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Original Study

Hospitalization and Aesthetic Health in Older Adults

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A B S T R A C T

Objectives: To assess the impact of hospitalization on arts engagement among older people; and to assess perceptions of whether hospitals are aesthetically deprived environments.
Methods: A Survey of Aesthetic and Cultural Health was developed to explore the role of aesthetics before, during and after hospital. Study participants were n = 150 hospital in-patients aged >65. Descriptive and inferential statistics were used to analyze the data.
Main findings: Attendance at arts events was an important part of life for this sample and a large drop off was noted in continuation of these activities in the year post-hospital stay. Physical health issues were the main causes but also loss of confidence and transport issues. Film, dance, and music were the most popular arts for this sample prior to hospital stay. Noise pollution caused by other patients, lack of control over TV/radio, and access to receptive arts in hospital (reading and listening to music) were important issues for patients in hospital.
Conclusions: This study identifies a trend for decreasing exposure to arts beginning with a hospital stay and concludes that older people may need encouragement to resume engagement in arts following a hospital stay. There is relatively limited evidence regarding the nature of, and potential benefit from, aesthetics in healthcare and limited studies with rigorous methodology, and further research is needed to understand the aesthetic preferences of older people in hospital.

The arts are an important part of human life and culture, and attract a significant amount of private and public funding, attention, and support.[1–3] While philosophers have engaged with the role and significance of arts in society for thousands of years, recent studies indicate that participation in arts activities and attendance at arts events is associated with health gains[4–6]; emerging evidence also suggests that aesthetic deprivation can be harmful for health and well-being in clinical settings.[7]

Aesthetics is defined, in this study, as the philosophy of the arts; why and how the arts affect us and their role in society.[8] This study examines the role of aesthetics in hospitals. Aesthetics refers to all art forms as defined by the Arts Council of Ireland 2006, including visual art, dance, theater, film, circus, and street theater.[2] The term aesthetics is used as it extends beyond traditional art forms to the role of the arts in all forms, from receptive engagement (for example listening to music on the radio, reading books, watching films) to participative arts (for example painting and playing a musical instrument) as well as engagement in cultural activities from crafts, to traditional native art forms to Western classical arts. The philosophy of aesthetics also encompasses everyday aesthetics, for example the crockery and textiles used in everyday life as well as environmental aesthetics such as the building design, access to nature, and light. These aesthetic experiences may be particularly important in hospitals, where everyday aesthetic experiences are perhaps more significant than access to classical art forms (for example the texture of the bed sheets).[9–11]

Existing literature points to 3 key areas of healthcare in which the arts particularly play a part, namely the arts as a therapeutic or clinical intervention; the arts in building design and environment enhancement and the arts as part of medical humanities training.[12–18]

Aesthetic enrichment such as building design may affect recovery rates and the requirement for pain relief, whereas participative

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arts activities contribute to improved confidence, self-esteem, and motivation of some patients.[19–22] However, the evidence base for all arts interventions in healthcare remains weak, with a need for larger, robust outcome studies to determine the benefit of arts on health and well-being.[20,23–27]

The role of aesthetics in healthcare facilities is a field that is not well understood.[28] In a study of the design strategies of 86 hospitals in Norway, only a few contained any concrete written guidelines or directions for the aesthetic dimension of the infrastructure. A survey of 400 Norwegian patients on 11 aspects of the aesthetics of the hospital indicated that patients were most dissatisfied with a lack of choice of different types of aesthetic input.[29] A study of stroke rehabilitation and music showed less positive outcomes in patients who were not routinely given access to their favorite recorded music.[30] However, no survey could be found that specifically addresses the artistic and cultural interests of patients before, during, and after hospital stay, an understanding of which may promote the development of patient-centered aesthetic reinforcement through arts and health programs.

Older people represent a particularly important focus for study as there is a concern that their ability to maintain aesthetic and cultural capital is impaired by a range of factors, including health and disability.[31] In the home setting, arts, leisure, and culture are important to older people.[32] Therefore, the aim of this study was to conduct a survey on older in-patients' perspectives regarding their aesthetic and cultural preferences, the effect of hospital stay on these activities, and their views on the aesthetics of the hospital environment.

Methods

Participants who had been in-patients in blinded for review hospitals from the period January 2009 to July 2013 were recruited using convenience sampling to participate in a survey. Participants were selected from 2 ambulatory care services in geriatric medicine between January and September 2013. Day hospital services are used when a patient requires at least 2 modalities of medical/rehabilitation care. Referral is from out-patient clinics and in-patient beds. Convenience sampling was used. Every patient attending the day hospital with an in-patient hospital stay of at least 7 days in the last 5 years were eligible for the study. Participants were excluded if their hospital stay in the last 5 years was less than 7 days or were cognitively unable to complete a survey. Informed consent was obtained for every participant. The researchers aimed to complete 150 surveys.

Survey of Aesthetics and Cultural Health

This survey instrument was developed following an extensive period of qualitative research.[12] The survey was divided in 2 sections. Section 1 has 4 questions, which documented which arts events and activities participants had attended in the 12 months prior to hospital stay and in the 10 years prior to hospital stay. Section 1 also documented if participants have difficulty attending these events and activities post-hospital stay and the reasons for these difficulties. These 4 questions were taken directly from a previous survey of public attitudes to the arts, conducted by The Arts Council of Ireland in 2006 with a sample n = 1210 from the Irish general population.[2]

Section 2 consists of 32 statements regarding hospital aesthetics, including noise, access to arts activities in hospital, and the visual art in hospital. All items used were tested utilizing a pilot survey, with reliability testing, content validity testing, and readability testing forming the validation process.

The survey instrument is self-report and includes 2 response style options to items: agree/disagree and yes/no responses depending on the survey questions. See Appendix 1: Copy of Survey of Aesthetic and Cultural Health (SACH).

Assistance was given to individuals where there was evidence of physical or literacy problems. Each person who agreed to participate was taken to a quiet room to complete the survey. A researcher accompanied them, and if they needed assistance, the researcher read out the questions and filled out the form as they answered verbally. Participants were free to ignore questions they did not wish to answer but the researcher checked any blank questions at the end to be sure they had deliberately not answered.

Other Measures

Three standard measures were used to assess mental, cognitive, and physical health levels. The Barthel Physical Function Index,[33] the 3DY Cognitive Test,[34] and the Geriatric Depression Scale.[35]

Data Analysis

Statistical analysis was conducted using SPSS v 7 (SPSS Inc, Chicago, IL). Descriptive statistics included frequency counts. Other

Table 1
Demographic Characteristics of Participants Completing Survey (n = 150)

Demographic Characteristics	n (%)
Age	
65–74	27 (18)
75–84	69 (46)
85–94	50 (34)
<95	4 (2.7)
Gender	
Male	57 (38)
Female	93 (62)
Marital status	
Single	14 (9)
Married	69 (46)
Divorced/separated	7 (5)
Widowed	60 (40)
Working status	
Retired	138 (92)
Unemployed	4 (3)
Full-time homemaker	3 (2)
Other	5 (3)
Education level completed	
No formal education	6 (4)
Primary level	37 (25)
Second level	80 (53)
Third level undergraduate	10 (7)
Third level postgraduate	10 (7)
Still at Third level	1 (1)
Dependents under the age of 18?	
Yes	4 (3)
No	146 (97)
Ethnic background	
White Irish	146 (97)
White Irish traveler	1 (1)
Any other white	2 (1)
All other	1 (1)
Accommodation during hospital stay	
Private room	32 (21)
Shared ward	96 (64)
Both	21 (14)
Don't know	1 (1)
Barthel Index of Activities of Daily Living (score out of 20, with 20 being most physically disabled)	
>10	11 (7)
10–15	22 (15)
16–20	117 (78)
Geriatric Depression Score	
0–4 (low probability of depression)	93 (62)
5–9 (probability of mild depression)	44 (29)
0–15 (probability of severe depression)	13 (9)