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Older people's experiences of vulnerability in a trust-based welfare society affected by the COVID-19 pandemic

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Abstract

The early coronavirus disease 2019 (COVID-19) outbreak inflicted vulnerability on individuals and societies on a completely different scale than we have seen previously. The pandemic developed rapidly from 1 day to the next, and both society and individuals were put to the test. Older people's experiences of the early outbreak were no exception. Using an abductive analytical approach, the study explores the individual experiences of vulnerability as described by older people hospitalised with COVID–19 in the early outbreak. In these older people, we found that the societal context and the individual experiences of vulnerability were inextricable linked. The study demonstrates that despite significant individual stress, informants displayed an interesting ability to also view their situation to reorient their perspective. The experience of vulnerability is both conditional and individual, which imposes a degree of unpredictability that neither they nor others were able to negotiate. The article discusses the phenomenon of unpredictability in light of a modern society with regard to how individuals and society may encounter unexpected events in the future where the potential to reorient will be vital.

KEYWORDS
abductive analysis, modernity, trust, unpredictability, vulnerability

1 | INTRODUCTION

1.1 | A worldwide crisis

During the coronavirus disease 2019 (COVID-19) pandemic, societal conditions were dramatically altered at the individual, national and global levels. Not since World War II have professional and commercial enterprises, political and social institutions and individuals' quality of life been impacted by such a global threat (Ayenigbara et al., 2020; Van der Wal, 2020; Ward, 2020). The lockdown of society during the COVID-19 pandemic has been described as a social crisis or a social experiment (Schippers, 2020). Social relationships were tested, and the authorities' ability to protect their citizens was undermined (O'Flynn, 2021). After the World Health Organisation characterised the COVID-19 outbreak as a pandemic in March 2020, infection rates increased rapidly both in Norway and globally (WHO, 2023). The images from the media left a strong impression; healthcare services globally were on the verge of collapse (Lusardi & Tomelleri, 2020), and the Western world was no exception.

Government considerations and decisions during the pandemic affected freedom, democracy, economics and health—areas that have

direct implications for individuals (Mitrović, 2020; Mulinari et al., 2021). The pandemic reinforced social inequalities (Wall & Bergmann, 2020), but the sociodemographic variables of the population groups impacted by the pandemic are not clear (Jukkala et al., 2021). Discussions of the pandemic and its dramatical social impact are part of an ongoing discourse about modernity. It has been argued that the pandemic was a result either of a failure of modernity or of its inadequacy (Arias-Maldonado, 2020). This claim is supported by the observation that severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) revealed inadequate knowledge, systems and tools to effectively address the ramifications of the virus (Domingues, 2022; Hossain et al., 2023) and by the fact that authorities had to resort to unsophisticated strategies, such as the total lockdown of society, to protect the population from infection, disease and death (Domingues, 2022). Lusardi and Tomelleri (2020) claim that the outbreak of COVID-19 highlighted a discontinuity in modern society. Despite previous pandemics that had serious consequences on both individual and societal levels, pandemics as a phenomenon seemed to have disappeared from our cultural consciousness (Outka, 2020). In that regard, the SARS-CoV-2 pandemic became a 'reminder of premodernity' (Arias-Maldonado, 2020).

1.2 | When the pandemic hit Norway

The first case of SARS-Cov2 in Norway was identified on 26 February 2020, and the first patients were admitted to hospitals during the first week of March 2020. In the following weeks, the rate of hospital admissions increased rapidly (Ihle-Hansen et al., 2020). The first wave of the Norwegian outbreak, which lasted until 1 July 2020, was characterised by respiratory failure and high mortality among hospitalised patients (Myrstad et al., 2022). The majority of the patients admitted during this period were older people.

During the very first phase of the pandemic, we had limited knowledge about SARS-COV-2, and society was not prepared for handling a pandemic. There was a lack of infection control equipment and equipment for testing patients, and authorities feared that intensive care units would become overloaded, resulting in very strict access to both testing and hospitalisation (Myrstad et al., 2022). Nevertheless, compared with many other countries, Norway had relatively few hospitalised patients and deaths due to COVID-19 (Christensen & Lægreid, 2020; Kvinnsland et al., 2021), which is related to its strong national institutions, sound economic situation and high-trust society (Jøranson et al., 2022).

Norway was one of the countries with the strictest infection control measures (Kvinnsland et al., 2021). The Norwegian government introduced a strict national lockdown on 12 March 2020. This lockdown affected the country on social, commercial and individual levels. On the social and commercial levels, universities, schools and businesses were shut down, and employees were required to work from home. Nursing homes and hospitals were closed, which meant that family members were banned from visiting patients. On the individual level, people were advised to wear face masks, wash their hands and avoid hugging and shaking hands with each other. For a time, they were not allowed to meet anyone other than those living in their household. The lockdown resulted in a reduction in infections and hospital admissions after a few weeks and was partially eased 2 months later (Matsen et al., 2022). In the aftermath, one of the main critiques of these measures was their unequal impact on society: The most vulnerable, including children, people living alone and older people had to bear the brunt of the lockdown measures when being forced to isolate (Kvinnsland et al., 2021). In particular, older people who were frail or lived alone and those who were totally dependent on family caregivers and friends were severely affected. Those who lived in nursing homes were isolated from their family and friends. The long-term consequences of the lockdown and isolation remain largely unknown.

1.3 | Aim of the study

The aim of this study was to explore the experiences of vulnerability among home-dwelling older people in Norway who were hospitalised due to COVID-19 during the first phase of the pandemic and to investigate individual responses to these experiences and society's handling of the outbreak.

A trust-based welfare society, like Norway's, experienced discontinuity as a result of COVID-19. The outbreak of COVID-19 had an immediate and dramatic impact on individuals' lives and on institutions. The outbreak impacted experiences of vulnerability (Stangier et al., 2021), and completely new and unpredictable situations of discontinuity occurred and lasted over time. The COVID-19 pandemic has, however, provided unforeseen experiences for individuals and society that can illuminate how to respond to unexpected events in the future. The study aims to contribute to the debate on how this discontinuity might be negotiable.

1.4 | Understandings of vulnerability

The most common approaches to understanding vulnerability are as either a property of an entity or conditional to specific situations or circumstances. The first understanding relies on a narrative of 'vulnerable groups' and their capacity of resilience while the second reflects a narrative of 'vulnerable situations' (Orru et al., 2022). The 'vulnerable groups' narrative has been widely criticised as being too essentialist because it frames vulnerability as an individual characteristic (Kemit, 2018; Orru et al., 2022; Thomassen, 2020). The 'vulnerable situations' narrative is a response to this critique. Belonging to a certain vulnerable group, such as being elderly or having a disability, does not make a person vulnerable per se (Bartlett et al., 2022). Vulnerability is in flux, dynamic and relational depending on the situation and 'cannot be reduced to a single metric for the purpose of classification' (Orru et al., 2022, p. 745). In other words, vulnerability is conditional and contextual (Orru et al., 2023) and is thus strongly influenced by discontinuity.

The COVID-19 pandemic has led to new experiences of vulnerability for individuals (Napier, 2020; Reiersen et al., 2022). The impact of lockdown, distancing and stricter access to healthcare assistance was greater on those who were already endangered due to their fragile relationships (Hansson & Petersson, 2021; Napier, 2020). A German study found that the degree of vulnerability during lockdown, associated with previous experience of illness, was closely related to personal actions in the form of preventive behaviours and that these behaviours facilitated adaptation to the challenges of the pandemic (Stangier et al., 2021). Other studies describe personal preventive behaviours as being influenced by fear of being infected (Lei et al., 2020; Liu et al., 2020). The experience of vulnerability associated with the outbreak of COVID-19 had a strong psychological impact, particularly in the form of depression, anxiety and stress (Jungmann & Witthöft, 2020; Wang et al., 2020). Nevertheless, information and adaptive emotional regulation played significant roles in moderating the level of vulnerability (Jungmann & Witthöft, 2020). Trust is related to the experiences of vulnerability (Petherbridge, 2021). Challenges caused by the COVID-19 pandemic produced new and greater concerns both at an individual and societal level (Kulin et al., 2021), which impacted the population's social and institutional trust (Brück et al., 2020).

1.5 | Norwegians' trust of the authorities during the crisis

The concept of the Nordic welfare state, which is built on principles of solidarity and shared rights, has high legitimacy among the population (Thualagant et al., 2022). The Nordic welfare model consists of robust institutions, laws and regulations designed to meet challenges in society at individual, institutional and social levels (Fløtten & Trygstad, 2020). Trust is a prerequisite for the legitimacy of the welfare state (Reiersen & Torp, 2020). Previous research on the Nordic model confirms that this trust endures in times of crisis (Fløtten & Trygstad, 2020). According to a Norwegian study, institutional trust, particularly related to the health authorities' competence, remained strong throughout the period of infection control measures in 2020–2022 (Wollebæk et al., 2022). This finding is confirmed in a Swedish study showing that both institutional and interpersonal trust endured and even increased (Esaiasson et al., 2021). However, measures affecting social relationships were implemented, which in turn shook the trust-based ideal (Nihlén Fahlquist, 2021). Initially, flexible services were subject to stricter regulations, and access to healthcare services was reduced to a bare minimum. We have previously published findings from the early stages of the pandemic showing that strict criteria affected older patients' access to hospitalisation, with some even being denied hospital admission despite displaying severe symptoms (Jøranson et al., 2022, 2023). Such experiences may alter the basic trust in the social order when the assumed norm no longer exists (Iversen et al., 2021).

2 | METHODS

The study was part of a larger multicentre cohort study in South-Eastern Norway investigating the first phase of the COVID-19 pandemic. This substudy has an explorative and descriptive design with qualitative interviews.

2.1 | Participants and context

Participants were recruited from two of the hospitals in the multicentre study on COVID-19 including hospitalised elderly individuals in the early phase of the pandemic. See Walle-Hansen et al. (2021) for further details on the multicentre study. Six months after hospitalisation and as part of a follow-up consultation with physicians, potential participants were invited to the substudy. All invited participants were considered by the responsible physicians to be physically and cognitively able to participate. Seventeen former hospitalised patients aged 60 years and older from two nonuniversity general hospitals in South-Eastern Norway accepted the invitation (see Table 1 for an overview of participants). The participants were evenly distributed between the two hospitals.

2.2 | Interviews

This substudy has a qualitative approach using semistructured individual interviews. The interviews took place between September and November 2020. Depending on the participants' wishes, the interviews were conducted either at the participants' home or in the researchers' office facilities. Each interview lasted for 1–1½ h, and two researchers (N. N./K. E. H., A. K. T. H./N. J., H. L./G. B.) were present each time. A total of 14 interviews were carried out: 11 individual interviews and three interviews with couples where both spouses had been hospitalised with COVID-19 at the same time. A thematic interview guide with open-ended questions based on three main themes was created and served as the starting point for all the interviews:

TABLE 1 Patient characteristics.

Age (years)	Informant	Number of informants divided by age	Divided by sex (male/female)
60–64	4, 6, 8, 9, 17	5	3/2
65–69	11, 12	2	2/0
70–74	1,7,10	3	2/1
75–79	2,5	2	1/1
80–84	15,16	2	1/1
85–89		0	
90–94	13,14	2	1/1
95–99	3	1	1/0

(1) experiences of being admitted to hospital, interacting with the healthcare system, both during hospitalisation and in the follow-up;
(2) experiences of how to be followed up after the hospital stay and experiences in connection with the rehabilitation and recovery process after COVID-19;
(3) experiences related to changed life situation, consequences of COVID-19 and/or other health-related changes, change in the quality of life.

All interviews were audio recorded and transcribed verbatim.

2.3 | Ethical consideration

The multicentre cohort study was approved by the Norwegian Geriatric Society, and ethical approval was granted by the Regional Research Committee in Eastern Norway (no. 155,425). The approval complies with the Declaration of Helsinki.

In this substudy, only participants from the multicentre cohort study who were able to provide written informed consent were invited to participate. Participants were assured confidentiality and could withdraw from the study at any time without consequences.

2.4 | Abductive data analysis

The first reading of the material identified different examples of vulnerability. A closer reading confirmed the impression of the first reading, and we decided to investigate the content of vulnerability further using an abductive approach. Abductive analysis applies theory as a resource to the empirical material and vice versa. Informants' wording is fused with theory, and theory is used as an interpretation of their wording (Alvesson & Kärreman, 2007). Empirical findings and theory therefore mutually inform each other with theory transcending empirical findings and empirical findings substantiating and serving to produce theory (Alvesson & Sköldberg, 2009, p. 3). In analysing the material, we lean on a theory that views vulnerability as in flux and contextual (Orru et al., 2022). The empirical findings reveal dramatic stories about complex situations, and by drawing on these situations, they contribute to the theoretical understanding of *what* is in flux, dynamic or relational. Abductive analyses involve reading the material supported by a theoretical preconception, which creates an interplay between the empirical findings and theories (Hammersley & Atkinson, 2007). The interplay creates new interpretations based on new observations and readings of the data, creating new sense making (Alvesson & Sköldberg, 2009; Patokorpi & Ahvenainen, 2009).

The phenomenon being investigated in this study is vulnerability, more precisely 'individual experiences of vulnerability'. We further narrow this down to 'older people's experiences of COVID-19 as a vulnerable situation', which we define as the unit of analysis in the study. The unit of analysis reflects our purpose, and defining the unit of analysis strengthens the correspondence between the studied area (older people's experiences of COVID-19 as a vulnerable situation), research interest (vulnerability in a trust-based welfare society) and the overall research process (Matusov, 2007).

2.5 | Findings

The circumstances of the experiences of COVID-19 described by our informants constitute a vulnerable situation. Applying the 'vulnerable situations' understanding of vulnerability, we organise our findings in terms of both contextual and individual sensitivity to vulnerability. We classify experiences of individual vulnerability as loneliness, marginality and reorientation and experiences of contextual vulnerability as vulnerable situations. (Table 2).

3 | THE CIRCUMSTANCES

3.1 | Experiences of COVID-19 as a vulnerable situation

The early outbreak caused limited access to emergency care and COVID-19 tests, particularly in admissions and during hospital stay and after discharge from hospital. The circumstances were different compared with what they used to be.

Admission to hospital was strictly regulated in the early phase of the pandemic. Several informants experienced that the hospitalisation process was unclear to a certain degree, and some even found the situation to be chaotic:

> Even though I was in a very bad shape, I remember that it was very chaotic when I was admitted. There were a lot of people rushing around, and the situation couldn't have been that easy for the hospital either. And in the beginning, several people died there. So, this was, for the doctors and for everyone, something completely new. (Informant 4)

The course of the disease was unpredictable. The informants found themselves in the midst of chaos they did not understand, and even healthcare professionals 'wondered themselves what was happening' (informant 13). The experience of chaos while being

TABLE 2 Experiences of vulnerability.

Contextual vulnerability	Individual vulnerability
Circumstances	Sensitivity to the circumstances
Vulnerable situations	Loneliness Marginality Reorientation

Note: The circumstances and the sensitivity to these circumstances influenced the informants' experiences of vulnerability.

hospitalised was reinforced as patients were exposed to news 'rolled out on all channels' about the rising death toll and overloaded healthcare services in Europe. This news was recognisable and transferable to the informants' own situation, and they recognised that they were taking part in 'something bigger'. Although the authorities had assured Norwegians that the health system was prepared for what was to come, informants expressed their uncertainty and questioned the preparedness of the authorities retrospectively.

When discharged from hospital after a severe illness, older people should be considered for rehabilitation. However, the routines for assessing COVID-19 patients seemed to be strict. One informant expressed that he felt 'extremely lucky' after what he called a 'sieving job' where only a few were offered rehabilitation, a situation which he assumed was caused by the large number of patients in need and limited availability (informant 12).

Several informants described the aftermath of the disease as challenging and causing major problems for normal functioning at home. One informant described the after effects of the illness as intensifying as time went by: 'even if I do all I can, it won't be any better' (informant 17).

3.2 | Individual sensitivity to the circumstances

3.2.1 | Experiences of loneliness

During the illness, the informants were left to themselves in the sense that they had to fight alone; 'this is a lonely disease', as one said (informant 1). Most of the informants expressed that their social life 6 months after their illness still was different from what it used to be. Even when the imposed isolation came to an end, their social life was put on hold because they did not have the strength to be socially active.[1]

> ...having contact with others requires energy, right (...). For the time being, I don't really have that, so I don't really feel the need for it (social contact) because I'm so tired. Today I am maybe 3% active compared with what I was a year ago. That is a huge difference. But that is how it is. (Informant 17)

The informants lacked the energy to host friends and family. Some informants also felt that friends were afraid of being exposed to infection and were hesitant to socialise with those who had been ill, even long after the acute illness phase. For some informants, the social aspect of their life was less important than it had been previously, as they felt they still had a long recovery process.

All informants experienced imposed isolation when being discharged from hospital. In the early phase of the pandemic, there was no defined time frame for the imposed isolation as this was based on the individual's state of health but also driven by the uncertainty in the society. For some, it could take several months after the acute phase to be released from the imposed isolation. One informant was required to isolate for a total of 4 months after discharge from the hospital for reasons he did not know, although he assumed that was the way it had to be (informant 17).

3.2.2 | Experiences of marginality

Several informants said that their experiences with COVID-19 illness had been severe, even extreme. Five informants needed invasive ventilator treatment in the intensive care unit for a long period of time (10–55 days), underscoring the severity of their condition. Moreover, those who did not need a ventilator experienced the illness acutely. Some lost track of the days, finding themselves at the mercy of an unpredictable and unknown situation. The fear of dying was real, and it took different forms. One informant compared her experiences with previous severe illness and found COVID-19 dramatically worse (informant 6), another described his symptoms as feeling as though he was about to drown (informant 7), and a third said he 'wasn't sure this was going to turn out so well in the end' (informant 4). One was simply afraid of being sent home from hospital to die and described the experience of the disease giving her 'suicidal headaches' (informant 9). Another reflected upon what he would leave behind for his family to take care of and that he should have been tidier in life (informant 8).

The severe illness they went through is also expressed by the fact that their experiences from the pandemic activated previous extreme life events. One of the oldest informants described the isolation when being admitted to hospital as evoking associations from the Second World War:

> (I)t brought back very strong memories of something that happened during the war where I was in isolation at the STAPO[2] (...) in solitary confinement. (...) Yes. It just brought back memories. (Informant 14)

Another described her feelings of being lost and at the same time being held by something that would not let her go, an experience she had also had in the past:

> I felt these black tentacles that I have had a lot of when I had depression years ago. They tried to grab me again and again. (Informant 5)

[1]At the time when the interviews took place, in October and November 2020—just before a new severe outbreak, Norway had not been in lockdown for a couple of months and normal life was about to resume.

[2]The State Police shortened STAPO during the German occupation in Norway from 1940 to 1945.

This informant also reflected on the feeling of marginality due to the fear of transferring the virus to others, indicating that it would be difficult to forgive oneself if someone among one's close family and friends became seriously ill. She told us she 'knew' she infected her sister.

3.2.3 | Experiences of reorientation

Despite the descriptions of marginality and loneliness illustrated above, informants also expressed a certain level of gratitude, not only for getting through the disease, somehow, but also for life. The experience of gratitude reflects the informants' experiences of being met by healthcare professionals when the situation seemed to be out of control. One said he felt he was in good hands (informant 2). Another thanked the hospital for their efforts in taking care of him in a time of crisis and said that now that he had recovered, he 'wants to make a change in life' and be 'more present' (informant 5).

A third, who turned 60 while he was ill, reflected on his recovery as a new start:

> …this must be the gift of life, the end of [my] 50 s was one thing, today [I am] on the road to recovery (from a severe illness), this is the start of a new decade. (Informant 8)

One informant underscored his gratitude for being in a relationship. The involvement of his family, who were often in touch, encouraged him to shift his focus from being severely ill to seeing the potential and possibility of taking advantage of training and rehabilitation. The fact that he survived reminded him of the importance of his marriage and to appreciate what he had in life (informant 11).

The woman who 'knew' she had infected her sister (informant 5) expressed great gratitude that her sister recovered well and that this was an immense relief, a relief so big that 'I want to become a new and better person'.

4 | DISCUSSION

The different stories told by our 17 informants provide insights into how our older informants experienced vulnerability in the early phase of the pandemic. Not only did they address concerns related to the disease itself and how it affected them, they also described experiences with different contextual and individual contents. Quotes from our informants express fear, shame and guilt in addition to gratitude and new perspectives on what is important in life. This complexity of feelings is recognised in the theory of vulnerability, which holds that individuals are constantly in motion, contextually sensitive and have personal responses to vulnerable situations (Bartlett et al., 2022; Kemit, 2018).

One central finding in this study is that individuals described their experiences of the circumstances in terms of a social welfare agency beginning to wobble. The study refers to a Norwegian context where access to healthcare services is strongly related to the premises of the welfare state. The Norwegian welfare institutions have been in place for decades, and the public has access to healthcare services mainly covered by tax funds, which support the welfare schemes. In a Norwegian context, people expect healthcare services to be prepared, available, well organised and equally accessible (Christensen & Lægreid, 2020; Fløtten & Jordfald, 2019; Fløtten & Trygstad, 2020). Trust in this context reflects the assumption that individual vulnerability will be met with competence and integrity by the institutions (Gilson, 2006; Straten et al., 2002; Zhao et al., 2019). However, the findings showed that the trust-based relationship between the public and the welfare health institutions was challenged during the COVID-19 outbreak.

All informants in this study were infected by SARS-CoV-2 early in the pandemic and admitted to the hospital. They became actors in a scenario of worldwide chaos unlike anything anyone had ever experienced. In addition, the situation was characterised by the need for extraordinarily strict infection control measures and concerns about a lack of infection control equipment and hospital capacity for intensive healthcare. The national lockdown on 12 March 2020 exacerbated it all. Overnight, the Norwegian context of regularity and orderliness had somehow disappeared, and our findings show that individuals experienced the fear of being left to fend for themselves, or even to die, due to unresolved situations. The collective trust in the Norwegian society was tested by what we argue was a new *unpredictability* being introduced into the society. The unpredictability developed gradually and affected not only those dealing with COVID but also the entire social order (Straten et al., 2002; Zhao et al., 2019). This raised the question of whether a trust-based welfare society like Norway's was capable of coping with unpredictability per se. Unpredictability caused by an external factor, in this case a virus, has been described by scholars as an ontological property, making it an 'operative condition for uncertainty' (MacPhail, 2010, p. 62). This unpredictability is not something either healthcare practice or society can exclude; it needs to be recognised and negotiated. Negotiation implies searching for compromises to respond to what in a given scenario is put into play (Afdal, 2013; Mol et al., 2010). We argue that uncertainty came into play in the scenario of the COVID-19 outbreak. Uncertainty is a significant factor when it comes to negotiating unpredictability in healthcare services or in a well-organised society such as Norway's.

The epidemiological uncertainty related to a new and unknown virus is only part of the scenario of the COVID-19 outbreak. The uncertainty associated with a virus will also have an impact on political, economic, ethical, individual and local aspects of society (MacPhail, 2010; Star, 1985). For instance, society's, the government's, and the healthcare system's responses to the outbreak had an impact on hospital admissions procedures and how individuals experience their contact with the healthcare system. Procedures, including follow-up, were perceived as random, which gave the impression that the provision of healthcare services had become arbitrary. No one could imagine the immediate and comprehensive

consequences of imposed withdrawal from society, either for individuals or for society (Kvinnsland et al., 2021). However, unpredictability was not sufficiently recognised by society in the early outbreak. Our informants experienced chaos related to access to emergency services due to a strict interpretation of prioritisation criteria (Jøranson et al., 2022). Others described disorder during their hospitalisation and that it continued after being discharged from the hospital. Based on our findings, we believe that the COVID-19 pandemic disrupted the trust levels in modern, welfare state healthcare systems, generating contexts of unpredictability and experiences of severe vulnerability for older persons seeking hospital admission. Further, we believe that these findings relate to a failure of modernity where individuals are exposed to completely new situations with regard to what they can expect in a trust-based society, making them extremely vulnerable. Rather than accepting unpredictability, the authorities responded to uncertainty by imposing immediate and general measures. We therefore believe that the welfare state's institutions, to a large degree, did not look for compromises to handle the unpredictability, rather they acted as though unpredictability could be eliminated. Retrospectively, we know this approach failed since unpredictability persisted in the society. Nevertheless, it is worth recognising that the healthcare services groped blindly in response to the measures that were immediately implemented to deal with the overall unclear situation. There was a limited opportunity to investigate whether the measures were sufficient or not. Trust was threatened because the immediacy of the situation was met with a corresponding immediacy, which in turn undermined the conditions that had historically helped to foster trust.

A better understanding of the content of uncertainty might come to light by acknowledging the complexity of the situation the informants found themselves in. By doing so, we can see unpredictability as something which cannot be left out; it is part of the richness of the informants' experiences and something that challenges the values of our modern welfare society. These findings include the chaos they experienced and the loneliness they felt but also what they acknowledged as gratitude for life. Vulnerable situations and responses to these situations developed differently depending on the sensitivity described by the informants. Identifying unpredictability by looking at the context of the informants' experiences allows us to recognise that what is predictable is unpredictability itself. The experiences from the COVID-19 outbreak put this at the forefront, but the recognition of unpredictability is transferable to general applications. Neither society, healthcare services nor individuals can exclude unpredictability from their contexts. Examining the context reveals that while unpredictability causes destabilisation and discontinuity, our findings also show that the situation's unpredictability also motivated the informants to appreciate what they had in terms of relationships and the gift of life. The sensitivity to the circumstances activated unexpected resources that maintained individual continuity. This is an example of what Outka (2020) describes as a paradox of the modern rationalist approach and the strong belief in measures to prevent discontinuity. One consequence of that approach, we argue, is that resources to counteract discontinuity are not sufficiently recognised because the rationalist approach seeks to exclude discontinuity.

During the outbreak, trust was put into play. Scholars describe trust in healthcare services as an intertwining of expectations with inherent vulnerability (Abelson et al., 2009). Trust is relational (Nihlén Fahlquist, 2021). Our findings show that individuals were sealed out for months, symptoms continued to develop for weeks after being discharged from hospital, and the experience of isolation evoked strong memories. We could assume that the complex situation of the informants became too burdensome. However, the way some of the informants reflected on their experiences of vulnerability shows that they also considered these experiences to be a turning point. They searched for compromises by negotiating the unpredictability caused not only by their illness but also by the complexity of illness. And in this search, they found confidence and trust. If we acknowledge that unpredictability is predictable, vulnerability will be less affected by the contextual factors that we are at the mercy of (viruses, systems, how disease unfolds). Vulnerable situations will then turn into situations of possibility. Recognising unpredictability allows us to mobilise resources to fight. With reference to the abductive approach, the unexpected moment (Alvesson & Kärreman, 2007) appears when the experience of vulnerability turns into gratitude as a result of informants' search for compromises.

5 | CONCLUSION

Our study shows that circumstantial context and individual experiences of vulnerability were inextricably linked. For older patients hospitalised early in the outbreak of COVID-19, their individual experiences of vulnerability revealed an experience of not only individual unpredictability but also unpredictability in general. Neither the Norwegian healthcare services nor the Norwegian welfare society were prepared for the COVID-19 outbreak. We argue, however, that what is inherently unpredictable cannot be preregulated, and we address the importance of accepting and negotiating unpredictability to prevent vulnerability. Unpredictability does not just produce destabilisation and discontinuity; when individuals bring their own personal narratives to bear on situations of unpredictability, it allows them to stabilise their understandings of what they have experienced. The ability to negotiate unpredictability is important not only for individuals but also for society and exemplifies what Outka (2020) describes as the paradox of the modern rationalist approach and the lack of consciousness of the awareness of what is precarious or not in our lives. As a response to the narrative of the failure of modernity, accepting unpredictability could generate more nuanced and supportive delivery of care in the future.

AUTHOR CONTRIBUTIONS

All authors developed in the planning of this substudy. Hilde Lausund, Anne Kari Tolo Heggestad, Nina Jøranson, Grete Breievne and Kristi Elisabeth Heiberg collected the data. Hilde Lausund, Anne Kari Tolo

Heggestad, Nina Jøranson and Grete Breievne conducted the main analysis of the data. All authors participated in the discussions about the study findings. Hilde Lausund prepared the first draft of the article. All authors revised the article critically and approved the version to be published. Hilde Lausund, Nina Jøranson and Anne Kari Tolo Heggestad revised the manuscript after review. All authors approved the revised version to be published.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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