization. They regarded hospitalization as a relief because they could receive the necessary treatment in a timely manner whereas they would have to manage exacerbation by themselves at home.

Summary of Experiences of Living with COPD

COPD represents a radical change in life. The literature has revealed that living with COPD is a complex experience shaped by multiple losses that arose from breathlessness. Patients struggle in the interplay of physical restriction, social restriction and psychological distress. When the disease progresses with time, they adjust with different extents to live with the disease. Moreover, physical limitation renders patients more dependent on their caregivers in daily activities. The lives of caregivers are also transformed because of the considerable losses from their caregiving roles. Older people living with COPD encounter similar restrictions, but the physical limitation exerts greater impact on them and their sense of connectedness to life becomes a concern. Lack of physical strength impedes their participation in activities and the fulfilment of their family roles. Hence, physical restriction impinges on their sense of social connectedness, which is dependent on their family relationships.

Gender roles considerably influence the illness experience of COPD patients. The experiences of patients living with COPD are also shaped in their socio-cultural contexts. COPD patients are more concerned about fulfilling their family roles with declining physical strength. People in the Western culture value engagement in family activities; by comparison, Chinese older people emphasize their responsibilities in their families. In addition, attitudes towards the disease are relatively negative and coping styles appear to be passive among

Chinese older people. They relate the disease to fatalism and rely on emotion-focused style to cope with COPD (Lee, 1995; Leung et al., 2002).

Hospitalization seems to be inevitable for patients with COPD. Apparently, patients experience stress before hospital admission and the stress continue to confound them after hospital discharge. In addition to emotional stress caused by the decision to seek emergency hospitalisation, exhaustion and demoralised feelings brought about by frequent hospital admissions suggest that hospital readmissions detrimentally influence COPD patients. To gain better understanding on hospital readmission of COPD patients, related studies are reviewed in the following sections.

Hospital Readmission of Patients with COPD

Through an extensive literature search, three themes in understanding hospital readmission among patients with COPD were identified. One of these is the exploration of this phenomenon from the patients' perspectives. The other two are the identification of the factors related to hospital readmission and the evaluation of disease management approaches used in reducing hospital readmission. Studies in these themes are described and reviewed in the following sections.

Patients' Perspectives on Hospital Readmissions

Only a single study has described the phenomenon of hospital readmissions from the patients' perspectives. Using an exploratory qualitative design, Yu, Lee, and Woo (2007) explored the perspectives of Chinese older COPD patients regarding hospital readmissions. They interviewed five male COPD patients aged 70 and above with readmission records of 10 to 22 times within a year. Four themes emerged from the patients' perspectives: perceived powerlessness to manage the disease after discharge, lack of confidence in community-based healthcare services, tension relationship between caregivers and care recipients, and satisfaction with the social atmosphere in hospital.

In the theme of perceived powerlessness to manage the disease, older patients conceived that they lacked confidence and ability to manage their disease after discharge, and they perceived a feeling of impending death during breathlessness. The perception and feeling are similar to those findings of previous studies which demonstrate that patients perceive incompetence to manage the disease independently and are fearful of dyspneic attack after they are discharged from hospitals (Gruffydd-Jones et al., 2007; Small & Graydon, 1999). The theme of lack of confidence in community-based healthcare services illustrated the belief of the older patients that community health services are incapable of managing their disease. Although it is commonly suggested that healthcare services supporting patients in the community can reduce avoidable readmission (Yam et al., 2010), these older COPD patients

lacked the confidence to utilize these services. The perception of lack of control over the disease, fear of impending death due to breathlessness and lack of confidence in community services prompted these older patients to seek medical care at hospitals for acute exacerbation. These perceptions correspond with the aforementioned experiences of living with COPD. Breathlessness elicits intense fear on patients. Together with the perceived lack of control over the body and resignation to their disease, patients do not make any attempts to manage the disease proactively. Instead, they would rather seek hospital care for any deconditioning.

With regard to the theme of tension in the relationship, caregivers would seek hospital admission as a means to relieve tension from their caregiving roles. Such request, however, induced in the older people a sense of being a burden, as well as being abandoned. Moreover, frequent readmissions allowed COPD patients to familiarize themselves with the healthcare professionals gradually and offered opportunities to interact with other patients. Compared with the loneliness and social isolation due to activity intolerance and confinement at home, they were more satisfied with the social atmosphere in the hospital environment where they found themselves connected with others. These feelings echo the need for and significance of social connectedness for patients with COPD as discussed previously.

Summary of Patients' Perspectives on Hospital Readmissions

Among the studies related to hospital readmissions of COPD patients, the study of Yu et al. (2007) is the only research that explored the phenomenon from patients' perspectives with its focus on older people. This study revealed older people's experiences in relation to hospital readmissions and healthcare services. Experiences of Chinese older people brought about by hospital readmissions can be viewed from individual and social perspectives. From the individual perspective, older COPD patients perceived themselves as powerless to manage the disease and lack of confidence in the healthcare services provided by the community. These perceptions mirror the experiences of COPD patients regarding hospitalization as described in previous studies (Gruffydd-Jones et al., 2007; Small & Graydon, 1993). Patients expressed that they regard hospitalization as a relief because they were confident with the treatment at the hospital (Kanervisto et al., 2007). In particular, some COPD patients were uncertain about disease management after their discharge (Small & Graydon, 1993). Therefore, hospital readmission provides reassurance to COPD patients in view of the unstable nature of the disease.

Considering social perspective, the older Chinese patients perceived tension in the relationship with caregivers and expressed admiration for the positive hospital atmosphere. Previous studies have noted that COPD patients perceive oneself as a burden and caregivers feel relieved when their care recipients are admitted to hospitals (Barnett, 2005; Simpson et

al., 2010). Yu et al. (2007) explicitly illustrated from the patients' views that COPD patients believe that they are a burden when caregivers feel exhausted from their duties and request hospital readmission from doctors. In addition, Yu et al. (2007) probed into a new perspective that older people appreciate the positive social interaction with hospital staff and fellow patients. Such a positive social atmosphere at a hospital is contrary to their strained relationships with their caregivers.

Yu et al. (2007) also provided a new insight in understanding the readmission phenomenon that the experiences are shaped by the cultural context of the patients. The study reflected a cultural issue embedded in hospital readmissions, in which Chinese caregivers might face a dilemma between relieving themselves from the burden of caregiving and perceiving their obligations to take care of sick family members. This proposition suggests that cultural influences should be considered to understand hospital readmissions.

Although Yu et al. (2007) is the only study that explored COPD patients' perspectives on hospital readmissions, the study was limited by the relatively small sample size. More themes may emerge if more COPD patients could be studied. Moreover, the experiences of older people living with COPD highlighted the significance of connectedness to life. The sense of connectedness depends on the family relationship. Yu et al. (2007) observed tension-filled relationships between older patients and their caregivers because of hospital readmissions. It is doubtful whether hospital readmissions and the dynamic with caregivers

would impair the sense of connectedness, as well as sense of well-being. Furthermore, previous studies have provided a comprehensive description of the experiences of living with COPD. Yu et al. (2007) also illustrated what could foster hospital readmissions from the patients' perspective. However, the current literature has not addressed sufficiently the experiences of hospital readmissions among patients with COPD and how they manage their lives amidst the frequent transfer between hospital and home.

Factors Related to Hospital Readmission of COPD Patients

Factors related to the hospital readmission of COPD patients have been extensively examined in the literature. A number of studies have identified factors that are correlated with or predictive of hospital readmission. These factors are categorized into four dimensions, namely, clinical factors, socio-economic status, psychological distress, and health-related quality of life (HRQOL). The following section reviews these factors accordingly.

Clinical factors

Physicians generally admit COPD patients to hospitals because of physical deconditioning or exacerbation. Thus, a substantial amount of studies have examined the physical factors that contribute to such readmission. A number of clinical variables have been identified by various studies. These variables include age, sex, lung function, comorbidity,

functional limitation and physical activity, and history of previous admission.

Age

Age is known as a factor of hospital readmission among patients with COPD (Carneiro et al., 2010; Chen & Narsavage, 2006; Coventry et al., 2011; Lau et al., 2001; McGhan et al., 2007). McGhan et al. (2007) identified 51,353 COPD patients by reviewing medical records from the Veterans Affairs healthcare system of the United States. Among this group of patients (mean age = 68.81 years), increasing age was found to be an independent risk factor for hospital readmission within a year (Hazard Ratio (HR) = 1.01, 95% CI: 1.00-1.01). Prospective studies have yielded similar findings. Chen and Narsavage (2006) followed-up 143 COPD patients (mean age = 72.17 years) in a Taiwan rural area. They determined that age was the only variable correlated with short-term hospital readmission within 14 days. Coventry et al. (2011) studied on 79 COPD patients (mean age = 65.3 years) in the United Kingdom, who were referred to an early discharge service. They reported that patients readmitted within a year were significantly older. Carneiro et al. (2010) followed-up a group of 45 Portuguese COPD patients (mean age = 68 years) through a hospital computerised system and observed that age correlated with hospital readmission ($r = .48$, $p = .003$) during a 66-week period.

Lau et al. (2001) retrospectively identified the factors associated with hospital

readmission for COPD exacerbation at a Hong Kong regional hospital using a computerised system. A total of 551 COPD patients (mean age = 73.75 years) were admitted in one year, and 327 patients (59.35%) were subsequently readmitted at least once. Consistent with Western studies, age is also related to subsequent admissions. The findings indicated that patients older than 75 years were more likely to be readmitted within a year (p = .001). Another local population-based study conducted by Chan et al. (2011) reported that COPD patients readmitted to hospitals within 30 days were younger compared with patients who were not readmitted (76.74 vs 76.83). Yet, both groups comprised older patients and the age difference was minimal. Previous studies consistently identify age as a factor associated with hospital readmission; however, none of the reviewed studies suggest a reason for this significant finding.

Sex

The association between sex and hospital readmission has also been widely examined in the literature. Male COPD patients are more likely to be readmitted (Barba et al. 2012; Cao et al., 2006; Chan et al., 2011; Chen & Narsavage, 2006; McGhan et al., 2007). Two population-based studies showed that males are more at risk of hospital readmission within one month. Chan et al. (2011) retrieved admission records from a computerised system of public hospitals in Hong Kong, which indicated that male COPD patients exhibited a 1.45-fold

(95% CI: 1.38 – 1.52, $p < .001$) increased risk of hospital readmission compared with female patients. Barba et al. (2012) also reviewed medical records from acute care hospitals in Spain and found that males exhibited a 1.28-fold (95% CI: 1.25 – 1.31, $p < .001$) increased risk of readmission within 30 days. McGhan et al. (2007) supported these observations by reporting a significant finding of a 1.28-fold (95% CI: 1.13 – 1.45) increased risk of male COPD patients being readmitted within a year. A cross-sectional study conducted in Singapore by Cao et al. (2006) compared the characteristics between 101 non-frequently readmitted patients and 85 frequently readmitted patients who were readmitted more than twice in the previous year. The results showed that frequently readmitted male COPD patients exhibited an OR of 2.35 (95% CI: 1.02 – 5.43, $p = .049$) for subsequent admission. Consistently, Chen and Narsavage (2006) obtained an OR of 3.00 (95% CI: 1.17 – 7.68, $p = .02$) for male patients readmitted within 90 days. Despite the strong association between sex and hospital readmission, none of the studies provide any explanation to the finding. Probably, male patients exhibiting more episodes of hospital readmission could be related to the fact that COPD is more prevalent in male (GOLD, 2010). Among the studies reviewed, men accounted for 70% to 97% of the samples. Therefore, the higher hospital readmission rate among male patients and the association between hospital readmission and male sex are predictable.

However, some studies conclude that sex is not related to hospital readmission.

Carneiro et al. (2010) did not detect any association between sex and readmission in a group of 45 patients. Nantsupawat, Limsuwat, and Nugent (2012) also failed to demonstrate the association in their study, wherein male patients accounted for 46.9%. The non-significant results of these studies can be attributed to a small sample size and small proportion of male patients in the samples.

Lung function

Lung function reflects the degree of severity of COPD and the level of physical impairment. FEV_1 and FVC are major indicators of the severity of airflow limitation (GOLD, 2010). According to the GOLD guideline, a person with a ratio of FEV_1 to FVC of less than 0.70 is diagnosed with COPD.

Related studies have shown that poor lung function is a factor related to hospital readmission (Almagro et al., 2006; Cao et al., 2006; Coventry et al., 2011; Garcia-Aymerich et al., 2003; Gudmundsson et al., 2005; Liu et al., 2007; Roberts et al., 2002). Lung function was measured by assessing the FEV_1, the FEV_1 predicted, and arterial pressure of oxygen (PaO_2) and carbon dioxide ($PaCO_2$). Roberts et al. (2002) reviewed the medical records of 1,373 patients from 43 hospitals in the United Kingdom. They examined 74 variables and determined that FEV_1 was a significant predictor of hospital readmission in as few as three months (Relative risk (RR) = 1.8, 95% CI: 1.4 – 2.3). Gudumundsson et al. (2005) studied

416 COPD patients in five European countries. They measured FEV_1 at discharge of the index admission and followed up the patients for a year. The results indicated that FEV_1 was an independent predictor of hospital readmission in a year (HR = 0.82, 95% CI: 0.74 – 0.90). The prominent effect of FEV_1 was also evident in the study of Coventry et al. (2011). Their results showed that FEV_1 remained a significant predictor of readmission within a year (HR = 0.95, 95% CI: 0.95 – 0.99) after adjusting for age and sex.

As for FEV_1 predicted, Liu et al. (2007) compared the characteristics between 50 readmitted and 50 non-readmitted Taiwanese COPD patients. They concluded that FEV_1 predicted was different between the two groups (p = .02) and was associated with a short readmission period of 14 days (p = .04). Furthermore, Cao et al. (2006) found that FEV_1 less than 50% predicted was related to frequent readmission with an OR of 2.60 (95% CI: 1.18 – 5.14, p < .018). Garcia-Aymerich et al. (2003) systematically assembled 340 patients in Spain. They recruited one out of every two COPD patients, and conducted a follow up for one year. The results indicated that the FEV_1 predicted and PaO_2 could predict hospital readmission in one year with HR of 0.97 (95% CI: 0.96-0.99, p < .001) and 0.88 (95% CI: 0.79-0.98, p = .024), respectively. On the other hand, Almagro et al. (2006) conducted follow ups with 129 patients admitted to a hospital for COPD exacerbation in Spain. They found that FEV_1 was not significantly different between readmitted and non-readmitted patients. However, readmitted COPD patients exhibited significantly higher $PaCO_2$ levels and had

more dyspnea at discharge compared with non-readmitted patients. Bahadori, FitzGerald, Levy, Fera, and Swiston (2009) also failed to detect a difference in FEV_1 between readmitted and non-readmitted patients, but they attributed the result to inadequate statistical power.

FEV_1, FEV_1 predicted, PaO_2, $PaCO_2$, and dyspnea are parameters that reflect lung function. COPD patients with lower FEV_1, FEV_1 predicted, PaO_2, and higher $PaCO_2$, experience greater impairment in lung functioning. Among the reviewed studies, only Liu et al. (2007) provided justification for the association between poor lung function and hospital readmission. They suggested that the severity of the disease predisposes patients for hospital readmission. Patients with poor lung function may suffer from more frequent and severe dyspnea, which may result in frequent medical consultation. Therefore, COPD patients with these characteristics have a high risk of hospital readmission.

Comorbidity

Association between comorbidity and hospital readmission of COPD patients is controversial in the literature. Comorbidity implies a more complex disease management process, which may lead to hospital readmission. Previous studies have identified that comorbidity and some pulmonary disorders are related to hospital readmission (Bahadori et al., 2009; Barba et al., 2012; Carneiro et al., 2010; Ghanei, Aslani, AzizAbadi-Farahani, Assari, & Saadat, 2007; McGhan et al., 2007; Nantsupawat et al., 2012). Ghanei et al. (2007)

followed up 157 COPD patients for 12 months in Iran and measured comorbidity using the Ifudu Comorbidity Index, which consists of 14 components covering various bodily systems. They identified comorbidity as an independent predictor for hospital readmission in one year with a RR of 0.93 (95% CI: 1.01–1.40, p = .05). Bahadori et al. (2009) quantified comorbidity using the Charlson Comorbidity Index, which consists of 19 categories based on the International Classification of Disease, Ninth Revision, Clinical Modification. They retrieved medical records of 310 COPD patients admitted for acute exacerbation from three hospitals in Canada. A multivariate analysis showed that having other chronic respiratory diseases (OR = 1.78, 95% CI: 1.06-2.99, p = .03) and history of lung infection (OR = 1.73, 95% CI: 1.01-2.97, p = .05) increased the risk of hospital readmission within 20 months. Bahadori et al. (2009) suggested that these conditions further impair lung function and increase the severity of COPD, thus increasing the risk of hospital readmission.

Some lung diseases are indicative of hospital readmission. These diseases include cor pulmonale (Caneiro, et al., 2010), pulmonary hypertension (McGhan, et al., 2007), and unilateral pulmonary infiltrate (Nantsupawat et al., 2012). The presence of other pulmonary disorders definitely further impairs lung function which predisposes COPD patients to hospital readmission. Anaemia is also associated with hospital readmission. After adjusting some commonly identified risk factors for hospital readmission, which include age and sex, Barba et al. (2012) concluded that anaemia remained a significant risk factor of hospital

readmission within one month (OR = 1.25, 95% CI: 1.21-1.29). A plausible explanation for anaemia is that the decreased oxygenation of blood in COPD patients, resulting in dyspnea, especially upon exertion. Therefore, such comorbidity is associated with hospital readmission for COPD.

By contrast, some studies did not show any association between comorbidity and hospital readmission (Cao et al., 2006; Chan et al., 2011; Chen & Narsavage, 2006). Chan et al. (2011) failed to detect an association, but they observed that comorbidity prolonged the length of stay at hospitals among readmitted patients. Chen and Narsavage (2006) also failed to detect the correlation of comorbidity with hospital readmission after controlling for age and sex. They explained this finding in terms of the minimal effect of comorbidity. Chen and Narsavage's (2006) explanation may support the finding of Cao et al. (2006) that the influence of comorbidity is obscured when compared with 18 other variables, including sex, lung function, duration of COPD, body mass index, anxiety, depression, family support. Among these variables, male, lung function with FEV_1 less than 50%, and duration of COPD more than five years were significantly associated with hospital readmission.

Functional limitation and physical activity

Previous studies have consistently indicated that functional limitation and physical activity are associated with hospital readmission among COPD patients (Bahadori et al.,

2009; Chen & Narsavage, 2006; Garcia-Aymerich et al., 2003; Lau et al., 2001). Regarding functional limitation, Chen and Narsavage (2006) measured performance in daily activities and social functioning using the Pulmonary Functional Status Scale. They found that daily activity functioning was negatively correlated with hospital readmission within 90 days (r = -.19, p = .02). They further confirmed that each point change in the difficulty of daily functioning increased the risk of hospital readmission by 44%. They suggested that physical condition deteriorates with each exacerbation, resulting exertional dyspnea when a patient has activities. For specific daily activities, Bahadori et al. (2009) identified that problems with dressing was a significant risk factor for readmission within 20 months (OR = 2.27, 95% CI: 1.32 – 3.91, p =.003). The findings of a local study are also consistent with those foreign studies. Lau et al. (2001) classified patients as dependent if they required assistance in at least one activity of daily living. Dependency in self-care activities was reported as an independent risk factor for hospital readmission within one year, with a HR of 1.396 (95% CI: 1.062-1.835, p = .017). In accordance with the above-mentioned studies, Garcia-Aymerich et al. (2003) measured physical activity using the Spanish validation of the Minnesota Leisure Time Physical Activity Questionnaire. Physical activity was indicated to be a protective factor, such that a higher level of activity reduced the risk of hospital readmission by 46%. They explained that high level of physical activity improves the cardiovascular system and respiratory muscle, increasing a patient's tolerance to the physical demands during

exacerbation.

History of previous hospital admission

The role of previous hospital admission has been extensively investigated in the literature. Studies have consistently found that COPD patients who have history of previous hospital admission have a higher risk of subsequent admission (Almagro et al., 2006; Baker et al., 2013; Coventry et al., 2011; Garcia-Aymerich et al., 2003; Lau et al., 2001; McGhan et al., 2007; Roberts et al., 2002). Roberts et al. (2002) indicated that a history of previous admission was predictive of subsequent admission for COPD in as few as three months with a RR of 2.5 (95% CI: 2.0-3.2). An insurance database of 6,095 persons in the United States showed that a history of more than two previous COPD hospitalisations predicted readmission within both 30 (OR = 3.20, 95% CI: 2.24 – 4.58, $p < .001$) and 90 days (OR = 3.92, 95% CI: 2.95 – 5.20, $p < .001$) (Baker et al., 2013). McGhan et al. (2007) further found that prior admission for either COPD or other reasons were significant risk factors, with a HR reported at 1.23 (95% CI: 1.22-1.24) and 1.03 (95% CI: 1.02-1.04), respectively. A local study of Lau et al. (2001) was consistent with these findings, indicating that COPD patients with a history of admission in the previous year had increased risk of subsequent admission (HR = 1.509, 95% CI: 1.200-1.898, $p <.001$). They explained that previous hospital admission suggests the severity of the underlying COPD. Thus, patients are readmitted to

hospital for deconditioning.

Studies using a prospective design also arrived at a similar conclusion. Coventry et al. (2011) reported that a significantly greater proportion of readmitted patients had a history of previous admission. Almagro et al. (2006) reinforced this finding. In the sample, they reported that 16.3% of COPD patients were readmitted within one month, and 41.1% and 58.1% were readmitted within six months and 12 months, respectively. An analysis of the probability for subsequent admission showed that COPD patients with a history of previous admission had a higher chance to be readmitted within one year, with an OR of 4.27 (95% CI: 1.51 – 12.04, $p < .005$). Resembling the explanation of Lau et al. (2001), they posited that a history of previous admission for COPD is a hallmark of advanced disease, as supported by deranged lung function, number of medications prescribed, and the chronic use of oxygen therapy. Therefore, history of previous admission implies severe COPD, which requires medical treatment and leads to subsequent admission. This suggestion supports the results from the multivariate analysis of Garcia-Aymerich et al. (2003), wherein more than three times of COPD admissions in the previous year was associated with risk of hospital readmission (HR=1.66, 95% CI: 1.16-2.39, $p = .006$).

Socio-economic status

Socio-economic status is commonly known for its effects on health-seeking behaviour

and health status of an individual (Adler, 1994; Hart, 1991; Marmot, 1996; Ross & Wu, 1995). Social support is also considered influential to the health of an individual (Phenninx, Kriegsman, van Eijk, Boeke & Deeg, 1996; Revenson & Majerovitz, 1991; Whitfield & Wiggins, 2002). Some studies in hospital readmission, therefore, include social factors in the analysis. The socio-economic factors examined with hospital readmission among patients with COPD are living arrangements, economic status, and social support.

Living arrangements

COPD patients who live alone or are nursing home residents are more at risk of hospital readmission. Wang and Bourbean (2005) examined 282 COPD patients following hospitalisation in Canada, indicating that living alone was a predictor of hospital readmission within a year (OR = 0.604, 95% CI: 0.001–0.823, p = .0092). They suggested that COPD patients who live alone may have poorer health status and problems in self-management of the disease. These conditions place the patients at a higher risk of hospital readmission. Problems in COPD management are also recognized among nursing home residents. Lau et al. (2001) found that approximately 76% of COPD patients who lived in nursing homes were readmitted in the previous year. Cox regression analysis showed that nursing home residency was an independent factor of hospital readmission within a year, with a HR of 1.718 (95% CI: 1.169-2.525, p = .006). Furthermore, approximately 24% of readmitted COPD patients in

the study of Chan et al. (2011) lived in nursing homes. A multivariate analysis demonstrated that nursing home residents had a higher risk of hospital readmission, with an OR of 1.41 (95% CI: 1.34-1.47, $p < .001$).

Local studies (Chan et al., 2011; Lau et al. 2001) consistently indicate that nursing home residents with COPD have a higher risk of hospital readmission, which support the findings in other countries that nursing home residency is associated with hospital admission (Wang, Shah, Allman, & Kilgore, 2011) and readmission (Bisharat, Handler, & Schwartz, 2012). Lau et al. (2001) suggest that nursing home staff members tend to send their residents to emergency departments more frequently and earlier for mild COPD exacerbation. Chan et al. (2011) further pointed out that nursing home staff lack knowledge in managing COPD and do not receive adequate clinical support in the community. Therefore, staff members are likely to send COPD residents to the emergency department when the residents experience any problems.

Economic status

Poor economic status also increases the risk of hospital readmission (Chan et al., 2011; Ghanei et al., 2007). Ghanei et al. (2007) determined that patients who had monthly income of less than US$200 had a higher risk of hospital readmission in a year (RR = 2.20, 95% CI: 1.84 – 7.03, $p = .002$). They postulated that people with lower income may have problems in

treatment compliance and unhealthy behaviour. Chan et al. (2011) found that COPD patients who received financial assistance in Hong Kong, such as Disability Allowance and Comprehensive Social Security Assistance Scheme, were likely to be readmitted within one month (OR = 1.41, 95% CI: 1.36 – 1.46, $p < .001$). They suggested that those people who receive public assistance experience financial hardship and their opportunities to obtain adequate home care equipment and healthcare services are limited, which lead to early hospital readmission.

Social support

Studies consistently conclude that social support is not associated with hospital readmission among COPD patients (Almagro et al., 2006; Cao et al., 2006; Chen & Narsavage, 2006; Coventry et al., 2011). Almagro et al. (2006) adopted the Social Resources Scale to obtain information on personal relationship and availability of care from COPD patients. They observed no significant difference between readmitted and non-readmitted patients regarding their social resources. Cao et al. (2006) assessed the family support received by COPD patients using a self-developed scale with six questions. Similarly, they did not find any difference in the level of family support between frequently readmitted and non-frequently readmitted patients. The findings showed that the association between social support and frequent hospital readmission was outweighed by other clinical variables,

including sex, lung function and duration of COPD.

Coventry et al. (2011) examined social support using the Enhancing Recovery in Coronary Heart Disease Social Support Inventory, which was originally developed for patients with coronary heart disease. They found that the levels of support were high in both groups of readmitted and non-readmitted patients and could not detect any difference between these two groups. They attributed the findings to some methodological limitations, suspecting that only COPD patients with adequate social support were referred to the study site. Moreover, the measuring scale was originally developed to assess social support for patients with heart disease. Thus, the scale may not be sensitive to reflect the needs of COPD patients who encounter different difficulties in daily activities and have different experiences of living with the disease. In a Chinese rural population, Chen and Narsavage (2006) measured perceived social support in terms of Personal Resource Questionnaire 2000. They indicated that perceived social support was not associated with short-term hospital readmission in neither 14 nor 90 days. Chen and Narsavage (2006) observed that rural people had limitations in accessing hospital care. However, they had sufficient perceived social support and informal support from the family which sustained disease management at home. Thus, Chen and Narsavage (2006) suggested that the lack of association between perceived social support and hospital readmission for COPD is related to the social context in the rural area.

Existing literature has consistently indicated that the level of social support is unrelated to hospital readmission among patients with COPD. However, these studies measured social support with different scales that may not sensitively capture the needs of COPD patients who undergo specific clinical courses of illness. This method of quantifying perceived social support may not sufficiently reflect the social needs of patients living with COPD. Therefore, the lack of association between social support and hospital readmission remains inconclusive.

Psychological distress

As delineated in patients' experiences of living with COPD, they suffer from psychological distress because of breathlessness. However, this distress is not easily detected on COPD patients because the signs of distress, such as fatigue and dyspnea, mimic respiratory symptoms (Shanmugam, Bhutani, Khan, & Brown, 2007). Indeed, anxiety and depression are common among patients with COPD. A study that examined anxiety and depression levels among community-dwelling Chinese patients with COPD reported that this group of patients had more depressive (35.7% vs 7.2%) and anxiety symptoms than healthy persons (18.3% vs 5.3%) (Lou et al., 2012). Previous studies have further showed that anxiety and depression are associated with increased dyspnea and relapse (Dahlén & Janson, 2002; von Leupoldt, Taube, Lehmann, Fritzsche, & Magnussen, 2011), which are coherent to the experiences described by COPD patients that psychological distress and breathing

difficulty affecting them in a vicious cycle.

Several studies have found that both anxiety and depression are associated with hospital readmission among COPD patients. Abrams, Vaughan-Sarrazin, and Vander Weg (2011) retrieved medical records of veterans in the United States and identified 26,591 patients who were admitted for COPD. Diagnoses of anxiety (11.6%) and depression (6.7%) were indicated in the medical records. After adjusting for clinical and demographic characteristics, they found that depression and anxiety were significantly associated with hospital readmission in 30 days, with a HR of 1.35 (95% CI: 1.19-1.55, $p < .001$) and 1.22 (95% CI: 1.04-1.44, $p < .05$), respectively. Aside from confirming psychiatric disorders from the medical records, the Hospital Anxiety and Depression Scale (HADS) is a scale commonly used to assess the levels of depression and anxiety. Using HADS, Coventry et al. (2011) found that both depression (43%) and anxiety (58%) were common in the sample. The HADS score demonstrated deterioration in psychological morbidity over a 12-month follow-up period among readmitted patients. Although the findings regarding hospital readmission for COPD from the above two studies are valuable, the authors could not suggest reasons for this finding because of the limitation of the correlational study.

By using HADS, Ghanei et al. (2007) indicated that depression is an independent predictor of hospital readmission on COPD patients (RR = .31, 95% CI: 1.02-1.22, $p = .05$). They suggested that depressed patients may harbour a sense of helplessness and lack

motivation to comply with medical advice, which increase readmission rate. On the other hand, Chen and Narsavage (2006) assessed the depressive symptoms of Taiwanese patients by using the Zung Self-Rating Depression Scale. They did not find any association between depressive symptoms and hospital readmission. Chen and Narsavage (2006) attributed the lack of association to cultural influence because Taiwanese rarely express negative emotions to others, and therefore few depressive symptoms were exhibited among Taiwanese COPD patients.

Besides examining psychological distress, HRQOL is also incorporated in studies regarding hospital readmission. The influences of depression and anxiety substantially diminish when HRQOL is included in the analysis. Ng et al. (2007) followed up 503 patients in Singapore for a year and measured depression and anxiety with HADS and HRQOL with the St. George's Respiratory Questionnaire (SGRQ). The findings indicated that HRQOL was associated with hospital readmission, but the number of readmissions did not differ between depressed and non-depressed patients. Ng et al. (2007) suggested that depressed patients are helpless and lack motivation to seek medical treatment and hospital readmission. Thus, depression does not predispose COPD patients for hospital readmission. The suggestion is similar to that of Ghanei et al. (2007); however, their results are contradictory. They determined depression was a predictor of hospital readmission. Ghanei et al. (2007) suggested the findings are related to a sense of helplessness among depressed COPD patients

and their lack of motivation to comply with treatment. Thus, hospital readmission was a result of poor compliance.

Gudmundsson et al. (2005) adopted the same scales to measure depression, anxiety, and HRQOL. No association was found between psychological status and hospital readmission, but an interaction effect between anxiety and HRQOL was detected. COPD patients with higher level of anxiety and poorer HRQOL had an increased risk of hospital readmission. A similar diminished influence was also found on depression by Almagro et al. (2006). They examined depression using the Yesavage Scale and quantified HRQOL by SGRQ. Readmitted COPD patients were significantly more depressed than non-readmitted patients. However, HRQOL was identified as a predictor of hospital readmission instead of depression. Almagro et al. (2006) attributed the result to the strong association between depression and quality of life. Moreover, depressive symptoms are actually a component of SGRQ. Therefore, the association of quality of life with hospital readmission overrides the role of depression. The review on HRQOL in terms of hospital readmission is further discussed in the following section.

Depression and anxiety are shown to be associated with hospital readmission among COPD patients, but methodological limitations are observed in the studies. HADS is developed to detect depression and anxiety in clinical settings (Zigmond & Snaith, 1983). Although HADS has been widely used to assess psychological disorders among COPD

patients (Cleland, Lee, & Hall, 2007; Oga et al., 2002; White et al., 1997), it assesses anxiety and depression in a general sense instead of being in a disease-specific approach. Previous studies indicate that the cause of anxiety is disease-specific in COPD patients. Vögele and Leupoldt (2008) found that the most common type of anxiety disorder in patients with COPD is agoraphobia, which is the fear of experiencing a panic attack in an open place where help may not be available. The finding echoes the experiences of patients living with COPD that they are anxious about failing to receive medication in case of breathlessness. Using a qualitative approach, Nicolson and Anderson (2003) revealed that anxiety is caused by several specific traits among people with respiratory problems. They observed that people with chronic bronchitis are anxious about breathing difficulties and acute exacerbation, and are physically and psychologically dependent on medications. The findings of Vögele and Leupoldt (2008) and Nicolson and Anderson (2003) demonstrate that psychological distress experienced by COPD patients are specifically attributed to the manifestations of the disease. As HADS is an assessment tool clinically measuring a general state of anxiety and depression, it may not be sensitive to detect the extent of psychological distress experienced by COPD patients. Although previous studies detected a significant association between anxiety and depression with hospital readmission, the results should be interpreted with caution. The correlation findings are also incapable of illustrating how psychological distress relates to subsequent admission for COPD.

Health-related quality of life

The studies that examined the association between HRQOL and hospital readmission for COPD adopted the SGRQ to measure quality of life. The SGRQ is a disease-specific scale which assesses HRQOL using three subscales: symptoms, impact and activity. The subscale of symptoms refers to the frequency and severity of respiratory symptoms, impacts is concerned with social functioning and psychological disturbances related to the respiratory symptoms, and activity assesses the activities that induce or are limited by dyspnea (Jones, Quike, & Baveystock, 1991). The total score of SGRQ is based on the weights of each subscale. A higher score indicates a worse quality of life. The minimal clinically significant difference in the total score and the subscale scores is defined as a four-unit change (Jones, 2002).

A considerable number of studies have demonstrated that poor HRQOL is related to increased risk of hospital readmission among patients with COPD (Almagro et al., 2006; Coventry et al., 2011; Gudmundsson et al., 2005; Osman et al., 1997; Wang & Bourbeau, 2005). Coventry et al. (2011) detected a significant decrease in HRQOL in the readmitted group. They reported that readmitted patients exhibited a mean change of 6.8 units in their HRQOL, whereas the HRQOL of non-readmitted patients remained stable throughout the year. Although Converty et al. (2011) showed a significant change in HRQOL among readmitted COPD patients, they were unable to conclude whether the change in HRQOL

increased hospital readmission or vice versa.

The associations of each subscale with hospital readmission were exhibited in different studies. Wang and Boubeau (2005) found the SGRQ total score (r = .456, p < .001) and the three subscales of symptoms (r = .330, p < .05), activity (r = .286, p < .05), and impact (r = .409, p < .001) were positively correlated with the number of hospital readmission. These results indicate that poorer HRQOL increased with the number of hospital readmission for COPD. Moreover, the SGRQ total score and all subscale scores were positively correlated with the number of COPD exacerbation and FEV_1 predicted. The findings showed that HRQOL was not only associated with the risk of hospital readmission, but was also related to the lung function and physical distress of patients. Gudmundsson et al. (2005) also supported the correlations between the subscales and hospital readmission. Significant results were observed in both the impact and activity subscales, wherein a four-unit change increased the risk of readmission, with a HR of 1.04 (95% CI: 1.0-1.07) and 1.07 (95% CI: 1.03-1.11), respectively. They suggested a higher score in the activity scale indicates a person has deconditioning; therefore, the risk of hospital readmission is higher.

The prominent effect of quality of life was demonstrated by Osman et al. (1997). Following up 266 COPD patients in Scotland for 12 months, they indicated that readmitted patients had higher SGRQ scores than non-readmitted patients with a mean difference of 4.8 (p = .003). The greatest difference was found in the impact subscale, with a mean difference

of 5.6 (p = .004). After controlling for age, sex, and lung function, all subscales exhibited significant associations with hospital readmission, with odd ratios from 1.13 to 1.14 for every five-unit change in each subscale. Consistently, Almagro et al. (2006) reported that the scores on the SGRQ of readmitted COPD patients and the three subscales were significantly higher than those of non-readmitted patients. The greatest difference was observed in the impact subscale (10.8, $p < .007$). Further analysis adjusting for age, sex, lung function, comorbidity, and social support, they showed that HRQOL continued to demonstrate an association with an OR of 0.79 (95% CI: 0.68-0.98, $p < .03$) for every 10-unit change. In the analysis of probability of hospital readmission, COPD patients with a history of previous admission, SGRQ total score higher than 50, and $PaCO_2$ higher than 45mmHg, had a 70.2% chance to be readmitted within one year. Despite the strong association between HRQOL and hospital readmission, Osman et al. (1997) and Almagro et al. (2006) did not provide justification to their results.

Existing studies using a disease-specific instrument demonstrate a strong association between HRQOL and hospital readmission among patients with COPD. Evidently, patients with poorer HRQOL have higher risk of subsequent admission. The three subscales in the SGRQ also arrive at consistent results, which indicate that COPD patients with more respiratory symptoms, more limitation in activity, more impairment in social functioning, and higher levels of psychosocial distress are likely to be readmitted. The greatest association is

found between the impact subscale and hospital readmission, which may explain the correlations between hospital readmission and psychological distress substantially diminish when the psychological distress is measured by HADS. The impact subscale relates to social functioning and psychological disturbance caused by respiratory symptoms (Jones et al., 1991). Thus, the subscale is sensitive to the symptoms and the impact experienced by COPD patients. However, HADS is a generic instrument measuring the states of anxiety and depression in a hospital setting (Zigmond & Snaith, 1983). Therefore, it is insufficient in detecting anxiety and depressive symptoms related to respiratory distress. For this reason, the associations of depression and anxiety with hospital readmission among COPD patients are diminished when they are not measured sensitively against the distress experienced by the patients. Consistent findings of strong associations between the impact subscale and hospital readmission not only highlight the significance of sensitivity in assessing the risk of subsequent admission, but also denote the necessity of understanding the related experience.

Studies have revealed the prominent role of HRQOL in hospital readmission among patients with COPD. In particular that social functioning and psychological disturbance have a great impact on subsequent hospital admission. Although all relevant studies have consistently concluded that HRQOL is associated with hospital readmission, only a few studies could suggest possible reasons to explain the results. The limited understanding of how quality of life relates to hospital readmission is attributable to the use of correlation

design that it cannot establish causal explanation. We are unclear about whether poor quality of life induces hospital readmission or whether hospital readmission impairs quality of life. The complexity between quality of life and hospital readmission remains unknown.

Summary of the factors related to hospital readmission of COPD patients

A considerable amount of studies have identified factors related to hospital readmission of COPD patients. The factors can be categorized into four different dimensions, namely, clinical factors, socio-economic status, psychological distress, and HRQOL. Regarding clinical factors, COPD patients who are older in age, male, have poor lung function, comorbid, more dependent, have a lower physical activity level, and have a history of previous hospital admission are more likely to be readmitted to hospitals. For socio-economic status, COPD patients who live alone or live in nursing homes and have a lower economic status are more at risk. Anxiety, depression and poor quality of life are also positively correlated to hospital readmission. These related factors indicate the characteristics of readmitted CODP patients; thus, allowing healthcare professionals to identify patients who are at risk of subsequent admission.

Retrospective and prospective designs are adopted to examine the related factors. Some of the factors, such as old age, male, comorbidity and history of previous hospital admission, are identified based on extensive population-based studies (Baker et al., 2013;

Barba et al., 2012; Chan et al., 2011; McGhan et al., 2007) and a longitudinal design followed up to five years (McGhan et al., 2007). Strong associations are demonstrated by certain factors, such as age, history of previous admission and HRQOL. Associations remain prominent even after controlling other variables, providing strong evidence that the factors are closely related to hospital readmission. In addition, some of the factors related to hospital readmission were verified in the Chinese population. These identified factors include old age, being male, having a higher level of dependency, a history of previous admission and poor lung function (Chan et al., 2011; Chen & Narsavge, 2005; Lau et al., 2001; Liu et al., 2007). The findings on older age and history of previous admission are consistent across Western and local studies. These findings have great implications to Hong Kong, suggesting that the problems of hospital readmission will become worse because of its growing aging population and high readmission rate.

The current state of knowledge, however, is inadequate in understanding hospital readmission among patients with COPD because of some methodological limitations. Several identified factors remain inconclusive. Some findings are based on retrospective studies, wherein researchers obtained data either by retrieving medical records or searching through hospital databases. This data collection method constrains the study because the types and amount of data obtained are limited by the availability of such information. Moreover, the time lag between hospital discharge and hospital readmission were defined differently across

studies, varying from two weeks to 20 months. Such discrepancy makes comparison difficult. In addition, the use of different assessment tools may also result in inconsistent findings. Furthermore, not all assessment tools were sensitive to the specific needs and experiences of patients with COPD. Thus, the findings may not adequately reflect patient conditions or the phenomenon of hospital readmission. Another reason is attributed to the different cultural groups being studied. Hospital readmission is a worldwide problem and studies have been conducted in various areas with different socio-cultural contexts. The socio-cultural environment may have an impact on hospital readmission among COPD patients. For instance, Chen and Narsavage (2006) explained the lack of association of hospital readmission with social support and depressive symptoms in terms of socio-cultural influences and accessibility to healthcare facilities. Therefore, the inconsistent findings could be related to the socio-cultural differences.

Moreover, the identified factors were determined by the researchers to be examined in the studies. The researchers decided the variables that should be tested or examined in the medical records of patients. However, previous studies suggest that the study design should be sensitive to the needs of COPD patients and the living context. Other possible factors that may influence disease experience and self-management are not considered in those studies.

Another limitation is related to the study design. The factors are identified by correlation study using a quantitative design. As previously discussed, a correlation study

cannot establish causal relationship. Despite some of the factors have been identified as having strong associations, the way these factors relate to hospital readmission among COPD patients remains unknown. Existing evidence of the characteristics of readmitted COPD patients enable us to identify the individuals at higher risk of subsequent readmission. Some of the related factors, like HRQOL, are modifiable. However, without understanding how they relate to hospital readmission, the ability to meet the needs of readmitted patients by manipulating these factors remains limited. Moreover, the interplay among clinical factors, socio-economic status, psychological distress, and HRQOL remain unclear. Additionally, results concluded by correlation studies are inadequate to reflect the unstable nature of COPD. The clinical course of COPD is fluctuating and changes with personal activity level, environmental stimulus, and even weather. Therefore, the related factors cannot sufficiently capture the specific needs and obstacles encountered by patients with COPD patients, as well as understand hospital readmission among them.

Disease Management Programmes in Relation to Hospital Readmission

Various disease management programmes have been implemented for COPD patients. With respect to the focus of this review, only programmes related to hospital readmission were scrutinized. These programmes can be categorized into three types; they are pulmonary rehabilitation, hospital at home service and nurse-led programmes.

Pulmonary rehabilitation

Pulmonary rehabilitation, which can be provided in inpatient and outpatient settings, is delivered by a multidisciplinary team that primarily aims to increase physical capacity and maximize independence for patients with respiratory diseases (Stewart et al., 2001). Rehabilitation programme usually involve endurance strengthening exercise and education about disease self-management.

Behnke, Jorres, Kirsten, and Magnussen (2003) compared 14 COPD patients in a rehabilitation group with 12 patients in a control group and monitor them for 18 months. Patients in the rehabilitation group, who were given training on walking for 10 days at a hospital, demonstrated less frequent hospital readmission (p = .026). Seymour et al. (2010) randomized 60 COPD patients into usual care group and rehabilitation groups, which underwent eight-week exercise training. The rehabilitation programme has a completion rate of 77%. The results showed that significantly less participants in the rehabilitation group required hospital readmissions compared with the usual care group (7% vs 33%, p=.02) over a three-month follow-up.

In other studies, the effect of pulmonary rehabilitation is not satisfactory. Man, Polkey, Donaldson, Gray, and Moxham (2004) randomized 42 COPD patients into community-based pulmonary rehabilitation programme and usual care groups. The rehabilitation group underwent exercise training and education on self-management of COPD, nutrition and

lifestyle modification. The readmission rate of the rehabilitation group was not significantly different from the usual care group during a three-month follow-up period. In a later study, Eaton et al. (2009) randomized 97 patients into inpatient-outpatient pulmonary rehabilitation group and usual care groups. Participants assigned to the rehabilitation group received exercise training at an inpatient setting. After hospital discharge, they continued the exercise training and attended education classes on disease self-management, stress management and relaxation techniques. Only 40% of the participants in the rehabilitation group adhered to the program with 75% or above attendee. The three-month follow-up showed an insignificant absolute risk reduction on hospital readmission. Puhan, Gimeno-Santos, Scharplatz, Troosters, Walters, and Steurer (2011) reviewed the above studies and concluded that pulmonary rehabilitation could significantly reduce the risk of hospital readmission in a three to eighteen months follow-up period (OR = 0.22, 95% CI = 0.08-0.58). However, the effect sizes are relatively small. Also, most of the studies monitored the effectiveness of pulmonary rehabilitation only for three months. Thus, the sustainability of reduction in hospital readmission is questionable.

Revitt, Sewell, Morgan, Steiner, and Singh (2013) recruited 160 COPD patients in a pulmonary rehabilitation programmes which involved four-week supervised exercise training and a three-week of unsupervised home-based exercise. The programme also included education on exacerbation management, medication and relaxation. This study reported a

74% completion rate and a significant reduction of hospital readmission from a median number of one prior to the rehabilitation to a median number of zero over 12 months after the programme. By contrast, the effect of pulmonary rehabilitation is not as promising in a local study of Ko et al. (2011). The COPD patients received an eight-week programme, which involved exercise training, education on breathing techniques, and energy conservation methods. The programme failed to reduce hospital readmission, but improved in quality of life as measured by the SGRQ. COPD patients in the rehabilitation group indicated better quality of life than the usual care group (42.3 vs 51.44, $p = .01$) at six months. Yet, the effect was not sustained in a follow-up after one year.

Previous studies show that pulmonary rehabilitation mainly focus on physical training and education on managing exacerbation, and about one fourth of patients drop out from the programmes. Indeed, there are barriers and facilitators for COPD patients participating in rehabilitation programmes. By interviewing patients with COPD, Thorpe, Kumar, and Johnston (2014) identified various barriers and enablers. The barriers included comorbidities, weather, and previous negative experience in similar programmes, whereas enablers consisted of social support, goals and motivations, and access to equipment and healthcare professionals. The unsatisfactory results of rehabilitation programmes may be attributed to the lack of consideration on the experiences of patients. Thus, incorporation of patients' identified barriers and enablers in pulmonary rehabilitation may increase their adherence.

Hospital at home service

Hospital at home service aims to reduce the demand of hospital beds by providing a patient-centred service to manage acute exacerbation of COPD (Ram, Wedzicha, Wright, & Greenstone, 2003). It is a multidisciplinary service in which respiratory nurses monitor patients' conditions by providing regular home visits. COPD patients admitted for acute exacerbation are discharged early to continue the care provided by respiratory nurses. In a systematic review on seven studies, Ram et al. (2003) concluded that no significant difference in readmission rates was observed between patients who received hospital at home service or inpatient care (Bowler et al., 2001; Cotton et al., 2000; Davies, Wilkinson, Bonner, Calverly, & Angus, 2000; Hernadex et al., 2003; Ojoo et al., 2002; Shepperd et al., 1998; Skwarska et al., 2000). Reviewing the services, they mainly provide physical care, such as assessment of respiratory status, monitoring the use of oral steroid and inhaled bronchodilators, and oxygen therapy. Apart from physical care, social support was given to COPD patients in the study of Davies et al. (2000), whereas psychological care was provided in the study of Ojoo et al. (2002). These two studies; however, do not describe how the psychosocial care was delivered to the patients.

Jeppesen et al. (2012) conducted a systematic review involving eight studies, wherein five overlapped with the review of Ram et al. (2003) review. They concluded that hospital at home is effective in reducing hospital readmission (RR = 0.76, 95% CI: 0.59-0.99, p = .04)

(Cotton et al., 2000; Davies et al., 2000; Hernadex et al., 2003; Nicholson, Bowler, Jackson, Schollay, Tweeddale, & O'Rourker, 2001; Nissen & Jensen, 2007; Ojoo et al., 2000; Ricauda et al., 2008; Skwarska et al., 2000). Although the result is statistically significant, reduction of hospital readmission is relatively small. Seven out of the eight studies reported that hospital at home did not reduce hospital readmission, however, only Ricauda et al. (2008) showed significant reduction of hospital readmission in a single-blind randomized controlled experiment involving 104 COPD patients. Patients who received hospital at home service had significantly lower hospital readmission rates than hospital-cared patients in a six-month follow-up period (42% vs 87%, p = .01). Compared with other programmes, it was a physician-led programme and the content was more intensive than others. Doctors discussed the specifics needs to each patient and formulated individualized care plan with nurses through daily meeting. Though the study showed that hospital at home service costs less than inpatient care, the difference is statistically insignificant. Moreover, hospital at home service is not suitable for COPD patients who have severe hypoxemia, hypercapnia and acidosis, whereas these symptoms are common during acute exacerbation.

Nurse-led management programme

Similar to hospital at home service, nurse-led management programme involves home visits by nurses. However, these two types of programme are different in that the nurse-led

management programme emphasizes more on nurse's role as coordinator. This type of programme provides support to COPD patients after hospital discharge and empowers them in disease management. In addition, these programmes do not attempt to discharge patients early.

In two randomized controlled trials, interventions focused on physical needs, including health education, identification of acute exacerbations, and treatment compliance (Littlejohns, Baveystock, Parnell, & Jones, 1991; Smith et al., 1999). Within a one-year follow-up period, both studies were unable to detect significant differences in the readmission rates of intervention and control groups. Hermiz et al. (2002) conducted a randomized controlled trial involving 177 COPD patients. Within a week of hospital discharge, a community nurse visited a patient's home to assess the patient's respiratory status, provide education on the disease, medications, management of daily activities, energy conservation techniques, and advise on smoking cessation. A second visit was arranged at one month later to review the patient's progress and assess the need for further follow-up. However, no significant difference in readmission rates was observed between the intervention and control groups, although patients with CODP in the intervention group showed improvement of knowledge on the disease. Another randomized controlled experiment was conducted by Egan, Clavarino, Burridge, Teuwen, and White (2002), in which 66 COPD patients were randomly assigned to receive nursing-based care management intervention or usual care. After hospital

admission, the nurses, who acted as care managers, assessed patient's physical, psychosocial and spiritual needs. However, the approach used to address the identified needs was not reported. Education was given to the patients and their caregivers regarding disease management, rehabilitation and community resources. Follow-up was provided on the first and sixth week after discharge. In a three-month follow-up period, no significant difference was observed between hospital readmission rates of the two groups.

A more intensive nurse-led programme incorporated with rehabilitation component was conducted by Sridhar et al. (2008), which involved 122 patients with COPD. Using a randomized controlled trial, patients in the intervention group received pulmonary rehabilitation, which involved education on the disease and treatments, and participated in individualized physical training. After completion of the rehabilitation programme, a respiratory nurse visited the patient's home to deliver individualized care plan with lifestyle advice and specific education on medications. Monthly telephone calls were made and home visits were arranged every three months up to two years. The programme was effective in reducing the number of consultation to general practitioners, but it failed to reduce hospital readmission in the intervention group.

In Hong Kong, Lee, Lee, Mackenzie, and Ho (2002) developed a care protocol to support nursing home staff in caring for COPD residents. Its effectiveness was examined by a matched randomized case-control trial. The protocol was implemented on 89 nursing home

residents aged over 65, wherein majority had severe COPD as defined by the guidelines provided by American Thoracic Society. Community nurses visited the residents within the first week after discharge to conduct assessment and develop an individualized care plan. Residents were educated about proper care procedures in medications and breathing exercise, and diet regime. Nursing home staff members were also educated about proper care of residents with written information given. Visits were arranged weekly in the first month to reinforce the education provided, and continuous support was given through a six-month monthly visits. No significant difference in the number of hospital readmission was observed between the intervention and control groups, but the psychological well-being of the residents in the intervention group significantly improved in a follow-up at sixth month.

Another nurse-led discharge programme was conducted by Kwok et al. (2004) using a randomized controlled trial on older patients in Hong Kong. The discharge programme emphasized continuous care by close liaison between community nurses and a respiratory specialist or a geriatrician. Patients aged 60 years above with chronic lung disease were recruited into the programme. A community nurse visited the patients before hospital discharge to provide health counselling in drug compliance, inhaler-administration techniques, and dietary advice. The community nurse also introduced a telephone hotline to the patients for reporting signs of exacerbation and deconditioning. A follow-up visit was arranged within a week of hospital discharge to monitor the condition of the patients,

reinforce health counselling and provide psychosocial support. Then visits were made weekly for four weeks and monthly for six months. In case of changes in the patient's condition, the community nurse could adjust medication dosage and arrange hospital admission after communicating with the respiratory specialist or the geriatrician. In a six-month follow-up, no significant difference in hospital readmission rates was observed between the intervention and control groups, but the intervention group had significantly improved social handicap scores compared with the control group.

Summary of the disease management programmes

Different types of disease management programmes have been developed to provide support to COPD patients after hospital discharge and empower the patients in self-management of the disease. These programmes ultimately aim to reduce hospital readmission. However, the evidence shows that these programmes are insufficient to significantly reduce the readmission rate of COPD patients. A common feature observed among these programmes is that such programmes primarily focus on the management of patients' physical conditions. Psychosocial support to relieve loneliness, anxiety, and fear of acute exacerbation are not incorporated in the programmes. Except the study of Kwok et al. (2004), psychosocial support was provided to the intervention group and patients showed improvement in the social handicap scores after six months. Nursing home residents in the

study of Lee et al. (2002) also showed improvement on their psychological well-being. This improvement may be a result of community nurses' frequent reinforcement on adherence to the care plan. Thus, psychological support promoted a sense of being cared for, which improved the psychological well-being of residents. These findings suggest that readmitted patients have unmet needs other than their physical ailment. Hence, understanding hospital readmission from patients' perspectives is essential; however, such understanding remains inadequate based on the existing literature.

Understanding Hospital Readmissions as an Experience

Previous studies have examined hospital readmission of patients with COPD from two different approaches, identifying associated factors and exploring from patients' perspectives. A vast amount of studies examined hospital readmission by identifying associated factors. However, studies on patients' perspectives remain scarce. Knowledge obtained from these approaches is divergent. For instance, factors identified to be associated with hospital readmission include old age, dependence, comorbidity, poor economic status, and poor HRQOL. Based on these factors, hospital readmission appears to be a negative experience. Conversely, the study explored hospital readmissions from the patients' perspectives revealed that readmitted patients perceived positive social interaction in hospitals (Yu et al., 2007). This difference suggests that actual experiences of hospital

readmissions of patients with COPD appreciably differ from the picture presented by the associated factors.

Patient-related reasons for hospital readmission are entirely different from the associated factors identified. For instance, Yu et al. (2007) showed that patients with COPD feel powerless to manage their symptoms and exacerbation after discharge. These reasons have prompted patients to seek hospital readmission instead of the associated factors indicated by researchers. This discrepancy implies that associated factors only correspond to the characteristics of readmitted patients with COPD, whereas more concerns from patients' perspective are considered in deciding to seek hospital care. Considering their experiences of living with COPD, patients suffer from considerable emotional stress when they decide to undergo emergency hospitalization (Hasson et al., 2008). Therefore, the identified factors remain insufficient to address why patients seek hospital readmission and how they make their decisions.

Previous studies have identified multiple factors associated with hospital readmission of patients with COPD. Yet, the knowledge is insufficient to understand this topic of interest. Previous studies indicate that physical activity is a protective factor against hospital readmission (Chen & Narsavage, 2006; Garcia-Aymerich et al., 2003). However, patients with COPD revealed that they struggle with physical restrictions and exhibit fear of dyspneic attacks based on their experiences (Barnett, 2005; Elofsson & Öhlén, 2004). Concerning

physical limitations and the fear of dyspneic attacks, patients with COPD strategically modify their daily activities to reserve energy and remain prudent during activities that may trigger breathlessness. Hence, they experience extreme difficulty in maintaining high levels of physical activity. This observation implies that the existing associated factors remain inadequate to illuminate hospital readmission among patients with COPD if relevant experiences are not elucidated. As for the prominent result in studies examining HRQOL, impairment level on the impact subscale of SGRQ, which reflects social functions and psychological disturbance of patients with COPD, has been consistently associated with hospital readmission (Almagro et al., 2006; Gudmundsson et al., 2005; Osman et al., 1997; Wang & Boubeau, 2005). The instrument corresponds to the experiences of patients with COPD that they encounter social restrictions and psychological distress. Nonetheless, the results are still inadequate in providing an in-depth understanding of the reason that prompts patients with high level of psychological disturbances and problems in social functioning to undergo hospital readmission. This limitation also stems from the lack of thorough understanding of patients' experiences related to hospital readmission.

Disease management programmes have been developed to address patients' experiences related to uncertainty of proper disease management. These programmes mainly focus on physical strength training and self-management teaching on the disease. However, these programmes heavily emphasize the physical needs of patients with COPD. In fact,

disease management for individuals with chronic illness is multidimensional (Hwu, Coates, & Boore, 2001). Therefore, a well-designed disease management programme that promotes self-management should comprehensively address various concerns based on patients' perspectives. Yet, patients' experiences of hospital readmissions, as well as disease management after hospital discharge remain poorly understood.

Studies have revealed that the experiences of hospital readmissions, hospitalization and living with COPD interweave with one another. Confined by physical limitation and concern about the accessibility of medications during breathlessness, patients become housebound and experience social isolation. This situation possibly explains the positive atmosphere experienced by readmitted patients at hospitals where they can connect with other people. Furthermore, patients experience fear of impending death during breathlessness, which prompt them to seek immediate care shortly after hospital discharge. Moreover, COPD patients' experiences regarding hospitalization reveal their uncertainty of disease self-management after discharge and are concerned about subsequent dyspneic attacks (Gruffydd-Jones et al., 2007). These uncertainties are consistent with the experiences of readmitted patients on disease self-management and their lack of confidence in community-based healthcare services (Yu et al., 2007). In addition, readmitted patients experience tension in their relationships with caregivers; this tension echo caregivers' experiences in providing care to their family members with COPD. Undoubtedly, hospital readmissions interweave with

experiences of living with COPD. Hence, a thorough understanding of hospital readmissions should be based on experiences of patients. These experiences can provide a comprehensive understanding of what patients encounter, why they are readmitted to hospital, what the meanings of hospital readmission are, and how they undergo the experiences.

Previous studies also have revealed socio-cultural issues embedded in the hospital readmission phenomenon (Chen & Narsavage, 2006; Yu et al., 2007). Indeed, cultural beliefs are influential in health-seeking behaviour and utilization of healthcare services (Hwu et al., 2001; Lai & Surood, 2009; Ray-Mazumder, 2001). Chan (2004) revealed that Chinese older patients with COPD believe that suffering from COPD is fate and they attribute exacerbation to environmental pollution. Considering the permanence of the chronic disease, they assumed their situations as unmodifiable and they would rather live with the disease instead of proactively managing it. This attitude vividly shows how a belief in fatalism and an external orientation in the locus of control influence the health-seeking behaviour of Chinese patients with COPD. Hence, the experiences of hospital readmissions should be understood in terms of its context. Moreover, whether any similar beliefs foster hospital readmission among Chinese COPD patients and whether other socio-cultural issues shaping their experiences of hospital readmission remain unknown; thus, these issues should be explored.

Studies on hospital readmissions of patients with COPD have evidently shown that readmission among older people is common. Indeed, older people experience multiple losses,

such as physical decline, loss of a loved one, and relocation of residence (Hooyman & Kramer, 2006; Walter & McCoyd, 2009). As shown in older patients' experiences, they described living with COPD as "hard work" (Elofsson & Öhlén, 2004). In addition to multiple losses from breathlessness and the apparently negative experiences of living with COPD, older people could be particularly vulnerable in undergoing hospital readmissions. Given the existing high readmission rate among COPD patients and the aging population in Hong Kong, the identified factors of old age and history of previous hospital admission suggest that hospital readmission would become more severe on older people with COPD. Furthermore, Chan (2004) showed that the Chinese older COPD patients passively accept their disease as fate. Leung et al. (2002) indicated that old age is a predictor of poor psychosocial adjustment to COPD among Chinese patients. It is unclear whether Chinese older people would have negative experiences when they require hospital readmissions for COPD. The existing knowledge, however, is insufficient to understand hospital readmissions of Chinese older people with COPD and address their related needs. Therefore, exploring experience of hospital readmissions among Chinese older people with COPD is of paramount importance.

A growing body of studies have identified the characteristics of patients with COPD who are at a high risk of hospital readmission. However, only a single study focused on exploring the related experiences of patients. In this literature review, the study of Yu et al.

(2007), which explored hospital readmissions from patients' perspectives, provides novel insights on the distinct reasons of hospital readmissions and explains how hospital readmissions are resulted from individual and socio-cultural perspectives (Yu et al., 2007). However, studies on exploring hospital readmissions of COPD from patients' perspectives are still lacking. Experiences related to living with COPD have been extensively studied and findings have shown that hospital readmission is linked to many experiences related to living with COPD. Nevertheless, very little is known about the experiences of patients with COPD who undergo hospital readmissions. This lack of understanding warrants an exploration of the experience of patients with COPD, particularly from Chinese older people. Phenomenology, which explores people's lived experience, was adopted to address this knowledge gap. The philosophical underpinnings of phenomenology and its method of inquiry to address the experiences of hospital readmissions are detailed in the next chapter. In this study, the lived experience of hospital readmissions was revealed from Chinese older people who were repeatedly readmitted to local public hospitals. Hence, the definition of hospital readmission in this study adheres to the criterion used in the local context and refers to admission to a hospital within 28 days of previous discharge.

This review reveals that the experiences of hospital readmissions of patients with COPD have not been sufficiently addressed. As such, patients' readmission experiences should be explored to enrich the understanding of this common phenomenon, which is

significant to COPD patients and the healthcare professionals as a whole. This understanding could highlight the experiences encountered by readmitted patients, reveal and address any unsatisfied needs, and promote their wellness. Furthermore, insights into the experiences can be used as basis to review the existing care delivery model, thereby improving the provision of healthcare services. Considering the growing aging population in Hong Kong and the imperative of understanding the experiences from older people as previously discussed, this review highlights the urgency to uncover the experiences of hospital readmission experience of Chinese older people with COPD. A thoughtful understanding of the experiences can be acquired through the use of phenomenology.

Conclusion

This chapter reviews and integrates diverse evidence related to hospital readmissions of patients with COPD. Furthermore, this review suggests that the existing knowledge is inadequate to understand this common phenomenon. This review reveals that understanding of hospital readmissions should be assimilated in terms of patients' experiences. The chapter also highlights the significance and necessity of exploring the experiences of Chinese older people. In the following chapter, the methods used to address the experiences of hospital readmissions of Chinese older people with COPD are described.

CHAPTER THREE

METHODS

Introduction

The primary aim of this study was to explore the lived experience of hospital readmissions of Chinese older people with COPD. The understanding on the experience of hospital readmissions was acquired through phenomenology. This chapter justifies the use of phenomenology to address the aim and how this methodology guided the research process. The development of phenomenology and the major philosophical underpinnings of this approach are reviewed. Then, a detailed description of the research process guided by phenomenology follows.

Phenomenology

Phenomenology comes from two Greek words, namely, phainomenon and logos (Stewart & Mickunas, 1990). Phainomenon refers to an appearance, and logos means reasons. Hence, phenomenology is a reasoned inquiry of the appearance of things. An appearance is whatever an individual is conscious of and it manifests the essence of a phenomenon. Therefore, phenomenology pertains to the study of a phenomenon as consciously experienced (Spiegelberg, 1975).

An assumption of phenomenology is that anything that appears to our consciousness has value and is legitimate for investigation (Lopez & Wills, 2004; Stewart & Mickunas, 1990). Our everyday experience, however, is not accessible to our consciousness because of the natural attitude. According to Husserl, the founder of phenomenology, human beings are living in the natural attitude, in which people experience things for granted (Giorgi, 1997; Streubert & Carpenter, 2011). Under this attitude, we accept our daily experiences as "taken-for-granted" and the assumption that things existing to us are real (Giorgi, 1997; Hein & Austin, 2001). Such an immediate and pre-reflective assumption to an experience is known as lived experience (Husserl, 1970). Since we are living in the "lifeworld", that is the world of lived experience, wherein we are limited to access the meanings of our experience (Cohen, 1987). Thus, phenomenological inquiry directs the lived experienced to our consciousness, so that we can articulate the implicit meanings hidden in our day-to-day experience and uncover the appearance of a phenomenon of interest.

Phenomenology reveals what is experienced in a given phenomenon and how such phenomenon is experienced within the living context (Giorgi & Giorgi, 2003; Wertz, 2011). It goes beyond the explicit meanings and articulates the pre-reflective lived experience to make the implicit meanings visible to others (Finlay, 2009; Kvale, 1996). The point of enquiry starts from individuals' lived experiences and then moves from a specific situation to a general understanding (Todres & Holloway, 2006). Reflecting on these individual's

experiences allows the essential meanings underlying a given phenomenon to emerge across different individuals.

Phenomenological Movement

Phenomenology is rooted in philosophy. It originally aimed to inquire the meanings in human experience from individuals' perspectives (Spiegelberg, 1975). Since phenomenology was initiated to focus on human experiences, it has undergone considerable changes and various schools of phenomenology have been formed in this evolving process. Spiegelberg (1982) describes the evolution of phenomenology as phenomenological movement. The word "movement" implies that phenomenology is not stationary but it comprises several interrelated changes across different periods. Spiegelberg reviewed the history of phenomenology and categorized the movement into three phases, namely, preparatory, German and French phases.

Preparatory Phase

Franz Brentano (1838–1917) was the figure of the preparatory phase. Brentano was not a phenomenologist. However, he was the person who began the discussion on the notion of intentionality, which became the foundation and the major concept underpinning phenomenology (Spigeleberg, 1982). Brentano understood the "intentional relation" as a

reference of human beings' perceiving acts to perceived objects (Spiegelberg, 1975).

German Phase

The German phase was dominated by two phenomenologists, who are Edmund Husserl (1859–1938) and Martin Heidegger (1889–1976). Husserl criticized the positivist view in understanding the nature, which assumes that human beings simply respond to an external stimulus in an automatic manner but disregard the fact that they also react differently to the meanings of that stimulus (Laverty, 2003). Therefore, he advocated for a philosophy to restore the missing pieces of individual's perspectives in the natural science. Husserl was a student of Brentano; thus, he was under the influence of Brentano's doctrine. Husserl did not only adopt the notion of intentionality from Brentano but also expanded its meaning. Intentionality, for Husserl, does not merely distinguish the perceiving acts and the perceived objects but is also about how consciousness relates and synthesizes the appearance of a referred object (Spiegelberg, 1975). He maintained that consciousness constitute human experience, which can be examined when it comes to our consciousness (Hein & Austin, 2011). Thus, Husserl upheld phenomenology to unfold lived experience as it appears in people's consciousness.

Husserl was considerably concerned about the epistemological issues of an experience. Epistemology refers to studying the nature of the relationship between the

knower and the known (Guba & Lincoln, 1994). His focus was on an experience and he was interested in the relationship between the persons who had the experience and what were learned from that experience (Koch, 1995). The goal of phenomenological inquiry, for Husserl, is to describe the meanings underlying an experience from the perspective of experiencing individuals (Cohen & Omery, 1994). Hence, phenomenological inquiry, being guided by Husserl's doctrine, is referred to descriptive phenomenology. This doctrine motivated the establishment of the Duquesne school, which is the first school of phenomenology.

Affirming phenomenology as a rigorous inquiry of human experience, Husserl proposed three major concepts in phenomenology, namely, essences, phenomenological reduction, and imaginative variation (Holloway & Wheeler, 2010; Streubert & Carpenter, 2011). An essence is the essential structure of a phenomenon which presents the invariant meanings of an experience (Dahlberg, 2006). To reduce the phenomenon into its essences without the influences from the inquirer's perspectives, phenomenological reduction is applied to withhold the personal presuppositions and past knowledge about the phenomenon (Giorgi, 1994). The essentiality of essences is then determined by imaginative variation (Moustaks, 1994). Although various types of phenomenology have been developed, these concepts remain as fundamentals to different phenomenologies and as the major principles to conduct phenomenological studies. These concepts are elaborated in the following section of

the philosophical underpinnings of phenomenology.

Descriptive phenomenology aims to uncover the universal essence of a given phenomenon, which are free from any assumption about the world. Therefore, the outcomes of this inquiry are the essence or the structure of the phenomenon experienced by individuals. The structure expresses the commonality across diverse appearances of a phenomenon and the shared meanings underlying its experiences (Hein & Austin, 2011). In other words, this structure reveals what a phenomenon essentially is for the individuals who have that particular experience (von Eckartsberg, 1986).

Heidegger was the influential leader in the late German phase. He was initially an assistant of Husserl; however, he disputed the focus of descriptive phenomenology that emphasizes on describing experience (Dowling, 2007). Heidegger believed that human beings are hermeneutic, which means interpretative; they are capable to understand the meanings of their lives (Dreyfus & Dreyfus, 1987). Therefore, he suggested that the focus of phenomenology should be about the experience of understanding.

Heidegger considered that understanding is not only a mean to know about the world but its ultimate goal is to manifest the mode of being (Koch, 1995). He then moved the emphasis of phenomenology to an ontological issue. Ontology is about exploring the nature of reality and nature of being (Guba & Lincoln, 1994). Hence, Heidegger was interested in what it means to be a person (Walters, 1995). He referred the situated meanings of being

humans to a Greek word, dasein (Walters, 1995). In English, dasein means being-in-the-world. Dasein implies that human beings cannot separate themselves from the world because the meanings embedded in their lived experience are influenced by the external environment (Wonjnar & Swanson, 2007). He asserted that the primary concern of phenomenology is to understand the meaning of being-in-the-world (Cohen & Omery, 1994). Hence, the focus of phenomenological inquiry shifted from examining an epistemological issue to examining an ontological issue that was from describing the consciousness appearance of an experience to understanding the human existence (Koch, 1995). Heidegger viewed human beings as self-interpretative and affirmed an approach to answer the ontological question using hermeneutic (Dowling, 20007). Hermeneutic is derived from the Greek word, hermeneusin, which means to interpret (Palmer, 1969). The second school was then evolved as Heideggerian hermeneutic and an inquiry following this approach is known as hermeneutic or interpretive phenomenology (Cohen & Omery, 1994).

The feasibility of phenomenological reduction is another refutation from Heidegger toward Husserl's doctrine. He used the words fore-structure and preunderstandings to refer to the meanings of a culture, which is present in the world before we come to understand it (Koch, 1995; Laverty, 2003). Heidegger believed that an interpretation cannot be made without referencing to a person's fore-structure, because human's understanding is given by the fore-structure (Laverty, 2003). With the tenet underlying being-in-the-world, researchers

are legitimate to bring their fore-structure to the inquiry (Walters, 1995). Therefore, the foundation of hermeneutic phenomenology is the belief that researchers and participants arrive to an investigation with their fore-structures and they cogenerate the meanings of being-in-the-world (Wonjar & Swanson, 2007). In this connection, Heidegger introduced the concept of co-constitutionality, which means that the findings are a blend of understanding given by researchers and the participants (Lopez & Wills, 2004). Unlike descriptive phenomenology, which concerns about eliminating researchers' influences on the findings, hermeneutic phenomenology emphasizes the shared interpretation on an experience and being-in-the-world. This shared interpretation is referred to as intersubjectivity (Walters, 1995). This intersubjectivity can be arrived through the hermeneutic circle, which is an interpretation process given by Heidegger. In this hermeneutic circle, a researcher moves back-and-forth between the parts of and the whole experience, and between own fore-structure and the experiences given by the participants (Wojnar & Swanson, 2007). The researcher keeps questioning and re-examining the text in this back-and-forth circular movement to yield a shared understanding of what it means to be being-in-the-world (Holloway & Wheeler, 2010; McConnell-Henry, Chapman, & Francis, 2009).

Heidegger's notion of hermeneutic was further advanced by Hans–George Gadamer (1900–2002) (Dowling, 2007). Gadamer named fore-structure as prejudice (Koch, 1995). He agreed with Heidegger that our interpretation inevitably involves our prejudice, which

determines our understanding of being-in-the-world (Koch, 1996). Gadamer introduced the concept of the "fusion of horizon" to the process of interpretation. He explained horizon as a range of vision and fusion as the merging of vantage points (Koch, 1996). Gadamer maintained that human beings are in a shared reality; therefore, meanings with broad insights emerge when the researcher's and participants' horizons fuse together (Koch, 1999; Todres & Holloway, 2006). This process of interpretation is similar to a researcher having a dialogue with the texts given by the participants (McConnell–Henry et al., 2009). Hence, the notion of the fusion of horizon echoes with intersubjectivity and further elaborates its meaning.

French Phase

The phenomenological movement was then evolved to the French phase after the World War II. It became the predominant and an influential philosophy in France (Cohen, 1987). Maurice Merleau–Ponty (1908–1961) was one of the key figures in this phase. He reinterpreted the role of consciousness in phenomenology. For Merleau–Ponty, consciousness gives us sensory awareness of the environment (Munhall, 1989). The mind-body dualism is eliminated when an individual experiences the world with the mind and body. The word "embodiment" is used to illustrate that human beings are conscious of their bodily sensory that responds to the environment. Thus, the body gives us an access to the world, while consciousness allows us to be aware of being-in-the-world.

Philosophical Underpinnings of Phenomenology

Four concepts, namely, intentionality, essence, phenomenological reduction, and imaginative variation underpin phenomenology (Giorgi, 1997; Moustaks, 1994; Polkinghorem, 1989; Priest, 2002). These concepts not only are the philosophy of phenomenology but also reveal the focuses and methods of inquiry. The meanings and the mutual relationships of these concepts are delineated in this section.

Intentionality

Consciousness is the starting point of inquiry in phenomenology. Although the focus of inquiry varies among the types of phenomenology, all types support consciousness to be the point of departure because it is the medium between human beings and the external world (Giorgi, 2005). The assumption behind intentionality is that an individual knows about an experience only by awakening the individual's conscious awareness (Beck, 1994). Therefore, nothing could be possible if consciousness is not considered (Giorgi, 1997). This conscious awareness is attained by intentionality, which means that the mind is consciously directed to the object of inquiry (Koch, 1995; Priest, 2002). In other words, intentionality is an individual's inner experience of being conscious (Moustakas, 1994). A person is able to experience the external world when the consciousness is intentionally directed to something (Baker, Wuest, & Stem, 1992). This conscious awareness then actualizes our presence to the

world (Giorgi, 2005). Hence, intentionality enables a person to be conscious of and to describe a lived experience. The experience becomes identifiable and presents itself with its essences (Dahlberg, 2006).

Essence

In Husserl's terms, studying the appearances of a lived experience is to "return things to themselves" (1970). These appearances are reduced to their essence, which is the invariant structure of the phenomenon (Creswell, 2007). Essences are universal in that they are the common features embedded in the lived experience of individuals who have similar experiences (Natanson, 1973). These essences are not explicitly added by inquirers but are already integrated into the lifeworld (Dahlberg, 2006). According to Dahlberg:

> An essence could be understood as a structure of essential meanings that explicates a phenomenon of interest. The essence or structure is what makes the phenomenon to be that very phenomenon. That is, the essence or structure illuminates these essential characteristics of the phenomenon without which it would not be that phenomenon. (p. 11)

An essence forms the common understanding of a phenomenon (Streubert & Carpenter, 2011). Searching for an essence assumes a uniformity that underlies human experience (Hallet, 1995). Essences articulate the fundamental and most invariant meanings

of experiences (Giorgi, 1997). These meanings do not exist between the act of consciousness and the perceived object but are rather the ways through which an object is experienced by individuals (Giorgi, 2009). The search for essences requires researchers to identify the commonality in the experiences given by participants before generalizing the description to a phenomenon (Lopez & Willis, 2004). The focus of researchers therefore shifts from describing an individual experience to identifying common features (Kvale, 1996). The essence of a phenomenon is elucidated from a relatively global perspective to account for various experiences that are presented under the same phenomenon (Giorgi, 2009). The shared and invariant meanings across experiences are presented in a general structure (Hein & Austin, 2001).

The outcome of phenomenological inquiry is a concrete description of a lived experience (Kleiman, 2004). That is, the essence or the general structure, which is composed of its constituents of a given phenomenon, is described (Dahlberg, 2006). Given that essence is formed by its constituents, such constituents make the phenomenon to be invariant and present itself fully (Dahlberg, Derw, Nyström, 2008). A constituent not only refers to a part of a whole but also highlights the role and relationship of such part with the whole (Gurwitsch, 1964). Constituents also characterize the meanings of a given phenomenon as context-laden (Polkinghore, 1989). Each constituent may vary at the empirical level of individual experiences. However, the meaning of each constituent remains the same across the

experiences (Giorgi, 2009).

Invariant constituents are presented in a general structure that is essential to an experience (Polkinghore, 1989). As described by von Echartsberg (1988), a general structure "characterizes the implicit universal structure of meaning true of all the individual descriptions" (p. 42). Therefore, this general structure addresses the commonality of the diverse appearances of a phenomenon (Hein & Austin, 2001). The general structure not only delineates the constituents but also manifests the interrelationships among these constituents. A holistic view is applied to the constituents to mediate their relationships with the phenomenon and their interrelationships with one another (Giorgi, 2009).

In presenting the findings of a phenomenological study, the general structure, that is the essence of a given phenomenon, is delineated prior to its constituents to elucidate "what the constituents are constituent of" (Dahlberg, 2006, p. 14). Thereafter, detailed descriptions of the constituents are given to show the empirical variations under each constituent.

Phenomenological Reduction

Phenomenology primarily aims to understand the human experience of a phenomenon. An approach that allows the lived experience presenting itself precisely to our consciousness is exceptionally significant. Husserl introduced phenomenological reduction as a philosophical approach to enhance the rigor of a phenomenological inquiry by critically

examining the experience described by people (Giorgi, 1997). He maintained that human beings are living within the natural attitude, in which "natural" implies that our experiences are naïve and have not undergone critical reflection (van Manen, 1990). Natural attitude is the most basic way of experiencing the world. Under the natural attitude, people perceive things as taken-for-granted and assume the real existence of things without critical examination (Moustakas, 1994). Hence, Husserl asserts that the essence of a phenomenon can emerge only when people abstain from their natural attitude.

Phenomenological reduction, as a philosophical approach, delineates how we hold the natural attitude in abeyance to reveal the lifeworld. Husserl described the process of refraining from the natural attitude as epoche, which is a Greek word meaning stay away (Moustakas, 1994). This meaning is elaborated as deliberately abstaining from judgment and holding common beliefs and presuppositions (Priest, 2002). This process enables inquirers to open to what is given and examine the phenomenon from different perspectives. The word "reduction" means reducing the lifeworld perceived under the natural attitude to a pure phenomenon (Valle, King, & Halling, 1989). To achieve reduction, phenomenological reduction requires inquirers to suspend all of the past knowledge and presuppositions about a phenomenon being explored and to withhold the existential claims to consider precisely what are presented (Giorgi, 1994; Wertz, 2011).

Husserl used bracketing as a method to abstain from the natural attitude. Bracketing is

a metaphor used in mathematical equation, in which we treat the bracketed part differently (Walters, 1994). Without eliminating the bracketed part, a mathematician focuses on handling the data outside the brackets (Stewart & Mickunas, 1990). Similarly, Husserl analogized this method as we place the natural attitude toward the world in the brackets (Priest, 2002). A researcher's previous knowledge and assumptions about the phenomenon of interest are set aside, such that the researcher can focus on the pure phenomenon having the natural attitude that is suspended in the brackets.

"Setting aside the prior knowledge" is often used to illustrate what to deal with bracketing. This description, however, has been misinterpreted by people to forgetting their previous knowledge about a phenomenon. The doubtfulness of how to eliminate the prior knowledge has inspired the concept of intersubjectivity in hermeneutic phenomenology and motivated the method of hermeneutic circle to address the co-generation of meanings by both researchers and participants (McConnell–Henry et al., 2009). Yet, eliminating what is known is neither an assumption of phenomenological reduction nor a task of bracketing. Giorgi (1994) explained, "For phenomenology, nothing can be accomplished without subjectivity, so its elimination is not the solution. Rather, how the subject is present is what matters, and objectivity itself is an achievement of subjectivity." (p. 205). Giorgi (2009) clarifies that bracketing does not mean being unconsciousness of or discarding all past knowledge but it is referred to as not to engage in the previous understandings.

Although Munhall (1994) describes bracketing as a process of unknowing, she emphasizes that being aware of own thoughts is the method to quit our own mind. Instead of attempting to forget what we know, we have to explicitly reflect what we have already known, because suspending presuppositions is impossible if we are unaware of them (Parahoo, 2006). Researchers can become independent of presuppositions only by bringing these implicit frameworks into our consciousness (Finlay, 2002). When researchers are conscious about their own assumptions, they can approach an object of inquiry with an open mind (Jootun, McGhee, & Marland 2009). Articulating presuppositions also provides opportunities for people to evaluate if the understanding toward a phenomenon is illuminated solely from a researcher's own perspectives (Hein & Austin, 2001). Therefore, bracketing is to acknowledge our presuppositions about a phenomenon of interest and to make it explicit. This method requires researchers to reflect on their assumptions and past knowledge about the phenomenon (Beck, 1994; Giorgi & Giorgi, 2009). Throughout the interpretation, the researchers maintain neutral, and respect and accept all of the descriptions given by the participants (Omery, 1983; Streubert & Carpenter, 2011). In this way, bracketing allows researchers to consider precisely what is presented to them.

Another requirement for phenomenological reduction is to withhold the existential claims. These claims are a form of reduction from existence to presence (Giorgi, 2007). Withholding the existential claims refers to refraining from positing the existence of an object

in the reality (Giorgi & Giorgi, 2008; Hein & Austin, 2001). Instead of seeking an objective account of a phenomenon, researchers only focus on the descriptions given by the participants. The researchers do not assert the phenomenon really exists similar to the way it presents itself in the reality but only declare that it is the way the phenomenon presents itself to people's consciousness. The researchers only affirm how the participants experience the phenomenon. Hence, they are refrained from perceiving things as taken-for-granted and are able to understand how the participants construct the phenomenon. Accordingly, phenomenological reduction provides a non-judgmental means to uncover a phenomenon. This concept allows us to step back attitudinally and to inquire into a phenomenon freshly in different ways (Giorgi, 1994). By holding the natural attitude in abeyance, researchers are enabled to have a critical examination on the lived experience and allow the essence of a phenomenon to emerge.

Imaginative Variation

During the process of a phenomenological inquiry, various meanings emerge from the descriptions given by the participants. Imaginative variation is a method suggested by Husserl to intuit on these meanings in order to determine their essentiality and the essence of a given phenomenon (Giorgi, 1997). Intuition, for Husserl, refers to experiencing an object of inquiry to a person's consciousness by imagination (Finlay, 2009). In other words, the

essence is conceptually verified (Wertz, 2011). This intuitive process requires researchers to reflect on and remain open to different meanings in order to identify the possible essence (Priest, 2002).

The task of imaginative variation is that an individual mentally varies different aspects of a phenomenon to examine it from divergent dimensions (Moustaks, 1994). This method requires researchers to change or remove any features of a phenomenon freely and to assess if the phenomenon remains identifiable or transforms to something else. If varying a feature changes the phenomenon radically, the varied part is identified to be essential to the experience. However, if the phenomenon remains identifiable after the variation or is only modified slightly, the varied part is likely to be a contingence instead of an essential feature (Giorgi, 2009). The intuition is continued by free imaginative variation until the invariant essence emerges from the inquiring phenomenon.

Summary of Philosophical Underpinnings of Phenomenology

In phenomenology, the four concepts of intentionality, essences, phenomenological reduction, and imaginative variation underpin inquiry. Under the nature attitude, people take their experiences for granted and therefore become limited in accessing the meanings of these lived experiences. An intentional direction of an individual's consciousness to an experience is the starting point of inquiry. With the use of phenomenological reduction and imaginative

reduction, the experience is reduced to its essence. The essence constitutes an essential structure that articulates the meanings of an experience and highlights their interrelationships of these meanings. The next section describes the research process and how these concepts are applied in the current study.

Research Design

This study aimed to explore the lived experience of hospital readmissions from the perspective of Chinese older people with COPD and to identify Chinese socio-cultural influences on the readmission experience. These aims were addressed through descriptive phenomenology, with its focus on understanding people's lived experienced on a phenomenon of interest. Descriptive phenomenology is a suggested method of inquiry for phenomena that have not been previously conceptualized (Lopez & Willis, 2004; Swanson–Kauffman & Schonwald, 1988). As discussed in the previous chapter on literature review, an understanding of the experiences of hospital readmissions is lacking in the literature. A comprehensive understanding of hospital readmissions is therefore warranted, especially in terms of a clear description of the experiences involved and the meanings of these experiences.

The current study aimed to obtain an understanding of the lived experience of hospital readmissions from the perspectives of Chinese older people. The use of descriptive

phenomenology, which focuses on describing the appearance of an experience from an individual's perspective, rather than hermeneutic phenomenology, which seeks to understand human existence, is justifiable for this study. Descriptive phenomenology emphasizes the philosophical underpinning of phenomenological reduction, which suspends a researcher's personal understandings to reveal the lived experience of a phenomenon under inquiry. The findings describe what are perceived and the experience lived by individuals from their own perspectives. Therefore, descriptive phenomenology is legitimate to address the aim of this study. It provides a thorough understanding of the lived experience of hospital readmissions from the perspectives of Chinese older people with COPD. This lived experience is illuminated by its essence and the interrelationships among its constituents.

Descriptive phenomenology is challenged by Heidegger in terms of the feasibility of conducting phenomenological reduction, in which researchers are required to abstain from their nature attitude. Hermeneutic phenomenology therefore emphasizes the meaning of being-in-the-world is constructed by researchers and participants (Wonjar & Swanson, 2007). The findings of hermeneutic phenomenology are cogenerated from the perspectives of the researchers and their participants. Indeed, the meanings of phenomenological reduction are twofold. One of the meanings is to prevent our pre-understanding about the phenomenon of interest from influencing the inquiry but not eliminating it. This goal is possible only when researchers are consciously aware of their own pre-understanding. In this study, reflexivity

was employed to enable the researcher to persistently acknowledge own pre-understanding and maintain openness to the data. As a result, the findings could be grounded from the descriptions of the participants rather than the researcher's own understanding. The method of reflexivity is elaborated in the subsequent section on the process of bracketing. Another meaning of phenomenological reduction is to withhold existential claims. Researchers describe a phenomenon of interest as perceived and experienced by participants instead of affirming a true existence in reality. A precise description of the experience of hospital readmissions from the perspectives of Chinese older people is what the current study aimed to achieve.

Although phenomenology is a form of inquiry in philosophy and no research method has been explicitly given by phenomenologists, this approach is well adopted in qualitative studies to explore various phenomena in different disciplines (Fleming, Gaidys, & Robb, 2003). In this study on the experiences of hospital readmissions of Chinese older people, the research design was inspired by phenomenology. The philosophical underpinnings of phenomenology guided the entire research process.

Setting

This study was conducted in three pulmonary wards of a rehabilitative hospital. The selection of the rehabilitative setting is mainly based on two considerations. First, the data are

considered richer when a person experiences the phenomenon closer in time (Todres & Holloway, 2006). Second, the participants' responses and behaviour during interviews could be affected by their symptoms (Scotto, 2005). Therefore, a rehabilitative setting where older people are readmitted and having their symptoms stabilized was selected to elicit rich and sufficient data that could precisely present the experiences of hospital readmissions. Another practical and ethical concern is the recruitment of older people at an acute setting where COPD patients may still suffer from dyspnea and other physical discomforts. Inviting such patients for interviews is unethical. The refusal of this group of patients to participate in this study to avoid over-exertion is also anticipated. Therefore, the rehabilitative setting is the most appropriate setting in view of the above considerations.

The rehabilitative hospital is situated at the lower level of a hill. This hospital provides rehabilitative care to patients who are mainly transferred from two acute hospitals. One of the acute hospitals is in a relatively old district with the majority of people in the lower socio-economic class. Another acute hospital is in a developing district with the people generally in the middle socio-economic class.

The three pulmonary wards are on the same floor. Two wards are at one side of a long corridor, whereas one ward is at the other end. Except during visiting hours, the corridor is usually quiet. At times, a few patients walk along the corridor. All wards received patients of both genders suffering from different pulmonary diseases. A nurses' station is in the central

area of the ward. Approximately four nurses work the day shift, whereas two nurses work the night shift. Three cubicles are situated at two sides of the nurses' station. Each cubicle has five to seven hospital beds. Patients could keep their personal belongings inside a cabinet at the side of the bed. Each cubicle is equipped with a television, but the volume level is usually adjusted to the minimum. Privacy could be provided by with the use of a curtain to enclose the hospital bed. Washrooms are located at the two ends of the ward. At one side of the ward, a common area with sofa and television is available for the patients.

The doctors make their rounds in the morning at around nine o'clock. After the doctors' rounds, some patients are escorted by supporting staff to the lower floor for physiotherapy session. Every day, there are two periods of visiting hours scheduled at noon and the evening. The periods last for two hours each. Relatives are only allowed to enter the ward and visit the patients during visiting hours.

Sampling

Phenomenological inquiry aims to gain a deep understanding of a phenomenon from the people who experience it. A diverse background of participants can enrich the understanding on a related experience and the participants are expected to be willing to share their experiences (Polkinghorne, 1989). Therefore, this study adopted purposeful sampling to recruit the participants. The researcher purposively identified participants on the basis of

phenomenological inquiry and the focus of this study.

This study aimed to uncover the lived experience of Chinese older people with COPD regarding hospital readmissions. Older people are identified as individuals aged 60 and above. According to the statistical data from the Hospital Authority, the average number of hospital readmission among patients with COPD was two times per year. Thus, older people who had been readmitted for COPD twice or more in the previous year were recruited. Given that the researcher does not know any other Chinese dialect except Cantonese, the participants were older people who were able to articulate in Cantonese and were willing to narrate their experience regarding hospital readmissions. In sum, five inclusion criteria were set for purposeful sampling. The criteria include:

1. Chinese person aged 60 or above;
2. diagnosed with COPD;
3. readmitted for COPD twice or more in the previous year and each readmission was within 28 days of their previous discharge;
4. articulate in Cantonese; and
5. willing to talk about their experience regarding hospital readmissions.

Theoretically speaking, a single participant is sufficient to conduct a phenomenological inquiry because an invariant essence is identifiable through any individual who had experienced the phenomenon being studied (Dukes, 1984). Practically, a small

sample of three to 12 participants is commonly suggested for multiple interviews to increase data richness and to avoid identifying contingent meanings (Dukes, 1984; Ray, 1994; Todres & Holloway, 2006). Considering that the physical condition of the participants may hinder them from participating in multiple interviews, the participants were therefore interviewed once in this study. The sample size of the current study was therefore larger than usually suggested to increase the richness of data and to ensure the researcher obtain a thorough understanding of the experiences of hospital readmissions from the older people.

In phenomenological inquiry, researchers engage in the interviews until no more essential meanings emerge in subsequent interviews (Streubert & Carpenter, 2011). A phenomenon is considered as well-described when no new patterns emerge from the additional participants (Thomas & Pollio, 2002). In this study, the researcher obtained an understanding about the experience of older people in hospital readmissions and she found the descriptions were reiterated after interviewing 17 participants. No new information was obtained from the two following interviews. However, the researcher observed that the sample comprised of 18 males but only 1 female. In order to achieve maximum variation and ensure a comprehensive understanding on the experience of hospital readmissions, the researcher purposively recruited female older people in the subsequent interviews. After interviewing for three more females, the researcher did not obtain new information from these interviews. Therefore, a total of 22 older people participated in this study. The

background of these participants is illustrated in the Appendix A.

Pilot Study

A pilot study was conducted prior to the main study to familiarize the researcher with the hospital environment and to assess the feasibility of data collection methods. The ward routine was observed and periods that would interrupt an interview were identified. These periods included doctors' rounds, physiotherapy sessions, bed making, and visiting hours. In the main study, the interviews were scheduled to minimize interruptions by these activities.

When potential participants were screened for the pilot study, the researcher observed that some patients still suffered from dyspnea although they met all the inclusion criteria. These patients were anticipated to be unable to tolerate long conversational interviews. Moreover, some of the patients had supplemental oxygen removed or level of oxygen support adjusted for only a few hours before the researcher coming to recruit participants. They were considered at high risk of developing physical distress from an interview. Thus, the main study excluded patient who suffered from dyspnea before the interview or who was undergoing adjustment in oxygen therapy.

Three older people were recruited in the pilot study. An unstructured interview asking participants to describe their experience in detail is commonly suggested to start an interview in a phenomenological study (Polkinghorne, 1989; Todres & Holloway, 2006). However, the

researcher found that Chinese older people were not used to telling their experiences in such detail at the beginning of an interview. Therefore, an interview guide (Appendix B) was revised with some prompts to facilitate older people to describe their experiences. The modification is described in detail in the data collection section.

Process of Bracketing

Bracketing is an approach employed in phenomenological reduction to acknowledge individual presuppositions about the object of inquiry and to make the understanding explicit for subsequent reflections. The identification of own presuppositions is a process of reflexive analysis (Finlay, 2002). Bracketing has been affirmed to entail reflexive thinking (Ahern, 1999; Jootun et al., 2009; Lamb & Huttlinger, 1989). Reflexivity pertains to a thoughtful and on-going reflection undergone throughout data collection and analysis (Fischer, 2009). Reflexivity is a continual self-critique of whether one's experience has affected the research process (Koch & Harrington, 1998). Researchers repeatedly examine emerging insights against the bracketed presuppositions to maintain openness to the description. Thus, this constant self-appraisal enables researchers to capture an immediate sense of the description while they remain aware of the bracketed presuppositions. Hence, bracketing is practiced as an iterative and reflexive journey to unfold a phenomenon (Ahern, 1999).

The concept of phenomenological reduction was applied in this study by using

bracketing, which was made feasible by incorporating reflexivity. Before each interview, the researcher sat at a quiet place in the hospital to reflect on current thoughts. During the interview, the researcher kept the bracketed knowledge in mind and kept from probing the older people using this knowledge. Immediately after each interview, the researcher reflected on the obtained information and on personal feelings toward the interview. The reflection was recorded in a diary. The researcher also remained conscious and sensitive to the bracketed knowledge throughout the data analysis. The findings about the lived experience of older people regarding hospital readmissions were compared with the original understanding of the researcher to ensure that all the findings were evident in and supported by the participants' descriptions.

Descriptive Bracketing

In this study, the researcher adopted descriptive bracketing, which was proposed by Gearing (2004), as a framework for guiding the reflection regarding the researcher's understanding on hospital readmissions of Chinese older people with COPD. Descriptive bracketing has its theoretical framework based on descriptive phenomenology. It guided the researcher to reflect on the foundational focus, internal suppositions, external suppositions, and temporal structure of the present study.

Foundational Focus

Foundational focus requires identifying the reasons of using bracketing to set aside the natural attitudes appropriately and focus on the phenomenon as it is presented in consciousness (Gearing, 2004). In this phenomenological study, bracketing is employed to withhold the natural attitude of the researcher to hospital readmissions for COPD patients and readmissions of older people in order to reveal the related essence. Hence, the foundational focus of bracketing is to suspend the understanding of the researcher on hospital readmissions and to attend to the descriptions given by the older people regarding hospital readmissions, which rendered the immediate phenomenon as experienced.

Internal Suppositions

Internal suppositions denote personal understanding, personal suppositions, and knowledge about the phenomenon being explored (Gearing, 2004). Personal suppositions originate from personal assumptions and experiences related to the phenomenon. Regarding the personal assumptions on hospital readmissions, the researcher considered hospital readmissions as a patient being admitted to a hospital frequently for the same problem within a short period. It is mainly due to the patient and the caregiver is unable to manage the disease by themselves after discharge. The inability to manage the disease may be related to the patient lives with and relies on a caregiver, particularly both of them are in their advanced

age. When the patient gradually becomes physically weak and fragile, both the patient and the caregiver are incapable of managing the disease. Thus, the patient experiences physical deterioration and requires hospital readmission. In turn, the patient and the caregiver are distressed and feel helpless with regard to the physical deterioration and frequent readmission.

The personal suppositions of the researcher regarding hospital readmissions for COPD patients were also derived from her clinical experience. The researcher worked in a male medical and geriatric unit for three years. Hospital readmissions for COPD were common in the unit and most of the readmitted patients were in advanced age. Upon admission, most readmitted COPD patients came to the hospital without any relatives or caregivers accompanying them because many older people live alone in the district where the hospital is situated. Readmitted COPD patients usually presented with physical symptoms, such as shortness of breath and laboured breathing. Compared with patients admitted for other reasons, the readmitted COPD patients appeared more agitated and anxious upon admission.

The researcher observed that these patients adapted to the ward environment better. They were more willing to move around their beds and they liked to sit out of bed to ease their breathing. They were also familiar with the ward routine and the schedule of different nursing activities. Their familiarity to the ward environment might be attributed to their

knowledge about the ward during previous hospitalizations.

The relationship between the hospital staff and the readmitted COPD patients appeared to be closer than the relationship with other patients. The readmitted COPD patients seemed to be more comfortable in verbalizing their needs and communicating with the nurses. Some of the readmitted COPD patients could recognize the nurses and ward assistants. The nurses also knew most of the frequently readmitted COPD patients well. They knew the background of the patients and became familiar with them gradually through previous hospitalizations. Sometimes, nurses called these frequently readmitted patients "old friends."

The internal suppositions of the researcher were gained from relevant literature. A qualitative study that explored the perspectives of Chinese older COPD patients regarding recurrent hospital readmission revealed that the readmitted COPD patients were satisfied with the social atmosphere in hospitals (Yu et al., 2007). Recurrent hospital readmission allowed them to establish social connections with fellow patients and hospital staff. Thus, they were more satisfied with the social atmosphere in hospitals.

The researcher also learned about factors that led to hospital readmissions for COPD patients from some quantitative studies. The results of these studies suggested that some physical factors were related to hospital readmissions for COPD, including being male, being older, having poor lung function, having acute exacerbation, and being previously admitted

for COPD (Connolly et al., 2006; Liu, et al., 2007; McGham et al., 2007). Poor quality of life was also related to hospital readmissions of COPD patients (Wang & Bourbeau, 2005). The associations of anxiety and depression with hospital readmissions for COPD were inconclusive (Almagro et al., 2006; Ng et al., 2007).

External Suppositions

External suppositions are part of the knowledge about a phenomenon, but these suppositions are centred on the phenomenon itself and are related to the external environment rather than personal knowledge (Gearing, 2004). The external suppositions to be bracketed in this study included two main areas, namely, definitions of hospital readmission given by other parties and the values of studying hospital readmissions for older people with COPD.

In Hong Kong, the Hospital Authority gives the definition of hospital readmission, which refers to admission via the accident and emergency department within 28 days since previous discharge. By contrast, how patients define hospital readmission is not known.

In the literature, studies on hospital readmissions were disease-specific rather than age-group oriented. The phenomenon of hospital readmissions for COPD has been recognized worldwide as exhibited in the vast amount of related studies and disease management programmes in various communities. Some of the studies have identified the risk factors of hospital readmission as related to COPD, and other studies have evaluated the

effectiveness of some COPD management programmes. The goals of these studies were to reduce the rate of hospital readmissions due to COPD, and ultimately, to lower healthcare expenditure. This observation implies that the topic of hospital readmissions for COPD is highly recognized in the healthcare context. However, the issue of hospital readmissions of older people has not been attended to.

Temporal Structure

The temporal structure specifies the period of applying bracketing in a study (Gearing, 2004). In this study, bracketing began when the researcher prepared interviewing the older Chinese people, and it was continued throughout the data collection and the analysis of the descriptions given by the participants. Bracketing ended after the researcher identified and articulated the general structure and the constituents of the phenomenon of hospital readmissions of Chinese older people with COPD.

Application of Bracketing and Reflexivity

The researcher reflected on her personal assumptions and understandings of hospital readmissions of Chinese older people with COPD from different dimensions by using the framework of descriptive bracketing. Particular examples of how bracketing and reflexivity were applied in this study are explicated in this section. From the researcher's clinical

observation, most COPD patients attended to the hospital without the company of their caregivers. Some of the readmitted patients lived alone without caregivers. Based on these observations, the researcher was interested in how older patients who lived alone self-manage the disease. For older people who were looked after by their caregivers, the researcher explored from the older people's perspective how the caregivers take care of and interact with them.

With regard to the researcher's personal assumption, the patients and their caregivers are old, and they are fragile and incapable to manage the disease. Therefore, older people require hospital readmission for disease exacerbation. During the interviews with the older people, the researcher remained conscious of these personal assumptions and kept from probing these bracketed knowledge. The researcher listened to how the older people self-manage their disease daily and learned what they do when the disease exacerbate. Listening to the older people with an open mind allowed the constituent of refraining from unnecessary readmissions to emerge. This constituent describes how older people exert every effort in their daily disease management to avoid unnecessary hospital readmissions.

A reflective diary was used to record the information obtained and the researcher's impression in each interview. Examples of reflective diary are provided in Appendix C. The diaries enabled the researcher to remain reflexive throughout the interviews. The knowledge obtained and personal feelings in each interview were bracketed. Hence, the researcher could

maintain her openness in the subsequent interviews. Throughout the data analysis, the researcher remained sensitive to the bracketed knowledge that the patients and their caregivers feel distressed and helpless to hospital readmissions. Keeping in mind her personal understanding, the researcher repeatedly compared and examined the emerging insights from the older people's description against the bracketed contents. The narrative descriptions consistently show that older people had resigned to hospital readmissions. Instead of feeling distressed and helpless, they accepted the inevitability of hospital readmissions. The constituent of resigning to hospital readmissions emerged from this iterative approach.

In brief, the researcher achieved phenomenological reduction by using bracketing and reflexivity in this study. Throughout the data collection to the writing up of the findings, the researcher bracketed and kept conscious on the personal assumptions and understandings as identified above. The researcher also reflexively reflected on new understanding obtained throughout the research process. The emerging insights and the findings of the lived experience of older people were constantly compared with the bracketed contents to refrain the personal understanding from influencing the findings.

Data Collection

After obtaining access to the hospital, a meeting was held with the Department

Operation Manager and ward managers to explain the purposes and the procedures of this study. The researcher visited the pulmonary wards twice in a week to recruit participants. Permission to read the documents of patients was granted by the hospital. The researcher reviewed the documents of patients to screen for potential participants who met the first three inclusion criteria in the sampling method. The researcher approached each potential participant to confirm the fourth inclusion criterion which was an older people can articulate in Cantonese. Each potential participant was given an information sheet, which stated with the purpose and tasks involved in this study. The researcher then explained the purposes and tasks in detailed using the information sheet. Potential participants were asked if they were willing to share their experiences about hospital readmissions to assess their eligibility for the final inclusion criterion. They then signed a consent form to show their agreement to participate in this study. Demographic and clinical data were collected using the form attached in Appendix D. The experiences of older people with COPD regarding hospital readmissions were then elicited through interviews.

Interviews

Using interviews to learn about the experiences of older people regarding hospital readmissions was based on the premise that the object of inquiry in phenomenology is the description given by individuals who experience the phenomenon (Baker et al., 1992).

Linguistic expression allows an individual to communicate the experience precisely as it presents itself into consciousness (Giorgi, 1997). Researchers can access and enter the experiences of participants through dialogue (Edward, 2006). Hence, participants are invited to describe their experience of the phenomenon being studied. Although the descriptions given by participants are within their natural attitudes, the concrete descriptions can guide researchers to the inner dimensions of the experience and transform their descriptions into meanings (Giorgi, 2009). Therefore, interviews were conducted with the older people in this study to uncover their experiences regarding hospital readmissions.

van Manen (1990) suggested that interviews could serve two purposes. First, an interview can explore and gather experiential narrative material for developing an understanding of a particular phenomenon. Second, interviews serve as a vehicle for developing a conversational relationship with participants. This conversational relationship helps in building rapport with the participants, such that researchers can receive more open, rich, and honest responses from the participants (Langdridge, 2007).

In order to establish a conversational relationship with the participants, unstructured interviews were employed in this study. Unstructured interviews encourage participants to share experiences from their perspectives, which facilitate the unfolding of common meanings in an experience (Sorrell & Redmond, 1995). At the beginning of an interview, the researcher asked the older people a few questions relating to hospital readmissions to engage

them in the interview. Examples of questions include, “How many times were you readmitted to hospital in the recent year?” and “how were you readmitted to this hospital?” When the older people were engaged in the topic, they were asked to unfold their experience by “Please tell me your experience in hospital readmissions.” According to the observation in the pilot study, the older people were not accustomed to describing their experiences in detail at the beginning of an interview. Therefore, some prompts were developed to facilitate the older people to unfold their experiences. These prompts are required to be open-ended without leading by the researcher and are constructed around the experience under study (Ray, 1994; Streubert & Carpenter, 2011). Examples of prompts include, “What do you feel when you come back to this hospital?” and “What are the differences between being at home and being at the hospital?” These prompts aimed to assist the older people reflecting and describing their experiences of hospital readmissions. The prompts were asked by the researcher only when an older person could not narrate the experience of hospital readmissions in detail. The contents of the interviews were neither led nor limited by the prompts.

Some of the interviews were conducted at a common area in the ward if the participants did not require oxygen therapy. The common area was decorated as a living room at one side of the ward. Although it was an open area, patients seldom stayed there. Hence, privacy could be maintained. The living room was quiet and the setting made the interviews comfortable. However, most of the older people required supplementary oxygen, which

confined the interviews at their bedside. All participants in such case agreed to have the interviews in their cubicle. The researcher then used the curtain to screen around the bed to provide a sense of privacy. The interviews were then audio-recorded.

The interviews lasted from forty minutes to one hour and ten minutes. Throughout the interviews, the researcher paid close attention to the conversation while remaining aware of the bracketed presuppositions. The researcher probed any ambiguous descriptions given by the older people to clarify and to expand their meanings. Given their physical limitation because of COPD, most of the older people showed mild dyspnea after the interview had been started for approximately 15 minutes. They had to pause briefly for a few times to complete a discourse. These older people were given opportunities to suspend the interviews and to rest. However, they preferred to continue the interviews even with physical distress. Before closing the interviews, the older people were asked to provide additional information about hospital readmissions. The researcher then ended the interviews when the older people believed that they had fully described their experience.

Data Management

The researcher assigned an identification number to each audio record. The records were then transcribed verbatim in Chinese for data analysis. The researcher checked the accuracy of the transcripts by listening to the audio record and constantly comparing it with

the text. As suggested by Twinn (1997), translating the transcripts into English was not considered in this study because the complexities involved in translating narrative data may threaten the rigor of a study. Moreover, Twinn observed that the major findings generated from a Chinese or English transcript did not differ significantly. Therefore, the researcher used the Chinese transcripts for the first two steps of data analysis, which are reading for a sense of the whole and determining of meaning units. The transformed meanings and the constituents were presented in English.

Data Analysis

In descriptive phenomenology, three different methods of data analysis given by three distinctive psychologists, van Kamm, Colazzi, and Giorgi, have been commonly adopted. To uncover the general structure of a phenomenon, the three methods undergo similar steps, which are dividing the description given by participants into meaning units, transforming these meaning units, and synthesizing the transformed meanings into a general structure (Polkinghorne, 1989). Although these methods are under the same phenomenological school and the steps appear similar, major differences exist in terms of the ways to determine the findings and this may impinge the rigor of a study.

The method of van Kamm (1966) is quantitative in nature that emphasizes the percentage of categorized expressions shown among participants in the early stage of

analysis. The method also involves using independent judges to review the analytic process. The findings are based on the consensual agreement of the judges. The method by Colazzi (1978) involves returning to participants and asking them to validate the resulting exhaustive descriptions. Asking participants to check the descriptions, however, is criticized for being an inappropriate method for validating findings because the findings are abstracted and synthesized across different participants (Morse et al., 2002; Sandelowski, 1993). Therefore, asking individuals to recognize their own experience in the findings is unreasonable. Indeed, both van Kamma and Colazzi developed their methods for their doctoral dissertations, but then they did not remain active in phenomenological inquiry (Hein & Austin, 2011; Dowling, 2007). By contrast, Giorgi continues to be an active phenomenological scholar (Dowling, 2007). The phenomenological approach developed by Giorgi adheres rigorously to Husserl's doctrine and it follows the philosophical underpinnings that the general structure is arrived by intuiting on the meanings of an experience through imaginative variation (van Manen, 1990). Hence, the Giorgi's (1985, 2009) method of data analysis was adopted based on the above considerations.

The phenomenological method proposed by Giorgi consists of four steps, which are 1) reading for a sense of the whole, 2) determining meaning units, 3) transforming meaning units into phenomenological expressions, and 4) determining the structure. The principles behind and tasks involved in each step are elaborated as follows. Examples of how the

researcher analysed the descriptions from the second to forth step are provided. These examples are extracted from an interview with the same participant who is assigned a pseudonym Chi Kin.

Reading for a Sense of the Whole

The purpose of this step is to obtain a sense of the experience (Giorgi, 1985). Data analysis begins by assuming the attitude of phenomenological reduction and reading the entire transcribed description. Because phenomenological perspective is holistic to a person, obtaining a global sense is important before proceeding to in-depth analysis (Giorgi & Giorgi, 2003). In addition, participants' meanings may refer back-and-forth in a description. Thus, reading through the data to gain a global sense of the description is necessary. Therefore, the researcher read and reread the descriptions to grasp a sense of the experience in hospital readmissions as narrated by the participants.

Determining Meaning Units

The outcome of the second step is a series of meaning units that are sensitive to the experience of hospital readmissions. This step is practically oriented. The purpose of establishing a series of meaning units is to make the description manageable for analysis and synthesis (Giorgi, 1985). The meaning units neither carry any theoretical weight nor any

objective value but they are large enough to allow for meaningful exploration and are small enough to manage (Giorgi, 2009). Being mindful of the topic and assuming phenomenological reduction, the researcher reread the description slowly. A slash was made when the researcher experienced a shift in meaning as given by an older person. At the end of the second step, the description was broken down into a series of manageable meaning units. Examples of how the researcher discriminated the meaning units are extracted in Table 1.

Table 1

Discrimination of meaning units

Participant	Descriptions
P12C84	I could barely breathe! After a bath, I began to wheeze. I knew it, I got used to it. Every time after a bath, I begin to wheeze. So I sit down slowly and dare not move. I need the inhaler. After taking the medication, wait for the symptoms to go. / I won't dial the emergency number at once. Definitely, I won't. Only if shortness of breath continues, I call emergency room. / This happens... nearly every day, how do I return to hospital every time?
P12C88	I have to manage it (breathlessness) myself. Take breath (pursed-lip breathing), do not move, take a few puff (of inhalers). Sit down and wait for about 10 minutes, it (breathlessness) will subside. I know what to do. / If the situation is very poor … I can't take a bath, can't move a bit. I even can't walk a few steps. When I can't bear it (breathlessness) and can't leave my home, I have to call an ambulance. / Sometimes, I go to a tea house. When I really feel difficult to breathe and can't tolerate it, I leave the tea house and take a taxi to a hospital. / That's what I can do. I know my body. If I am not feeling that suffering, I won't go to the hospital.
P12C131	About three to four years ago, I returned back to hospital right after discharge. Now I can bear it (breathlessness) more. The doctor gives me some steroid medications. If I find my condition is not that serious, I take the steroid medication at home. I take the steroid medication for a week. After taking the medication for a week, my condition is more stable for one week. Then, I'm only suffered from severe shortness of breath about once a month. / I remember in 2008, I was (re)admitted to hospital for 8 times. / When the wheezing becomes sever, you can't deal with it.

Transforming Meaning Units into Phenomenological Expressions

Transformation is a process of reflection on the meaning units. The identified meaning units are transformed to serve two purposes. The first purpose is to make implicit meanings explicit, and the second purpose is to generalize the meanings for integration (Giorgi, 1985). The concrete expressions given by participants are described under the natural attitude; hence, researchers have to grasp the implicit meaning and make it explicit to others (Giorgi, 2009). The transformation also requires researchers to change the transcription from the first-person to the third-person expression. Changing the expression protects researchers from projecting themselves into the data and allows researchers to be sensitive to the perspectives of the participants and withhold the existential claims (Giorgi, 2006). The transformed meanings need to be generalized to a certain degree to integrate the data obtained from different participants into a structure (Giorgi, 1985).

Being mindful of the topic of hospital readmissions, the researcher interrogated and articulated the implicit meanings in each meaning unit and kept aware of the whole experience of the older people. The researcher changed an older people's description into a third-person expression and described the meanings appeared on the meaning unit. Then, the researcher intuited into the implicit meaning within an attitude of phenomenological reduction. This expression became the transformed meaning. Examples of transformation of meaning units are provided in Table 2.

Table 2

Transformation of meaning units

Participant	Descriptions	Third-person expressions	Transformed meanings
P12C84	I could barely breathe! After a bath, I began to wheeze. I knew it, I got used to it. Every time after a bath, I begin to wheeze. So I sit down slowly and dare not move. I need the inhaler. After taking the medication, wait for the symptoms to go. / I won't dial the emergency number at once. Definitely, I won't. Only if shortness of breath continues, I call emergency room. / This happens... nearly every day, how do I return to hospital every time?	Chi Kin states that he experienced severe breathlessness after bathing. He knew that he would suffer from breathlessness after bathing because he had got used to such situation. He sat down slowly and stayed still. At that moment, he needed an inhaler to relieve the breathlessness. He then used the inhaler and waited for the symptoms to be resolved. Chi Kin asserts that he would not seek emergency care once he suffers from breathlessness. He explains that he calls an ambulance to send him to the emergency room only when the breathlessness could not be relieved. Chi Kin expresses that he experiences breathlessness from activities, which happens nearly every day. He considers that it is unreasonable to seek emergency care for every episode of breathlessness.	Chi Kin frequently suffers from breathlessness from daily activities. He has gotten used to such situations and he is familiar with methods of relieving breathlessness. He adopts self-management strategies to avoid hospital readmission.
P12C88	I have to manage it (breathlessness) myself. Take breath (pursed-lip breathing), do not move, take a few puff (of inhalers). Sit down and wait for about 10 minutes, it	Chi Kin states that he has to manage breathlessness by himself. He performs pursed-lip breathing, stays still, uses inhalers, sits for a while, and waits for breathlessness to be relieved.	Chi Kin considers that he has to manage the disease by himself. He adopts some self-management methods to relieve breathlessness and refrain from seeking hospital

	(breathlessness) will subside. I know what to do. / If the situation is very poor … I can't take a bath, can't move a bit. I even can't walk a few steps. When I can't bear it (breathlessness) and can't leave my home, I have to call an ambulance. / Sometimes, I go to a tea house. When I really feel difficult to breathe and can't tolerate it, I leave the tea house and take a taxi to a hospital. / That's what I can do. I know my body. If I am not feeling that suffering, I won't go to the hospital.	Chi Kin expresses that he cannot take a bath, move and walk when he is suffering from severe distress. He calls an ambulance to send him to the hospital when he cannot tolerate the distress and is unable to leave the house. Chi Kin mentions that he sometimes goes to a tea house. During the meal, he suffers from breathlessness. He leaves the tea house and takes a taxi to the hospital when he is unable to tolerate breathlessness. Chi Kin states that those are the strategies he uses to manage breathlessness. He asserts that he knows about his body well. Chi Kin affirms that he does not seek emergency care unless he is very much distressed.	readmission. Chi Kin considers that he knows when to seek hospital readmission. He regards hospital readmission as a last resort and only when he is unable to manage the exacerbation by himself.
P12C131	About three to four years ago, I returned back to hospital right after discharge. Now I can bear it (breathlessness) more. The doctor gives me some steroid medications. If I find my condition is not that serious, I take the steroid medication at home. I take the steroid medication for a week. After taking the medication for a week, my condition is more stable for one week. Then, I'm only suffered from severe shortness of breath about once a month. / I remember in 2008, I was (re)admitted to hospital for 8 times. / When the wheezing becomes	Chi Kin states that he has been readmitted to the hospital soon after discharge in the previous three to four years. He describes that he has been more able to bear breathlessness in the recent years. A doctor has prescribed steroid medication for him. He takes the medication at home to relieve the symptoms when his physical condition is not critical. He takes the medication for a week, and his physical condition stabilizes for a period. Chi Kin states that he only experiences severe breathlessness about once in a month. Chi Kin recalls that he was readmitted to hospitals for 8 times in 2008.	Chi Kin perceives that he is more able to bear breathlessness and he has learned to manage the disease in the recent years. He takes medications at home in an attempt to refrain from hospital readmission. Chi Kin considers that he has fewer hospital readmissions in the recent years because he has attempted to manage breathlessness. However, he also perceives that hospital readmission is necessary to relieve unbearable breathlessness.

	sever, you can’t deal with it.	Chi Kin describes that it is so distressing to him when breathlessness becomes severe. He explains that he cannot resolve the situation by himself in such cases.	

Determining the Structure

This process determines the essence or the general structure of a lived experience (Giorgi, 1985). The transformed meanings of each participant were then clustered and synthesized into themes of an individual experience (Beal, 1993; Hein & Austin, 2001). An example of integrating the transformed meanings from Chi Kin's narrative descriptions into a theme is provided in Table 3.

Table 3

Clustering of transformed meanings into a theme

Participant	Descriptions	Third-person expressions	Transformed meanings	Theme
P12C84	I could barely breathe! After a bath, I began to wheeze. I knew it, I got used to it. Every time after a bath, I begin to wheeze. So I sit down slowly and dare not move. I need the inhaler. After taking the medication, wait for the symptoms to go. / I won't dial the emergency number at once. Definitely, I won't. Only if shortness of breath continues, I call emergency room. / This happens... nearly every day, how do I return to hospital every time?	Chi Kin states that he experienced severe breathlessness after bathing. He knew that he would suffer from breathlessness after bathing because he had got used to such situation. He sat down slowly and stayed still. At that moment, he needed an inhaler to relieve the breathlessness. He then used the inhaler and waited for the symptoms to be resolved. Chi Kin asserts that he would not seek emergency care once he suffers from breathlessness. He explains that he calls an ambulance to send him to the emergency room only when the breathlessness could not be relieved. Chi Kin expresses that he experiences breathlessness from activities, which happens nearly every day. He considers that it is unreasonable to seek emergency care for every episode of breathlessness.	Chi Kin frequently suffers from breathlessness from daily activities. He has gotten used to such situations and he is familiar with methods of relieving breathlessness. He adopts self-management strategies to avoid hospital readmission.	Bargaining with readmitting to hospital using self-management methods
P12C88	I have to manage it (breathlessness) myself.	Chi Kin states that he has to manage breathlessness by himself. He	Chi Kin considers that he has to manage the disease by himself.	

	Take breath (pursed-lip breathing), do not move, take a few puff (of inhalers). Sit down and wait for about 10 minutes, it (breathlessness) will subside. I know what to do. / If the situation is very poor … I can't take a bath, can't move a bit. I even can't walk a few steps. When I can't bear it (breathlessness) and can't leave my home, I have to call an ambulance. / Sometimes, I go to a tea house. When I really feel difficult to breathe and can't tolerate it, I leave the tea house and take a taxi to a hospital. / That's what I can do. I know my body. If I am not feeling that suffering, I won't go to the hospital.	performs pursed-lip breathing, stays still, uses inhalers, sits for a while, and waits for breathlessness to be relieved. Chi Kin expresses that he cannot take a bath, move and walk when he is suffering from severe distress. He calls an ambulance to send him to the hospital when he cannot tolerate the distress and is unable to leave the house. Chi Kin mentions that he sometimes goes to a tea house. During the meal, he suffers from breathlessness. He leaves the tea house and takes a taxi to the hospital when he is unable to tolerate breathlessness. Chi Kin states that those are the strategies he uses to manage breathlessness. He asserts that he knows about his body well. Chi Kin affirms that he does not seek emergency care unless he is very much distressed.	He adopts some self-management methods to relieve breathlessness and refrain from seeking hospital readmission. Chi Kin considers that he knows when to seek hospital readmission. He regards hospital readmission as a last resort and only when he is unable to manage the exacerbation by himself.	
P12C131	About three to four years ago, I returned back to hospital right after discharge. Now I can	Chi Kin states that he has been readmitted to the hospital soon after discharge in the previous three to four years. He describes that he has been	Chi Kin perceives that he is more able to bear breathlessness and he has learned to manage the disease in the recent years. He takes	

	bear it (breathlessness) more. The doctor gives me some steroid medications. If I find my condition is not that serious, I take the steroid medication at home. I take the steroid medication for a week. After taking the medication for a week, my condition is more stable for one week. Then, I'm only suffered from severe shortness of breath about once a month. / I remember in 2008, I was (re)admitted to hospital for 8 times. / When the wheezing becomes sever, you can't deal with it.	more able to bear breathlessness in the recent years. A doctor has prescribed steroid medication for him. He takes the medication at home to relieve the symptoms when his physical condition is not critical. He takes the medication for a week, and his physical condition stabilizes for a period. Chi Kin states that he only experiences severe breathlessness about once in a month. Chi Kin recalls that he was readmitted to hospitals for 8 times in 2008. Chi Kin describes that it is so distressing to him when breathlessness becomes severe. He explains that he cannot resolve the situation by himself in such cases.	medications at home in an attempt to refrain from hospital readmission. Chi Kin considers that he has fewer hospital readmissions in the recent years because he has attempted to manage breathlessness. However, he also perceives that hospital readmission is necessary to relieve unbearable breathlessness.	

The researcher examined the themes and synthesized them to form the possible constituents of the lived experience of hospital readmissions among older people. An example of synthesizing the constituent of "resigning to hospital readmissions" across the participants is provided in Table 4. In this example, one meaning unit us extracted from each participant for the purpose of demonstrate the process of data analysis. Imaginative variation was applied to determine the most invariant constituents that are essential to account for the experience (Giorgi, 1985). The researcher imagined a constituent that was removed from the experience and examined if the expression was changed or collapsed. When the expression was collapsed through this manipulation, the researcher identified the constituent as an invariant constituent. The determination of invariant constituents is further elaborated in the chapter on findings. The general structure was synthesized by examining the meaning of each invariant constituent to the experience and the relationships that connecting to the other constituents. The researcher then described the general structure with the relationships among the constituents highlighted and articulated the meanings of each constituent.

Table 4

Synthesis of the constituent "resigning to hospital readmissions"

Participant	Descriptions	Third-person expressions	Transformed meanings	Theme
P1C670	It (COPD) keeps getting worse. I'm getting old. I understand my situation. I don't have energy and my body is deteriorating.	Ka Keng perceives that his physical condition is gradually deteriorating due to aging. He considers the deterioration is a result of lack of physical strength.	Ka Keng experiences physical deterioration. He believes that his physical condition is gradually impaired with aging.	Perceiving a sense of powerlessness to physical deterioration
P2C444	Well, things are beyond our control, it's fate! I hope I'd better not come (to hospital), right? That's what I think. The point is, can I do that? Not necessarily.	Wai Fat believes that hospital readmission is destined by the powerful others. Although he considers that it would be good of not requiring hospital readmission, he believes this is impossible.	Wai Fat believes that he is lack of control over hospital readmission as this is destined. So, he is prepared that hospital readmission continues to happen.	Attributing hospital readmissions to fate
P3C286	It's getting worse and may never be cured. Just lessened, right? Just try to go to the hospital fewer times. The doctors have told me that this disease (COPD) can never be cured. There is no way out. Only gets worse and can never be cured!	King Tai believes that the disease will only get worse but it won't improve. He could only hope for being readmitted to hospital less. King Tai adds he learned from the doctors that his disease would only get worse instead of having any improvement.	King Tai learns from the doctors that he is unable to restore his health. He is prepared for being readmitted to hospital repeatedly.	Preparing to be readmitted to hospital repeatedly
P4C412	No, I don't think about not requiring hospital (re)admission. I know, I	Mei Fung states that she knows her physical condition and how the disease is progressing. She does not	Mei Fung understands her condition and the disease progression. She believes hospital	Perceiving hospital readmission as unavoidable

	know my body and I know how my disease is going.	consider that she would not require hospital readmissions.	readmissions are unavoidable in her situation.	
P5C124	I can't deal with this (hospital readmissions). When people reach my age, it's common to have different kind of illness. I know about this. People are frail when they come to 70s.	Tung Nam believes that he could not prevent from hospital readmissions. He realizes that people at his age or aged over 70 would become frail and have different diseases.	Tung Nam perceives powerlessness to hospital readmissions. He attributes hospital readmissions to physical deterioration resulted from aging.	Perceiving a sense of powerlessness to physical deterioration and hospital readmissions
P6C352	There's no solution for this problem (hospital readmissions). Those doctors can only control my condition. This disease can't be cured.	Hang Kei believes that there is no solution for hospital readmissions. Doctors can only relieve his symptoms but not treat the disease.	Hang Kei understands COPD is incurable. Doctors only alleviate the symptoms but they cannot provide meaningful support to avoid hospital readmissions.	Perceiving helpless to hospital readmissions
P7C156	I looks fine, likes a normal person. People don't know I have any illness… But when I use effort, I start to wheeze. I may require hospital care again.	Kam Ching states that he appears as a healthy person. People do not realize that he is a COPD patient. However, when he exerts effort, I suffered breathlessness when he might require hospital readmission.	Kam Ching believes that his disease is not recognized by others. But he his condition fluctuates easily which requires hospital readmission.	Experiencing unstable condition of COPD
P8C38	I am 80. Nothing can help when a person is getting old. That's the fact, right?	Tat Cheung states that he is 80 years old. He considers it is the fact that there is no way to help an older person.	Tat Cheung conceives that he is powerlessness to his health as related to aging.	Perceiving a sense of powerlessness to control own health
P9C264	I can't deal with this (hospital readmissions). Everyone is ill when they get old. When people get old, all kinds of diseases	Yah Man mentions that he is incapable to deal with hospital readmissions. People suffered from disease when they become old. He emphasizes that people have	Yah Man normalizes hospital readmissions to aging which he is out of control.	Normalizing hospital readmissions to aging

	come, all kinds of diseases	different disease when they get old.		
P1C129	What can I think of? Nothing should be a concern. I'm in bad luck, so I'm here (hospital). When I'm not feeling well, I should return here (hospital) again. There is no other choice.	Ying Kong believes that nothing he should be concerned. He is readmitted to a hospital because of his bad luck. When he feels unwell, he has to be readmitted to a hospital without other choice.	Ying Kong attributes hospital readmissions to misfortune.	Attributing hospital readmissions to misfortune
P11C10	In that time, it wasn't that serious. Now, it is getting worse each year. Every lung patient experiences the same condition. It gets worse each year and won't get better.	Yat Lam recalls that his physical condition was not as poor in the beginning. But, he observes that his condition has been deteriorating every year. Yat Lam believes that the physical condition of people with lung disease deteriorates year by year and that they do not improve with time.	Yat Lam experiences that his physical condition has been deteriorating gradually. Yat Lam believes that physical deterioration is inevitable for him.	Resigning to the nature of COPD
P12C147	Everyone (COPD patients) knows about such situation. For this disease, we (COPD patients) stay at hospital for a few days. When the wheezing stops, we are discharged from hospital. Many patients have similar experience. We stay for one to two months if the disease becomes more severe.	Chi King states that every COPD patient knows how the disease progresses. Patients are hospitalized for a few days for exacerbation. Then they are discharged to home when the dyspnea subsided. Chi Kin observes that many patients undergo a similar process. If the physical condition is severe, patients are hospitalized for one to two months. Otherwise, patients are hospitalized for a few days.	Chi Kin normalizes the happening of revolving between hospital and home for COPD patients.	Normalizing hospital readmissions for COPD patients

	Otherwise, we stay for a few days. Then, we are discharged.			
P13C274	I don't bother about it (hospital readmissions). I come to hospital when I feel unwell. I don't think too much. That's out of my control.	Hoi Fai states that he does not bother about the happening of hospital readmissions. He seeks hospital readmission when he feels unwell. He does not think too much about hospital readmission because this happening is out of his control.	Hoi Fai reconciles to the need of hospital readmission which he believes as out of his control.	Being reconciling to the need of hospital readmissions
P14C328	The doctors told me before that I would keep having breathing problem… He asked me to take more rest after being discharged to home. If anything goes wrong, attend the emergency department again. That's what the doctors told me.	Some doctors told Kwok Hing that he would persistently suffer the breathing problem. They advised him to have more rest after hospital discharge. When he experiences disease exacerbation, he has to attend the emergency department.	Kwok Hing understands from some doctors that the respiratory problem would persistently exist. He is prepared for readmission for any respiratory distress.	Preparing for continuing hospital readmissions.
P15C132	For hospital (re)admission, I have used to being back-and-forth between hospital and home. I don't care about it. I know I have to face it.	Yuen Tak states that he is used to being back-and-forth between hospital and home. He does not care about hospital readmissions. He understands that he has to confront with it.	Yuen Tak perceives that he is accustomed to revolving between hospital and home. He positively accepts hospital readmissions.	Positively accepts hospital readmissions
P16C129	I'm prepared for (re)admitting to hospital. Sometimes, I'm (re)admitted after one to	Pak Fung mentions that he is prepared for readmitting to hospital after discharge. He recalls that he was readmitted to hospital after one	Past experience of frequent hospital readmissions makes Pak Fung to be prepared for hospital readmission after discharge.	Preparing for continuing hospital readmissions

	two months of discharge. Sometimes, it only takes one to two weeks. At the very beginning, I'm (re)admitted to hospital after a few days.	to two months of discharge. Sometimes, he was readmitted to hospital after one to two weeks of discharge. In the early period, he was readmitted to hospital after a few days of discharge.		
P17C36	The doctor said he couldn't help to treat my illness and reduce hospital (re)admission. Of course, there's no solution for chronic lung disease. He said he couldn't help, just don't let the disease deteriorate. I know there's no way to recover.	Yiu Pan recalls what a doctor told him. The doctor could not treat his disease and reduce hospital readmissions for him but only control the disease progression. Yiu Pan understands that his chronic lung disease is incurable.	Yiu Pan understands his condition from the doctors that his chronic lung disease is incurable. Hospital readmissions become unavoidable.	Perceiving hospital readmission as unavoidable for COPD patients
P18C294	I have to accept it (hospital readmissions), right? If I'm diagnosed with cancer, I also have to accept it. I have no way out of my illness (COPD). I get used to be here.	Hiu Ming believes that he has to accept hospital readmissions. That likes if he is diagnosed with cancer, he has to accept it. Hiu Ming finds that he cannot recover from COPD. He states that he gets used to hospitalization.	Hiu Ming perceives that he needs to accept hospital readmission resulted from an incurable disease. Hiu Ming is accustomed to hospital readmissions.	Resigning to hospital readmissions
P19C189	I have accepted (re)admissions for my illness (COPD). I am too old, I don't have alternative. I don't grumble about it.	Yau Ming states that he has accepted hospital readmissions for COPD. He considers that he is old without alternative. He adds that he does not grumble about hospital readmissions.	Yau Ming is resigned to hospital readmissions. Yau Ming feels powerlessness to aging.	Resigning to aging and hospital readmissions
P20C172	I'm prepared for this (hospital readmissions),	Lai Kune states that she is prepared for requiring hospital readmissions.	Lai Kune is prepared for continuing hospital readmissions	Preparing for continuing hospital

	I'm prepared for coming back (to hospital)… Once I wheeze, it's really difficult to breath and suffering.	When the disease exacerbates, she has breathing difficulty which she feels suffering.	because of the unstable nature of COPD.	readmissions for the unstable nature of COPD
P21C266	My body only gets worse but won't improve. Only gets worse without improvement. That's what I expect. Only becomes weak. I don't have method for this. I am getting old, I can't help.	Siu Lam states that her physical condition keeps deteriorating without improvement. She emphasizes that she anticipates his condition would become worse. Siu Lam believes that she cannot avoid physical deterioration because of aging.	Siu Lam believes that physical condition must deteriorate with aging. She conceives that his health cannot be restored.	Perceiving the health cannot be resorted with aging
P22C258	For this kind of lung disease, it's incurable. It's fluctuates with the weather. When I have flu, I wheeze and (re)admit (to hospital) again. I can't avoid it.	Siu Mui believes that COPD is incurable. Her physical condition fluctuates with weather change. When she has flu, he suffers breathlessness which she requires hospital readmission. Siu Mui considers that she cannot avoid such happening.	Siu Mui understands that COPD is incurable. She feels helpless to the unstable nature of COPD. Exacerbation is easily triggered and hospital readmission is required.	Perceiving hospital readmission as unavoidable because of the nature of COPD

Trustworthiness

Phenomenology, which is founded on philosophy, does not provide any definite criteria to appraise the research process or findings. Adopting conventional methods used in quantitative studies is certainly problematic because of the discrepancy in the purposes and assumptions between two different paradigms (Leininger, 1994). Referring to the aim and outcome of phenomenological inquiry, this approach intends to understand human's experience and to describe the experience in the form of a general structure. Therefore, the appraisal of the trustworthiness of a phenomenological study has two major focuses: methodological and experiential issues (Pollio, Henley, & Thompson, 1997). Methodological issues assess the rigorousness and appropriateness of the inquiry methods, whereas experiential issues require the findings to be plausible and illuminating. A reciprocal relationship can be drawn on the methodological issue and experiential criteria, "the more rigorous and appropriate the methodology, the more plausible and illuminating the results are likely to be" (Pollio et al., 1997, p. 55).

A rigorous phenomenological study should demonstrate methodological coherence (Rose, Beeby, & Parker, 1995). According to Creswell (2007), a quality phenomenological study should state the phenomenon under study clearly, show understanding of philosophical tenets, adopt methods of data analysis specific to phenomenology, and have a reflexive researcher. A faithful description of the lived experience also determines the trustworthiness

of a phenomenological study (Beck, 1993). Phenomenology does not acquire a reality claim. Therefore, trustworthiness does not depend on the correspondence between participants' descriptions and the reality, but on convincing evidence that the findings offer insights into the participants' experiential world (Pollio et al., 1997). Polkinghorne (1989) explains that the meaning of validity in a phenomenological study refers to the following question: "Does the general structural descriptions provide an accurate portrait of the common features and structural connections that are manifest in the examples collected?" (p. 57). In other words, the findings should truly present the experience from the participants' perspectives and be capable of accounting for an example of the experience.

In this study, trustworthiness was guided and monitored by the four criteria given by Lincoln and Guba (1985): credibility, transferability, dependability, and conformability. These criteria were adopted not only because they are originally proposed to appraise the quality of qualitative studies but also because they can address the two major issues concerning the quality of a phenomenological study as mentioned above. Descriptions of and the strategies adopted in each criterion were depicted as follows.

Credibility

Credibility refers to a researcher's degree of confidence in the established findings (Lincoln & Guba, 1985). For a study that is credible, persons who have the experience under

study would recognize themselves in an accurate description (Sandelowski, 1986). This recognition is also called phenomenological nod, which indicates that people nod to show their agreement when they read a description (Munhall, 1994).

A faithful description of older people regarding hospital readmissions was attained by observing the methodological coherence in this study. The researcher reflected on personal presuppositions on the research topic and withheld the understandings into brackets to remain aware of the preconceived ideas to avoid influencing the findings of this study. Unconscious influences were further minimized by reflexively evaluating personal understandings and insights gained on the topic throughout the research process. To ensure that the researcher was widely exposed to the phenomenon, participant recruitment and interviews were continued even after data saturation appeared to have been reached. The researcher purposively recruited more female older people in the subsequent interviews to assure that new information could no longer be obtained from the older people to prevent premature closure of data collection. Atypical experiences were also obtained in the interviews, which further convinced that the researcher was fully exposed to the experiences of hospital readmissions among older people. The interviews were audio-recorded to provide accurate records of participants' descriptions. The researcher also sought expert advice on the methodology, data analysis, and findings from the supervisor to enhance the credibility.

Transferability

The extent to which the findings can be applied to other groups of people or context is reflected by transferability (Lincoln & Guba, 1985). A feature of qualitative approach is conducting a study in a naturalistic setting; thus, the fittingness of findings is determined by the degree of similarity between two contexts (Krefting, 1991). The current study was conducted among Chinese older people with COPD in Hong Kong. Although the severity of COPD was not assessed among the older people, their diseases were not in an advanced stage so that they were physically fit to participate the interviews. Therefore, it is possible to transfer the findings of this study to COPD patients living in a similar context.

Given that readers are also responsible for determining the fittingness of findings if they transfers the findings to another setting; thus, the researcher is responsible for providing a detailed description of the study for comparison (Lincoln & Guba, 1985). In this study, detailed descriptions of the setting, sampling method, data collection procedure, data analysis method, and findings were provided for scrutiny. The justifications supporting the decisions in each stage were stated clearly. The detailed description enables other readers to determine the transferability of the findings on Chinese older people's lived experience of hospital readmissions to other contexts.

Dependability

The third criterion, dependability, refers to the consistency of findings in qualitative studies (Lincoln & Guba, 1985). Dependability is often analogized as reliability in quantitative approach. Replication of findings, however, is limited to qualitative studies that are conducted in an unstructured environment and highlight learning from participants instead of controlling variables on them (Krefting, 1991). Therefore, variation in experience is expected and is sought in qualitative studies (Giorgi, 1971). Lincoln and Guba (1985) use auditability to judge the consistency of qualitative findings. Following a decision trail, other researchers could come to similar or comparable findings. Detailed descriptions from how the researcher identified the phenomenon of hospital readmissions as a topic of study to how the researcher unfolded the experience and presented the findings were explicitly described in this study. Examples of preliminary data analysis are provided in Appendix E.

Confirmability

Confirmability is interpreted as neutrality. This criterion represents the degree to which the findings are grounded on participant descriptions rather than researcher's own motivations and perspectives (Lincoln & Guba, 1985). Maintaining methodological consistency with bracketing and reflexivity strengthens the confirmability of this study. The raw data are the starting point of interpretation, such that the researcher verified the accuracy

of transcriptions to preclude any discrepancy from the actual descriptions and to avoid distortion in subsequent analysis. During the process of data analysis, the researcher iterated between the data and the emerging insights to affirm that the findings were grounded on and supported by the older peoples' descriptions. The findings were presented with the older peoples' verbatim accounts as low inference descriptors. The quotes enable others to compare the older people's actual descriptions with the researcher's interpretation.

Protection of Human Rights

The Joint CUHK-NTEC Clinical Research Ethics Committee granted the ethical approval to this study (Appendix F). The hospital involved in this study is situated in the Kowloon East Cluster, and thus, ethical approval was also sought from the Kowloon East Cluster Research Ethics Committee (Appendix G). The researcher then obtained approval from the hospital and gained access to the pulmonary wards.

Before each interview, the researcher explained to the older people that participation in this research was voluntary and would not affect the care and treatment received in the hospital. They had the right to refuse answering any question asked by the researcher or withdraw from this study at any time. A possible risk in this study was that the older people might feel distress about discussing their experiences of hospital readmissions. They would be referred to counselling service if they were in need. Confidentiality was also ensured. The

researcher assigned a pseudonym to each participant, and only the pseudonym was used in the transcript and the thesis. The participants could ask any question regarding the research at any time. They were informed that the interviews would be audio-recorded. Before giving their consent to participate, they were given enough time to clarify any concerns.

An information sheet stated with the purposes, procedure of the study and the above mentioned rights were given to the eligible participants in Chinese version. Consent was then signed by the participants to show their agreement. English version of the information sheet and consent form is attached as Appendix H and I, whereas Chinese version is attached as Appendix J and K respectively. The consent forms, interview records and identification list of the participants were stored in a locked cabinet and were only accessible by the researcher.

Summary

This chapter reviews the development of phenomenology and the major philosophical underpinnings of this methodology. It justifies the use of descriptive phenomenology to uncover the experiences of hospital readmissions of Chinese older people with COPD. This chapter provides a thorough description of how the philosophical underpinnings of phenomenology guided the research process from sampling of older people to monitoring the trustworthiness of the findings. The general structure and the constituents of the lived experience regarding hospital readmissions are presented in the next chapter.

CHAPTER FOUR

FINDINGS

Introduction

This chapter describes the lived experience of hospital readmissions of Chinese older people with COPD. The experience was revealed from 22 Chinese older people. Before depicting the experience, a brief individual description about the experience of hospital readmissions of each older people is presented. The general structure of hospital readmissions derived from the narrative descriptions of these Chinese older people is followed. It provides a holistic view of the experience. From the general structure, six constituents in the experience of hospital readmissions were identified and each constituent is then delineated. These constituents illustrate what the experience of hospital readmissions is, why older people are readmitted to hospital and how older people live with their experience.

Portraits of the Chinese Older People

The narrative descriptions of experience of hospital readmissions were given by the 22 Chinese older people, including eighteen males and four females. The characteristics of the older people are listed in Appendix A. These older people aged from 62 to 89. They were readmitted to a hospital from four to fourteen times in the previous year. Seventeen older

people were married and lived with family. The wives were their primary caregivers, except three married older people were cared for by a maid. One older individual was a widower and lived alone. Two older people were widows. One of them was looked after by a maid and another one lived with her older daughter. The remaining two older people were single, one of them lived alone and the other one lived with his younger brother. Regarding their education level, only one older people studied at the tertiary level. Majority of these older people received education at primary level and the rest were illiterate. For the religious belief, three of them had religious belief in Buddhism, one in Christianity, and one in Catholic. The other older people did not have any formal religious affiliation but six of them worshiped their ancestors.

Individual Descriptions

The following individual descriptions of the 22 older people provide an overview of their experiences of hospital readmissions. The overview familiarizes readers with the older peoples' experiences prior to understanding the lived experience of hospital readmissions. To ensure confidentiality, Chinese pseudonyms are assigned to each individual.

Participant 1: Ka Keng

Ka Keng was a 79-year-old male living with his wife, who is a Thai and is younger

than him by approximately 30 years. After his parents died when he was young, he went to Thailand to make a living and married there. Ka Keng settled with his wife back in Hong Kong about 30 years ago, but his son and daughter still live in Thailand.

Ka Keng was familiar with what circumstances triggered breathlessness, such as stuffy environment or changes in weather. He complained about experiencing shortness of breath easily in daily activities. In such moment, he stopped his activities immediately and performed pursed-lip breathing to relieve the breathing difficulty. But when he failed to ease his breathing and the distress got worse, he submitted to seek hospital care as the only option to alleviate the distress.

Ka Keng was readmitted to the hospital nine times in the previous year. Every time he stayed in the hospital, Ka Keng perceived a sense of purposelessness without meaningful activities. To maintain alertness and occupy his time, he used paper towels to record in Thai the medications and meals he took. When Ka Keng was readmitted to the hospital, his wife visited him on alternate day. However, he preferred that his wife went on with her daily routines rather than visited him daily because he thought that his wife was still young and should not stop enjoying her life just because he was ill. In his previous hospital readmissions, Ka Keng became acquainted with hospital staff, including nurses and paramedic. Being a patient, he believed that he was expected to maintain a harmonious relationship with the staff. Yet, he was frequently questioned by the doctors regarding his

frequent admissions to the hospital because they doubted his frequent need for hospital care in relieving physical distress. Sometimes, the doctors discharged him even when he was not ready to go home. He followed the discharge order because he believed that he lacked authority in making discharge decisions but the doctors did. Thus, he followed the discharge order but was prepared for readmission soon.

Following hospital discharge, Ka Keng maintained mild exercise within his limitation though he found his physical strength was declining with the disease. Ka Keng expressed that he was used to alternating between the hospital and home. His neighbour even mistook him for having died because he had been hospitalized for long and had been discharged for only a few days before being readmitted to hospital.

Ka Keng believed that his lung had been impaired when he was young. He attributed his lung disease to a working environment with poor ventilation, where he breathed in much exhaust gas. In addition to the perceptions of aging and lack of medication could effectively control his lung disease, he realized that his physical health would keep deteriorating. Thus, worrying about frequent hospital readmissions was worthless. Instead, he was content with his basic needs, such as eating and sleeping, being sufficiently met at the hospital. Moreover, he was still alive, whereas several other patients with respiratory diseases, whom he knew at hospitals, had died.

Participant 2: Wai Fat

Wai Fat was a 73-year-old male cared for by his wife. He was readmitted to the hospital seven times in the previous year. A few years ago, Wai Fat experienced severe respiratory distress and was resuscitated at an Emergency Department. He was saved through intensive treatment at the hospital. After that critical admission, Wai Fat seldom left his house because he feared being unable to seek help during a dyspneic attack. Wai Fat's wife, therefore, always stayed with him so that she could provide help whenever he was in distress.

Wai Fai admitted that hospital readmission was necessary because only the medical treatment at the hospital could effectively relieve his physical distress. Wai Fat felt safe at the hospital because he could seek help from staff and obtain treatment whenever he experienced breathlessness. Besides, when he was readmitted to the hospital, his wife could flexibly manage the housework and arranged her activities. Thus, he considered readmission could alleviate her stress from caring duties. During his hospitalization, Wai Fai considered he should respect the hospital staff and avoid any inconvenience to them. There was once he requested continuing hospitalization for one more day before discharge. He was frustrated with being refused by his doctor with poor attitude.

After hospital discharge, Wai Fat rode an aerobic bike at home to maximize the opportunity to exercise and manage his lung disease. He also walked around the yard path outside his house, but he had to carry a safety alarm with him so that he could call the

emergency service in case of a dyspneic attack. Observing other patients who were admitted to hospital for respiratory problems and requiring intensive treatment, Wai Fat realized that having an unstable physical condition was common among people who had lung disease. He also knew that his health was deteriorating because of his aging. In addition, he believed hospital readmission was out of his control because what he encountered had been predestined. Still, Wai Fat strived to live with his deteriorating health condition. As he got older, he did not have many expectations about his life but was satisfied with being able to eat well and be satiated.

Participant 3: King Tai

King Tai was a 75-year-old male living with his wife and granddaughter. In the previous year, King Tai was readmitted to the hospital six times, four of which occurred within half a year. During the early stage of his lung disease, King Tai followed up on the state of his disease from a private practitioner. As the disease worsened, the practitioner advised him to seek care at hospitals, where he could obtain potent medications.

King Tai agreed that hospital treatment to be more effective in relieving his respiratory distress and in stabilizing his condition. He was satisfied with the well-equipped hospital setting and being able to meet his basic needs at the hospital. Yet, he did not feel secure in continuing hospital care because it depended on the availability of hospital beds. At

the hospital, King Tai required some activities to maintain alertness. He disliked staying in the bed all day and preferred to walk outside the ward. He informed the nurses before leaving the ward to avoid troubling them in case he suffered a dyspneic attack outside the ward. King Tai also mindfully minimized burdening his family with his hospital readmissions. After having surgery on a lower limb, his wife had difficulty visiting him at the hospital. King Tai also did not allow his children to come to the hospital because doing so would occupy their time, particularly he could still independently care for himself.

King Tai was proud of fulfilling his responsibility as a father and of the way he had brought up his children. When he was young, he anticipated the inevitable deterioration of his health during old age. Learning from his doctor that his lung condition would gradually deteriorate and no longer improve, King Tai was prepared for readmitting to hospital repeatedly. In addition to unstable nature of COPD, he was prepared for readmission soon after being discharged. Although he believed that physical deterioration was unavoidable, he considered himself was responsible for his health, and for his hospital readmission. He followed the advice of doctors to quit smoking and to exercise within his physical limits to delay physical deterioration which required hospital readmission. Whenever he suffered from breathlessness, he adopted pursed-lip breathing in an attempt to control the distress and to avoid unnecessary hospital readmission. However, he felt the distress was so afflicting when it continued. Therefore, he was necessary to seek hospital readmission to relieve and survive

his distress. Although King Tai considered himself did not have much control over hospital readmission, he regarded seeking hospital care as a positive approach to manage his lung disease.

Participant 4: Mei Fung

Mei Fung was a 78-year-old female cared for by a maid at home. She was readmitted to hospital six times in the previous year. At home, she stayed inactive to avoid inducing shortness of breath. When she experienced breathing difficulty, she tried using medications to relieve the distress. However, she considered hospital care to be necessary when the distress did not subside.

After receiving treatment at the hospital, Mei Fung was relieved to survive the respiratory distress. However, she was often frustrated that she did not receive attention from the hospital staff and she complained of developing complications from staying at the hospital. At home, she could walk around and urinate on a commode chair, but in hospital, she had to stay in bed and was put on diapers by the hospital staff. Sores were then developed on her back, and she experienced pain, particularly during wound dressing.

Mei Fung realized that her family was occupied by their work and study. In addition to the high transportation expenses and the danger of leaving the hospital after visiting hours at night, Mei Fung did not require her daughter to visit her frequently at the hospital. Yet, she

appreciated their visits during weekends. Mei Fung knew from a doctor that her lung disease deteriorated with each hospital readmission. Therefore, she wore religious accessories to pray for relief from her physical suffering at the hospital. The doctor's explanation also made her to expect that she would ultimately not survive hospital readmission. Although she was prepared not to survive before being discharged one day, she worried neither about being readmitted to hospital nor about dying from her lung disease. Instead, Mei Fung was most concerned about leaving her family if she passed away.

Participant 5: Tung Nam

Tung Nam was an 84-year-old male cared for by his wife. He was an accountant in a large-scaled Chinese company, which he supervised thousands of staff. He witnessed the Cultural Revolution and he came to Hong Kong in the late 1960s. He then started a business and ran it successfully.

Tung Nam was readmitted to the hospital seven times in the previous year. He was concerned with his personal needs were not met at the hospital because only his family at home understood and met his needs. He was also frustrated about being required by physiotherapists to exercise, which demanded on and distressed him. Still, Tung Nam was submissive and followed the orders given by hospital staff.

During Tung Nam's stay in the hospital, his wife visited him regularly, but he strongly

refused his son coming to hospital and visiting him. He would rather have his son spend time studying. Tung Nam found that he became weak as time went by. He then came to realize that people become frail with age. However, he was happy about being alive because only few people live to 70 years.

After being discharged from the hospital, he was not concerned about possible hospital readmission because he believed that it was unpredictable and that thinking about it would be a waste of time. Restricted by limited physical strength, Tung Nam stayed inactive at home to prevent exertion. He was impressed by an experience that he was suffered from severe dyspneic attack and required resuscitation at the hospital. He survived the respiratory distress but was in a coma for a long time. After that critical incident, he was confident to the emergency care and he sought emergency care when he experienced respiratory distress.

Participant 6: Hang Kei

Hang Kei was a 79-year-old male who took care of his wife at home. He was readmitted to the hospital six times in the previous year. Realizing his lung disease was unstable and experiencing breathlessness easily, Hang Kei always brought an inhaler with him. Still, he perceived a necessity to go to hospital for survival when the respiratory distress was severe. At the hospital, Hang Kei also perceived a sense of powerlessness to hospital staff. He had to follow the requirements of hospital staff. He was even put at risk by several

incompetent staff who carried out invasive procedures on him. During his hospital stay, Hang Kei could only stay in the bed. At home, he could do housework and go to the wet market to buy food.

Hang Kei was initially full of uncertainty regarding his health and hospital readmission. But then he came to realize hospital readmission was unavoidable. His frequent hospital readmissions drew the attention of his neighbour and they mistakenly thought that he had an infectious disease. Indeed, Hang Kei attributed his hospital readmissions to the stimulants released from his neighbour. He requested reallocation from the Housing Authority but he failed to receive special arrangement. Hang Kei's outlook regarding his lung disease became negative when his condition did not improve even after receiving treatment for a long time. Nonetheless, his duty to care for his wife gave him a positive outlook on his life. His wife was 10 years older than him and had difficulty in walking. Thus, he was frustrated about she had visited him regularly at hospital during his readmissions. In addition, Hang Kei was disappointed to himself being limited to look after his wife in the recent hospital readmission. During this period, his wife fell at home and could only yell to the neighbour for help. She was then admitted to a hospital and Hang Kei learned about her condition merely from his brother-in-law. He looked forward to being discharged from the hospital so that he could take care of his wife again. Although being retained in the hospital, Hang Kei still thought about the needs of his wife over his.

Participant 7: Kam Ching

Kan Ching was a 61-year-old male, who lived with his wife and daughter. He was readmitted to the hospital 10 times in the previous year and he had monthly follow-up for his lung disease at the hospital. Thus, he went to the hospital more than 20 times in a year and believed that he was on a "black list of hospital readmissions." A few years prior, Kam Ching had follow-up and hospital readmissions at another hospital. He was prescribed three inhalers, but those hospital staff did not inform him about the indications of the medications. He attributed frequent hospital readmissions to the lack of knowledge about the medications, which he therefore took in inappropriate amounts. In the present hospital, the staff taught him how to use the inhalers, so he was readmitted less frequently in recent years.

For Kam Ching, even mild movement easily triggered breathlessness. During a dyspneic attack, he tried using pursed-lip breathing and drank a glass of warm water to ease his breathing. He knew when he required hospital readmission because he considered himself had lived with the disease for a long time and knew much about the disease. Kam Ching once suffered from breathlessness on a street, but nobody helped him because people thought he was a drug addict. After that experience, he did not use a safety alarm to avoid misusing medical resources and letting his neighbour knew that he called for emergency service. To save face, he did not let other people knowing that he had been sent to hospital by taking a taxi to hospital by himself. On the taxi, Kam Ching reminded himself that he should relax and

that he would be safe once he arrived at the Emergency Department.

During hospitalization, Kam Ching worried that prolonging his hospital stay would increase the risk of getting cross infection; and thus worsened his lung disease. He was also concerned that his family would be infected if they visited him at the hospital. Also, hospital visit would cost their time and money. At the hospital, he was once frustrated about his early discharge by a doctor. Kam Ching believed that he knew his disease better than the doctor. However, he was reluctant to make request from the doctor. Thus, he followed the discharge order, but he was prepared for readmitting to the hospital soon.

In his first few hospital readmissions, Kam Ching was worried of being blamed by doctors for frequent readmissions. After being readmitted for more times, he became apathetic and accustomed to it. Kam Ching believed that only he could help in reducing hospital readmission but not depending on others. He knew exercise was good for him, so he maintained exercise but his motivation was affected when his physical condition was poor. He also followed his doctor's advice to quit smoking, hoping to reduce hospital readmission. Kam Ching was happy about having a good appetite after stopping his unhealthy habit.

Participant 8: Tat Cheung

Tat Cheung was an 80-year-old male who was readmitted to the hospital eight times in the previous year. He was independent and lived with his wife. For his lung disease, Tat

Cheung attended a general practitioner when he could afford it. He found the medications prescribed by the practitioner were more effective in relieving his respiratory distress. Thus, Tat Cheung did not take the whole course of medications and saved them in case of breathlessness. Yet, he could not afford attending the general practitioner every time he suffered from respiratory distress.

Every four months, Tat Cheung followed up on his lung disease at a public hospital. Before a follow-up appointment, however, Tat Cheung required hospital readmission for a dyspneic attack. The breathlessness was so distressing and intolerable that he considered emergency care as necessary and thus prioritized it. When his distress could not be stabilized at the Emergency Department, Tat Cheung was suggested to be hospitalized for further management. When all the hospital beds were occupied, the staff provided him only with a camp bed at the corridor, where many people walked around. After staying for one to two days, he was discharged by the doctors because they considered that he suffered only from mild dyspnea. Tat Cheung was frustrated that the doctors did not understand how distressing he experienced and his need for hospital care. However, he believed that he was incapable of changing the doctors' decision, so he did not argue with but followed the discharge order. Meanwhile, Tat Cheung expected a conflict with his wife when he was discharged early because his wife preferred him to be in the hospital until his breathlessness subsided. Therefore, Tat Cheung became helpless and stressful every time he was discharged from the

hospital.

After hospital discharge, Tat Cheung consciously conserved energy in daily activities to avoid inducing breathlessness. Physical mobility was considered as the most important to him. Yet, Tat Cheung noticed that his lung disease deteriorated gradually year by year. He believed that older people were powerless to stay healthy. After being readmitted to hospital the several times, Tat Cheung did not expect his health to be restored. However, it was also unexpected to him that he could live to 80.

Participant 9: Yah Man

Yah Man was a 75-year-old male living with his younger brother and sister-in-law. In the previous year, he was readmitted to the hospital six times. Although he declined to be regularly readmitted to the hospital, he admitted that hospital care was necessary to relieve his respiratory distress. Yah Man was bored and felt uneasiness at the hospital. Although Yah Man was free of physical distress when he was discharged, he was uncertain about how long this stable condition would last because his condition fluctuated easily. A few days after hospital discharge, his physical condition changed, and he required hospital care again.

Yah Man regarded his younger brother as his only close family member, so they mutually supported each other. However, hospital readmissions imposed a great burden on his younger brother. When Yah Man suffered from respiratory distress, his younger brother

assisted him to call emergency care and attended the hospital with him. During Yah Man's hospitalization, his younger brother visited him every other day. Therefore, he understood that taking care of him was difficult for his younger brother who also had chronic illnesses.

Yah Man was most concerned about the financial burden of hospital readmissions. He received financial support only through government subsidy. Yet, frequent hospital readmissions cost him a great deal of money and nearly used up his monthly subsidy. Yah Man attributed one of the reasons for hospital readmissions to the poor performance of the ventilator he used at home. In the recent readmission, a doctor recommended him a new ventilator. Although Yah Man thought that the new model would be effective and thus prevent further readmissions, the rent for this ventilator was unaffordable. Besides, Yah Man consulted general practitioners instead of attending the hospital when the respiratory distress was endurable. However, consulting those practitioners cost him a lot. Despite the considerable medical expense, he would rather bore them himself to relieve the burden on his younger brother. Yah Man complained about the high cost of living and he believed that health depended on a person's wealth.

Yah Man related another reason for hospital readmissions to physical deterioration with aging. In this sense, his health and hospital readmissions were out of his control. Hence, he only sought to meet several basic needs in daily life and hoped that the government would provide adequate subsidy to cover his medical expenses.

Participant 10: Ying Kong

Ying Kong was an 87-year-old male cared for by a maid. He was readmitted to the hospital nine times in the previous year. Ying Kong noted that he had been readmitted to hospital frequently, about once a month. However, he found no alternative to relieving physical distress other than seeking hospital care. His bouts of breathlessness had been so distressing which was out of his control. In such situations, he had to attend hospital and receive care.

Through multiple hospital readmissions, Ying Kong became well acquainted with several nurses and supporting staff, who treated him like an old friend whenever he returned. However, Ying Kong considered his physical limitation was overlooked by the staff who required him to exercise before his distress had been subsided. Ying Kong did not inform his children about his hospital readmissions. He viewed hospital readmission as a minor issue that not worth bothering his children. Although he know that his children would feel sorry if they were unable to visit him at the hospital, Ying Kong would rather his children take a rest after work and save money than commute between the hospital and home.

Ying Kong complied with the treatment regimen but he found the medications did not improve his lung condition. Following hospital discharge, he was meticulous in daily activities to prevent from shortness of breath. Ying Kong related hospital readmissions to his poor fate of suffering from an incurable lung disease. Yet, Ying Kong recognized that the

physical health of people at his age deteriorates. He also observed that most of his friends had died at 60 to 70 years. Though he perceived his circumstances to be unfavourable, he was happy about having good mobility and being able to live beyond 80.

Participant 11: Yat Lam

Yat Lam was a 62-year-old male living alone. He was readmitted to the hospital seven times in the previous year and three of which occurred in the recent month. Yat Lam found pursed-lip breathing was the most effective way to alleviate his breathing difficulty and therefore he used this method whenever he experienced breathlessness. Yet, he admitted that hospital care was necessary when the respiratory distress was out of his control. After calling for emergency care, he felt safe because an ambulance would arrived shortly and sent him to a hospital.

Yat Lam had been readmitted to all pulmonary wards in the hospital. Nurses recognized him when he returned to the ward. At the hospital, Yat Lam felt protected in a well-ventilated environment and to receive prompt care. He was closely observed throughout the day, whereas at home, he managed the disease by himself because he did not have an informal caregiver. However, Yat Lam perceived that doctors are weary of treating readmitted patients. He was also annoyed with undergoing several routine activities at the hospital during each readmission. Every day, he waited for doctors making their rounds, received

medications and injections, underwent repeated investigations, and took a nap after finishing a meal. In one of his readmission experiences, Yat Lam was impressed that he was forced to leave the hospital early. Although he preferred transferring to a rehabilitative setting for further management to avoid unnecessary readmission, he did not convey this notion to the doctor. He followed the doctor's order even he expected that he would be readmitted within a few days.

Before hospital discharge, Yat Lam exercised his feet to ensure that he could walk properly because he had to lead his life independently afterward. He was also eager to learn self-management methods related to his lung disease, and he even derived his own method from daily activities. Yat Lam appreciated the concern of his children for his health. However, if his children visited him at the hospital, he considered it would only unnecessarily use up their time for resting, especially he was frequently readmitted.

Yat Lam believed that gradual physical deterioration was inevitable for people with lung problems. He also recognized that his lung disease worsened with each readmission. Therefore, he was ready for frequent hospital readmissions. However, he was not anxious about this. He thought he had no other option if his body weakened further.

Participant 12: Chi Kin

Chi Kin was a 78-year-old male cared for by his wife. He was readmitted to the

hospital eight times in the previous year. Chi Kin frequently experienced shortness of breath from daily activities and he would attempt to manage the breathing difficulty by himself with medications and breathing technique. Hospital care was the last resort when he failed to relieve the respiratory distress. Chi Kin wanted to maintain independence, so he tried hard not to burden others. He understood that taking a taxi to the hospital was risky, but he was reluctant to rely on others when he was still capable. Though Chi Kin was anxious about the respiratory distress, he knew that he could survive by receiving prompt treatment upon arriving at the Emergency Department.

Although Chi Kin was certain that he required hospital care to relieve his physical distress, he understood the continuation of care depended on the availability of hospital bed. After several times of readmission, Chi Kin got familiar with the hospital staff. Still, he believed that he was expected to be cooperative and patient in the hospital. He had to follow several structured activities and the orders from staff, but at home, he could go to Chinese restaurants and arrange his own activities. He also performed basic care by himself to minimize burdening busy staff and making demands on them.

Chi Kin speculated that his lungs had been impaired during a period of hardship adulthood. When he was young, he devoted himself to his family and to raise his children. He was contented with his marriage, and his wife faced hardship with him. However, he was disappointed with his older son, who did not care about his health. On the other hand, he was

pleased with his younger son, who called him regularly and showed concern for his hospital readmissions. Indeed, Chi Kin realized that his hospital readmissions had become frequently. The children had to work and had difficulty visiting him regularly at the hospital. Therefore, Chi Kin minimized the burden on his children by keeping his readmission from them.

Chi Kin believed that life events had been predestined. After being readmitted to hospital many times, he was used to it and anticipated that he would be hospitalized for a few days only and then would be discharged again. Though he acknowledged that exercise was good to his health, he was hesitated to exercise and threatened by the associated distress. Still, he remained alert in some self-management strategies to avoid shortness of breath which required hospital readmission. Chi Kin's friends who had lung disease were also commonly readmitted to the hospital, so he accepted frequent hospital readmissions happening on him. During hospitalization, Chi Kin observed patients whose ages were similar to his but who were frailer and required machines to support their lives. Therefore, he was satisfied with still being mobile and independent. After surviving critical admission, Chi Kin considered subsequent hospital readmissions as trivial to him.

Participant 13: Hoi Fai

Hoi Fai was a 77-year-old male cared for by his wife. He was readmitted to the hospital six times in the previous year. At home, Hoi Fai regularly had mild exercise and

walked around the area provided by the nasal cannula. But he limited other activities to avoid exertion. When he suffered from respiratory distress, he considered emergency care was the only option to alleviate the physical distress.

Although Hoi Fai considered hospital readmission was necessary, he encountered several constraints while staying at the hospital. He was prohibited from leaving the bed because the doctors considered his feet were weak. Sometimes, Hoi Fai sat out of the bed, causing edema in his feet. He complained to the doctors about having edema, but they told him that no medication was available for this problem. Hoi Fai thought that the doctors disregarded his minor physical complaints other than respiratory problems, so he could only use his own method to relieve the edema by lifting his feet off the bed. He also avoided making requests to nurses to reduce demands on them. Nonetheless, when Hoi Fai compared being at the hospital and being at home, Hoi Fai felt that being at the hospital was safer because he could seek help from nurses whenever he was in distress. He could also meet different people at the hospital, whereas at home he had only his wife and his son. But, he seldom talked to others at the hospital to avoid arguments.

Being readmitted shortly after his previous discharge, Hoi Fai found that his health and hospital readmission were out of his control. Yet, he was not irritated with having to be readmitted at the hospital because he believed that receiving hospital care to relieve physical distress was necessary even if he refused to do so.

Participant 14: Kwok Hing

Kwok Hing was a 70-year-old male living with his wife. Kwok Hing was readmitted to the hospital seven times in the previous year. He would manage breathlessness using inhalers by himself when he had breathing difficulty. He admitted that hospital readmission was necessary if he failed to manage the distress. Kwok Hing tried to manage the distress and avoided hospital readmission because Kwok Hing believed that he was regarded by hospital staff as a "chronic user" of hospital service. He observed that the quality of care had worsened. Bed linens were inadequate, and staff did not tidy his bed before the doctors did their rounds in the morning. He attributed the decline in the quality of care to lack of resources and poor management of the hospital. However, Kwok Hing believed that complaining about the service was fruitless. He had to accept the hospital environment and adapt to it.

Kwok Hing knew that his family cared about his lung problem. When he stayed in the hospital, his wife commuted between hospital and home, which was a long distance, to visit him. His children were overseas and therefore he communicated with them by phone while at the hospital. Kwok Hing described his life as full of difficult challenges. He believed that his lung disease developed from his hardship. Kwok Hing also thought that health could not be restored at old age and he realized that medications could only control symptoms but not prevent hospital readmission. However, he still took the medications because he had no

alternative. After being readmitted to hospital soon after discharge, together with the beliefs that hospital readmission would be frequent with aging and respiratory distress as inevitable, he was prepared for continuously readmitting to hospital. Nevertheless, Kwok Hing was receptive to his own experience and he believed that he should not be too obsessive at old age. Thus, he was prepared for what the disease brought to him and accepted that his situation could not be changed. After witnessing the death of patients at the hospitals, he viewed death simply as a light going off. In addition, Kwok Hing considered his children as grown-ups, so he had no more concerns in life.

Participant 15: Yuen Tak

Yuen Tak was a 77-year-old male living alone. He was readmitted to the hospital six times in the previous year. Yuen Tak considered that everyone desired to live long, so he had to be readmitted to hospital when he suffered from respiratory distress. Yuen Tak felt secure at the hospital because he was under care but he considered the hospitalization period was relatively short. Although he was bored there and disliked staying in bed, he felt less lonely than when he was at home. Though Yuen Tak had been used to hospital readmission, he was still annoyed with having to undergo invasive procedures in each readmission. However, he believed that he should not have high expectations in the hospital and that he had to adapt to this environment. Yuen Tak reminded his daughter not to visit him at the hospital. They

communicated by phone so that he would not interfere with her work and daily life. Yuen Tak realized that he required frequent hospital readmission, but he did not want to be a burden of others.

Yuen Tak led a difficult life when he was young and identified himself to be at the lower social class. According to his experience, life was difficult for the poor. Still, he was satisfied with the healthcare service provided for the poor by the government. He did not consider himself should have high expectations because he belonged to the lower social class. Yuen Tak believed that wealth could resolve his hardships and make him healthy. He would not need to manage his lung disease by himself. He might employ an informal caregiver to assist him in relieving physical distress, and he could then be readmitted to hospital less frequently. Although he did not have a caregiver, he appreciated the social support he received from his neighbours who also had chronic illness.

Yuen Tak knew that mild exercise was good to his health but he was limited by his impaired physical mobility. He could only adopt some energy conservation methods to reduce exertion in daily life. Yuen Tak understood that older people eventually developed illness and that the lives of other people were more unfavourable than his. Therefore, he accepted his health problems and was satisfied with his health status as an 80-year-old person. As breathlessness was inevitable, he was prepared for unexpected readmissions to hospital. However, he maintained that seeking hospital readmission was for the sake of him.

Participant 16: Pak Fung

Pak Fung was a 68-year-old male living with his wife. He was readmitted to the hospital 14 times in the previous year. Pak Fung noticed that he had been readmitted to hospital more frequently in recent months. He was even readmitted to the hospital two days after a previous discharge. However, he had no alternative other than to call for emergency care when he suffered from breathlessness at home.

Although the physical distress was controlled by medication at the hospital, Pak Fung still complained of mild shortness of breath throughout his stay. He disliked staying in bed. He left his bed and walked carefully step by step in the ward whenever he could bear his breathlessness. Pak Fung had become familiar with the ward environment and recognized several staff after being readmitted to the hospital multiple times. However, he did not interact with the staff much and only observed how they worked. He knew that several staff was short-tempered so he avoided having conflict with them. Pak Fung was once discharged forcibly while he was still suffering severe shortness of breath. His condition was so distressing that he had difficulty making even small movements. Yet, he still followed the discharge order because of the belief that he had to follow once the doctors gave the order. After Pak Fung returning to home, he could only rely on oxygen therapy and stay inactive to avoid triggering breathlessness.

Pak Fung's wife could not fully take care of him because she had been diagnosed with

cancer and was receiving radiotherapy. His daughter visited him at the hospital, but he would rather she took more rest after work. In fact, Pak Fung thought that his family was accustomed to his hospital readmissions. The most bothersome issue for Pak Fung was the financial burden because of hospital readmissions. He received government subsidy every month, but it was used up for the hospital charge. Despite the increasing cost of living for him, he bore it on his own instead of relying on his daughter. After a traffic accident happened when he was young, Pak Fung described himself as more open-minded in accepting different challenges, including his health problems and requiring for hospital readmission. Therefore, he would take the world as it was; even he realized that his respiratory problem had worsened in the recent year.

Participant 17: Yiu Pan

Yiu Pan was a 73-year-old male living with his wife. In the previous year, he was readmitted to the hospital six times. Yiu Pan sought hospital readmission once he could not bear the breathlessness. He took a taxi to the hospital by himself to avoid demanding on others. He also considered his physical distress was relieved and he was independent in self-care, so he refused his family visiting him at the hospital. Although Yiu Pan agreed that hospital care was necessary for relieving physical distress, he always desired to avoid hospital confinement. Yiu Pan thought that he was deprived of freedom at the hospital because his

activities were limited by a nasal cannula, which restricted him to the area around his hospital bed. Thus, he left his bed whenever he was able to tolerate the distress. Yiu Pan understood that his lung disease fluctuated from time to time. Therefore, requesting that the doctor relieve his breathlessness completely before hospital discharge was meaningless. Following hospital discharge, he had to put on oxygen therapy at home to ease his breathing.

Yiu Pan previously consulted private practitioners for ways of relieving his respiratory problem. However, he was frustrated that those practitioners only made money from him because his condition did not improve with the medications. He then accepted that the disease was incurable and breathlessness could be triggered easily. In addition that his respiratory problem became more severe when the weather changed, he was conceived that hospital readmissions were uncontrollable and was prepared for readmission whenever the weather changed. Yiu Pan observed that his lung disease worsens with age, but he was pleased with being able to live to his age. He considered hospital as merely a transient place during physical distress and expected that he would be discharged again after a few days.

Participant 18: Hiu Ming

Hiu Ming was a 72-year-old male living with his wife and daughter. He had been readmitted to the hospital six times in the previous year. Hiu Ming himself noted his frequent readmission; sometimes he returned to the hospital within one day. Although Hiu Ming would

try to deal with his breathing difficulty by himself, he was compelled to seek hospital care because the distress was so intolerable. Frequent hospital readmission familiarized Hiu Ming with the hospital staff, and he regarded himself as a "regular customer." Hiu Ming felt secure at the hospital when he was in respiratory distress because of the relief he felt after receiving medications. However, he became exasperated when doctors failed to understand his needs for hospital care and displayed dismissive attitudes toward him. He also found the hospital environment not conducive to recovery because of the physical limitations imposed by his oxygen therapy; and the constant, sometimes painful examinations. Yet, he underwent the procedures because the doctors told him that they were necessary.

During hospitalization, Hiu Ming refused visits from his busy wife, who came on weekdays. He was also concerned about his young daughter, who was left to manage on her own. Thus, Hiu Ming was relieved when he was finally discharged from the hospital. However, he had to deal with the challenges of managing daily activities with his limited physical strength. He deliberately and cautiously carried out his daily activities to avoid shortness of breath. Hiu Ming believed that effective treatment for his lung disease was unavailable and therefore he only could perform mild exercise at home to maintain his physical strength. After several readmissions to hospital, Hiu Ming became resigned to being back and forth between hospital and his home. He realized the necessity of hospital care whenever he suffered unbearable distress. Although he related hospital readmissions to "bad

luck," he held the belief of "living one day at a time."

Participant 19: Yau Hong

Yau Hong was a 68-year-old male living with his wife. He was readmitted to the hospital seven times in the previous year. Yau Hong was confident in managing his breathing difficulty by himself and he relieved the distress by performing pursed-lip breathing, taking medication, and using home-based oxygen. Unless the distress was too severe to manage, Yau Hong refused to seek hospital care.

Of his various hospital procedures, Yau Hong was most weary of blood taking. He noted that he had to undergo this procedure multiple times for every readmission and several bottles of blood were withdrawn every time. However, he followed orders despite his aversion to the procedures because he considered that he lacked medical knowledge to understand what doctors did. During his hospital stay, his wife prepared meals for him every night. Considering that she worked in the daytime, he preferred to lessen his demands on her. Nevertheless, Yau Hong realized from his hospitalization experience that he would be discharged once his condition stabilized. He also understood that his lung disease was incurable. Therefore, he accepted that hospital care only alleviated his respiratory distress and he could be discharged to home even without complete symptomatic relief.

Yau Hong continued medication at home knowing that it only controlled the

symptoms and would not improve his health. He strongly believed that the only way to reduce his hospital readmissions was to exercise regularly. After receiving training from a rehabilitation program, he understood how exercise enhances physical strength. Thus, he persistently performed daily exercises. Yau Hong also enjoyed going out his house and walking around his neighbourhood. He brought a handy oxygen cylinder with him in case of unpredictable breathlessness. Observing that his physical condition was gradually deteriorating, he grasped the opportunity to walk as long as he was mobile.

Although Yau Hong was confident in managing his respiratory distress and was assertive with regard to maintaining exercise to reduce hospital readmission, he had already become accustomed to readmissions. He knew that hospital readmission was unavoidable because he was becoming old. Nevertheless, Yau Hong believed that he had to confront and manage his lung disease because nobody but himself could do it for him.

Participant 20: Lai Kuen

Lai Kuen was a 72-year-old widow in the care of a maid. She was readmitted to the hospital eight times in the previous year. She could perform some simple activities of daily living and walk a short distant. However, she preferred to remain inactive at home.

Lai Kuen observed that her physical condition deteriorated with each hospital readmission and that it was most terrible during her recent readmission. She realized her

physical condition was poor because of the intensive treatment but she did not know how the treatment worked for her. As a result of her discomfort with the treatment, she sought relieving methods from nurses. However, she was disappointed by the advice that those treatments were necessary as per doctor's orders. Lai Kuen also experienced a lack of social interaction at the hospital. She looked forward to being discharged to home because she felt at ease in that environment. Furthermore, she could meet her grandchildren.

During hospitalization, Lai Kuen anticipates her discharge for a family gathering. However, she was ambivalent about her deteriorating physical condition because it would increase the burden on her family. In particular she was concerned about the difficult livelihoods of her children. After several hospital readmissions, she realized that she could not address her deteriorating physical condition by herself. Thus, Lai Kuen submitted to the fact that hospital readmissions were unavoidable given her situation.

Participant 21: Siu Lam

Siu Lam was an 89-year-old woman who lives with her husband and is being looked after by a maid. She was readmitted to the hospital four times in the previous year and required long-term oxygen therapy at home. Although she was under the care of a maid, her older daughter also looked after her during the day. Whenever Siu Lam experienced any discomfort, she immediately sought help from her older daughter, who then accompanied her

to the hospital.

Siu Lam understood that hospital readmissions were necessary given her respiratory disease. Once her physical distress was relieved, she impatiently anticipated her discharge to home. Siu Lam felt that the hospital lacked meaningful activity, and she could not learn about her condition from the hospital staff. Despite a few readmissions, Siu Lam could not adapt to the hospital environment where she perceived many restrictions.

Siu Lam appreciated the care and concerns expressed by her family. She considered hospital visits to be a waste of time for her family members because she was readmitted repeatedly. However, she was pleased that her family members nearly filled all of the space around her hospital bed when they visited her during each hospital readmission. She was satisfied with the attitudes and respect showed by her family when she observed how other patients were alone.

Participant 22: Siu Mui

Siu Mui was a 78-year-old women living with a daughter who works full-time. She was independent and could manage her daily activities; she took care of herself unless she suffered from breathlessness. In this situation, she called her daughter for assistance.

Siu Mui was readmitted to the hospital five times in the previous year. During her hospitalization, she remained independent and she seldom sought assistance from hospital

staff. Although she desired for choices regarding the meals and activities available at hospital, she did not convey her preference to the hospital staff and accepted what she was given. Siu Mui herself observed that she usually still suffered from mild breathlessness during hospital discharge. In fact, she was readmitted to the hospital because of relapses of this. Although Siu Mui herself felt that she was discharged prematurely without completely addressing her symptoms, she did not worry about her condition because she was gratified with living at an old age.

Siu Mui was satisfied with being independent at her age. She was particularly content with her good mobility and her ability to meet other basic needs in life. She was also pleased with the social support from her neighbourhood; her neighbours were concerned about her frequent hospital readmissions. Having lived to old age, Siu Mui felt that she did not expect much from life based on the insight she gained from her past experience.

General Structure of the Lived Experience of Hospital Readmissions of Chinese Older People with COPD

The individual descriptions of Chinese older people briefly depict their experiences regarding hospital readmissions. Although the experiences vary among them, a general structure is revealed. The following general structure portrays the lived experience of hospital readmissions of older people and delineates the interrelationships of the constituents.

Chinese older people with COPD easily experience breathlessness in their daily lives. They rely on themselves and their caregivers to manage their daily activities and the disease. Day-to-day self-management of the disease aims not only to delay disease progression but also refrain from unnecessary hospital readmissions. Recognizing that hospital care only relieves their breathlessness without improving the underlying disease, older people regard hospital readmission as the last resort to survive breathlessness. Therefore, they endeavour to employ various means, from active to passive approaches, to refrain from being readmitted to a hospital. However, when breathlessness becomes unmanageable and intolerable, the condition induces intense physical and psychological distress, which signifies impending death. Older people perceive the urgency of the need to survive from breathlessness. Craving for survival, they abandon their efforts in refraining from hospital readmission and resign themselves to seek hospital care. They regard hospital readmission as the only alternative that can provide them with immediate relief from the imminent threat imposed by the disease.

Older people are intuitively familiar with their bodies. They are keenly aware of the necessity of hospital care for survival. However, the urgent need to survive breathlessness is often disregarded by doctors. Older people understand that the physical and psychological distress induced by breathlessness is subjective experiences. Therefore, doctors cannot recognize such urgent need to survive because they do not have similar experiences. Older people feel powerless when their urgent need to survive is disregarded by their doctors.

However, they do not communicate their need with doctors because of the perceived submissive patient role from the paternalistic doctor-patient relationship.

After being readmitted to a hospital, although their distress has not been completely resolved and their needs are often disregarded by doctors, older people are not overwhelmed by these issues because their primary concern is the possible burden they impose on their families. Viewing themselves as demanding to their families in daily lives, older people remain conscious about relieving the burden on their families during periods of hospital readmission. They are mindful of the collective interests of their families; thus, they perceive themselves as responsible for exempting caregivers from related duties and avoiding any demands on their children during hospitalization.

Older people exert every effort to refrain from hospital readmission. However, hospital care remains necessary when breathlessness becomes uncontrollable. They come to realize that hospital readmissions are unavoidable and that their effort to self-manage the disease merely delays the next readmission. Older people who perceive uncertainty about hospital readmissions initially feel helpless and require more time to accept its occurrence. Perceptions of aging and belief in fatalism foster the acceptance of hospital readmissions. Doctors' accounts of COPD and experiences in and knowledge on the disease further rationalize the inevitability of hospital readmissions. Older people therefore eventually accept the inevitability of hospital readmissions and resign themselves to its occurrence.

Resignation to hospital readmissions precipitates an attitudinal shift toward the belief of living for the moment. A positive comparison between present and past life experiences provides insights to older people and reminds them to be satisfied with their current state rather than be preoccupied with the thought of hospital readmissions. Therefore, they shift their focus to everyday life, seizing each day and engaging in the present. With this positive outlook, older people can accept the need for frequent hospital readmission to ensure their survival and continue to attempt every effort to refrain from unnecessary hospital readmissions. They can overcome the feelings of powerlessness and being disregarded of their needs by doctors. They also feel positive about themselves in terms of contributing to their families by relieving the burdens during periods of hospital readmission. The attitude of living for the moment enables Chinese older people to embrace the experience of hospital readmissions in their lives.

The Constituents of the Lived Experience of Hospital Readmissions

Six constituents are captured in the general structure. These constituents coexist across the narrative descriptions of the experiences of hospital readmissions among Chinese older people with COPD. These six constituents are:

1. Refraining from unnecessary readmissions
2. Craving for survival

3. Feeling being disregarded and powerless
4. Being conscious of relieving burden to families
5. Resigning to hospital readmissions
6. Living for the moment

With the use of imaginative variation, these constituents were identified to be essential to the lived experience of hospital readmissions among Chinese older people with COPD. Each constituent was imaginatively removed from the general structure to examine whether the experience of hospital readmissions changed and could not present itself fully. The meanings of each constituent to the whole experience and to the other constituents were closely scrutinized. The six constituents were then considered to be invariant in the lived experience. The process of imaginative variation in determining their essentiality is described as below.

Breathlessness, as a predominant symptom of COPD, gives rise to the constituents "refraining from unnecessary readmissions" and "craving for survival". These two constituents are fundamental to the experience, as the former describes the day-to-day disease management in relation to hospital readmissions and the latter delineates why older people seek hospital readmissions. The two constituents are interrelated to inform in what circumstances older people submit themselves to seek hospital care.

As for the constituent "feeling being disregarded and powerless", it is also engendered

from the symptom of breathlessness. The older people revealed that their urgent need for surviving breathlessness is disregarded by their doctors. Other needs related to hospital readmissions are also unrecognized by other parties. Therefore, this constituent is necessary to illustrate what older people encounter regarding hospital readmissions. "Being conscious of relieving burden to families" depicts what older people concern the most after being readmitted to a hospital. It is essential in the experience that being mindful of relieving burden to families was consistently emphasized by the older people. Older people are more concerned about the collective interests of their families rather than own. They are not overwhelmed by the need for frequent hospital care to survive their distress and by having their needs disregarded by others.

"Resigning to hospital readmissions" describes how older people understand the occurrence of hospital readmissions. To a certain extent, this understanding is under the influence of "refraining from unnecessary readmissions," as older people believe that hospital readmissions are unavoidable. This constituent is pivotal to the whole experience that it precipitates the attitudinal shift to the last constituent of "living for the moment" which provides insight into how older people live with their experiences of hospital readmissions. The essentiality of this constituent is highlighted by its relationship with the other constituents. With the attitude of living for the moment, older people accept the occurrence of hospital readmissions and integrate it into their lives. Hence, these six constituents maintain

the lived experience of hospital readmissions invariant and describe the meanings of hospital readmissions to Chinese older people with COPD.

The totality of the lived experience of hospital readmissions of Chinese older people is understood together with the six invariant constituents. They closely relate to each other in meaningful ways to present the whole phenomenon. The empirical experiences of older people vary in each constituent; however, the meanings of the constituents regarding hospital readmissions are similar among older people. The detailed descriptions of each constituent in the lived experience of hospital readmissions are followed.

Refraining from Unnecessary Readmissions

Having lived with COPD for years, the older people were familiar with the disease and the ways to refrain from unnecessary hospital readmissions. Their effort toward day-to-day self-management aimed at not only detaining the progression of their disease, but also preventing unnecessary readmission. The self-management activities that they engaged in every day to refrain from hospital readmission ranged from passively staying inactive to avoid inducing breathlessness to actively performing exercises to maintain their physical strength. Nevertheless, the older people realized from their experiences that hospital readmission as necessary when breathlessness became unbearable. They considered no alternative but only hospital care could provide them with prompt relief, which survived them

from breathlessness. Therefore, they were keenly aware that their endeavour of refraining from hospital readmission was merely an effort to delay the next readmission. Nonetheless, the older people were keen on exerting their limited control to defer hospital readmission.

The older people regarded hospitals as transient place where they were only saved from severe distress and their symptoms were controlled. From their experiences, they observed that they were discharged from a hospital when their condition had stabilized, although they were not completely relieved from breathlessness. Yau Hong understood the nature of COPD and the purpose of hospitalization. He described, “This (COPD) is not a curable disease. Just control it (at hospital) and back to home, get some rest. This is the only way! There is no other choice for this kind of disease!” The older people were aware that hospitalization merely alleviated their distress but could not improve the progression of the disease. They appreciated that the hospital environment provided them with a sense of security because they could instantly receive care and assistance whenever they experienced breathlessness. However, they grumbled a lack of meaningful activities and felt powerless to struggle for their personal needs at hospitals. Therefore, they preferred their home environment where their personal needs were understood by their family members. At home, they were well looked after by their caregivers who assisted them in daily activities and relieving breathlessness. In contrast to assuming a submissive patient role at hospitals, they were respected as a senior family member at home. Therefore, the older people expressed

their desire to stay for longer periods at home and to attempt to refrain from unnecessary hospital readmission, unless they failed to endure and manage their distress on their own.

The hospital care needed by the older people, as well as their need to avoid unnecessary hospital readmission, was often overlooked by their doctors. Through their knowledge about COPD, they became aware of the futility of receiving pragmatic support from the healthcare sector to reduce hospital readmissions. The older people believed that the treatment regimen could neither improve their health status nor avoid hospital readmission. Moreover, their doctors had convinced them that COPD is an incurable chronic disease, and that its management is only aimed at controlling the progression of the disease but not curing it. Yiu Pan recollected how a doctor explained the nature of COPD to him and said, “The doctor said my illness (COPD) can’t to be improved, but just don’t let it deteriorates. That’s no way for improvement. Everyone (doctors) said so.” In addition, their treatment regimens had been modified based on the progression of the disease. Most of the older people believed that despite having tried all available medications, they had yet to experience favourable results. Certain older people had asked their doctors for new medication but they were disappointed when their doctors told them there was no alternative.

Indeed, the older people realized that medications merely relieve the symptoms, but do not cure the disease. Respiratory modalities, such as supplemental oxygen, only help to stabilize a critical condition or meet daily needs. The treatment process was even described

by Kwok Hing as “treating the symptoms without curing the disease.” For these reasons, the older people considered that relying on a treatment regimen is inadequate to avert hospital readmissions. Therefore, their plan of action was to refrain from unnecessary hospital readmission on their own. Although the older people also considered that following their doctors’ health advice might reduce hospital readmission, they believed that the effectiveness of such advice depended on their determination to adhere to it. Therefore, the responsibility of avoiding hospital readmission still rested on them.

The older people endeavoured to refrain from unnecessary hospital readmission using passive and active approaches. Through rehabilitative programmes, the older people learned about the importance of exercise in improving their endurance and delaying the progression of the disease. However, a few older people hesitated to exercise because they were concerned it could induce breathlessness, which would only make them suffer as well as result in hospital readmission. They remained vigilant about all movement or activities that might trigger breathlessness. Therefore, they preferred to stay inactive at home and perform their daily activities with the assistance of their caregivers. On the contrary, most of the older people took an active role to manage the disease and attempt to delay hospital readmission. For instance, Yau Hong affirmed that refraining from hospital readmission depends on the perseverance of an individual to perform regular exercises. He explained the reason as follows:

> You must exercise to improve your condition. This is the only way to reduce hospitalizations. Exercise is all on your own. Doctors can control your symptoms. As this kind of disease is incurable, they can only control your symptoms by medication. If you don't exercise, you will lose physical strength, and physical condition will deteriorate.

With this understanding, most of the older people seized opportunity to delay physical deterioration as well as to avoid hospital readmission. Hence, they regularly exercised within their limitations. For older people who were able to go out, they walked to nearby parks or rode on aerobic bikes at community centres. Although the parks were close to their homes, the distance could be demanding for them, and thus, they would sometimes experience several breathlessness before reaching the parks. Therefore, they acknowledged the need for perseverance in maintaining this habit. For the others such as those who required home-based oxygen therapy, those who were physically insufficient to sustain a short walk, or those who feared the lack of immediate aid in case of respiratory distress, they maximized every opportunity to exercise despite their confinement at home or in a limited area. For example, Wai Fat bought an aerobic bike to exercise without leaving his home. Some of these older people stretched their limbs or walked within the area allowed by their nasal cannula. With full commitment to maintain a regular exercise regimen, these older people overcame their limitations. Despite their difficulties, they were motivated to maintain this habit in an attempt

to improve their endurance and to prevent the next hospital readmission.

Indeed, the older people were aware that they often experienced shortness of breath from daily activities. Only a few of them sought immediate hospital care to relieve their breathlessness for the sake of their lives. Most of the older people, however, considered seeking hospital care every time they experienced distress as impractical. As described by Chi Kin:

> I could barely breathe! After a bath, I began to wheeze. I knew it, I got used to it. Every time after a bath, I begin to wheeze. So I sit down slowly and dare not move. I need the inhaler. After taking the medication, wait for the symptoms to go. I won't dial the emergency number at once. Definitely, I won't. Only if shortness of breath continues, I call emergency room. This happens... nearly every day, how do I return to hospital every time?

When the older people experienced breathlessness, most of them expended every effort to relieve the distress before submitting to seek hospital care. They realized that they would be readmitted to the hospital more frequently if no attempt was made to manage the distress. For this reason, they regarded hospital care as their last resort if they failed to manage their breathlessness. In this case, strategies to prepare for and resolve the distress were essential. Having struggled with the disease for a long period, these older people were familiar with the methods of relieving breathlessness, as it occurred from time to time. They

were cautious about breathlessness because they understood that it could be easily induced by daily activities. Hence, many of them would bring an inhaler with them whenever they would go out. Moreover, older people, who experienced weakness during breathlessness resulting in difficulties in calling for emergency service, always carried a safety alarm to seek hospital care in case of severe distress. The inhaler and the safety alarm assuaged not only their breathing difficulties but also provided them with a sense of security.

These older people also attempted various self-management methods to ease their breathing and refrain from hospital readmission during bouts of breathlessness. As Kam Ching recounted, “Self-control, I know how to manage. If there is medication at home, take the medication in advance, just control in advance, right? If I can’t take the medication, there’s nothing I can do. This is the worst case.” When the older people experienced shallow breathing and tightening in their chests, they would immediately relax their bodies and stay still. To relieve the tightness in their throat, they would also perform purse-lip breathing. Most of the older people agreed that this breathing technique was most effective for easing their breathing and minimizing the need for hospital care. Several older people took medications, such as aerosol and steroid, to alleviate their breathing difficulty. Experiencing a medication was effective in relieving his respiratory distress; Tat Cheung did not complete the entire course of the medication but saved it for later use in case of respiratory distress. Certain older people even derived their own strategies from daily experience. Kam Ching, for

instance, would drink a glass of hot water when he felt out of breath because he had found drinking hot water could relax his throat and enable him to breathe with less effort. Similarly, Yat Lam, who lived by himself, with nobody to provide immediate support when he was in distress, confided in his method used to save himself from shortness of breath. He would use a blanket to cover his body when he felt his throat tightening during episodes of breathlessness. Yat Lam explained that his throat could relax when his body was warm. Having successfully alleviating the respiratory distress and refraining from unnecessary hospital readmission, Yat Lam was proud of devising the method from his daily experience.

Similarly, caregivers had an important role in helping to refrain from hospital readmission among the older people. Together with his wife, Wai Fai devised a method which assists him to manage breathlessness. They designated two gestures: one meant that he needed an inhaler, and the other one meant that he required emergency care. When he experienced shortness of breath, he would make the first gesture to his wife. She would then pass an inhaler to him immediately and remained silent to let him relax. When Wai Fai failed to manage his breathlessness, he would show the other gesture, and his wife would call emergency care. With the assistance of his spouse, Wai Fai was satisfied with this method to avoid unnecessary readmission. He was pleased to share this method with others, who were also frequently admitted to hospitals, and encouraged them to devise a plan with their caregivers and attempt to manage breathlessness before seeking hospital readmission. Wai

Fat was proud of himself having his own method as well as with the support from his wife.

In spite of the various methods they used for managing respiratory distress, the older people affirmed that their strategies would not alleviate their distress every time. They knew when hospital readmission is necessary. When their breathing difficulty became more severe and they felt suffocated, they knew that they must abandon their own methods and seek hospital care for survival. The older people likewise acknowledged that hospital readmission was inevitable but that they attempted to refrain from readmitting to a hospital as much as they could. As unfolded by King Tai, he was satisfied with his own method of delaying his hospital readmission, noting that, "I am quite smart this time. With this method (pursed-lip breathing), I can stay away (from hospital) longer. Last time, I came back (to hospital) just one week after discharge." The older people shared that their struggle with breathing difficulties gave them a sense of control in delaying hospital readmission. Given that they were resigned to hospital readmissions, they were keenly aware that their effort to refrain from readmitting to hospital was merely an attempt to delay the next readmission. Still, the older people were eager to exercise this limited control through various means. When they failed to manage breathlessness and perceived the threat of being out of breath, they craved to survive from the distress and would then scramble to find immediate relief. Hence, they were readmitted to the hospital to obtain prompt care and alleviate their suffering.

Through their experiences of living with COPD, the older people became familiar

with the management of the disease and with the ways to refrain from hospital readmissions. They sought hospital care as a last resort for survival. Having their physical condition stabilized and being discharged from the hospital signified that the older people survived from breathlessness once again. It also implied that they would have to manage the disease on their own or through the support of their caregivers instead of relying on hospital staff. Following hospital discharge, they would actively or passively refrain from readmitting to the hospital. For the self-management of the disease, they would attempt various approaches to assert their limited control over hospital readmissions. In such cases, those who had derived their own methods particularly expressed great satisfaction. Nonetheless, their experiences had made the older people to realize that breathlessness and hospital readmissions were inevitable for people with COPD. Having been resigned themselves to hospital readmissions, they were submitted to seek hospital readmission for the sake of their lives when breathlessness became uncontrollable. Thus, they were resigned to shuffling between hospitals and their homes. Accepting the inevitability of hospital readmissions, they were aware that their endeavour of refraining from hospital readmission was simply an effort to delay the next readmission.

Craving for Survival

The older people with COPD were vigilant in avoiding breathlessness, which might

result in hospital readmission. However, breathlessness was easily triggered in their daily lives. Though they exerted every effort in an attempt to refrain from hospital readmissions, they had to forgo their endeavour to save themselves from critical distress. When the breathing difficulty became unmanageable, the feeling of being out of breath caused considerable physical and psychological distress to these older people. They felt the threat of suffocation and feared of not receiving timely help. Such distress alerted them to an impending death. Therefore, the older people craved to survive from breathlessness. From their experiences, emergency care provided them with immediate interventions to relieve their distress to a certain extent. Hence, they considered no alternative but only to seek hospital care. Stabilizing their physical conditions at a hospital signified that they survived from breathlessness once again.

The older people experienced physical threats, impeding their breathing when they suffered from breathlessness. Their throats and chests tightened and their breathing became shallow. The feeling of air hunger was very exhausting and distressing, signalling they might lose their breath in a minute. Under such a critical situation, the older people considered hospital care as essential to survive the threat. Yuen Tak asserted that the decision to seek hospital readmission was easy to make. He believed that everyone has the desire to stay alive; thus hospital care is necessary when death is approaching. Yuen Tak shared his view, “If I want to remain alive, I will go to the hospital, right? This’s so simple. No one wants to die. If

I want to die, why should I go to the hospital?" Yuen Tak believed that hospital readmission was crucial to survive from respiratory distress without doubt. He returned to the hospital when he felt the breathlessness was out of his control.

The intense feeling of imminent death threatened a few older people, prompting them to immediately seek hospital readmission to survive respiratory distress. The physical distress of the older people also had considerable influences on their caregivers. For instance, Tung Nam was once in physical distress and became comatose. He was then saved by resuscitation at a hospital. Thereafter, his wife became anxious whenever he breathed exhaustedly with effort. Worrying about Tung Nam might not survive the distress, she would immediately call for emergency care in an attempt to save him when she found Tung Nam suffered from breathlessness. The wife of Chi Kin's would panic when she heard the alarm from an ambulance. Whenever Chi Kin was in severe distress, his wife was responsible for seeking emergency care for him. She was impressed by witnessing Chi Kin struggled each breath arduously and being impatient for the arrival of ambulance. Therefore, she associated the alarm with the breathlessness of Chi Kin because it denoted his critical distress. After Chi Kin was readmitted to the hospital for a few times, his wife became accustomed to his readmissions and became less agitated, but she still remained nervous whenever she heard the alarm. Hence, the physical distress experienced by the older people affected not only themselves but also induced stress on their caregivers. The suffering of the older people

reminded their caregivers that they might not survive the dyspneic attack. The caregivers were warned to seek hospital readmission for the older people promptly.

Indeed, most of the older people regarded hospital readmission as the last resort when they failed to relieve respiratory distress themselves. They were familiar with the management of breathlessness. They used medication, performed pursed-lip breathing, and reminded themselves to remain calm to ease their breathing difficulty. To prepare for breathlessness, the older people always kept an inhaler with them. However, some older people failed to use the medication during breathlessness. For example, Yuen Tak shared that he could not catch his breathing, which impaired his ability to take a deep breath and inhale the medication. When the breathing difficulty exacerbated, their breathing required more effort. Breathlessness became unmanageable and they failed to endure the feeling of suffocation. In such a critical situation, these older people considered no alternative but only hospital care could relieve them of the distress. Hence, they felt that they were necessary to seek hospital care for survival. For instance, King Tai explained the need for hospital readmission:

> That (hospital readmission) is for the sake of my body. If I can't hold it (breathlessness) anymore, I need to go to the hospital. I don't seek hospital care causally. I really need to be here (hospital), isn't it? When I really can't hold it, I don't have other choices. It is nonsense to do nothing but die. It's a

must, a must to attend hospital. They (hospital staff) can save me.

Hospital care became imperative for these older people when they were incapable of enduring the laborious breathing. Concerning late hospital arrival could be fatal, the older people were obliged to seek hospital readmission because it was the only option to relieve their suffering and ensure survival.

The older people also experienced psychological distress from breathlessness, particularly when they failed to relieve it on their own. They felt anxious and required a sense of security to assure survival. The older people considered their physical conditions as unstable because breathlessness could easily be induced by daily activities. For instance, the mild movement of putting on clothes or bathing could trigger attacks. In other words, their physical condition could easily fluctuate in a short period. The older people, who were hesitant to leave their homes, felt insecure about being able to obtain help in public areas when they could not catch their breaths. Under severe breathlessness, the older people were unable to speak a word and became too weak to take out the inhaler. They felt being out of breath and suffocated. King Tai described such feeling as “miserable.” This debilitating distress was very stressful for them. They were considerably overwhelmed by their moment of breathlessness. They perceived urgency during such events, which prompted them to seek hospital care to alleviate their suffering and ensure survival. For example, the hands of Wai Fat trembled during an attack that he was unable to take an inhaler out of his pocket or to call

emergency service on his mobile phone. He perceived helplessness to obtain help and alleviate his distress. After experiencing this traumatic event, he carried a safety alarm with him. Wai Fat felt secure with this alarm, assuring him that he could seek help under any situation, especially when his wife was not nearby.

The older people, who lived alone, were particularly sensitive to the psychological distress and perceived the urgency of receiving support when they were unable to tolerate the breathlessness. In order to ensure survival, Yat Lam immediately sought emergency care with a safety alarm when he failed to manage the respiratory distress on his own. He described:

> Press the safety alarm, just for safety. He (staff of the safety alarm system) knows it. Next, inhale with the nose and exhale with the mouth. By doing so, I hope to buy some more time. When he (ambulance man) comes, I can have oxygen.

Yat Lam felt secure when another person was aware that he needed help, meaning that his physical distress could possibly be relieved by emergency care. Meanwhile, his psychological distress was also assuaged because his survival could be assured.

The psychological distress of being out of breath among the older people was relieved to a certain degree upon calling for and receiving prompt emergency care. The positive impression of emergency care was acquired from their previous experience of hospital readmissions. An ambulance arrived shortly and the emergency staff proficiently

administered oxygen therapy and medications. The immediate treatment not only eased their breathing difficulty, but also allayed their fears. Upon arrival to a hospital, they continued to receive supportive care at the Emergency Department. Most of the times, the older people were required by their doctors readmitting to the hospital for further management after receiving care at the Emergency Department. In the ward, they continued to receive treatment to further stabilize their physical condition. Their sense of security was maintained by being in a well-equipped environment with hospital staff working around. The older people realized that their critical conditions were under control and managed at the hospital. Such experiences not only helped them survive respiratory distress but also relieved them from psychological stress. The experience of efficient and satisfactory emergency care reinforced the idea of seeking hospital care again when they failed to self-manage respiratory distress and perceived the threats from exhausted breathing.

The physical and psychological distress experienced during breathlessness alerted the older people an impending death. Under this threat, they craved to survive from the respiratory distress. They considered no alternative, but only hospital care could help them. Hence, the older people sought hospital readmission to alleviate their physical distress from laborious breathing and relieve their psychological distress from the fear of inability to obtain help. Although the older people considered themselves as getting used to hospital readmissions and normalized its inevitability, the threat of impending death was so vivid to

them. They perceived the urgency of hospital care and were desperate for survival. Hospital readmission of the older people connoted that they survived from intense feeling of imminent death.

Feeling Being Disregarded and Powerless

The older people sought hospital readmission to resolve critical distress for the sake of their lives. However, this urgent need for survival was often disregarded by their doctors. Living with COPD for years, the older people became familiar with their bodies and their diseases. From their experiences, they knew when hospital readmission was necessary to survive the threat. However, they felt powerless when their need for hospital care was disrespected by their doctors. Some needs related to hospital readmissions were also neglected by other groups. They perceived a sense of helplessness from the neighbourhood, inadequate attention from the healthcare sector, and a lack of financial support from the government regarding their hospital readmissions. Nevertheless, the older people confronted with these needs which were disregarded by others.

Living with COPD for a long period of time, the older people were acquainted with their disease and their bodies well. They were familiar with the type of circumstances that would trigger breathlessness and how to manage the physical distress to refrain from unnecessary hospital readmission. They had an intuitive familiarity with their bodies that they

were keenly aware when hospital care was necessary to survive breathlessness. However, many older people felt powerless when their urgent need for survival was disregarded by their doctors, whom patients presumed to be knowledgeable about their disease as well as about their related needs. By contrast, the doctors thought that these older people did not understand the nature of their disease and sought hospital readmission arbitrarily. Hiu Ming, for instance, attempted to manage his breathlessness and only sought hospital care unless he failed to control the distress. When he was submitted to seek hospital care to alleviate his unmanageable breathlessness, a doctor criticized him for frequently attending hospital without accepting that breathlessness was inevitable for COPD. He was agitated when he recalled his conversation with the doctor, "She (doctor) pulled a long face and said, 'You must accept the fact.' I (Hiu Ming) ask her, 'What's that?' She said, 'Wheezing. You don't have to come here (hospital) whenever you're short of breath. This's the fact.'" While Hiu Ming was still suffering laborious breathing on admission, he was frustrated about the doctor's lack of empathy. He deemed that his effort to refrain from hospital readmission and his compelling need for hospital care to survive breathlessness were unrecognized by the doctor. However, he was certain about his need for hospital readmission because he had no alternative for the unbearable distress.

After several readmissions to hospitals, most of the older people were already familiar with the nurses and some allied healthcare professionals. Some older people found nurses

regarded them as “old friends” who are often readmitted to the hospital. These nurses showed understanding to their suffering and distress, which required repeated medical treatment at the hospital. For example, Ka Keng told that when he was readmitted to the hospital, he felt the nurses greeted him warmly and said “You come back (to hospital) again.” Yat Lam also shared that some physiotherapists expressed concerns regarding his hospital readmissions. They asked about why he was readmitted to the hospital but did not criticize his inability to manage the disease. Several older people told that they knew some healthcare assistants and supporting staff from previous hospital readmissions. They found these hospital staff were helpful and respected their need for hospital care. These attitudes rendered the older people to consider that their frequent need of hospital care was accepted and empathized by nurses and other hospital staff.

The older people also realized that their doctors had known them from previous hospitalizations. Different from the interaction with other hospital staff, a few older people were prepared to be blamed by their doctors for their frequent need for hospital care when they were readmitted to the hospital. The blame of being incapable to manage the disease and arbitrarily seeking hospital readmission lowered their self-esteem. They believed that their hospital readmission was regarded by their doctors as an abuse of medical resources. They felt helpless to the lack of understanding from their doctors. Kam Ching recalled that he was initially ambivalent about seeking hospital readmission when he was suffered from

breathlessness. He was concerned about his doctor would criticize his frequent hospital readmission. He said, “In the first few times, I worried the doctor would blame me. He may say, ‘How come you are readmitted again?’ Now, I get used to this (hospital readmissions).” Considering that hospital care was essential to survive the distress, these older people felt that it is necessary to seek hospital readmission regardless of the attitudes of their doctors.

In contrast with the interaction with nurses, Ka Keng described how he was questioned by a doctor on admission, “The doctor asked me, ‘Woo, why you have seen doctors so many times?’ I (Ka Keng) am ill, so I need to see doctors, right? If not, why should I come (to hospital)! I’d rather stay at home definitely.” Ka Keng was annoyed with the doctor’s disrespect for his need of hospital care. He was most exasperated at the doctor’s failure in understanding his urgent needs, whereas he considered the need as unquestionable for people with COPD.

Indeed, some of the older people were repeatedly doubted by their doctors about the frequent need for hospital readmission. Although they acknowledged that their doctors were knowledgeable in medical science, they discerned that their doctors did not understand the distress and urgency of hospital care for survival as experienced by patients. They explained that this lack of understanding was ascribed to the latter had not personally experienced COPD or breathlessness. Tat Cheung, for instance, complained that his doctors could not sympathize with his suffering, “They (doctors) don’t know how much I have suffered. It is I

who can't breathe. If they don't have the same experience, they'll never know how much I have suffered." Given that breathlessness is a subjective feeling, the older people had difficulty conveying their experiences and their urgency to survive critical distress. Therefore, they believed that doctors could not easily realize their suffering and need for hospital care. The older people considered it as exceptionally true when a doctor was not interested in understanding their experiences.

In addition that the older people have lived with COPD for years, several older people believed that they understood the disease better than their doctors did. Kam Ching explained, "We (COPD patients) understand our needs. We observe what happen to us. They (doctors) just rely on the (medical) books. We got the disease, so we certainly know what happens." Compared with the doctors, these older people evaluated themselves only did not know much about the medications as the doctors did. However, their bodies and experiences with the disease vividly informed them of their needs. Hospital readmission was regarded as essential because it was the only option to relieve the distress and the feeling of impending death. The older people were keenly aware of the necessity to receive hospital care, but they were frustrated about their doctors did not recognize their urgency and how they craved to survive the breathlessness. Anticipating that their doctors would not be sympathetic to their physical distress and their views would be disrespected, the older people asserted that discussing their concerns with the doctors was futile. Nonetheless, they considered no alternative to ensure

survival except to receive hospital care. Therefore, they were insistent that hospital readmission was essential to relieve their distress even if they found themselves unwanted by doctors.

The need for the continuation of care was also overlooked by their doctors. From their previous experiences of hospital readmissions, the older people realized that hospital care only stabilized their critical distress without completely resolving their symptoms. However, they considered that they were discharged prematurely, and the need for the continuation of care was neglected by their doctors if they still experienced distress. Tat Cheung described that he was required by a doctor to be discharged on the second day of admission:

> On the following day, the doctor came to see me. He said, "You only have shortness of breath, you can go home and use oxygen." I wanted to tell him, "I wouldn't have to come if I could." (But) I dared not saying a word. If I said anything, he is a doctor, he doesn't understand me. I knew it wouldn't work. So I shut my mouth up. I simply kept silent… I packed my things up and left with my bag.

Although these older people were frustrated with the attitudes of the doctors and unreasonable discharge order, they did not voice their dissatisfaction. Instead, some older people ventilated their frustration to the nurses who were considered as more empathic to their needs. Nevertheless, they believed that they were powerless to argue with the

doctors and they would rather save their “face” from having confrontation with the doctors. They were prepared for readmission to the hospital shortly after discharge when they followed the orders of their doctors against their will. Kam Ching followed the discharge order of his doctors, although he realized from his experience that his physical condition was unsuitable to be managed at home. He said:

> The doctor urged me to discharge. Okay, I left the hospital. In fact, I knew that I couldn’t leave the hospital. Phlegm filled up my chest. It must be a big mistake for him (doctor). Two days later, I was admitted again... I didn’t freak out (to the doctor).

The older people observed that they could be transferred to a rehabilitative setting and maintained the treatment when hospital beds were available. They found their condition gradually improved when they could continue to receive hospital care and rest in a well-ventilated hospital environment. However, the older people believed that the significance of continuation of care was disregarded by their doctors. When the hospital beds were fully occupied at the rehabilitative settings, they were compelled to be discharged to home soon after readmission. After discharge, these older people believed that they could rely only on themselves or their caregivers to manage the disease without other meaningful support. They could only endure the unresolved breathlessness and rely on supplemental oxygen to ease their breathing. They remained vigilant when performing daily activities that might induce

respiratory distress. Without stabilizing their physical condition, these older people were prepared for hospital readmission within a short period of time.

The older people considered that continuation of care could further stabilize their conditions as well as avoid early readmission. Nevertheless, they followed the discharge order despite their shallow breathing. It was not only because they realized that hospital care simply relieved their critical distress, but they also perceived themselves as powerless to request continuation of hospitalization from their doctors. The perceived powerlessness arose from playing the role of a submissive patient, assuming that patients should be cooperative with and obedient to hospital staff. Being dependent on the hospital staff for taking care of them, the older people presumed that they were in a subordinate position. The dependent role reminded the older people that they were expected to maintain a harmonious relationship with the hospital staff. Although they considered that nurses were more approachable and understood their needs, they reduced their demands and avoided conflicts with the nurses, as well as other hospital staff. Chi Kin shared his perceived expectation of being a "good patient" in hospitals:

> You need to understand, people like us, a patient in a hospital must cooperate with the nurses, the doctors, and the healthcare assistants. Just cooperate with everyone. If you don't cooperate, you will induce conflict. This is definitely not a good sign. Also, when they are busy working and you need some water, you

need to wait. Don't think you are a patient and you are the boss. This will make you a troublemaker. Don't think it this way, right? If you really need them, say when you don't feel well, you must call the nurse and wait for further instructions. The nurse will tell the doctor to see what they can do to help. You can't keep complaining to the nurse and the healthcare assistants.

The sense of powerlessness was most prominent when the older people interacted with their doctors. They regarded their doctors as authoritative figures being at a superordinate position with absolute right in making medical decisions in hospitals. As such, they felt a lack of autonomy to make decisions regarding their treatments and to change their doctors' decisions. Pak Fung, for example, considered himself powerless to refuse discharge order even though he still suffered from severe distress. He grumbled, "I wheezed so hard that I could barely walk but I was discharged (by a doctor). The doctor is the boss. It's all up to him but not me." Wai Fat also described his impression of the doctors. Although he was annoyed with his doctor's decision in hospital discharge, he believed that he had to "save the face" for the doctors. He said:

He is a doctor, (he is) the boss. He is the doctor. When he discharges me, I must leave. Why do I ask him (for the reasons)? (That means) I am not respecting him and he can't cure me.

Such kind of frustration was commonly observed when the older people described

their interactions with doctors. Yet, the older people believed that they had to follow and respect the doctors' treatment plans, because they considered that no alternative was provided to them. This perceived powerlessness hindered communication between them and doctors, thereby causing complaints from the older people that their needs were disregarded. Believing that doctors lacked experience of breathlessness together with the perceived submissive role, these older people did not express their concerns and feelings; thus their needs were kept unware to their doctors.

The frequent need for hospital care was not only disregarded by doctors, but also being contempt by neighbours of some older people. After several hospital readmissions, the neighbour of Hang Kei misunderstood his frequent need for emergency service and thought that he had an infectious disease. This misunderstanding resulted in a sense of helplessness to obtain assistance and help from his neighbour in case he suffered from breathlessness. Likewise, Kam Ching worried that his neighbour might mistakenly think his illness was contagious. To conceal his distress from his neighbour, he endured the discomfort and sought emergency care at the hospital by taking a taxi. Even though Kam Ching realized his behaviour was terribly risky, he was reluctant to use a safety alarm for calling an ambulance because such action might draw attention from his neighbour. With these misunderstandings, these older people considered that their need for hospital readmission could not be understood by their neighbour. Therefore, they perceived a lack of support in the

neighbourhood.

Furthermore, some older people believed that their needs related to hospital readmissions were overlooked by the healthcare sector and the government. Yau Hong completed a rehabilitation programme for COPD patients at a hospital, and he learned about self-management of the disease. Nevertheless, he waited for long time before taking this programme. He expected fewer hospital readmissions if he could receive the rehabilitation programme and learn how to manage the disease early. Hence, he believed that the healthcare sector did not provide adequate support for people with COPD, particularly for readmitted patients. The older people who lived alone also considered that their needs regarding hospital readmissions were neglected by the healthcare sector. Yuen Tak desired for an informal caregiver to assist his daily activities. Most importantly, he believed that the caregiver could provide support whenever he suffered from breathlessness. Thus, he might be readmitted to hospitals less frequently. As mentioned by Yuen Tak “I don’t need to go to the hospital if she (informal caregiver) helps me. When I wheeze and there is someone tapping my back, things will be much better.” However, submitted to the fact that he had to manage the disease independently, Yuen Tak regarded hospital readmission as a proactive means for survival and could only remain cautious in daily activities that might trigger respiratory distress.

In addition, a few older people complained that their cost of living was high. They afforded not only the expenses of daily living but also the hospitalization fees for

readmissions. Their financial burden accumulated with each readmission. Nevertheless, they bore the heavy burden of hospital readmission without receiving any support provided by the government. Therefore, they believed that the government ignored their financial needs in terms of their hospital readmissions.

The needs regarding hospital readmissions seemed to be disregarded by various parties. Apparently, only the older people could understand their needs and empathize with people who required hospital readmissions. Older people who had suffered from severe distress and had been rescued from critical condition at hospitals were keenly aware of the necessity and urgency for hospital care during breathlessness. Such experiences reminded them to be thoughtful to the needs of other COPD patients. Wai Fat, for instance, attempted to save a hospital bed for other COPD patients who might be more in need of care by alleviating breathlessness on his own. He explained vividly:

> We (COPD patients) need to save ourselves first, right? That's how I think. Although I suffer, I had to save myself. There is someone else suffering more than me. Well, let the person who suffered the most, more than me, come in and take over my place (hospital bed).

The older people considered themselves the most reliable persons to know the needs for hospital readmissions; however, they were frustrated about their urgency and necessity of hospital care were disregarded by their doctors. Without experiencing their suffering, the

older people believed that their needs in terms of hospital readmissions were invisible to others. In addition to the influences of submissive patient role, the older people concealed their concerns from their doctors. Nevertheless, they insisted that hospital readmission was imperative to relieve their distress because they considered no alternative other than readmitting to the hospital to manage their distress and ensure survival. Although the older people felt powerless when their needs were disregarded by their doctors, they were more concerned about the possible burden to their families during the periods of hospital readmission.

Being Conscious of Relieving Burden to Families

Repeatedly caught in the revolving door between hospitals and their homes, the older people expressed that they have become accustomed to hospital readmissions. Although they repeatedly required hospital care to survive breathlessness, they were not stressed regarding hospital readmissions. Instead, they were more mindful of the strain caused by living with a member who was frequently readmitted to hospitals. The older people were conscious of not becoming a burden to other members of their families, including their spouses and children.

Older people who lived with their spouses were being looked after by them. The spouses became their informal caregiver. Mei Fung, Ying Kong, Lai Kuen, and Siu Lam were cared for by their maids. Yah Man was being looked after by his younger brother. Yat Lam

and Yuen Tak, who lived alone, had to take care of themselves. Although Siu Mui lived with her older daughter, she took care of herself because she was independent and her daughter was engaged in work. The level of disability varied among these older people. Only a few of them totally depended on their spouses to take care of their daily needs. The rest were relatively independent in terms of daily activities. Nevertheless, most of their spouses remained close to them and seldom left them alone because their spouses were concerned about the need of assisting them to relieve breathlessness or to call for emergency care anytime. These older people were aware of their demands from their spouses and were grateful to the effort of taking care of them. Therefore, they considered frequent need for hospital care could become an extra burden. Instead of augmenting demands on their caregivers, the older people regarded the periods of hospital readmission as opportunities to relieve the stress of caregiving. Hence, they were conscious of not imposing additional duties and becoming a burden to their spouses when they were readmitted to hospitals.

The older people regarded hospital readmission as a brief respite for their spouses from the caregiving role. This respite not only provided their spouses with a physical rest but also allowed a relief from the strain of caregiving. In hospitals, the older people felt secure to receive professional care and were able to seek help from hospital staff whenever they suffered from respiratory distress. During their stay in such a safe environment, readmission could provide a physical and mental break for their spouses, exempting them from caregiving

duties. Their spouses could then regain control over their time and pursue personal interests. The respite was particularly valued by the older people who were more dependent on their spouses. For instance, Wai Fat seldom left his house because he was concerned about the inability to obtain support during breathlessness. His wife was also worried that he might suffer a dyspneic attack, and that nobody could provide assistance to relieve his breathing difficulty when she was not at home. Hence, she would not leave their home for long period and tend to rush back home after purchasing goods from a wet market. Wai Fai was concerned that this routine was very demanding for the time and effort of his wife, and her haste might cause an accident. When Wai Fat was readmitted to a hospital, his wife was provided with flexibility to arrange her activities, and her stress was relieved. Therefore, the older people who were more demanding on their spouses to take care of them at home regarded their hospital readmissions as a chance to relieve their spouses from caregiving stress.

For older people who were less dependent, they were also regardful of not imposing extra burden to their spouses because of hospital readmission. Indeed, the older people and their spouses were of similar age; some of the spouses likewise suffered from various health problems. Moreover, several spouses bore multiple roles in their respective families. They not only acted as an informal caregiver of the older people, but also took care of other family members at home. Hence, hospital visits and looking after the older people at hospitals were

particularly demanding during readmission. Chi Kin appreciated the dedication of and the attachment formed with his wife. Therefore, he was very sensible to the additional burden caused by his readmissions. As Chi Kin talked about his wife:

> My wife really is a dedicated, very dedicated perfect wife! Back-and-forth (between hospital and home) frequently. I said (to her), "Don't commute so much. You are 70+, if I really need you, I will call you." I have told her not to come (to hospital). She never listens. When she is at home, after our granddaughter goes to school, she prepares soup and brings to the hospital. You know, Pingshek (where Chi kin lived) is a long way from here (hospital), but she still comes even she is so busy. I know she thinks we both are old, and I am in the hospital, if she doesn't come, she can't live with that.

The continuation of caregiving provided by their spouses at hospital and the respite desired by the older people revealed the mutual support between the couples. The older people keenly appreciated the dedication of their spouses. They understood the constraints on taking care of them, particularly for the spouses who suffered from chronic illnesses as well. Hence, they preferred that their spouses considered the readmission period as a break for them to rest at home.

Although the spouses were exempted from taking care of the older people throughout the day, they still cared for the older people during the hospital readmission. Considering that

the older people disliked the food provided by the hospital, some of the spouses prepared meals for them. For instance, the wife of Hoi Fai prepared lunch and dinner for him because he complained about the “disgusting” food provided by the hospital. Being aware of the extra work imposed on his wife commuting between the hospital and their home, Hoi Fai would rather take the food prepared by the hospital to avoid imposing additional burden on her because of his hospital readmission.

While most of the older people were mindful of reducing their demands from the spouses during hospital readmission, Tat Cheung was preoccupied with the burden to his wife after hospital discharge. Prior to every hospital discharge, Tat Cheung became stressed and anticipated conflicts with his wife. She complained about the inadequate support provided in the community after he was discharged from the hospital. She preferred Tat Cheung to be hospitalized for a longer period to further stabilize his respiratory problems and avoid early hospital readmission. Although Tat Cheung understood the motives of his wife, he felt powerless to request continuing hospitalization from his doctors. Therefore, he was stressed prior to hospital discharge because of the anticipated conflict and his inability to alleviate the concerns of his wife. For Lai Kuen, she was also ambivalent about hospital discharge. She missed her grandchildren at the hospital; thus, she looked forward to enjoy family gathering after hospital discharge. However, Lai Kuen noticed that her health condition deteriorated with each hospital readmission. Although she was looked after by a maid at home, she was

concerned about her deteriorating health might impose burden on her family after hospital discharge.

As senior members in their respective families, the older people were mostly conscious about not becoming a burden to their children and other family members. Frequent respiratory distress and hospital readmission have elicited the attention of their children. Their children visited them at the hospitals when they were readmitted. Realizing their repeated admission to hospitals could become a burden to their children, these older people assumed the responsibility of an elder who should be considerate to their family members, particularly to the younger generation. They were mindful that their children were heavily engaged in their work to earn a living and that younger family members were preoccupied with their studies. These older people considered coming to hospitals as an imposition on their family members, especially because they were frequently readmitted to the hospital. Therefore, they avoided this burden by refusing to have their family visit them at hospitals.

In addition, most of the older people were independent in self-care; thus they considered visits from family members during each readmission as meaningless and demanding. They would rather have their family members pursue other more purposeful activities or take a rest after work. Several older people even concealed their readmission from their family members. For Chi Kin, he normalized his need for hospital readmissions. The shuffling between hospital and home was burdensome for his sons, who were

preoccupied with their work and frequently visiting him at the hospital. Therefore, he reminded his wife not to inform their children of his readmission unless he was critically ill and unlikely to survive. He described the discussion with his wife as follows:

> No, no, no! Definitely no! Don't tell them (sons) my admission. Unless my son calls me, he will know about my admission. I have told my wife not to call anyone. I need to go to the hospital because of the disease. But they need to work. Even friends or relatives, don't disturb others. Don't tell anyone. After it is over, I can come out (from the hospital). Unless he (son) phones to me, "How are you, dad? How did you feel these days?" If he phones to me, tell him. Otherwise, don't let him know. Well, that time, when I was put under a big machine (ventilator), then, she (wife) told him.

Yat Lam and Yuen Tak, who lived alone, were also conscious about not imposing demands on their children because of their hospital readmission. Yat Lam was concerned about his demands on the children, particularly when his readmission became more frequent. He maintained that he should be considerate as a father. Yuen Tak discouraged his daughter from visiting him during his hospitalizations. He remarked, "I tell her (daughter) not to come anymore and go to work instead. Patients with chronic disease like me need to go to hospital at any time. It's useless for her coming to visit me. Just talking on the phone will do." Concerned that the hospital staff might contact the family members regarding his hospital

readmission, Yuen Tak deleted all of the contact numbers on his phone so that the staff could not bother his family every time he was readmitted to the hospital. Undoubtedly, these older people who lived alone were aware of their possible demands from their children. They strived to maintain independence not only in daily living, but also during their hospital readmissions.

Indeed, the older people were satisfied with the respect and attention they received from their children; thus, they did not require their children to visit them regularly during their hospital readmissions. They expressed that they had fulfilled their roles in the family. The older males were particularly satisfied with their devotion to the families during their adulthood. For the older females, they appeared to express more concern about the daily lives of their children might be affected by their hospital readmissions. Understanding the living conditions of their children, the older people appreciated filial piety showed by their children, reciprocating them through demonstrating their respect and providing attention. For instance, Kam Ching was pleased to receive a telephone call from his daughter, who inquired about his health condition. He was satisfied with the attention provided by his child concerning his hospital readmissions, but he did not wish to burden her further.

The financial burden incurred from hospital readmissions was another concern for the older people. Many of them were concerned about the travel expenses for each hospital visit. This high expense was another reason why the older people refused family visits at hospitals.

Hang Kei, for example, talked about his wife, “If she listened to me, nothing would have gone wrong. I told her not to visit me here, she kept doing this. The round trip fare was one hundred dollars, a hundred and ten.” Moreover, hospitalization fee accumulated each time the older people were readmitted. The older people acknowledged the high cost of living. In addition to the expenditure on hospital readmissions, this high cost of living could further increase the financial burden on their family. Hence, a few older people shouldered the heavy financial burden instead of shifting such burden to their family members. For instance, Yah Man was looked after by his younger brother who also suffered from some health problems. He relieved the burden on his brother by paying for his high hospitalization fees. In such a way, Yah Man felt good to himself that he could made contribution to his family.

In addition, some older people were conscious about not making demands on their families when they attended a hospital. Suffering from breathlessness, Chi Kin and Yiu Pan insisted on attending a hospital by themselves when they were still able to endure the distress. Even though they realized the high risk of their behaviour, they were unwilling to bother their family members to send them to the hospital or abuse medical resources.

Undoubtedly, the older people were closely bonded with their families and they were more concerned about the collective interests rather than their own. They appreciated the dedication of and the attachment formed with their spouses. They also valued the filial piety expressed by their children. Acting for the collective welfare to their respective families, they

maintained conscious of relieving possible burden because of their hospital readmissions. While they were still experiencing distress at a hospital, they were heedful of their possible demands on their families. In the revolving door of hospital readmissions, the older people had limited control in delaying the next readmission. Relieving the caregiving duties for their spouses and reducing demands on their children would be tasks which the older people could exert more control. Although the older people often experienced the threats from breathlessness and required hospital care, they sought hospital readmission simply for survival. As they survived breathlessness at a hospital, they were not worried about own physical problems, but were solicitous of the needs of their respective families. Notwithstanding their needs related to hospital readmissions were disregarded by their doctors, relieving burden to their families was their primary concern. In addition, the older people were gradually accustomed to and resigned themselves to hospital readmissions. They were not stressful about it but were concerned about it might affect their families. Being aware of their demands on their families in taking care of them, they took the periods of hospital readmission as the only opportunity to relieve the burden of the families. The older people mentioned that they had already fulfilled their roles in the family; nevertheless, they still assumed the role of a senior member who was obliged to show consideration and thoughtfulness to the younger generation. They regarded this thoughtfulness as their responsibility. Obviously, the older people were committed to their families and they assumed

their responsibility regardless of the places or their situations.

Resigning to Hospital Readmissions

As the older people had been living with COPD for years, they gradually resigned to the inevitability of hospital readmissions. Even though they put every effort into refraining from hospital readmissions, hospital care was necessary when they perceived the threat from breathlessness. They realized from their experiences that hospital readmission was unavoidable. They perceived it as part of their lives and felt hopeless to halt it. This perceived inevitability was affirmed by their perception of aging, doctors' influence, their knowledge and experience in living with COPD, and their belief in fate. Resigned to the inevitability, the older people were prepared for readmitting to hospital perpetually.

The older people felt hopeless to avoid hospital readmissions. They believed that they could only delay the next hospital readmission but they lacked control over its occurrence. Hence, they gradually realized that worrying of hospital readmissions was worthless. The perceived hopelessness was ascribed to their perception of aging. Observing that physical illnesses were common among their friends of similar age, the people rationalized physical decline to be inevitable. For instance, Yah Man stated his perception of aging, "I can't deal with this (hospital readmissions). Everyone is ill when they get old. When people get old, all kinds of diseases come, all kinds of diseases." The older people considered their physical

weakness and deterioration as part of normal aging. Kwok Hing further explained his view of hospital readmissions as a result of physical deterioration and aging, “Well, people go to hospital more often when they grow old. It’s about energy consuming. When we don’t have energy anymore, our health will go down. The body has changed.” These older people considered the decline in their physical strength as expected. Thus, they rationalized that hospital readmissions were the result of degeneration and that they were incapable of preventing it.

Observing subtle changes in their treatment further convinced some older people of their physical deterioration. They became aware that their physical condition continued to deteriorate, noting changes in their treatment regimen, increase in medication dosage, and frequent hospital readmission. Yat Lam realized his deteriorating physical condition by comparing the frequency of his current and past hospital readmission. He described, “In the very beginning, it’s not that worse. I could still breathe well with inhalers. I had follow-up once every four months. See, I come to the hospital three times a month now. What a big difference!” The frequent hospital readmission alerted Yat Lam that his health was declining and the disease was progressing. The deterioration rendered the older people to believe that hospital readmission was inevitable.

Doctors’ opinions on COPD were influential to the older people. Although they were aware that their doctors did not experience their suffering and recognize their needs in

hospital readmissions, they believed that the doctors were knowledgeable about their disease. Learned from their doctors, the older people were convinced that their health condition would keep deteriorating; thus, hospital readmission would be unavoidable. Ka Keng inferred from a doctor that his physical condition could not be restored to that of a young adult. King Tai further elaborated his understanding from the doctors:

> It's getting worse and may never be cured. Just lessened, right? Just try to go to the hospital fewer times. The doctors have told me that this disease (COPD) can never be cured. There is no way out. Only gets worse and can never be cured!

The doctors' explanations definitely influenced King Tai to anticipate that hospital readmission would be inevitable for patients with COPD. Thus, he could only aim to be readmitted to hospital less frequently instead of being exempted. Doctors' accounts of the disease, together with their perception of aging, affirmed the older people's belief that they could not restore their normal health conditions. Therefore, the older people justified the inevitability of hospital readmissions. They were prepared to live with the disease and be perpetually readmitted to hospitals.

The older people's knowledge and experience of living with COPD also influenced their acceptance of the inevitability of hospital readmissions. Their knowledge of the disease, that the treatment only controlled the symptoms, and that no curative treatment was available,

convinced them that hospital readmission was unavoidable. Kwok Hing was prepared for the repercussions when he was diagnosed with COPD. Thus, he considered worrying of hospital readmissions as meaningless. The older people also experienced shortness of breath easily from daily activities. Difficulty in breathing could be induced simply by mild movement or coughing. Hospital readmission was then required, and this condition might occur soon after they were discharged. Moreover, their physical conditions fluctuated with the weather. The older people observed that they suffered from breathlessness frequently and was readmitted to the hospital when the weather became cold. They believed that they were lack of control under such circumstances. Thus, the unstable nature of COPD reinforced the uncertainty of their physical condition and the older people were also prepared to be readmitted to a hospital unexpectedly. Such readiness for hospital readmissions was illustrated by King Tai and Kwok Hing:

> I can't really tell you when I will return (to hospital) again. It may happen at any time. Maybe I leave (the hospital) this morning but I return at night. I start to wheeze severely once I cough. (King Tai)
>
> It's expected, expected to come back (to hospital) one day. I expect this. Don't think that long, right? It's all expected, expected to come back to the hospital, right? Particularly this kind of disease, when shortness of breath begins, it is difficult to breathe, really very difficult to breathe. (Kwok Hing)

A few older people also normalized hospital readmissions for patients with COPD. They considered it was common and justifiable for patients to receive hospital care. For example, Ka Keng gave the analogy of hospital readmissions as his routine of coming home to rest after an exhausting day. These "resting" periods were so long, that his hospitalizations were longer than his stays at home. He said, "Come back (to hospital) in the morning, just come back. Back again. Why not? I come back because I am ill!" After several readmissions, the older people gradually learned from their experiences and submitted to the inevitability of their readmission. Although they were ready to manage their respiratory distress themselves, they were compelled to seek hospital care to survive uncontrollable breathlessness. They were aware that hospital readmissions were unavoidable. Their attempt would only refrain from the unnecessary and delay the next readmissions. Therefore, they accepted the necessity of readmission when their respiratory distress became intractable, and they knew this condition might happen soon after they were discharged.

The belief in fate further reinforced their resignation to hospital readmissions. Some of the older people were conceived that what they encountered had been predetermined and that they were incapable of changing or challenging such experiences. Wai Fat expressed his view on hospital readmissions in relation to his fate, "Well, things are beyond our control, it's fate! I hope I'd better not come (to hospital), right? That's what I think. The point is, can I do that? Not necessarily." Although the older people recognized that medication could stabilize

the disease and resolve the symptoms, it would not alter the predetermined consequences of hospital readmissions. Therefore, several older people reconciled themselves to hospital readmissions, which they regarded as their fate. Ying Kong also related hospital readmissions to misfortune which was irresistible but should be accepted. He remarked, “What can I think of? Nothing should be a concern. I’m in bad luck, so I’m here (hospital). When I’m not feeling well, I should return here (hospital) again. There is no other choice.” Submitting herself to the powerful others, Mei Fung shared that she did not plead to the divinity for exemption from hospital readmission, but only hoped to be relieved of her suffering from illnesses.

Notwithstanding the older people realized hospital readmissions as unavoidable, those who perceived uncertainty about hospital readmissions took longer time to accept it. Hang Kei initially was depressed about being readmitted to hospital without improvement in his health. He perceived uncertainty about hospital readmissions and hopeless to restore his health. In addition to the lack of support to his daily living after hospital discharge, Hang Kei was frustrated at his suffering of physical and psychological distress. After several times of readmission, the perceived lack of control over hospital readmissions eventually convinced Hang Kei to accept its occurrence.

The outlook of the older people changed when they accepted the inevitability of their hospital readmissions. They became resigned to its occurrence. Under the abovementioned

influences, they gained insight into the inevitability of hospital readmissions. Throughout the interviews, it had been observed that these older people shared a common notion when they were asked about their feelings on hospital readmissions. They instinctively expressed that they were used to going back and forth between hospitals and their homes and they were indifferent toward it. This typical notion of being accustomed to revolving between hospital and home markedly reflected that they had coped with hospital readmissions and accepted such events as part of their lives. These beliefs relieved the older people's negative feelings of being disregarded by their doctors and powerless at hospitals. Their experiences of refraining from unnecessary readmissions also fostered them to believe that hospital readmissions are unavoidable. The day-to-day self-management of the disease was to delay the next hospital readmission only. Nevertheless they accepted hospital readmission as an inevitable phenomenon. This acceptance precipitated an attitudinal shift, holding a positive attitude towards hospital readmissions. They were resigned to hospital readmissions with the belief that they should be "living for the moment."

Living for the Moment

Resigned to hospital readmissions, the older people assumed a positive outlook and gained an insight into it, which was, living for the moment. The older people were satisfied with their current situations. This satisfaction was profoundly influenced by their past living

experiences. Under this influence, the older people were content with satisfying their basic needs, as they considered themselves had already fulfilled their personal roles to their families. They seized the day despite leading lives that revolved between hospitals and their homes.

Past predicaments shaped the older people's experience of hospital readmissions. Most of the older people were agitated when they recalled and shared their difficult lives and the hardships they endured during adulthood. These older people experienced their adulthood between the 1950s and the 1990s. During the early 1950s, the global economic depression occurred after World War II. The Hong Kong economy started to grow only after the 1970s. While the older people went through their adulthood under such an adverse economic environment, they assumed their responsibilities for their families. These older people withstood poverty to raise their children and sustain the necessities of their families. Some older people even experienced a chaotic period before they arrived in Hong Kong. They did their best to confront their adversities and strived to earn a living for their families. These experiences transformed the older people into receptive persons. For instance, Kwok Hing revealed how hardships shaped him to become open-minded. He shared, "I have walked through all ups and downs. I can accept anything at this stage. I'm not young. I'm 70 now." These hardships influenced the perception of the older people and how they experienced hospital readmissions.

The older people who had led difficult lives in their adulthood were particularly satisfied with themselves. When they were young, they shouldered the burden of their families. They earned a living and nurtured their children. Some of the older people remarked that they raised their children during an impoverished period. These older people were devoted to their families and proud of fulfilling their responsibilities. They regarded the maturity and independence of their children as their pride and personal achievement. These older people believed that their wishes and duties had been accomplished; and therefore they no longer worried about any issue in their lives, including being constantly revolving between hospital and home. They had no unfinished business and were prepared for hospital readmissions, which they viewed as destined. King Tai vividly illustrated the following:

> Frankly speaking, I've expected this (hospital readmission). This's life. No one can change it. No one! Particularly after I have suffered so long, for decades. They're (children) all grown up. I am quite satisfied with myself. I finished my duties. I have no responsibility (to my children) now.

Positive comparison also profoundly influenced how the older people experienced hospital readmissions. Contentment was expressed by those who positively compared their current situations with their difficult adulthood. Struggling through their past hardships to earn a living, they valued meeting daily needs as the most significance in their lives. They were satisfied with meeting their basic needs, such as food, sleep, and mobility. Given that

they were resigned to the occurrence of hospital readmissions, they were not annoyed with it but were rather concerned about whether their basic needs would be fulfilled at hospitals. Ka Keng, who led a difficult young life in Thailand, shared his view of hospital readmissions, "Don't think too much, right? When there is food, shelter, and a place to sleep, just get some rest." During readmission, these older people cared more about whether they would receive meals regularly and be satiated at this transient place. Compared with their past experience, they appraised the hospital environment was not so difficult for them.

The older people were also satisfied with reaching old age. They considered themselves as old enough and did not expect much out of their remaining lives. When Siu Mui talked about she had been readmitted to a hospital soon after previous discharge, she said, "I have no worry. I am old and over 70. Let them (hospital staff) treat me. I don't care if they can't help." During hospitalizations, most of them observed that their fellow patients of similar age were frail and required mechanical support to sustain their lives. Yuen Tak shared his observation:

> We are not in deep trouble when compared to others. Some people really use more than minutes to take one step forward. I face my problem in this way. Those people are very old, they really use minutes to take one step and walk slowly… Face the problem. I cheer up myself in this way.

Compared with their delicate peers, these older people were gratified with their

physical conditions and independence. Although they were readmitted to hospital repeatedly to manage their health, they were content with having good mobility at old age. Satisfaction was particularly enhanced in those who were aware that other patients with COPD required hospital readmissions had died. They believed that they had outlived other people of similar age and with similar disease. They evaluated their health conditions as optimal in the degenerative process even though they experienced breathlessness and occasionally required hospital readmission. Furthermore, a few older people went through a chaotic period when they were young. They lived out adversities and life-threatening accidents. Tung Nam, for instance, survived the Cultural Revolution. He recalled that people were executed daily. He was also prosecuted during that time because he was part of the upper social class. His miserable experiences reminded him to be content with his current state.

Past experiences not only enabled the older people to make a positive comparison between their past and their current situations but also shaped their attitude toward hospital readmissions. They held the attitude of living for the moment, inspired by their hardships and suffering from diseases. The older people gained insight that they should not be obsessed by the occurrence of hospital readmissions. In particular that they accepted the inevitability of hospital readmissions; being absorbed by it was inane. Yat Lam, for example, shared the following view to hospital readmissions, “If I keep thinking when I’ll return (to hospital) again, it will make me too troublesome. What I wish is that I can stay at home longer, no big

change." Yat Lam was prepared to be readmitted to hospital repeatedly, and therefore he focused more on delaying its happening than being preoccupied by it. Most of the older people believed that being absorbed by hospital readmissions was similar to "thinking of a dead end." Yuen Tak, for instance, maintained that he should be open-minded and confront the fact of requiring hospital readmissions. He positively regarded seeking hospital care as a proactive means for survival. Therefore, he would seek readmission when necessary for the sake of his life instead of trapping in the 'dead end." For Ka Keng, he would rather reconciled himself to hospital readmissions but not being obsessed by its occurrence as he was gratified to be alive after going through hardships in his life. Ka Keng described his life vividly:

> It's all luck if I'm alive! Ha! Ha! What else do I expect? Take it easy and accept it. After hanging on for so long, if I keep thinking I'm not as good as others, I can't sleep well, and I'll break down, right?

Yiu Pan also remarked that he accepted his physical illness and hospital readmissions because he understood that his health condition was deteriorating in a normal aging process. He regarded hospital readmissions as "taking the natural course of life." Likewise, Pak Fung viewed hospital readmission as "accepting the world as it is." For Yuen Tak, the insight he gained from his life experiences was that he should enjoy the present moment because time flies. He shared his view:

People will understand when they come to that stage. They will soon turn to be a 60 years old elderly. At that time, they will know that a person aged 30 and 60 is different. Time flies. Life is too short, right?

Linked to his view, Chi Kin also focused on living at the present but disregarded possible future adversities. He explained, “Both my wife and I don’t think that much. A time to be born, and a time to die. Even it comes, we have to face that. I would only think about it when it happens.”

Accepting the perceived inevitability of hospital readmissions and with the insight from their past experiences, the older people were not preoccupied by their condition but they seized the day with their families instead. During the periods of hospital readmission, they looked forward to family gathering after hospital discharge. The older people cherished the close family bonding. They appreciated the affinity and the close attachment established with their spouses through the hardship adulthood. Particularly, they were grateful for the effort of caregiving. They were also gratified with the filial piety and respect shown by their children. In the interviews conducted during their hospital readmission, the older people liked to talk about their family issues. Male older people tended to share their devotion to their families, while female older people were more concerned about the livelihood of their children. Also, the older people liked to share issues about their children and grandchildren. They felt honourable when talking about the accomplishment and self-sufficiency of their younger

generation. These older people treasured and cared more about the cohesive and harmonious family relationship rather than being absorbed by hospital readmissions. The older people were also aware of their demands on their family in taking care of them. They prioritized the collective interest over their own and were mindful of reciprocate their family. Therefore, the older people take hospital readmission as an opportunity to relieve their possible burden.

Moreover, most of the older people focused on issues that were enjoyable, such as looking forward to resuming social activities and going to “Yum Cha” (tea house) with friends after they were discharged from a hospital. Some older people endeavoured to maintain an independent life. For instance, Yat Lam, who lived alone, was pleased with incorporating his treatment modality into his daily life to prevent unwanted respiratory distress, which would require hospital readmission. He said that he would hand goods bought from a wet market on his oxygen cart to prevent shortness of breath and maintain his independence. Yat Lam also made the disease management as enjoyable. He preferred to relish a glass of Chinese tea before performing rehabilitative exercise. These examples vividly showed how the older people engaged in the present moment while they were revolving between hospital and home.

On the contrary, Hang Kei and Mei Fung found themselves still leading a difficult life. Hang Kei felt hopeless to his health after he had received a long period of treatment without improvement and had undergone hospital readmission multiple times. He even

considered ending his life if he would suffer more illnesses. The health problems of his spouse, however, drew his attention from his own hospital readmissions. Assuming the responsibilities of a husband, he was solicitous of his wife's health problem than his own even when he was readmitted to a hospital. He maintained the attitude of "taking one step at a time." His attention was on caring for his wife instead of being preoccupied with his health problems. For Mei Fung, she found her physical condition deteriorating with each readmission, and therefore she was prepared to eventually die before hospital discharge. Instead of being overwhelmed by the threat of dying, Mei Fung was regardful of meeting her family in the hospital on weekends. Although Hang Kei and Mei Fung were concerned about their health and hospital readmissions, they were more mindful of their families. They treasured and engrossed in the time being with their families.

Resignation to hospital readmissions fostered the attitude of living for the moment on the older people. Accepting that hospital readmission was unavoidable, they were not preoccupied with such inevitability but focused on and engaged in the present. It is observed that many older people expressed they were not affected by the hospital readmissions. Indeed, this notion was related to their satisfaction with their current situations under the influence of their past experiences. These past experiences were formed under similar social contexts and the experiences also gave rise to their attitude toward living with hospital readmissions. They conducted a positive comparison between their past and present

experiences in such a way that they were more satisfied with the present. Moreover, satisfaction with their current states and their attitude of living for the moment mutually reciprocated each other. Satisfaction provided room to cultivate their positive attitudes, which in turn reminded them to be grateful for their lives after living out their hardships during their adulthood. With the attitude of living for the moment, the older people embraced needing hospital care frequently for survival, confronting their needs for hospital readmission being disregarded by their doctors, and putting every effort into delaying the next hospital readmission. They also felt positive to remain conscious of relieving burden to their families.

Summary

The lived experience of hospital readmissions of Chinese older people with COPD was revealed from the narrative descriptions of the participants. A holistic view of the experience of hospital readmissions is outlined in the general structure. Six constituents emerged from this general structure, including refraining from unnecessary readmissions, craving for survival, feeling being disregarded and powerless, being conscious of relieving burden to families, resigning to hospital readmissions and living for the moment. Although the descriptions shared by the 22 older people vary, the six constituents coexist across them. The constituents are common among these older people because they underwent their adulthood around the same era and they encountered similar experiences during each hospital

readmission; thus they shared similar life experiences. These common and invariant constituents become the essence of the phenomenon of hospital readmissions of Chinese older people with COPD.

The general structure provides not only an overall view of the experience but also explicates the invariant constituents and highlights the interrelationships among the constituents. Each constituent illuminates the meanings of hospital readmissions to Chinese older people. The constituent "refraining from unnecessary readmissions" describes how older people manage their disease in relation to hospital readmissions. "Craving for survival" explains why older people require hospital readmissions. "Feeling being disregarded and powerless" and "being conscious of relieving burden to families" portray the experience of revolving between hospital and home. "Resigning to hospital readmissions" illustrates how older people understand the occurrence of this phenomenon and "living for the moment" uncovers how they live with their experiences. The lived experience of hospital readmissions reveals that older people are cognizant of their needs for hospital readmissions. They crave for survival when their breathlessness becomes unmanageable and intolerable. Despite they are certain about their urgent need for hospital readmission, they feel powerless when the necessity is disregarded by their doctors. Regardless of their distress and their needs for hospital care being unrecognized by their doctors, they keep conscious of relieving burden to their families during periods of hospital readmission. After they are discharged from

hospitals, they remain alert in delaying the next hospital readmission. Accepting hospital readmissions as inevitable, they resigned themselves to its occurrence. Nevertheless, older people are not bothered by this revolving door. Their past hardship inspires them to be satisfied with the current state of living. Therefore, older people lead their lives requiring hospital readmissions with an attitude of living for the moment which embrace readmissions into their lives.

CHAPTER FIVE

DISCUSSION

Introduction

The lived experience of Chinese older people with COPD on hospital readmissions was revealed with the use of the phenomenological approach. This chapter discusses issues pertaining to this experience. Socio-cultural influences to such experience in the Chinese context will be examined. The first section focuses on the constituents of the experience, and the extant literature is discussed. The second section discusses the totality of the experience of hospital readmissions in Chinese older people.

The Lived Experience of Hospital Readmissions of Chinese Older People with COPD

Six constituents of the lived experience of hospital readmissions were revealed from the Chinese older people's narrative descriptions in this study. These constituents include refraining from unnecessary readmissions, craving for survival, feeling being disregarded and powerless, being conscious of relieving burden to families, resigning to hospital readmissions, and living for the moment. In the following sections, these constituents are discussed in relation to the literature, and the socio-cultural influences are explored in the Chinese context.

Refraining from Unnecessary Readmissions

With hospital readmission considered as the last resort to survive breathlessness, the Chinese older people in this study exert every effort to refrain from unnecessary readmissions. They believed that only they themselves could help avoiding unnecessary readmissions. Their approaches ranged from passively staying inactive at home to avoid provoking breathlessness to actively performing regular exercise to delay physical deterioration. With their experiences of relieving dyspneic attack, they were well prepared to manage exacerbation of their condition. Although older people submitted to seek hospital care when their breathlessness became uncontrollable, they were satisfied when they were able to exercise limited control in delaying their next hospital readmission.

Reasons to avoid unnecessary hospital readmissions

The literature has shown that COPD patients are inclined to refrain from being readmitted to hospitals. Hasson et al. (2008) and Schofield et al. (2006) have shown in their studies that the most common reason for this situation is that the patients observe that the ward environment and hospital staff as being too busy to assist them. Therefore, these patients avoid imposing demands on the staff, and they deem that only severely ill patients deserve to receive care. In addition, Hasson et al. (2008) highlighted that the patients in their study felt demoralized from previous hospital readmissions. This feeling caused the patients

to abstain from going to hospitals, even though they understood the danger of disease exacerbation without immediate treatment. Therefore, patients' feelings toward hospital readmissions were significant in influencing their decision to avoid hospital readmissions.

Compared with the literature, the Chinese older people in the current study refrained from hospital readmissions for different reasons based on their personal experiences. They viewed hospitals as a transient place that only saved them from critical distress without improving their condition. Compared with the hospital environment, the older people felt more at ease at home and that their needs were well understood and respected by their family members at home. Although the older people felt secure with being able to receive prompt treatment in case of respiratory distress at the hospital, they lacked meaningful activities and felt that they were subservient because they were dependent on the hospital staff. Particularly, the older people considered that seeking hospital care every time they suffered from breathlessness was unrealistic because they often experienced shortness of breath. Therefore, the older people preferred to manage disease exacerbation by themselves and regarded hospital readmission as the last resort for treating uncontrollable breathlessness.

Similar to the findings of Hasson et al. (2008), in particular that their COPD patients were demoralized by hospital readmissions and abstained from hospital readmission, the Chinese older people in the current study also experienced negative feelings toward hospital readmissions. However, these feelings arose from the older people's perceived lack of

understanding and empathy from their doctors. The attitudes of doctors initially discouraged some of them from being readmitting to the hospital. However, the older people considered hospital care necessary when they could not manage their breathlessness, particularly after they had tried their own means of avoiding unnecessary hospital readmission. In addition, the older people commonly expressed that they had become accustomed to shuffling between hospitals and their homes. These attitudes reflect that the older people coped well with their negative feelings and adapted to hospital readmissions. Their acceptance of repeated hospital admissions is discussed in a later section that focuses on resignation to hospital readmissions.

Relying on oneself and caregivers to avoid unnecessary readmissions

From their experiences of living with COPD, the Chinese older people believed that they could rely only on themselves and their caregivers to avoid unnecessary readmissions. Their perceptions of disease management in terms of refraining from hospital readmissions pertain to the concept of illness perceptions. This concept uses a perceptual-cognitive model to explain how a patient appraises the threat of a disease and the treatment effect (Leventhal, Leventhal, & Cameron, 2001). The appraisal is made according to five dimensions: (1) identity – illness label, and symptoms; (2) causes – identified factors that result in the disease; (3) consequences – expected outcomes of the disease; (4) timeline – expected duration of the disease; and (5) controllability – beliefs about whether the disease is curable.

Studies have shown that illness perceptions are related to some health-related outcomes of COPD patients in terms of medication adherence, hospitalization, and quality of life (Borge, Moum, Lein, & Austegard, 2014; Scharloo, Kaptein, & Schlösser, 2007; Stehr, Klein, & Murata, 1991).

In this study, the Chinese older people understood that COPD is a chronic illness. Thus, they expected to be readmitted to the hospital as a consequence of the disease. This assumption was strengthened by their perception of aging, which was that their physical condition would keep deteriorating. Hence, they realized that their controllability of COPD was very limited and that hospital readmissions were inevitable. This belief was further affirmed by their doctors, who told them that the disease is incurable. The older people found that medications could only relieve their symptoms but not improve disease progression. Therefore, their illness perceptions concluded that adhering to the treatment regimen was inadequate to avoid hospital readmissions. With these understandings about their disease and the perception that they were personally responsible for their own health, the older people could rely only on themselves and their caregivers to avoid unnecessary hospital readmissions.

Furthermore, the older people in this study observed a lack of continuation of care after an acute exacerbation of their COPD, as they were discharged to home without receiving any support from the hospital or the community. Similar complaints were also made

by discharged COPD patients in the study of Gruffydd-Jones et al. (2007). Without pragmatic support, Chinese older people manage the disease and refrain from unnecessary hospital readmissions on their own or with the assistance of their caregivers. Nevertheless, the older people in the current study perceived that their dependency on caregivers inevitably imposed a burden, which was a concern for the older people. Hence, they desired their caregivers to have a respite when they were readmitted to hospitals.

Becoming experienced in the self-management of COPD

When people are first diagnosed with a chronic disease, they follow the prescriptions given by their doctors and learn about disease management. Chronic disease is characterized by its slow progression. Patients gradually learn more about the disease and devise their own ways of managing it based on their daily experiences. Therefore, people with chronic disease become "expert patients" who are not only familiar with their disease but also initiate their own regimen to relieve discomfort. Patients with COPD likewise adopt various methods to relieve their symptoms and meet their daily needs within physical limitations. These methods are devised based on "trial and error" or their daily experiences (Apps et al., 2014). This phenomenon reflects the idea of a Chinese proverb, which states that "a long illness turns the patient into a doctor."

Studies have shown that patients with lung disease commonly modify their prescribed

regimen according to their degree of breathlessness or perceived needs (Horne, 2006; Restrepo et al., 2008). When patients experience exacerbated symptoms, they prefer to self-medicate to relieve the symptoms instead of visiting doctors (Kessler et al., 2006). Some patients also stockpile their drugs for self-medication in case of disease exacerbation to avoid seeking medical consultation (Oliver, 2001).

This study illustrated that the Chinese older people have also evolved their own ways of self-managing COPD based on their experiences. Their approaches ranged from passively avoiding breathlessness to actively strengthening their physical condition. They had learned methods of managing dyspneic attacks from pulmonary rehabilitation programmes, but their confidence in these methods was enhanced by their successful experiences of refraining from unnecessary hospital readmissions. In addition to using conventional methods of disease management, some older people also devised their own strategies that involved items that were easily accessible at home, such as a glass of water and a blanket, while others devised simple methods with their caregivers. The older people employed these strategies not only to relieve breathlessness but also to refrain from unnecessary hospital readmission; thus, the methods were convenient and practical for them.

The older people become experienced in managing their disease and knew how to avoid unnecessary readmissions. Their experiences suggest that confidence and perceived capabilities in managing the disease are important. As shown in the study of Yu et al. (2007)

which explored the perspectives of Chinese older people regarding recurrent hospital readmission, the older people felt powerless to manage the disease after hospital discharge because of their perceived lack of confidence and abilities to manage breathlessness. In addition to the perceived threat of imminent death from breathlessness, they were prompted to seek hospital care for disease exacerbation. Therefore, the perceived confidence and capabilities in managing COPD are important attributes in motivating older people to make attempts to avoid unnecessary hospital readmissions.

Previous studies have reported that hospitalized COPD patients are concerned about the lack of discharge planning and ways to self-manage the disease after discharge (Gruffydd-Jones et al., 2007; Small & Graydon, 1993). In the current study, however, the Chinese older people were not bothered about discharge planning. Their experiences in seeking hospital readmission repeatedly after making an effort to manage their breathlessness led them to realize that hospital readmissions are inevitable. Thus, they understood that disease management merely delayed the next readmission, and they resigned themselves to hospital readmissions. After being discharged from the hospital, they remained vigilant in preventing triggers for breathlessness that might result in unnecessary readmission. With their experiences in handling breathlessness and avoiding hospital readmission, the older people were not concerned about the discharge planning, but accepted their own responsibility in managing the disease and refraining from unnecessary hospital readmission.

In summary, the Chinese older people strived to refrain from unnecessary hospital readmissions. They believed that only they and their caregivers could help manage the disease. With their experiences in managing the disease, they were familiar with the ways to avoid hospital readmissions. Nonetheless, older people realized that their effort would merely delay the next hospital readmission, and this awareness fostered the acceptance of the inevitability of hospital readmissions.

Craving for Survival

The lived experience of the Chinese older people in this study revealed that they sought hospital readmission to survive their respiratory distress. They attempted to refrain from unnecessary hospital readmission using various approaches. Breathlessness, however, causes considerable physical and psychological distress when this condition becomes unbearable and uncontrollable, resulting in a feeling of suffocation. Thus, older people became anxious and were afraid of not being able to receive timely help. Such distress warned them of impending death, which drove them to find ways to survive such a threat. Perceiving the urgency of the situation, older people considered no alternative other than to receive hospital care to assure survival.

Older people's reasons of seeking hospital readmissions

The urgent need to survive breathlessness echoes the experiences of older people revealed in the study of Yu et al. (2007). In their study, the older people with COPD were prompted to seek hospital readmission because of the feeling of impending death from breathlessness. Given their lack of confidence in community-based healthcare services, these older people returned to the hospital for medical care instead of attending community clinics during episodes of exacerbation. Similarly, the older people in the current study considered no alternative but to receive hospital care to alleviate their intolerable distress and ensure their survival. They also found that the medications provided by the hospitals were more effective in soothing their respiratory distress. A few older people even considered that private practitioners only made money from them without improving their physical conditions, and thus they would rather seek hospital care during exacerbation.

Previous studies have identified several factors associated with hospital readmission from the perspective of healthcare professionals. These factors can be categorized into four dimensions, including clinical factors (Almagro et al., 2006; Chen & Narsavage, 2006; Garcia-Aymerich et al., 2003; McGhan et al., 2007; Roberts et al., 2002), socio-economic status (Chan et al., 2011; Ghanei et al., 2007; Lau et al. 2001), psychological factors (Abrams et al., 2011; Coventry et al., 2011; Ghanei et al., 2007), and HRQOL (Osman et al., 1997; Wang & Bourbeau, 2005). Although these factors cover various dimensions, they are

insufficient to illustrate why and how COPD patients seek hospital readmission. Previous studies have also indicated that disease exacerbation is the most common reason for unplanned hospital readmission among COPD patients (Pooler & Beech, 2014; Wedzicha & Seemungal, 2007). Parashall (1999) reported that admissions were nearly twice as likely among patients who complained of laboured breathing compared with patients without related complaints. Some studies have also shown that exacerbation is viewed by patients as a crisis that represents a life or death situation (Kvangarsnes, Torehein, Hole, & Öhlund, 2013; Oliver, 2001).

The current study did not intend to address the abovementioned factors and their relationships, but it clearly revealed how physical and psychological distress arose from breathlessness, and drove the older people to seek hospital readmission. The described experiences in this study support the findings of previous studies, which argued that older people required hospital readmission as their conditions exacerbated. The older people in this study consistently stated that they sought hospital care because of breathlessness. Their experiences further vividly unveiled their drive to survive the crisis through hospital readmission. This urgent need for survival was reinforced by their perceived physical and psychological distresses. When the older people became exhausted from laborious breathing, they were afraid of losing their breath. In addition to their inability to use inhalers because of their weakness, these people were physically threatened with the feeling of imminent death.

Therefore, the older people required hospital readmission to relieve their distress.

The psychological impact of breathlessness has also been widely investigated in the literature. By examining the perceptions of COPD patients toward exacerbation, Kvangarsnes et al. (2013) noted that these patients adopted words with negative connotations to describe their experiences, such as scary, choking, and ugly. Anxiety and depression are also commonly found to be associated with COPD-related hospital readmission (Coventry et al., 2011; Ghanei et al., 2007). In a systematic review of 24 studies, Pooler and Beech (2014) established a theoretical relationship among anxiety, depression, and exacerbation of COPD that leads to hospital readmissions. Such a relationship shows that anxiety and depression, the number of disease exacerbation, the resultant hospital readmissions, and the inability to cope with the diseases all exist in a vicious cycle.

Instead of understanding anxiety and depression in a general sense, the experiences of older people highlight that their psychological distress is disease-specific and warrants hospital readmissions. This study explicitly illustrated why the older people experienced psychological distress and how such distress prompted them to seek hospital readmission. The older people in this study also described that they experienced psychological distress when their breathlessness became unmanageable. They mentioned that they were overwhelmed by the unbearable distress and required a sense of security to ensure their survival. This sense of security was obtained once they used a safety bell to call for

emergency care. The older people who lived alone particularly felt insecure when they could not control their breathlessness because they were afraid that they would not be able to receive help. The treatment that was provided by emergency care swiftly allayed their psychological distress to a certain level. After readmitting to the hospital, the threat of imminent death was further alleviated by receiving treatments that stabilized their physical condition. The relief from breathlessness signifies not only the resolution of psychological distress but also survival from a crisis.

Studies on COPD patients show that these patients experience stress when deciding to seek hospital readmission (Hasson et al., 2008; Schofield et al., 2006). They consider that the hospital staff would be too busy and that only severely ill patients warranted hospital care. However, the older people in the current study found that seeking hospital readmission was an easy decision. This was most likely because they had managed their breathlessness as best as they could until their conditions became uncontrollable. They believed that hospital readmission was necessary because of the perceived threat of breathlessness. Therefore, they considered that without alternatives it was legitimate to seek hospital care for the sake of their lives.

Caregivers' reasons of seeking hospital readmissions

This study did not aim to explore the experiences of caregivers in taking care of older

people with COPD. However, the narratives of the older people revealed that their caregivers' psychological stress prompted them to seek hospital readmission. The findings on the psychological stress of caregivers are consistent with those of previous studies (Bailey, 2004; Semark et al., 2004). Caregivers are vigilant to the care recipients' conditions. They consider hospital readmission as a break from their caregiving duties. Yu et al. (2007) found that caregivers sought hospital readmissions for their care recipients as a way to relieve themselves from the tension caused by their caregiving role.

In this study, some older people expressed that their caregivers also experienced psychological distress from disease exacerbation. The caregivers were under hyperarousal to environmental stimulants that could be associated with disease exacerbation. Instead of treating hospital readmission as a relief from caregiving-related stress, some caregivers sought hospital care for their care recipients because of their own panic in response to the older people's crisis. Such a discrepancy in the intention of caregivers seeking hospital readmission could be attributed to differences in caregiving burden. The present study and Yu et al.'s (2007) study did not measure the disability of the older people and the caregiving burden on the caregivers. However, most of the older people in this study could perform their daily activities independently. Moreover, the number of hospital readmissions of the older people in this study was less than that in Yu et al. (2007). Although the severity of COPD in these two groups of older people was not quantified, a higher number of hospital

readmissions suggests worse physical conditions (Garcia-Aymerich et al., 2003; Gudmundsson et al., 2005). The older people in the current study were postulated to be less demanding and dependent on their caregivers. Therefore, although the caregivers were worried about their care recipients, they would not regard hospital readmission as a respite. The dynamic relationship between older people and their caregivers are further discussed in the section on being conscious of relieving the burden on the families.

In summary, the lived experience of the Chinese older people clearly revealed how intense physical and psychological distresses caused by breathlessness rendered them to seek hospital readmissions. Older people yearned for a sense of security and relief from their distress. The urgent need for survival from impending death prompted these older people to seek hospital readmission. The psychological stress of caregivers also may have played a part. However, litter is known about the experiences of caregivers in taking care of older people who are repeatedly admitted to hospitals.

Feeling Being Disregarded and Powerless

For the Chinese older people seeking hospital readmissions to survive breathlessness, breathlessness was an utterly subjective experience. Older people were familiar with their diseases and bodily needs. However, they believed that healthy individuals, such as doctors,

might not have experienced their symptoms, such as breathlessness, so they did not understand how they feel. Thus, older people believed that doctors disregard their urgent need for hospital readmission. Assuming the submissive patient role, older people believed that they were expected to be cooperative with and obedient to the hospital staff. Such a perceived expectation may have hindered communication with the staff, which could have led to a sense of powerlessness that became most salient when they struggled with their need for hospital readmission.

Being disregarded of subjective illness experience

Early signs of COPD exacerbation, such as breathlessness, fatigue, and chest tightness, are subjective feelings of distress. Healthy individuals may have difficulty understanding these subjective feelings. Studies have shown that people with other chronic problems that are also characterized by subjective feelings perceive their physical complaints as not being recognized by their doctors. Werner and Malteurd (2003) explored the experiences of women with chronic pain during consultation with their doctors. The women reported difficulties in presenting their pain visibly to their doctors. They strived to be perceived as credible patients while they struggled to maintain their self-esteem. Bathe, Weisshaar, and Matterne (2012) depicted subjective illness perceptions of people suffering from chronic pruritus. The participants expressed difficulty in describing their symptoms,

which often resulted in feelings of being misunderstood and the burden caused by pruritus of being overlooked by healthcare professionals.

People with COPD also feel that their symptoms are not recognized by their family members and friends (Apps et al., 2014). As the predominant symptom of COPD, breathlessness is not easily identified by others. Even spouses, who presumably know the patient well, find breathlessness to be difficult to detect because of the normal appearance of the patient (Gysels, 2008). For doctors who recognized that their patients are suffering from breathlessness, they may underestimate the severity and psychological impact of disease exacerbation (Kessler et al., 2006). Doctors have also been criticized by patients for being interested only in objective clinical data (Bailey, 2002; Oliver, 2004), and having a lack of understanding of the disability of COPD patients (Gysels, 2008).

Similarly, in this study the subjective nature of breathlessness could have led doctors to disregard the Chinese older people's need to seek hospital readmissions. Several clinical signs, such as cyanosis, as well as rapid and shallow breathing, are commonly known as the sings of breathlessness. However, these signs are observable only when the breathing difficulty has become too severe. Indeed, breathlessness is a complex phenomenon to sufferers. Gift (1990) proposed a model of dyspnea with five components, including physiological sensation, perception of dyspnea with regard to one's own expectation and past experience, psychological distress correlated to dyspnea, strategies and coping methods for

dyspnea, and descriptors of dyspnea. Therefore, attention to the physical signs of dyspnea without taking patients' feelings and other aspects into consideration can underestimate or overlook their suffering.

People who have suffered from breathlessness understand this complex experience the most. Therefore, people without such an experience tend to disregard the feelings and needs induced by breathlessness. In the current study, the Chinese older people did not doubt the urgent need for hospital readmission when their breathlessness became uncontrollable. Their body sensations and experiences of struggling with breathlessness vividly informed them of the necessity of hospital readmission. The practical knowledge acquired from the experience of managing a disease enabled patients to identify crisis sensitively (Janson-Bjerklie, Ferketich, Benner, & Becker, 1992). However, the older people in this study found that some doctors failed to understand their experience and discounted their need for hospital care because of the lack of a similar experience. The most disappointing aspect for these older people was the fact that some doctors normalized their breathlessness and expected them to bear and accept the symptoms. Such arbitrary requests are related to the lack of experience in suffering breathlessness. Thus, the urgent need for hospital care of older people to survive respiratory distress is complicated by the subjective nature of breathlessness. If doctors solely use their medical knowledge to assess the observable signs of dyspnea, the feelings and healthcare needs of older people could be disregarded and neglected.

Feeling powerless in the paternalistic doctor-patient relationship

In this study, a paternalistic relationship was observed in the interaction between the Chinese older people and their doctors. Given the specialized knowledge and training of doctors, they are regarded as guardians who can make the best decisions for their patients. Such a relationship resembles a father-child relationship and thus is referred to as paternalism (Chin, 2002). This relationship implies unequal power between doctors and patients. The doctor's status is another source of power in addition to power from social prestige, exclusive medical knowledge and skills, and medical resources (Goodyear-Smith & Buetow, 2001). However, such power has been weakened by advanced information technology and upholding of patient's autonomy in Western countries (Chin, 2002; Goodyear-Smith & Buetow, 2001), where the doctor-patient relationship has become more client-centred (Goodyear-Smith & Buetow, 2001; McKinstry, 1992).

Nonetheless, the paternalistic nature remains in the typical doctor-patient relationship in the Chinese context. This paternalistic relationship is probably strengthened by the Confucian beliefs of accepting hierarchy and being obedient to authority (Luo, 2001). Doctors possess high social status and reputation in Chinese societies (Cong, 2004). In fact, the feature of the father-child relationship implies a hierarchical structure underlying the relationship. As noted in a study investigating doctor-patient communication among Chinese people (Wang, 2010), doctors dominated and controlled conversations, as well as asked

patients with authority. Chinese patients commonly show respect to doctors by nodding their heads, even when they do not understand what the doctors are saying. They agree and try to avoid conflict with their doctors because of the fear of possibly becoming a victim.

The perceived powerlessness experienced by the Chinese older people in the current study arises from this paternalistic relationship. Dependent on the hospital staff, the older people assumed a submissive patient role to fit in with the hospital environment. They believed that they were expected to be subservient to the hospital staff. Such a perceived expectation instilled a sense of powerlessness that became most salient when they interacted with their doctors, who the older people viewed as authoritative figure. Doctors are their decision-makers in terms of the utilization of hospital resources and prescriptions for treatment, so the older people relied on their doctors to provide hospital care to relieve their distress from disease exacerbation. Such reliance, together with the power disparity, led them to experience top-down communication when they interacted with their doctors. Therefore, the older people felt powerless and helpless when their urgent need for hospital readmission was disregarded by their doctors.

The superior status of doctors not only comes from their medical knowledge but also from their power to allocate medical resources. Their decisions on hospital admission and discharge and what kind of treatment patients receive are greatly related to patients' physical needs. Moreover, they may also induce psychological stress in patients. Although doctors

make major decisions regarding treatment for older people, they interact the least with older people compared with other health disciplines. During hospitalization, nurses have the most frequent interaction with older people and they constantly provide different nursing interventions to meet their various needs. The older people in this study perceived that compared with doctors, nurses were more empathetic and sensitive to their needs for hospital care in managing respiratory distress. The older people also found that physiotherapists were approachable. They perceived that the physiotherapists were concerned about why they were readmitted to the hospital instead of criticizing their inability to manage their disease. The older people also recognized some supporting staff from previous hospital readmissions. Although they did not have much communication, the older people found the supporting staff to be helpful and respect them. The concerns expressed by nurses, physiotherapists, and supporting staff are examples of care using a client-centred approach. Although the older people presumed the expected submissive patient role to all hospital staff members, their sense of wellness was maintained when the hospital staff showed an understanding of their feelings and personal needs. As a result, the older people were willing to express their needs when they felt that they were respected.

In the paternalistic relationship, however, the power disparity discourages open communication between older people and doctors. Patients with an egalitarian relationship with doctors typically attempt to convey their subjective symptoms visibly (Werner &

Malteurd, 2003). Yet, the Chinese older people in this study considered that it was futile to explain their subjective feeling of breathlessness and convince their doctors of the urgent need for hospital readmission. The perceived powerlessness hindered communication between the older people and their doctors. Some older people ventilated their frustration to those who they were considered to be as more empathetic, such as nurses and physiotherapists. Nevertheless, the sense of powerlessness also made the older people act passively to the orders given by their doctors to avoid confrontation, and this frustration was suppressed under the paternalistic relationship.

Protecting face

In the experience of hospital readmissions, the Chinese older people had constant interactions with hospital staff. The findings of this study reveal that they were concerned about losing face in these social interactions. The older people not only protected their face during the hospitalization period but also attempted to preserve their face from making the decision of seeking hospital readmission to hospital discharge. Face is an intrinsic and ingrained concept embedded in Chinese culture. As defined by Hwang (2006), face refers to "a person's cognitive response to social evaluation of his conduct in a particular situation" (p. 277). Hence, face represents the social image and social worth of an individual with reference to the person's demeanour in a given interpersonal context (Hwang, 1997). It pervades every

social situation from informal personal interactions to formal organizational relationships (Qi, 2011). In Chinese societies, face is important because it maintains social order and interpersonal relationships (Bond & Lee, 1981). It is highly salient in hospital setting which is operated under a hierarchical structure. Given that older people assume a submissive patient role that is presumably with a low social status, they strive to protect their face in the hierarchical structure.

In the current study, several older people expressed their hesitation in seeking hospital care during the first few times of readmissions. They worried about being blamed by their doctors for frequent hospital readmissions. The concern about being criticized by doctors is a form of behavioural judging; causing patients to worry about whether seeking hospital readmission will cause them to lose face. The older people in this study initially felt ambivalent toward the dilemma between obtaining hospital care to relieve breathlessness and protecting face. They felt their self-esteem was impinged when their urgent need for survival was disregarded by their doctors, who were in control of medical resources and were regarded as superior in the hospital setting. Disapproval and rejection in interpersonal interactions can threaten the social image of the older people. A debilitated self-image cause a person to perceive face loss (Liao & Bond, 2011) and decreases the level of self-esteem (Hwang, 2006). Previous studies also demonstrate that concern for losing face affect patients' help-seeking behaviours (Gang, Gang, & Tacata, 2003; Lay & Wong, 2008). Despite their

concern about protecting face, the older people in this study eventually resorted to seeking hospital readmission for survival.

The findings of this study show that the older people cooperated with and minimized their demands on the hospital staff during hospitalizations, such as nurses and healthcare assistants. The older people believed that patients are expected to maintain harmony with the hospital staff. This belief rendered them to comply with social norms as a means to save face (Thomas & Liao, 2010). Face is maintained when people fulfilled their social role (Mak, Chen, Lam, & Yiu, 2009). People also seek respect and approval in interpersonal relationships, which provide them a feeling of social acceptance. Therefore, individuals deliberately evaluate whether they would lose or gain face in a given situation (Hwang & Han, 2010) and consciously appraise how their social image might be affected by their behaviour (Brown & Levinson, 1987). This self-appraisal then determines the behaviour of an individual. The Chinese older people in this study, therefore, conformed to their perceived expectations of submissive patient roles. It allowed them saving their face by being regarded as "good patients" in the hospital.

When the Chinese older people considered that they were being discharged from the hospital prematurely, they did not request to continue hospitalization. It was because they believed that their doctors did not listen to their concerns; thus, they saved the face by avoiding confrontation with and refusal by their doctors. Chinese people protect their face in

front of other individuals when they believe they will have a long-term relationship with these individuals (Hwang & Han, 2010). Given that the older people were resigned to the inevitability of hospital readmissions, they prepared to have frequent interactions with the hospital staff. Therefore, they strived to protect their face even they were not ready to be discharged.

Face has a significant role in interpersonal relationships. It is of particular concern in collectivistic cultures (Redding & Ng, 1983). Hence, Chinese people even save their face for the other party in a conflicting situation (Gabrenya & Hwang, 1996). Face can be distinguished into "self-face" and "other face". The former refers to an individual's motivation to protect own face, whereas the latter denotes a person who preserve face for others (Mak et al., 2009). Other face is significant in interpersonal relationships in Chinese societies and emphasizes the maintenance of group harmony (Bond & Hwang, 1986). Disagreement with the treatment plan is regarded as challenging the social status of the assigned doctor and undermines social harmony (Shih, 1996). In the paternalistic doctor-patient relationship, passive agreement with doctors not only protects face for the two parties but also facilitates the maintenance of harmony between the older people and the hospital staff by avoiding open confrontation. Although face is saved, vigilance in avoiding face losing situations can induce psychological distress (Mak et al., 2009).

In brief, the subjective nature of breathlessness rendered the Chinese older people's suffering and urgent need for hospital readmission more complicated. The perceived powerlessness in a paternalistic doctor-patient relationship discouraged the older people from conveying their subjective feelings to their doctors. Meanwhile, the older people had to protect face, even when they felt powerless in that their needs and feelings were being disregarded by their doctors. Although the older people perceived other healthcare team members as helpful and supportive, the lack of respect from their doctors may have impinged on their dignity. Nevertheless, the Chinese older people were most mindful of the possible burden they imposed on their families. In addition, they were not bothered by these negative feelings when they eventually became used to and accepted the inevitability of hospital readmissions.

Being Conscious of Relieving Burden to Families

The Chinese older people were eventually resigned to hospital readmissions, but they were still concerned with the possible burdens imposed upon their families by their hospital readmissions. Older people were aware of the demands on their informal caregivers, who were usually their spouses, and they positively regarded hospital readmission as an opportunity to allow a respite from caregiving duties. They also upheld the collective welfare of their families. Older people remained conscious of not being a burden on their families

because of their frequent need for hospital readmissions.

Relieving burden on caregivers

People with COPD are keenly aware of their daily needs, as well as the demands on their caregivers in day-to-day living. Often, they are concerned about becoming a burden to their caregivers. Jeng, Tsao, Ho, and Chang (2002) studied the experiences of older Taiwanese people with COPD in daily activities after hospital discharge. They found that the participants worried that their daily activities might cause another dyspneic attack while they strived for independence to avoid being a burden to their families. The older people in this study considered their hospital readmissions as a chance to diminish the existing burden on their families, particularly their caregivers. Instead of boosting their demands, hospital readmission was deemed as an opportunity to provide a physical and psychological respite for their caregivers.

The stress of taking care of a family member with COPD has been described in previous studies (Berges, 2002; Semark et al., 2004; Simpson et al., 2010). Caregivers regard the hospital admission of their care recipients as a respite (Simpson et al., 2010). Apart from caregiving duties, strain also arises from the unstable nature of COPD, thereby adding difficulties to caregiving. Dyspneic attacks not only threaten COPD patients but also cause considerable stress for caregivers. According to Bailey (2004), caregivers are relieved from

the stress brought on by the breathing difficulty of their care recipient once the latter decides to seek hospital care. The study of Yu et al. (2007) uncovered a tense relationship between the older people with COPD and their caregivers. The caregivers relieved their burden by requesting doctors to readmit their care recipients to the hospital. Such a request affirmed the perception of older people of being a burden and induced a feeling of abandonment.

The current study adds to the understanding of the caregiving burden in relation to hospital readmissions from the perspective of care recipients. The older people in this study were keenly aware of their demands on their caregivers in daily care and they were grateful for their efforts. However, the older people could not relieve the burden of their caregivers unless they were readmitted to hospital, where they received care from hospital staff. Therefore, they were conscious of relieving their burden on their caregivers during periods of hospital readmission. Furthermore, the older people also recognized that their caregivers became nervous upon seeing them suffering from breathlessness. Some of the caregivers, therefore, sought hospital readmissions for the sake of the older people. Although the older people preferred that their caregivers take the periods of their hospital readmissions as an opportunity to relieve themselves from their caregiving stress, the caregivers remained supportive and caring during the care recipient's hospital stay. The older people greatly appreciated the dedication of their caregivers, and their mutual support was observed and heightened during hospital readmissions.

The relationship between the older people and their caregivers in this study was different from that described in the study of Yu et al. (2007) probably because of two reasons. The first attribute is related to the physical condition of the two groups of older people in these two studies. As previously discussed in the section on craving for survival, the number of participants' hospital readmissions was higher in Yu et al. (2007) compared with this study. Thus, the physical condition of those older people might have been poorer. In addition, the severity of COPD has been positively correlated to the subjective caregiving burden (Figueiredo, Gabriel, Jácome, Cruz, & Marques, 2014). Hence, the perceived burden could have been heavier for the caregivers in the Yu et al. (2007) study compared with the caregivers in this study. The second attribute could be related to the quality of the relationship between the caregivers and the older people. Studies have shown that the quality of a relationship is negatively correlated to the perceived caregiving burden (Baronet, 2003; Pinto, Holanda, Medeiros, Mota, & Pereira, 2007). Although the quality of relationship between the caregivers and the care recipients was not assessed in these two studies, the mutual support expressed by the older people in the current study suggests a positive relationship with their caregivers. The perceived burden of their caregivers was possibly lower. Hence, these attributes may have affected the subjective burden on the caregivers, as well as their attitudes and supportive behaviours to the older people with regard to hospital readmissions.

The older people in this study were mindful of relieving the burden of their caregivers

whereas the caregivers were dedicated to provide continuous care during the periods of hospital readmission. This mutual support between the older people and their caregivers was particularly pronounced between spouses. This unconditional support could be understood in terms of their cultural context. Among the Chinese population, most informal caregivers of older people are the females in the family, and they are usually the spouses of the care recipients and are similar in age (Zhan & Montgomery, 2003). Traditionally, a husband is "the master of the family" and a wife is socialized to obey her husband (Shek, 2006). Husbands take the dominant role in families, acting as the head and earning the main livelihood. Meanwhile, wives prioritize family issues over their own issues and are committed to sacrificing themselves to maintain the health of the families (Yu, 2000). Although a hierarchy is apparent in that the husband acts as the "master" and wife supports the families, the traditional marital philosophy also emphasizes a lifelong commitment to taking care of one's partner (Tu, 1998). A local study about the attitude of Chinese older people toward informal support provided by their families found that the older people preferred to approach their spouses for informal care rather than their children (Lee & Kwok, 2005). The study also indicated that married older persons were more satisfied with the informal care they received from their spouses.

Nevertheless, taking care of a family member with a chronic illness is a debilitating task. The perceived obligation of caring for a frail husband induces not only a physical

burden but also a psychosocial burden on the wife. In Hong Kong, Chan and Chui (2011) examined the caregiving burden on spousal caregivers who took care of older family members. Quantifying the subjective burden with the Caregiver Burden Inventory, spousal caregivers who maintained strong traditional Chinese family values and a low degree of marital satisfaction suffered from a higher level of perceived caregiving burden compared with others. Although the caregivers who strongly held on to family values experienced higher level of caregiving burden, forgoing their caregiving duties was viewed as a violation of the traditional marital philosophy and roles of spouses. Such a dilemma is regarded as struggling in a "caring trap" (Ngan & Cheng, 1992). Interviewing Chinese older women who were spousal caregivers, Holroyd (2005) found that women were determined to take up and continue their caregiver roles because of their duty-bound role and the need to uphold the reputation of Chinese wives. The above studies show that the Chinese spousal caregivers' resolution to maintain caregiving duties is supported by their cultural values.

Bergs (2002) interviewed wives who looked after their husbands with COPD to explore their experiences. Findings revealed that the women were often frustrated with losing the freedom to enjoy recreation and social activities, as well as lack of support from their families and healthcare providers. The current study did not aim to assess the subjective burden on spousal caregivers or explore their experiences of providing care to older patients who frequently required hospital readmission. Whether the decision of spouses to continue

providing care during hospital readmission is related to the cultural obligation is unknown. Nonetheless, the narratives of the older people showed that caregivers were eager to fulfil their roles even when they were given the opportunity to exempt from it. For example, caregivers persisted in undertaking their roles of wives despite knowing that their care recipients were securely under professional care at the hospital. In this case, it appears that the wives internalized the duty-bound role as caregivers. In addition, the male older people were not autocratic in demanding that their spouses provide support and care. Indeed, the gender roles in the traditional Chinese marital relationship have transformed to become relatively more egalitarian (Shek, 2006), in that when husbands are supported and cared for by their wives, they are grateful for their devotion and are concerned about the burden they impose.

In the present study, the male older people were more concerned about the demands they imposed on their caregivers than their own health problems. They relied on their caregivers for disease management and some of them were dependent on their caregivers in managing daily activities. The older people valued mutual support the most. Therefore, they remained conscious of attempting to relieve the burden to their spousal caregivers. Apparently, altruism between the Chinese older people and their caregivers emerged from their experiences of hospital readmissions.

Relieving burden on other family members

The Chinese older people were not only aware of the demands on their caregivers but also mindful of demanding on their family members by hospital readmissions. They deliberately relieved burden to their families. Their intention and ways of relieving burden reflect the cultural issues of collectivism and filial piety.

Collectivism

The Chinese older people discouraged their children from visiting them at the hospital and even concealed their readmission because of the demands imposed on their working children. The older people were regardful that their children were engaged in work to earn a living. They preferred that their children pursue meaningful activities or take a break after work instead of spending time on hospital visits. Consciously relieving the burden on the whole family was salient in the lived experience of the Chinese older people. In the literature, studies related to the experiences of hospitalization of people with COPD reported only the relationship with informal caregivers (Bailey, 2004; Simpson et al., 2010). In the study of Yu et al. (2007), they described the tension in the relationship between Chinese older COPD patients and their caregivers. Their study suggested that caregivers may experience caring dilemma between the moral obligation to care for sick family members and relieving their caregiving burden. The current study further reveals that Chinese older people are concerned

not only with the demands they impose on their caregivers but also with the possible burden they impose upon the entire family.

The Chinese older people in the present study were more concerned about the needs of their children than their own needs. The findings highlight the solicitude of the Chinese older people toward the family, which is related to the ingrained influence of collectivism. Collectivity pervades Chinese societies under the influence of Confucianism. Based on a close-knit social structure, goals of groups are prioritized over individual's needs (Hofstede & Bond, 1988). Chinese people follow the Confucian principles in social interactions (Chan, 2001). In Confucian philosophy, every individual has a definite social role in a group and is expected to show certain behaviour (Cheng, Lo, & Chio, 2010). A group can prosper when an individual acts in the interest of the group (Leung, 2010). Family is one of the basic social groups, and family lineage is of vital importance in Chinese culture (Chu & Yu, 2010). Loyalty to family is highly valued in Confucianism (Chan, 2001). Each family member is an integral part and members are closely connected. When children are young, they are socialized to act for the collective welfare of the family. Therefore, the sense of responsibility and obligation is the core value in a family (Ward & Lin, 2010). When Chinese people suffer from sickness, they also have self-sacrificing behaviour to ensure normal operation of their family (Kaur, Lopez, & Thompson, 2006). Assuming the responsibilities of parents and based on collective welfare, the older people in this study attempted to relieve burdens from their

families in the forms of discouraging hospital visits and bearing the expense arising from hospital readmissions. These actions reflect the influence of collectivism, in which the older people prioritized the welfare of their family over their own.

The findings of the current study show that the Chinese older people were conscious of fulfilling their roles as parents, who are expected to attend to every need of their children. In Chinese families, their self-identity is determined by their roles and their interrelationship in the family. Parents are responsible for raising and protecting their children. Specifically, fathers are responsible for implementing disciplinary action, whereas mothers take on the caring and nurturing role (Shek, 2007). As for children, they are expected to repay their parents with filial piety. The value of filial piety is further discussed in the following section. Based on these indigenous notions, the older people in this study fulfilled their roles and took their responsibilities in the family. They protected their children through reliving possible burden.

In this study, harmony in the family was maintained through relieving burden from their families. Chinese people are not only socialized to consider the family's welfare instead of their own welfare but also are expected to maintain a harmonious and cohesive relationship within the family. Interdependency and harmony are emphasized in any group that individuals have to fulfil their roles to maintain harmony in their groups and contribute to the society. The attitudes and behaviours of the older people in the current study are

beneficial not only to their children and family but also to themselves. Having opportunities to contribute to their families can promote their sense of well-being.

The findings of the current study also reveal that the Chinese older people were grateful to the care provided by their families. Thus, they were conscious of relieving burden to reciprocate their families. People with chronic illness are commonly under care and receiving support from their families. Studies on the experience of living with chronic illness showed that women appreciate the physical and psychological support provided by their family members (Dingley & Gayle, 2003; Roberto, Giglotti, & Husser, 2005). As for COPD patients, they are concerned that their physical limitation will impede the fulfilment of their family roles (Avşar & Kaşikçi, 2011; Gullick & Stainton, 2008). Moreover, older COPD patients desire to participate in social activities with their families to maintain their roles (Williams et al., 2007). Patients in both Western and Chinese cultures appreciate their families' support and become conscious to fulfill their family roles even under the constraints of their disease. However, subtle differences are observed in attitudes toward care and support provided by families between people in Western and Chinese cultures. In a study exploring the experience of patients with congestive heart failure, the patients were grateful to their families and friends for providing them with support to cope with the changes imposed by the disease (Thornhill, Lyons, Nouwen, & Lip, 2008). Yet, these patients considered certain helping behaviours as intrusive and found that their overprotective family

members jeopardized their independence. As shown in the literature, older people in the Western context appear to put more emphasis on their personal needs. These patients are more concerned about achieving their personal roles. By contrast, the findings of this study show that Chinese people focus on the needs of their families. They are mindful of contributing to the collective interest of their families by fulfilling their roles. The emphasis on collectivity becomes pronounced when the Chinese older people underwent hospital readmissions.

Adjusting notions of filial piety

The Chinese older people in this study did not expect to receive unconditional support in various aspects but were satisfied with the intent of emotional support from their children. Specifically, they were content with their children showing attention to their health problems and hospital readmissions. The children's responses to the older people's needs regarding hospital readmissions pertain to the cultural value of filial piety. In Chinese societies, filial piety is upheld as an obligation of the young to the senior members of a family. Traditionally, filial piety is a form of reciprocation from children to their parents. Adult children are expected to show obedience and respect, as well as to provide caregiving to their older parents (Lee & Kwok, 2005). For older people, the filial piety of the children is a criterion for aging well (Chong, Ng, Woo, & Kwan, 2006). However, in the context of globalization and

the attainment of higher education, it has been argued that the superiority of older people and the practice of filial piety have eroded (Lee & Kwan, 2005; Ng, Phillips, & Lee, 2002). Modernization has changed the family structure and the form of family support such that the young now focuses on caring for their nuclear families instead of the extended families (Aboderin, 2003). Yet, a study investigating the function of filial piety in China, Taiwan, and Hong Kong, showed that reciprocal filial piety, a fundamental element of filial piety, remains salient in contemporary societies (Yeh, Yi, Tsao, & Wan, 2013). Adult children are grateful for the sacrifices made by their parents and are willing to repay them for such sacrifices.

Nevertheless, Hong Kong adult children are limited in their reciprocation to their parents under the competitive social environment. Economic instability renders couples fully occupied with their work. The findings of this study suggest that the Chinese older people have changed their expectation of filial piety from what was traditionally required. In other words, they have adjusted their notion of filial piety to fit the contemporary Hong Kong social environment. Indeed, older people acknowledge the constraints of their children. A study exploring the views of middle-aged and older people in Hong Kong on positive aging showed that the participants valued the significance of filial piety, but they also realized the difficulties their children faced amid unfavourable economic situations (Chong et al., 2006). They recognized that their children are occupied by working long hours and having busy lives; thus, they consider material support as non-essential and understand that their children

have limited time to spend with them. The older people in the current study likewise did not require their children to reciprocate them as traditionally expected by means of providing caregiving. Instead, they appreciated their children expressed filial piety by showing respect and attention, and they valued the cohesiveness among family members.

Differences in gender roles in relieving burden on families

Gender roles are culturally relevant in shaping the experience of hospital readmissions. The differences in the experience of hospital readmissions in terms of gender roles among the Chinese older people were most prominent in the concerns of families. The older males were satisfied with their dedication to the families during adulthood. When they underwent hospital readmissions, they placed more stress on maintaining independence to avoid imposing demands on their children. These older males expressed a strong sense of responsibility in terms of relieving the burden of their families. In contrast to the older males, the older females in this study displayed more concern about the daily lives of their children. Their attitudes could be related to the socialized family role of taking care and maintaining the health of their families (Yu, 2000). In Chinese societies, gender roles are primarily socialized in the family and these roles are further reinforced by several social institutions (Cheung, 1996).Power and responsibility are instilled in boys, whereas providing care and support to a family are socialized in girls. In this study, the different foci of the older people

reflect the Chinese notion of family values in which "men are breadwinners, whereas women are housewives." The older people of both genders, therefore, contributed to their families through their different gender roles.

Despite the lack of previous studies on the experience of hospital readmissions, the cultural relevance of gendered experience has been observed in Chinese culture when compared with the experience of living with chronic illnesses in Western culture. Studies conducted in the Western context show that male patients are more concerned with the debilitating nature of the illness in terms of physical strength and masculine image (Mårtensson et al., 1997; Solimeo, 2008). On the other hand, the Chinese older males in this study placed higher emphasis on their responsibility to the family. Female patients in Western cultures are concerned about being incapable of performing domestic duties and the loss of family relationship (O'Neil, 2002; Solimeo, 2008), whereas the Chinese older females in this study cared about the daily needs of their children during the periods of hospital readmissions. Females living in the two contexts are both attentive to family issues, however, the concerns expressed by the Chinese older females manifested altruistic behaviour. As discussed previous, gender roles in Chinese societies influence older males and females to have different experiences of hospital readmissions. Yet, their experiences point notably to the cultural principle of collectivism when compared with the gendered experiences of those living with chronic illnesses in the Western context. Findings of this study reveal that the

older males and females prioritized the collective welfare of their families over their own health. Fulfilling gender roles in the family to protect collective family interests was of paramount importance when they set amid the context of continued hospital readmission.

In summary, the Chinese older people were conscious of relieving the possible burdens that they may have imposed upon their families. They were also mindful of any demands caused by their hospital readmissions. The burdens were not necessarily physical demands, but also include psychological and financial stress. The lived experience of the Chinese older people highlighted the meaning of hospital readmissions, which was being shaped under their socio-cultural context. Hospital readmission was not an individual issue for the older people, but it also involved the whole family. Moreover, strong family bonding was significant to their experiences. Most importantly, it may have been the key in assisting older people to live with the experiences of hospital readmissions.

Resigning to Hospital Readmissions

Resignation illuminates how the Chinese older people in this study understood the occurrence of hospital readmissions. These older people, who have live with COPD for years and have been admitted to the hospital repeatedly, have come to terms with themselves with regard to hospital readmissions. Although they endeavoured to refrain from unnecessary

readmission, they were keenly aware of the inevitability of hospital readmissions. Under the influences of the perception of aging, their doctors' account of the disease, their knowledge and experiences of living with COPD, and their fatalistic view, the older people perceived hospital readmissions as unavoidable. Thus, they were already prepared to be readmitted to hospitals iteratively.

Attribution of hospital readmissions to normal aging

The perceptions of aging greatly influence older people's experiences with chronic illnesses and health-seeking behaviours. Research has shown that older people are inclined to attribute chronic illnesses as part of the aging process. Some chronic illnesses, like cardiovascular disease (Husser & Roberto, 2009), stroke (Faircloth, Boylstein, Rittman, & Young, 2004), and arthritis (Sanders, Donovan, & Dieppe, 2002) are perceived by older people as diseases that come with normal aging. Clarke and Bennett (2013) explored the experiences of older people living with multiple chronic illnesses. They found that older patients experienced unpleasant physical suffering but seldom complained about it because they thought these discomforts were associated with aging. The acceptance of one's own health problems as normal aging can also be reinforced by healthcare professionals. Gignac et al. (2006) compared the experiences of middle- and old-aged people with osteoarthritis. When the participants presented their osteoarthritis symptoms to their physicians, the

complaints were either ignored or normalized to aging. They were convinced by their physicians to accept the symptoms instead of seeking treatment. The doctors disregarded the symptoms because they considered them to be signs of inevitable age-related decline.

Attribution is a process of inferring the causes of behaviours or events (Weiten, 2013). Relating one's health problems to aging is a form of external attribution. People subscribe to internal attribution to explain that the causes of an event or a person's behaviour as personal traits or abilities, whereas with external attribution, people infer that the causes are influenced by situational or environmental factors (Heider, 1958). The external attributional style is commonly adopted by Chinese people (Cheng, Lo, & Chio, 2010), as they tend to ascribe the causes of events to situational cues. For instance, patients in Western culture relate the cause of COPD to their smoking behaviour, whereas in the current study, the Chinese older people attributed the disease to the hardship they experienced in adulthood, which worsened their health. The older people also rationalized hospital readmissions as the effect of deteriorating health conditions caused by aging, a situation that they feel is out of their control. They believed that the aging process is related to physical changes and is, therefore, irresistible. Thus, they came to terms with hospital readmissions without reservations.

Attribution of hospital readmissions to external locus of control

Accepting the inevitability of hospital readmissions suggests that older people

renounced their sense of control over its occurrence. The perceived control over one's health can be understood in light of the health locus of control (Wallston & Wallston, 1982). People with a high internal locus of control believe that they are responsible for their own health, whereas those with a high external locus of control consider their health as influenced by powerful others, such as powerful figures, chance, or fate. Wallston and Wallson (1981) examined the types of locus of control among people with chronic illnesses. They reported that the locus of control is predominantly attributed to the external sources among the participants, regardless of their illness. They suggested that the high level of dependency on healthcare professionals and family members may have contributed to their belief in external control.

Frazier (2002) compared the perceived control over health between healthy older adults and older people with Parkinsonism. The study concluded that the former group perceived a sense of control over their health, whereas the latter group related their health condition to the powerful others. Empirical evidence has shown that the sense of control noticeably declines with aging (Lachman & Firth, 2004; Lachman & Wearer, 1998). Using the life-span theory of control as a framework, Wrosch, Heckhausen and Lachman (2006) reviewed the use of strategies in goal attainment. They indicated that older people replaced primary control strategies with secondary control strategies when they encountered obstacles. That is, older people mediated their own cognitive response rather than changed their external

environment.

Although Chinese older people relate their health problems to external sources of control and mediate their controlling strategies, their acceptance of personal change can be a sign of adaptation. When older people with chronic illness lose control over their health, a realistic estimation of personal control is more beneficial in reducing stress and promoting adaption (Helgason, 1992; Lachamn, Nunpert, & Agvigohoaei, 2011). Adjustment to health problems, with a shift of forgoing perceived control, can be a defensive mechanism for older people in maintaining life satisfaction (Frazier, 2002).

Acceptance of hospital readmissions

The Chinese older people in this study accepted and rationalized the inevitability of hospital readmissions. It suggests that they already adjusted their inner thoughts about hospital readmissions to fit their bodily needs instead of struggling with its occurrence. This adjustment can be viewed as using emotion-focused coping. Coping styles are commonly categorized into two types: problem-focused coping and emotion-focused coping. Problem-focused coping is adopted when the situation is controllable, whereas emotion-focused coping is used in uncontrollable situations (Papalia, Olds, & Feldman, 2005). Considering age, older people tend to shift their coping style from problem-focused to emotion-focused (Blanchard-Fields, Jahnke, & Camp, 1995; Blanchard-Fields, Stein, & Watson, 2004). In

addition, they use more emotion-focused coping, particularly when they consider that using problem-focused coping is futile (Blanchard-Fields, Chen, & Norris, 1997). Chinese people deploy both problem-focused and emotion-focused coping to tackle stressors. As recognized by Cheng (2009), Chinese people realize that the effectiveness of coping methods varies with different stressors. Therefore, a single coping method is inadequate in resolving all kinds of stressors so they manage stress with a flexible coping style (Cheng et al., 2010).

Leung et al. (2002) found that Chinese patients with COPD predominantly adopted emotion-focused copying styles to cope with the disease. The findings of this study showed the older people with COPD also use this copying style when they undergo hospital readmission because various personal and situational cues convinced them that hospital readmissions were uncontrollable. They personally experienced the ever-changing nature of the disease. Moreover, the older people were advised by doctors, who represent authoritative and knowledge figure in medicine, that the disease is incurable and would not improve. In addition to their perception of aging, the older people concluded that hospital readmissions were unavoidable. Although they adopted both active and passive approaches to avoid hospital readmission, they realized that their efforts merely delay the next readmission instead of avoiding it. In accepting hospital readmission as out of their control, the older people adjusted their thoughts to reduce negative feelings about hospital readmissions. In other words, they came to terms with its happening on them and were prepared for being

readmitting to hospitals repeatedly.

Fatalistic views to hospital readmissions

Several Chinese older people related hospital readmissions to fatalism. Such a belief reinforced their sense of the inevitability of hospital readmissions. Assuming that hospital readmissions were her fate, an older woman in this study did not expect to be exempted from readmission but only desired to experience less suffering. Fatalism refers to a philosophical doctrine that an event is predetermined by the supernatural, wherein human beings cannot change the outcome (Taylor, 1962). Reviewing the nature of fatalism described in literature, Keeley, Wright, and Condit (2009) identified that it encompasses three dimensions, including lack of control over events in one's life, belief in luck, predestination and destiny, and feelings of meaningfulness. The notion of lack of control over events in fatalism is closely linked to the belief in an external locus of control (Chen, Cheung, Bond, & Leung, 2006). Nevertheless, fatalistic views also involve predetermination and predictability (Leung et al., 2002).

Fatalism is usually associated with feelings of hopelessness, powerlessness, and vulnerability (Durkheim, 1952). However, fatalism is not necessarily regarded as submission to life events. Under the belief that life events are predetermined, people are inclined to accept what they encounter; thus, they obtain tranquility (Chen et al., 2006). Several studies

have shown that a fatalistic view helps people to reduce self-blame (Bolam, Hodgetts, & Chamberlain, 2003) and cope with disease (Langue & Piette, 2006). In a study exploring the functions of fatalism in health belief, Keeley et al. (2009) found that fatalistic talk reduce stress, helps manage uncertainty, and makes sense of present illnesses in terms of past negative health behaviour.

Fatalism is a common form of inference in Chinese culture. Its notions are coherent with the teachings of the three major schools of thought in Chinese culture, namely, Confucianism, Taoism, and Buddhism. Confucians believe that "heaven" is a supernatural force that determines the fate of an individual (Hansen, 2010). Taoism teaches people to follow the force of nature and maintain harmony with nature (Coward, 1996). Buddhism emphasizes the chain of causes and effects, that is, what an individual did in the previous life determines the outcomes of later life (Chan, 2000). People are cultivated under these teachings that they should not challenge their fate. Studies have shown that fatalism significantly influences health-related issues, such as use of screening tests (Holroyd, Twinn, & Adab, 2004; Kwok & Sullivan, 2006), symptom control (Willis & Wootton, 1999; Yin, Tse, &Wong, 2011), and use of coping strategies for advanced disease or critical condition (Cheng, Sit, Twinn, Cheng, &Thorne, 2013; Chui & Chan, 2007). In this study, the Chinese older people accept hospital readmissions as a life event that they cannot resist. In the readmission experience, the older people suffer from the threat of impeding death from

disease exacerbation and feeling powerless because their needs for hospital readmission are disregarded by their doctors. Nevertheless, they could positively accept hospital readmissions when they ascribed these to their fate. As mentioned by several older people, they encountered hospital readmissions with such attitudes as “taking the natural course of life”, and “accepting the world as it is.” Therefore, a fatalistic view helps the Chinese older people to accept and cope with negative feelings associated with hospital readmissions.

In the current study, the Chinese older people employed various ways to avoid and manage breathlessness to refrain from unnecessary hospital readmissions. Their behaviours appeared to be contradictory to the fatalistic view and showed that they attempted to confront their fate. Yet, a belief in fatalism does not simply mean accepting everything without exerting any effort in life. The concept of fatalistic voluntarism can explain the paradox between the common belief in fate and the behaviour of the Chinese older people. Fatalistic voluntarism refers to the behaviour of individuals who accept their fate and exert effort in a given situation (Lee, 1995). This behaviour enables individuals to maintain positive thinking, reduce their sense of guilt in uncontrollable situations, and promote an optimistic view of life (Chen, Cheung, Bond, & Leung, 2006; Chui & Chan, 2007; Hamind, Yue, & Leung, 2003). People can maintain confidence and hope, and reduce their sense of uncertainty when they accept their fate (Lee, 1995; Liu & Mencken, 2010). Therefore, fatalistic voluntarism is a positive coping orientation that protects a person’s mentality under life’s vicissitudes.

Liu and Mencken (2010) demonstrated a positive correlation between fatalistic voluntarism and life happiness in Chinese individuals. The Chinese older people in the current study exerted every effort to refrain from unnecessary hospital readmissions while acknowledging that their occurrence is predetermined in their lives. Although they believed that hospital readmissions are unavoidable, they were satisfied with their efforts to exercise limited control over delaying the subsequent hospital readmission. Hence, the belief of fatalism allows the Chinese older people to accept hospital readmissions in their lives. Under the concept of fatalistic voluntarism, the older people in this study could further maintain their mentality and a positive self-image to cope with hospital readmissions despite of their inevitability.

Positive ways of resignation

When people are newly diagnosed with a chronic disease, they may consider the disease as a long-term suffering. However, patients may eventually become resigned to the disease and may accept living with the disease and its associated problems. Studies have shown that such acceptance can result in positive outcomes. Dickon and Kim (2003) explored the experience of older Korean American women with osteoarthritis pain. These women suffered from pain and initially struggled to relieve the pain. After using different pain relief methods, they accepted the pain and integrated it as part of the aging process. This acceptance

enabled them to continue their self-management and enhance their tolerance to pain. Roberto et al. (2005) stated that women who were resigned to chronic health conditions coped better than women who were not. They suggested that resignation is an assimilative and accommodative process, in which women balanced the gains and losses from health conditions. Zhang, Shan, and Jiang (2014) found the attitude of "letting nature take its course" in Chinese older people with chronic illness; such attitude implies an uncertainty toward the illness, leaving the older people no choice but to accept their infirmity. However, they added that this attitude enabled older people to confront the illness under the teachings of Taoism. The Chinese older people in this study also resigned themselves to hospital readmissions. They appeared to passively accept the inevitability of its occurrence. Indeed, they actively confronted these challenges with their cultural beliefs. Fatalistic voluntarism enables older people to maintain a positive outlook in spite of adversities. Positive resignation also allows older people to live with experiences of inevitable loss in their lives (Christian, 2005). Therefore, resignation can be a positive approach that older people can take an active role to cope with life's vicissitudes.

The acceptance of the inevitability of hospital readmissions creates a negative impression on the attitude of resignation toward hospital readmissions. However, the older people actually asserted their control over this phenomenon by using the ways which are congruent with Chinese philosophies. The philosophies of Confucianism, Taoism and

Buddhism consistently emphasize transforming one's thought instead of changing the environment to cope with distress (Cheng et al., 2010). This transformation is not deemed as a passive way of coping, but is valued for facing adversity through adjusting oneself. Fitting into the external environment by changing oneself is regarded as a proactive means to dealing with stressors and reserve resources to meet other needs (Spector, Sanchex, Siu, Salgado, & Jianhong, 2004). Therefore, acknowledging inevitability does not imply surrendering to the phenomenon of hospital readmissions. This resignation may signify that the older people assumed an active role to fitting into the phenomenon, as well as to meet bodily needs. Hence, resignation can be considered to be a positive approach toward understanding and accepting hospital readmissions for the Chinese older people. As Chinese philosophies advocate people to reconcile with their life experience, older people may easily accept hospital readmissions.

In summary, the Chinese older people resigned to hospital readmissions because they related its happening to attributes that were out of their control. They rationalized hospital readmissions as being related to the normal aging process. The occurrence of hospital readmissions was also attributed to the external locus of control. With their perceived lack of control over hospital readmissions, the older people adjusted their inner thoughts and held the belief of fatalistic voluntarism to cope with its inevitability. Apparently, the Chinese older people passively submitted themselves to hospital readmissions. However, their attributional

and copying styles used in understanding hospital readmissions promoted adaptation and protected them from being obsessed with its inevitability. In addition to ingrained cultural beliefs, the Chinese older people not only accepted hospital readmissions as unavoidable but also positively resigned themselves to this phenomenon.

Living for the Moment

In this study, the Chinese older people who had already accepted the inevitability of hospital readmissions gained an insight of living for the moment. They experienced satisfaction in their current situations by positively comparing their past experiences and with other people who were in a worse situation. They found meanings in living to an old age. These meanings enabled the older people to focus on their everyday lives and engaged in the present.

Downward social comparison

The Chinese older people maintained a positive outlook when they compared themselves with other people who were of similar age with chronic illnesses. The older people appraised that they were more fortunate and had outlived others. Such downward social comparison developed positive feelings among the older people. Downward social comparison is a cognitive strategy for enhancing self-image (Wills, 1981). When individuals

evaluate themselves against people around them who are in worse condition, they reinterpret their situation and feel positive toward themselves (Frieswijk, Buunk, Steverink, & Slaets, 2004). In the aging process, older people can maintain satisfaction in life by making download social comparisons (Baltes & Baltes, 1990).

Previous studies have shown that obtaining a sense of satisfaction by comparing oneself with other people who are worse off is common among older people (Bailis & Chipperfield, 2006; Frieswijk et al., 2004). These studies have also illustrated that older community-dwelling people have a higher level of satisfaction in life and have a more positive appraisal of themselves when making download comparison with others who are worse-off. Silverman et al. (2009) interviewed older people with chronic diseases to examine the affective responses to their illness. The participants who responded positively to their illness accepted their limitations of their diseases and perceived themselves as being better off than others. Small and Graydon (1993) and Habraken et al. (2008) also found COPD patients use downward social comparison to cope with their disease.

Chinese older people with chronic disease also have been found to use a similar kind of comparison to view themselves as more fortunate than other patients (Mok, Lai, & Zhang, 2004). In the current study, the older people likewise employed downward social comparison to maintain a sense of positivity. The experience of hospital readmissions provided them with many opportunities to positively compare themselves with other patients. They witnessed

other patients were in worse condition. They also observed patients who were frailer or had passed away during their hospitalization. Although these older people were frequently readmitted to hospitals, they appreciated that they had good mobility and were not totally dependent compared with other patients. The Chinese older people not only compared their situations with other patients but also made sense of hospital readmissions with their past life experiences. Comparing their current standard of living with that during their adulthood enabled them to become more contented in meeting the basic needs in life. These comparisons positively protected and enhanced their sense of self. Particularly, when they perceived hospital readmissions as an uncontrollable event, these comparisons enabled them to use the least mental effort to protect their self-image. Therefore, downward social comparison allowed the older people to maintain a sense of positive self when they underwent hospital readmissions.

Aging well with hospital readmissions

Among theories on aging, Rowe and Kahn (1997) have provided a classical definition of successful aging. They defined successful aging as avoiding diseases and disabilities, having a high level of physical and cognitive functioning, and active engagement with life. Under this definition, older people with chronic diseases and who are frequently readmitted to hospital have failed to undergo successful aging. Some studies have shown that older

people can age well despite their health problems. Older Hispanic women integrated chronic illness into their lives by drawing strength from past experience, focusing on possibilities, receiving social support, knowing one's life purpose, and strengthening their spirituality (Dingley & Gayle, 2003). Zhange et al. (2014) found that Chinese older people with chronic illness were more content with their present state when they compare their situations with the difficult times in their past. The sense of responsibility of these older people to self and others also suggests their need for self-actualization at old age. The older Chinese people in this study also maintained a positive outlook, although their lives may have revolved between the hospital and their homes. Therefore, older people can gain a positive experience while aging with chronic illness and its related problems.

Successful aging should be understood on the perspectives of older people. In the study of Chong et al. (2006), middle- and older-aged Hong Kong Chinese people described their views on positive aging. From their perspective, positive aging referred to having good health, maintaining a positive attitude, active participation, receiving social support, having financial security, and residential stability. Good health meant being able to eat and sleep well, having good mobility, and independently taking care of themselves. A positive attitude referred to a sense of purpose in life and happiness. For participants with chronic diseases, a positive attitude was understood as accepting their illness without affecting their emotions.

In the current study, the Chinese older people also pursued similar attitudes as they

underwent hospital readmissions. Life satisfaction was not maintained by being free from diseases or disabilities but also obtained from the ability to fulfil basic needs. Even though the older people preferred their home environment, where their needs were understood by their family members, they appreciated being able to meet the basic needs during the periods of hospital readmission.

Under the influence of collectivism, the Chinese older people assumed the responsibility of raising their children during their adulthood. The older people were content with seeing their grown children as independent. Although they considered that they had fulfilled their responsibility to their children, they were mindful of their possible demands to their families during their hospital readmissions. The older people still had a purpose in life that they cared about their families. Ek and Ternestedt (2008) study described that a sense of having meaningful life and feeling connected was important for COPD patients because these patients were socially isolated. Elofsson and Öhlén (2004) further showed that the sense of connectedness of older COPD patients was related to their family relationship and ability to participate in former interests. In the current study, the life purpose of contributing to their families as they underwent hospital readmissions highlight that Chinese older people emphasize the family value. Assuming a life purpose that protects the collective interest of their families, the older people perceive their lives as meaningful.

Two older people in this study were still frustrated by hospital readmissions because

they considered themselves still leading a difficult life. One older male felt hopeless about his health condition after having been readmitted to the hospital multiple times. An older female had a similar frustration in that she observed her physical condition deteriorate with each readmission and she anticipated eventually dying because of her poor health. However, their concerns about their families drew their attention and provided them with a life purpose. The older male perceived his duty of taking care of his frail spouse, while the older female looked forward to family gathering. These life purposes in terms of their families preserved the meaningfulness of their lives.

From a psychological perspective, the attitudes of the Chinese older people regarding their lives were consistent with the eighth stage of Erikson's (1982) model of psychodynamic development. At this stage, which is the last stage of development, people retrospectively review their lives and fall in either a state of integrity or despair. Integrity is a sense of wholeness in which an individual is satisfied with and accepts one's life, whereas despair is a state in which a person feels hopeless about the past (Garner, 2003). People who develop "wisdom" from their past life experiences can achieve a state of integrity. Erikson (1982) defined wisdom as accepting one's life without the feeling of regret. With wisdom, older people continue to engage in life with age related changes (Ardelt, Landes, Gerlach, & Fox, 2013). In the interviews with the Chinese older people, they expressed acceptance to their life experiences, including hospital readmission and their hardship during adulthood. They were

also satisfied with their current situation through their use of download social comparison. The wisdom they acquired from their life experiences provided the older people with insight, shifting their focus to enjoying the present. This type of wisdom will be elaborated in the following section.

Although the older people experienced negative feelings from their needs for hospital readmissions, being disregarded by their doctors, and their perception of powerlessness at the hospital, they were more concerned for their families than for their personal needs and they shifted their focus to everyday life. They perceived a sense of wholeness in their lives when they considered themselves having fulfilled their roles in their families. At the last stage of psychodynamic development, the older people accepted not only their past life experiences, but also their experiences of hospital readmissions.

In brief, the Chinese older people were satisfied with their current situations when they made downward social comparison to reappraise in terms of others and their past life experiences. This satisfaction may have provided a positive sense of self when they reviewed their lives. With a purpose in life and by accepting their past experiences, the older people were able to engage in the present and perceive their lives as meaningful when they revolved between the hospital and their homes.

Summary

Studying the lived experience of Chinese older people can promote a better understanding of hospital readmissions. In the literature, only a single study explored related experience. Yu et al. (2007) explored hospital readmissions from the perspectives of Chinese older people and described their experiences in terms of disease self-management, utilization of community healthcare services, relationships with caregivers and hospital staff. Using the phenomenological approach, the present study provides a deeper understanding of why older people seek hospital readmissions, their experience during periods of hospital readmission, how they understand the occurrence of hospital readmissions and how they live with their experience. This study also uncovers various socio-cultural influences in the hospital readmissions experiences of Chinese older people and provides a more comprehensive understanding on the phenomenon of hospital readmissions.

The findings of the current study show that the experiences of hospital readmissions and living with COPD are closely interrelated. The pivotal role of socio-cultural influences pervaded every aspect of the Chinese older people's experiences. In the Chinese context, past life experiences and socio-cultural values shaped the experiences of the older people and impinged on how they responded to hospital readmissions. The lived experience of hospital readmissions was framed under the influences of a paternalistic doctor-patient relationship, collectivism, external attribution style, and fatalistic voluntarism. A holistic view of the lived

experience of hospital readmissions of Chinese older people with COPD is explored in the following section.

A Holistic View of Hospital Readmissions for Chinese Older People with COPD

This phenomenological study revealed the lived experience of hospital readmissions of Chinese older people with COPD. In the literature, very little is known about the experience of hospital readmissions because studies have mainly focus on understanding the experience of living with COPD and factors associated with hospital readmissions. These studies are usually conducted in Western countries, and they show that COPD patients have negative experiences of living with the disease. Patients struggle with breathlessness and experience physical disability (Barnett, 2005; Gullick & Stainton, 2008; Seamark et al., 2004), social restriction (Ek & Ternestedt, 2008; Elofsson & Öhlén, 2004; Gullick & Stainton, 2008), and psychological distress (Clancy et al., 2009; Hall et al., 2010; Hasson et al., 2008; Willgoss et al., 2012) from this predominating symptom. Moreover, their experiences related to hospitalization appear to be negative (Bailey, 2004; Oliver, 2001; Schofield et al., 2006). The Chinese older people with COPD in this study also encountered similar problems of breathlessness and suffered from physical and social restrictions. In spite of these difficulties, they were able to integrate their experiences of hospital readmissions into their lives. They felt powerless in that their needs regarding hospital readmissions were

disregarded by various parties. Still, they maintained a positive sense of well-being when they underwent hospital readmissions. The socio-cultural values of harmony and dignity significantly preserved the wellness of the Chinese older people.

Maintaining Harmony

The lived experience of hospital readmissions of the Chinese older people was shaped under an indigenous cultural value of harmony. Harmony refers to a state of homeostasis within a person's mind and body, as well as between the person and the surrounding environment (Lu & Gilmour, 2004). This homeostasis parallels the concept of wellness, which is preserved by a good balance between body-mind-spirit and social connectedness (Miller, 2012). In Chinese culture, subjective well-being is conceptualized as a harmonious state of existence (Luo, 2001). The meaning of health is also structured around maintaining harmony with various aspects of life. In a study on social representation of health and illness among Chinese, Jovchelovitch and Gervais (1999) identified the definition of health in Chinese people:

> Harmony within the family and respect for its hierarchy and fundamental values, the primary of collective goals over individual needs and desires, obedience to authority and self-discipline, all maintain the self in balance with society and give to the Chinese definition of health a breadth that goes far

beyond bodily conditions. (p. 252).

In the Chinese context, people's beliefs and attitudes are profoundly influenced by different schools of thought. Confucianism and Taoism are the two major schools. People comply with Confucianism principles in dealing with social relationship, while they hold on to Taoism beliefs to survive in nature (Luo, 2001). Confucianism acknowledges a state of equilibrium, which refers to reaching a balance and harmony (Li, 1992). It particularly emphasizes the concept of collectivism; thus, a sense of well-being stems from the harmony of a group. Taoism pursues an ultimate goal of inner peace in life, upholding the freedom of desire and the satisfaction of leading a simple life (Lee et al., 2013). Taoism advocates following the force of nature; that is, accepting one's fate and life to achieve the sense of well-being. The teaching and beliefs of these two schools are seemingly different. However, both emphasize the core value of harmony in their doctrines, suggesting a state of homeostasis in mind, body and spiritual self, as well as the social and natural environment (Luo, 2001).

The Chinese older people's lived experience of hospital readmissions revealed their tendency to maintain harmony with various aspects, including within their mind, body, and spiritual self, and with social groups and the natural environment. Regarding homeostasis in the mind, the older people exercise limited control in managing their disease, not only to refrain from unnecessary hospital readmissions but also to relieve their sense of guilt about

surrendering to hospital readmissions. In seeking a balance within their body, the older people submitted to hospital readmission to meet their bodily needs and to survive uncontrollable breathlessness. The relief of physical and psychological distress signified a homeostasis within and between the mind and body, preserving an internal state of equilibrium. Furthermore, the older people's acceptance of and satisfaction with their lives and the current condition were conducive to achieving homeostasis in their spiritual selves and an inner sense of peace.

In relation to social groups, the Chinese older people were concerned about interdependence and collective welfare. They relieved possible burden to act in the interest of the family and to promote harmony within the family. During periods of hospital readmission, the older people avoided confrontation with hospital staff and adjusted themselves to fit into the hospital culture. To achieve equilibrium with the natural environment, they followed the natural force of aging and reconciled themselves to their fate.

For the Chinese older people, the lived experience of hospital readmissions was focused on maintaining harmony in their intrapersonal self and their interpersonal environment. Equilibrium within the mind, body, and spiritual self results in harmony in one's intrapersonal self, whereas homeostasis with social groups and with nature results in harmony with one's interpersonal environment. The maintenance of balance in every aspect of the experience is congruent with the socio-cultural values. The state is regarded as

desirable in Confucianism and Taoism.

The six constituents that emerged from narrative descriptions of the Chinese older people in this study describe their lived experience of hospital readmissions. These constituents were also inextricably linked to achieving a harmonious state in their experiences of hospital readmissions of Chinese older people. The constituents "refraining from unnecessary readmissions," "craving for survival," and "living for the moment" contributed to harmony in the intrapersonal self. The constituents "being conscious of relieving burden to families," "feeling being disregarded and powerless," and "resigning to hospital readmissions" preserved harmony with the interpersonal environment.

The older people achieved a sense of well-being when they maintained harmony within their interpersonal self and with their interpersonal environment. Balance was achieved in each aspect of their experience, while each aspect was interrelating with one another. For instance, when the older people sought hospital readmission for unbearable breathlessness, homeostasis was maintained within and between the mind and the body. In the meantime, they were concerned about the possible burden on their families and felt powerless when their need for hospital readmission was disregarded. In this case, the older person attempted to maintain harmony within the family and with the hospital staff. Undoubtedly, preserving homeostasis in every aspect of the experience was a challenging task. The success of the older people can be ascribed to their wisdom in life.

The wisdom of older people does not refer to scientific knowledge. As discussed in the previous section, Erikson's (1982) model of psychodynamic development suggests that people develop wisdom to accept their lives and to obtain a state of integrity from their life experiences. Therefore, wisdom is knowledge about human life (Nordenfelt, 2003). Older people have gone through different milestones and ups and downs in their lives. Their life experiences are good sources of knowledge with which to manage different situations. In the current study, the Chinese older people learned from their day-to-day experiences. The hardship they experienced during adulthood particularly enriched their wisdom in life. They overcame poverty and confronted adversities in a city that was rebuilding itself after World War II. Some of them even survived life crises. These experiences can provide insights to foster the development of wisdom in life. Stressful life experiences facilitate the formation of wisdom by enabling individuals to have a higher tolerance for uncertainty, realize the unpredictability of life, and have a new understanding of oneself and the world (Le, 2008). The hardships the older people experienced in the past positively transformed them to become more receptive to different circumstances. Using the wisdom they gained from life, they remained open to the experiences and challenges of hospital readmissions. They were also capable of accommodating the occurrence of hospital readmissions in their lives. Therefore, the wisdom they gained from life assisted the Chinese older people in maintaining harmony in various aspects of their experiences of hospital readmissions.

Given its roots in the socio-cultural beliefs, the totality of the lived experience of hospital readmissions for Chinese older people is to maintain harmony within oneself and the environment. The wisdom of life enabled the older people to preserve the homeostasis in this complex experience. Nevertheless, their dignity might have been undermined during the periods of hospital readmission.

Maintaining Dignity

The Chinese older people in this study integrated their experiences of hospital readmissions into their lives. Maintaining a positive outlook, they accepted their experiences and engaged in the present. A harmonious state was achieved within the self and their external environment. However, their experiences revealed a threat that might prevent them from maintaining such harmony and jeopardize their integrity. The disregard shown to the older people's needs regarding hospital readmissions by their doctors, as well as the feeling of powerlessness over their situations may have undermined the older people's dignity.

As a universal attribute, dignity is regarded by both Western and Chinese cultures as the worth of a person (Koehn & Leung, 2008). As such, preserving dignity is important for maintaining a person's sense of well-being (Tao & Lai, 2007). However, the conceptions of these cultures are rather different. Primarily, people in the West understand dignity as an innate personal worth, whereas the Chinese emphasize dignity as worth acquired from social

relationships (Koehn & Leung, 2008).

In healthcare settings, patients are vulnerable to losing their dignity. Thus, the maintenance of dignity is upheld as a virtue in both the medical and nursing code of ethics. The perspectives of patients with regard to dignity have been explored in the literature. Gennip, Pasman, Oosterveld-Vlug, Willems, and Onwuteaka-Philipsen (2013) developed a conceptual model of dignity in illness based on seriously ill patients. In the model, dignity comprises the individual self, the relational self, and the societal self. The individual self requires a person to have meaning in her life, whereas the relational self emphasizes the need to be significant to and contribute to others' lives. The societal self refers to a person who is seen by people outside one's immediate social groups. Jacelon (2003) used grounded theory to understand how hospitalized older people value dignity. Dignity was conceptualized by the older people as self-dignity, comprising the sense of self-worth and interpersonal dignity, which depends on the respect accorded to a person by others. In Taiwan, Lin, Tsai, and Chen (2011) explored patients' perspectives on dignity in care. The participants believed that dignity involved being respected as a person, preventing body exposure, caring from the nursing staff, maintaining confidentiality of disease information, and providing prompt response to needs. These studies show that dignity is conceptualized into both intrinsic and extrinsic dimensions of a person, and respect is a crucial element in maintaining dignity.

The dignity of the Chinese older people may have been undermined when they

underwent hospital readmissions. The experiences of hospital readmissions of the older people revealed perceptions of powerlessness and of being disregarded by their doctors. Their urgent need for hospital readmissions, suffering breathlessness, and efforts made in the self-management of their distress were disrespected by doctors. The lack of understanding and respect from doctors also may have undermined their dignity. Studies have shown that patient dignity is affected by the attitudes and behaviours of healthcare providers, as well as the culture of institutions (Baillie, 2007; Gallagner, Li, Wainwright, Jones, & Lee, 2008). Patients lose their dignity when they feel powerless or perceive that they are not being treated seriously (Gennip et al., 2012). The current study showed that some doctors not only failed to recognize but also normalized suffering of breathlessness for COPD patients. Among the doctors, the older people observed a lack of empathy and attention to their personal needs, which are considered as elements of respect (Dicker & Kass, 2009). The feeling of helplessness and concealing their own disease because of a lack of support from the neighbourhood also diminished their dignity.

In Chinese culture, doctors symbolize authoritative figure. People are socialized to follow and respect persons who are in a higher social ranking. Therefore, patients seldom confront their doctors. Conversely, autonomy is commonly identified as an element of dignity in Western countries (Jacelon, 2003; Matiti & Trorey, 2008). Considering the paternalistic relationship, Chinese older people passively accept their doctor's decisions with regard to

their treatment plan. Although Chinese people do not consider autonomy necessary in the doctor-patient relationship, the dignity would have been violated when their feelings and needs are not recognized and respected. Dignity would be further eroded when older people consider themselves to be more "experienced" than doctors in disease management. In addition, some of the older people in this study perceived that their hospital readmissions were regarded by their doctors as an abuse of medical resources. Such a belief can impinge on their dignity and their moral self.

With respect to the relationship with other hospital staff, the older people in this study felt respected in the client-centred approach of care given by the nurses. In contrast to blaming the older people's incapability, concern for and understanding to their needs promoted a sense of self-worth. These attitudes also invite communication. Thus, the older people ventilated their feelings to the nurses but considered discussing their concerns with doctors as futile. The older people interacted with different healthcare professionals during the periods of hospital readmission. Nurses were the healthcare team members who constantly provided care to the older people, and as such they were in a good position to understand older people's needs and protect their dignity.

In the current study, the emphasis on family values and the attitude of living for the moment may have preserved the dignity of the Chinese older people. Chinese culture highly values family relationships. The older people in this study perceived themselves as being

significant in the family based on the unconditional support from their caregivers, respect and attention from their children, and their ability to contribute to their families by relieving possible burden to them. The older people thus acquired a sense of self-worth from their family, which might have preserved their dignity. In this regard, meaning in life and the mutual support with family compensated for the loss of dignity in other aspects.

In addition, the older people gained a positive outlook after they resigned themselves to hospital readmissions. They redirected their attention to engaging in every day of their lives rather than dwell on their negative feelings about hospital readmissions. Therefore, this positive attitude not only enabled the older people to freely accept the experiences of hospital readmissions but also to reduce the threat to their dignity. Nonetheless, the Chinese older people may have lost their dignity from hospital readmissions. If they did not receive adequate family support or did not accept the inevitability of hospital readmission, which instilled the positive outlook, they may have been overwhelmed by the feeling of powerlessness and their dignity may have been undermined. Hence, the delivery of dignified care should be a priority of healthcare providers for frequently readmitted older people.

Summary

An in-depth understanding of hospital readmissions was embodied in the lived experience of the Chinese older people. The meanings of hospital readmissions for the older

people were framed by their socio-cultural context. The findings highlighted that hospital readmissions of Chinese older people is a complex experience. Every aspect of the experience inextricably interweaves with each other to maintain the wellness of the older people in the revolving door of hospital readmissions. A tendency to maintain harmony and preserve dignity was salient in the older people's lived experience. The implications of the findings and limitations of this study are discussed in the next chapter.

CHAPTER SIX

CONCLUSIONS

Introduction

This study is the first to use a phenomenological approach in exploring the lived experience of hospital readmissions of Chinese older people with COPD. The findings have shed light on the experience to enhance the understanding of the phenomenon. This chapter discusses the limitations of the study, presents implications for clinical practice and education, and recommend directions for further research based on the major findings. The chapter is concluded with a summary of this study.

Limitations

This phenomenological study describes the lived experience of hospital readmissions of Chinese older people with COPD. However, the findings should be understood with caution. The older people were recruited from a single hospital. Although the sample is not representative of all Chinese older people with COPD, generalizing the findings is not the objective of this study. This phenomenological study attempted to explore the lived experience of hospital readmissions; therefore, purposeful sampling was adopted to identify older people who had such an experience under study. Transferability of findings is a more

appropriate concern in qualitative studies than generalizing the findings (Guba & Lincoln, 1994). Phenomenological inquiry reveals the essence of a lived experience which is universal and invariant to people who have similar experiences (Natanson, 1973). The lived experience revealed in this study represents the essential meaning of hospital readmissions to Chinese older people with COPD. Therefore, the findings are transferable to older people who experience hospital readmissions in a similar context. In the current study, the methods, justifications and backgrounds of the participants were described in detail to enable readers to further determine the transferability of the findings to other older people undergoing hospital readmissions. The major consideration in the transferability of the findings of this study is the male-dominant sample. This limitation is discussed in the subsequent paragraph. Nevertheless, the older people in this study possess diverse backgrounds that can enrich and provide a comprehensive understanding of the experience of hospital readmissions among Chinese older people with COPD.

The male-dominant sample of this study comprised 18 males and 4 females. The main difference in the background between the males and the females is that the spouses of the males served as their caregivers, whereas the females were looked after by their children or maids. This difference may be related to the traditional family roles among the Chinese in which females, rather than males, are expected to be caregivers (Zhan & Montgomery, 2003). The major discrepancy in their lived experience of hospital readmissions, as identified from

the narrative descriptions, lies in the focus of conversation when the older people talked about their families. The older males emphasized their devotion to their families more than the older females, especially on how they sustained the livelihood of their respective families during adulthood. On the other hand, the older females preferred to share their concerns about the daily lives of their children. Although the older males and females expressed different concerns about their families, their foci converged to protecting the collective interest for their family members. They prioritized the family welfare over their own in their experience of hospital readmissions. Therefore, the subtle difference based on a male-dominant sample does not affect the major findings in this study. Although the older females appeared to be more concerned about their families, the small number of females in the sample is inadequate to substantiate this observation. Future studies should focus on exploring the lived experience of hospital readmissions of Chinese older females with COPD.

Older people with an advanced stage of COPD were excluded from this study based on the consideration that their physical strength could not tolerate a long conservational interview. Majority of the older people were observed to suffer from breathing difficulties after the interview had been conducted for approximately 15 minutes; they paused and used pursed-lip breathing between conversations. The researcher advised them to withhold the interview and rest, but they preferred to continue with the interview. Anticipating that older people with an advanced stage of COPD could not afford the physical demand of

conversational interviews, the researcher excluded them from this study. Therefore, the findings of this study do not reflect the lived experience of hospital readmissions of older people with severe COPD.

On the basis of a similar consideration of physical limitations, the older people with COPD were interviewed only once in this study. Although multiple brief interviews can meet the physical demands of these older people, short interviews may affect the richness of data. Another limitation of a single interview is that the researcher was unable to follow the transitional change of older people in hospital readmissions. Nevertheless, the sampling method purposefully identified the older people with rich experiences in hospital readmissions to provide thorough descriptions. During the interviews and data analysis, the researcher also noted any behavioural and emotional changes when the older people were readmitted to the hospital in increasing frequency. Moreover, data collection was ceased when the researcher noticed that the narrative descriptions becoming repetitive and a clear understanding of the experience of hospital readmissions was already obtained. With these methods, the researcher minimized the limitations of a single interview for each participant and achieved a thorough understanding of the lived experience of hospital readmissions of Chinese older people with COPD.

Implications of the Study

This phenomenological study pioneers the exploration of the lived experience of hospital readmissions of Chinese older people with COPD. The lived experience provides an in-depth understanding of the phenomenon of hospital readmissions among older people. The findings clearly describe the experiences of older people in revolving between hospitals and homes, why they seek hospital readmissions, how they understand the occurrence of hospital readmissions, and how they live with this experience. The findings also highlight the role of socio-cultural influences that shape their experience in the given context. Understanding this experience is of paramount importance to guide the provision of healthcare services and education to healthcare professionals. This section discusses the implications of this study for clinical practice and education.

Implications for Clinical Practice

The findings of this study show that Chinese older people can integrate the experience of hospital readmissions into their lives. However, their experiences also reveal certain unmet needs when they undergo hospital readmissions, which can undermine their sense of wellness. Wellness is maintained by good body-mind-spirit balance and social connectedness (Miller, 2012). This balance resembles the tendency of Chinese older people to maintain a harmonious state in various aspects of their lives. Strategies addressing these unmet needs

when they are revolving between the hospital and their homes are suggested and discussed as follows. These strategies consider the socio-cultural aspect of Chinese older people. In addition, the strengths of older people are incorporated into the strategies to maximize their potential to maintain their wellness. The older people's past life experiences, which are independent of their physical strength, are a good resource for promoting their wellness.

Two important points should be noted before these strategies are discussed. First, although the lived experience shows that older people can master the experience of hospital readmissions and engage upon the present after they have accepted the inevitability of hospital readmissions, the following strategies do not attempt to facilitate the acceptance and attitudinal shift in their respective lives. These strategies are instead directed at enhancing the wellness and preserving the dignity of older people. Second, phenomenological studies reveal the essence and the constituents of an experience based on the premise that commonalities in a given phenomenon exist. The findings do not imply that the experiences and the needs of each individual are the same. Therefore, the strategies discussed below suggest the principles and directions for clinical practice, which should be flexibly applied to address the uniqueness and specific needs of each individual.

Providing dignified care

The value of dignity is highly recognized in the codes of clinical practice of

healthcare professionals. Patients should be regarded as worthy individuals despite their illnesses (Gennip et al., 2013). However, its virtue is seldom practiced in the busy clinical environment (Matiti & Trorey, 2008; Webster & Bryan, 2009). Hospital staff usually focuses on the physical problems of patients, especially on observable and objective clinical signs (Bailey, 2004; Oliver, 2001). However, the lived experience of hospital readmissions revealed in this study shows that older people crave to survive intolerable breathlessness, which is a subjective feeling. They are frustrated when their physical and psychological distresses, as well as their urgent need for hospital readmission, are unrecognized and disrespected by doctors, who are the only persons with the right to determine hospital admissions and discharge, and the treatment received at hospital. This lack of recognition of their individual needs undermine their dignity, particularly when doctors show indifference. Moreover, frequent contact with the hospital staff because of hospital readmissions can further threaten their dignity.

As discussed in the previous chapter, dignity is a duality that involves the intrinsic and extrinsic dimensions of an individual. Having a sense of life purpose strengthens the dignity of older people in their intrinsic self. Chinese older people highly value the respect they obtain from interpersonal relationships, which impinge on the extrinsic dimensions of dignity (Koehn & Leung, 2008). Older people who are recurrently admitted to hospitals have frequent contact with different hospital staff during hospitalizations. They are vulnerable to

lose their dignity if their relationship with hospital staff is poor. Therefore, the attitudes of hospital staff greatly influence the dignity of readmitted older people. Strategies, such as understanding the experience of hospital readmissions of older people and use of therapeutic communication can help to establish a mutually respectful relationship with readmitted older people and preserve their dignity.

Understanding the experiences of hospital readmissions

The respect and sensitivity of hospital staff are important elements of dignified care (Gennip et al., 2013). Healthcare team members involved in the care should possess and demonstrate these traits to older people. Respect covers not only the values and beliefs of older people but also their past experiences in everyday life and hospital readmissions. The lived experience revealed in this study provides an understanding of the common experience of Chinese older people in hospital readmissions. Hospital staff should respect the uniqueness of each individual and should therefore learn the experiences of each older patient to sensibly identify their unique needs.

The past life experiences of older people enable the hospital staff to understand their background, strengths, and resources, which can be mobilized to resolve the difficulties encountered in hospital readmissions. Understanding their experience in hospital readmissions allows the staff to realize the various bio-psycho-social-spiritual needs of older

people as they undergo hospital readmissions. This understanding enables the staff to acknowledge and respect the subjective feelings of suffering from invisible symptoms, as well as understand why and how older people crave to survive breathlessness through hospital readmission. The older people in the current study considered that their doctors disregarded their feelings and needs. Therefore, such understanding is particularly required by doctors. In addition, the experiences of older people obtained from managing the disease and their effort in refraining from unnecessary hospital readmissions should also be acknowledged. Recognizing the experience of older people and the thoughtful consideration of each individual needs the respect and sensitive of hospital staff to older people. This consideration forms the basis of building a mutually respectful relationship.

Use of therapeutic communication

The major findings of this study reveal that older people are most frustrated when their urgent need for survival is disregarded by their doctors. The influences of a paternalistic doctor-patient relationship in the Chinese culture impede older people from expressing their views (Wang, 2010). A top-down communication style is a barrier to understanding the needs of older people. They remain silent and passively accept the decisions of their doctors, which are not necessarily what they want. The Chinese older people are hesitant to express their views because of the perceived expectation of a submissive patient and of maintaining

harmony with the hospital staff.

Communication is an indispensable means in preserving the dignity of a patient (Price, 2004; Webster & Bryan, 2009). Considering that older people experience frequent contacts with hospital staff because of hospital readmissions, therapeutic communication is necessary to maintain their dignity. Therefore, open communication with readmitted older people should be encouraged. Hospital staff should provide opportunities for older people to voice out their needs during their interactions. Chinese patients are commonly regarded as not considering autonomy to be important because of their belief that only doctors have the right to make decisions on their health (Cong, 2004). Although a previous study showed that people in Hong Kong preferred joint decision-making with doctors (Bennett, Smith & Irwin, 1999), the older people in this study were influenced by the cultural belief that only doctors have the authority to make decisions. Nevertheless, involving older people in decision-making on the treatment plan and in discharge planning can instil in them a sense of being valued. Therefore, open communication and involving older people in decision-making on their treatment plan can help to establish a mutually respectful relationship and preserve their dignity.

During periods of hospital readmission, older people interact most frequently with nurses. Hence, nurses should appropriately use therapeutic communication to promote the dignity of older people. Older people feel that they are understood when they are provided

with choices in their care (Henderson, Van Eps, & Pearson, 2009). They also feel respected when nurses explain to them the procedure prior to the intervention (Webster & Bryan, 2009). Other health disciplines, such as physiotherapists and occupational therapists, and healthcare assistants, should also understand that their attitudes and interactions with older people are significant in maintaining the dignity of older people during hospitalization. Using of these strategies to establish a mutually respectful relationship preserve the dignity of older people when they undergo hospital readmissions. Furthermore, hospital staff can proactively develop a harmonious relationship with older people rather than older people adjusting themselves to maintain harmony in their interpersonal relationship.

Enhancing older people's capability in managing COPD

The findings of this study suggest that older people with COPD need a comprehensive understanding of the nature and prognosis of their disease from different health disciplines. The constituent of resigning to hospital readmissions revealed from this study shows that the focus on the chronicity of COPD influences the perceptions of older people of the disease. Older people learn from their doctors that COPD is an incurable chronic disease that causes their physical health to progressively deteriorate.

Doctors' descriptions of COPD considering the nature of the disease are accurate. This information also enables older people to accept the inevitability of hospital

readmissions. However, such accounts can debilitate the perceived capability of older people in managing their disease. From their professional training, doctors are familiar with how to deliver bad news, like terminal illness, and provide psychological support to patients and caregivers. However, psychological support in revealing the diagnosis and explaining the prognosis of chronic diseases is overlooked. Although COPD is an incurable chronic disease, doctors should emphasize the capability of older people in managing the disease, delaying the progression, and avoiding unnecessary hospital readmissions when they inform the diagnosis of COPD to older people and during each medical follow-up.

Indeed, older people learn about the nature and management of COPD from different health disciplines. When patients are newly diagnosed with COPD, they also learn from specialty nurses about the nature of the disease, medication, and disease management. Some patients also follow up on the disease in nurse-led clinics, where their pulmonary function and medication adherence are monitored. In addition, patients receive rehabilitative training provided by multi-disciplinary teams. Therefore, different health disciplines should use these opportunities to promote the capability of older people in self-management of the disease and to emphasize the ways of controlling the progression of the disease rather than focus on the incurability of the disease. The findings of this study show that the sense of responsibility of own health, perceived capability and successful experiences in relieving breathlessness and refraining from unnecessary hospital readmissions are important in day-to-day disease

management, but the perception of aging reinforces the belief of inevitable physical deterioration. During regular follow-up, nurses can emphasize older people to be responsible for their own health and that they are capable of managing their disease. Nurses should not convince older people to accept the disease as part of aging. When older people are observed of being readmitted to the hospital more frequently, their approaches to day-to-day disease management should be explored instead of emphasizing hospital readmissions as a result of the chronicity of the disease. Acknowledging the efforts of older people in managing the disease also enhances their confidence and assures their capability to avoid unnecessary hospital readmission.

The findings of this study suggest that confidence in avoiding hospital readmissions are related to whether older people take an active role in refraining from unnecessary readmission. The successful experiences in avoid unnecessary hospital readmission positively reinforces them to attempt to relieve breathlessness by themselves before seeking hospital care. These experiences can be employed to empower CODP patients. Although COPD patients learn about self-management of the disease through formal rehabilitative training given by health professionals, some older people are hesitant to follow the regimen because they fear inducing breathlessness and perceive a lack of physical strength. In a pilot study evaluating the feasibility of a group therapy for older COPD patients in Hong Kong, participants appreciated the group dynamics that promoted the exchange of ideas in self-

management and provided psychosocial support (Woo et al., 2006). Similar support groups can be setup for readmitted older patients with COPD to enhance their psychosocial support. Given that the patients in such a group share similar characteristics, the successful experiences of older people can provide other patients in the group with vivid and convincing examples to enhance self-efficacy. Experience sharing not only benefits the group members in terms of disease management but also promotes the sense of self-worth to older people.

Assisting to identify purposes in lives

The constituent of living for the moment reveals that Chinese older people become satisfied with their current condition when they positively compare their present state with their past living conditions. The past life experiences of older people are good resources for promoting their wellness. The "wisdom" acquired from their past experiences can assist them to cope with the new challenges in their lives. The insights obtained from their past experiences enable them to remain open and receptive to hospital readmissions. Therefore, healthcare professionals can conduct life review with older people who are frequently readmitted to hospitals to bring their past experiences into full play.

Conducting a life review helps older people achieve a state of ego integrity and identify their purpose in life (Burnside & Barbara, 1992). As previously discussed, having a life purpose and achieving a state of integrity enable older people to age well with hospital

readmissions. A life review is a systematic re-examination of one's past experiences (Miller, 2012; Shellman, 2008). It provides older people with the opportunity to have an in-depth reflection of their past experiences. Re-examination helps a person achieve a state of ego integrity based on the model of psychodynamic development introduced by Erikson (1982) by resolving conflicts in and accepting one's life (Binder et al., 2009). People can reappraise the meaning of their lives from their past experiences and identify new meanings for the future (Haber, 2006; Miller, 2012; Randall & Kenyon, 2001). Therefore, older people will be able to accept their experience of hospital readmissions and identify their new purpose in life when they achieve the state of integrity. Reviewing and interpreting one's past experiences assist to find purpose in life and create a positive outlook for the future (Scott & Debrew, 2009). Reflecting on their past life experiences can inspire older people to identify their purpose in life as they go between the hospital and their homes. Hodges (2009) found that older heart failure patients with a poor sense of life purpose had a higher number of hospital readmissions. Therefore, a life purpose is significant in maintaining wellness as older people age, particularly when they encounter challenges in hospital readmissions.

In the current study, the older people gained insight from their past experiences that they wanted to continue contributing to their families and that they should engage upon the present. Reviewing one's life is considered a universal and spontaneous phenomenon when a person is confronted with a life crisis (Shellman, 2008). However, a systematic life review

conducted by trained personnel can aid older people to identify their purpose in life early on. These purposes also assist older people in integrating their experience of hospital readmissions into their lives. As the values of Chinese older people are structured around their families, life review themes can start from this aspect of their lives. Family members are encouraged to participate in life reviews with older people because doing so increases the younger generation's understandings of the life of their senior family members and strengthens their family relationship (Butler, 2002; Haber, 2006). Moreover, healthcare professionals can develop a trustful relationship with older people in the process of conducting the life review (Binder et al., 2009; Shellman, 2006). Therefore, performing life reviews with older people who are frequently readmitted to hospitals can achieve therapeutic purposes that promote their wellness, as well as strengthen their relationships with family and healthcare professionals.

Support for caregivers and family members

The findings of this study show that older people consider themselves as imposing burdens to their families because of their physical limitation and the need for assistance during breathlessness. After being readmitted to a hospital, they therefore take the periods of hospital readmission as opportunities to relieve their families of their perceived burden. Current healthcare services mainly focus on the physical needs of patients but overlook the

needs of their families. Giving support to families by assisting them to live with older people who require hospital readmission is essential; providing support to caregivers can relieve their caregiving burden and also relieve the older people's sense of being a burden.

The findings of this study show that the older people eventually accepted the inevitability of hospital readmissions. Still, their caregivers were anxious when the older people suffered from breathlessness and they were concerned about the older people's condition during hospitalization. Hence, hospital readmissions of older people could create stress on their caregivers. In addition, although caregivers seemed to be committed to their caregiver roles as described by the older people, their commitment could have been influenced by the cultural value of taking care of their spouses or older family members (Zhang & Montgomery, 2003). Their behaviours and attitudes do not mean that their caregiving burden is at a low level. Therefore, their psychosocial needs and perceived caregiving burden should be carefully assessed to identify their unmet needs and provide timely assistance. Support groups in the community usually provide instrumental support in daily activities to older people who live alone. This kind of services can be extended to support older people who are frequently readmitted to the hospital and their caregivers to relieve some of their burdens in their daily lives.

Apart from keeping families informed about the condition and disease management plan during hospitalization of older people, helping families to become sensitive to the needs

of older people is also important. Chinese older people expect to receive attention and respect from their family members. They are most concerned about imposing possible burdens on their children and thus refuse their children visiting them during hospital readmissions. Nurses can discuss with the family members the expectations and needs of older people. The promotion of mutual understanding between older people and their families can strengthen their family bonding. In addition, it supports the family members to live with older people who are prone to recurrent hospital readmission.

Strengthening the continuity of care

The older people's experience of hospital readmissions reveals a lack of continuity of care for readmitted COPD patients in Hong Kong. From the perspective of older people, only the main physical complaints for hospital readmission are addressed by hospital staff. They are discharged from the hospital when a doctor determines their disease exacerbation is relieved. The experience of older people in hospital readmissions have led them to regard hospitals as transient places where they only obtain potent treatment that saves them from breathlessness. Chan et al. (2011) commented that the care pathway provided to readmitted COPD patients in Hong Kong is fragmented and lacks continuity. Although support for patients is available in the community after hospital discharge, such as telephone follow-up, day care centre, these services are offered only by a few large-scale hospitals. This situation

reflects that healthcare service provision pertaining to hospital readmissions is relatively confined to providing physical care to readmitted patients in a hospital setting. Continuity of care after hospital discharge is not provided to all COPD patients who are frequently readmitted to hospitals. In addition, support to their caregivers in terms of relieving their caregiving burden and stress induced by hospital readmissions is lacking.

Hospital readmissions denote that patients are revolving between hospital and home. Therefore, the plan of care should address the various needs from being readmitted to an acute hospital setting to having support in disease management at home. The findings of this study provide directions in maintaining the continuity of care. During the periods of hospital readmission, healthcare staff should not only attend to physical symptoms but also provide dignified care. The significance and the ways to deliver dignified care are discussed as mentioned previously. The decision of destination of discharge from an acute hospital should be made with the patients. Older people perceive themselves as being discharged prematurely when they still suffer breathlessness. As mentioned by the older people in this study, their need for hospital care was not recognized because of the subjective nature of breathlessness. Therefore, the destination of discharge should be discussed with the patients. Doctors can transfer COPD patients to a rehabilitative setting for further stabilization of the disease instead of discharging them to home.

In the existing provision of care, community nursing service is provided to COPD

patients who have problems in disease management. Home visits are made by community nurses but the care only focuses on the physical needs of patients. Continuity of care for readmitted patients is lacking in the transition from hospital to home. Indeed, community nurses can have a significant role in this transition. Thus, the community nursing service should be strengthened. Older COPD patients who are identified to have readmission problems should be referred to community nurses. Home visits after hospital discharge need to be arranged as early as possible. Older people who regard themselves prematurely discharged are prepared to be readmitted to a hospital within a short period of time. Early home visit can be particularly significant to them. The care provided should be personalized to each COPD patient. The findings of this study show that older people refrained from unnecessary hospital readmissions using passive or active approaches. The older people who lacked confidence or perceived themselves to lack the capability to manage the disease remained inactive to avoid triggering exacerbation and hospital readmission. Therefore, community nurses can sensibly assess older peoples' perceived barriers in disease self-management and the usual methods used in disease exacerbation. Older people would actively perform rehabilitative exercise and attempt to relive exacerbation before seeking hospital readmission only if they perceive that their barriers could be resolved. Active participation in the self-management of COPD is vital in avoiding unnecessary hospital readmissions and in turn reduces the readmission rate.

In addition to following up on the physical condition after hospital discharge, community nurses should assess older people' difficulties in managing daily activities and any psychosocial needs. As discussed in the previous section, the process of hospital readmissions could create stress to caregivers. Therefore, support to caregivers is necessary after older people are discharged to home. Community nurses should assess these caregivers' barriers in taking care of older people and their caregiving stress. Relevant support can be particularly important to older people who live alone or whose caregivers also suffer from chronic disease with disability. Apart from community nursing service, hospitals are also recommended to liaise with support groups in the community to strengthen the continuity of care and to ensure that patients and their families are well supported in the community after hospital discharge. Therefore, good continuity of care is necessary to address the various needs of COPD patients in the revolving door of hospital readmissions. Care after hospital discharge in promoting patients' self-efficacy in disease management and providing adequate support in disease management at the community level possibly can reduce hospital readmission.

Implications for Education

The findings of this study suggest implications for education to healthcare professionals, older people with COPD, and their caregivers. This study highlights that the

disease-oriented approach and prejudiced attitudes of doctors affect engagement and therapeutic interaction with older people. The professional training of doctors emphasizes on curing diseases. Medical psychology and sociology are covered in the undergraduate curriculum. However, the experiences revealed from the older people in the current study suggests that doctors practice by following a disease-oriented approach rather than by incorporating knowledge on various aspects and treating their patients as a whole person. Older people with COPD, who are frequently readmitted to a hospital, have a greater demand for hospital care. Therefore, the treatment approach of doctors significantly affects the outcomes of these older people. Hence, a client-centred approach that addresses the whole person rather than the disease should be introduced starting from the undergraduate education. The curriculum is suggested to include medical science, psychology and sociology in the junior year of study. Then, these fields should be integrated in the senior year of study to prepare their clinical practice. A client-centred approach should be used as the basis on the clinical placement of intern doctors. Restructuring and shifting the focus in the curriculum can prepare doctors to practice medicine in a humanized approach.

The prejudiced attitudes of doctors toward older people are also influenced by their personal impressions on patients readmitted to hospitals for COPD. Therefore, self-reflection on personal impressions and attitudes to hospital readmissions of older people with COPD is necessary in building a mutually respectful doctor-patient relationship. The basic training of

doctor should also include methods of performing self-reflection. Reflective journal writing and videotaping of interactions with patients are effective ways to guide self-reflection and improve communication skills (Callister, 1993; Jarvis, 1992). These skills enable doctors to conduct continuous self-reflection and to recognize their own assumptions, beliefs, and stereotypes on hospital readmissions. Therefore, self-awareness reminds doctors to remain open when they interact with readmitted older people to make a mutually respectful relationship possible.

Doctor's clinical competence not only refers to their proficiency in treating diseases but also the quality of relationship with their patients (de Monchy, 1992). As suggested by the findings of this study, older people feel powerless to communicate their needs to their doctors under a paternalistic relationship. Therefore, the importance of therapeutic communication skills and the influence of doctor-patient relationships should be emphasized in doctors' undergraduate education. With this understanding, doctors can be well prepared to establish a more egalitarian doctor-patient relationship that encourages open communication.

In the current study, the older people seemed to communicate well with other healthcare team members in hospitals. They found those team members are more approachable; thus, they did not express any frustration toward them. Nonetheless, older people, who are recurrently readmitted to hospitals, have frequent contact with different hospital staff. Therefore, the above implications for education are also relevant and applicable

to other healthcare disciplines.

As for nurses, they have the most frequent contact with older people during the periods of hospital readmission and are responsible for providing continuous support to older people in the community. The older people in this study indicated that nurses are empathetic and caring to patients. These attitudes are generic characteristics of nurses. A comprehensive understanding of the needs of older people is necessary to promote wellness. Undergraduate education curricula cover COPD and gerontological nursing. However, the problems of hospital readmissions among people with chronic diseases are not highlighted in these courses. Therefore, these issues are suggested to be incorporated into these courses to increase the awareness of and provide understanding to undergraduate nurses. For post-graduate education, the issue of hospital readmissions and patient perspectives on hospital readmissions should be emphasized in respiratory specialty training. This knowledge is particularly important to specialty nurses who run nurse-led clinics for COPD patients. The knowledge can be put into practice to address the various needs of COPD patients who are frequently readmitted to hospitals.

The older people in this study felt powerless in their need for hospital care being disregarded by their doctors. This sense of powerlessness was prominent when they considered that they were prematurely discharged to home. In addition to advocating for older people's needs, nurses can teach older people assertive communication skills to enable

them to negotiate their needs with hospital staff. The use of these skills not only reduces older people's frustration when interacting with hospital staff but may also reduce unnecessary early readmission because of perceived premature discharge.

Caregivers play an important role in assisting older people to relieve breathlessness and avoid unnecessary hospital readmissions. However, the methods used by caregivers are usually learned from actual experience. The findings of this study show that caregivers seek hospital care for older people because of anxiety about their suffering from breathlessness. Aside from providing education to COPD patients about the self-management of this disease, nurses are suggested to involve caregivers in the education. The teaching contents should not only cover the general management of COPD but also the subjective feelings of breathlessness and ways to manage disease exacerbation. This understanding will enable caregivers to provide practical assistance to reduce unnecessary readmission and relieve their stress when taking care of their care recipients.

Recommendations for Further Research

The findings of this study clearly describe the lived experience of hospital readmissions of Chinese older people with COPD. The findings suggest the directions for further research to facilitate the acquisition of a more in-depth and comprehensive understanding of the phenomenon of hospital readmissions from different perspectives. The

findings of the current study reveal the socio-cultural influences that shape the lived experience of hospital readmissions of older people in the Chinese context. Lived experience of hospital readmissions in people from other cultures can be explored using the phenomenological approach. Comparisons of the lived experiences of people in different cultures can provide a thorough understanding of the phenomenon.

As the findings were derived from a male-dominant sample, future research could explore the lived experience of a large sample of older females and compare the perspectives between older males and females relative to hospital readmissions. Moreover, the major findings of this study illustrate that older people feel powerless to communicate their needs with doctors. The paternalistic doctor-patient relationship impedes older people from voicing out their needs. In future studies, ethnography could be used to examine the interactions between readmitted older people and healthcare professionals of different disciplines. The differences in interactions among various disciplines can be compared, and an inquiry can be made into how such differences come about. The findings will have significance in promoting effective communication between readmitted older people and healthcare professionals.

Older people perceive a lack of pragmatic support in the management of COPD and in avoiding hospital readmissions. They believe that they can rely only on themselves and their caregivers to manage their disease and their daily activities after hospital discharge. Although

self-management is a crucial component of chronic disease management, patients should receive meaningful support from healthcare professionals. An in-depth understanding of the perceptions of readmitted older people relative to the self-management of COPD and their daily lives after hospital discharge could improve the support for older people and consequently empower such patients.

Older people who are frequently readmitted to hospital remain vigilant in avoiding breathlessness after hospital discharge. Thus, they become increasingly dependent on their caregivers. The caregivers also stay close to and become more alert to any physical needs of their care recipients. Therefore, understanding on caregivers is a significant area for further research. A future study can explore the lived experience of caregivers in taking care of older people who are frequently readmitted to hospital. In particular, the dynamic interaction between caregivers and older people should be explored when the frequency of hospital readmission increases.

Furthermore, the caregiving role is an ingrained belief rooted in Chinese women. The caregiving burden of women who have dual roles as wives and caregivers is an interesting topic for future studies. This study revealed that the caregivers are commonly in their senior age. The experience of taking care of care recipients who are frequently readmitted to hospital by old-aged spousal caregivers is worth exploring.

Conclusion

This phenomenological study contributes to the literature by adding to the knowledge on the understanding of hospital readmissions of Chinese older people with COPD. Hospital readmissions for COPD are a global health issue. The high readmission rates among older people particularly draw the attention of healthcare professionals. Empirical studies have identified several factors associated with hospital readmissions. However, a thorough understanding of hospital readmissions should be based on and derived from the experiences of patients relative to hospital readmissions.

This study is the pioneer in the use of the phenomenological approach to explore the lived experience of hospital readmissions. The study aimed to describe the lived experience of hospital readmissions of Chinese older people with COPD and to explore Chinese socio-cultural influences on their readmission experience. A comprehensive understanding of hospital readmissions is embodied in the experiences of older people. Six constituents emerged from the narrative descriptions of older people. These constituents include refraining from unnecessary readmissions, craving for survival, feeling being disregarded and powerless, being conscious of relieving burden to families, resigning to hospital readmissions, and living for the moment. The general structure that explicates the interrelationship among these constituents is illustrated in the chapter on findings. The findings reveal that hospital readmissions are complex experiences for Chinese older people

and highlight the pervasive socio-cultural influences that shape the experiences of hospital readmissions of older people.

Accepting the inevitability of hospital readmissions and the insight gained from their past life experiences transform Chinese older people into having a positive outlook that enables them to embrace the experiences of hospital readmissions in their lives. They strive to maintain an intrapersonal and interpersonal state of harmony when they are revolving between the hospital and the home. Older people appear to accept and cope well with the experience of hospital readmissions. However, the findings also unveil several unmet needs from their experiences. Implications for clinical practice and education are suggested based on the needs. Directions for further research are recommended to enrich the understanding of hospital readmissions.

This phenomenological study provides an in-depth understanding on the lived experience of hospital readmissions of Chinese older people with COPD and how their experiences are shaped in the Chinese context. This understanding is important to enable healthcare professionals to promote the wellness of Chinese older people as they undergo hospital readmissions and improve the quality of healthcare provision.

References

Aboderin, I. (2003). Modernization and economic strain: The impact of social change on material family support for older people in Ghana. In V. L. Bengston, & A. Lowenstein (Eds.). *Global aging and challenges to families* (pp. 284-304). New York: Aldine de Gruyter.

Abrams, T. E., Vaughan-Sarrazin, M., & Vander Weg, M. W. (2011). Acute exacerbations of chronic obstructive pulmonary disease and the effect of existing psychiatric comorbidity on subsequent mortality. *Psychosomatis, 52*(5), 441-449.

Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research, 9*(3), 407-410.

Almagro, P., Calbo, E., & de Echagüen, A. O. (2002). Mortality after hospitalization for COPD. *Chest, 121*(5), 1441-1448.

Almagro, P., Barreiro, B., & de Echagüen, A. O. (2006). Risk factors for hospital readmission in patients with chronic obstructive pulmonary disease. *Respiration, 73*(3), 311-317.

Anderson, G.F., & Steinberg, E.P. (1984). Hospital readmissions in the medicare population. *New England Journal of Medicine, 311*(21), 1349-1353.

Anderson, G.F., & Steinberg, E.P. (1985). Predicting hospital readmissions in the medicare population. *Inquiry, 22*(3), 251-258.

Apps, L., D., Harrison, S. L., & Williams, J. E. A. (2014). How do informal self-care strategies evolve among patients with chronic obstructive pulmonary disease managed in primary care? A qualitative study. *International Journal of COPD, 9*. Art. No.: PMC3942113. doi: 10.2147/COPD.S52691

Ardelt, M., Landes, S. D., & Gerlach, K. R. (2013). Rediscovering internal strengths of the aged: The beneficial Impact of wisdom, mastery, purpose in life, and spirituality on aging well. In J. D. Sinnott (Ed.), *Positive psychology: Advances in understanding adult motivation* (pp. 97-119). New York: Springer New York.

Ashton, C. M., Del Junco, D. J., & Souchek, J. (1997). The association between the quality of inpatient care and early readmission: A meta-analysis of the evidence. *Medical Care, 35* (10), 1044-1059.

Ashton, C. M., Kuykendall, D. H., & Johnson, M. L. (1995). The association between the quality of inpatient care and early readmission. *Annals of Internal medicine.122*(6), 415-421.

Avşar, G., & Kaşikçi, M. (2011). Living with chronic obstructive pulmonary disease: A qualitative study. *Australian Journal of Advanced Nursing, 28*(2), 46-52.

Bahadori, K., FitzGerald, J. M., & Levy, R. D. (2009). Risk factors and outcomes associated with chronic obstructive pulmonary disease exacerbations requiring hospitalization. *Canadian Respiratory Journal, 16*(4), e43-e49.

Bailey, P. H. (2004). The dyspnea-anxiety-dyspnea cycle – COPD patients' stories of breathlessness: "It's scary /when you can't breathe". *Qualitative Health Research, 14*(6), 760-778.

Bailis, D. S., & Chipperfield, J. G. (2006). Emotional and self-evaluative effects of social comparison information in later life: How are they moderated by collective self-esteem? *Psychology and Aging, 21*(2), 291-302.

Baillie, L. (2007). The impact of staff behaviour on patient dignity in acute hospitals. *Nursing Times, 103*(34), 30-31.

Baker, C., Wuest, J., & Stem, P. N. (1992). Method slurring: The grounded theory/ phenomenology example. *Journal of Advanced Nursing, 17*(11), 1355-1360.

Baker, C. Zou, K. H., & Su. J. (2013). Risk assessments of readmissions following an initial COPD-related hospitalization. *International Journal of COPD, 8*, 551-559.

Baltes, P. B., & Baltes, M. N. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. In P. B. Baltes, & M. M. Blates (Eds.), *Successful aging: Perspectives from the behavioral sciences* (pp. 1-34). New York: Cambridge University Press.

Barba, R., de Casasola, G. G., & Marco, J. (2012). Anaemia in chronic obstructive pulmonary disease: A readmission prognosis factor. *Current Medical Research and Opinion, 28*(4), 617-622.

Barnett, M. (2005). Chronic obstructive pulmonary disease: A phenomenological study of patients' experiences. *Journal of Clinical Nursing, 14*(7), 805-812.

Baronet, A. (2003). The impact of family relations on caregivers' positive and negative appraisal of their caretaking activities. *Family Relations, 52*(2), 137-142.

Bathe, A., Weisshaar, E., & Matterne, U. (2012). Chronic pruritus – more than a symptom: A qualitative investigation into patients' subjective illness perceptions. *Journal of Advanced Nursing, 69*(2), 316-326.

Beal, K. A. (1993). *Transpersonal psychotherapy: A phenomenological inquiry* (Unpublished doctoral 's thesis). The Ohio State University: United States.

Beck, C. T. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research, 15*(2), 263-266.

Beck, C. T. (1994). Phenomenology: Its use in nursing research. *International Journal of Nursing Studies, 31*(6), 499-510.

Behnke, M., Jorres, R. A., & Kirsten, D. (2003). Clinical benefits of a combined hospital and home-based exercise programme over 18 months in patients with severe COPD. *Monaldi Archives for Chest Disease, 59*(1), 44-51.

Bennett, K., Smith, D. H., & Irwin, H. (1999). Preferences for participation in medical decisions in China. *Health Communication, 11*(3), 261-284.

Bergs, D. (2002). 'The hidden client' – women caring for husbands with COPD: Their experience of quality of life. *Journal of Clinical Nursing, 11*(5), 613-621.

Binder, B. K., Mastel-Smoth, B., & Hersch, G. (2009). Community –dwelling, older women's perspectives on therapeutic life review: A qualitative analysis. *Issues in Mental Health Nursing, 30*(5), 288-294.

Bisharat, N., Handler, C., & Schwartz, N. (2012). Readmissions to medical wards: Analysis of demographic and socio-medical factors. *European Journal of Internal Medicine, 23*(5), 457-460.

Blanchard-Fields, F., Jahnke, H. C., & Camp, C. (1995). Age differences in problem-solving style: The role of emotional salience. *Psychology and Aging, 10*(2), 173-180.

Blanchard-Fields, F., Chen, Y., & Norris, I. (1997). Everyday problem solving across the adult life span: Influence of domain specificity and cognitive appraisal. *Psychology and Aging, 12*(4), 684-693.

Blanchard-Fields, F., Stein, R., & Watson, T. L. (2004). Age differences in emotion-regulation strategies in handling everyday problems. *Journal of Gerontology, 59*(6), 261-269.

Bolam, B., Hodgetts, D., Chamberlain, K. (2003). 'Just do it': An analysis of accounts of control over health amongst lower socioeconomic status groups. *Critical Public Health, 13*(1), 15-31.

Bond, M. H., & Hwang, K. K. (1986). The social psychology of Chinese people. In M. H. Bond (Ed.), *The psychology of the Chinese People* (pp.213-266) New York: Oxford University Press.

Bond, M. H., & Lee, P. W. H. (1981). Face saving in Chinese culture: A discussion and experimental study of Hong Kong students. In A. Y. C. King, & R. P. L. Lee (Eds), *Social life and development in Hong Kong* (pp. 289-304). Hong Kong: Chinese University Press.

Borge, C. R., Moum, T., & Lein, M. P. (2014). Illness perception in people with chronic obstructive pulmonary disease. *Scandinavian Journal of Psychology, 55*(5), 456-463.

Bowler, S., Schollay, D., & Nicholson, C. (2001). Home vs hospital treatment of exacerbations of COPD: A randomized controlled trial. *Respirology, 6*, A67.

Bowler, S., Serisier, D., & Schollay, D. (2001). *A pilot study comparing substitutable care at home with usual hospital care acute Chronic Obstructive Pulmonary Disease*. Final report to National Demonstration Hospital Program.

Boyle, A. H. (2009). Living with a spouse with chronic obstructive pulmonary disease: The meaning of wives′ experiences. *Journal of Nursing and Healthcare of Chronic Illness, 1*(4), 273-282.

Brand, C., Sundararajan, V., & Jones, C. (2005). Readmission patterns in patients with chronic obstructive pulmonary disease, chronic heart failure and diabetes mellitus: An administrative dataset analysis. *Internal Medicine Journal, 35*(5), 296-299.

Brown, P., & Levinson, S. C. (1987). *Politeness: Some universal in language usage*. New York: Cambridge University Press.

Bulter, R. (2002). Life review. *Journal of Geriatric Psychiatry, 35*(1), 7-10.

Burns, R., & Nichols, L. O. (1991). Factors predicting readmission of older general medicine patients. *Journal of General Internal Medicine, 6*(5), 389-393.

Burnside, I., & Haight, B. K. (1992). Reminiscence and life review: Analysing each concept. *Journal of Advanced Nursing, 17*(7), 855-862.

Cakir, B., & Gammon, G. (2010). Evaluating readmission rates: How can we improve? *Southern Medical Journal, 103*(11), 1079-1083.

Callister, L. C. (1993). The use of student journals in nursing education: Making meaning out of clinical experience. *Journal of Nursing Education, 23*(4), 185-186.

Cao, Z., Ong, K. C., & Eng, P. (2006). Frequent hospital readmissions for acute exacerbation of COPD and their associated factors. *Respirology, 11*(2), 188-195.

Carneiro, R., Sousa, C., & Pinto, A. (2010). Risk factors for readmission after hospital discharge in chronic obstructive pulmonary disease. The role of quality of life indications. *Revista Portuguesa de Pneumologia, 16*(5), 759-777.

Census and Statistics Department. (2012). *Population census. Main report: Volume 1.* Retrieved from http://www.census2011.gov.hk/pdf/main-report-volume-I.pdf

Chan, S. C. C. (2004). Chronic obstructive pulmonary disease and engagement in occupation. *The American Journal of Occupational Therapy, 58*(4)*,* 408-415.

Chan, C. L. F., & Chui, E. W. T. (2011). Association between cultural factors and the caregiving burden for Chinese spousal caregivers of frail elderly in Hong Kong. *Aging & Mental Health, 15*(4), 500-509.

Chan, F. W. K., Wong F. Y. Y., & Yam, C. H. K. (2011). Risk factors of hospitalization and readmission of patents with COPD in Hong Kong population: Analysis of hospital admission records. *BMC Health Services Research, 11*, 186.

Chan-Yeung, M., Ai-Khaled, N., & White, N. (2004). The burden and impact of COPD in Asia and Africa. *The International Journal of Tuberculosis and Lung Disease, 8*(1)*,* 2-14.

Chen, Y. C. (2001). Chinese values, health and nursing. *Journal of Advanced Nursing, 36*(2), 270-273.

Chen, S. X., Cheung, F. M., & Bond, M. H. (2006). Going beyond self-esteem to predict life satisfaction: The Chinese case. *Asian Journal of Social Psychology, 9*(1), 24-35.

Chen, Y. J., & Narsavage, G. L. (2006). Factors related to chronic obstructive pulmonary disease readmission in Taiwan. *Western Journal of Nursing Research, 28*(1), 105-124.

Cheng, C. (2009). Dialectical thinking and coping flexibility: A multimethod approach. *Journal of Personality, 77*(2), 471-493.

Cheng, C., Lo, B. C. Y., & Chio, J. H. M. (2010). The Tao (way) of Chinese coping. In M. H. Bond (Ed.), *The Oxford handbook of Chinese psychology* (pp. 399-419). New York: Oxford University Press.

Cheng, H., Sit, J. W. H., & Twinn, S. F. (2013). Coping with breast cancer survivorship in Chinese women: The role of fatalism or fatalistic voluntarism. *Cancer Nursing, 36*(3), 236-244.

Cheung, F. M. (1996). Gender role development. In Lau, S. (Ed.). *Growing Up the Chinese Way: Chinese Child and Adolescent Development* (pp. 45-68). Hong Kong: Chinese University Press.

Chin, J. J. (2002). Doctor-patient relationship: From medical paternalism to enhanced autonomy. *Singapore Medical Journal, 43*(3), 152-155.

Chong, A. M. L., Ng, S. H., & Woo, J. (2006). Positive ageing: The views of middle-aged and older adults in Hong Kong. *Ageing & Society, 26(2)*, 243-265.

Christian, M. (2005). Phases of life and despair. *Schweizer Archiv fur Neurologie und Psychiatrie, 156*(3), 118-121.

Chu, L. W., & Pei, C. K. W. (1999). Risk factors for early emergency hospital readmission in elderly medical patients. *Gerontology, 45*(4), 220-226.

Chu, C. Y. C., & Yu, R. (2010). *Understanding Chinese Families: A comparative study of Taiwan and Southeast China*. UK: Oxford University Press.

Chui, W. Y. Y., & Chan, S. W. C. (2007). Stress and coping of Hong Kong Chinese family members during a critical illness. *Journal of Clinical Nursing, 16*(11), 372-381.

Cicutto, L. Brooks, D., & Henderson, K. (2004). Self-care issues from the perspective of individuals with chronic obstructive pulmonary disease. *Patient Education and Counseling, 55*(2), 168-176.

Clancy, K., Hallet, C., & Caress, A. (2009). The meaning of living with chronic obstructive pulmonary disease. *Journal of Nursing and Healthcare of Chronic Illness, 1*(1), 78-86.

Clarke, L. H., & Bennett, E. (2013). 'You learn to live with all the things that are wrong with you': Gender and the experience of multiple chronic conditions in later life. *Aging and Society, 33*(2), 342-360.

Cleland, J. A., Lee, A. J., & Hall, S. (2007). Associations of depression and anxiety with gender, age, health-related quality of life and symptoms in primary care COPD patients. *Family Practice, 24*(3), 217-223.

Cohen, M. Z. (1987). A historical overview of the phenomenology movement. *Journal of Nursing Scholarship, 19*(1), 31-34.

Cohen, M. A., & Omery, A. (1994). Schools of phenomenology: Implications for research. In J. M. Morse (Ed.), *Critical issues in qualitative methods* (pp. 136-156). Thousand Oaks: Sage Publications.

Colazzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle, & M. Kings (Eds.), *Existential phenomenological alternative for psychology* (pp. 48-71). New York: Oxford University Press.

Cong, Y. (2004). Doctor-family-patient relationship: The Chinese paradigm of informed consent. *Journal of Medicine and Philosophy, 29*(2), 149-178.

Connolly, M. J., Lowe, D., & Anstey K. (2006). Admissions to hospital with exacerbations of chronic obstructive pulmonary disease: Effect of age related factors and service organization. *Thorax, 61*(10), 843-838.

Cotton, M. M., Bucknall, C. E., & Dagg, K. D. (2000). Early discharge for patients with exacerbations of chronic obstructive pulmonary disease: A randomized controlled trial. *Thorax, 55* (11), 902-906.

Coventry, P. A., Gemmell, I., & Todd, C. J. (2011). Psychosocial risk factors for hospital readmission in COPD patients on early discharge services: A cohort study. *BMC Pulmonary Medicine, 11*(1), 49.

Coward, H. (1996). Taoism and Jung: Synchronicity and the self. *Philosophy East and West, 46*(4), 477-495.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks: Sage Publications.

Dahlberg, K. (2006). The essence of essence: The search for meaning structures in phenomenological analysis of lifeworld phenomena. *International Journal of Qualitative Studies on Health and Well-being, 1*(1), 11-19.

Dahlberg, K., Drew, N., & Nyström, M. (2008). *Reflective Life-world Research* (2nd ed.). Lund: Studentlitteratur.

Dahlén, I., & Janson, C. (2002). Anxiety and depression are related to the outcome of emergency treatment in patients with obstructive pulmonary disease. *Chest, 122*(5), 1633-1637.

Davies, L., Wilknson, M., & Bonner, S. (2000). 'Hospital at Home' versus hospital care in patients with exacerbations of chronic obstructive pulmonary disease: Prospective randomized controlled trial. *British Medical Journal, 321*(7271), 1265-1268.

de Monchy, C. (1992). Professional attitudes of doctors and medical teaching. *Medical Teacher, 14*(4), 327-331.

Department of Health, Hong Kong. (2013). *Health facts of Hong Kong*. Retrieved from http://www.dh.gov.hk/english/statistics/statistics_hs/files/Health_Statistics_pamphlet_E.pdf

Dicker, N. W., & Kass, N. E. (2009). Understanding respect: Learning from patients. *Journal of Medical Ethics, 35*(7), 419-423.

Dickson, G. L., & Kim, J. I. (2003). Reconstructing a meaning of pain: Older Korean American women's experiences with the pain of osteoarthritis. *Qualitative Health Research, 13*(5), 675-688.

DiMarco, F., Verga, M., & Reggente, M. (2006). Anxiety and depression in COPD patients: The roles of gender and disease severity. *Respiratory Medicine, 100*(10), 1767-1774.

Dingley, C., & Gayle, R. (2003). Inner strength in older Hispanic women with chronic illness. *Journal of Cultural Diversity, 10*(1), 11-22.

Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies, 44*(1), 131-142.

Dreyfus, H., & Dreyfus, S. (1987). From Socrates to expert systems the limits of calculative rationality. In P. Rabinow, & W. Sullivan (Eds.), *Interpretive Social Science: A second look* (pp. 327-350). Berkley: University of California Press.

Dukes, S. (1984). Phenomenological methodology in the human sciences. *Journal of Religion and Health, 23*(3), 197-203.

Durkheim, E. (1952). *Suicide, a study in sociology.* London: Routledge.

Eaton, T., Young, P., & Fergusson, W. (2009). Does early pulmonary rehabilitation reduce acute health-care utilization in COPD patients admitted with an exacerbation? A randomized controlled study. *Respirology, 14*(2), 230-238.

Edward, K. L. (2006). A theoretical discussion about the clinical value of phenomenology for nurses. *Holistic Nursing Practice, 20*(5), 235-238.

Egan, E., Clavarino, A., & Burridge, L. (2002). A randomized control trial of nursing-based case management for patients with chronic obstructive pulmonary disease. *Lippincotts Case Management,* 7(5), 170-179.

Ek, K., & Ternestedt, B. M., (2008). Living with chronic obstructive pulmonary disease at the end of life: A phenomenological study. *Journal of Advanced Nursing, 62*(4), 470-478.

Ek, K., Sahlberg-Blom, E., & Andershed, B. (2011). Struggling to retain living space: Patients' stories about living with advanced chronic obstructive pulmonary disease. *Journal of Advanced Nursing, 67*(7), 1480-1490.

Elofsson, L. C., & Öhlén, J. (2004). Meanings of being old and living with chronic obstructive pulmonary disease. *Palliative Medicine, 18*(7), 611-618.

Erikson, E. H. (1982). *The life cycle completed: A review*. New York: Norton.

Evangelista, L. S., Kagawa-Singer, M., & Dracup, K. (2001). Gender differences in health perceptions and meaning in persons living with heart failure. *Heart and Lung, 30*(3), 167-176.

Faircloth, C. A., Boylstein, C., & Rittman, M. (2004). Disrupted bodies: Experiencing the newly limited body in stroke. *Symbolic Interaction, 27*(1), 71-87.

Fethke, C. C., Smith, I. M., & Johnson, N. (1986). Risk factors affecting readmission of the elderly. *Medical Care, 24*(5), 429-437.

Figueiredo, D., Gabriel, R., & Jácome, C. (2014). Caring for relatives with chronic obstructive pulmonary disease: How does the disease severity impact on family carers? *Aging & Mental Health, 18*(3), 385-393.

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology and Practice, 3*(1), 6-25.

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531-545.

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research, 19*(4), 583-590.

Fleming, V., Gaidys, U. & Robb, Y. (2003). Hermeneutic research in nursing: Developing a Gadamerian-based research method. *Nursing Inquiry, 10*(2), 113-120.

Fraser, D. D., Kee, C. C., & Minick, P. (2006). Living with chronic obstructive pulmonary disease: Insiders′ perspective. *Journal of Advanced Nursing, 55*(5), 550-558.

Frazier, L. D. (2002). Perceptions of control over health: Implications for sense of self in healthy and ill older adults. In A. M. Columbus (Ed.), *Advances in psychology research.* (pp. 145-163). New York: Nova Science Publishers.

Frieswijk, N., Buunk, B. P., & Steverink, N. (2004). The effect of social comparison information on the life satisfaction of frail older persons. *Psychology and Aging, 19*(1), 183-190.

Gabrenya, W. K., & Hwang, K. K. (1996). Chinese social interaction: Harmony an hierarchy on the good earth. In M. H. Bond (Ed.), *The handbook of Chinese psychology* (pp. 309-321). Hong Kong: Oxford University Press.

Gallagner, A., Li, S., & Wainwright, P. (2008). Dignity in the care of older people: A review of the theoretical and empirical literature. *BMC Nursing, 7*(11).

Gang, F., Gang, S. J., & Tacata, L. A. (2003). Helpseeking behaviour among Filipino Americans: A cultural analysis of face and language. *Journal of Community Psychology, 31*(5), 469-488.

Garcia-Aymerich, J., Farrero, E., & Félez, M. A. (2003). Risk factors of readmission to hospital for a COPD exacerbation: A prospective study. *Thorax, 58*(2), 100-105.

Garner, J. (2003). Psychotherapies and older adults. *Australian and New Zealand Journal of Psychiatry, 37*(5), 537-548.

Gautam, R. Macduff, C., & Brown, I. (1996). Unplanned readmissions of elderly patients. *Health Bulletin, 54*(6), 449-457.

Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative health Research*, *14*(10), 1429-1452.

Gennip, I. E., Pasman, H. R. W., & Oosterveld-Vlug, M. G. (2013). The development of a model of dignity in illness based on qualitative interviews with seriously ill patients. *International Journal of Nursing Studies, 50*(8), 1080-1049.

Ghanei, M., Aslani, J., & AzizAbadi-Farahani, M. (2007). Logistic regression model to predict chronic obstructive pulmonary disease exacerbation. *Archives of Medical Science, 3*(4), 360-366.

Gift, A. G. (1990). Dyspnea. *Nursing Clinics of North America, 25*(4), 955-965.

Gignac, M. A. M., Davis, A. M., & Hawker, G. (2006). "What do you expect? You're just getting older": A comparison of perceived osteoarthritis-related and aging-related health experiences in middle- and older-age adults. *Arthritis and Rheumatism, 55*(6), 905-912.

Giorgi, A. (1971). Phenomenology and experimental psychology: II. In A. Giorgi, W. F. Fischer, & R. Von Eckattberg (Eds.), *Duquesne Studies in Phenomenological Psychology* (pp. 17-29). Pittsburgh: Duquesne University Press.

Giorgi, A. (1985). *Phenomenology and psychological research*. Pittsburgh: Duquesne University press.

Giorgi, A. (1994). A phenomenological perspective on certain qualitative research methods. *Journal of Phenomenological Psychology, 25*(2), 190-220.

Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological methods as a qualitative research. *Journal of Phenomenological Psychology, 28*(2), 235-260.

Giorgi, A. (2005). The phenomenological movement and research in the human sciences. *Nursing Science Quarterly, 18*(1), 75-82.

Giorgi, A. (2006). Concerning variations in the application of the phenomenological method. *The Humanistic Psychologist, 34*(4), 305-319.

Giorgi, A. (2006). Difficulties encountered in the application of the phenomenological method in the social sciences. *Análise psicológica, 24*(3), 353-361.

Giorgi, A. (2007). Concerning the phenomenological methods of Husserl and Heidegger and their application in psychology. *Collection du Cirp, 1*, 63-78.

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Pittsburgh: Duquesne University Press.

Giorgi, A., & Giorgi, B. (2003). Phenomenology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 26-52). London: Sage.

Giorgi, A. P., & Giorgi, B. (2008). Phenomenological psychology. In C. Willing, & W. Stainton-Rogers (Eds.), *The SAGE handbook of qualitative research in psychology*. Los Angeles: SAGE.

Giorgi, A. P., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspective in methodology and design.* Washington: American Psychological Association.

Global Initiative for Chronic Obstructive Lung Disease. (2010). *Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease*. Retrieved from http://www.goldcopd.org/uploads/users/files/GOLDReport_April112011.pdf

Global Initiative for Chronic Obstructive Lung Disease. (2014). *Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease.* Retrieved from http://www.goldcopd.org/uploads/users/files/GOLD_Report_2014_Jun11.pdf

Glynn, N., Bennett, K., & Silke, B. (2011). Emergency medical readmission: Long-term trends and impact on mortality. *Clinical Medicine, 11*(2), 114-118.

Goodyear-Smith, F., & Buetow, S. (2001). Power issues in the doctor-patient relationship. *Health Care Analysis, 9*(4), 449-462.

Gorman, J., Vellinga, A., & Gilmartin, J. J. (2010). Frequency and risk factors associated with emergency medical readmissions in Galway University Hospitals. *Irish Journal of Medical Science, 179*(2), 255-258.

Gruffydd-Jones, K., Langley-Johnson, C., & Dyer, C. (2007). What are the needs of patients following discharge from hospital after an acute exacerbation of chronic obstructive pulmonary disease (COPD)? *Primary Care Respiratory Journal, 16*(6), 363-368.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. Thousand Oaks: Sage Publications.

Gudmundsson, G., Gislason, T., & Janson, C. (2005). Risk factors for rehospitalisation in COPD: Role of health status, anxiety and depression. *European Respiratory Journal, 26*(3), 414-419.

Gullick, J., & Stainton, M. C. (2008). Living with chronic obstructive pulmonary disease: Developing conscious body management in a shrinking life-world. *Journal of Advanced Nursing, 64*(6), 605-614.

Gurwitsch, A. (1964). *The field of consciousness*. Pittsburgh: Duquesne University Press.

Gysels, M. (2008). Access to services for patients with chronic obstructive pulmonary disease: The invisibility of breathlessness. *Journal of Pain and Symptom Management, 36*(5), 451-460.

Haber, D. (2006). Life review: Implementation, theory, research, and therapy. The *International Journal of Aging and Human Development, 63*(2), 153-171.

Habraken, J. M., Pols, J., & Bindels, P. J. E. (2008). The silence of patients with end-stage of COPD: A qualitative study. *Journal of General Practice.* doi: 10.3399/bjgp08X376186

Haines-Wood, J., Gilmore, D. H., & Beringer, T. R. O. (1996). Re-admission of elderly patients after in-patient rehabilitation. *The Ulster Medical Journal, 65*(2), 142-144.

Hall, S., Legault, A., & Côté, J. (201). Dying means suffocating: Perceptions of people living with severe COPD facing the end of life. *International Journal of Palliative Nursing, 16*(9), 451-457.

Hallet, C. (1995). Understanding the phenomenological approach to research. *Nurse Research, 3*(1), 55-65.

Hamind, P. N., Yue, X. D., & Leung, C. M. (2003). Adolescent coping in different Chinese family environments. *Adolescence, 38*(149), 111-130.

Hansen, C. (2010). Chinese Confucianism and Daoism. In P. L. Quinn, & C. Taliaferro (Eds), *A companion to philosophy of religion* (pp. 23-33). Malden: Wiley-Blackwell.

Hasson, F., Spence, A., & Waldron, M. (2008). I can not get a breath: Experiences of living with advanced chronic obstructive pulmonary disease. *International Journal of Palliative Nursing, 14*(11), 526-531.

Heider, F. (1958). *The psychology of interpersonal relations*. New York: Wiley.

Hein, S. F., & Austin, W. J. (2001). Empirical and hermeneutic approaches to phenomenological research in psychology: A comparison. *Psychological Methods, 6*(1), 3-17.

Helgeson, V. S. (1992). Moderators of the relation between perceived control and adjustment to chronic illness. *Journal of Personality and Social Psychology, 63*(4), 656-666.

Henderson, A., Van Eps, M. A., & Pearson, K. (2009). Maintenance of patients' dignity during hospitalization: Comparison of staff-patient observations and patient feedback through interviews. *International Journal of Nursing, 15*(4), 227-230.

Hermiz, O., Comino, E., & Marks, G. (2002). Randomized controlled trial of home based care of patients with chronic obstructive pulmonary disease. *British Medical Journal, 325*(7370), 938-941.

Hernadez, C., Casas, A., & Escarrabill, J. (2003). Home hospitalization of exacerbated chronic obstructive pulmonary disease patients. *European Respiratory Journal, 21*(1), 58-67.

Hodges, P. (2009). Factors impacting readmissions of older patients with heart failure. *Critical Care Nursing, 32*(1), 33-43.

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). Iowa: Wiley-Blackwell.

Holroyd, E. (2005). Developing a cultural model of caregiving obligations for elderly Chinese wives. *Western Journal of Nursing Research, 27*, 437-456.

Holroyd, E., Twinn, S., & Adab, P. (2004). Socio-cultural influences on Chinese women's attendance for cervical screening. *Journal of Advanced Nursing, 46*(4), 42-52.

Hooyman, N. R., & Kramer, B. J. (2006). *Living through loss: Intervention across the life span.* New York: Columbia University Press.

Horne, R. (2006). Compliance, adherence, and concordance: Implications for asthma treatment. *Chest, 130*(1), 65S-72S.

Hospital Authority (2012). *Unplanned readmission for COPD* [Data file]. Retrieved from Clinical Data Analysis and Reporting System.

Husser, E. K., & Roberto, K. A. (2009). Older women with cardiovascular disease: Perceptions of initial experiences and long-term influences on daily life. *Journal of Women and Aging, 21*(1), 3-18.

Husserl, E. (1970). *Logical investigations*. New York: Humanities Press.

Hwang, K. K. (1997). Guanxi and mientze: Conflict resolution in Chinese society. *Intercultural Communication Studies, 7*(1): 17-42.

Hwang, K. K. (2006). Moral face and social face: Contingent self-esteem in Confucian society. *International Journal of Psychology, 41*(4), 276-281.

Hwang, K. K., & Han K. H. (2010). Face and morality in Confucian society. In M. H. Bond

(Ed), *The Oxford handbook of Chinese psychology* (pp. 479-498). New York: Oxford University Press.

Hwu, Y. J., Coates, V. E., & Boore, J. R. P. (2001). The health behaviours of Chinese people with chronic illness. *International Journal of Nursing Studies, 38*(6), 629-641.

Jacelon, C. S. (2003). The dignity of elders in an acute care hospital. *Qualitative Health Research, 13*(4), 543-556.

Janson-Bjerklie, S., Ferketich, S., & Benner, P. (1992). Clinical markers of asthma severity and risk: Importance of subjective as well as objective factors. *Heart and Lung, 21*(3), 265-272.

Jarvis, P. (1992). Reflective practice and nursing. *Nurse Education, 12*(3), 174-181.

Jeng, C., Tsao, L., & Ho, C. (2002). Experiences of daily activities within two weeks after hospital discharge among Taiwanese elderly patients with chronic obstructive pulmonary disease. *Journal of Nursing Research, 10*(3), 168-174.

Jeppesen, E., Brurberg, K. G., & Vist, G. E. (2012). Hospital at home for acute exacerbations of chronic obstructive pulmonary. *Cochrane Database of Systematic Review, 5*. Art No.: CD003573. doi: 10.1002/14651858.CD003573.pub2

Jones, P. W. (2002). Interpreting thresholds for a clinically significant change in health status in asthma and COPD. *European Respiratory Journal, 19*(3), 398-404.

Jones, P. W., Quirk, F. H., & Baveystock, C. M. (1991). The St George's Respiratory Questionnaire. *Respiratory Medicine, 85*(1), 25-31.

Jonsdottir, H. (1998). Life patterns of people with chronic obstructive pulmonary disease: Isolation and being closed in. *Nursing Science Quarterly, 11*(4), 160-166.

Jootun, D., McGhee, G., & Marland, G. R. (2009). Reflexivity: Promoting rigour in qualitative research. *Nursing Standard, 23*(23), 42-46.

Jovchelovitch, S., & Gervais, M. C. (1999). Social representative of health and illness: The case of the Chinese community in England. *Journal of Community & Applied Social Psychology, 9*(4), 247-260.

Kanervisto, M., Kaistila, T., & Paavilaninen, E. (2007). Severe chronic obstructive pulmonary disease in a family's everyday life in Finland: Perceptions of people with chronic obstructive pulmonary disease and their spouses. *Nursing and Health Sciences, 9*(1), 40-47.

Kaur, R., Lopez, & Thompson, D. R. (2006). Factors influencing Hong Kong Chinese patients' decision-making in seeking early treatment for acute myocardial infarction. *Research in Nursing and Health, 29*(6), 636-646.

Keeley, B., Wright, L., & Condit, C. M. (1999). Functions of health fatalism: Fatalistic talk as face saving, uncertainty management, stress relief and sense making. *Sociology of Health and Illness, 3*1(5), 734-747.

Kessler, R., Ståhl, E., & Vogelmeir, C. (2006). Patient understanding, detection, and experience of COPD exacerbation: An observational, interview-based study. *Chest, 130*(1), 133-142.

Kirby, S. E., Dennis, S. M., & Jayasinghe, U. W. (2011). Frequent emergency attenders: Is there a better way? *Australian Health Review, 35*(4), 462-467.

Kleiman, S. (2004). Phenomenology: To wonder and search for meanings. *Nurse Researcher, 11*(4), 7-19.

Ko, F. W. S., Lai, C. K. W., & Woo, H. (2006). 12-year change in prevalence of respiratory symptoms in elderly Chinese living in Hong Kong. *Respiratory Medicine, 100*(9), 1598-1607.

Ko, F. W. S., Woo, J., & Tam, W.(2008). Prevalence and risk factors of airflow obstruction in an elderly Chinese population. *European Respiratory Journal, 32*(6), 1472-1478.

Ko, F. W. S., Dai, D. L. K., & Ngai, J. (2011). Effect of early pulmonary rehabilitation on health care utilization and health status in patients hospitalized with acute exacerbation of COPD. *Respirology, 16*(4), 617-624.

Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing, 21*(5), 827-836.

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of Advanced nursing, 24*(1), 174-184.

Koch, T. (1999). An interpretive research process: Revisiting phenomenological and hermeneutical approaches. *Nursing Researcher, 6*(3), 20-34.

Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: The case for reflexivity. *Journal of Advanced Nursing, 28*(4), 882-890.

Koehn, D., & Leung, A. (2008). Dignity in Western versus in Chinese cultures: Theoretical overview and practical illustrations. *Business and Society Review, 113*(4), 477-504.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy, 45*(3), 214-222.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks: Sage Publications.

Kvangarsnes, M., Torehein, H., & Hole, T. (2013). Narratives of breathlessness in chronic obstructive pulmonary disease. *Journal of Clinical Nursing, 22*(21-22), 3062-3070.

Kwok, C., & Sullivan, G. (2006). Influence of traditional Chinese beliefs on cancer screening behaviour among Chinese-Australian women. *Journal of Advanced Nursing, 54*(6), 691-699.

Kwok, T., Kum, C. M., & Chan, H. S. (2004). A randomized, controlled trail of an intensive community nurse-supported discharge program in preventing hospital readmissions of older patients with chronic lung disease. *Journal of the American Geriatrics Society, 52*(8), 1240-1246.

Lachman, M. E., & Weaver, S. L. (1998). Sociodemographic variation in the sense of control by domain: Findings from the MacArthur studies of midlife. *Psychology and Aging, 13*(4), 553-562.

Lachman, M. E., & Firth, K. M. (2004). The adaptive value of feeling in control during midlife. In O. G. Brim, C. D. Ryff, & R. Kessler (Eds.), *How healthy are we? A national study of well-being at midlife* (pp. 320-349). Chicago: University of Chicago Press.

Lachman, M. E., Neupert, S. D., & Agrigoroaei, S. (2011). The relevance of control beliefs for health and aging. In K. W. Schaie, & S. L. Willis (Eds.), *Handbook of the psychology of aging* (pp. 175-190). Boston: Elsevier/Academic Press.

Lai, D. W., & Surood, S. (2009). Chinese health beliefs of older Chinese in Canada. *Journal of Aging and Health, 21*(1), 38-62.

Lamb, G. S., & Huttlinger, K. (1989). Reflexivity in nursing research. *Western Journal of Nursing Research, 11*(6), 765-772.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. England: Pearson Prentice Hall.

Lange, L. J., & Piette, J. D. (2006). Personal models for diabetes in context and patients' health status. *Journal of Behavioural Medicine, 29*(3), 239-253.

Lau, A. C. W., Yam, L. Y. C., & Poon, E. (2001). Hospital re-admission in patients with acute exacerbation of chronic obstructive pulmonary disease. *Respiratory Medicine, 95*(11), 876-884.

Lau, Y., & Wong, D. F. K. (2008). Are concern for face and willingness to seek help correlated to early postnatal depressive symptoms among Hong Kong Chinese women? A cross-sectional questionnaire survey. *International Journal of Nursing Studies, 45*(1), 51-64.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 2-29.

Le, T. N. (2008). Cultural values, life experiences, and wisdom. *International Journal of Aging and Human Development, 66*(4), 259-281.

Lee, R. P. L. (1995). Cultural tradition and stress management in modern society: Learning from the Hong Kong Experience. In Y. L. Tsung, W. S. Tseng, E. K. Yeh (Eds.), *Chinese societies and mental health* (pp. 40-56). Hong Kong: Oxford University Press.

Lee, W. K. M., & Kwok, H. K. (2005). Differences in expectations and patterns of informal support for older persons in Hong Kong: Modification to filial piety. *Ageing International, 30*(2), 188-206.

Lee, D. T. F., Lee, I. F. K., & Mackenzie, A. E. (2002). Effects of a care protocol on care outcomes in older nursing home patients with chronic obstructive pulmonary disease. *Journal of the American Geriatrics Society, 50*(5), 870-876.

Lee, Y., Lin, Y., Huang, C., & Fredrickson, B. L. (2013). The construct and measurement of peace of mind. *Journal of Happiness Studies, 14*(2), 571-590.

Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 95-115). London: Sage.

Leung, K. (2010). Beliefs in Chinese culture. In H. M. Bond (Ed.), *The Oxford Handbook of Chinese Psychology* (pp. 221-240). Oxford: Oxford University Press.

Leung, K., Bond, M. H., & de Carrasquel, S. R. (2002). Social axioms: The search for universal dimensions of general beliefs about how the world functions. *Journal of Cross-Cultural Psychology*, 33(3), 286-302.

Leung, M. Y., Molassiotis, A., & Chau, J. P. C. (2002). Coping and adjustment in Chinese patients with chronic obstructive pulmonary disease. *International Journal of Nursing Studies, 38*(4), 383-395.

Leung, G. M., Wong, I. O. L., & Chan, W. S. (2005). The ecology of health care in Hong Kong. *Social Science & Medicine, 61*(3), 577-590.

Leventhal, H., Leventhal, E. A., & Cameron, L. (2001). Representations, procedures, and affect in illness self-regulation: A perceptual-cognitive model. In A. Baum, T. A.

Revenson, & J. E. Singer (Eds.), *Handbook of health psychology* (pp. 19-48). Mahwah: Lawrence Erlbaum Associates.

Li, Y. Y. (1992). In search of equilibrium and harmony: On the basic value orientations of traditional Chinese peasants. In C. Nakane, & C. Chaio (Eds.), *Home bound: Studies in East Asian Society* (pp. 127-148). Hong Kong: The Center for East Asian Cultural Studies.

Liao, Y., & Bond, M. H. (2011). The dynamics of face loss following interpersonal harm for Chinese and Americans. *Journal of Cross-Cultural Psychology, 42*(1), 25-38.

Lin, Y. P., Tsai, Y. F., & Chen, H. F. (2011). Dignity in care in the hospital setting from patients′ perspectives in Taiwan: A descriptive qualitative study. *Journal of Clinical Nursing, 20*(5/6), 794-801.

Lincoln, Y. S., & Guba, E. A. (1985). *Naturalistic inquiry*. Beverly Hills: Sage Publications.

Littlejohns, P. Baveystock, C. M., & Parnell, H. (1991). Randomised controlled trail of the effectiveness of a respiratory health worker in reducing impairment, disability, and handicap due to chronic airflow limitation. *Thorax, 46*(8), 559-564.

Liu, S. F., Lin, K. C., & Chin, C. H. (2007). Factors influencing short-term re-admission and one-year morality in patients with chronic obstructive pulmonary disease. *Respirology, 12*(4), 560-565.

Liu, E. Y., & Mencken, F. C. (2010). Fatalistic voluntarism and life happiness in post-socialist China. *Sociological Spectrum, 30*(3), 270-288.

Lopez, K. A., & Wills, D. G. (2004). Descriptive versus interpretative phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research, 14*(5), 726-735.

Lou, P., Zhu, Y., & Chen, P. (2012). Prevalence and correlations with depression, anxiety, and other features in outpatients with chronic obstructive pulmonary disease in China: A cross-sectional case control study. *BMC Pulmonary Medicine, 12*. doi: 10.1186/147-2446-12-53

Lu, L., & Gilmour, R. (2004). Culture, self and ways to achieve SWB: A cross-cultural analysis. *Journal of Psychology in Chinese Societies, 5*(1), 51-79.

Luo, L. (2001). Understanding happiness: A look into the Chinese folk psychology. *Journal of Happiness Studies, 2*(4), 407-432.

Mahler, D. A., Harver, A., & Lentine, T. (1996). Descriptors of breathlessness in cardiorespiratory disease. *American Journal of Respiratory & Critical Care Medicine, 154*(5), 1357-1363.

Mak, W. W. S., Chen, S. X., & Lam, A. G. (2009). Understanding distress: The role of face concern among Chinese Americans, European Americans, Hong Kong Chinese, and Mainland Chinese. *The Counseling Psychologist, 37*(2), 219-248.

Man, W. D., Polkey, M. I., & Donaldson, N. (2004). Community pulmonary rehabilitation after hospitalization for acute exacerbations of chronic obstructive pulmonary disease: Randomized controlled study. *British Medical Journal, 329*. doi: http://dx.doi.org/10.1136/bmj.38258.662720.3A

Mårtensson, J., Karlsson, J. E., & Fridlund, B. (1997). Male patients with congestive heart failure: How they conceive their life situation. *Journal of Advanced Nursing, 25*(3), 579-586.

Mårtensson, J., Karlsson, J. E., & Fridlund, B. (1998). Female patients with congestive heart failure: How they conceive their life situation. *Journal of Advanced Nursing, 28*(6), 1216-1224.

Mathers, C., & Loncar, D. (2006). Projections of global mortality and burden of disease from 2002 to 2030. *PLOS Medicine*. doi: 10.1371/journal.pmed.0030442

Matiti, M. R., & Trorey, G. (2008). Patients' expectation of the maintenance of their dignity. *Journal of Clinical Nursing, 17(20)*, 2709-2717.

McConnell-Henry, T., Chapman, Y., & Francis, K. (2009). Husserl and Heidegger: Exploring the disparity. *International Journal of Nursing Practice, 15*(1), 7-15.

McGhan, R., Radcliff, T., & Fish, R. (2007). Predictors of rehospitalization and death after a severe exacerbation of COPD. *Chest, 132*(6), 1748-1755.

McKinstry, B. (1992). Paternalism and the doctor-patient relationship in general practice.

British Journal of General Practice, 42(361), 340-342.

Miller, C. A. (2012). *Nursing for wellness in older adults* (6th ed.). Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Minott, J. (2008). *Reducing hospital readmissions*. Retrieved from http://academyhealth.org/files/publications/ReducingHospitalReadmissions.pdf

Mistiane, P., Francke, A. L., & Poot, E. (2007). Interventions aimed at reducing problems in adult patients discharged from hospital to home: A systematic meta-review. *BMC Health Services Research, 7*(1), 47-65.

Mok, E., Lai, C., & Zhang, Z. (2004). Coping with chronic renal failure in Hong Kong. *International Journal of Nursing Studies, 41*(2), 205-213.

Morse, J. M., Barrett, M., & Mayan, M. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(1), 1-19.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks: Sage.

Munhall, P. L. (1989). Philosophical ponderings on qualitative research methods in nursing. *Nursing Science Quarterly, 2*(1), 20-28.

Munhall, P. L. (1994). *Revisioning phenomenology: Nursing and health science research*. New York: National League for Nursing Press.

Nantsupawat, T., Limsuwat, C., & Nugent, K. (2012). Factors affecting chronic obstructive pulmonary disease early rehospitalization. *Chronic Respiratory Disease, 9*(2), 93-98.

Natanson, M. (1973). *Edmund Husserl: Philosopher of infinite tasks*. Evanston: Northwestern University Press.

Ng, A. C. Y., Phillips, D. R., & Lee, W. K. M. (2002). Persistence and challenges to filial piety and informal support of older persons in a modern Chinese society: A case study in Tuen Mun, Hong Kong. *Journal of Ageing Studies, 16*(2), 135-153.

Ng, T. P., Niti, M., & Tan, W. C. (2007). Depressive symptoms and chronic obstructive pulmonary disease: Effects on mortality, hospital readmission, symptom burden, functional status and quality of life. *Achieves of Internal of Medicine, 167*(1), 60-67.

Ngan, R., & Cheng, I. C. K. (1992). The caring dilemma: Stress and needs of caregivers for the Chinese frail elderly. *Hong Kong Journal of Gerontology, 6*9(1), 34-41.

Nicolson, P., & Anderson, P. (2003). Quality of life, distress and self-esteem: A focus group study of people with chronic bronchitis. *British Journal of Health Psychology, 8*(3), 251-270.

Nicholson, C., Bowler, S., & Jackson, C. (2001). Cost comparison of hospital-and home-based treatment models for acute chronic obstructive pulmonary disease. *Australian Health Review, 24*(4), 181-187.

Ninot, G., Fortes, M., & Poulain, M. (2006). Gender difference in coping strategies among

patients enrolled in an inpatient rehabilitation program. *Heart and Lung, 35*(2), 130-136.

Nissen, I., & Jessen, M. S. (2007). Nurse-supported discharge of patients with exacerbation of chronic obstructive pulmonary disease. *Ugeskrift for Laeger, 169*, 2220-2223.

Nordenfelt, I. (2003). Dignity and the care of the elderly. *Medicine, Health Care and Philosophy, 6*(2), 103-110.

O'Neill, E. S. (2002). Illness representations and coping of women with chronic obstructive pulmonary disease: A pilot study. *Heart and Lung, 31*(4), 295-302.

Ødegård, Ø. (1968). The pattern of discharge and readmission in Norwegian mental hospitals, 1936-1963. *The American Journal of Psychiatry, 125*(3), 333-340.

Oga, T., Nishimura, K., & Tsukino, M. (2002). Relationship between different indices of exercise capacity and clinical measures in patients with chronic obstructive pulmonary disease. *Heart & Lung, 31*(5), 374-381.

Ojoo, J. C., Moon, T., & McGlone, S. (2002). Patients' and carers' preferences in two models of care for acute exacerbations of COPD: Results of a randomized controlled trial. *Thorax, 57*(2), 167-169.

Oliver, S. M. (2001). Living with failing lungs: The doctor-patient relationship. *Family Practice, 18*(4), 430-439.

Omery, A. (1983). Phenomenology: A method for nursing research. *Advances in Nursing Science, 6*(1), 49-63.

Osman, L. M., Godden, D. J., & Fried, J. A. R. (1997). Quality of life and hospital re-admission in patients with chronic obstructive pulmonary disease. *Thorax, 52(1)*, 67-71.

Palmer, R. E. (1969). *Hermeneutics: Interpretation theory in Schleiermacher, Dilthey, Heidegger and Gadamer*. Evanston: Northwestern University Press.

Papalia, D. E., Olds, S. W., & Feldman, R. D. (2005). *Human development* (10th ed.). New York: McGraw-Hill Higher Education.

Parahoo, K. (2006). *Nursing research: Principles, process and issues*. (2nd ed.). Basingstoke: Palgrave Macmillan.

Parashall, M. B. (1999). Adult emergency visits for chronic cardiorespiratory disease: Does dyspnea matter? *Nursing Research, 48*(1), 62-70.

Pauwels, R. A., & Rabe, K. F. (2004). Burden and clinical features of chronic obstructive pulmonary disease (COPD). *The Lancet, 364*(9434), 613-620.

Pinto, R. A., Holanda, M. A., & Medeiros, M. M. C. (2007). Assessment of the burden of caregiving for patients with chronic obstructive pulmonary disease. *Respiratory Medicine, 101*(11), 2404-2408.

Polanczyk, C. A., Newton, C., & Dec, G. W. (2001). Quality of care and hospital readmission in congestive heart failure: An explicit review process. *Journal of Cardiac Failure, 7*(4), 289-298.

Polkinghorne, D. E. (1989). Phenomenological research methods. In R. S. Valle, & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology* (pp. 41-60). New York: plenum.

Pollio, H. R., Henley, T. B., & Thompson, C. J. (1997). *The phenomenology of everyday life.* Cambridge: Cambridge University Press.

Pooler, A., & Beech, R. (2014). Examining the relationship between anxiety and depression and exacerbations of COPD which result in hospital readmission: A systematic review. *International Journal of COPD, 9*, 315-330.

Price, B. (2004). Demonstrating respect of patient dignity. *Nursing Standard, 19*(12), 45-521.

Priest, H. (2002). An approach to the phenomenological analysis of data. *Nurse Researcher, 10*(2), 50-63.

Puhan, M. A., Gimeno-Santos, E., & Scharplatz, M. (2011). Pulmonary rehabilitation following exacerbations of chronic obstructive pulmonary disease. *Cochrane Database of Systematic Review, 10*. Art No.: CD005305. doi: 10.1002/14651858.CD005305.pub3

Ram, F. S. F., Wedzicha, J. A., & Wright, J. (2003). Hospital at home for acute exacerbations of chronic obstructive pulmonary disease. *Cochrane Database of Systematic Review, 4*. Art No.: CD003573. doi: 10.1002/14651858.CD003573

Randall, W. L., & Kenyon, G. M. (2001). *Ordinary wisdom, biographical aging and the journey of life*. Westport: Praeger.

Ray, M. A. (1994). The richness of phenomenology: Philosophic, theoretic, and methodological concerns. In J. M. Morse (Ed.), *Critical issues in qualitative methods* (pp. 117-135). Thousand Oaks: Sage Publications.

Ray-Mazumder, S. (2001). Role of gender, insurance status and culture in attitudes and health behavior in a US Chinese student population. *Ethnicity & Health, 6*(3), 197-209.

Redding, S. G., & Ng, M. (1983). The role of "face" in the organizational perceptions of Chinese managers. *International Studies of Management and Organization, 13*(3), 92-123.

Restrepo, R. D., Alvarez, M. T., & Wittnebel, L. D. (2008). Medication adherence issues in patients treated for COPD. *International Journal of COPD, 3*(3), 371-384.

Revitt, O., Sewell, L., & Morgan, M. D. L. (2013). Short outpatient pulmonary rehabilitation programme reduces readmission following a hospitalization for an exacerbation of chronic obstructive pulmonary disease. *Respirology, 18*(7), 1063-1068.

Ricauda, N. A., Tibaldi, V., & Leff, B. (2008). Substitutive "Hospital at Home' versus inpatient care for elderly patients with exacerbations of chronic obstructive pulmonary disease: A prospective randomized, controlled trial. *Journal of the American Geriatrics Society, 56*(3), 493-500.

Roberto, K. A., Giglotti, C. M., & Husser, E. K. (2005). Older women's experiences with multiple health conditions: Daily challenges and care practices. *Health Care for Women International, 26*(8), 672-692.

Roberts, C. M., Lowe, D., & Bucknall, C. E. (2002). Clinical audit indications of outcome following admission to hospital with acute exacerbation of chronic obstructive pulmonary disease. *Thorax, 57*(2), 137-141.

Robinson, T. (2005). Living with severe hypoxic COPD: The patients' experience. *Nursing Times, 101*(7), 38-42.

Rose, R., Beeby, J., & Parker, D. (1995). Academic rigor in the lived experience of researchers using phenomenological methods in nursing. *Journal of Advanced Nursing, 21*(6), 1123-1129.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist, 37*(4), 433-440.

Sandelowski, M. (1986). The problem of rigor in qualitative in qualitative research. *Advances in nursing Science, 8*(3), 27-37.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16*(1), 1–8.

Sanders, C., Donovan, J., & Dieppe, P. (2002). The significance and consequences of having painful and disabled joints in older age: Co-existing accounts of normal and disrupted biographies. *Sociology of Health and Illness, 24*(2), 227-253.

Scharloo, M., Kaptein, A. A., & Schlösser, M. (2007). Illness perceptions and quality of life in patients with chronic obstructive pulmonary disease. *Journal of Asthma, 44*(7), 575-581.

Schofield, I., Knussen, C., & Tolson, D. (2006). A mixed method study to compare use and experience of hospital care and a nurse-led acute respiratory assessment service offering home care to people with an acute exacerbation of chronic obstructive pulmonary disease. *International Journal of Nursing Studies, 43*(4), 465-476.

Scotto, C. J. (2005). The lived experience of adherence for patients with heart failure. *Journal of Cardiopulmonary Rehabilitation, 25*(3), 158-163.

Scott, K., & DeBrew, J. K. (2009). Helping older adults finding meaning and purpose through storytelling. *Journal of Gerontological Nursing, 35*(12), 38-43.

Seamark, D. A., Blake, S. D., & Seamark, C. J. (2004). Living with severe chronic obstructive pulmonary disease (COPD): Perceptions of patients and their carers. *Palliative Medicine, 18*(7), 619-625.

Seymour, J. M., Moore, L., & Jolley, C. J. (2010). Outpatient pulmonary rehabilitation following acute exacerbations of COPD. *Thorax, 65*(5), 423-428.

Shanmugam, G., Bhutani, S., & Khan, D. A. (2007). Psychiatric considerations in pulmonary disease. *Psychiatric Clinics of North America, 30*(4), 761-780.

Shek, D. T. L. (2006). Chinese family research: Puzzles, progress, paradigms, and policy implications. *Journal of Family Issues, 27*(3), 275-284.

Shek, D. T. L. (2007). Perceived parental control based on indigenous Chinese parental control concepts in adolescents in Hong Kong. *The American Journal of Family Therapy, 35*(2), 123-137.

Shellamn, J. (2006). Making a connection: BSN students' perceptions of their reminiscence experiences with elders. *Journal of Nursing Education, 45*(12), 497-503.

Shellman, J. (2008). Life review. In E. A. Capezuti, E. L. Siegler, M. D. Mezey (Eds), *Encyclopedia of elder care: The comprehensive resources on geriatric and social care* (2nd ed.) (pp. 480-482). New York: Springer Publishing Company.

Shepperd, S., Harwood, D., & Jenkinson, C. (1998). Randomized controlled trial comparing hospital at home care with inpatient hospital care. I: Three month follow up of health outcomes. *British Medical Journal, 316*(7147), 1786-1791.

Sheridan, N., Kenealy, T., & Salmon, E. (2011). Helplessness, self blame and faith may impact on self management in COPD: A qualitative study. *Primary Care Respiratory Journal, 20*(3), 307-314.

Shih, F. J. (1996). Concepts related to Chinese patients' perceptions of health, illness and person: Issues of conceptual clarity. *Accident & Emergency Nursing, 4*(4), 208-215.

Silveman, M., Nutini, J., & Musa, D. (2009). "Is it half full or half empty?" Affective responses to chronic illness. *Journal of Cross Cultural Gerontology, 24*(3), 291-306.

Simon, P. M., Schwartzstein, R. M., & Weiss, J. W. (1990). Distinguishable types of dyspnea in patients with shortness of breath. *American Review of Respiratory Disease, 142*(5), 1009-1014.

Simpson, A. C., Young, J., & Donahue, M. (2010). A day at a time: Caregiving on the edge in advanced COPD. *International Journal of COPD, 5*(1), 141-151.

Skwarska, E., Cohen, G., & Skwarski, K. M. (2000). Randomized controlled trial of supported discharge in patients with exacerbations of chronic obstructive pulmonary disease. *Thorax, 55*(11), 907-912.

Small, S. P., & Graydon, J. (1993). Uncertainty in hospitalized patients with chronic obstructive pulmonary disease. *International Journal of Nursing Studies, 30*(3), 239-246.

Smith, B. J., Appleton, S. L., & Bennett, P. W. (1999). The effect of a respiratory home nurse intervention in patients with chronic obstructive pulmonary disease (COPD). *Internal Medicine Journal, 29*(5), 718-725.

Smith, D. M., Norton, J. A. & McDonald, C. J. (1985). Nonelective readmission of medical patients. *Journal of Chronic Disease, 38*(3), 213-224.

Solimeo, S. (2008). Sex and gender in older adults' experience of Parkinson's Disease. *Journal of Gerontology, 63B*(1), S42-S48.

Sorrell, J. M., & Redmond, G. M. (1995). Interviews in qualitative nursing research: Differing approaches for ethnographic and phenomenological studies. *Journal of Advanced Nursing, 21*(6), 1117-1122.

Spector, P. E., Sanchex, J. I., & Siu, O. L. (2004). Eastern versus Western control beliefs at work: an investigation of secondary control, socioinstrumental control, and work locus of control in China and the US Applied. *Psychology: An International Review, 53*(1), 38-60.

Spiegelberg, H. (1975). *Doing phenomenology: Essays on and in phenomenology*. Hague: M. Nijhoff.

Spiegelberg, H. (1982). *The phenomenological movement: A historical introduction* (3rd ed.). Hague: M. Nijhoff.

Sridhar, M., Taylor, R., & Dawson, S. (2008). A nurse led intermediate care package in patients who have been hospitalized with an acute exacerbation of chronic obstructive pulmonary disease. *Thorax, 63*(3), 194-200.

Stehr, D. E., Klein, B. J., & Murata, G. H. (1991). Emergency department return visits in chronic obstructive pulmonary disease: The importance of psychosocial factors. *Annals of Emergency Medicine, 20*(10), 1113-1116.

Stewart, A., & Mickunas, A. (1990). *Exploring phenomenology* (2nd ed.). Athens: Ohio University Press.

Stewart, D. G., Drake, D. F., & Robertson, C. (2001). Benefits of an inpatient pulmonary rehabilitation program: A prospective analysis. *Archives of Physical Medicine and Rehabilitation, 82*(3), 347-352.

Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative* (5th ed.). Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Swanson-Kauffman, K. M., & Schowald, E. (1988). Phenomenology. In B. Sarter (Ed.), *Paths to knowledge: Innovative research methods for nursing* (pp. 97-105). New York: National League for Nursing.

Tao, J., & Lai, P. W. (2007). Dignity in long-term care for older persons: A Confucian Perspective. *Journal of Medicine and Philosophy, 32*(5), 465-481.

Taylor, R. (1962). Fatalism. *Philosophical Review, 71*(1), 56-66.

Thomas, D. C., & Liao, Y. (2010). Inter-cultural interactions: The Chinese context. In M. H. Bond (Ed), *The Oxford handbook of Chinese psychology* (pp. 679-697). New York: Oxford University Press.

Thomas, J. W., & Holloway, J. J. (1991). Investigating early readmission as an indicator for quality of care studies. *Medical Care, 29*(4), 377-394.

Thomas, S. P., & Pollio, H. R. (2002). *Listening to patients: A phenomenological approach to nursing research and practice.* New York: Springer Publishing Company.

Thornhill, K., Lyons, A. C., & Nouwen, A. (2008). Experiences of living with congestive heart failure: A qualitative study. *British Journal of Health Psychology, 13*(1), 155-175.

Thorpe, O., Kumar, S., & Johnston, K. (2014). Barriers to and enablers of physical activity in patients with COPD following a hospital admission: A qualitative study. *International Journal of COPD, 9*. doi: 10.2147/COPD.S54457

Todres, L., & Holloway, I. (2006). Phenomenological research. In K. Gerrish, & A. Lacey (Eds.), *The research process in nursing*. Massachusetts: Blackwell Publisher.

Tu, W. M. (1998). Probing the "Three Bonds" and "Five Relationships". In W. H. Slote, & G. A. De Vos (Eds.), *Confucianism and the Family* (pp. 121-136). Albany: State University of New York Press.

Twinn, S. (1997). An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research. *Journal of Advanced Nursing, 26*(2), 418-423.

Valle, R. S., King, M., & Halling, S. (1989). An introduction to existential-phenomenological thought in psychology. In R. S. Valle, & S. Hallings (Eds.), *Existential-phenomenological Perspectives in Psychology* (pp. 3 – 16). New York: Plenum.

van Kamma, A. (1966). *Existential foundations of psychology*. Pittsburgh: Duquesne University Press.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy.* New York: State University of New York Press.

Vinson, J. M., Rich, M. W., & Sperry, J. C. (1990). Early readmission of elderly patients with congestive heart failure. *Journal of the American Geriatrics Society, 38*(12), 1290-1295.

Vögele, C., & Leupoldt, A. (2008). Mental disorders in chronic obstructive pulmonary disease (COPD). *Respiratory Medicine, 102*(5), 764-773.

von Eckartsberg, R. (1986). Life-world experience: Existential-phenomenological research approaches in psychology. Washington, DC. Center for Advanced Research in Phenomenology and Lanham, MD: University Press of American.

von Leupoldt, A., Taube, K., & Lehmann, K. (2011). The impact of anxiety and depression outcomes of pulmonary rehabilitation in patients with COPD. *Chest, 140*(3), 730-736.

Wallston, K. A., & Wallston, B. S. (1981). Health locus of control scales. In H. Lefcourt (Ed.), *Research with the locus of control construct* (pp. 189-243). New York: Academic Press.

Wallston, K. A., & Wallston, B. S. (1982). Who is responsible for your health? The Construct of health locus of control. In G. S. Sanders, & J. Suls (Eds.), *Social psychology of health and illness* (pp. 65-98). Hillsdale: Erlbaum Associates.

Walter, C. A., & McCoyd, J. L. M. (2009). *Grief and loss across the lifespan: a biopsychosocial perspective*. New York: Springer Publishing Company.

Walters, A. J. (1994). Phenomenology as a way of understanding in nursing. *Contemporary Nurse*, *3*(3), 134-141.

Walters, A. J. (1995). The phenomenological movement: Implications for nursing research. *Journal of Advanced Nursing, 22*(4), 791-799.

Wang, H. E., Shah, M. N., & Allman, R. M. (2011). Emergency department visits by nursing home residents in the United States. *Journal of American Geriatrics Society, 59*(10), 1864-1872.

Wang, Q. (2010). *Doctor-patient communication and patient satisfaction: A cross-cultural comparative study between China and the U.S.* (Unpublished doctoral dissertations). Purdue University, United States.

Wang, Q., & Bourbeau, J. (2005). Outcomes and health-related quality of life following hospitalization for an acute exacerbation of COPD. *Respirology, 10*(3), 334-340.

Ward, C., & Lin, E. Y. (2010). There are homes at the four corners of the seas: Acculturation and adaption of overseas Chinese. In M. H. Bond (Ed.), *The Oxford Handbook of Chinese Psychology* (pp. 657-677). Oxford: Oxford University Press.

Webster, C., & Bryan, K. (2009). Older people's views of dignity and how it can be promoted in a hospital environment. *Journal of Clinical Nursing, 18*(12), 1784-1792.

Wedzicha, J. A., & Seemungal, T. A. R. (2007). COPD exacerbations: Defining their cause and prevention. *The Lancet, 370*(9589), 786-796.

Weiten, W. (2013). *Psychology: Themes and variations* (9th ed.). Belmont: Cengage/Wadsworth.

Werner, A., & Malterud, K. (2003). It is hard work behaving as a credible patient: Encounters between women with chronic pain and their doctors. *Social Science and Medicine, 57*(8), 1409-1419.

Wertz, F. J. (2011). A phenomenological psychological approach to trauma and resilience. In F. J. Wertz, K. Charmaz, & L. M. McMullen (Eds.), *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry* (pp. 124-164). New York: Guilford Press.

Westert, G. P., Lagoe, R. J., & Keskimäki, I. (2002). An international study of hospital readmissions and related utilization in Europe and the USA. *Health Policy, 61*(3), 269-278.

White, R. J., Rudkin, S. T., & Ashley, J. (1997). Outpatient pulmonary rehabilitation in severe chronic obstructive pulmonary disease. *Journal of the Royal College of Physicians of London, 31*(5), 541-545.

Willgoss, T. G., Yohannes, A. M., & Goldbart, J. (2012). "Everything was spiralling out of control": Experiences of anxiety in people with chronic obstructive pulmonary disease. *Heart & Lung, 41*(6), 562-571.

Williams, V., Bruton, A., & Ellis-Hill (2007). What really matters to patients living with chronic obstructive pulmonary disease? An exploratory study. *Chronic Respiratory Disease, 4*(2), 77-85.

Willis, B. S. H., & Wootton, Y. S. Y. (1999). Concerns and misconceptions about pain among Hong Kong Chinese patients with cancer. *Cancer Nursing, 22*(6), 408-413.

Wills, T. A. (1981). Download comparison principles in social psychology. *Psychological Bulletin, 90*(2), 245-271.

Woo, J., Chan, W., & Yeung, F. (2006). A community model of group therapy for the older patients with chronic obstructive pulmonary disease: A pilot study. *Journal of Evaluation in Clinical Practice, 12*(5), 525-531.

Wojnar, D. M., & Swanson, K. M. (2007). Phenomenology: An exploration. *Journal of Holistic Nursing, 25*(3), 172-180.

World Health Organization. (2007). *Global surveillance, prevention and control of chronic respiratory disease: A comprehensive approach.* Retrieved from http://www.who.int/gard/publications/GARD%20Book%202007.pdf?ua=1

Wortz, K., Cade, A., & Menard, J. R. (2012). A qualitative study of patients' goals and expectations for self-management of COPD. *Primary Care Respiratory Journal, 21*(4), 384-391.

Wrosch, C., Heckhausen, J., & Lachman, M. E. (2006). Goal management across adulthood and old age: The adaptive value of primary and secondary control. In D. K. Mroczek, & T. D. Little (Eds.), *Handbook of personality development* (pp. 339-421). Mahwah: Lawrence Erlbaum Associates.

Yam, C. H. K., Wong, E. L. Y., & Chan, F. W. K. (2010). Avoidable readmission in Hong Kong-system, clinician, patient or social factor? *BMC Health Services Research, 10*(11), 311.

Yeh, K. H., Yi, C. C., & Tsao, W. C. (2013). Filial piety in contemporary Chinese societies: A comparative study of Taiwan, Hong Kong and China. *International Sociology, 28*(3), 277-296.

Yin, H. H., Tse, M. M. Y., & Wong, F. K. Y. (2011). Postoperative pain experience and barriers to pain management in Chinese adult patients undergoing thoracic surgery. *Journal of Clinical Nursing, 21*(9-10), 1232-1243.

Yu, K. W. (2000). *Chinese older people: A need for social inclusion in two communities.* Bristol: Policy Press.

Yu, D. S. F., Lee, D. T. F., & Woo, J. (2007). The revolving door syndrome: The Chinese COPD patients′ perspectives. *Journal of Clinical Nursing, 16*(9), 1758-1760.

Zhan, H. J., & Montgomery, J. V. (2003). Gender and elder care in China: The influence of filial piety and structural constraints. *Gender and Society, 17*(2), 209-229.

Zhang, H., Shan, W. Y., & Jiang, A. L. (2014). The meaning of life and health experience for the Chinese elderly with chronic illness: A qualitative study from positive health philosophy. *International Journal of Nursing Practice, 20*(5), 530-539.

Zigmond, A. S., & Snaith, R. R. (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavica, 67*(6), 361-730.

張本, 張媛, 劉衡川, 田軍, 涂國平. (2007). 成都市社區慢性阻塞肺病患者衛生服務利用及其影響因素分析 [Factors influencing the use of health care services from patients with COPD in Chengdu]. *Journal of Sichuan University, 38*(2), 316-320.

Appendix A
Characteristics of Participants

Name	Sex	Age	No. of hospital readmission	Marital status	Primary caregiver	Education level	Religion
Ka Keng	M	79	9	Married	Wife	Primary	Buddhism
Wai Fat	M	73	7	Married	Wife	Illiterate	Nil
King Tai	M	75	6	Married	Wife	Illiterate	Buddhism
Mei Fung	F	78	6	Married	Maid	Illiterate	Nil
Tung Nam	M	84	7	Married	Wife	Tertiary	Nil
Hang Kei	M	79	6	Married	Wife	Primary	Nil
Kam Ching	M	61	10	Married	Wife	Primary	Nil
Tat Cheung	M	80	8	Married	Wife	Illiterate	Nil
Yah Man	M	75	6	Single	Brother	Illiterate	Nil
Ying Kong	M	87	9	Married	Maid	Primary	Buddhism
Yat Lam	M	62	7	Widower	Self	Primary	Nil
Chi Kin	M	78	8	Married	Wife	Primary	Nil
Hoi Fai	M	77	6	Married	Wife	Primary	Nil
Kwok Hing	M	70	7	Married	Wife	Primary	Worship
Yuen Tak	M	77	6	Single	Self	Primary	Christianity
Pak Fung	M	68	14	Married	Wife	Primary	Nil
Yiu Pan	M	73	6	Married	Wife	Primary	Nil
Hiu Ming	M	72	6	Married	Wife	Primary	Nil
Yau Hong	M	68	7	Married	Wife	Primary	Nil
Lai Kuen	F	72	8	Widow	Maid	Illiterate	Nil
Sin Lam	F	89	4	Married	Maid	Primary	Catholic
Siu Mui	F	78	5	Widow	Self	Primary	Nil

Appendix B

Interview Guide

The interview aims to understand the experiences in hospital readmissions of Chinese older people with chronic obstructive pulmonary disease. The interview question used to elicit the hospital readmissions experiences is:

Please tell me your experience in hospital readmissions.

Prompt:

1. What had happened that made you readmitting to hospital?
2. What do you feel when you come back to this hospital?
3. What are the differences you experienced before readmission and after discharge?
4. What are the differences between being at home/ residence and hospital?
5. How do you manage the disease(s)?
6. How do you understand your condition now?

The following probing questions may be used in the interview:

- Can you give me an example of that?
- Can you tell me more about that?
- What do you mean by that?
- How did you feel about that?

At the end of the interview, the participant is asked for any additional information:

Is there anything else related to your experience in hospital readmissions that you would like to discuss?

Appendix C

Reflexive Diaries

Reflective diary: Wai Fat

Wai Fat was interviewed on the morning of August 25, during his seventh hospital readmission. He was assigned to a hospital bed situated in a cubicle next to the nurse station. The interview was conducted at the bedside. Wai Fat remained emotionally calm throughout the interview. He was observed to have shortness of breath after having been interviewed for 30 minutes. He took a few pauses to complete a long description. He also used pursed-lip breathing to relieve his dyspnea. Wai Fat was asked if he needed to suspend the interview, but he insisted to continue. He seemed eager to share with me about his experience in hospital readmissions.

From the interview, Wai Fat appears to have accepted hospital readmissions when he cannot manage the disease. When he experiences dyspnea, he takes medications for relief. If he fails to control the exacerbation, he is submitted to seek hospital care. Wai Fat considers himself a “good patient” who takes responsibility in managing his own illness. He compares himself with his neighbour who calls emergency services more frequently than him. His neighbour’s behaviours seem to remind him to not seek hospital care arbitrarily. Therefore, he accepts that hospital readmission is necessary after failing to relieve the distress.

Wai Fat finds the positive side of hospital readmission. The periods of hospital readmission provide breaks to relieve the caregiving stress for his wife. Although he appreciates the respite from his hospital readmissions, he does not seek hospital readmission intentionally for this purpose. He remains to be a “good patient” and only regards his hospitalization as an opportunity for respite.

Reflective diary: Hang Kei

Hang Kei was interviewed on the morning of November 18, during his sixth hospital readmission. The interview was conducted at the bed side. Throughout the interview, Hang Kei seemed to be more concerned about his wife than himself. He was inclined to talk about his wife rather than describe his experience in hospital readmissions. His wife was 10 years older than him, and she was admitted to the hospital during the same period. Hang Kei was readmitted to the hospital for disease exacerbation, but he did not worry about his health condition. Hang Kei expressed negative views when he described how he spent a day at the hospital. He was frustrated about feeling bored and the lack of meaningful activities. However, he appeared to relax when he talked about his wife. He mentioned that his wife did not follow his advice, so she fell at home and was admitted to the hospital. Although Hang Kei described her wife as too careless, he kept talking with a smile on his face. His wife's health issue seemed to draw his attention from his own health condition, which requires hospital readmissions. Hang Kei looked forward to hospital discharge to take care of his wife. The duty of caring for his wife allows him to maintain a positive outlook.

Appendix D

Demographic and Clinical Data Sheet

Demographic data

Age: _____

Sex: _____

Marital status:

☐ Single ☐ Married ☐ Divorced ☐ Widower/ Widow

Living arrangement:

☐ Alone ☐ Family ☐ Friend ☐ Nursing home residence

Relationship with primary caregiver: _____

Educational level:

☐ Illiterate ☐ Primary □ Secondary □ Tertiary

Religion: _____

Clinical profile

No. of year diagnosed with COPD: _____

No. of hospital readmission in the previous year: _____

Use of home oxygen:

☐ Yes ☐ No

Other medical diagnosis(es):

_____

Appendix E
Preliminary Data Analysis

Name: Yat Lam
Duration of interview: 52:24
Demographic data

Age: 62 Sex: M

Marital status: widower Living arrangement: live alone

Educational level: Primary Religion: No

No. of hospital readmission in the previous year: 7

I : Interviewer C : Informant

I/ C	No	Transcription	Third-person expression	Transformed meanings
I	1.	Can you recall how many times you have been hospitalized this year?		
C	2.	Five… one, two, three... Right, three times within a month. /	Yat Lam states that he has been readmitted to hospital five times that year. He recalls that he was readmitted three times within a month.	Yat Lam is impressed by the experience of revolving between hospital and home frequently.
I	3.	Three times a within month!?		
C	4.	Right. Five days after my discharge, I was admitted to the hospital again; five days after my discharge, I was admitted to the hospital again. I remember clearly, three times of come and go. This time, this month I am in the hospital again. /	Yat Lam states that he was once readmitted to a hospital five days after discharge. He remembers this situation clearly. He has gone back and forth three times between a hospital and his home. He was admitted to the hospital again month in the recent month.	
I	5.	Well, are you required to stay every time you go to the hospital?		
C	6.	Mostly. Do you know why? My lungs are getting worse. I need to exhale gas. Sometimes when there is too much carbon	Yat Lam states that he usually requires hospitalization because his condition has worsened. Sometimes, he has to undergo therapy	Yat Lam perceives hospital readmissions as necessary when he cannot manage his

		dioxide, I need to remove the gas, suck the gas out. / I can't help with this disease, right?	to remove excessive carbon dioxide. Yat Lam conceives that he cannot deal with his exacerbated condition by himself.	aggravated condition.
I	7.	How long have you suffered from this disease?		
C	8.	It broke out in 2002, it was my first time of hospitalization. / In that time, it wasn't that serious. Now, it is getting worse each year. / Every lung patient experiences the same condition. It gets worse each year and won't get better. /	Yat Lam recalls that he was diagnosed with COPD in 2002 and he was admitted to a hospital for COPD in that year. Yat Lam recalls that his physical condition was not as poor in the beginning. But, he observes that his condition has been deteriorating every year. Yat Lam believes that the physical condition of people with lung disease deteriorates year by year and that they do not improve with time.	Yat Lam remembers when he was first admitted for COPD. Yat Lam experiences that his physical condition has been deteriorating gradually. Yat Lam believes that physical deterioration is inevitable for him.
I	9.	Getting worse each year.		
C	10.	In the very beginning, it's not that worse. I could still breathe well with inhalers. I had follow-up once every four months. See, I come to the hospital three times a month now. What a big difference!/	Yat Lam repeats that his condition was not so poor in the beginning. He was prescribed inhalers and was followed-up on every four months. Yat Lam observes that his condition has changed significantly. Moreover, he was readmitted to a hospital three times within a month.	Yat Lam experiences physical deterioration with the change in his treatment regimen and requires hospital readmissions.
I	11.	Three times...what was your condition when you were admitted?		
C	12.	I had asthma and shortness of breath. Sometimes I called 999, sometimes I used my safety alarm. /	Yat Lam states that he seeks hospital readmission for breathlessness. He usually either dials 999 or presses a safety alarm to obtain emergency service.	Yat Lam seeks hospital readmission to relieve his physical distress.
I	13.	Press the safety alarm.		
C	14.	I have installed it, so I use it. /	Yat Lam states that he has used the safety bell to seek help since it was installed.	Yat Lam considers the emergency service to be

I	15.	So you waited for the ambulance?		efficient. Yat Lam is familiar with how to self-manage his condition before he can receive emergency care.
C	16.	Right, that's it. It usually took ten minutes or so to come. /	Yat Lam indicates that he usually waits only approximately 10 minutes for the ambulance to arrive.	
I	17.	Ten minutes or so.		
C	18.	There is a fire services division where I live, a fire station, so they come to rescue me. Firemen come first, then the ambulancemen. Every time is the same. / When you call for emergency service, you need to wait and stay calm. If you have SOB, don't panic. Why? If you have SOB and you can't stay calm, the condition gets worse; this won't do any good for you. So you must, must stay calm, and breathe out through nose and breathe in mouth in with mouth to relax. When firemen and the ambulancemen come, I can get oxygen (therapy). /	Yat Lam explains that a fire station situated near the area in which he lives. Thus, firemen arrive first when he calls emergency service, followed by ambulancemen. Yat Lam knows that he has to remain patient while he is waiting for the ambulance arrives. He explains that anxiety and impatience exacerbate the breathlessness, which does not help his condition. So, he should remain patient and perform pursed-lip breathing to manage his breathlessness. Once the ambulancemen arrive, he can then receive oxygen therapy.	
A healthcare assistant came with a wheelchair.				
I	19.	Umm... Hm, X-ray? X-ray? All right. All right. Go to the X-ray first and I'll get back to you later.		
C	20.	I had an X-ray yesterday, now it's X-ray again… hahaha… /	Yat Lam laughs and states that he had an X-ray taken on the previous day. He is required to undergo the same investigation again.	Yat Lam was subject to repeated investigation at the hospital.
The interview continued after an hour.				
I	21.	Right, I just wanted to ask about your hospital readmissions. You have been readmitted to		

		hospital for multiple times, what did you do exactly in the hospital?		
C	22.	Take medications, see the doctor, sleep, and eat. That's all.	Yat Lam describes his activities at the hospital include taking medications, seeing doctors, sleeping, and eating. Aside from these activities, he thinks that he has nothing else to do.	Yat Lam performs routinized activities at the hospital.
I	23.	Sleep and eat.		
C	24.	Take medications and get injections. That's all... I also see the doctor...sleep... When the meal is served, I take it. After finishing the meal, I sleep. After waking up, I wait for the meal… I stayed in the hospital, just like that.	Yat Lam states that the activities at the hospital include receiving oral medications and injections, and seeing doctors. He takes his meal when it is served. Following his meal, he sleeps. After sleeping, he waits for the next meal time. Yat Lam repeats that he performs only these activities in the hospital and nothing else.	
I	25.	Did you sometimes want to find out what the hospital staff does? Like what are the nurses doing?		
C	26.	No, none of my business. They are doing their job.	Yat Lam states that he does not observe what the nurses are doing. He considers that their works are not related to him.	Yat Lam perceives that he is dependent on the nurses.
I	27.	They are doing their job.		
C	28.	I am a patient and I need their care.	Yat Lam states that he is a patient; thus, he has to rely on the nurses to take care of him. /	
I	29.	What do you think about the difference between being at hospital and being at home?		
C	30.	Honestly, doctors don't really want to cure you. / You say you are ready, but when the doctor says no, they won't discharge you. Even you leave today, and you will be sent	Yam Lam believes that doctors are disinclined to treat his illness. Yat Lam states that while a patient may consider himself suitable for discharge, the doctors do not	Yat Lam perceives that doctors are disinterested in treating frequently readmitted patients.

		back tomorrow. I've tried this. /	allow hospital discharges if they find that he is not physically fit. Yat Lam tells that he was readmitted to hospital soon after discharge.	
I	31.	You have tried it before, have you?		
C	32.	It was in United Christian Hospital. I didn't bug the doctor. I told the nurse that I wasn't ready. SpO2 was below average, only 80+. /	Yat Lam recalls that an incident of early readmission occured in an acute hospital. Instead of arguing with a doctor, he rather told a nurse that he was unsuitable for discharge because the oxygen saturation in his blood was only about 80%. He believed that they oxygenation was inadequate.	Yat Lam perceives that he occupies a subordinate position in the doctor-patient relationship. He lacks of autonomy in the decision regarding hospital discharge; hence he is forcibly discharged from hospital. He is prepared for readmission. Yat Lam discusses his concerns with nurses. Yat Lam experienced early hospital readmission. He attributes it to a perceived premature hospital discharge. Yat Lam believes that stabilizing his physical condition in a rehabilitative setting can avoid early hospital readmission.
I	33.	80+, not ready		
C	34.	Next, the doctor kicked me out, and I said all right, I left. / Three days later, I was sent back again. /	Yat Lam recalls that he was forced to leave the hospital by the doctor, so he agreed to be discharged first. However, Yat Lam was readmitted to hospital three days later.	
I	35.	Sent back again…		
C	36.	I have told the doctor, "(I am) Out today, but (I will be readmitted) back tomorrow". This (hospital discharge) cannot be forced if I am not ready. / Here (rehabilitative setting) is a different story. After staying for three to five more days, I feel much better, right? There, they only asked me to leave. /	Yat Lam told the doctor that he would be readmitted into hospital soon after discharge. He believed that he would be readmitted again if he was discharged early. Yat Lam feels that he would not require hospital readmission if he could stay in a rehabilitative setting for 3 to 5 more days. But the doctors only required him to be discharged to home.	
I	37.	They didn't ask you to come here for recovery and simply asked you to go home…		
C	38.	Right. When I came here (hospital), nurses	Yat Lam states that he can receive medications	Yat Lam perceives that

		medicated me and asked me to take a rest. Just like that. Here...the mess (disease), just clean it up, clean it up for you. / Honestly, things at home and in the hospital are different. In the hospital, they (nurses) measure blood pressure several times a day. At home, no one will do this for you, right? Air (ventilation) is also different. In the hospital...central air conditioning...air quality is stable. At home, when you open the window, air quality is different, very different. / In the hospital...you are just normal. At home, you will feel sick after not more than three days. /	and rest in a hospital setting. His physical condition can be stabilized. Yat Lam describes a hospital stay as being different from being residing at home. His blood pressure is measured several times a day at the hospital, but nobody monitors his condition at home. He observes that the ventilation varies as well. The hospital is equipped with central air-conditioning; thus, the ventilation is more stable than generated by keeping the windows open at home. Yat Lam finds that his physical condition is stable at the hospital but deteriorates after he is discharged to home for a few days.	continuation of hospital care is necessary following the acute exacerbation. Yat Lam identifies the hospital setting as more beneficial to his health than staying at home given the well-equipped environment and the care of the hospital staff.
I	39.	That is to say...when you are in the hospital, at least someone measures blood pressure for you, someone looks after you, and air quality is better.		
C	40.	In the hospital, they (hospital staff) take care of you 24 hours. At home, no one cares about you, and you are on your own, and no one measures blood pressure for you, you don't even know if you are all right. I live alone. /	Yat Lam explains that he can receive care throughout the day at the hospital. When he is at home, nobody takes care of him. He has to take care of himself. Yat Lam gives an example that his blood pressure is not monitored at home and he has no way of knowing his blood pressure level. Yat Lam adds that he lives alone.	Yat Lam perceives a sense of security at the hospital because he is under care.
I	41.	You live alone...so you take care of yourself all alone.		
C	42.	Right...I shop, cook, and everything on my own. /	Yat Lam tells that he buys food and cooks by himself.	Yat Lam is independent in daily activities.
I	43.	I see, you take care of yourself at home.		

C	44.	This means, someone is looking after you, this is much safer. At home, right, there is the personal safety alarm... but I leave far away. /	Yat Lam feels that he is safer in the hospital than at home because he is under care. Although he has a safety bell at home, his house is too far to reach in case of emergencies.	Yat Lam perceives a sense of security in the hospital because he can receive prompt care.
I	45.	So, you find it is safer at hospital.		
C	46.	Right, but if the doctor says you are ready to leave, you have no reason to stay. If the doctor says no, you will need to stay a day or two longer. /	Yat Lam believes that the doctor would require him to be discharged to home once he is physically fit. The doctor requires him to stay for a few more days when the doctor considers him to be unsuitable for discharge.	Yat Lam is confident in the management and the decisions made by doctors.
I	47.	Um, it sounds that you follow your doctor's orders.		
C	48.	Well, eh... There is a saying: If you don't trust someone, don't hire him. So, if you don't trust your doctor, why should you see him, right? /	Yat Lam quotes an idiom that people would not employ a mistrusted person. He questions why a patient would consult a doctor if the patient does not confide the doctor.	
I	49.	So...you have been in and out of the hospital for several times. When you are discharged, what do you feel?		
C	50.	Um... If I keep thinking when I'll return (to hospital) again, it will make me too troublesome. / What I wish is that I can stay at home longer, no big change… / Warm, I feel better when the weather is warm. /	Yat Lam believes that it is troublesome for a person to always worry about when would be readmitted to hospital. Following hospital discharge, Yat Lam would look forward to the stability of his physical condition and to staying at home for a long period of time. Yat Lam adds that he feel better in warm weather.	Yat Lam is prepared for the next hospital readmission, but he believes that it is troublesome to be preoccupied with this possibility.
I	51.	Why?		
C	52.	Warm...warm. When the weather is warm, in summer, I can leave the hospital for four to five months before coming back. If it is	Yat Lam states that he usually does not require hospital admission for about 4 to 5 months during summer time. He explains that his trachea	Yat Lam is familiar with the pattern of hospital readmission and with the

		warm, the trachea won't contract easily, and I can breathe more easily, and everything is...just better. That's it. Patients like us are afraid of cold weather, humid weather, these kill us. /	does not constrict much when the weather is warm; therefore, he breathes well under such weather conditions. Yat Lam tells that people with COPD dread low temperatures and dampness because these situations threaten to them.	situations that provoke hospital readmission.
I	53.	I see.		
C	54.	Yes, it's true.	Yat Lam believes that COPD patients dislike cold weather.	
I	55.	You mean when the weather is cold, your trachea gets worse.		
C	56.	Right, when December begins...13 to 14°C, 11 to 12°C, condition turns bad. /	Yat Lam states that the temperature lowers to a range of 11℃ to 14℃ at the beginning of December. This temperature range is difficult for him.	
I	57.	Very tough throughout winter.		
C	58.	Right, honestly, I need to do everything on my own, no one else will help, right? / In summer, I can wear fewer clothes. In winter, it's different, I need to wear more clothes. /	Yat Lam states that he has to manage everything by himself because nobody takes care of him. Yat Lam adds that he wears little clothing in the summer, but he has to wear on more clothes in the winter.	Yat Lam realizes that he has to be independent to take care of himself.
I	59.	What about here, this hospital, how many times you have been admitted?		
C	60.	Many times, all three wards. /	Yat Lam states that he has been admitted to all three wards of the present hospital many times.	Yat Lam has stayed in all pulmonary wards during previous hospital readmissions.
I	61.	All three wards...You mean the whole floor? All chest wards?		
C	62.	Admitted to ward 3C, then discharged. /	Yat Lam states that he was discharged from ward 3C previously.	

I	63.	It was ward 3C last time.		
C	64.	Came back one week after discharge. This time, it is...chest ward...They gave me and ECG, nothing wrong. X-ray, nothing wrong. When I breathed, I had shortness of breath again. No one knows what's wrong with me. /	Yat Lam states that he was readmitted to the hospital a week after the previous discharge. He had undergone ECG and x-ray, but no abnormality was detected. Yat Lam suffered breathlessness when he breathed. He wonders why nobody can diagnose his physical problem.	Yat Lam does not know his condition despite undergoing various investigations.
I	65.	Shortness of breath...all right...		
C	66.	They collected blood samples twice, gave me IV drip, checked X-ray twice, just like what they did today. /	Yat Lam recalls that his blood was taken twice. He also received infusion therapy and had an x-ray taken twice. He adds that he has been subjected to these investigations and treatments repeatedly.	
I	67.	Yes, one just now.		
C	68.	Another time today. The doctor wanted a result. Why does here (chest) hurt? Near the heart... near the right. / When I got up early this morning...it started to hurt, dull pain, intermittently, just like that.	Yat Lam states that he had to undergo those investigations again because the doctor needed to identify his problem. Yat Lam complains of pain on the right chest. Specifically, he feels a dull pain when he wakes up early in the morning.	Yat Lam complains of chest discomfort, thus requiring him to undergo some investigations.
I	69.	Is it the first time?		
C	70.	No. I had angina when I was admitted to the hospital before. /	Yat Lam replies that this instance of pain is not the first. He was admitted to hospital for chest pain previously. He adds that he has a history of angina.	Yat Lam was previous readmitted to hospital for angina.
I	71.	Oh...but...hurts in the same way?		
C	72.	No...in a different way. /	Yat Lam states that the present chest discomfort is different from the previous one.	
I	73.	I see… So, you just said that you have been in this hospital several times, and you have been		

		admitted to all three wards. Do you recognize the doctors and nurses here?		
C	74.	I recognize them. /	Yat Lam states that he recognizes the hospital staff members in the wards.	Yat Lam perceives that he and the healthcare staff recognize each other, but they maintain a distant relationship.
I	75.	All of them?		
C	76.	Of course I recognize all of them. They are hospital staff and will not quit very often. Some have worked here for years. But we do not know one another well, we seldom talk. /	Yat Lam is certain that he recognizes the hospital staff. He explains that people do not resign from this kind of job shortly. He recognizes that some of the staff members have been working in the ward for a few years. Since they seldom interact because they do not know on another well.	
I	77.	All right...you recognize all of them.		
C	78.	Right, they all recognize me too. /	Yat Lam thinks that the staff also recognizes him.	
I	79.	You mean they can recognize you.		
C	80.	Those physiotherapists, they ask, “What is it this time? What’s wrong?” I said, “No, nothing wrong.” They asked, “Everything all right?” I said, “I would not be here if everything is all right.” /	Yat Lam describes that the physiotherapists asked why he was readmitted to hospital. He replied that he would not be readmitted if he was fine.	Yat Lam perceives that he has a closer relationship with the physiotherapists.
I	81.	You mean those physiological therapists also recognize you.		
C	82.	Very well. I finished the whole course here. /	Yat Lam states that the physiotherapists know him well. He adds that he completed rehabilitative training at the hospital before.	
I	83.	Ah... Do you meant those rehabilitative training? Exercise, breathing, etc.		
C	84.	Yes, 20...20... finished on 4 June 2010.	Yat Lam recalls that he completed the rehabilitative training on 4 June in 2010.	Yat Lam tells that he completed a rehabilitative training.
I	85.	Wow, great memory!		
C	86.	It was respiratory therapy. The doctor gave me a certificate! He signed it. This means,	Yat Lam states that the rehabilitative training was referred by a doctor. The doctors issued a	

		you have completed the course. The doctor sent me there. /	certificate to him after he completed it.	
I	87.	After learning respiratory exercise, do you do it regularly?		
C	88.	Of course, I do it at home. /	Yat Lam states that he continues to exercise at home.	Yat Lam exercises regularly at home.
I	89.	You also do the exercise at home.		
C	90.	Yes, all thirteen parts. I do the exercise every morning. /	Yat Lam states that the exercise consists of 13 maneuvers. He performs the exercise every morning.	
I	91.	Do they help?		
C	92.	More or less. Of course, they help. / As for the exercise, after exercise a bit, I feel quite good. Why? After buying some pu'er tea in the morning, I boil water to brew a cup of pu'er. Then, I have a cup of pu'er before exercise. After exercise, I have an Ensure. After that, at about ten o'clock, I go out to buy some food. Then, it is one day. Next, I go home. If there is time, I watch the news. After watching the evening news, I cook my dinner.	Yat Lam considers exercise to be beneficial for him. Yat Lam states that he feels good after performing exercises. He describes that he usually prepares a glass of Pu'er tea in the morning, which he drinks before exercising. He then has a glass of Ensure. When it is about 10am, he goes to the market and buys food. He then returns home. If he has sufficient time, he watches the news on TV before preparing dinner.	Yat Lam makes exercise enjoyable. Yat Lam describes the independent life he leads.
I	93.	You cook.		
C	94.	I cook my lunch after watching the mid-day news.	Yat Lam adds that he prepares lunch after watching the news 12noon.	
I	95.	Then, that's a day.		
C	96.	In the evening, I like to watch the evening news at 6, until 6 to 7. Then, I cook my dinner. After my dinner, I watch some TV, if the program interests me. Otherwise, just go to bed earlier. /	Yat Lam states that he likes to watch the news on TV from about 6pm to 7pm. After watching the news, he prepares dinner. He watches TV again after dinner if a programme interests him. Otherwise, he sleeps early at night.	
I	97.	Say, when you go out to buy some food and		

		cook your meals, do you have any problems breathing?		
C	98.	No problem. You...just a bit difficult to carry the food. I carried...just take a look...$10 for four oranges, I paid $20, and I carried 8 oranges. /	Yat Lam states that he can manage his daily activities. He mainly feels difficult in carrying foods. He recalls that he can to carry roughly 8 oranges.	Yat Lam incorporates treatment modality with daily activities to manage everyday problems.
I	99.	Eight oranges, it sounds a bit heavy.		
C	100.	Sometimes, I buy some gourds and vegetables and carry them home. Yes, sometimes I could manage, it depends. / Now, I don't need to carry this way. I bought a set of oxygen tanks. I put the large one in the living room and carried the small one with me when I went out. It was about $300, including the trolley, stainless steel trolley, they are made in USA.	Yat Lam states that he can carry some vegetables back home sometimes. Yat Lam tells that he currently does not have to carry food by himself. He explains that he has bought a set of portable oxygen equipment. He placed the larger one at the living room and he used the smaller one when he went out. He also bought a cart for about 300 dollars. He adds that the cart is composed of stainless steel and was made in the US.	
I	101.	Really, they are not cheap.		
C	102.	Just put a cylinder of oxygen into it. That is...you can't save it if you are ill, you can't save this money. / When you go out, then, just in case one day the weather is bad, you can't make a move, if you don't have oxygen. Say walk about 20-30 feet, I need to rest and need oxygen. / I learned how to breathe at the rehabilitation center, nose in and mouth out, nose in and mouth out. If not, I couldn't help myself!	Yat Lam continues that he placed an oxygen cylinder into the cart. He considers that he had to spend on treatment modality because of his disease. When Yat Lam goes to the outdoors in unfavorable weather, he cannot walk without supplementary oxygen. After walking for about 20 – 30 feet, he has to rest and use the supplementary oxygen. Yat Lam adds that he learned pursed-lip breathing at a rehabilitation center. If he does not perform it, he cannot help himself in instances of	Yat Lam considers some expenses on treatment modality to be necessary. Yat Lam describes the difficulty of daily activities and how he manages his challenge. Yat Lam regards the pursed-lip breathing technique as useful in the self-management of breathlessness.

			breathlessness.	
I	103.	Feeling better?		
C	104.	Of course much better. /	Yat Lam states that he feels much better after performing the breathing exercises.	
I	105.	Right. Many patients told me that this method is effective.		
C	106.	I helped myself several times. /	Yat Lam claims that he has saved himself several times.	Yat Lam devises self-management strategies from daily life to relieve himself from breathlessness. Yat Lam identifies the pursed-lip breathing as the most effective method of relieving breathlessness.
I	107.	With this method?		
C	108.	I shower. When I put soap on my body, it's all right. When I was drying my body after rinsing, I... I couldn't dry my body, put on my trousers... wheeze began. When it started...I went back to my room, put a blanket on the body to get warm.	Yat Lam describes an incident in which he was still fine while showering. However, he suffered breathlessness while he was drying his body and was unable to put on his trousers. He went to his room and used a blanket to warm his body.	
I	109.	Oh, just warm the body up.		
C	110.	Right. Cover my body with a blanket to warm the body. When my body becomes hot, the trachea expands. It is a new self-help method. / Nose in and mouth out, it's the most useful. Even when asthma attacks, I had it several times, I try nose in and mouth out, nose in and mouth out. Asthma won't last long, just three minutes, or three to five minutes. /	Yat Lam states that he used a blanket to warm his body. He explains that when the body is warm, the airway is dilated. This is a new method saving him from breathlessness. Yat Lam pursed-lip breathing to be the most effective method of relieving breathless. He has suffered from dyspneic attacks several times and has used this technique to relieve it. He states that the breathlessness does not last long; it usually lasts about 3 to 5 minutes.	
I	111.	It's very uncomfortable.		
C	112.	Of course, I can't take it. However, I get used to it. Stay calm. I know I need to stay calm when it comes, handle it with nose in and mouth out, nose in and mouth out. If you	Yat Lam tells that a few minutes of breathlessness is distressing enough for him. However, he is used to this situation. Thus, he remains calm and performs pursed-lip breathing	Yat Lam understands how to manage breathlessness. Yat Lam learned self-management methods from

		panic, afraid, your heartbeat rises, and the situation gets worse. Therefore, those occupational therapists tell me to stay calm. If you can't stay calm, the situation gets worse, heartbeat rises. When heartbeat rises, it means you need to breathe more, right? /	to relieve the breathlessness. He understands that if he panics and becomes anxious, his heart rate increases. He recalls that some occupational therapists taught him to remain calm and to be patient when he suffers breathlessness. He explains that respiration rate increases with heart rate, thereby worsening the situation.	some occupational therapists.
I	113.	Very good, you understand!		
C	114.	They (occupational therapists) taught me. If they didn't teach me, I wouldn't know it. I didn't know what "noise in and mouth out" means. I used to breathe with the nose and the mouth, and the effect was not that good. That's why I always had had shortness of breath before. / Now, it's different. If I sit this way, my (blood) oxygen level is only 87.	Yat Lam states that he learned the breathing technique from occupational therapists. Previously, he didn't know about pursed-lip breathing. He used both his nose and mouth to breathe, and these methods were ineffective in relieving his distress. Therefore, he suffered breathlessness frequently. But Yat Lam states that the situation has changed. He then claims that his oxygen saturation was only 87% when he seated.	Yat Lam identifies pursed-lip breathing as an effective technique that relieves breathlessness.
I	115.	Oh, really?		
C	116.	When I had follow-up, the nurse was surprised it (blood oxygenation) was 87 and asked if I wore the oxygen mask. I told her no need to bother, I would be all right later. Next, I began to breathe nose in mouth out and nose in mouth out. A minute or so later, the reading rose to 92. So the nurse said, "You made it!" So I told her, "This is the only method." / Rose to 92, but this value… this value was not accurate.	Yat Lam recalls that when he had follow-up, a nurse was surprised to learn that his oxygen saturation was 87% and asked whether he use the oxygen therapy. He assured that his oxygen saturation could resume. He performed pursed-lip breathing for about a minute, then the oxygen saturation increased to 92%. The nurse praised him for resuming his oxygen saturation. He responded to the nurse that he knew only this method and that he was unaware of alternatives. Yat Lam considers that an oxygen saturation of 92% to an inaccurate.	Yat Lam knows how to increase his oxygen saturation temporarily. Yat Lam considers that the strategy to be deceptive because his actual physical condition is unstable actually.

I	117.	Why?		
C	118.	Why was it not accurate? Because you can't always keep it at 92. If you don't breathe with nose in and mouth out, the value drops. True, that's why I said this value was not accurate, because it dropped to 80+ again. /	Yat Lam explains that he cannot maintain an oxygen saturation of 92%; if he does not perform pursed-lip breathing, his oxygen saturation declines. So, he regards the value as inaccurate because the oxygen saturation decreases to about 80% without performing the breathing technique.	
I	119.	This means, you need to breathe a bit to get this value.		
C	120.	Right. I need to breathe it this way to get this value. So I say it is not accurate. /	Yat Lam states that he has to perform the breathing technique to achieve the value. So, he regards the level of oxygen saturation as inaccurate.	
I	121.	It sounds that you know your body pretty well.		
C	122.	It is my body. / That is… experience is the mother of wisdom. If people talk about this, listen carefully. /	Yat Lam states that he has to take care of himself. / Yat Lam learns from experience. When someone discusses about the disease, he pays attention and learns more about it.	Yat Lam believes he has to take care of himself. Yat Lam learns how to the self-manage the disease from experience. Yat Lam is eager to learn about self-management.
I	123.	Well you just said that if asthma attacks, you will find a way first.		
C	124.	Right, that's right. When I wheeze, I lean against the wall and breathe nose in and mouth out, nose in and mouth out. Later on… when I wheeze, this way of breathing works. /	Yat Lam describes that when he suffers breathlessness, he leans against a wall, and performs pursed-lip breathing for a while. Yat Lam finds that the breathing technique effectively relieves his breathlessness.	Yat Lam familiarizes himself with self-management strategies to manage breathlessness.
I	125.	Sometimes people get nervous when asthma attacks.		Yat Lam believes that

C	126.	Well, even you breathe nose in and mouth out, you still need to go to the hospital, right? Many times I have wheezing when I am sitting at home, I press the personal safety alarm. When they (staff of the safety alarm system) asked me what had happened, I told them, “Wheezing, very bad, please call the ambulance.” They understand it. Then, I also need to breathe nose in and mouth out, nose in and mouth out to buy some time for myself. When the ambulancemen comes, they give me an oxygen mask and help me breathe. / Some patients were overly panicking. So those occupational therapists tell you to stay calm, you must stay calm, don’t...don’t rush, don’t panic. I have told you, if you rush and panic, your heartbeat rises, immediately...heartbeat rises, breath increases. Right, just like running, and heartbeat keeps rising. This is the entire process, that’s the logic. /	Yat Lam states that admission to hospital is necessary after performing pursed-lip breathing. He describes that he often suffers from breathlessness when he sits at home. He presses the safety alarm to notify the responsible person of the alarm system that an ambulance should be called for him. Then, he must perform pursed-lip breathing to cope with the distress. When the ambulancemen arrives, they apply an oxygen mask on him and assist him in breathing. Yat Lam finds that some patients are too anxious when they suffer breathlessness. He remembers that occupational therapists taught him to stay calm and should not be anxious. He explains that when a person is panic, the heart rate increases and in turn accelerates the respiration rate. He believes that the reactions are resulted in a logical sense. It likes the heart beats fast when a person is running.	hospital readmission is necessary even when self-management strategies are applied. Yat Lam understands the mechanisms of some self-management methods.
I	127.	This means, if asthma attacks, you must press the personal safety alarm. Then, you will breathe with this method?		
C	128.	Press the safety alarm, just for safety. He (the staff of the safety alarm system) knows it. Next, inhale with the nose and exhale with the mouth. By doing so, I hope to buy some more time. When he (ambulanceman) comes, I can have oxygen. / I didn’t have oxygen at home before, but I have now.	Yat Lam states that he first presses the safety alarm for safety reasons when he suffers from breathlessness. It lets someone to know about his need Then, he keeps performing pursed-lip breathing to maintain his respiration. When the ambulancemen arrive, he can then obtain supplementary oxygen.	Yat Lam requires a sense of security when he suffers breathlessness.

			Yat Lam adds that he didn't have home oxygen before, but he has recently installed the oxygen equipment at home.	
I	129.	You also need oxygen even you are in the hospital now. How do you get to the toilet?		
C	130.	I can take it off, it won't kill me for a little while. Honestly, sometimes I can breathe smoothly. Although I need oxygen, when I was at home, I took it off and went out to get some food. /	Yat Lam considers himself to be fit enough to remove the oxygen supplement for a while. Yat Lam states that he can breathe well sometimes Although he is on oxygen therapy at home, he removes the oxygen equipment when he goes to a wet market to buy foods.	Yat Lam is always prepared to manage breathlessness. Yat Lam manages his daily needs independently.
I	131.	You don't worry about that, without oxygen?		
C	132.	No. I carry...carry this (an inhaler). /	Yat Lam states that he does not worry about leaving home without supplementary oxygen because he brings an inhaler with him.	
I	133.	Right...the inhaler.		
C	134.	In case of an emergency, this, one...one...just 4-5 shots, I buy some more time. / In fact, when I go to the market...go to the market...market, it takes...if I walk fast ...about five minutes to get to the market. Very close. Cross the flyover to the mall, the market is right down the mall. There is an escalator down to the market. I take the flyover of the mall...to the market to buy some food. /	Yat Lam states that he draws 4 to 5 puffs from his inhaler to cope with breathlessness. Yat Lam goes to a wet market that is close to his home. If he walks quickly, it takes him for about 5 minutes. He describes that he crosses a bridge to arrive at a shopping center, then he rides an escalator to the wet market to buy foods.	
I	135.	Now when you are in the hospital, will you get down and go out for a walk?		
C	136.	Yes. When I...even when I am in the hospital, when I...I feel better, I go out for a walk, that corridor...a few rounds. If you sit in bed, the	Yat Lam tells that he leaves the ward and walks around the corridor when his condition stabilizes. He explains that remaining in a hospital bed for	Yat Lam has to exercises his lower limbs to prepare himself for discharge.

		longer you stay, the worse you will be come, really. Say, if you lie in bed for 3-4 days without getting out, your legs will be weak when they touch the ground, suddenly. No kidding, true...So, why do you need to train your legs? You need to walk when you go home. If you don't train your legs, you can't walk properly, right? /	long periods of time worsen his physical condition. He emphasizes that his lower limbs weaken after being subject to complete bed rest for a few days. Therefore, he considers exercising his lower limbs to be necessary for him while he was in the hospital so that he can walk properly after discharge.	
I	137.	This means, you won't stay in bed all the time, and you must take a walk in the hallway.		
C	138.	At one, I will go out to watch the midday news. /	Yat Lam tells that he goes to the common area to watch the news on TV at 1pm.	In the hospital, Yat Lam maintains some activities as much as he can tolerate.
I	139.	Well, to that lobby, there.		
C	140.	When I go there, I have to bring the oxygen. /	Yat Lam states that he has to go to the common area with portable oxygen.	
I	141.	Right.		
C	142.	...something wrong with the congee.	Yat Lam mentions a recent food problem.	
I	143.	Tasteless?		
C	144.	That congee...you know it. Now, the congee from Mainland. Oh, I know that congee. You know it well, evil factories that do anything. I seldom try that. /	Yat Lam tells the congee was cooked in the Mainland. He knows that some problems are encountered with the congee. Therefore, he consumes it.	
I	145.	What about the meals in the hospital, did you try them?		
C	146.	I take every meal...frozen meals from the fridge.	Yat Lam states that he eats the food provided by the hospital, which he finds stored in the fridge.	Yat Lam explores alternatives to eating well while he is in the hospital.
I	147.	Really, the hospital prepares meals this way.		
C	148.	Even the vegetables and the meat...hospital foods, tasteless, why? Some patients can't have salt, no salt. /	Yat Lam states that the hospital food is tasteless because some patients cannot take salt in their foods.	
I	149.	Right, those with hypertension.		

C	150.	If I find the food tasteless, I go out and buy seasonings...soy sauce is quite good, a few drops.	Yat Lam states that he adds some seasoning to the food when he finds it tasteless to improve the flavor.	
I	151.	Oh, right, right...some patient even bring...		
C	152.	“Maggie”...I want one...$15 a bottle at the shop on the lower floor (of the hospital)...Buy a “Maggie”...this one is out.	Yat Lam states that he bought a bottle of soya sauce from a store at the lower floor of the hospital because he finished old bottle.	
I	153.	You finished the whole bottle?		
C	154.	Well, you...you...you know how much you add to pork, for vegetables...sometimes even the soup... /	Yat Lam states that he adds soya sauce to meat and vegetables. He sometimes even adds soya source to the soup.	
I	155.	Haha...even for soup!		
C	156.	Here, even steamed mud carp with fermented black soybeans is unavailable...when there is, people will buy it immediately.	Yat Lam tells that canned fish was sold out at the hospital because people buy all of the available cans at the store.	
I	157.	Because...it has taste, right?		
C	158.	Right, steamed mud carp with fermented black soybeans. Therefore, only sardines are left. /	Yat Lam states that canned sardines are available at the store.	
I	159.	Do you think hospital food is the biggest problem, because it is tasteless? You’ve just said that the hospital is better because there are people looking after you, and air quality is better, temperature is stable.		
C	160.	Yes, that’s right… / You are from CU med school?	Yat Lam finds the tasteless hospital food to be the major problem at hospitals.	Yat Lam is most dissatisfied with tasteless hospital food.
I	161.	Right, I work here.		
C	162.	I have seen a few CU med school students. They all learn the same thing; just see which one is smarter. /	Yat Lam noticed that some CU medical students practiced at the ward previously.	Yat Lam observes what other people do at the hospital.
I	163.	Right, they need to get some real experience,		

		an internship.		
C	164.	My son... He said he didn't know the drug.	Yat Lam mentions that his sons do not know about his medications.	Yat Lam is eager to learn more about his treatment regimen, but he fails to obtain this knowledge.
I	165.	Well, what does he do?		
C	166.	My son?		
I	167.	Right.		
C	168.	He does finance work. Now...he is working…at...a bank. He is a university graduate. / He said he didn't understand the drug name...his drugs, sometimes I read their names...he said he couldn't read them, the code was different.	Yat Lam states that his son works at a bank and is a university graduate. Yat Lam tells his son does not know what kind of drug Yat Lam is taking. He wants to know about it, but his son does not know the name of the drug.	
I	169.	Right...names are different.		
C	170.	He said...he said...We don't know those names, those... are in English.	Yat Lam's son told him that he didn't know the names of the medications in English.	
I	171.	Also, there are many drugs.		
C	172.	Right. He said, he knows English, but drug names are difficult... /	Yat Lam's son told him that while he knows English, the names of the medications are difficult for him to read.	
I	173.	They are special drugs, more difficult.		
C	174.	Right...you are right...like…those herbs...In the old days...herbal stores...herbal pharmacists. /	Yat Lam describes the situation as being similar to identifying the herbs in a Chinese herbal store.	
I	175.	No, I don't know herbal medicine either.		
C	176.	The prescription...the drug names, you don't know, if you are not them (pharmacists)...you won't understand. Their handwriting is difficult to read, you will never know, but the herbal pharmacist understands and he can get the herbs for you, really. /	Yat Lam states that only Chinese practitioners can read their prescriptions. He cannot read what is written on the prescription. But those pharmacists can read it and pack the herbs for him.	
I	177.	Right…		

C	178.	Some herbal...herbal medicine...some say herbal medicine is good, some say Western medicine is good. Some patients are treated with herbal medicine, they use herbal medicine because it is milder, the treatment is slower.	Yat Lam learned about some people said Chinese medicine is good while others consider Western medicine to be effective. He knows that some patients take Chinese medicine. He tells that the effect of Chinese medicine is milder than that of Western medicine, and it takes effect more slowly.	Yat Lam wants to explore alternative treatments for his disease.
I	179.	It takes more time.		
C	180.	Right, slower. If you catch a cold, herbal medicine is the best, it can cure everything. Western medicine can treat but may not cure completely. When people take medication and get a shot for a cold, it means they suppress the cold. You need some herbal medicine to dig it out and cure it. If you don't, it will be difficult to get cured. It's like you can't sleep in the night, ha...	Yat Lam finds that Chinese medicine takes effect slowly. He considers that influenza should be treated using Chinese medicine which cures the disease completely, but Western medicine may not have the same effect. Injection and oral medications only control the disease, but herbs are necessary to treat the disease completely. He adds that uncured influenza is troublesome and causes a person to always feel drowsy.	
I	181.	Really?		
C	182.	Like sleepwalking, shoulders are heavy.	Yat Lam adds that the drowsy feeling is similar to sleepwalking and that it tires the shoulder.	
I	183.	Does your son visit you at hospital?		
C	184.	Yes, he will come tonight. /	Yat Lam tells that his son will visit him at hospital on that day.	Yat Lam's children brought some commodities to him after he was readmitted to the hospital.
I	185.	Tonight.		
C	186.	Tonight. My son and my daughter brought me these things (commodities) yesterday. /	Yat Lam tells that his children brought some commodities to him on the previous day.	
I	187.	Well, they have all come.		
C	188.	They need to work. /	Yat Lam adds that his children have to work.	
I	189.	They will come to see you.		
C	190.	They worry about me...my son and my daughter. Both of them care about me. / They	Yat Lam knows that his children do care about him.	Yat Lam is satisfied with his children being self-motivated

		didn't need a push to study. I didn't need me to push them, they just do it naturally.	Yat lam recalls that he did not need to worry about their studies because they possess initiative.	persons.
I	191.	So they study voluntarily.		
C	192.	They study themselves. This...this needs self-motivation. If they are not self-motivated, it won't work even you push them, right? That is, self-motivation is very important. /	Yat Lam states that his children were self-motivated to study since they were young. He considers that self-motivation to be the most important characteristic. Even close supervision cannot help a child lacks self-motivation.	
I	193.	Well, they know what they should do.		
C	194.	I am not boasting. My son graduated from St. Paul co-ed. My daughter graduated from St. Stephan's Girls High School.	Yat Lam is grateful that his children graduated from two well-known secondary schools.	Yat Lam is proud of the achievement of his children.
I	195.	Well, very smart...		
C	196.	It's good enough. /	Yat Lam states that he is satisfied with the achievements of his children.	
I	197.	So they do worry about you. Have they asked the doctor why you need to hospitalize so often?		
C	198.	My daughter asked for a day off to take me to the hospital, took me to follow-up, and asked the doctor.	Yat Lam states that his daughter took a day off to accompany him to his follow up and asked the doctor about his illness.	Yat Lam appreciates that his children care about him.
I	199.	Asked the doctor...		
C	200.	My daughter is very thoughtful...I can't complain more... She has a heart. Otherwise, she won't even come, right? If she wants to come, she will come; otherwise, she won't. I've seen the children of some patients are like that. Like the one in the next bed, he always complains that his children didn't come...I say if they come to see you once,	Yat Lam states that his daughter is thoughtful to him. He considers that his daughter visits him at the hospital out of her self-motivation. Yat Lam tells that there is a patient complained about the children not visiting. He believes that children would visit if they are willing. Otherwise, he has no way to force them to.	

		they should come voluntarily. If not, you can't push them, right? /		
I	201.	I've heard some patients had similar idea…		
C	202.	I am this type of person...Sometimes when they came, I told them...All right, I am fine...Unless I need them to buy me something...oranges...Also, I need them to buy me things I need here...Otherwise, I told them only to come on weekend. /	Yat Lam states that he asked his children not to visit him at the hospital. He thinks he is fine there. Unless he needs fruit or some commodities, he would ask his children to buy for him. Otherwise, he asks them coming to visit only on weekend.	Yat Lam attempts to relieve the burden on his children when he is readmitted to hospital.
I	203.	Not on weekdays?		
C	204.	As a father, (I know) they finish work at six to seven every day, will you still want them to waste time to come? Sunday is a different case. What...if they come on Saturday, they can stay longer, they have nothing else to do home. We (parents) need to be thoughtful. / Some fathers act like a king, really, some are like this. I don't understand. It's not wise to behave this way. Even they have time, but it's still their time. My daughter, she said she will come tomorrow. I said no, no need to bother. It's very far away, you have to walk a long way. If there is something, we can talk on the phone, right? Sunday is different, there is plenty of time. Sometimes, a father needs to understand and think. /	Yat Lam knows that his children usually leave work at about 6pm to 7pm; thus, he does not occupy the rest of their time of his children. However, they can stay with him longer on weekends because they are free then. Yat Lam disagrees with some parents who are too authoritative with their children and demand much of them. When he knows that his daughter is coming to visit the next day, he refuses her because she often has to travel. He prefers to contact his children by other means. Yat Lam believes that his children have plenty of time to visit him on Sundays. As a father, Yat Lam feels that he should be considerate of his children.	Yat Lam believes that as a father, he should be considerate of his children. Yat Lam minimizes the burden on his children.
I	205.	Right. I've heard the same thing from some patients. Their condition is not that bad, compared to those who can leave their bed.		
C	206.	If I can walk, just walk downstairs and buy something from a shop. But I am just	Yat Lam states that he would buy commodities at the store himself if he is able to ambulate. But he	

		transferred to here and have nothing, then I can ask my children to bring the things I need. /	was newly transferred to the present hospital and he lacked those commodities, so he asked his children to bring those commodities to him.	
I	207.	You have been in and out of the hospitals many times, what do you feel?		
C	208.	Hey, hey... I am familiar with some nurses, I meet them when I come back to this ward, ha...	Yat Lam states that he knows some of the nurses well. He met them when he was readmitted to the hospital.	Yat Lam knows the nurses from previous hospital readmissions. Yat Lam perceives a sense of powerlessness to control his hospital readmission.
I	209.	Met them again...ha...they recognize you.		
C	210.	Right...well...I don't want to. I want to see them outside, haha... /	Yat Lam tells that he would rather meet those nurses outside the hospital rather than in the ward.	
I	211.	Ha...What else? Does anything bother you?		
C	212.	My body. Each time I came, it got worse…right, can't say each time is better than before. /	Yat Lam observes that his physical condition deteriorates with each hospital readmission. He believes that the body does not improve with hospital readmission.	Yat Lam realizes his physical deterioration from the occurrence of hospital readmission.
I	213.	That is, each time you come to the hospital, you feel your condition gets worse?		
C	214.	Right. The doctor has prescribed medication, those are steroids. From two tablets to four tablets, from four to five. Then, you know it. /	Yat Lam observes that the steroid prescribed by doctors was increased from 2 tablets to 4 tablets and then to 5 tablets. He realizes that his physical condition has deteriorated.	Yat Lam realizes the gradual deterioration of his physical condition based on the prescription of the doctor.
I	215.	So you know your dose has been increased.		
C	216.	Right, that's it.		
I	217.	In this case, what do you think?		
C	218.	Well, I am not worried. If this should happen, I can't avoid it, right? Well...ha...nothing specific on my mind...It's beyond my control. /	Yat Lam states that he does not worry about his physical deterioration. He considers that he does not have alternatives if deterioration should happen. He believes that his condition is out of his control.	Yat Lam perceives a sense of powerlessness with respect to his physical deterioration. Yat Lam lets go the sense of powerlessness to relieve himself from the stress.
I	219.	Just let it go.		

C	220.	Right, don't put yourself in a dead end…some people just can't let it go.	Yat Lam states that he will not place himself at a "dead end." He finds that some people cannot let go because they place themselves in this situation.	
I	221.	You mean don't think too much, don't waste time on something that can't be resolved.		
C	222.	Right, people can't get out from a dead end. If you don't let it go, you can't get out. /	Yat Lam observes that some people cannot escape the "dead end." He believes that if he does not let the situation go, then neither can he escape the "dead end".	
I	223.	Well, I just want to know how you feel about your frequent in-and-out of the hospital. Anything else you want to tell me?		
C	224.	No, nothing else.	Yat Lam states he has described all of his experiences in hospital readmissions.	

Appendix F

Ethics Approval from the Joint CUHK-NTEC Clinical Research Ethics Committee

香港中文大學醫學院
Faculty Of Medicine
The Chinese University Of Hong Kong

醫院管理局
新界東醫院聯網
Hospital Authority
New Territories East Cluster

Joint Chinese University of Hong Kong-New Territories East Cluster Clinical Research Ethics Committee
香港中文大學-新界東醫院聯網 臨床研究倫理 聯席委員會

Flat 3C, Block B, Staff Quarters, Prince of Wales Hospital, Shatin, HK
Tel : (852) 2632 3935 / 2144 5926 Fax : (852) 2646 6653 Website : http://www.crec.cuhk.edu.hk

To: Ms. Wing Ki TANG
PhD Student
The Nethersole School of Nursing
The Chinese University of Hong Kong

14 JAN '11

Ethics Approval of Research Protocol

CREC Ref. No.:	**CRE-2010.592**
Date of Approval:	**04 January 2011***
Study Title:	**Revolving door syndrome: A phenomenological study of hospital readmissions of Chinese older people with chronic obstructive pulmonary disease**
Investigator(s):	**Wing Ki TANG**
Academic Supervisor(s):	**Prof. Diana LEE**

I write to inform you that ethics approval has been given for you to conduct the captioned study in accordance with the following document(s) submitted:

- Proposal
- Participant Information Sheet and Informed Consent Form, English Version
- Participant Information Sheet and Informed Consent Form, Chinese Version
- Interview Questions, English Version
- Demographic and Clinical Data, English Version

This ethics approval* will be valid for 12 months. Application for further renewal can be made by the submission of the Ethics Renewal and Research Progress Report Form to the CREC (Download the electronic form template from the http://www.crec.cuhk.edu.hk or http://ntec.home/Research%20Ethics/main.asp). You are kindly requested to report to the Committee upon completion of the project.

The Joint CUHK-NTEC Clinical Research Ethics Committee is organized and operated according to ICH-GCP and the applicable laws and regulations.

Miss Winkie Lui
CREC Officer
Joint CUHK-NTEC
Clinical Research Ethics Committee

Appendix G
Ethics Approval from the Kowloon East Cluster Research Ethics Committee

Research Ethics Committee
(Kowloon Central / Kowloon East)

c/o Queen Elizabeth Hospital
30 Gascoigne Road Kowloon

Ms TANG Wing Ki

Professor Consultant
The Nethersole School of Nursing
Faculty of Medicine
Esther LEE Building
The Chinese University of Hong Kong
Shatin, New Territories

10 March 2011

Ref: KC/KE-11-0016/ER-2

Dear Ms TANG,

The REC(KC/KE) members are appointed by the Cluster Chief Executives to review and monitor clinical research independently according to the guidance of Declaration of Helsinki and ICH GCP Guidelines in order to safeguard the rights, safety and well-being of research subjects. It has the authority to approve, require modifications (to secure approval), or disapprove research. This committee has power to terminate/suspend a research at any time if there is evidence to indicate that the above principles and requirements have been violated.

The Committee has reviewed and approved your research application on 10 March 2011 by an expedited process. The approval decision was based on the documents submitted. You are required to adhere to the attached conditions:

Title of Study	Revolving door syndrome: A phenomenological study of hospital readmissions of Chinese older people with chronic obstructive pulmonary disease
Principal Investigator	Ms TANG Wing Ki, Professor Consultant, The Nethersole School of Nursing, Faculty of Medicine, CUHK
List of Co-investigators	Dr CHAN Kam Keung, Pulmonary Unit, HHH
	Ms KO Ki Tsing, Pulmonary Unit, HHH
Protocol title and version	Research Protocol
Consent Form versions	English and Chinese Versions [Revised versions submitted 23 February 2011]
Information sheet title and versions	English and Chinese Versions [Revised versions submitted 23 February 2011]
Certificate of indemnity/insurance	N/A

Other Documents	- REC(KC/KE) Clinical Research Ethics Review Application Form [REC SOP001F3] [Revised version submitted 9 March 2011] - Appendices - Corresponding emails 8 and 24 February, 2 and 9 March 2011 - C.V. of Principal Investigator
Study site approved	Haven of Hope Hospital
Conditions	1. Be compliant with the applicable laws and regulations (including Hong Kong laws), HA policy, professional code of conduct, guidance of ICH GCP and Declaration of Helsinki. 2. Apply a clinical trial certificate from Department of Health if indicated and submit a copy to this committee before the study begins. 3. Not deviate from, or make changes to the study protocol without prior written REC approval, except when it is necessary to eliminate immediate hazards to research subjects or when the change involves only logistical or administrative issues. 4. Report the followings to REC(KC/KE): (i) unexpected and serious adverse event (use KCKE SOP001F8)* within 7 calendar days for life-threatening or fatal event and within 15 calendar days for others from the date of first knowledge of the event (ii) study protocol or consent document change (use KCKE SOP001F7)* (iii) new information that may be relevant to a subject's willingness to continue participation in the study. 5. Report the first study progress to REC by March 2012 and thereafter at 12 monthly intervals until study closure (use KCKE SOP001F9a)*. 6. Report study closure (use KCKE SOP001F9b)* by July 2013. 7. Report the study results and submit any relevant publications to REC(KC/KE).

** Download forms from the KCC/KEC intra-net for use*

Encl. KCKE SOP001F7
KCKE SOP001F8
KCKE SOP001F9a
KCKE SOP001F9b

Dr MOK Ka Ming
for Chairman of REC(KC/KE)

Appendix H
Information Sheet

Revolving door syndrome: A phenomenological study of hospital readmissions of Chinese older people with chronic obstructive pulmonary disease

You are sincerely invited to participate in a research. Please take time to read the following information about the study and decide whether you wish to participate in this study.

Hospital readmission is a common phenomenon among older people with chronic obstructive pulmonary disease (COPD). It impacts on the patients, caregivers and healthcare system. To reduce hospital readmission, increase understanding to this phenomenon is necessary. The aim of this study is to examine the phenomenon of hospital readmissions from the perspectives of Chinese older people with COPD. Your information provided is valuable to this study. The results of this study are significant to healthcare professionals in understanding the experiences of hospital readmissions and the needs of readmitted people. These understandings can allow healthcare professionals to design appropriate interventions for COPD patients and reduce the number of hospital readmission ultimately.

This study will recruit about 30 participants. The study will involve an audio-recorded interview which will last about 45 to 60 minutes. The interview aims to understand your experience in hospital readmissions. Participation in this study is voluntary. You will be updated timely of any new information that may be relevant to your willingness to continue participation in this study. You have the right to refuse answering any questions. You also have the right to terminate the interview or withdraw from this study at any time without any reason. This will not affect the care and treatments that you will receive in the future. Confidentiality is ensured, your name will be identified by code and will not be designated in the research report. The research data will only be collected and analyzed by the researcher. It will be kept strictly confidential in a locked cabinet and can only be accessed by the researcher. The data will only be used for research purpose.

This study is conducted by Miss Tang Wing Ki (Candidate of Doctor of Philosophy in Nursing, The Chinese University of Hong Kong) and under the supervision of Prof. Diana Lee and Prof. Ann Shiu. The result of this study will form part of the thesis. Please feel free to contact me at any time for any enquiries (Tel: 3163 4235). For any questions about human rights, you may contact the Research Ethics Committee (Kowloon Central/ Kowloon East) (Tel: 2958 6623).

Thank you for your worthful participation!

Yours sincerely,

Tang Wing Ki
Candidate of Doctor of Philosophy in Nursing
The Nethersole School of Nursing
The Chinese University of Hong Kong

Appendix I
Consent of Participation in Research

Title of study : Revolving door syndrome: A phenomenological study of hospital readmissions of Chinese older people with chronic obstructive pulmonary disease

Researcher : Tang Wing Ki

Code No. :

I _____ hereby consent to participate in this study. I confirm that I have read and understood the information of this study. I have had the opportunity to question about the study with clear answer.

I understand the research purpose, procedures and possible risks in this study. I understand that my personal information will be kept confidential. I understand that information obtained from this study will be published and used in future research. My participation in this research is voluntary. I understand that I have the right to refuse answering any questions, terminate the interview and withdraw from this study at any time without giving any reason. Upon signed on this consent, I grant the Research Ethics Committee and the regulatory authority(ies) to directly access to my study data for data verification.

Please feel free to contact Miss Tang Wing Ki at any time for any enquiries (Tel: 3163 4235). For any questions about human rights, you may contact the Research Ethics Committee (Kowloon Central/ Kowloon East) (Tel: 2958 6623).

Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature
_____	_____	_____

Appendix J
研究簡介

«慢阻性肺病中國老年人再住院的現象學研究»

現誠邀請 閣下參與一項研究, 請詳閱以下有關此項研究的資料, 並考慮是否參與此項研究。

再住院對於慢阻性肺病老年患者是一項常見的現象, 這情況會對患者、照顧者及醫療體系帶來影響。要減少再住院情況出現, 增加對這個現象的了解是必需的。此項研究的目的在於從患有慢阻性肺病中國老年人的角度了解再住院的現象。你所提供的資料對這個研究非常寶貴。這項研究的結果非常重要, 能使醫護人員了解再住院病人的經驗及需要。這些了解能夠讓醫護人員為慢阻性肺病患者計劃出合適的醫療服務, 最終達致減少再住院的次數。

這項研究將會徵募約 30 位參加者。研究內容包括進行一次錄音訪問, 訪問將需時約 45 至 60 分鐘。 這個訪問旨在了解你再住院的經驗。參與此項研究純屬自願性質。你將會及時收到任何有可能影響你是否願意繼續參與這項研究的更新資料。你有權拒絕回答任何問題, 你亦有權終止訪問或隨時退出此項研究, 而無需提出任何理由。 這些均不會對你將來接受的護理或治療有任何影響。你所提供的個人資料絕對保密, 你的名字會用編碼取代, 並不會在研究報告中提及。所有研究資料只由研究員進行收集及分析, 研究資料會被鎖起, 只有研究員才可使用, 所有資料亦只會作學術研究之用。

這項研究由鄧穎琪小姐(中文大學護理學博士研究生)進行, 並由李子芬教授及邵德英教授監督。研究結果會成為博士論文一部份。如有任何疑問, 你可隨時聯絡鄧穎琪小姐查詢 (電話: 3163 4235)。有關任何人權問題, 你可與九龍中及九龍東聯網臨床研究倫理委員會聯絡 (電話: 2958 6623)。

衷心感激 閣下參與此項研究!

此致

香港中文大學
那打素護理學院
護理學博士研究生
鄧穎琪 謹啟

Appendix K
同意書

研究項目 : 慢阻性肺病中國老年人再住院的現象學研究

研究員姓名 : 鄧穎琪

研究編號 :

本人 _____ 同意參與這項研究。本人已閱讀及明白有關此項研究的資料。本人有充份的機會就是項研究作出提問, 並獲得清晰的解答。

本人明白此項研究的目的、程序和涉及的風險。本人明白我的個人資料會絕對保密。本人理解此項研究的資料會被刊登和用作未來的學術研究。本人參與此項研究純屬自願性質。本人明白有權隨時拒絕回答任何問題, 終止訪問和退出這項研究, 而不需提出任何理由。通過簽訂此同意書, 我授權臨床研究倫理委員會和監管機構直接核查我的研究資料。

如有任何疑問, 可隨時聯絡鄧穎琪小姐查詢 (電話: 3943 4235)。有關任何人權問題, 你可與九龍中及九龍東聯網臨床研究倫理委員會聯絡 (電話: 2958 6623)。

參與者姓名	日期	簽署
_____	_____	_____
研究員姓名	日期	簽署
_____	_____	_____