Analysis of The Problem of Family Members who lingering in Unaccompanied Hospitals and Its Causes——An Example of A Tertiary Hospital in China

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Abstract. Family caregivers play an essential role in providing support to patients, but the understanding and practice of this role can vary significantly across cultures. In China, family caregivers often consist of relatives who accompany and care for the patient during their hospital stay. This practice is rooted in Chinese family values and the traditional kinship companionship system. However, in recent years, some Chinese hospitals have started experimenting with an 'unaccompanied care model.' In this model, mirroring traditional Western hospital practices, professional staff members, not related to the patients, undertake all patient care tasks. However, many Chinese families struggle to accept this new model that precludes them from accompanying their loved ones during hospitalization, leaving them feeling somewhat lost and helpless in the hospital setting. To better understand the behavior and motivations of these family caregivers, we conducted a study utilizing in-depth interviews and participant observation. The results of this research contribute to our understanding of reasons of the behavior. These findings not only enrich the practical understanding of the role of family caregivers but also support the evolution of the kinship companionship system in healthcare.

Keywords: family caregiving, family members, unaccompanied, cause

1 Introduction

In the Chinese cultural context, values such as familism and filial piety are greatly emphasized, which stands in stark contrast to Western culture's understanding of family caregivers. In China, family caregiving is considered a priority and is reinforced by the concept of filial piety (Qiu et al., 2018). This particular family ethic compels family caregivers to fulfill their responsibilities of care and companionship during a patient's hospitalization (Li Na et al., 2011). Family members serve as the primary caregivers for patients, providing nearly all daily care during hospitalization.

In China, experts have started to recognize the adverse effects caused by family members accompanying hospitalized patients, such as increasing cross-infection rates

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in wards and reducing nursing efficiency. Researchers are now exploring new, unaccompanied models to meet the demands of conceptual renewal and social development. The most significant difference between this new model and the traditional hospital management model in China is that patients' family members are not permitted to enter the inpatient ward to provide daily care. Instead, they can only visit during specified hours each day (Yang Guiyun et al., 2012; Fan Weiying et al., 2022). However, the challenges faced by family caregivers in China have become more direct, specifically reflected in their lingering outside the patients' wards or in public hospital spaces throughout the entire hospitalization period. This phenomenon suggests that, under traditional Chinese culture, family caregivers struggle to adapt to this new model, which prevents them from accompanying and caring for inpatients.

The purpose of this study is to examine the behavior of family member caregivers lingering in public hospital spaces for extended periods and to gain a deeper understanding of their needs. This insight will enable the development of tailored interventions from the perspective of family member caregivers to address the nursing system's new challenges.

2 Method

2.1 Study Design

Due to the small number of hospitals implementing the new unaccompanied model and the relatively limited research on this topic, this study mainly adopted participant observation and in-depth interviews to collect data. We selected X Hospital, the first hospital in China to implement the new unaccompanied model in Fujian Province, as the study site. After obtaining approval from the hospital, the study was conducted over four months using the above research methods .

Participant selection began with cluster sampling. We chose the family groups who were stopping (wondering) in the waiting area for an extended time, which was the only area specially set up by the hospital for family members. The facilities in the family waiting area included rest chairs, toilets, drinking fountains, and video visiting rooms, providing basic services for patients' family members to stay. Some family member caregivers were waiting temporarily, and the others were stopping (wondering) for a long time. The former might leave the hospital after handling some hospitalization procedures for patients, while the latter would remain in the hospital for an extended period after completing necessary tasks. We selected participants through long-term participant observation. With the hospital's assistance, the author obtained the office location of the skill training room next to the waiting area for family members, helping the hospital handle part of the daily work and conducting participant observation of the family members in the waiting area for at least 8 hours every day. The researchers conducted in-depth and semi-structured interviews with each participant at least twice and performed participant observations on each family member caregiver for over 24 hours. This sample size was sufficient for focused ethnography (Muecke, 1994); the data began to repeat and tended towards saturation when the sampling reached the ninth participant.

2.2 Study Participants

Based on the author's four-month participatory observation, the average number of family members staying in the hospital overnight every month is approximately 12 to 15. The author selected the patients' family members who stayed at the temporary waiting area on the third floor of the inpatient department from November to December 2021 as the research subjects.[1] This waiting area is the most concentrated area for families. The inclusion criteria were as follows:

1.Stopped/Wondered overnight in the hospital.

2.Agreed to participate in the research with informed consent.

3.Basic communication ability in Mandarin.

Exclusion criteria: having a strong local accent, unable to understand Mandarin, and unable to conduct basic communication. Finally, 12 patients' family members were chosen, and their real names were replaced by the codes N1-N12. In order to fully understand the specific situation of the detained family members, the interviewees also included one doctor, one nurse, and one security officer in the waiting area, with the codes D1[2], D2, and D3 instead of their real names, respectively. The information of each interviewee is shown in Table 1 below.

Table 1. Basic information of interviewees

Number	Age	Gender	Level of Education	Relationship
N1	58	Male	Primary School	Patient's Son
N2	50	Male	Middle School	Patient's Husband
N3	55	Male	Illiteracy	Patient's Son
N4	48	Female	Middle School	Patient's Daughter
N5	50	Female	Primary School	Patient's Younger Sister
N6	45	Female	High School	Patient's Wife
N7	51	Male	Middle School	Patient's Son
N8	52	Female	Primary School	Patient's Daughter

Number	Age	Gender	Level of Education	Relationship
N9	41	Female	Junior College	Patient's Wife
N10	57	Male	Primary School	Patient's Younger Brother
N11	42	Female	Middle School	Patient's Daughter
N12	44	Female	Middle School	Patient's Daughter
D1	38	Female	High School	Security in the Family Waiting Area
D2	40	Male	High School	Nurse
D3	41	Male	Middle School	Doctor

2.3 Data Analysis

We chose the Colaizzi analysis method (Liu Ming, 2019) to describe the data in detail. The specific steps included:

1. The authors carefully read all original materials, including recordings and transcripts, in conjunction with the memorandum notes taken during the interviews to form a general understanding of the participants' descriptions.
2. Meaningful statements were identified.
3. Meaningful statements were coded and summarized.
4. Common characteristics were found, and multiple thematic concepts were formed.
5. Thematic concepts were connected with the participants and described in detail.
6. Various themes were organized and optimized layer by layer to extract the core structures (spatial factors and strategic selection).
7. The final analysis results were returned to the participants via telephone follow-up visits, and the authenticity of the research results was verified.

3 Results

3.1 Concerns about the Effectiveness of the Unaccompanied Hospital's Policy

The traditional Chinese value of filial piety within families leads the younger generation to have a deep sense of respect and care for their elders. When faced with the illness

of their elderly family members, there is a prevalent belief of "not being far away when parents are sick." As a result, 60% of the surveyed respondents accompany their elders to the hospital for medical treatment. Many of them choose to stay and not leave the hospital premises, even if it is just to be readily available for any need the patients may have. Through the doctors' calls, they can promptly reach their loved ones' side[3].

"To be honest, I know it's not appropriate to do so, but I'm still worried. What if there's an emergency and I'm not able to check my phone after leaving the hospital? Three to five days is not that long, so just to be safe, I decided to stay." (N1)

3.2 The Connection of Family Sense of Responsibility

One of the main connections in the family members' spiritual world lies in the concept of a sense of responsibility within the family. When a major family member falls ill and needs medical treatment or hospitalization, their role and functions within the family temporarily or permanently diminish. In traditional Chinese family values, there is a stable division of responsibility. Issues like these are meant to be faced collectively by the entire family. This inevitably leads other family members to take on relatively greater responsibilities to maintain the functioning of the family. However, the no accompanying policy results in a separation of family responsibility, and they choose to stay to maintain the connection of their sense of responsibility.

"I don't have a stable income to begin with, and she used to take care of some part-time work. Now, in this situation, I can only stay nearby and do what I can." (N2)

3.3 High expenses and travel costs

One of the main reasons for family members to stay in the hospital is that all the public facilities in the waiting area are provided free of charge, including basic amenities like hot water and restroom lights. This relieves them of the financial burden. Without exception, they are not locals and do not reside in the area. Therefore, the cost of living in a different city becomes a major concern for them. The hotel prices in urban areas like the city are unaffordable for them in their daily lives in counties or towns.

"The hotels outside cost two to three hundred per night, which is very expensive for us working people. At least here, it's a temperature-controlled hospital with toilets and water. It's much better than sleeping on the roadside." (N3)

In addition to accommodation expenses, travel costs are also a major consideration for family members. During the perioperative period, the length of stay for each patient is around 3-5 days, with few patients staying for more than 7 days. Generally, patients can be discharged within 5 days. For patients from out of town, their family members are hesitant about whether to return home and wait during the patient's treatment[4].

"The doctor said my mother would be discharged in 3-4 days. We drove here, and it takes almost three hours one way. It's not worth it to go back now." (N1)

3.4 Patient Support and Hospital Compromise

On one hand, the social interactions in the no-accompanying mode construct interpersonal relationships, where staying family members share similar characteristics and roles as a group. Various explicit and implicit social interactions, such as communication among staying family members and the hospital atmosphere in the waiting area, give rise to different interpersonal relationships within the context of staying. Staying in the hospital benefits family members in obtaining support from their peers in the absence of support from their own relatives, thus fulfilling certain needs.

"I've been staying here for about two days. The patient in the family across the aisle also had valve surgery. Their elderly relative has come for the second time, and they shared a lot of experiences with me, especially about what to pay attention to after the first surgery. They also offered help regarding some medical insurance procedures, and we exchanged contact information. With people coming and going all the time, to be honest, if I didn't stay overnight here, I wouldn't have the chance to ask about many things I don't understand." (N4)

On the other hand, family members also seek compromise with the hospital in their own way to achieve a certain level of support. Observing the overall living conditions of the staying family members, it can be seen that the hospital is aware of the situation of family members staying, but because of the strong will of the family members and the fact that their staying behavior has not yet had an impact on the hospital's office order, this issue has not received much attention, and corresponding management measures have not been institutionalized. Therefore, the hospital's compromise also provides support for the staying behavior of family members.

"When the security guards are not paying attention, I can go in and have a look. Sometimes I can even run into the nurses from my sister's department. Even if I'm caught by the security, we can still communicate. Sometimes, they allow me to bring in some things." (N5)

4 Discussion

The experiences of family member caregivers demonstrate their need for more convenient and appropriate services. Hospitals must consider the long-term-staying family members in their management arrangements, enabling smoother reintegration into society. Hospitals can foster a support network among family members by organizing planned activities for these long-term patients and providing offline and instant communication opportunities. Efforts should be made to avoid superficial promotion of the accompanying mode without follow-up. Strengthening social relationship interactions and implementing practical measures for the future are essential. The ultimate goal of this study is to promote the development of harmonious doctor-patient relationships, enabling a gradual shift in traditional patient and family member caregiver perspectives and ultimately achieving a breakthrough in the management system of the unaccompanied model[5].

5 Conclusion

This article presents a study of family member caregivers who linger in hospitals implementing the unaccompanied model in China. The purpose is to explore the reasons and subjective feelings of family member This study provides references for improving the unaccompanied model. Through in-depth interviews and participant observation with 12 family member caregivers and 3 hospital medical staff members, the major reasons were extracted from their statements, In recent years[6], China has actively advocated for the pilot of unaccompanied wards. In future practice, we should pay more attention to the multiple subjectivities under the unaccompanied model. From the perspective of family-centered care, it is one of the key points for hospitals, especially in the global context of the current epidemic situation. There is no doubt that the unaccompanied model is a development trend for future hospital management models, which requires our continuous innovation and improvement.

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