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Falls and falling as explanations concerning health and self in older people

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ABSTRACT

FACULTY OF MEDICINE, HEALTH AND BIOLOGICAL SCIENCES

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Doctor of Philosophy

FALLS AND FALLING AS EXPLANATIONS CONCERNING HEALTH AND SELF IN OLDER PEOPLE

by Claire Ballinger

Falling in older people is currently represented as a significant problem warranting attention, in health care research and practice. Within this thesis, discourse analysis is employed as an underpinning methodology to explore this assertion.

An initial literature review suggested that most research to date in the area of falling in older people is based on three problematic assumptions; that a fall is a serious event for an older person; that it is possible to establish an objective reality about causes and consequences of a fall; and that it is possible to prevent a fall.

An initial empirical study aimed to explore how occupational therapists, physiotherapists and older people who had fallen talked about falls and falling. Semi-structured interviews were conducted with a purposive sample of twenty therapists from two NHS trusts, and eight in-patients aged over 65 years with fractured hips (shown to be closely associated with falls), consecutively recruited from an acute elderly care orthopaedic trauma ward over a two month period.

Analysis and interpretation based on discourse analysis principles, suggested that risk featured prominently in therapists' accounts of their work with older people who fall. However, the older service user participants focused on presentation of themselves as deserving, not culpable for their fall, competent and able to manage at home.

Following consideration of theoretical approaches to the study of risk, a second empirical study aimed to explore how risk was invoked, communicated and managed in a day hospital for older people. Data were generated through fifty hours and fifteen minutes participant observation, semi-structured interviews with fifteen older service users and documentary sources, and again analysed according to discourse analysis principles. It was suggested that activity and interaction within the day hospital could be variously cast within three 'frames': the 'medical', 'rehabilitation' and 'social' frames. Risk was constructed within the three frames as threat of bodily harm, threat of loss of independence and challenge to valued social identities, respectively.

Falls in older people were retained as an exemplar in subsequent discussion to illustrate how risk in health has been constituted in technical, positivist terms (or within 'medical' and 'rehabilitation' frames) to the exclusion of social and cultural explanations. It is argued that this has resulted in health care and health promotion activities which fail to recognise older service users' perspectives and priorities and neglect implications for older peoples' social identities.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDICES

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1. Chapter one: Introduction: rationale and context

1.1 Introduction

In the United Kingdom in May 1999, the Department of Trade and Industry, in partnership with the Health Education Authority, launched a major campaign entitled 'Avoiding trips, slips and broken hips'. The aims of this campaign included the raising of awareness about and prevention of older people's falls. The introductory letter to the home safety resource pack accompanying the campaign incorporated the "shocking" statistic that "every five hours an older person is killed as a result of falling in the home" (Department of Trade and Industry and Health Education Authority 1999). Included in the pack were fact sheets about older people in the community, guidance for professionals, a poster, and information leaflets targeted at both older people themselves, and their friends, neighbours, relatives and carers.

The identification of falls in older people as an area warranting attention has been apparent in two influential health White Papers produced both by the current Labour administration and the previous Conservative government (Department of Health 1992, Department of Health 1999). The 1992 White Paper, 'The Health of the Nation: a Strategy for Health in England', included a specific target to reduce the death rate from accidents in people aged 65 years and over by at least 33% by the year 2005. Figure 7.5 in the latest White Paper (Department of Health 1999) indicates that deaths from accidental falls amongst older people are not reducing (based on data from the Office for National Statistics), in spite of this previous target. The more general aim of reducing the death rate from accidents by at least one fifth and rate of serious injury as result of an accident by at least one tenth by the year 2010, is included in this 1999 White Paper.

One of the major injuries sustained as a consequence of a fall in older people is a fractured hip. In 1995, it was estimated that hip fractures cost United Kingdom hospital services £250 million per year (Audit Commission 1995), and people with hip fractures account for 20% of all orthopaedic beds (Kisely 1996). The number of hip fractures is predicted to rise by a minimum of 33% by the year 2016 (Royal

College of Physicians 1989). Some of the epidemiological information concerning morbidity and mortality associated with falls is considered in chapter two of this thesis. Falling, then, is currently represented as a major problem, with huge costs; "emotional, social and financial" (Department of Trade and Industry 1999). As the Department of Trade and Industry campaign suggests, it is also seen as a problem about which something might be done.

However, other major causes of mortality in older people have not always been consistently viewed or described in this way. Pneumonia, for example, was known in common parlance as "the old man's friend", suggesting that for some at least, death through illness or disease was accepted, commonplace and even welcomed (Barnitt 1999).

It is this divergence of perspectives which provides a starting point for this thesis. The possibility that a fall could be viewed in a number of different ways potentially challenges the prioritising of falls among older people as a public health issue, and the allocation of large resources to try and prevent them. A focus on this divergence and the reasons for it might also reveal insights into how what passes as 'knowledge' about health, ageing and even the self is created.

1.2 Presentation of older people who fall to medical and social care services

This section provides a brief overview of how people who fall receive medical and social care. In later chapters, the biomedical construction of falls as a problem is questioned. However, information about medical treatment is included in this introductory chapter as the two empirical studies described subsequently were located in health care settings. The following description therefore provides a context for this work.

The majority of older people who fall do not require any medical attention (Downton and Andrews 1991). The minority of people requiring intervention will present to medical and social care services in a variety of different ways. The

service they receive will vary, depending on the environment in which they are treated, the perceived priority of the fall, and their other needs.

If the fall results in trauma, for example a fractured hip, the most likely route to medical attention is via the Accident and Emergency department of the nearest general hospital. The general principle for management of lower limb fractures in older people is immediate surgery, followed by early post operative mobilisation. Prior to operation, the patient will generally be transferred to the care of an orthopaedic surgeon, and may well receive input from a geriatrician (Downton 1993).

Hip fractures are usually treated through internal fixation, involving reduction of the fracture and insertion of pins or screws through the head of the femur. With more complex fractures, the head of the femur may be replaced with a prosthesis, or a total hip replacement carried out (Apley and Solomon 1993). A period of rehabilitation involving input from nurses, occupational therapists and physiotherapists ('therapists') is recommended following surgery (Downton 1993).

Older people who fall may also be admitted to general medical or elderly care wards usually via the Accident and Emergency department, or their own general practitioner (Bennett and Ebrahim 1995). This may occur particularly if the cause of their fall is unclear or complex, or the fall is secondary to other problems requiring hospital admission. Specific diseases associated with falls include epilepsy, Parkinson's disease, myopathies and peripheral neuropathies, cardiogenic syncope, cervical spondylosis, normal pressure hydrocephalus, dementia and hypotension. "Falling syndromes" include multiple sensory deficits, cerebrovascular disease, frontal lobe gait and balance disorder and drop attacks (Downton 1998: 1362).

General practitioners may encounter older people who fall, perhaps within the context of minor injuries which do not require treatment in hospital or through the general practitioner contract introduced in 1990 which requires that general practitioners offer a home visit and assessment to all people aged 75 years and

over. Within primary care, assessment and treatment pertaining to the problems of falling might focus on areas of vision, gait, mobility and review of medication (Downton 1993).

Within social services, inclusion of mention of a falls in a referring letter is one of the criteria for awarding the referral a priority designation in some areas (personal communication, D Sims). Such referrals would usually include the social services occupational therapist, whose remit includes modification of the home environment to facilitate everyday functioning and also improve safety (Bull 1998).

1.3 Therapist contact with older people who fall

Therapists work with older people who fall in any one of the four types of setting described in the previous paragraphs, although in general physiotherapists are not employed within social services. Their interventions will depend on their discipline and training, the priority awarded to different patient needs, the resources and equipment they have and the time available to work with patients. The Audit Commission (Audit Commission 1995) for example found that rehabilitation provision for elderly patients following hip fracture varied considerably across nine hospitals, and concluded that it was 'rare ... for rehabilitation services to be designed to meet the whole range of needs' (Audit Commission 1995: 42). In general terms, physiotherapists' work with people who fall tends to be orientated to balance, gait and mobility, whilst occupational therapists tend to focus on activities of daily living and the environment (see chapter two).

Therapists are becoming increasingly involved in primary care, and specialist falls prevention initiatives (eg Clemson, Fitzgerald and Heard 1999, Hagedorn, McLafferty and Russell 1998, McIntyre 1999, O'Brien, Pickles and Culham 1999, Piotrowski Brown 1999). The importance of their contribution in working with older people who fall has been acknowledged by their respective professional bodies, the College of Occupational Therapists and the Chartered Society of Physiotherapists, who have endorsed guidelines for this work (Simpson, Harrington and Marsh 1998, Simpson, Marsh and Harrington 1998). These

guidelines were recognised more formally by the Department of Health, who funded a national audit of therapists' work with older people who fall, completed in 1999 (Anderson, Tobin and Sealey 1999).

1.4 Personal interest

My interest[1] in this area arose both through my clinical experience as an occupational therapist working with older people and as an academic. As a Lecturer in Occupational Therapy, I joined a multi-disciplinary group in the mid 1990s, working to generate research proposals in the area of falls prevention in older people. The group included representatives from the disciplines of public health, geriatric medicine, health psychology, occupational therapy and physiotherapy. In looking to contribute to the design of a multi-disciplinary intervention to prevent falls, I reflected back on my admittedly limited clinical experience with older people as a practising occupational therapist almost a decade earlier. However, I could not remember using any assessments or interventions specifically developed to address falls, nor recall it as a problem which was specifically recognised at this time. I therefore agreed to review the occupational therapy literature to determine what work had been done in this area within the profession. As we reported back to the larger group, I was struck by how our professional disciplines appeared to determine the nature of the interventions each of us proposed. Balance and mobility was seen to be the domain of the physiotherapists, the public health physician focused on combinations of medications and as an occupational therapist, I reflected the emphasis within the occupational therapy literature on environmental modification. These individual contributions appeared to reflect our professional understandings about the causes of falls.

In reviewing the literature for inclusion in the background section of a grant proposal, I also noted that there appeared to be no papers reflecting the perspective of older people about the causes or significance of a fall. In addition, our efforts to design an intervention became increasingly problematic as we

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[1] In general, passages in first person indicate personal perspectives and reflections of the author.

wrestled with the many methodological difficulties encountered in researching this topic, such as how to define a fall, and how to select a group with whom to target an intervention. I therefore concluded that it would be both interesting and fruitful to investigate how the different parties in the therapeutic encounter (ie older people and therapists) make sense of falls, the importance they attribute to them and latterly how falls feature in explanations about risk and self within health care settings for older people. These interests are reflected more formally as aims for the two empirical studies in this thesis in chapters five and seven.

1.5 Plan of thesis

This current chapter (chapter one) has introduced the topic of falls in older people and illustrated how falling has become a priority area for intervention in current health policy. The contexts within which older people who fall are seen and treated have also been briefly described. This chapter has also provided information about how therapists work with this group and demonstrated how falling in older people came to be the focus of this thesis.

Chapter two provides an overview of the literature, initially from a chronological perspective, before identifying three main assumptions underpinning biomedical research in this area. These assumptions are then shown to be problematic, and the chapter concludes by focusing on those few studies which have attempted to explore falls from the perspective of older people.

Chapters three and four provide a rationale for and describe the theoretical and methodological context for this thesis. Chapter three focuses on discourse analysis, contrasting the two main schools using discursive approaches in social psychology in the United Kingdom, and showing how this thesis draws on method and theory from both. Criteria for evaluating qualitative research are discussed, and some potential difficulties with discourse analysis as a methodology are identified. Chapter four discusses the specific methods used in more detail; semi-structured interviews, participant observation, analysis of documentary sources, use of mixed methods and transcription, and also considers the use of computer

software packages in qualitative analysis. An initial study which aimed to explore how both therapists and older people with fractured hips talked about falls and falling in an acute health care setting is next described in chapter five. A brief overview of the current theories about risk and health is provided in chapter six, thus provided a theoretical context for a second study described in chapters seven and eight. This study explored how risk was perceived and managed in a community health care setting for older people. Finally, chapter nine discusses both studies in relation to previous work. Implications of this study for both research and practice are discussed. Shortcomings in this work are highlighted before the identification of conclusions and recommendations.

2. Chapter Two: Falls in older people - the biomedical perspective. A literature review

2.1 Introduction

Following the introduction of the topic in chapter one, the literature relating to falls in older people is reviewed in this chapter. The aims and search strategy are first clarified, and a rationale provided for the inclusion of papers in this chapter. The review is then presented, firstly in chronological order of publication, followed by an exploration of the three main assumptions underpinning research in this area to date. These assumptions are then critiqued. Several papers are next considered in more detail, and finally the summary reiterates the main limitations with the literature to date.

2.2 Aims and search strategy of the literature review

The aims of the literature review were as follows:

- to explore and describe how the 'problem' of falling has been constructed within research to date
- to identify papers focusing on the experience of falling from the perspective of older people
- to highlight limitations within the literature to date

Whilst an association of falling with hip fractures has been illustrated, the review did not explore the hip fracture literature, excepting those papers identified using the key words identified below.

The following electronic databases were used to search the literature:

- MEDLINE EXPRESS (years 1966 to present)
- EMBASE (years 1980 to present)
- Bath Information and Data Services (BIDS) Social Science Citation Index (SSCI) (years 1981 to present)

- Cumulative Index to Nursing and Allied Health Literature (CINAHL) (years 1982 to present)

These databases were selected on the basis that they cover a broad spectrum of literature ranging from biomedical to the social sciences. EMBASE and CINAHL include therapy and nursing literature which is not represented as extensively in MEDLINE EXPRESS. In addition, these databases are those most likely to be accessed by health professionals working with older people who fall, and therefore both reflect and influence clinical practice and policy in this area. These electronic databases have all been searched from the date of their inception.

The search was limited to papers in the English language and, depending on the thesaurus of the individual database, the following keywords were used:

- MEDLINE EXPRESS: 'accident*[1]', 'falls', 'aged'
- BIDS EMBASE: 'accident*', 'falling', 'aged'
- BIDS SSCI: 'fall', 'elderly'
- CINAHL: 'falls', 'accident*', 'aged'

In addition, relevant papers and reports drawn to my attention by colleagues and other postgraduate students have been included in this review.

This search strategy generated a large number of papers, and the review presented here is therefore necessarily selective. In general, the criteria for inclusion of papers in this chapter are that they:

- are widely cited
- are review papers
- have been selected as representative of literature in a particular area (eg papers focusing on research into falling within the therapies, section 2.3.5)
- they are the only examples of their kind (eg papers exploring the experience of falling, section 2.6)

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[1] The symbol '*' is used to denote any truncation of the word to which it is attached. In this example, 'accident*' will identify 'accident', 'accidents' and 'accidental', for example.

2.3 Development of research into falling in older people in chronological order of publication

2.3.1 Incidence and physical consequences of falling in older people

Early work in the 1970s and 1980s focused on the extent to which falling occurred amongst elderly people. Widely cited studies state that around 30% of people over 65 living in the community will fall each year (Campbell, Reinken, Allan and Martinez 1981, Prudham and Grimley Evans 1981), rising to around 40% in the 75 years and over age group (Downton and Andrews 1991).

An early review of the literature by Perry (1982) identified 22 research papers exploring falling amongst older people. The review confirmed the incidence of falls of around one third in older people, and suggested that female gender and increasing age were associated with falling, findings reported in many other studies (eg Downton and Andrews 1991, Gryfe, Amies and Ashley 1977, Prudham and Grimley Evans 1981). This review also suggested that there were two groups of older people who experienced falls; younger healthier older people, whose fall tended to be associated with 'environmental factors' and older sick elderly people, whose falls tended to occur because of 'host factors'. These two groups were also identified in a commentary on falling by Grimley Evans (1988), who suggested that falls for the younger group tended to occur outdoors, whilst those for the older group, indoors. Perry's (1982) review also acknowledged the implications of looking at different populations of older people (eg those living in the community, those in institutions) in researching the epidemiology of falling.

Until comparatively recently, the focus of outcomes of fall has been on readily observable physical factors; soft tissue injury, fracture and death. Consequences of a fall for an older person in terms of physical damage sustained can vary immensely; Gryfe et al (1977), in a widely cited longitudinal study of active institutionalised people aged over 65, identified that injury of some sort occurred in

approximately half of those who fell, a finding supported in a later study by Downton and Andrews (1991). Nevitt, Cummings, Kidd and Black (1989) and Tinetti, Speechley and Ginter (1988) also investigated physical injuries resulting from falls, and a table summarising and contrasting the findings of these studies is shown over:

Table 1: Summary and comparison of studies reporting soft tissue injuries and fractures resulting from falls

Author, date and country	Study design	Sample	Total number of falls	Hip/femur fracture (% of total falls)	Other fracture	Severe soft tissue/major injury excluding fractures	Minor soft tissue injury
Gryfe et al (1977) (Canada)	5 year prospective study	441 people aged >65 years, 'active ambulatory' and residing in institution	651	1%	5%	11%	28%
Nevitt et al (1989) (USA)	1 year prospective study	325 community dwelling persons aged ≥ 60 years with history of falling	593 falls reported, 539 met study definition, 490 'non-syncopal' falls analysed	0.2%	3%	1%	56%
Tinetti et al (1988) (USA)	1 year prospective study	336 community dwelling people aged ≥ 75 years	272	1.5%	6%	4%	Not reported

In a widely cited paper, Lucht (1971) estimated that approximately 0.15% of people over 65 die each year as a result of accidental falls. Because of the different ways information sources relating to mortality record and categorise information, direct comparisons with other causes of death are difficult. However, in focusing on accidents, the Department of Trade and Industry and Health Education Authority (1999: Guidelines for professionals who work with older people) conclude that falls are "a major cause of death and disability in older people", basing this statement on Home Accident Surveillance System figures (Department of Trade and Industry 1998).

2.3.2 Risk factors for falls in older people

As indicated in the previous paragraph, alongside research exploring the extent of and problems associated with falling, early work also focused in identifying causes of falls. Retrospective studies (eg Campbell et al 1981, Prudham and Grimley Evans 1981) provided some information about factors associated with falling based on self report of older person experiencing the fall. Increasingly, however, reliability of reporting of falls was identified as a problem (Cummings, Nevitt and Kidd 1988) and cross sectional studies (eg Blake, Morgan, Bendall, Dallosso, Ebrahim, Arie, Fentem and Bassey 1988) considered insufficiently rigorous. Prospective studies (eg Campbell, Borrie and Spears 1989, Tinetti et al 1988) came to be favoured as more methodologically sound. Much of this early work laid the conceptual frameworks for subsequent research in this area.

Whilst many papers acknowledge the complexity of determining causes of falls, often preferring to focus on 'risk factors' for falling, there remains a dominant epistemology of causes of falling, broadly comprising characteristics pertaining to the individual and environmental aspects. Each of these will now be discussed in more detail.

Falls associated with characteristics of the individual have sometimes been called 'internal' (Campbell et al 1989), 'intrinsic' (Nevitt 1991) and the individual aspects

described as 'host factors' (Cwikel and Fried 1992). Until fairly recently, the vast bulk of this work has focused on physical characteristics of people who have fallen, "...producing a greater knowledge and understanding about the risk of falling associated with intrinsic, predisposing factors compared with situational, acute, and episodic risk factors" (Nevitt 1991: 479). A large range of impairments and disorders have been implicated and various typologies have been developed to describe a variety of different problems, ranging from the relatively simple (eg Erasmus Fleming and Pendergast 1993) to the complex (eg Rubenstein, Robbins, Josephson, Schulman and Osterweil 1990). A recent review of 52 studies examining risk factors for falls (Myers, Young and Langlois 1996) summarised risk factors in the following nine categories, reflecting the heavy emphasis in the literature on physical and functional characteristics:

- general physical functioning
- gait, balance and physical performance
- musculoskeletal and neuromuscular measures
- demographic factors
- sensory impairments
- medical conditions
- indicators of general health
- medication use
- psychological, behavioural, social and environmental factors

Studies looking at causes of hip fracture, already demonstrated to be closely linked with falls in the introduction, have focused even more exclusively on physical aspects (eg Cummings, Nevitt, Browner, Stone, Fox, Ensrud, Cauley, Black and Vogt 1995, Lord, Sambrook, Gilbert, Kelly, Nguyen, Webster and Eisman 1994).

The role played by factors other than the individual in precipitating a fall, often characterised as 'external' (Campbell et al 1989), 'extrinsic' (Lach, Reed, Arfken, Miller, Paige, Birge and Peck 1991) or 'environmental' (El-Faizy and Reinsch 1994) is gaining more recognition within the falling literature. A particular focus has been the home environment, and the identification of precipitating hazards for

falls (Ashley, Gryfe and Amies 1977, Josephson, Fabacher and Rubenstein 1991, Tideiksaar 1986).

The relative contributions of factors relating to the environment ('extrinsic') to the incidence of falls in some prospective studies are illustrated in the table over:

Table 2: Summary and comparison of prospective studies reporting contribution of 'extrinsic' factors to the incidence of falls

Author, date and country	Length of prospective study	Sample	Total number of falls	Percentage of falls in which 'extrinsic' factors were implicated	Specific factors mentioned
Campbell, Borrie, Spears, Jackson, Brown and Fitzgerald (1990) (New Zealand)	1 year	761 community dwelling people aged ≥ 70 years	507	21% ('trips and slips caused by objects')	'Loose mats, chair, electric cord, footpath irregularity, steps, ramp, miscellaneous objects'
Lach et al (1991) (USA)	1 year	1358 community dwelling people aged ≥ 60 years	366	55%	'Slipping on slippery surface' and 'tripping over discrete objects'
Nevitt et al (1989) (USA)	1 year	325 community dwelling persons aged ≥ 60 years with history of falling	593 falls reported, 539 met study definition, 490 'non-syncopal' falls analysed	47%	'Stairs or tripping and slipping hazards'
Tinetti et al (1988) (USA)	1 year	336 community dwelling people aged ≥ 75 years	272	44%	'Objects tripped over, stairs, snow or ice'

In a review of nine studies, Josephson et al (1991) identified that a mean of 38% of falls were caused by 'Accident/environmental-related' factors (range 12-53%).

2.3.3 Psychological and social aspects of falling

Comprehensive reviews of the falls literature have highlighted the lack of research into 'psychological and social factors' (Askham, Glucksman, Owens, Swift, Tinker and Yu 1990, Kellogg International Work Group on the Prevention of Falls by the Elderly 1987, Lilley, Arie and Chilvers 1995) both as risk factors for falls, and consequences of falls. Early papers commented anecdotally on the toll of falls on sense of well being (eg Prudham and Grimley Evans 1981) but such factors have not been investigated systematically until fairly recently.

Falls in older people have been associated with diminished cognitive abilities (eg Tinetti et al 1988) and anxiety and/or depression (eg Downton and Andrews 1991). The 'post fall syndrome' was first identified by Murphy and Issacs (1982) and 'fear of falling' is emerging from the biomedical literature as a discrete entity with its own definition and detection tests (Tinetti, Mendes de Leon, Doucette and Baker 1994, Tinetti, Richman and Powell 1990, Vellas, Cayla, Bocquet, de Pemille and Albarede 1997).

There remains a paucity of literature investigating the association of social factors such as housing and poverty with falling (Lilley et al 1995). Individual studies have shown an association between increased number of falls, or poor recovery from falls, and reduced staffing levels in care homes (Blake and Morfitt 1986), outside toilets (Wickham, Cooper, Margetts and Barker 1989), changes in housing conditions (Luukinen, Koski, Kivela and Laippala 1996) and the presence of grandchildren in the home (Grisso, Schwarz, Wolfson, Polansky and LaPann 1992). However, the scope of such studies remains the exception, and they have not led to major new lines of inquiry.

2.3.4 Prevention of falls

Following early work to establish the epidemiology of falling in older people, the 1990s have seen an increase in the number of studies testing interventions to reduce the incidence of falling among various groups of older people. Recognition of the need to promote clinical effectiveness in health care (NHS Executive 1996) has led to a renewed emphasis on methodological rigour in research into falls and their prevention. An 'Effective Health Care' bulletin (Nuffield Institute for Health and NHS Centre for Reviews and Dissemination 1996) investigating prevention of falls in older people reviewed only randomised controlled trials, and identified thirty six such studies. These included a series of trials carried out between 1990 and 1993 at seven sites in the USA, known as the 'FICSIT' ('Frailty and Injuries: Cooperative Studies of Intervention Techniques') studies (a study at site seven was not a randomised trial, and not therefore included). The table over, based on a table in Ory, Schechtman, Miller, Hadley, Fiatarone, Province, Arfken, Morgan, Weiss, Kaplan and the FICSIT group (1993), demonstrates the range of interventions tested within the FICSIT studies.

Table 3: Brief description of interventions included in FICSIT series of trials to prevent falls among older people (Ory et al 1993)

Site	1: Portland	2: New Haven	3: Seattle	4: San Antonio	5: Atlanta	6: Boston	8: Farmington
Intervention	Endurance exercise group and modification of environmental risks at home	Behavioural and medication changes, education and exercise	Resistance and endurance training	Physiotherapy: general conditioning and functional activity training	Static balance exercise and dynamic exercise (Tai Chi)	Resistance training and nutritional supplement	Balance and resistance training

These interventions are broadly illustrative of intervention trials to prevent falls to date, being focused on exercise, environmental modification, and nutritional supplements, either individually, or in combination. The pooled results of these seven trials illustrated that people assigned to the exercise groups had a 10% reduced risk of a fall, when compared to controls (Province, Hadley, Hornbrook, Lipsitz, Miller, Mulrow, Ory, Sattin, Tinetti and Wolf 1995).

Of the seven randomised controlled trials focusing on home assessment and surveillance interventions reported in the 'Effective Health Care' bulletin (Nuffield Institute for Health and NHS Centre for Reviews and Dissemination 1996), five were carried out in the United States of America and one in Canada. A striking differences between practice in the United Kingdom and North America in terms of environmental assessment and modification is that this area is not usually seen as falling within the remit of occupational therapists in the United States and Canada. The majority of home assessments in these trials were therefore carried out by nurse practitioners. The results generally did not demonstrate any statistically significant differences between control and participant groups, with the exception of Tinetti, Baker, McAvay, Claus, Garrett, Gottschalk, Kock, Trainor and Horwitz (1994), in which the intervention was multifactorial.

The most recent review of interventions to reduce the incidence of falling in the elderly from the Cochrane Centre (Gillespie, Gillespie, Cumming, Lamb and Rowe 1998) also focused on papers describing randomised controlled trials, classified according to prescribed criteria. Main results from the eighteen trials and one meta-analysis (Province et al 1995, discussed above) included in the review suggest that exercise alone does not protect against falls. However, interventions targeting multiple risk factors were more successful.

Two randomised controlled trials of interventions to prevent falls reported since publication of the 'Effective Health Care' bulletin, and not included in the Cochrane review, have demonstrated larger intervention effects (Campbell,

Robertson, Gardner, Norton, Tilyard and Buchner 1997, Close, Ellis, Hooper, Glucksman, Jackson and Swift 1999). Intervention in the former study comprised home exercise programmes. The latter study was based in the United Kingdom and the intervention comprised both medical and occupational therapy assessment.

2.3.5 Therapy interventions and falling

As suggested in the previous section, research into prevention of falls in the current decade has also developed within the two disciplines of occupational therapy and physiotherapy. In general, physiotherapy has focused on exercise and gait assessment and intervention (eg Skelton and McLaughlin 1996, VanSwearingen, Pashcal, Bonino and Yang 1996) and more particularly balance (eg Bogle Thorbahn and Newton 1996, Heitmann, Gossman, Shaddeau and Jackson 1989, Meldrum and Finn 1993, Shumway-Cook, Baldwin, Polissar and Gruber 1997). However, a review of balance assessments has also been included in the occupational therapy literature (Whitney, Poole and Cass 1998).

The occupational therapy journals reflect the professions' focus on environmental assessment and modification, in considering falls prevention (eg Clemson, Cumming and Roland 1996, Clemson, Roland and Cumming 1992, Clemson, Roland and Cumming 1997, El-Faizy and Reinsch 1996, McLean and Lord 1996), although a widely cited paper discusses the necessity of broad ranging interventions including education, environmental safety, discussion about risk-taking behaviours, assertiveness training and physical fitness (Walker and Howland 1991).

Other recent work within the therapy and rehabilitation press has focused on preparing older people to manage their fall (Reece and Simpson 1996, Simpson and Mandelstam 1995).

2.3.6 Instruments to predict falls

A third direction in which research into falling has developed, in addition to falls prevention and therapy interventions, is the development of instruments which can predict those older people most at risk of falling. Two such fall risk assessment tools reported recently in the literature are the STRATIFY (Oliver, Britton, Seed, Martin and Hooper 1997), for hospital in-patients, and the Elderly Fall Screening Test (Cwikel, Fried, Biderman and Galinsky 1998) for older people living in the community.

2.4 Assumptions underpinning research into falling amongst elderly people

In this section, the assumptions underpinning research in this area are highlighted, together with evidence to support these assertions.

2.4.1 Assumption one: A fall is a serious event for an older person.

One of the most striking points to emerge from the literature is that falls in older people represent a serious public health problem, with expensive implications for health services.

Downton (1993, Preface) describes falls as one of the 'Geriatric Giants', and Campbell et al (1990: 140) conclude that falls are a "marker of underlying morbidity and increased likelihood of death". In focusing on the consequences of a fall, Shumway- Cook et al (1997: 813) state that these are "often devastating", and that even those falls not resulting in injury "often begin a downward spiral of fear". Campbell et al (1989: M117) describe a cycle of "falls - loss of confidence - increasing inactivity and weakness - further falls".

Older women in particular are often characterised as particularly vulnerable. Campbell et al (1989), using a logistic regression model, illustrated how the relative risk of falling increased from 1.2 for women aged 75-79, to 2.5 for those

aged 80-89 years, to 8.1 in women aged 90 and over. Thus for these older women, the risk incurred by virtue of their gender and age for falling was second only to that of stroke. The perception of women at risk has persisted to the extent that some interventions have been targetted and trialed solely with women (eg Campbell et al 1997, Lord, Ward, Williams and Strudwick 1995).

A close association between fall and hip fractures has been illustrated previously. Hayes, Myers, Robinovitch, Van den Kroonenberg, Courtney and McMahon (1996: 77S) describe hip fractures as a "public health problems of crisis proportions", arguing that hip fractures account for much of the disability, death and medical costs associated with falls. At the conclusion of this paper, the worldwide prevalence of hip fractures is described as an "epidemic" (Hayes et al 1996: 84S).

The exact costs of falls in terms of resource use of the National Health Service and Social Services is difficult to quantify. Alexander, Rivara and Wolf (1992) estimated the cost of fall related injuries to people aged 65 and over in Washington State, USA, at $53 346 191 (or £33 341 369 at 1998 exchange rates) in 1989. Recent work into the direct cost of hip fractures in England and Wales by Hollingworth, Todd and Parker (1995) has predicted a rise of £72 million pounds from £288 million in 1991 to £360 million in 2011.

Cumulatively, this implies that falls are undesirable events for older people, and the selection of falls in older people as the subject of a Cochrane Systematic Review (Gillespie et al 1998) and an 'Effective Health Care' bulletin (Nuffield Institute for Health and NHS Centre for Reviews and Dissemination 1996) suggests that the Department of Health in the United Kingdom shares this perception.

2.4.2 Assumption two: a fall is an event with an objective reality

Although difficulties in terminology have been acknowledged (eg Nevitt 1991, Lilley et al 1995), the objective reality of a fall has been treated largely as an unproblematic phenomenon. Some studies have not reported a definition of what was accepted as a fall (eg Clemson et al 1996, Cwikel, Kaplan and Barell 1990), presumably relying on common-sense understandings about what constituted such an event. A common definition of a fall was used across the sites participating in the FICSIT studies in the USA ie '"unintentionally coming to rest on the ground, floor or other lower level". Coming to rest against furniture, wall, or other structure does not count as a fall' (Buchner, Cress, Wagner, de Lateur, Price and Abrass 1993: 300). This definition has also been adopted in other studies into falling (eg Campbell et al 1997).

As has been indicated, some investigators have attempted to categorise different types of falls, according to precipitating factors. Lach et al (1991) have argued that clarification of type of fall allows for better description, and identification of risk factors pertinent to different types of falls. The classification of falls into those caused by 'external' or 'extrinsic' factors and those precipitated by 'internal' or 'intrinsic' factors is widely recognised within the literature (eg Campbell et al 1989, Erasmus Fleming and Pendergast 1993, Lach et al 1991) and use of these terms persists in current research reports (eg Luukinen et al 1996, Myers, Powell, Maki, Holliday, Brawley and Sherk 1996). Although prospective studies in this area are now the norm, many still rely on retrospective reporting by person experiencing the fall in determining information about the occurrence of a fall, in the absence of the event being witnessed by another individual (eg Campbell et al 1997, Wolf, Kutner, Green and McNeely 1993).

In general, the perspective of the researcher in determining and classifying falls has been pre-eminent, with the exception of a few studies (reviewed in the final section), in which the description of and attribution for the fall by the person experiencing it has been the main focus of interest. Where there has been any

disparity, the perception of the researcher has generally dominated. Campbell et al (1990: 139), for example, report that men were more likely than women to "deny" having falling, and that details about the fall were often determined through discussion with a wife, observer, or only after close questioning. In determining cause of fall, Wild, Nayak and Issacs (1981: 157) concluded that "patients' statements, even when most carefully listened to, are not of themselves a very good guide", and that "fallers are rarely sufficiently aware of what happened, or sufficiently articulate in their description, to provide doctors with the necessary information". They therefore disregarded comments from older people in formulating their classification system of falls. In reporting (or not reporting) falls, the "notorious forgetfulness of the elderly" (Gryfe et al 1977: 207) and the "limited accuracy of (their) recall" (Cummings et al 1988: 613) has been alluded to many times (eg Downton 1993, Kellogg International Work Group on the Prevention of Falls by the Elderly 1987).

Falls, then, are represented as discrete, objective events, with causes which are identifiable, although the older person experiencing the fall may not be able to contribute much to their understanding.

2.4.3 Assumption three: A fall can be prevented.

A natural corollary of assumptions one and two is that falls in older people can and should be prevented.

As indicated in the section detailing the development of research in falling, interventions designed to prevent falls are now the object of much work in this area, after this gap was highlighted in major reviews (Askham et al 1990, Kellogg International Work Group on the Prevention of Falls in the Elderly 1987, Lilley et al 1995).

There is evidence suggesting that both exercise interventions and interventions which include modification of home environment have some success in reducing falls amongst older people (Campbell et al 1997, Close et al 1999, Wolf, Barnhart, Kutner, McNeely, Coogler, Xu and the Atlanta FICSIT group 1996). A multifactorial intervention has also reduced incidence of falls (Tinetti et al 1994), and further analysis has succeeded in identifying the relative contributions of the various factors to the overall success of the package (Tinetti, McAvay and Claus 1996).

Close et al (1999: 96) felt sufficiently confident about the results of their intervention to recommend "that there is now a strong case to incorporate falls and injury prevention strategies of proven efficacy into routine clinical service".

2.5 Critique of assumptions underpinning research into falling in older people

The main assumptions which underpin the vast majority of papers focusing on this topic have been clarified in the previous section. It is suggested, however, that these assumptions, whilst appearing rational, are problematic, and have served to develop research and clinical practice in particular directions which are not necessarily warranted.

In this section these assumptions will be critiqued. Each assumption will be reiterated, before evidence which challenges their veracity is discussed.

2.5.1 Critique of assumption one: A fall is a serious event for an older person

Studies such as those cited have been used to construct a fall in an older person as a potentially dangerous event, liable to have serious consequences for the individual and for society. However, falls are very common and occur as much among fit and active older people as those who are more frail (Downton and Andrews 1991). They report that although injuries are common, they are usually not serious, and the majority of older people who fall do not require medical

attention. Hindmarsh and Estes (1989: 2217) also state that "most falls do not result in injuries". Thus while falling may be a significant cause of injury amongst the elderly population as a whole, it is misleading to view an individual fall in an older person as a grave or significant event in all cases.

As with any population based estimates, the figures cited for frequency of falls and fractures are calculated over large numbers, and do not perhaps represent those particular subgroups who are more at risk. Blake and Morfitt (1986: 387), for example, reported that in their sample of elderly people in a residential home, "residents fell because they were sick, and the excess mortality of those who sustained multiple falls reflects their ill health rather than any injury sustained". The higher reported figures for falls in older women perhaps reflect the fact that women generally live to a greater age than men, and therefore experience more health events then men in their later years. Comparisons of fall related injuries and mortality to other precipitating causes are rarely given. The two intervention studies focusing on women (Campbell et al 1997, Lord et al 1995) did not provide a rationale for this selection, beyond the fact that age and female gender are "the two most easily observable risk factors" for falls, and a population for intervention could therefore easily be identified on the basis of these (Campbell et al 1997: 1065).

Whilst there appears to be general consensus about the increase in rate of hip fracture amongst older people, Kannus, Parkkari, Sievanen, Heinonen, Vuori and Jarvinen (1996) cite studies which suggest that in some populations the increase in rate has actually decreased in recent decades. Meyer, Tverdal and Falch (1993) also highlight the increase in hip fracture rates amongst middle aged men and women. These papers suggest that while the incidence of hip fracture appears to be increasing in line with the ageing of the general population, the interpretation of epidemiological information relating to hip fracture is not straight forward. The representation of hip fracture solely as a problem of elderly people may not therefore be strictly accurate. Hayes et al (1996) raise the possibility that falls

which cause hip fractures may differ from other types of falls and also cite work suggesting that as many as 25% of pathological hip fractures may actually precipitate a fall. In addition, a hip fracture in itself is an event which has a variety of outcomes. Kisely (1996) makes the point that most patients recover well from a hip fracture, and cites the East Anglian Audit (Todd, Freeman, Camillieri-Ferrante, Palmer, Hyder, Loxton, Parker, Payne and Rushton 1995) demonstrating striking differences in outcome, of which the overall care provided by the hospital appears to be a significant determinant.

Whilst the figures given by Alexander et al (1992) and Hollingworth et al (1995) appear alarming, they also reflect current health care practice and the projected figures do not allow for any developments in health care which in the future may reduce the cost of fall related injuries, including fractured hips, such as 'Hospital at Home' schemes (Byers and Parker 1992, Meeds and Pryor 1990).

2.5.2 Critique of assumption two: a fall is an event with an objective reality

Whilst there have been repeated calls for standardisation of definitions of a fall for research purposes, use of different descriptions has persisted. These definitions are sometimes in direct opposition to each other (eg Luukinen et al [1996: 116] include "falls onto a piece of furniture", specifically excluded from the definition of a fall provided for the FICSIT studies in Buchner et al [1993]). Within the FICSIT studies, whilst a standardised definition of a fall was agreed, one site elected to include an alternative definition which "discounts minor events such as stumbles" (Wolf et al 1996: 429). There was a major difference between the number of falls recorded at this site meeting the FICSIT definition (n=209) and the site specific definition (n=110), illustrating how critical the definition of a fall can be. Norton, Campbell, Lee-Joe, Robinson and Butler (1997) highlight the World Health Organisation International Classification of Diseases (ICD) in identifying and classifying falls, also included in other studies (eg Alexander et al 1992) and used to identify baseline and targets in the 1999 White Paper 'Saving Lives: Our Healthier Nation' (Department of Health 1999). They comment that whilst

providing standardisation, these classifications are 'extremely limited' (Norton et al 1997: 1112) for research purposes, and reiterate the call for clearer definitions and classification. Another factor which may have implications for the validity of many epidemiological studies is the reliance on existing recording systems, which are mistakenly viewed as objective sources of data. Lilley et al (1995) highlight shortcomings of routinely published United Kingdom data on accidents as a means of determining incidence of falls and fall related injuries. The Home Accident Deaths Database (HADD) contains data relating to all fatal home injuries, but in order to be included, death must occur within thirty days of the event. For some elderly people, a fall is the first in a chain of events which may include fracture, hypothermia, pressure sores and pneumonia, any of which might lead to death. This process may last longer than thirty days, and the attribution of death might not be to the original fall. Both Lilley et al (1995) and Askham et al (1990) also highlight limitations in the Home Accident Surveillance System (HASS). Currently, two 1999 publications by United Kingdom government departments estimate the number of people aged over 65 years who die from falls at home as "over 3000" (Department of Health 1999) (based on ICD-9 figures), and "over 1500" (Department of Trade and Industry and Health Education Authority 1999) (based on HASS figures [Department of Trade and Industry 1998]). This disparity brings into sharp focus the importance of classification systems in the construction of epidemiological 'facts'.

Langlois, Smith, Baker and Langley (1995) examined this problem in terms of international comparisons of injury mortality in elderly people using hip fracture as an example. They explored the apparent inconsistency between the similar hospitalisation rates for falls and hip fractures between New Zealand and the United States, but considerably higher fall injury death rates for older people in New Zealand. They concluded that differences in use of death certification and coding were responsible for the discrepancy.

Whilst the classification of causes of falls into 'internal' and 'external' factors is widespread, there also exists a wide range of other typographies. In addition, some investigators have modified their system of classification over a series of papers. Campbell at al (1981: 264) identify two types of "trip and slip" falls; those due to eternal circumstances which would lead a "fit and active person to tumble", and those due to a "minor obstruction which would only cause a fall in someone already unstable and at risk" which are deemed likely to happen again. The first type of fall they name an 'occasional fall' and the second, a 'pattern' fall. In a later paper by the same main author, the terms 'external' and 'internal' falls are used (Campbell et al 1989). Campbell et al (1990: 138) present data showing that "trips or slips led to 105 falls" and identify the objects causing trips or slips. The same terminology is used in both the 1990 and 1981 papers, but a 'trip or slip' type fall in 1990 is directly attributable to an external object although this was further subdivided in the earlier (1981) paper.

A paper by Connell and Wolf (1997) draws attention to the interactional nature of what have been described as environmental risk factors with attitudes and behaviour. They emphasise the temporary and changing nature of some obstructions, and also identify how some apparently desirable environmental features (such as non-slip footwear and flooring material) could in some circumstances become hazardous (as when individuals attempt to pivot).

The 'Effective Health Care' bulletin (Nuffield Institute for Health and NHS Centre for Reviews and Dissemination 1996: 2) concludes that "no agreed and reliable set of risk factors can be presented" and cites Gillespie (1996) who identified over 400 variables identified as potential risk factors in falls. The picture regarding whether factors are the causes or consequences of falling is also confused. In reviewing the literature on cause and effect of falling, the distinction between the two is blurred; for example, whether a fall leads to decline or is a marker of decline is one of nine key research questions in the area of falls research proposed by Tinetti (1994) and Cwikel et al (1990) and Downton (1993) have debated whether falls should be

regarded as a precursor to or a consequence of increased frailty. The distinction between cause and effect is also confused in considering psychosocial issues. Franzoni, Rozzini, Boffelli, Frisoni and Trabucchi (1994) found that 'fear of falling' was one of the consequences of falling, but was also a predictor for functional decline and Downton and Andrews (1991) question if the raised levels of anxiety and depression found in their sample of people who had fallen were the cause or effect of the fall.

2.5.3 Critique of assumption three: A fall can be prevented.

Whilst some interventions designed to prevent falls have had notable success (eg Campbell et al 1997, Close et al 1999), others have had more equivocal results. Lord et al (1995), for example, found that whilst significant improvements were found for the intervention group as a result of exercise on a number of measures, including strength and balance, this improvement did not translate itself into a significant reduction in falls for this group. Buchner et al (1993: 321) provide a useful commentary in clarifying the rationale for exercise in preventing falls, explaining it as a causal chain: "exercise improves physiologic function which improves functional status which reduces risk of falls". At present, they claim, only the first link is proven, and their study aimed to provide evidence to support the second link. The study by Lord et al (1995) also falls into this category.

Similarly the findings with regard to environmental modification interventions have been ambiguous, with some investigators claiming this approach looks promising with regard to falls prevention (eg Rubenstein et al 1990, Gill, Robison, Williams and Tinetti 1999), whilst others argue that its potential for falls prevention or reduction is minimal (Norton et al 1997, Parker, Tremlow and Pryor 1996). Whilst reasonable inter-rater reliability can be demonstrated in recognition of potential hazards (Clemson et al 1992), the actual risk posed by such items as throw rugs is subject to debate (Rubenstein 1999). In addition, environments identified as hazardous by health professionals have sometimes not been identified in this way by the older people living in them (Carter, Campbell, Sanson-Fisher, Redman and

Gillespie 1997), and other environments deemed 'safe' have also been a major cause of falls (Erasmus Fleming and Pendergast 1993).

The multifactorial intervention described by Tinetti et al (1994) appears promising. However, Hayes et al (1996) criticise the intervention package on the basis that it is expensive, given the relatively small reduction in falls which resulted. It could be argued that valuable resources for health care would be better targeted at more general, and more consistently demonstrated, means of improving and maintaining older people's health.

2.6 Review of studies focusing on older person's understanding of a fall or hip fracture event

The literature reviewed in the previous sections has been shown to be based on implicit assumptions about the nature and consequences of falls. Evidence has been provided to demonstrate that these assumptions may be problematic. The studies reviewed in this section have been identified using the search strategy described at the beginning of this chapter. However, they differ from studies reviewed earlier in that their primary objective is to explore the meanings attributed to a fall or hip fracture and expectations regarding outcome from the perspective of older people. In these papers, psychological theory has often (although not always) been used to provide a theoretical framework for the explanation provided.

The 'fear of falling' literature (eg Tinetti et al 1990, Tinetti et al 1994) has not been included in this section. Whilst psychological theory (Bandura 1987 in Tinetti et al 1990) underpins this work, the main focus of these studies has been the extent to which people develop a concern about future falls, and the correlation of this fear with other factors such as functioning in activities of daily living. The meaning of the fall is not therefore included in this body of work.

The six studies reviewed in this section are summarised in table 4, overleaf:

Table 4: Summary of six studies focusing on older person's understanding of a fall or hip fracture event

Authors, date and location	Design	Sample	Method of data generation	Theoretical framework	Analysis	Main conclusions
Borkan, Quirk and Sullivan (1991) USA	Longitudinal	80 people with hip fracture (#) admitted to hospital, meeting entry criteria, including aged over 65 years, 'functionally hardy'	Interview	Not specified	Qualitative ('narrative analysis combining ethnographic and epidemiologic techniques') and quantitative	Greater ambulation at 3 and 6 months for those who perceived their problem in more external or mechanistic fashion, also those whose perception of disability was linked to autonomy, independence and connection
Braun (1998) USA	Cross sectional	120 resident council meeting attendees, average age 78.8 years	Self administered questionnaire	Not specified	Quantitative; chi-square, analysis of variance and linear regression	Most subjects considered falling a preventable health problem of moderate importance. Environmental factors were perceived as more likely to cause falls. 'Other' older people perceived to be more at risk

Table 4 (cont): Summary of six studies focusing on older person's understanding of a fall or hip fracture event

Authors, date and location	Design	Sample	Method of data generation	Theoretical framework	Analysis	Main conclusions
Furstenberg (1986) USA	Community study: cross sectional Hospital study: unclear (combining cross sectional and longitudinal?)	• 9 community dwelling older people aged 69-85 years • convenience sample of 11 people aged 59-85 years admitted to hospital with hip #	Interview	Ethnography	Qualitative: ethnography	Both groups anticipated physical and social impairment following hip #. However, for hip # subjects, this was modified by progress, feedback and perceptions of functional health
Furstenberg (1988) USA	Reports further findings from hospital study (see above)	Convenience sample of 11 people aged 59-85 years admitted to hospital with hip #	Interview	Attribution theory Ethnography	Qualitative: ethnography	3 groups: - those who was own behaviour as responsible for hip # were likely to identify changes in behaviour - those who didn't blame themselves, but could identify changes in behaviour - those who viewed accidents as unavoidable
McKee (1998) UK	Longitudinal, 'multi factorial'	Convenience sample of 40 people aged 65 years and over admitted to general hospital as result of fall	Self administered questionnaire	Attribution theory - 'Body Drop'	Quantitative: unclear - multivariate model produced	Causal belief about fall contributed to 11% of variance in recovered activity, and belief regarding whether fall was preventable a further 16%

Table 4 (cont): Summary of six studies focusing on older person's understanding of a fall or hip fracture event

Authors, date and location	Design	Sample	Method of data generation	Theoretical framework	Analysis	Main conclusions
Weinburg and Strain (1995) USA	Cross sectional	Stratified random sample of 162 community dwelling adults aged 65 yrs and over who had experienced a fall	Questionnaire administered during interview	Attribution theory Locus of control	Quantitative: step wise regression analyses	Diversity in attribution of falls to internal and external causes. Those with poor self-rated health, having dexterity difficulties and living in apartment more likely to attribute to own limitations. Those with better self-rated health and falling outdoors more likely to attribute fall to surroundings

In considering rigour of methodology, these six studies vary considerably. Only two employ a longitudinal design, generally considered more rigorous when attempting to determine cause and effect (with two of unclear design).

The detail in which three of the studies are described (Furstenberg 1986, Furstenberg 1988, McKee 1998) is insufficient to allow replication, again demonstrating clear methodological shortcomings. The extent to which findings can be generalised on the basis of sample selection also varies considerably. Three studies use convenience samples with small numbers (Furstenberg 1986, Furstenberg 1988, McKee 1998), whilst insufficient detail is provided about the criteria for residency of the buildings from which Braun selected her sample (Braun 1998).

For the purposes of a review of subjective experiences, the combining of studies utilising samples of older people with experience of a fall, and those with hip fractures is potentially problematic. This presupposes that a fall and a hip fracture are equivalent. However, whilst the vase majority of hip fractures are caused by a fall, some are not (see for example Hayes et al 1996). One of the studies (Furstenberg 1986) utilising participants with hip fractures included details of participant Mr P, whose hip fracture is the result of a motor cycle accident, providing evidence of this point. The effect of severity of fall on significance for and understanding by older people has not been explored. It might be reasonable, for example, to suppose that participants hold stronger views about falls with more serious consequences, thus throwing into question the pooling of these two groups of studies. However, whilst these problems are acknowledged, the paucity of literature in this area provides a compelling rationale for inclusion of all studies exploring meaning of a fall, whatever the outcome.

The variety of methods of analysis are of note, ranging from purely qualitative (Furstenberg 1986, Furstenberg 1988), to a combination of qualitative and quantitative (Borkan et al 1991), to purely quantitative (Braun 1998, McKee 1998,

Weinberg and Strain 1995). The method of analysis is hard to determine from the descriptions provided in several of the studies. McKee (1998) does not provide adequate details, and Furstenberg (1986, 1988) describes simply the identification of salient and recurrent issues and themes. No information is provided regarding how longitudinal and cross sectional data were combined in these latter two studies. Borkan et al (1991) describe the method of establishing inter-rater reliability for the twelve main dimensions identified in their study. However, the manner of the imposition of the 'organic - mechanistic' pole over the initial seven dimensions, on which much of their interpretation is dependent, is unclear.

The selection of attribution theory (eg Weiner 1986 in Weinberg and Strain 1995) as a theoretical perspective in which to locate several of these studies appears logical. Those studies not explicitly acknowledging this theory also use concepts of 'internal' and 'external' causation of fall event (Borkan et al 1991, Braun 1998). However, this selection raises one of the methodological problems of research in this area. If asked why they thought their fall or hip fracture occurred, it seems unlikely that older interview participants will challenge the premise of the question, even if they have not thought about this issue before, or are unclear about the answer. The interviewer therefore gains an 'attribution' for the fall. Furstenberg (1988) gives an example of an older participant continually attempting to find a reason for her fall in an interview situation, although none was immediately apparent to her. When asked to complete a questionnaire consisting primarily of closed questions (eg Braun 1998), the rejection of suggested factors influencing falls is even more unlikely, and in Braun's study questionnaires in which less than two items were marked were not included in the analysis. Critics of attribution theory question how stable and reliable such attributions are, and variation and inconsistency within the same accounts are precisely the focus of interest within discourse analysis (Potter and Wetherell 1994).

The selection of attribution of fall event as independent variable or explanatory (or dependent) variable is also of interest within these studies. Within the two

longitudinal studies (Borkan et al 1991, McKee 1998), the contribution of attributions to outcomes in terms of ambulation and recovered activity respectively was examined. In Braun (1998), however, the perceived importance of fall-related risk factors (grouped into four categories) were retained as dependent variables. Similarly in Weinberg and Strain (1995), 'internal' and 'external' attributions also acted as dependent variables.

Given the complexity with which attributions for hip fracture and falls are discussed and analysed in the two longitudinal studies (Borkan et al 1991, McKee 1998), the selection of the apparently simplistic outcome measures of 'ambulation' and 'recovered activity' warrant a mention. Even more surprisingly given the plethora of measures of mobility and function in activities of daily living, the outcome identified in McKee's (1998) study is not reported as having been determined using standardised instruments. Borkan et al (1991) elected to use a subscale of a standardised outcome measure, selected because of its perceived relevance for hip fracture. However, the impact of this choice on the psychometric properties of the tool were not discussed. Other studies have illustrated how conventional rehabilitation outcome measures such as mobility and function have limited utility in reflecting the expectations and desires of older people receiving treatment (eg Doolittle 1991).

Discussion about the implications of particular attributions for fall and hip fracture events is complex. Furstenberg (1986, 1988) writes from the perspective of a social work practitioner. The assumption of guilt for the event of the hip fracture is recognised as potentially unhelpful in some instances. However, in general, social workers are encouraged to extend their clients' sense of control, thus maximising their potential for rehabilitation (Furstenberg 1988). Weinberg and Strain (1995) however suggest that the direction (ie 'internal' or 'external') of the attribution is less important than its stability (ie potential for remaining the same) and controllability (ie potential for being changed by individual) in determining response to rehabilitation and falls prevention programmes. They maintain that an

'adaptive' response is an attribution of the fall to an internal or external, unstable and controllable cause. Borkan et al (1991: 954) demonstrated that the assumption of a "more primitive mechanistic" perspective appeared to predict better outcomes, arguing that this appears to be in contrast to current developmental theory. They also acknowledge, however, that this may be an artefact of the level of outcome measure selected.

2.7 Summary

This review has illustrated how the development of research into falls amongst older people has been premised on three implicit assumptions, namely that a fall is a serious event for an older person, that a fall has an objective reality and that a fall can be prevented. These assumptions have been shown to be problematic. Those few studies which have focused on older people's perceptions of falls and hip fractures vary considerably in terms of methodological rigour. In general, attribution theory has been adopted as the theoretical framework within these studies. However, some shortcomings with this approach have been illustrated. Analysis has been both qualitative and quantitative, with attributions acting as both independent and dependent variables. The association of particular attributions with positive responses to rehabilitation and falls prevention programmes, and participants' expressed expectations and desires also remains unclear.

The following chapter details the methodological approach which underpins the empirical work reported in this thesis; discourse analysis. Perspectives based on cognitive frameworks, such as attribution theory, will be shown to be incompatible with this particular approach. The two empirical studies reported subsequently in this thesis aim to explore how accounts about falling are constructed, and more generally how risk is realised.

3. Chapter Three: Methodological and theoretical underpinnings of this work.

3.1 Introduction

It has been argued in the previous chapter that the biomedical literature relating to falls and falling has had particular consequences for the ways in which both falling, and older people who might fall are constructed. In this chapter, the theoretical framework underpinning the current work, discourse analysis, will be discussed. This chapter will demonstrate how the location of this current research within this approach opens up new and fruitful areas of study and provides a theoretical framework from which much of the work focusing on falls can be challenged.

The term 'discourse analysis' is used widely across disciplines to represent many different methods of studying and analysing texts. In addition, there are two different 'schools' of discourse analysis within the area of social psychology, the discipline from which the methods and perspectives in this work are derived. After defining discourse analysis, therefore, this chapter will explore the antecedents to this methodology, as a means of distinguishing it within social psychology from those located within other disciplines.

A rationale for the grounding of this current work in discourse analysis will then be provided. This will be followed by a more detailed discussion of the two major schools of discourse analysis in social psychology in the United Kingdom, highlighting differences in intent, researcher position and interpretation. The ways in which the current research draws from theory and practice from both of these schools will then be discussed.

The current debates about criteria for determining rigour within qualitative research will then be considered, and some standards against which it is suggested this work be judged provided. This chapter concludes with a discussion about problems with current discourse analysis approaches, and some of the solutions

which have been proposed. The contribution of this current work in addressing some of these problems will be highlighted.

3.2 Definition

The term 'discourse analysis' encompasses a variety of approaches used in disciplines located mainly within the humanities and social sciences. The theoretical propositions underpinning this work, however, are drawn from the body of work ascribed to discourse analysts from the discipline of social psychology in the United Kingdom. Discourse analysis is usually included as a qualitative research method (eg Smith, Harré and van Langenhove 1995) although its description as a method has been debated by some of its proponents (see section 3.5). A useful description of the focus of discourse analysis is provided by Potter and Wetherell (1995):

'... it is concerned with what people *do* with their talk and writing ... and also with the sorts of *resources* that people draw on in the course of those practices'
(Potter and Wetherell 1995:80-81)

As they themselves state, this description highlights two assumptions implicit in discourse analysis: firstly, that talk and text is action orientated, and that particular functions are performed by texts, and secondly, that wider means or reserves are available which people can employ in the crafting of their individual accounts. This focus on talk and text means that interviews and collection of textual documentation are usually the data generation methods of choice employed by discourse analysts.

The description above also represents the different foci of the two schools of discourse analysis in social psychology. The Loughborough school (eg Potter 1996, Potter and Wetherell 1987, Wetherell and Potter 1992) is more interested in the action orientation of talk, the means and devices used to achieve particular ends. The Manchester school, conversely, (eg Parker 1992, 1994, 1997) sets itself a more overtly political task in focusing on the resources, or discourses, employed in the construction of 'reality', and how dominant, 'common-sense'

understandings come to prevail. By implication, it also has an interest in voices which are not represented, or silenced, in the construction of meaning about every day life.

As a means of explaining their particular positions, discourse analysts have written at length about the origins and antecedents of their methodologies (eg Parker 1997, Potter 1996). This assists in locating the two main approaches within existing disciplines and traditions, thus helping to illustrate their concerns, their methods, and the assumptions underpinning them. For some, this location has enabled particular contrasts to be drawn which further clarifies their own theoretical propositions. Edwards, for example, has contrasted "discursive psychology" (Edwards 1997:1) with the current dominant school in psychology, cognitivism. A discussion about the precursors to discourse analysis also helps to illustrate differences between the two schools of discourse analysis, as they recognise and acknowledge different influences. The following brief overview has therefore been included both to illustrate the central concerns, and methods employed in discourse analysis, and also to highlight variations in the different approaches as proposed by the Loughborough and Manchester schools. Due to the brevity of this section, the treatment of the various fields of study is simplistic, in particular, consideration of the contribution of Michel Foucault, but reference is made to the major texts in each area. Attention is also drawn to the specific contribution of each field to discourse analysis.

3.3 Precursors to discourse analysis

3.3.1 Ethnomethodology

Garfinkel (1967), usually accredited as the major theorist, described ethnomethodology as "the investigation of the rational properties of indexical expressions and other practical actions as contingent ongoing accomplishments of organised artful practices of everyday life" (Garfinkel 1967:11). The focus of ethnomethodology is therefore the talk and actions that people use in order to make their descriptions of the social world seem reasonable and justifiable. This definition draws attention to Garfinkel's belief that the meanings of particular

words or statements are dependent on the context in which they are uttered, and also to his claim that the achievements of particular ends through talk are skilful accomplishments. The topics of interest to ethnomethodologists are very often those which would be regarded as 'common sense' and not warranting further investigation. Garfinkel, for example, studied and wrote about the classification of suicide, jurors' decisions in trials, and the means by which people achieve a particular gender status (Garfinkel 1967). More recently, ethnomethodologists have studied claims submitted to the Small Claims Courts (Pomerantz 1987 in Potter 1996) and medical practice (Ten Have 1995).

Potter (1996) identifies three concepts from ethnomethodology which have particular significance for discourse analysis; indexicality (the reliance on words and context to provide meaning), reflexivity (the process of recognising that descriptions form a part of that which they describe) and the 'documentary method of interpretation' (Garfinkel's description of the circular process whereby people make sense of the world through underlying models, which in turn are modified by the understanding gained). Thus while there are elements in ethnomethodological theory with which discourse analysts would take issue (for example the underlying concepts or models in the documentary method of interpretation), the major contribution of ethnomethodology to discourse analysis is its "radically different understanding of the nature of facts" (Potter 1996:43) as a focus for study, rather than as the uncontested foundations from which research proceeds.

3.3.2 Conversation analysis

Conversation analysis developed out of ethnomethodology and shares with it a focus on what Drew (1995) citing Clark (1992) describes as the "action tradition" of studies of discourse (Drew 1995:65), in looking at the performative qualities of speech. Conversation analysis, however, relies on very close and detailed analysis of short passages of recorded speech, with much emphasis placed on transcription. Typically, transcribed data which form the basis for analysis within this tradition include pauses, stressed words, inbreaths and volume, according to the system described by Jefferson (see Drew 1995). This meticulous representation of text

enables the systematic study of structures and phrases which perform particular functions within speech. Examples of speech conventions which are of interest to conversation analysts include 'repair' (Schegloff 1992 cited in Potter 1996), idioms and topic closure (Drew 1995) and non-correction of errors (Jefferson 1988 cited in Drew 1995). The aim of conversation analysis is therefore to identify and document the use of such devices in speech.

The dissociation of speech from the cognitive states which, in cognitive models, occasion it, is a presupposition shared by both conversation and discourse analysts. The Loughborough school of discourse analysis, in particular, draws heavily from conversation analysis methods, with Potter utilising a modified version of the Jeffersonian method of transcription for analysis (eg Potter 1996, Potter and Wetherell 1995). The close attention to text in analysis, and the aim of investigating some of the 'building blocks' of speech (in Potter and Wetherell's terms, "interpretative repertoires" [Potter and Wetherell 1995:89]) are examples of the influence which conversation analysis has had on both the methods and project of discourse analysis.

3.3.3 The work of Michel Foucault

The work of Foucault is acknowledged by discourse analysts from both schools (eg Parker 1997, Potter 1996, Potter and Wetherell 1995), but is particularly influential amongst the Manchester school, in which interpretation has a broader, more overtly critical function (Nikander 1995). Foucault's influence on the social sciences and philosophical thought has been enormous (Petersen and Bunton 1997), and it is impossible in this brief summary to describe it in its totality. Of particular importance for discourse analysts, however, is his interest in discourses, defined as "practices that systematically form the objects of which they speak" (Foucault 1972:49 cited in Nikander 1995). Foucault wrote about the possibilities opened up and suppressed by particular discourses and sought to document the 'archaeology', or historical origins and perspectives, of discourses in a variety of different areas including madness, medicine, punishment and sexuality (Foucault 1967, 1975, 1977, 1979 in Petersen and Bunton 1997). As Parker (1997) states,

Foucault's task was to "lay bare the conditions of possibility for modern experience" (Parker 1997:2). The impact of the work of Foucault for discourse analysts lies in the larger focus on discourses as resources with which dominant understandings of the world are constructed and sustained.

3.4 Different schools in discourse analysis

In discussing the antecedents to discourse analysis in the previous section, reference has been made to two different traditions of discourse analysis in the United Kingdom, identified as the Loughborough and Manchester schools. This is an artificial division, which presents discursive work as being located within either one or the other schools in terms of intent, focus and interpretation. As will be argued, it is possible to draw from the work of both schools in carrying out analyses of discourse. However, this division does allow for clarification of the different positions within discourse analytic work, and enable contrasts to be drawn.

The following table, reproduced from Nikander (1995:11), identifies the characteristics and key points of difference between the two schools:

Table 5: Comparison of the Loughborough and Manchester schools of discourse analysis (Nikander 1995:11)

SCHOOL	Loughborough (eg Potter and Wetherell 1987)	Manchester (eg Burman and Parker 1993)
DISCOURSE	"All forms of spoken interaction, formal and informal, and written texts of all kinds" (1987:7)	Defined in the critical foucauldian sense as "collections of texts, as sets of statements which construct objects" (Parker 1989:102)
FOCUS OF ANALYSIS	The strategic variability, construction and functions of language. Focus on shared patterns of meaning and the performative qualities of our situated, natural discourse.	The analysis and deconstruction of cultural and ideological discourses (eg Burman 1994). Focus on the tensions within discourses and on how discourses reproduce and transform the material world.
TOOLS OF ANALYSIS	Interpretative repertoire: Recurrently used systems of terms used for characterising and evaluating actions, events and other phenomena. Repertoires are 'tool kits' that speakers use strategically for a special function while justifying, excusing, blaming etc.	Reluctant to treat as specific method, but offer practical criteria to consider when undertaking this kind of an analysis (Parker 1992:3-22). Sometimes focuses on analysing the 'subject positions' made possible within a particular discourse.
CRITICISM	Represents ideological individualism and ignores wider political implications of discourses.	The analysis turns discourses into objects that exist independently of individuals or groups of individuals. Seen as relying on and enforcing a particular (political) view on the relationship between discourse and reality.

The differences between the two schools can be further illustrated by considering how pieces of text have been managed within the two traditions.

Parker (1994) uses the instructions on a packet of children's toothpaste to illustrate in more detail the process of discourse analysis within the Manchester school formulation (see appendix 1). From the beginning of the analysis, the focus is clearly on the larger discourses which have informed the creation of this particular piece of text. Also of evident interest is how 'subjects' such as children and parents are positioned by the text.

The piece which has been selected for analysis does not form part of a conversation or interview. Whilst analysis remains close to the text, it is focused on the selection of particular words and how they are placed together to reinforce particular understandings about how the world is, for example the use of the second person to suggest that the passage is intended to be instructive. This excerpt does not contain any of the transcription conventions often used by Potter and colleagues (eg Potter and Wetherell 1995). As the analysis proceeds, there are many references to other 'voices', such as conservative political discourse, and health professional talk. These are used to inform and develop the analysis by hypothesising about the sorts of things these voices might say, the types of objects which are the focus of their attention and identification of interests that are served and positions reinforced through their use.

The analysis concludes by identifying that the institutions of medicine and the family are reinforced by this text, and that children are the objects of discipline and control. This interpretation, then, is concerned with the exercise of power, and thus assumes a critical (Parker 1997) or political position.

In another example, this time from the Loughborough School, Potter (1996) makes extensive use of excerpts from a relationship counselling session involving two characters, Jimmy and Conny. The text is therefore derived from a naturally occurring conversation, and has been transcribed in detail, with attention paid to pauses, stresses, prolonged sounds, termination of words etc (eg Potter 1996;

198). Potter's explicit intention with this particular excerpt is to illustrate an example of a device first discussed by Edwards (1994), called 'script formulation' (or how a particular action can be described as normal and commonplace, using talk). The case is closely argued with reference only to the text, another device ('gerrymandering'), and other excerpts from the same counselling session elsewhere in the book.

Whilst cognitive psychologists are identified as targets, there is no reference to 'discourses' or overtly to the exercise of power within Potter's account. Consequently, it is more difficult to recognise the influence of Foucault in this formulation of discourse analysis.

These two examples have therefore illustrated differences between the two schools in terms of intention, focus on text and researcher position. The following section considers how analysis within this methodology is carried out, further exploring differences between the Loughborough and Manchester schools which have been alluded to in this section.

3.5 Analysis within discourse analysis

It is difficult to access information which details precisely how to perform discourse analysis. There are a number of reasons for this. Perhaps one of the most powerfully articulated is that once discourse analysis is presented as a research tool, it has the potential to be used as a "value-free technology" (Parker and Burman 1993:162) without recourse to reflexivity and explication of the position of the researcher within the research. It thus loses its critical position and becomes one of a number of 'methods' of qualitative research, rather than representing a particular perspective from which research is carried out. This will be further discussed later in this chapter. Another reason advanced by Potter and Wetherell for the lack of prescription is that the conduct of discourse analysis is a craft or a skill which is difficult to describe, like riding a bike or sexing a chicken (Potter and Wetherell 1987:168, 1995:55). However, in spite of these

reservations, a number of suggestions and guidelines have been advanced regarding the process of discourse analysis.

One of the first guides detailing 'How to analyse discourse' was proposed by Potter and Wetherell (1987). However, the ten stages proposed include steps important in all research (such as stage two: sample selection), and stages common to other qualitative methods (eg stage four: interviews), albeit written from a discursive perspective. Stage seven, 'analysis', refers to the search for pattern in the data, specifically in the form of variability (Potter and Wetherell 1987:168), but is vague in relation to detail about how this is achieved.

Parker (1992) offers the following guidelines, or steps, as a means of carrying out discourse analysis:

Figure 1: Parker's guidelines for carrying out discourse analysis (Parker 1992: 3-22)

1. Treating our objects of study as texts which are described, put into words
2. Exploring connotations through some sort of free association which is best done with other people
3. Asking what objects are referred to, and describing them
4. Talking about the talk as if it were an object, a discourse
5. Specifying what types of person are talked about in this discourse, some of which may already have been identified as objects
6. Speculating about what they can say in the discourse, what you could say if you identified with them
7. Mapping a picture of the world this discourse presents
8. Working out how a text using this discourse would deal with objections to the terminology
9. Setting contrasting ways of speaking, discourses, against each other and looking at the different objects they constitute
10. Identifying points where they overlap, where they constitute what look like the 'same' objects in different ways
11. Referring to other texts to elaborate the discourse as it occurs, perhaps implicitly, and addresses different audiences
12. Reflecting on the term used to describe the discourse, a matter which involved moral/political choices on the part of the analyst
13. Looking at how and where the discourses emerged
14. Describing how they have changed, and told a story, usually about how they refer to things which were always there to be discovered
15. Identifying institutions which are reinforced when this or that discourse is used
16. Identifying institutions that are attacked or subverted when this or that discourse appears
17. Looking at which categories of person gain and lose from the employment of the discourse
18. Looking at who would want to promote and who would want to dissolve the discourse
19. Showing how a discourse connects with other discourses which sanction oppression
20. Showing how the discourses allow dominant groups to tell their narratives about the past in order to justify the present, and prevent those who use subjugated discourses from making history

As Parker and Burman (1993) themselves point out, there are various problems with the processes described in these steps, not least the fact that they are very time consuming. Some of these problems will be returned to in the final section.

Potter and Wetherell return to the problem of analysis in a later publication (Potter and Wetherell 1995), in which they illustrate how they carried out a piece of discourse analysis with reference to five principles, as follows:

Figure 2: Potter and Wetherell's analytical considerations in discourse analysis (Potter and Wetherell 1995:55-61)

1. using variation as a lever
2. reading the detail
3. looking for rhetorical organisation
4. looking for accountability
5. cross-referring discourse studies

Reference will be made to both figures 1 and 2 in the following section.

3.6 Discourse analysis as the underpinning methodology for the current work

Whichever 'variant' of discourse analysis is used, reflexivity is considered a critical element (Parker 1992, Potter 1996), not only because it makes transparent the position of the researcher, but also because it can contribute unique insights into the research process itself (reflexivity is further discussed in the following section as a criterion for evaluating qualitative research). In this section, therefore, I consider the process whereby discourse analysis was chosen as an appropriate methodology, locate this work with reference to the Loughborough and Manchester schools of discourse analysis, and discuss criteria for analysis. I have elected to write this and further passages in the following sections in the first person because I feel it better represents the decisions I made concerning my

research, and foregrounds my own role as researcher in the planning, carrying out, analysis and interpretation of my research.

From the beginning of this work, I had identified qualitative research methods as being particularly appropriate for my work, given my interest in the subjective perspectives of health service users and providers (Henwood and Pidgeon 1992, Smith, Harré and Van Langenhove 1995). The grounding of the research in discourse analysis methodology occurred during the first seven months of the research studentship period, during which time I read as widely as I could around qualitative research methods generally, and discourse analysis particularly, and also attended a three day 'Discursive Practice' workshop facilitated by Ian Parker, amongst others, at the Bolton Institute. As I became increasingly familiar with the methodology, I recognised that the assumptions in the literature about the possibilities of apprehending an objective truth about the causes and consequences of falls in older people, the representation of falls as serious events and the contributions of each profession allied to medicine to the enterprise of 'falls prevention' could all be productively explored within a discourse analysis framework. Additionally, I was attracted by the critical perspective, and the focus on underlying assumptions as the topic of research, which discourse analysis offered.

I was initially more familiar with discourse analysis as described by Potter (eg Potter and Wetherell 1987, Potter and Wetherell 1995, Potter 1996) and this influenced decisions taken at an early stage regarding detail included in transcription and initial criteria used in analysis. However, as I learnt more about the work of Parker (eg Parker 1992, 1994) and others from the Manchester school, I felt that their critical perspective and wider interest in how ideologies are reproduced through discourses were more akin to my concerns than the focus on 'interpretative repertoires' of Potter and colleagues.

Criteria for analysis were therefore drawn from suggestions by Parker (1992, 1994) and Potter and Wetherell (1995). From Parker (1992, 1994), the early focus on object and subject positions within text, and the suggestions for free associating,

and discussing early ideas with colleagues were particularly useful. Potter and Wetherell's (1995) suggestions of focusing on variability in text, and looking for rhetorical organisation were of key importance to me as a 'way into' the text when starting analysis. Details and examples of the processes of manual coding, use of 'Ethnograph' (Seidel, Friese and Leonard 1995) and development of theoretical perspectives are provided in subsequent chapters.

Both Parker (1992) and Potter and Wetherell (1995) suggest that their steps or guidelines need not be used sequentially. For me, the process of analysis and interpretation has lasted many months and involved repeated reworking of the data. The representation of the research in the written account is often presented as the 'last stage' of the research (eg Potter and Wetherell 1987), but for me has been an integral, and difficult part of the interpretation. The many drafts of the accounts of this research represent the developing theoretical construction which renders the work interesting and credible. Many of the later drafts have been informed by further reading, and the writing of additional sections and chapters of the thesis. These are akin to some of the later steps suggested by Parker (1992), such as step 19, which links discourses emerging from the data with other discourses, and step 20 which brings a historical perspective to the process. Similarly, Potter and Wetherell's (1995) criterion of cross referring to other discourse studies has also become more pertinent as more studies were located which made reference to discourses and frames in research about health events and processes. Parker (1992) and others have argued against being too prescriptive about how analysis in discourse analysis is conducted, although they have recognised the importance of clarity of analysis for teaching purposes (Parker and Burman 1993) and to demonstrate rigour in research (see next section). This tension between a transparent, chronological account of analysis, and its representation as an intuitive, disorderly process exists more widely within qualitative research, and is further addressed in the following section.

3.7 Criteria for determining rigour

Conventionally, research has been understood and described as either quantitative (involving the collection and analysis of numerical data) or qualitative (involving

generation of data which aim to explore, describe and contextualise experience) (Henwood and Pidgeon 1992). In general, the dominant epistemology underpinning quantitative research is positivism, in which knowledge is deemed to be objective and value-free, to be discovered by the researcher (Guba and Lincoln 1998).

Traditionally, the quality of research in the quantitative tradition has been judged with reference to notions of 'reliability' (when results are demonstrated to be reproducible and consistent) and 'validity' (when tests measure what they are intended to measure) (Atkinson, Atkinson, Smith and Bem 1993). Qualitative research embraces a range of epistemological positions, and consequently there is less consensus about the criteria which should be employed to evaluate research carried out within this paradigm (named by Guba and Lincoln the 'naturalistic paradigm' [Guba and Lincoln 1998]).

Discourse analysis is a relatively new methodology, located within the 'qualitative research' tradition (Smith, Harré and Van Langenhove 1995), and there has as yet been little debate about how discursive analytic work should be judged. Potter and Wetherell (1994:63) have offered the following suggestions, which they state will determine how well analytic interpretations are warranted:

- how well interpretations account for the detail in material
- how well potential alternatives can be discounted
- how plausible the overall account seems
- whether the account meshes with other studies carried out within a discursive tradition

In the absence of generally agreed criteria with which to judge discourse analytic work, therefore, this section will focus on the wider debate concerning determinants of rigour within the realm of qualitative research generally, although reference will be made to the suggestions above by Potter and Wetherell (1994).

In 1982, Guba and Lincoln attempted to 'translate' the criteria used to demonstrate trustworthiness of research within the positivist (or 'rationalistic') paradigm into concepts and methods that could be employed within a naturalistic framework. The rationalistic terms, and corresponding naturalistic expressions, and means of evaluating qualitative research against them are summarised in the following table:

Table 6: Criteria for demonstrating trustworthiness of naturalistic inquiry (Guba and Lincoln 1982)

'Rationalistic' terms	'Naturalistic' equivalents	Means of testing for naturalistic criteria
Internal validity	Credibility	• Prolonged engagement • Persistent engagement • Peer debriefing • Triangulation • Referential adequacy materials • Member checks
External validity	Transferability	• Theoretical/purposive sampling • Thick description
Reliability	Dependability	• Use of overlap methods • Stepwise replication • Dependability audit
Objectivity	Confirmability	• Triangulation • Practising reflexivity • Confirmability audit

It is recognised that subsequent formulations (eg Guba and Lincoln 1998) present more sophisticated theoretical propositions in which some early criticisms of the above proposal are acknowledged and addressed. However, this early paper and their subsequent book, 'Naturalistic Inquiry' (Lincoln and Guba 1985), have been very influential within the enterprise of qualitative research. The following discussion is therefore based on this early work, because it provides a clear representation of a particular perspective, within the broad church of qualitative approaches, which is still current. However, it is acknowledged that this early

paper does not represent the present position held by Guba and Lincoln (eg Guba and Lincoln 1998).

For some, myself included, the above formulation is problematic, not just because of the means suggested to check the quality of interpretative research, but because many of the assumptions underpinning the central tenets are still premised on positivistic notions of a single reality.

Some of these assumptions will now be discussed with reference to Guba and Lincoln (1982), in order to illustrate why an alternative set of criteria have been suggested against which the work in this thesis should be judged.

For those employing critical methods within qualitative research (Fox and Prilleltensky 1997), including some forms of discourse analysis, the criteria suggested by Guba and Lincoln (1982) are wanting because they do not acknowledge that power relations are implicit the way in which knowledge is created. Those power relations determine who or what is the focus of attention and inquiry, how the objects of research are constituted and who is deemed to possess the expertise to speak and write about them. Thus research itself, like the topics which form the object of qualitative research, should be contextualised. The academic community, as the source of production of academic knowledge, is the site of fiercely contested claims about what constitutes the truth, and the means through which this is accessed (eg Collins and Pinch 1982, Kuhn 1970).

Statements about "distortions", "biases" and the necessity of remaining "honest" as a researcher (Guba and Lincoln 1982:247) are still referring to a truth which is value-free and neutral, rather than recognising that individual experiences and perspectives are implicit in any analysis. "Prolonged engagement", for example, is advocated as a means of identifying "salient characteristics", and "persistent engagement" as a way of eliminating those characteristics deemed 'irrelevant' (Guba and Lincoln 1982:247). However, such suggestions do not acknowledge the flexible nature of what is deemed 'relevant' in terms of understanding qualitative interpretation. For example, in some qualitative research methods, a

personal account of one's own position as researcher is imperative (eg Reason and Heron 1995); in others it is less important (eg Drew 1995).

The criteria continue to contain a tacit reference to a single truth; "triangulation", for example, is advocated as a means of "cross checking data and interpretation", with no discussion about how one might deal with apparently conflicting versions or analyses (Guba and Lincoln 1982:247). This single truth remains relatively stable; the call for "prolonged engagement" for example does not acknowledge additional problems this might pose for the researcher in terms of shifting and negotiated versions of 'the truth' which occur during the course of the research. Rather, the implication is that the researcher, over time, works steadily to overcome biases, and moves nearer to the definitive version of what passes for 'reality'.

The alternatives proposed by Guba and Lincoln (1982) also fail to acknowledge potential power differentials between the researcher, the researched and those evaluating the researcher and their research. They do not recognise that research is used in various ways to perform particular functions which are dependent on context, as has been argued earlier in this chapter for talk and text. For those utilising a research methodology which is concerned with the performative qualities of talk and text, such as discourse analysis, this failure presents difficulties for the use of such practices as "member checking". This practice assumes that the research participants and the researcher will not only share a vocabulary and epistemology which will enable them both to understand the purpose of the research in the same way, but also to agree about its conclusions, regardless of implications for the status and credibility of the research participants or the researcher. The thoroughness of the various 'audits' proposed by Guba and Lincoln (1982:248) will depend to a large extent on who the 'auditors' are. If one is trying to convince a line manager, or an examiner, for example, that the research has been carried out in a systematic fashion, the steps of which can be retraced, one might pay greater attention to the transparency of the trail, than one might if describing the research to a non-academic friend. Similarly, calls for "thick description" and "theoretical/purposive sampling" are dependent on shared

perspectives with regard to the details and criteria to be used. In theoretical sampling, for example, gender and age are sometimes unreflexively assumed to be key criteria around which to structure a theoretical sampling strategy. However, the relevance of these criteria are entirely dependent on the theory developing from the research.

Having articulated some of the problems with the alternative criteria proposed by Guba and Lincoln (1982) for demonstrating trustworthiness in qualitative research, I will next argue for individual criteria, specified for particular research enterprises within the qualitative tradition. These criteria are dependent on the explicit recognition of epistemological and ontological assumptions underpinning the research for which they have been specified. In this account, these assumptions have been articulated in sections 3.3, which considered the origins of discourse analysis, and 3.4, which compared the two different schools of discourse analysis. However, for clarity, these main assumptions will be repeated here:

- that there are 'as many knowings as there are knowers' (Reason and Heron 1995:125) ie researchers using discourse analysis reject a positivistic belief in one objective reality
- that power relations are inherent in the social world which researchers utilising discourse analysis are aiming to explore (Parker 1992), and in which research takes place and of which it is itself a part
- that individual versions of the world are constructed by people through the course of their interactions (Potter and Wetherell 1995).

Some more criteria, together with justifications, are provided below against which it is suggested this current research be judged. They are drawn from the work of Henwood and Pidgeon (1992), Mason (1996), Parker (1992, 1994), Potter (1996) and Potter and Wetherell (1994). These are also the criteria which have determined how this account has been written.

3.7.1 Rationale provided for data source(s), data generation method(s) and interpretation

This criterion is concerned with demonstrating firstly that a justification has been provided for the sample, including a precise description of what is being sampled (for example, in qualitative research, whilst 'people' usually constitute the units within the sample for pragmatic reasons, it may be more meaningful to sample experiences, behaviour, beliefs or attitudes, rather than people per se [Mason 1996:87]). The extent and nature of generalisations on the basis of this sample should also be clarified.

The selection of the data generation method(s) in relation to the research questions being posed, and their potential to provide explanations in the methodological framework in which the research is being carried out should also be addressed. Within the current research, for example, a reliance on talk and text within discourse analysis has been demonstrated, thus providing an explanation for the methods of choice within discursive research, interviews and collection of documents. However, the choice of participant observation as a method employed in the second study is unusual in discursive research, particularly as the 'text' produced in the form of fieldnotes represents an initial 'level' of analysis, rather than 'raw data'. Some explanation is therefore warranted. This is provided in chapters four and nine.

Finally, some attention should be paid to explaining how the interpretation is warranted. Mason (1996) lays emphasis on the 'end product' of the research, and argues for a demonstration of how the interpretation was reached. This is similar to the use of 'audit trails' proposed by Guba and Lincoln (1982), but is proposed in order to encourage reflexivity (see below) in addition to the more familiar argument of strengthening the validity of the interpretation. In addition to the completed thesis, the audit trail of my work is visible within two diaries, which have been completed throughout the duration of the research studentship period. These diaries comprise a daily diary and a research diary. The daily diary provides a brief record of daily activities, but is also useful to cross reference dates and times of particular ventures, such as literature searches. The research diaries

comprise written records of my thoughts about the research process, copies of early drafts of chapters, agendas for supervision and problems encountered, filed in chronological order. They thus provide a record of my developing ideas and construction of theory. Memos written during the second study, which have also been treated as data, have been filed in chronological order, along with hard copies of fieldnotes in a separate file.

3.7.2 Reflexivity

Reflexivity, or "critical self-scrutiny" (Mason 1996:5) is widely recognised as important in qualitative research. However, reflexivity in discourse analysis is imperative, because of the project of discourse analysis (to explore how particular versions of the world are constructed and maintained) and the means through which this is achieved (reliance on talk, words and text). Potter (1996) repeatedly returns to the issue of reflexivity in his book about fact construction, and describes it as a book "that refers to itself" (Potter 1996:9). Thus the work being done and the means through which this is achieved are highlighted within this particular piece of text, or thesis.

Reflexivity is illuminating not only as a practice which can lead the researcher to greater insights about their own position and assumptions, but also as a contribution to the enterprise of research and construction of knowledge. In struggling to make sense of the accounts of the service user participants interviewed in the first study, for example, I gradually realised that my own preconceptions about the importance of falling to the way older people (service users) accounted for, and explained their circumstances and their futures was influenced by my health professional background. As a consequence, I was at first unable to understand the contribution of these research participants, as I did not understand their perspectives or concerns. This insight not only influenced how I subsequently interpreted data generated in both studies, but has also caused me to reflect on the current preoccupation with falling in research programmes and biomedical and therapy literature.

I hope that reflexivity is self-evident throughout this work. My research diary additionally documents thoughts, problems and challenges as I have proceeded through the research. In light of the comments above about the implications for this thesis, I have considered a variety of ways to highlight reflexivity in my own work, such as the inclusion of a personal account alongside a research account (eg Wolf 1992), use of italics to highlight sections where reflexivity is particularly important or helpful to insights into the research, and use of the first person in writing. However, I feel that the first two alternatives are too self-conscious, and can be understood as devices or tropes to convince others of a reflexive position, rather than being indicative, necessarily, of true reflexivity. I have, however, used the first person in this account where it has felt natural to do so, in particular where the claiming of decisions and insights as my own have been more easily explained in this way.

3.7.3 Plausibility

As for reflexivity, it has been argued that the evaluation of discursive research depends more on the quality of the account of it than for other types of 'social research' (Potter and Wetherell 1994). To some extent, the criterion of 'plausibility' is similar to that of 'face validity' in a positivistic paradigm, in that the value of the research is immediately apparent, without recourse to other devices or means. However, two of the key questions relating to the exposure of one's analyses are firstly, to whom, and secondly, how often. Potter and Wetherell (1994) advocate the "regular attempt to make interpretations stand up publicly" as a "very useful discipline" (Potter and Wetherell 1994:64). To be able to produce an account of one's research enterprise which is credible to one's colleagues and peer group, particularly when they are unfamiliar with discourse analysis as a methodology, is a challenging task. This task is often assisted if epistemological and ontological assumptions are laid bare, and the research process is described in detail, with many illustrations. Throughout the conduct of this research, I have sought opportunities to discuss this work in the public forum, through posters, papers and seminars (see appendix 2, 'Dissemination of research').

Questions asked at the end of presentations have been particularly illuminating in illustrating how well I have explained what I have done, and how convincing it is perceived to be. At a recent occupational therapists' conference for example (23rd College of Occupational Therapists Annual Conference 23.7.99), the only questions forthcoming at the end of my fifteen minute paper were from a close colleague who is familiar with my work. This caused me to reflect on whether the work that I presented was appropriate for an audience predominantly of clinicians, whether my explanation lacked plausibility, was too theoretical or was not of interest to them. I concluded that my subsequent presentations at similar venues should either more explicitly address practice, or focus more exclusively on issues pertaining to research methodology, and thus be included in sessions with other research papers. This latter option would mean that I would be presenting to an audience primarily interested in research issues. I also recognised that because of my current preoccupation with theory development in the preparation of my thesis, I was at this time unable to focus on practical concerns in my paper for the benefit of my clinical colleagues. This led to further reflection on the purpose of my research.

3.7.4 Accounts for detail and volume of data

Whilst of lesser importance than the first three criteria, an account of research which provides many detailed examples from different methods and participants to illustrate developing theory is likely to appear more convincing than research which is dependent on, or presents few examples. This is particularly true if it is apparent that large amounts of raw data are unrepresented in the account with no explanation for this. Representation of detail and volume of data are in themselves insufficient to ensure rigour, but the case can be made more convincing if 'negative case analysis' (Henwood and Pidgeon 1992) is presented. This refers to the inclusion of data which would seem initially to contradict the developing theory, but the theory is refined and reworked sufficiently to account for these data. The demonstration that theory is derived from different sources of data and has been modified on various occasions to take account of material that seems not to 'fit' the developing explanation provides evidence that the researcher is open and flexible. However, as in the marking of 'reflexive passages' there is the possibility

that the self-conscious inclusion of material from diverse sources and the 'negative case' is a calculated device designed to perform just this task.

Within the accounts of the two studies carried out in the course of this research, most of the research participants are represented, some 'negative cases' have been demonstrated and in the case of the second study, data from each of the three data generation methods have been included.

3.7.5 Exclusion of ethical issues from criteria demonstrating rigour in qualitative research

Many researchers include mention of ethical considerations in criteria for determining rigour of qualitative research (eg Mason 1996, Yardley in press). For Mason (1996) these encompass not only issues relating to the conduct of the researcher towards the research participants (for example, maintaining confidentiality), but also an observation of the responsibility to produce good quality research and an anticipation about how that research might be utilised. The absence of a criterion relating to ethics and politics of research from the above list is not an indication that I think that the way in which research is conducted is unimportant. In many ways, because issues relating to power and dominance are central in discourse analysis, I would argue that researchers employing discursive methods should be particularly aware of the implications of their work, and thus to the concerns of participants, and the potential use of the research. It could be argued therefore that discourse analysts have a particular responsibility to behave in an ethical way with respect to the research process. However, a discursive perspective also highlights problems with some of the traditional ways in which qualitative researchers have attended to ethical concerns, for example through 'member checking', and cautions against an unreflexive turn to well used methods as a device for dealing with ethical questions about power and responsibility in research. Talk and texts about ethics within representations of research also draw on discourses and are constructed to perform particular tasks.

A statement to the effect that the research has been carried out in an ethical manner has been excluded from the above list of criteria because it does not, in itself, convey information about the adequacy of the research. Whilst it would be hard to

imagine that qualitative research carried out without heed to ethical concerns, such as confidentiality, could be judged rigorous, attention to ethical concerns within research is, in itself, not a guarantee of the quality of the research. In addition, whilst there may be general agreement about the need to carry out research in an ethical manner, there is less consensus regarding the translation of this requirement into practice.

3.8 Some problems with discourse analysis

In this section, some of the acknowledged problems with the current approaches within discourse analytic work will be discussed. The theoretical basis for this section is a comprehensive chapter by Parker and Burman (1993) which draws on the experience of many discourse analysts, including those identified with both the Manchester and Loughborough schools.

Problematic issues within discourse analysis are therefore considered from a personal perspective, but with reference to Parker and Burman (1993). Whilst many of the issues are interconnected, they will be considered within four discrete areas; methodological problems; problems with the academic practice of discourse analysis; problems relating to relativism and problems with the persona of the researcher in an account of the research.

Some of the ways in which these problems have been addressed within this work will be discussed. However, these issues have in part been raised because they warrant further general debate, and therefore still remain problematic within this approach.

3.8.1 Methodological problems

Some methodological problems have already been alluded to in previous sections, particularly as identified by each school about the other. These will not be reiterated here, but rather the focus will be on broader issues of relevance to discourse analysis more generally, rather than its practice as exemplified by either the Loughborough or Manchester schools.

One of the first problems discussed by Parker and Burman (1993) is the difficulty in moving from the specific to the general, or identifying features of a particular text that have a wider theoretical significance. The point at which a 'discourse' is identified and how it should be labelled in order that it achieves a wider recognition is also at issue here. This has been a difficulty in the present work, and as indicated in section 3.5, there are few guidelines available to assist the researcher. Within this thesis, this problem has been treated predominantly as an issue of plausibility and efforts have been focused on achieving a credible account. This issue is further discussed in chapter 9.

The authoritative position of the researcher as the 'producer' of her own research has already been mentioned in previous sections. However, this position also has specific methodological implications. Firstly, in representing an analysis in one particular way, alternative readings are forestalled. Thus the very project of discourse analysis to challenge dominant ways of sense-making is potentially subverted as authority is simply transferred from one powerful institution or individual to another. Again, the point at which the interpretation is deemed 'complete' and the space allocated to potential alternative readings of the data are critical. Whilst theoretically unsatisfactory, these parameters are usually determined by amount of time available, and length of report, paper or thesis. Another problem raised by Parker and Burman (1993) is the power of the researcher to impose a particular perspective on texts which have been written by others. Even before the analysis begins, the researcher makes a strategic and political decision about which texts to study. The authority of the researcher as an 'expert' in 'reinterpreting' other people's words utilises well established discourses about the siting of knowledge in universities and the position of academics as creators of knowledge. The practice of discourse analysis within academic institutions, and the production of a thesis as an exemplar are discussed in the following section.

Another methodological problem that exists within discourse analysis is the heavy emphasis on texts, largely to the exclusion of other media, or means of sense-making. As Parker and Burman (1993:158) point out, "power is also at work in

the structural position of people when they are not speaking". A central question about which the proponents of discourse analysis are generally quiet is whether discourses are manifest in ways other than words. The choice of participant observation as a method in the second study was an unusual but deliberate decision in a piece of discursive research work. This was based on the premise that data generated through observation also allows insights into dominant understandings of health and illness. For example, it will be argued that the use of space within the location for the second study, a day hospital for older people, supports perspectives about the role of health care workers which emphasise monitoring, checking and observation.

The word 'discourse' is associated with text and language and in the second study, the term 'frame' has been used in preference, with its allusions to visual as well as textual data. This also acknowledges the work of Goffman (1974) as cited in Coupland, Robinson and Coupland (1994).

The final problem with discourse analysis in relation to methodology is concerned with the "cultural competence" of the reader and researcher (Parker and Burman 1993:158). Parker and Burman (1993) discuss the location of discourse analysis within the discipline of psychology and raise the isolation of psychology from other academic disciplines as an issue. As a researcher from a discipline other than psychology, and a discipline with as yet a limited theory base of its own, I have experienced particular problems in identifying an appropriate theoretical base to assist in developing the analysis. I have at times felt disadvantaged by my lack of exposure to the philosophical ideas and concepts within psychology from which discourse analysis is derived, and which also form the target for much discursive work, such as cognitivism. My analysis is informed by my academic discipline, which perhaps leads to oversimplistic interpretation, limited by the epistemology of the discipline from which I come. I also have difficulty in knowing whether to describe my work as located within psychology (although I am not a psychologist), or occupational therapy (where there is no tradition of discursive work, and where it will not therefore be easily understood).

3.8.2 Problems with the academic practice of discourse analysis

Parker and Burman (1993) have included seven problems (including those two discussed below) as issues concerned with the 'teaching' of discourse analysis, defining teaching as "all attempts to persuade someone that discourse analysis is a 'good thing' and to explain why" (Parker and Burman 1993:161). Whilst specific problems with the treatment of discourse analysis as a method have already been discussed, the issues explored within this section are more related to the practice of discourse analytic work in academic environments.

One of the charges levelled at proponents of the Manchester school variant of discourse analysis by Potter and colleagues, is that in the course of their analysis, they reify discourses (eg Potter, Wetherell, Gill and Edwards 1990). One of the reasons for this is that academics generally are perceived as exploring abstract ideas and knowledge, with little or no action orientation. Thus the danger is that discourse analysis can become an intellectual pursuit, with the identification of discourses the major objective of the analytic process. Parker and Burman (1993) acknowledge the tendency to reification, but in the summary to their paper identify some future applications for discourse analysis which include training and action research. Willig has also been interested in the practical application of discourse analysis and its potential in transforming dominant understandings about, for example, women's sexuality (Willig 1997).

An issue bracketed by Parker and Burman (1993) with other problems in this section is the "inadequately theorized notion of resistance and discursive position" (Parker and Burman 1993:163). They argue that in explaining discourse analysis, there is a reductionist tendency to represent individuals as consciously selecting discourses from a number of alternatives from which to fashion their accounts. Not only does this misrepresent the way in which discourses operate, but also appeals to a cognitive notion of agency, itself often a target of discourse analytic work (eg Edwards 1997). One of the problems here lies in the paucity of metaphors and language with which to illuminate the use of discourses in action. The nature of discourses is also currently inadequately theorised, and as has already

been argued, too heavily dependent on text and language. The role of the individual in utilising and sustaining discourses within social contexts is also problematic in current theory.

A personal problem relating to the location of discourse analysis in academic institutions lies in writing a thesis based on research utilising a discourse analysis methodology. Reference has already been made to this issue in the above section which considers criteria for determining rigour of qualitative research. I argued that reflexivity was imperative in discourse analysis, given its focus on the ways in which 'knowledge' is produced. However, even with reflexive insight, the task of writing a thesis remains. As a postgraduate student, I am expected to conform to academic conventions, whilst recognising that such conventions reinforce powerful discourses which work to the benefit of the academic community, and must artfully use rhetorical devices to achieve my own ends (the creation of my doctoral thesis).

3.8.3 Problems relating to relativism

The position(s) of the discourse analyst with regard to moral authority and relativism has been debated at length (eg Edwards, Ashmore and Potter 1995, Gill 1995, Potter 1998b, Willig 1998). As Parker and Burman (1993) point out, it may be useful to draw on arguments about relativism and multiple readings when challenging dominant positions. However, this is also problematic when arguing for the privileging of one account over another, or the iniquities of one position in comparison to potential alternatives. As has previously been argued, however, the potential for action, predicated on a 'better' alternative, is vital if discourse analysis is to be considered more than an intellectual pursuit,. Using the 'death and furniture' argument, Edwards et al (1995) have skilfully argued that debates about realism and relativism are, in themselves, discursive devices, invoked to perform particular functions, such as weakening the credibility of alternative perspectives. They argue that recognition of this, and the discourse analyst's focus on rhetorical practices, mean that the researcher is in effect freed to embrace and express a political view without recourse to discursive practices. In the final chapter of this thesis, a case is made for recognising both realist and relativist possibilities in this present work, in part challenging the dualities of these assumed positions.

3.8.4 Problems with the persona of the researcher in an account of the research

The final problem to be discussed here is a mainly stylistic issue relating to the demonstration of reflexivity in an account. This has also been alluded to in this chapter and the concern about the use of devices which supposedly indicate reflexivity have also been considered. The point to be made here is that, whilst reflexivity is to be commended (see 'Criteria for evaluating rigour of qualitative research'), excessive articulation of this reflexivity draws attention away from the central argument within the account. As Parker and Burman (1993:168) express it; "wallowing in the researcher's interpretive assumptions and processes can detract from the importance of the topic and possible political interventions".

There is recognition of the potential of this hazard in the latter sections of this chapter. However, I hope that a balance between the project of this work, and the necessary attention to researcher position has been achieved within the larger scope of the thesis.

3.9 Summary

This chapter has provided a description of the methodological and theoretical framework underpinning the current research.

The origins of discourse analysis were identified in order to clarify its central concerns, and illustrate the differences between the two main ways in which it is utilised within the discipline of social psychology. An exposition of these two different traditions of discourse analysis was next provided, and the influences of both of these on the current work identified. Particular attention was paid to analysis.

This was followed by a discussion about the criteria for evaluating qualitative research generally, in the absence of literature focusing specifically on the quality of discourse analytic interpretations. Some criteria which might be used to evaluate this current work were also suggested. Finally, some problems with current theory and practice of discourse analysis were presented.

In the following chapter, the methods used to generate data in the two empirical studies which are included in this thesis are considered in more detail. These comprise semi-structured interviews, participant observation, collection of documentation, transcription and use of 'Ethnograph' (Seidel et al 1995).

4. Chapter Four. Rationale for selection of methods, and their use in discursive research.

4.1 Introduction

This chapter considers more specifically the data generation methods used in the two empirical studies described in subsequent chapters. In this chapter, discussion about the rationale for choice of method is combined with consideration of the use of different methods within a discursive framework. Some detail is provided about how the methods were used, for example, the development of the interview schedules in semi-structured interviews. However, other details relating to settings, sampling strategies, participants, ethical issues, access, procedure, data analysis and interpretation are included in chapters five and seven. The rationale for this decision is that these issues are more easily explained and discussed within the context of the specific studies in which they arose.

The artificiality of dividing an account of research up in this way is acknowledged. The separation of methodology, methods and interpretation should not be taken to imply that the selection and use of research methods discussed in this chapter are viewed as purely technical matters. My position as researcher in the production of the research in this thesis is acknowledged throughout. However, the presentation of work in this format allows for the consideration of different issues without undue repetition. In this chapter, then, the following methods are then discussed with reference to their use within a discursive framework; semi-structured interviews; participant observation; analysis of documentary sources; use of mixed methods; transcription and use of computer software packages. Although not traditionally described as a research method, the use of software packages in qualitative analysis have been included in this chapter as they have provided a means of preparing and managing data prior to, and within, analysis.

The following table briefly details the aims, settings, participants and methods used in the two empirical studies, as a means of providing some context for discussion of specific methods in this chapter.

Table 7: Aims, settings, participants and research methods used in two empirical studies described in this thesis

	First study	Second study
Aims	• To explore how older people with hip fracture as the result of a fall, occupational therapists and physiotherapists construct accounts about falls and falling • To identify the influences which have an impact on how these accounts are created	To explore how risk was invoked, communicated and managed within a day hospital setting for older people
Settings	Acute orthopaedic trauma elderly care ward (service user interviews) Two NHS trusts (therapist interviews)	Day hospital for older people
Participants	Eight older service users with fractured hip following fall Twenty therapists	Service providers and users at the day hospital (participant observation) Fifteen service users (interviews)
Methods used	Semi-structured interviews	Participant observation Analysis of documentary sources Semi-structured interviews

4.2 Semi-structured interviews

Smith (1995) suggests that semi-structured interviews, when combined with a qualitative analysis, are particularly useful for exploring the complexities of social processes, in order to "gain a detailed picture of a respondent's beliefs about, or perceptions or accounts of, a particular topic" (Smith 1995: 9).

Within discourse analysis, Potter and Wetherell (1995) suggest that naturally occurring conversation should ideally provide the data for analysis. However, for practical and ethical reasons, semi-structured interviews are usually the method of choice, particularly for those focusing on interpretative repertoires, in the Loughborough School tradition.

The use of semi-structured interviews was therefore suited to the aim of the first study (see table 7). This method was additionally identified as contributing an illuminating perspective which was more difficult to access through participant observation in the second study as discussed later in this chapter (ie whether and how service users made use of ideas about risk in accounting for their experiences of health and health care interventions).

4.2.1 Developing questions in semi-structured interviews

Most textbooks which consider the use of semi-structured interviews as a research method advocate a number of different strategies for developing questions to be used in the interviews. Over the course of the two studies, my adherence to, and deviation from such strategies reflected my growing appreciation of the epistemological position associated with discourse analysis, and how it is manifest in practice.

Initially I attempted to follow guidelines from Mason (1996) in developing interview questions, which involved initially identifying the 'big' research questions to be explored in the interviews, then breaking these down into 'mini' research questions. Specific interview questions are then developed which address each 'mini' question. All levels are then cross-referenced, and a structure or format for the interview identified. I was also influenced by suggestions by Smith (1995) who emphasises the role of the researcher in working with interview participants' own agenda, and trying to remain impartial by, for example, avoiding the use of 'leading' questions.

I had the additional problem of trying to develop two sets of questions for interview participants; one set for service users (older people with fractured hips as the result of a fall), and another set for service providers (occupational therapists and physiotherapists). I endeavoured to make these two sets of questions as similar as possible, in order that the responses would bear comparison and discussion (see appendices 3 and 4 for interview schedules). I was also wary of assuming commonly held differences between 'health professional' and 'lay' accounts of health events without evidence of this. However, it was impossible to

ask exactly the same questions of both groups of participants. Service users would be responding with the benefit of personal experience of the event of the fall (thus enabling direct reference to a specific fall in the questions). Therapists, however, would be speaking from the perspective of working with people who have either fallen or might be assumed to be at risk of falling (questions therefore orientating around other people's falls).

The strategies suggested by various textbooks (Mason 1996, Smith 1995) were therefore problematic for the following reasons:

- The initial number of questions included as 'big' and 'mini' issues seemed was unrealistic to address in the course of a half hour interview whilst interviews of a longer duration would potentially have been more difficult to recruit to.

- The 'big' and 'mini' issues seemed to become indistinguishable: 'mini' research questions identified under a 'big' issue also seemed equally pertinent to other 'big' issues.

- The number and structure of the questions were difficult to commit to memory, and interfered with the process and flow of the interview.

- As analysis began, the exact nature and structure of the questions seemed less important than the requirement that the participants should talk freely about the topic in general.

- As the pilot interviews with therapists occurred more quickly, and therapist recruitment in the main study was more successful than with older service users, parity between the 'mini' questions was particularly problematic.

In addition, I experienced difficulties in interpreting the service user interviews, as the participants appeared not to be answering the questions in their immediate

responses, or were addressing them elsewhere in the interview. This has been reported in other work employing semi-structured interview method within a discursive framework (Widdicombe and Woofit 1995).

Over the course of the initial study, through the process of analysis and interpretation, and into preparation for the second study, I became increasingly aware of the rhetorical nature of conversation. I began to appreciate more meaningfully the discourse analytic focus on what is being achieved through talk, and how it is informed through larger discourses (Parker 1992, Potter 1996) rather than the focus on content. In particular, I understood the implications that this methodology had for the use of methods such as semi-structured interviews. Far from the apparently neutral position of the interviewer advocated by Smith (1995), for example, Potter and Wetherell suggest that the interviewer should reveal personal views, or even argue with interviewees, in order that rhetorical devices can be more easily available and accessed (Potter and Wetherell 1995).

Whilst not formalised, I therefore focused on a number of different tactics for the use of semi-structured interviews in the second study:

- identifying general issues of interest, the priority being to encourage the interviewee to participate through talk as much as possible, and also enabling me to remember questions with greater ease (and therefore less disruption to the conversation)

- drawing on experience gained in the first study in order to feel more confident and therefore more relaxed myself during the interview

- remaining as 'participant-centred' as possible in allowing participants more freedom to explore their own agendas, rather than being concerned to stay directly 'on-track' with regard to the interview questions identified

- attending to ethical considerations about not causing distress or anxiety to the participant (in contrast to the position advocated by Potter and Wetherell 1995 - see above).

- thinking very deliberately about own persona and role in producing responses, and employing strategies to reflect on this, such as frequent memos, which themselves constituted part of the data

- being aware of the context within which the interviews were taking place.

4.2.2 Use of semi-structured interviews within discursive research

Miller and Glassner (1997) have argued that a 'radical social constructionist' approach to interview data is problematic, because by inference it is impossible to 'know' anything about the social world outside of the interview (Miller and Glassner 1997: 99). From their perspective, the lack of ability to generalise beyond the immediate context implied within such an approach severely limits the utility of interview data.

However, the strength of interviews conducted and analysed within a discourse analysis methodology is that, in common with social constructionism, the purpose of the interview as data generation method is changed. Thus, rather than revealing insights into the content of social realities, the construction of talk itself becomes the focus of interest (Potter and Wetherell 1987). In chapter three, it was argued that discourse analysis is jointly concerned with the action orientation of text, and the resources used in constructing accounts. Whilst it may be difficult to generalise in an empirical sense the content of such accounts beyond the immediate interview, theoretical generalisation allows for utility at a conceptual level (Mason 1996). Widdicombe and Woolner (1995), for example, state that their analysis of skills and strategies within discursive practices employed by young people who belong to youth subcultures "may be relevant to a wider community of persons", because everyone functions within a "natural language community" (Widdicombe and Woolner 1995: 208).

Miller and Glassner themselves allude to the dual orientation toward action and resources in study of talk, in their account of young women's affiliation to gangs (Miller and Glassner 1997). They discuss the potential of interview situations as a means of trying out different social identities (ie what people might 'do' with their talk), and also the 'cultural' and 'collective' stories from which accounts were crafted (the resources used) (Miller and Glassner 1997: 106-110). Issues relating to the generalisability of discursive work is further discussed in chapter nine.

4.3 Participant observation

As has been discussed in the previous section, discourse analysis has to date been heavily dependent on research methods which generate or utilise texts, primarily analysis of transcripts from semi-structured interviews and textual documents. Parker argues that 'all tissues of meaning' can be realised as texts, including non-verbal behaviour, architecture and bus tickets (Parker 1992: 6-7). However, less attention has been paid to how such data sources should be treated in analysis, and how to generate texts from these items as a precursor to interpretation. Problems with this heavy dependency on text have been recognised, although not resolved (Burman and Parker 1993). Mason (1996) has also argued that text has been over privileged in qualitative research more generally, to the exclusion of other means of generating and representing data.

However in considering how risk was realised in a day hospital for older people, a reliance solely on interviews and textual material, as in the initial study, appeared limiting. I felt that visual information regarding the setting, practices and interactions in the day hospital could also generate valuable data which would contribute to the interpretation. However, I was unable to locate any studies which had utilised observational methods within a discourse analysis framework. In considering the use of observation, one problem immediately becomes apparent: the textual data which form the basis of a discourse analysis have been generated by the researcher, and are therefore very overtly influenced by the discourses employed by the researcher. However, whilst the researcher may not appear to be as visible in use of other methods, he or she is still present, and impacts on generation and interpretation of data. Problems with the supposed 'neutrality' of

the interviewer in semi-structured interviews, for example, were discussed in the previous section. Interviewers inevitably influence participants' responses in many ways, including whom they are perceived to be, what their motives appear to be in conducting the interview, topics identified for discussion and how questions are phrased and asked.

I therefore felt that whilst use of observation as a method was unusual within a discourse analysis, the benefits of additional data generated through observation outweighed potential problems, providing the process of interpretation was described carefully and reflexively.

The use of observation as a research method is closely associated with ethnography (Banister, Burman, Parker, Taylor and Tindall 1994), described by Fetterman (1989:11) as "the art and science of describing a group or culture", characterised by fieldwork, which can extend from six months to two or more years.

This work is not described as falling within the ethnographic tradition as it differs in terms of research aim, time spent at research site and the influence of a discourse analysis perspective in interpreting data. However, it does share some principles and assumptions with ethnographic practice, particularly reflexivity (Hammersley and Atkinson 1995), which has been discussed in the previous chapter, and emergent research design (Fetterman 1989).

One of the key decisions to be made when carrying out observational research work is how much of a participant in the setting one should be. Mason (1996) makes the point that the researcher in likely to move up and down the continuum between complete observer and complete participant during the course of a period of participant observation. However, the initial question encourages the researcher to think about their own role in the production of data. A second critical question for the observer is the type of identity or role which they should adopt, an attention to the sort of impression they will create (Mason 1996).

The term 'participant observer' has been interpreted in a variety of different ways. For some, to be a participant observer in a health setting means that, in addition to a research function, one is also employed in delivering care. For others, the term 'participant observer' is suggested simply by being present within a particular setting, because one is interacting and participating in the setting or environment (Mason 1996). Whilst not providing care or treatment during the course of the research, I would describe my position during the period of observation within the day hospital as closer to the 'participant observer' pole for the following reasons:

- I felt it important to establish relationships with the people whom I would be observing in order to gain access to their perspectives. This required interaction in order that they might feel comfortable with me, trust me and be willing to talk to me. Whilst mindful of the identity selected for the purposes of the research, I therefore chose specifically at particular points to initiate action.

- The term better reflects my perspective of my role as an active generator and producer of data together with other people in the research setting, rather than a more passive, neutral observer of action.

Further details about the research persona adopted, and how this was achieved within the period of participant observation are described in chapter seven. This was considered more appropriate than discussion at this point, as decisions affecting this choice were made as a result of outcomes of the first study. The rationale for the selection of my identity as researcher in the second study is therefore clearer to understand in its present location. The process of carrying out the participant observation, and details such as recording action and reflection, are also described in chapter seven. Further discussion about the implications of using participant observation within research utilising a discourse analysis methodology is provided in chapter nine.

4.4 Analysis of documentary sources

Various documentary sources were collected throughout the period of the second study, to supplement the two major data generation methods employed; participant observation and semi-structured interviewing. These data sources have been included at various points in the analysis. Examples of the types of documents collected include assessment forms, information leaflets and posters, the Service Profile and Operational Policy of the day hospital and an information booklet about the day hospital prepared for new service users. Some of these data were freely available (eg information leaflets for service users on a display stand by the front door), whilst others were requested from staff (eg Service Profile and Operational Policy).

The rationale for including documentary sources was that they would provide insight into both the culture of the day hospital, and also how risk was manifest. At the start of the analysis, these sources were considered to be tangential to the major project of generating and interpreting observational and later interview data. At this point they were not formally included in the analysis. Later in the interpretation, however, their potential value was recognised, and they were used in an interpretive sense (ie "factors relevant to ... their context, production and consumption" Mason 1996: 77). These documents were subjected to a discourse analysis based in criteria identified by Parker (1992, see chapter three), in which object and subject positions were primarily considered.

4.5 Use of mixed methods

As indicated in table seven, the data generation methods of observation, interviewing and analysis of documentary sources were combined in the second study, which focused on how risk was invoked, communicated and managed within a day hospital for older people. Whilst each method has so far been considered separately, Mason (1996) argues that in using combinations of methods, an explanation should be provided regarding the role of each in addressing the research question(s). This explanation is usually restricted to combinations of qualitative and quantitative methods, but is equally pertinent when considering

combinations of qualitative methods (Mason 1994). In this section, therefore, a rationale is provided for the use of multi-methods, and the various stages at which they were employed within the second study. These decisions are also addressed in chapter seven.

Whilst the research aim provided some degree of focus, the approach to data generation in the early stages of the second study was deliberately unstructured, in line with ethnographic principles (Banister et al 1994). This therefore allowed key issues influencing the research design and choice of methods to emerge through the research rather than be superimposed onto it. As discussed in subsequent chapters, prior assumptions about the significance of a fall for older people had hindered interpretation of service user accounts in the first study. The broad ranging aim for this second study would therefore allow for the development of the research in as yet unforeseen directions, whilst providing space and time for reflection. The exploration of risk therefore provided a framework for the second study. However, participant observation was initially employed in order to learn more about the context within which the research was being conducted. It was felt that this was necessary and integral to interpretation which would follow, about how risk was understood and enacted within the environment of the day hospital. During the period of participant observation, therefore, attention was paid to such issues as how different groups ('staff' and 'patients', for example) were constituted and positioned relative to each other and how the business of the day hospital was described and understood. Within the methodological framework of discourse analysis, an understanding of how authority and knowledge are constructed and exercised is critical to appreciate how discourses "bring phenomena into sight" (Parker 1992: 4-5). The broader perspective gained during participant observation influenced the later interpretation regarding which objects and actions were deemed risky within the day hospital, and how these were managed.

As has already been indicated, one of the principles of ethnographic research which influenced this work was the notion of an emergent design, allowing for the introduction of different methods at various stages of the research project. The preliminary analysis of the observational data constructed a picture of the day

hospital in which perspectives relating to health professional explanations and functions seemed to dominate. However, another perspective which challenged these understandings also seemed evident, although difficult to access. At this stage, therefore, semi-structured interviews were introduced. It appeared that this additional and different perspective, whilst not used exclusively by service users, seemed best articulated by them. Semi-structured interviews therefore provided a more direct and focused way to explore the saliency of risk as a concept in seeing how older service users accounted for themselves and their association with the day hospital. In addition, documentary sources were collected as a secondary source of data throughout the study, to support the developing analysis.

4.6 Transcription

O'Connell and Kowal (1995) cite Du Bois in defining transcription as "the process of creating a representation in writing of a speech event so as to make it accessible to discourse research" (Du Bois 1991:72). As such, then, transcription is the means of transforming raw data usually generated through interviews, such as audio-recorded speech, into data which is then amenable to analysis.

There are many aspects of speech besides the verbal which it is possible to transcribe. O'Connell and Kowal (1995) identify prosodic, paralinguistic and extralinguistic elements, all of which can be represented in written form.

Decisions regarding level and type of transcription system to be utilised were taken after the pilot phase of the first study, in which both a fuller and reduced system were tried in the transcription of pilot interviews (see appendix 5). The decision to adopt the reduced system was based on both theoretical and practical considerations:

- whilst initially unsure, it became clear that analysis and interpretation was focusing on the broader ideological issues, after Parker (1992) and colleagues, rather than details and devices of speech which are typically the focus of Potter and those from the Loughborough School (eg Potter 1996,

Potter and Wetherell 1994).

- Having attempted to conform to the transcription system advocated by Potter (eg Potter 1994) during the pilot study, I concur with comments made by O'Connell and Kowal (1995). They suggest that the inclusion of timed conversational events such as pauses confer a misleading objectivity to the "subjective perceptions and/or categorizations of the transcriber" (O'Connell and Kowal 1995: 100). In reality, duration of conversational events such as inbreaths and pauses are subjectively estimated in this type of transcription. As the subsequent analysis may be dependent on the representation of these split second conversational events, the validity of the interpretation is consequently thrown into question.

Many of the examples of transcribed data in this thesis have been further shortened to enable them to be read with greater ease. One of the primary ways in which this has been done is by excluding the researcher's responses, such as "Um hmm", or "Yes". When this has been done, attention has been paid to both indicate that material has been excluded (through the use of repeated dots '...'), and that the original sense has not been misrepresented or distorted.

Whilst transcribed material from the first study indicated overlap in speech through the use of square brackets ('['), this device was not used in the second study as it did not contribute to the analysis and was therefore rendered redundant. Punctuation was avoided on the basis that this added a spurious intelligibility and meaning to speech which was in fact part of the process of interpretation.

Additional help with transcribing was sought both in the first and second studies. The people carrying out transcription were provided with details about the conventions to be used, and the transcribed material was checked against the audio-tape recording of the interview to ensure accuracy.

The transcription conventions used in this work can be found in appendix 6.

4.7 Use of computer software packages in interpretation

4.7.1 Use of Word for Windows 95 Version 7.0

The use of computer packages has been integral to this work. The word processing package Word for Windows 95 Version 7.0 was used for the following functions, taken from a longer list provided by Miles and Huberman (1994: 44), and cited in Coffey and Atkinson (1996): writing up and transcribing fieldnotes, coding, storage, search and retrieval (locating relevant segments of text and making them available for inspection), memoing, theory building, preparing interim and final reports.

Coding of interview data in the study focusing on accounts of falls was carried out in the following way (chapters five and seven provide further details and examples of theoretical considerations during this process):

Figure 3: Process for coding of data using Word for Windows 95 Version 7.0 in initial study focusing on accounts of falls

1. Hard copies of interview transcripts manually coded.
2. Themes identified, and a file for each theme opened in the word processing package.
3. File containing interview transcript opened in word processing package. Passages pertaining to different themes copied and pasted into relevant files, with a note made of filename, page and line numbers. Coding tended to be inclusive, with all possible examples copied into the file. All transcribed interview files coded in this way.
4. Original transcribed interview files saved unamended.
5. Files containing coded data saved under theme name.
6. Hard copies of each theme file printed and available for further analysis and interpretation.

This process was time-consuming, particularly in terms of labelling each coded segment with its location in the original document. However, it enabled coding to be carried out in a systematic fashion, and ensured that data could be located. Themes could also be combined easily by incorporating two existing files into a new file, or subdivided by creating two new files and allocating segments accordingly.

4.7.2 Use of 'Ethnograph' (Seidel et al 1995)

'Ethnograph' (Seidel et al 1995) is a computer package specifically designed to assist with qualitative analysis. It was used in the second study as a means of coding observational data, memos, interview data and interview notes. The manner in which it was used was very similar to the use of Word for Windows 95 Version 7.0 as described in the previous section. However, the process of coding was much quicker; segments could be marked more simply, and were automatically given an identifier which showed their location in the original document. Codes could also be combined and broken down more easily.

The major benefits of programmes such as 'Ethnograph' are therefore that they are quicker to use for coding purposes, enable easy retrieval and can handle large data sets with relative ease. However, it is vital that analytic strategies have been clarified before using such packages (Coffey and Atkinson 1996).

Another attraction of software packages designed to assist with qualitative analysis, such as 'Ethnograph', is that they can appear to make the process of analysis more visible. One's interpretation can appear more credible if one can illustrate using the software package how initial codes were combined to form overarching themes, or relate hierarchically to each other.

However, my experience in carrying out this work is that it is difficult to represent codes or themes in this way, as they work at different conceptual levels which are not equivalent, and are used in a variety of different ways to inform and develop interpretation. For example, I had originally envisaged that the set of codes used to categorise data during the period of participant observation would be integrated

with those developed for the interview data, resulting in a new set of codes with which the entire set of data would be recoded. However, the two sets of codes fulfilled different purposes. The initial set, developed for the data generated during participant observation, were more orientated to context and setting, and informed preliminary analysis. The data resulting from semi-structured interviews were coded later in the analysis, and the codes developed were informed by the preliminary work. The two sets of codes were not therefore equivalent, and to combine them would mean a loss of richness and complexity in describing the data.

One may also begin to understand and use codes in different ways over the process of the interpretation. It is my experience that one's interpretation of the data becomes theoretically more complex as analysis progresses, informed by re-reading of the data, reflection, discussion, and reading of the literature. Some of the codes developed initially for analysing the data generated through participant observation appeared tangential to the project of exploring risk in the day hospital setting (eg 'passive', used to mark passages in which service users appeared, or were spoken about in a passive sense). It was unclear initially how this code would contribute to the analysis. However, later during the interpretation, a sense of passivity came to be associated with the medical frame, in which the service users' bodies are prioritised, and they themselves are not seen to be capable of exercising choice or autonomy.

It is therefore suggested that there are some potential problems with the use software packages designed to assist with qualitative analysis, depending on the stage at which they are utilised. If one has invested a lot of time systematically coding data with a set of categories or themes developed relatively early on in the analysis, one might not have the available time to recode at a later date with a more sophisticated coding scheme. Conversely, if one waits until later in the analysis to code, much of the creative potential of the package in exploring and making sense of the data is wasted.

My perception of using computer software to assist with analysis and interpretation of qualitative data, therefore, is that it can greatly facilitate storage, management

and retrieval of data. The process of deciding on, refining and applying codes is also a critical stage in the analysis of such data. However, a rigorous and credible interpretation is developed through the process of coding, and afterwards, when reflecting on hard copies of coded data. The initial coding scheme may not, then, bear much resemblance to the complex explanation developed subsequently to account for the data. Computer software packages such as 'Word for Windows 95 Version 7.0' and 'Ethnograph' therefore are very useful tools, but do not replace the rigour and creativity involved in developing a credible interpretation within qualitative research. This view echoes the perspective of the creators of the software package 'NUDIST' (Richards and Richards 1994).

4.8 Summary

This chapter has discussed the use of specific data generation methods employed in the two empirical studies on which this thesis was based, carried out within a discourse analysis framework. Although much has been written about the origins of and epistemological perspective employed within discourse analysis, there is little work which has detailed the processes of generating data within this framework, using methods other than semi-structured interviews and documentary sources. In this chapter, reference has been made to relevant literature from the broader field of qualitative research methods more generally. Where necessary, the implications of using a discourse analysis framework on method have been highlighted. Further details regarding the application of these methods, such as issues around access, sample selection, and process of analysis can be found in chapters five and seven.

5. Chapter Five: Falls and falling: accounts of therapists and older people with fractured hips.

5.1 Introduction

This chapter describes the procedures and interpretation of an initial study which was designed to explore how older people with fractured hips and therapists talk about falls and falling.

In chapter three, discourse analysis was introduced as a methodology for exploring both the resources and the action orientation of talk. The aims of this study are framed in discursive terms below, reflecting this dual orientation. In chapter four, the case was made for the use of semi-structured interviews as a means of generating data for a discourse analysis. This study therefore focused on how both older service users[1] and therapists talk about falls, by analysing data generated through semi-structured interviews, and interpreted using discourse analysis principles.

After stating the aims of this initial study, this chapter provides details of the context of the research, details of sampling, procedures for the pilot and main study, recruitment and analysis and a profile of the research participants. This is then followed by consideration of both the therapist and service user accounts, clarifying the main differences between them, and considering possible functions of these accounts.

5.2 Research questions and aims

Initial experiences as a member of a multi-disciplinary academic group focusing on falls in older people had led me to question whether the perspectives of older people were reflected in research and practice in this area. There also appeared to be many untested assumptions inherent in the practices of health professionals in work with older people considered to be at risk of falling, and as a therapist myself,

[1] In this and subsequent chapters, the terms 'patient' and 'service user' have been used interchangeably

I was interested in investigating these further. The research questions in this initial study were therefore:

- How do older people and therapists talk about falls and falling?
- What kinds of perspectives inform these accounts, what (if any) are the differences between them, and what purpose do they serve?

These were translated into the following research aims:

- To explore how people with fractured hips aged 65 years and over, occupational therapists and physiotherapists construct accounts about falls and falling.
- To identify the influences which have an impact on how these accounts are created.

The reasons for the selection of people aged over 65 years with fractured hips are detailed in section 5.5, 'General sampling considerations'.

5.3 Context of research and persona of researcher

This section describes both the context within which this research was carried out, and also addresses the persona of the researcher within the research, which is later demonstrated to be of importance in interpreting the accounts of both the older service users and the therapists.

5.3.1 Ward

The patients were recruited from a ward situated in a large General hospital. The ward is one of four wards grouped together in the Accident/Orthopaedic Directorate. At the inception of the study, it was described as a general orthopaedic trauma ward; however one week into the nine weeks of data generation, its designation changed to that of orthopaedic trauma elderly care ward. This change had been anticipated for some time, although it was not possible to obtain information concerning when this would occur. Information

included in the documentation provided at the launch of the 'new' ward included a ward profile containing the details which can be found in appendix 7.

The change in status of the ward meant that the following changes occurred:

- the minimum age for admission to the ward was increased to 85 years of age (although this was not strictly adhered to)
- a daily ward round was carried out with the Elderly Care Physician
- additional assessments were included in the information gathered on admission; a Barthel Index score (Collin, Wade, Davies and Horne 1988) to indicate level of dependency in activities of daily living, and a Mini-Mental State Examination score (Folstein, Folstein and McHugh 1975) to test cognitive mental state
- instigation of a weekly multidisciplinary team meeting including physiotherapists and occupational therapists

My initial impression on visiting the wards was that the staff appeared very busy. I was anxious that my efforts to recruit service users for interview should not result in more work for staff, and accordingly learnt how to access the information I needed through existing channels of communication. I identified names of potential participants through access to the admissions book maintained by the ward clerk, and attended the nurses handover in order to identify those people who were too ill or too confused to participate. I also checked initial verbally reported diagnoses against medical records in order to confirm that potential participants had fractured hips.

Another of the characteristics I soon noticed about the ward was the lack of privacy afforded to patients. This meant in effect that there was nowhere private to carry out interviews with patients who were in shared rooms. Anxious to assure interview participants of confidentiality, if they desired, I did manage to locate a room not far from the ward where we could have some privacy for the interviews, although the times when this room was available were limited. Therapist participants confirmed that neither staff nor patients had access to a room where

they were assured of complete privacy, for example, for talking with relatives, or discussing details of an intimate nature.

I was anxious to create a professional impression when recruiting service users, and accordingly dressed smartly, and elected to wear an identity badge, specifying my name and affiliation to the University. My rationale for this was that a casual appearance might detrimentally affect recruitment. I introduced myself to potential service user participants as a funded researcher interested in therapy and falls.

5.3.2 Therapy services

Information was requested from the two occupational therapy and physiotherapy managers about the people working within their services. This provided background knowledge which informed sampling decisions with these groups. However, the physiotherapy information in particular was a little out of date by the time the study commenced.

The occupational therapists were selected from a staff list (dated May 1997) covering two NHS trusts providing the following services (taken directly from the list):

- community hospitals and adult services
- elderly services
- services for the physically disabled
- wheelchair service
- learning disabilities
- forensic and challenging behaviours
- children's services
- university hospital
- continuing development team
- mental health

The director of occupational therapy practice provides professional advice and management to the 89 occupational therapists and 76 therapy support staff.

The physiotherapy service also covered the same two trusts, providing services as follows:

- child health
- learning disability
- mental health
- severe disability
- community hospitals
- elderly services
- outpatients
- university hospital

However, from 1 April 1997, the Physiotherapy manager was responsible for physiotherapy staff in the university hospital service only.

I had previously worked in the occupational therapy service for a short period, and in addition was known to many of the occupational therapists through my previous work as a researcher investigating disability equipment. Immediately prior to the start of my studentship, I had been working as a Lecturer in Occupational Therapy at the University, and would have been known to both occupational therapists and physiotherapists in this capacity. In my introductory letter and consent form sent to therapists (see appendix 8) when recruiting, I confirmed my identities as an occupational therapist, lecturer and currently postgraduate student. I also indicated that both therapy managers had given me permission to approach therapists working in their services.

5.4 Ethical approval

Prior to commencing the study, ethical approval was obtained from the Joint Research Ethics Committee. This committee requested that consent from individual service users' consultants should be obtained before they could be included in the study. As a consequence, letters were sent to the nine orthopaedic

surgeons with patients on the ward, of whom seven gave permission for people under their care to be approached about participating.

As a matter of courtesy, anyone else perceived to have an interest in the project was also informed, including the Service Manager of the Accident and Trauma Directorate in which the project was to take place. Subsequently I was also asked to submit a copy of the ethics form and protocol to the monthly Directorate meeting for consideration once ethical approval had been given.

5.5 General sampling considerations

The decision to interview people aged 65 years and over was reached because much of the research on falling to date has been carried out with older people. A preliminary review of the literature suggested that a fall was represented as a serious event for this group, and I was interested to see if this perception influenced how older people themselves spoke about falling. The rather arbitrary cut off point of 65 years was also selected because much of the biomedical literature has used this parameter. I was aware that the use of chronological age as a categorical variable is a social and research practice and decided that it would therefore be useful to invoke a well recognised descriptor in identifying my sample.

Whilst potentially interested in the accounts of a broad spectrum of older people, I elected to interview people whom I knew had experienced a fall. Most hip fractures are reported as resulting from a fall (Audit Commission 1995), and a sample of people with fractured hips would be relatively easy to identify, particularly within the ward environment to which I could negotiate access. Whilst this meant difficulties with empirical generalisation of the interpretation to other groups, theoretical generalisation concerning the processes involved in the crafting of accounts about falling, and the consequences of these would in principle still be possible within this study (Mason 1996).

The rationale for selection of occupational therapists and physiotherapists was that they are key health professionals involved in the rehabilitation of older people who have fractured their hips, and are increasingly involved in working with people who

are at risk of falling. As an occupational therapist myself, I had a particular interest in how therapist accounts were constructed, and the influences upon them. Wetherell and Potter (1992) have also suggested that to be a member of a group with whom one is participating in research can be advantageous in terms of interpretation. The two professions are often grouped together for the purposes of education, practice (the Guidelines for Managing Falls among Elderly People [Simpson, Harrington and Marsh 1998, Simpson, Marsh and Harrington 1998] were written both by and for occupational therapists and physiotherapists) and research (eg Department of Health 1994).

Mason (1996) advocates the clarification of the unit being sampled in qualitative research, although illustrates how, for mainly practical reasons, 'people' often comprise the 'sampleable unit'. The larger resources, or discourses, informing the accounts generated through interviews were of interest. However this study also focused on how groups of people (eg 'therapists', 'older health service users', 'older people who have fallen') used these resources, and what their accounts were designed to achieve. For practical and theoretical reasons, therefore, people who were either therapists or older people with fractured hips therefore formed the samples. Specific inclusion criteria for the samples are detailed later in section 5.7.1.

5.6 Pilot study

The original intention for the pilot study was that it would take place on the ward on which the main study was to occur. This would therefore enable the testing of recruitment procedures, feasibility of original design (which had included observation and recording of therapy interventions, thus providing an additional perspective views on falls elicited during interviews) and determine order for interviews and observation, in addition to improving interviewing skills. However, due to delays in gaining consent and access, the decision to pilot the initial interview schedules with contacts and colleagues outside the ward environment was taken. Whilst this meant that not all of the original aims for the pilot study were addressed, it did prevent further delays, in addition to fulfilling those aims focusing on improving interview skills.

The process of developing the interview schedules is described in chapter four. The therapist questions were piloted with two physiotherapy and two occupational therapy colleagues known to have experience of working with older people at risk of falling. Through colleagues, contact was made with three older women aged over 65 years known to have fallen. Whilst they were not currently in hospital, it was felt that the experience of interviewing them would be valuable both in terms of allowing for older people's perspectives to be incorporated into the interview schedule, and also for allowing feedback on method and style of interviewing. The aims of the pilot study were therefore:

- to provide practice at interviewing both health professionals and older people
- to provide opportunity to receive feedback about both style and content of interview
- to practice preparing and using tape-recorder
- to test different transcription conventions and make decision regarding those to be used for main study
- to start address how coding and interpretation might proceed

The pilot study allowed for practice and growth in confidence in interviewing. As detailed in chapter four, different transcription techniques were tried (appendix 5) and the conventions in appendix 6 were eventually used in both empirical studies in this thesis. The data generated also provided some material which stimulated initial ideas about coding.

Whilst feedback from the pilot therapist interviews had appeared to support the interview schedule designed for this group, I experienced difficulty in making sense of the pilot interviews with older people who had fallen. Some changes were made to the interview schedule for older service users following the pilot, but I felt that I was struggling to identify the 'right' questions to ask, and this confusion persisted on into the main study. In reflecting on this problem later, I became aware that my inability to understand what service users appeared to be saying was possibly related to the assumptions I brought to the interviews as a health professional

myself. In addition, the service users' responses to my questions were inextricably linked to their perceptions of me as a researcher.

As stated, the original design of this study had, in addition to interviews, included observation of therapy interventions with therapists and older people with fractured hips. The rationale for this additional data generation method was that it would provide an additional perspective which might compliment, or more interestingly, contradict the views on falling elicited during the interviews. This would thus provide a more complex picture of how both therapists and older health service users with fractured hips talked about falls and the functions served by this talk during interviews, and in the context of a health intervention.

However, because of the limited nature of the pilot study, assumptions about the ease with which therapy interventions could be observed remained untested. As my contact with the ward increased, it became apparent, for practical and logistical reasons, that this would be extremely difficult to organise. Problems were evident in identifying which service users had been referred for therapy, the rapid throughput on the ward meant that observation would have to be arranged in a very short space of time, and it was difficult to identify when therapists would be working with service users. Observation was therefore dropped as a data generation method from this study.

Semi-structured interviews therefore became the primary method of data generation. In addition, the length of time committed to this study was reduced from around twelve months to three months (including pilot study). The rationale for this was both that the exclusion of observational data meant less time would be required for analysis, and also that this would also allow for the planning and implementation of a second study, further exploring issues raised in this initial study. The intended number of interviews was also reduced from a total of 75 (25 with service users, 25 with occupational therapists and 25 with physiotherapists) to 40 (20 with occupational therapists and physiotherapists and 20 with service users). I felt that as an initial smaller-scale study, this number would allow

exploration of relevant issues, whilst still admitting a degree of variability and diversity.

5.7 Main study

5.7.1 Specific sampling decisions

The original intention specified in the protocol had been to employ a purposive sampling strategy for both therapists and older service user groups. This was possible and practical for the therapists, and decisions regarding sampling are illustrated later in figure 6. However, the limited number of service users able and willing to participate meant that this strategy could not be used. Whilst deviation from the entry criteria would have assisted with the development of theory, these had been agreed with the Joint Research Ethics Committee, consultants and ward staff. In addition, I did not yet feel sufficiently confident as a qualitative researcher to be clear about the theoretical implications of choosing to do this. I therefore retained the specified criteria during the nine week period identified for main data generation period. All service users meeting the entry criteria specified below were therefore included. In addition, one participant who had sustained a fractured hip as the result of being hit by a falling structure was also interviewed. Several of her observations have been included as 'negative instances' (Mason 1996), thus enabling extension of the interpretation.

The criteria for inclusion of older service users in the study were governed by practical considerations and were as follows:

- aged 65 years and over and having fractured hip, identified in medical notes as fractured neck of femur, hip, 'painful hip', or details of surgical procedure at hip
- having given written consent to audio-taped interview
- consultant having given consent
- admitted to orthopaedic trauma ward of general hospital
- medically stable
- able to comprehend and use English

Criteria for therapists were as follows:

- working within two specified NHS trusts
- having given written consent to audio-taped interview
- working with people who have had falls, or latterly, were deemed to be at risk of falling
- able to be interviewed within 30 miles of workbase (thus limiting potential travel costs incurred).

5.7.2 Recruitment and procedure

Due to the limited nature of the pilot study, recruitment and procedure were not tested prior to the start of the main study. Their inclusion in the report of the main study, whilst unconventional, therefore reflects the order in which practical issues such as these were addressed.

The older service user participants were recruited in a number of different ways. I visited the ward on either Monday, Tuesday or both during recruitment period, first checking the admissions book, in which was detailed new admissions to the ward, diagnosis and age of the patient, and the name of the consultant. The medical records of the service users seeming to fit the specified criteria were then checked for additional information such as how the fracture occurred, the medical state of the patient and if there was any mention of confusion. I then attended the nurse handover at lunchtime to check that the nurses felt that the service user was well enough to be approached about participating in the study, and that they were sufficiently orientated to understand what was being asked of them. In retrospect, this reliance on nurses as gatekeepers perhaps had unanticipated consequences on the ways in which I was perceived by service users during interviews. This is considered in more depth later in this chapter.

The procedure employed to inform older service users about the study and enlist their participation is illustrated in the flow chart below:

Figure 4: Flow chart illustrating procedure for recruiting older service users in initial study

Having identified that service user met entry criteria, researcher introduced herself and service user informed about study. If they indicated that they were willing to consider taking part, an information sheet (appendix 9) was left with them.

⇓

Service user visited later in the week, to provide opportunity to ask questions and check willingness to participate

⇓

If prepared to participate, written consent form (appendix 10) read and signed.

Venue for interview agreed

⇓

Semi-structured interview takes place

⇓

Entry made in medical notes to effect that service user had participated in study (as required by Joint Ethics Committee), and letter thanking service user for participating written and sent

At the start of the interview, service users were asked if they would prefer to work through questions at their own pace, or have the interviewer guide them through the interview. If they chose the former, they were given the list of interview questions in large bold font to read.

In addition to the interviews, service users were also asked to complete questionnaire supplying demographic details (see appendix 11).

The figure below details information about all service users on ward during study period 30/6/97 - 21/8/97 with a diagnosis of fractured neck of femur or hip, 'painful hip' or having surgical procedure to the hip. This information was derived from admissions book on ward, and medical notes, and outcomes regarding participation noted by researcher. There was no record of the first participant in

the admissions book, although she was identified as a potential participant from nurses handover. She is not therefore included in this figure.

Figure 5: Outcomes regarding participation in initial study for all service users with fractured hips on orthopaedic trauma ward during study period 23/6/97 - 21/8/97

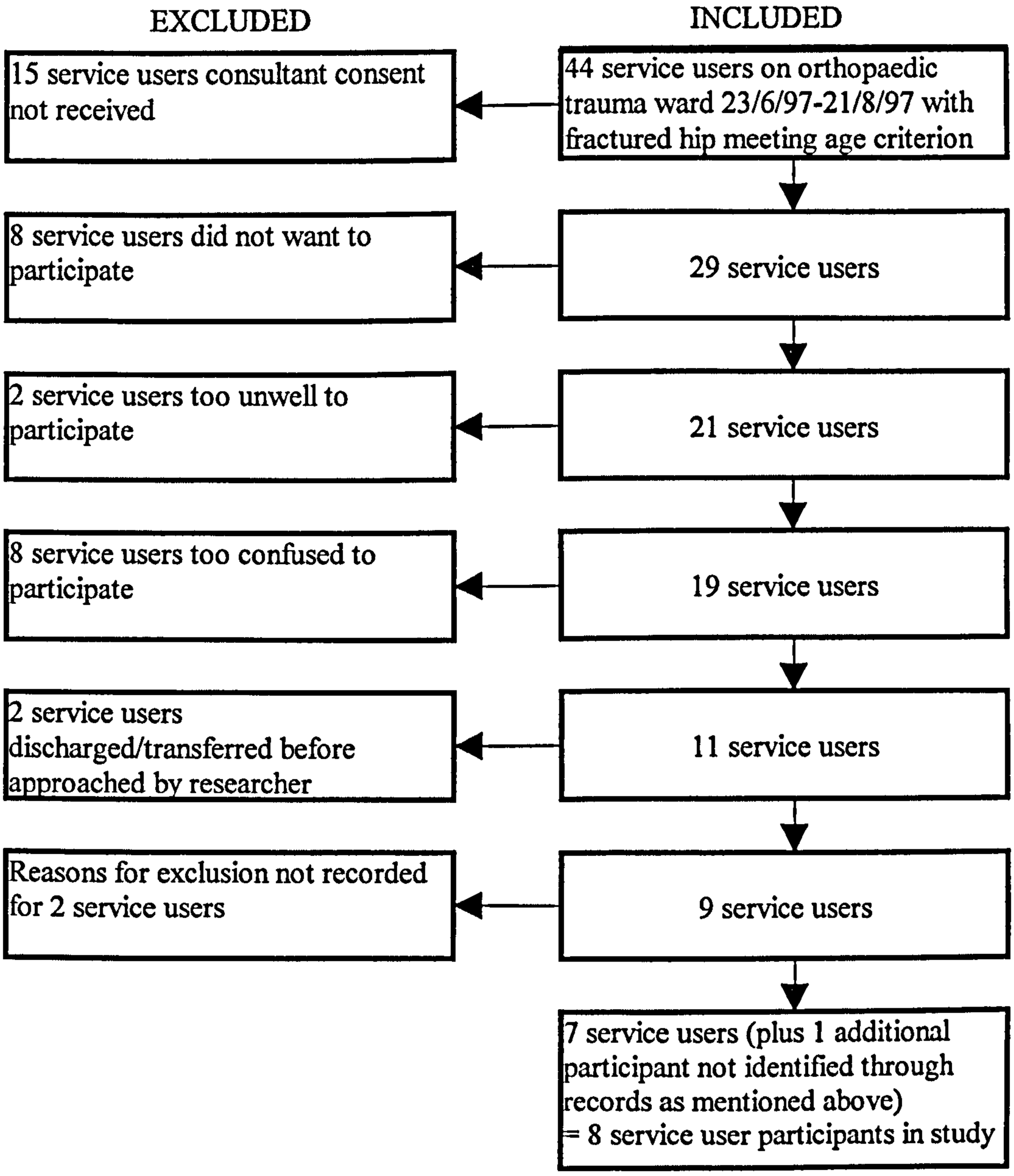


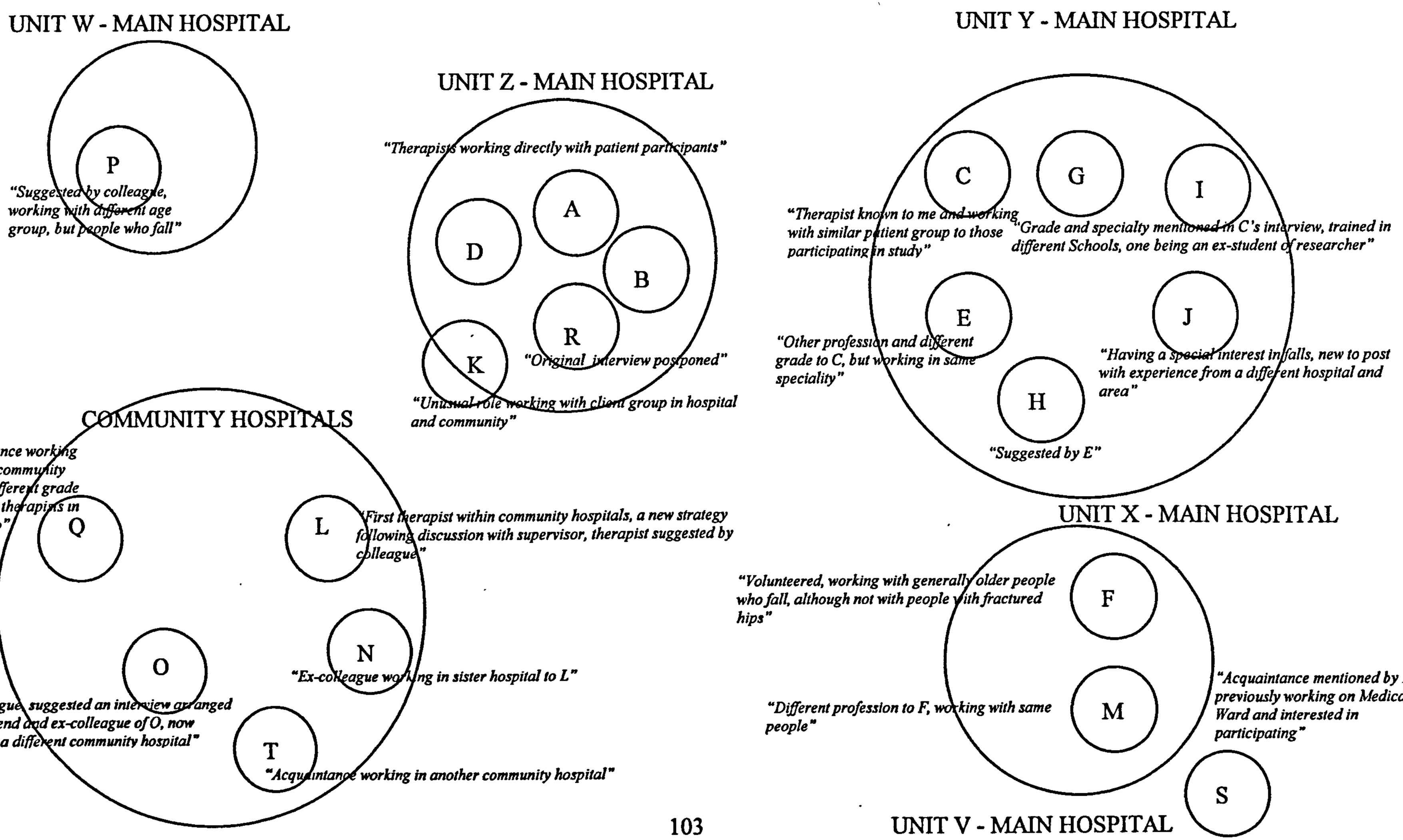
Figure 8 later in this chapter indicates rate of participation of service users to the study over the nine week recruitment period.

The original intention of recruiting 20 service users was not therefore fulfilled during the data generation period. This in part reflected a misplaced assumption regarding the ability of some older people with hip fractures to participate in

interviews, although informal discussions with staff prior to the start of data collection had not indicated that this was likely to be problem. However, the blanket refusal of two consultants to permit any of the patients in their care to be approached excluded fifteen service users from the sample.

The purposive sampling strategy used for recruitment of therapists is detailed overleaf in figure 6, with the rationale for selection included in italics alongside circle representing therapist participant. Larger circles represent units labelled in upper case letters.

FIGURE 6: PURPOSIVE SAMPLING STRATEGY EMPLOYED FOR THERAPIST PARTICIPANTS IN INITIAL STUDY



As for service user criteria, entry criteria for therapists were governed by practical considerations. As with 'age' in the service user sample, the purposive sampling strategy utilised a number of constructed categories such as 'grade' and 'place of work' in identifying potential participants who might contribute to the developing theory. My rationale in using such categories was that such constructions represented an epistemology shared by both participants and myself, as a therapist, about how therapy services are organised and provided. I therefore chose to utilise this insight.

The process of recruitment of therapist participants to the study is illustrated in the following flow chart:

Figure 7: Procedure for recruiting therapist participants to initial study

Information sheets (appendix 12) distributed and talk within one of the two trusts arranged to create awareness of study

⇓

Individual therapists contacted by telephone by researcher, who reminded them about study. On most occasions provisional interview date was set, contingent on them feeling comfortable with information sent subsequently.

⇓

Information sheet (as above) and letter with tear off consent slip (appendix 8) sent to potential therapist participant

⇓

Therapist returns signed consent slip in prepaid self-addressed envelope

⇓

Interview carried out

⇓

Letter of thanks written and sent to participant

The therapists were given a list of interview questions at the start of the interview, and as with service users interviews, asked to complete a short self-administered

questionnaire (appendix 13). Whilst these provided basic demographic details, they were not included formally in the analysis.

With both the service user and therapists interviews, fieldnotes were completed by the researcher detailing contextual information such as events immediately preceding or following the interview and subjective impressions. The process of completing the fieldnotes provided both the time and a mechanism for reflection, and the fieldnotes were used to inform the analysis at an early stage, although were not themselves included as raw data in the analysis, as in the second study.

5.7.3 Analysis and interpretation

The audio-tape recorded interviews were transcribed according to the conventions in appendix 6. Decisions regarding transcription are described in chapter four. Transcription was carried out as close to the interview as possible. This was in order that coding and analysis could begin, thus informing the evolution of the interview schedules and the direction of the purposive sampling of therapist participants. Coding was carried out using the word processing package Word for Windows 95 Version 7.0, as described in chapter four.

The discourse analysis principles used to guide the coding, analysis and interpretation are elaborated in chapter three. As already discussed at some length, the process of coding was used as a means of becoming familiar with and starting to interpret the data, rather than providing an illustration about how the interpretation outlined later in this chapter evolved. An example of the many ways and levels at which codes feed into subsequent interpretation is provided in appendix 26 for the 'rehabilitation frame', part of the theoretical argument deriving from data in the second study, described in chapters seven and eight.

Originally it had been envisaged that one set of codes would be developed for both the service user and therapist interviews. However, the two sets of interviews seemed to be constructed differently, and be concerned with different issues. In addition, the therapist interviews were well underway before recruitment began in earnest for the service user interviews. The explanations which were starting to evolve for the

therapist interviews did not seem appropriate for the service user interviews at this stage. As a consequence, two sets of codes were developed for the two groups of interviews. The process of developing and refining these codes, together with progress with recruitment of participants is illustrated in the flow diagram below:

Figure 8. Flow chart demonstrating service user and therapist recruitment, and development of coding schemes

Week 1	1 therapist recruited
	⇓
Week 2	1 therapist recruited
	⇓
Week 3	2 therapists and 2 service users recruited
	⇓
Week 4	3 therapists and 2 service users recruited
	⇓
Week 5	2 therapists and 1 service user recruited
	⇓
Week 6	1 therapist and 1 service user recruited Initial codes generated for therapist interviews
	⇓
Week 7	2 therapists recruited Additional therapist codes added
	⇓
Week 8	3 therapists and 1 service user recruited Therapist interview codes revised
	⇓
Week 9	5 therapists and 1 service user recruited Initial codes generated for service user interviews (INTERVIEWS FINISHED)
	⇓
Week 11	Service user interview codes revised

A list of the revised codes used for analysis of the therapist and service user interviews, together with definitions, is provided in appendices 14 and 15.

5.8 Profile of research participants

Some brief details are provided in this section about the interview participants. The gender, age, profession and grade of the therapists have not been identified for individual therapists as it was felt this might compromise confidentiality.

In addition, the foci of interest in this study are the larger resources used to inform individual accounts about falling, and also what this talk is designed to achieve. Individual biographical details were neither solicited nor suggested as providing an explanatory framework for particular accounts. Whilst the purposive sampling strategy used to identify therapist participants focused on individuals, the criteria used to guide the strategy, such as 'profession' and 'place of work', are largely social rather than individual. The subsequent interpretation is concerned with how identities such as 'patient', 'therapist' and 'older person who falls', themselves discursive labels, are resisted or asserted. In those examples where individual biography appears to impact on the account created, details are provided alongside the examples.

Table 8: Details of eight service users participating in initial study

PARTICIPANT NUMBER	AGE	GENDER
1	82	Female
2	86	Female
3	75	Female
4	70	Female
5	78	Female
6	86	Female
7	82	Female
8	89	Male

Table 9: Gender of therapists participating in initial study

GENDER	FREQUENCY
Female	17
Male	3

Table 10: Age of therapists participating in initial study

AGE	FREQUENCY
21-30 years	10
31-40 years	4
41-50 years	4
51-60 years	2

Table 11: Profession of therapists participating in initial study

PROFESSION	FREQUENCY
Occupational therapy	10
Physiotherapy	10

Table 12: Grade of therapists participating in initial study

GRADE	FREQUENCY
Basic/staff grade	4
Senior II	8
Senior I	6
Head/superintendent	2

5.9 Interpretation

5.9.1 Introduction

The interpretation of the therapist and service user accounts will be presented separately. However, both sections share a common focus on the larger resources, or discourses, which inform the accounts, and also on the action orientation of the therapists' and service users' talk. As will be illustrated, the perceived identities of the researcher are also implicated in both sets of interviews, in providing one explanation about what is being achieved within the accounts.

Individuals use a variety of sometimes contradictory influences in constructing their descriptions and explanations. However, the explanatory framework described subsequently best characterises the distinctions between the two sets of data within the context of these interviews.

In the following account, each interview excerpt is followed by a code (eg 'm18t pg3 lines 23-30'). This code provides details about where the excerpt is located in the original transcription: 'm' indicates the main study (as opposed to the pilot study data), '18' indicates the number of the participant, 't' or 'p' whether the participant was a therapist or patient. The page number of the transcription is then provided, followed

by the line numbers of the excerpt. Therapist 4 agreed to be interviewed twice, as the first interview did not record. Excerpts from this transcription are coded 'm4bt'.

5.9.2 Therapist accounts: risk discourse

The interview responses of the occupational therapists and physiotherapists were influenced by what is described here as a 'risk discourse'. The characteristics of this discourse will be illustrated, and the risk discourse shown to be premised on particular assumptions about falls and falling.

Within this discourse, a fall is not a random, chance occurrence, but is both predictable and preventable. This therapist, in discussing patients on the ward where she works, describes some of the strategies that might prevent falls from occurring:

'Cause a lot of the people up here are in here because they've fallen ... an awful lot of them so if we could stop them or sort of screen them or somehow pick out the ones that are at risk ... you might be able to stop them fracturing their femurs and various bits that they do to themselves' (m18t pg 11 lines 6-10)

This following excerpt also illustrates the assumption underpinning the risk discourse that the likelihood of an undesirable event such as a fall can be lessened:

'I think I think there's a team expectation what we've all got to have a go and see if we can reduce the risk ... and and do whatever it takes to try and reduce the risk' (m3t pg 21 lines 8-12)

Health events such as a fall can be predicted and prevented because it is possible to identify antecedents. Within a risk discourse, these causative factors are usually related to the individual service user. Physical problems and conditions are often implicated in therapists' explanations about the causes of falling, as in this example:

'Um so there may be somebody who's had some sort of neurological event who falls and fractures um or somebody who's got um say you know blood pressure problems who then falls and fractures um so you've usually got some some or often got some

sort of underlying condition um and the fracture is really the sort of you know the final ... thing on the pile that uh sends them into hospital' (m17t pg 1 lines 25-31)

Patient behaviour is sometimes also cited as contributing to the likelihood of a fall. This therapist discusses how choice of footwear may be an important determinant of a fall, in identifying the factors she would consider if working with someone deemed to be at risk:

' ... or um if they trip over their feet or they wear stupid shoes or ... basic sort of things like that' (m4bt pg 1 lines 29-32)

Cognitive assets or abilities also feature prominently in therapists' accounts regarding the reasons why falls occur. Lack of awareness, confusion and dementia were all mentioned as factors which cause falls. This therapist is describing the type of people she encounters on the ward who have falls:

' ...but I would I would say its probably the- the sort of little tottery ... sort of senily type ones that really are just getting a bit unsteady thats the majority of the ones we would see here I think' (m2t pg 3 lines 30-33)

In some of the therapists' accounts, these characteristics of confusion and dementia were linked with frailty and old age, as in this excerpt:

'Right the sort of people that fall ... um older generally a little bit confused ... without wishing to uh over generalise um ... sometimes you could describe them as frail elderly but not always ...' (m6t pg 3 line 27 - pg 4 line 5)

Another cause of falls also relating to the individual service user is their home environment, in which many different types of objects pose a threat:

' ... but I think as um as an OT one is tending to think about the environment that people are in and all the sort of hazards in the environment um I mean which I won't

go through but all the sorts of cables the rugs the dogs all those sorts of things' (m11t pg 7 lines 22-25).

However, problems outside of the home, such as uneven paving stones, or high steps were rarely mentioned as posing a risk for falling.

To summarise, within the risk discourse, the occurrence of a fall for an older person is an undesirable event which is both predictable and preventable. Falling is closely associated with individual service user characteristics such as physical impairments or conditions, behaviour, cognitive abilities and home surroundings.

An apparent exception to the assertion that falls are preventable is illustrated in the account of participant 18:

' ... perhaps they're not really mentally with it enough to be taught how to do the various different things so they're always really difficult and they're quite often they're demented patients that will actually get up in the middle of the night and just wander off and fall over and be found in a heap on the floor ... so they're sort of really the the main the biggest difficulty the biggest challenge there is cause there's not an awful lot I think you can do about people like that' (m18t pg 7 line 28 - pg 8 line 2)

This would initially seem to contradict the premise of a fall as a preventable occurrence. However, this failure in prevention is attributed to the mental state of the service user, in the same way as was argued for the causes of falls. The premise of the fall as an event which can be foreseen and forestalled remains intact. Rather, it is the 'difficult' nature of some service users which means that the usual tactics and strategies are not applicable in their case.

More unusually, however, participant 10 challenged the central tenet of the risk discourse, in acknowledging that falls in general are difficult to prevent. She was a senior therapist with experience of both clinical and research work with older people

who had fallen. In the past, the focus of her interventions with such people had been on assisting them to manage once they had fallen:

'Mm I mean you can give advice on once they've had the fall how to get up of the floor and may look at Lifelines[2] *and looking at sort of keeping yourself warm and stuff like that but how you stop the process of them actually falling ... I think you have to accept as an OT you can't really stop that process of them actually'* (m10t page 11 lines 15-20)

The risk discourse positions therapists as experts in assessing for risk factors for falling. The detail in which this therapist describes assessments of balance reflects the complex professional epistemology through which loss of balance is constructed and understood:

'... and then as I say you're you you're then checking things like their balance but in much more detail ...so you know standing (.....) sitting balance um standing balance standing posture um whether you know how their weight is distributed on their feet whether they can withstand disturbance in their balance um whether they can actually you know move out of their base of support uh if they can stand on one foot and sustain that for you know a few seconds ...because those are all indicators then that yes you know they have (a) they the significance of their balance problem and therefore their their consequent level of risk' (m17t pg 4 lines 18-29)

The therapists' accounts generally represented their authority and knowledge on the topic of falling. However, the degree of prescription with which their advice was proffered varied considerably within their accounts. Some therapists spoke about their interventions as technical skills which were applied to people. In this excerpt, for example, the position of the service users is passive, with the effort to improve balance exerted by the therapist and her colleagues:

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[2] 'Lifeline': pendant device worn by individual which can be activated to summon help if wearer experiences distress

'... on X (ward) *there was quite a few sort of older people that were falling quite regularly and you would see them come in sort of time after time through up there (...) come in for various different things um we sort of used to take them in the gym and work on their balance mainly and things like that to improve their balance'* (m18t pg 1 lines 17-22).

Other therapists, whilst still positioned as experts with regard to service user safety, combine this with a respect for service users' autonomy in their accounts:

'So I suppose I I'm going back from it I'm coming from keeping people independent and safe but equally hopefully respecting their wishes and trying to problem solve around things and come up with solutions which are acceptable to them rather than just saying you mustn't bend down and do that because you'll fall' (m11t pg 10 lines 26-29).

Within a risk discourse, however, service users are not perceived to possess the skills or knowledge to keep themselves safe and prevent themselves from falling. The causal attribution of falls to individual service user characteristics was discussed at the beginning of this section. The ways in which these characteristics are represented in the accounts suggests that service users are ignorant of danger, and vulnerable:

'... some of it the patient problems that the- they you know have cognitive problems so they're not aware of of of the dangers of uh the environment they're in to cause them to have a fall' (m16t pg 3 lines 20-24).

The association of frailty, ageing and lack of awareness mentioned previously is reiterated in this excerpt:

'... if they're the the group that are just becoming physically more frail um that's something that happens slowly over time and therefore you don't go round adapting your environment or you know moving all the rugs or whatever else you need so that you reduce your risk cause you're not aware of your decline' (m17t pg 11 lines 28-32)

In general, then, older people who fall are represented in therapist accounts as vulnerable, ignorant about the risks they face, and in need of therapy services.

In this following excerpt, to the contrary, the service user is ascribed an assertive voice:

'... and uh she refused a Lifeline or even to discuss it well I said well I think I think you're being rather foolish not to consider that because that's the reason you came into hospital in the first place cause nobody actually found you' (m20t pg 25 lines 21-5).

However whilst this women is not represented with the passivity attributed to service users within some therapy accounts, she is portrayed as foolhardy, and not acting in her best interests. The therapist responds to this woman's decision as a challenge to her advice and authority, rather than as an expression of an alternative perspective about risk and safety.

Even in those therapist accounts in which service users' desires, whilst running counter to professional advice, are respected, risk of falling is still represented as an objective fact, not open to reinterpretation or representation in alternative ways. In this excerpt, for example, having hypothetically created a patient who is 'coping with their falling', the therapist continues by elaborating on the many checks she would instigate to ensure risk to the patient is minimised. The patient's right to 'go and keep falling every day' (a 'worst case scenario') is contingent on him or her accepting responsibility for the objective fact of their position of risk. No alternative perspectives regarding degree of risk are discussed nor potential benefits of the situation for the patient which could outweigh the threat of a fall:

'... but I mean if the patient is falling and coping with their falling and you've done everything that you can to sort of make their environment safe um give them the right advice do they know what to do if they do fall have they got an alarm so they can call somebody do they know how to get themselves up if they feel confident and competent to do that um if you've done all those things um and they know the risk and they

accept the risk then that's their right to go and keep falling over every day' (m17t pg 19 lines 21-7).

5.9.3 Function of therapist accounts

The therapists' representation of falls in older people as predictable, avoidable and undesirable, having serious consequences for older people, mirrors the assumptions underpinning the biomedical research into falling. In reproducing these axioms, therapists can demonstrate that they share well accepted and respected explanations about health events such as falls, that they are aware of the literature pertinent to their work and have regard to professional responsibilities to safeguard service users. The research base for therapy practice is in its infancy (Department of Health 1994). The allusions in the therapists accounts to positivist tenets underpinning biomedical practice and research into falls could illustrate a desire for credibility, in the face of absence of evidence for practice.

As a therapy researcher investigating falls in older people, it would have been reasonable for the therapists I interviewed to expect that I also shared these assumptions about the nature of falls. Their accounts may therefore have been designed to convince me of their abilities and knowledge as therapists. Participant 10, who had expressed a view that it was difficult to prevent falls, was a senior therapist who had already alluded to her experience in clinical practice and research in the area of falling amongst older people. In addition she had been known to me for a number of years. It is possible, therefore, that having demonstrated that she was familiar with the issues, she did not feel it necessary to convince me of her ability, and could herself claim status as expert. She could therefore make an assertion which contradicted prevailing understandings about how and why falls occur. In addition, she was able to highlight another role for therapists in working with people once they have fallen.

Therapists' position as experts in detecting hazards and determining level of risk of fall is premised on recognition from service users and fellow health professionals that people require and benefit from this form of assistance. The therapist accounts therefore detail the many ways in which therapists can contribute to safety of patients and prevention of falls. The representation of older service users as ignorant of

dangers, frail and vulnerable also helps to support this position, and reinforces the need for professional intervention.

Another factor which might possibly have influenced the therapist accounts is an increased awareness of the possibility of litigation as a result of claims of incompetence. One of the means of safeguarding oneself professionally is to use well recognised means of assessing risk, such as standardised measures, and to err on the side of caution with regard the advice that one gives. There did appear to be some awareness of perceived professional responsibilities in advising service users and the health care team about returning home or modifying lifestyle after a fall. In this following excerpt, the therapist seems to recognise this obligation reluctantly, aware of the cost of following this advice to the service user:

'... we often have to advise people you know well you know we just can't advise that you actually go out or go on the stairs or go out out on the step or whatever on your own things like that which does limit people's lives' (m8t pg 5 lines 1-4).

5.9.4 Service user accounts: moral discourse

The accounts of the eight service users with fractured hips expressed different interests and concerns, being influenced by a 'moral discourse' in which commendable personal qualities and attributes were highlighted. In some of the accounts, service users did not talk about themselves as responsible for their fall, but attributed them to circumstances or other people. Additionally, their accounts were illustrated with personal stories which initially appeared peripheral to the main focus of the interview, but provided a context for their talk.

The use of the 'moral discourse' positioned service users as being deserving of approval for both their personal qualities and behaviour. One of the questions on my interview schedule asked about the different staff that the service users had encountered, as a means of exploring whether they distinguished different professional identities. Almost without exception the response was as in this account:

'R: Right right again thinking about in being here in hospital can you tell me a bit about the different staff that you've you've kind of had contact with
P: They've all been alright kindness in theirselves ... nothing ever too much trouble' (m3p page 11 lines 12-18).

The service user participants thus affirmed that they were appreciative of the help that they were receiving, often with an acknowledgement that the nurses in particular were working in difficult circumstances, for example, that they usually appeared busy. Another question was designed to investigate with service users whether they felt that different health professionals approached their care and treatment differently:

'R: Yeah yeah and d'you think d'you think say the physio has a different way of looking at things than the nurses with regard to your fall and your getting better or
P: Heh I've got no idea I mean I don't pribe (sic) *into the nurses minds ... or anything like that you know ... I do as I'm told ...'* (mp1 page 8 lines 2-9)

This response appeared designed to refute any suggestion that the service user was 'nosy', inappropriately interested in other people's business, or likely to tell the professionals what to do.

Whilst the interview schedule did not specifically ask about returning home, many of the service user accounts suggested that they were healthy and able to manage at home, if not independently then with help which was readily available. Whilst this excerpt appears to acknowledge the possibility that at this point some change might occur ('... up til now'), the subsequent use of the present tense (as in 'I don't walk with a stick', 'I do my own shopping ...') performs the function of reaffirming that this woman does not rely on anyone for help in daily life, and in fact is able to help others:

'P: Well um I- I- up til now I've always been a very active sort of person I I don't walk with a stick and um er I do my own shopping washing mm I I drive ... and I take people shopping ... and um up til now as I say I've never had any problems ...no problems at all' (m5p pg 2 lines 19-26)

Some of the accounts portray the service users as struggling hard to work at their recovery in spite of pain and the temptation to give up:

'I had a card from a friend of mine's son and he said get out of that bed aunt auntie now and that uh that really did push me on I thought yeah M (friend's son) *I've got to otherwise I'm going to give in' (m2p pg 4 lines 11-14)*

Some notable exceptions to this were proposed in the interview with participant 7. Describing the effort required to walk out of the ward to the toilet, she said:

'You feel as if you've climbed mountains you know' (m7p page 4 line 30),

and in response to a question about the effect of the fall on her life replied:

'I think it might affect one especially when I go home because I live alone ... and then there you think at night you know ... you think of these things you try to forget but it's an awful job I think' (m7p pg 4 lines 2-6)

This is also in contrast to responses by other service user participants to the same question, as for example in this excerpt:

'Um so um you know that I hopefully I won't have I hope I hope it won't have any effects on my life I can just carry on as I have done' (m4p pg 3 lines 13-14)

One explanation for these different representations is that participant 7, whilst having a fractured hip, had sustained it because a large structure had fallen on her. Whilst she had fallen to the floor, the event of her fall was rather different to the circumstances in which other people had fallen. Whilst details have not been provided to maintain her anonymity, the event had received some local publicity. It is suggested that there is a difference between the two examples above because participant 7 could in no way be seen as responsible for her fall. The unfortunate event could have occurred to anyone of any age, and she did not therefore need to represent herself as deserving,

independent and brave, as her competence and identity had not been challenged by the fracture and the hospital admission.

Some of the service user accounts attribute the fall causing the fracture to bad luck or the incompetence of others. This woman was on holiday and playing cards with some companions when she fell as described in this excerpt:

'... then I played one hand of the second half and I was just about to move from this table here to that table over there and I just went down ... with a bang on this polished floor ... which shouldn't have been ... not for elderly people to play cards I don't think' (m5p pg 1 lines 18-24)

Other accounts represent service users as physically and/or mentally competent at the time of the fall. This has the effect of pre-empting any suggestion that these older people require regular support, or are unable to care for themselves.

'And so I um I didn't have no feeling I I remember apologising to the ladies for causing trouble ... so I couldn't do that if I had a blackout or ... anything like that could I cause I remember the I was saying I'm so sorry I'm causing this trouble ... you see so I was quite in my right mind' (m1p pg 1 lines 21-8)

Not all interview participants rejected any responsibility for their fall. This woman identifies that she forgot her walking stick and blames her fall on this, as she exited from her taxi. She offers some qualifying statements however; firstly that she has travelled without her stick before, but without consequence as she has received help from the taxi driver in getting out of the car, and secondly that she has only recently started to use her stick more regularly. With these qualifications, she is able to refute charges of forgetfulness which could compromise her independence:

'I feel stupid and sort of I don't know what you call it where you think uh say that I should have know better or what than go out without my stick ... but I've often done it you know in the taxi ... and they've got out and helped me ... he would have got out and helped me but he hollered out are you alright and I always turns round and says

yes ... cause he was at the side of another one outside the shop that let me in ... I should have known better than realise I never had my stick with me before I went out but at times I go out without a stick you see I'm only just getting used to having it in- using it more indoors' (m3p pg8 line 19 - pg 9 line 3)

Several of the service user participants commented spontaneously that they had not been drinking at the time of the fall, thereby asserting that they had not been engaged in any disreputable activity which additionally had caused them to fall.

A striking quality about the majority of the accounts was the 'story-like' character in some sections. The circumstances of the fall and admission to hospital were recounted in some detail, usually in chronological order. This longer excerpt illustrates the detail and contextual information often present (the participant starts by reading the initial question from the list of questions provided at the start of the interview):

P: 'Hm can you tell me about your fall uh yes I can tell you about my fall I got up early on ss oh Monday morning I think it was Monday or Tuesday ... um Mo- Tuesday morning to make a cup of tea well my I gave my (son) *some money and we went went to a boot sale and we bought some geraniums ... and they were so lovely and I wanted to go out and see what they looked like I walked out in the garden we've had the ground concreted but the step was like that*

R: Sort of wobbly was it

P: Well no the wa- step wasn't wobbly it was um tin like steel and a bit of wood but they didn't do (..) and I must have tripped onto a bit of wood and I was going in our outer house to have a cup of tea cause it was such a nice morning ... and before I got in there I fell over a piece of wood and that was all there was (..) ... and uh I never got to see the flowers' (m2p page1 lines 1-17)

5.9.5 Function of service user accounts

The following few paragraphs advance some suggestions regarding the function of the service user accounts. As with the therapist interviews, the perceived persona of the researcher is also important in interpreting the possible action orientation of interview talk. The service users appeared to respond to me as someone with influence over

their future. They represented themselves as people of good character, one implication of which could be that they deserved to be treated fairly. As illustrated previously, many of their accounts demonstrated their independence and ability to care for themselves. The event which had brought them into hospital, the fall, was sometimes accounted for in ways designed to show how they had not been responsible. The event of the fall itself was recounted in chronological order, and the manner in which this was done sometimes suggested that this same sequence of events had been presented in this way several times before.

It is suggested that in the service user interviews, I was perceived as a health profession with the capacity to make decisions about the fitness of individuals to return home following treatment in hospital. These people had recently experienced a traumatic accident and a major operation. They had been seen and assessed by a number of different health and social care workers, to whom they had recounted the events precipitating their fall.

I dressed in a similar fashion to some of those they had met, asking them to sign consent forms and began my interaction with them by asking them about their fall. I had accessed written medical and nursing information in order to gain access to them, and could have been observed doing this. In many ways I behaved as I would have done, had I been acting in a capacity as a health professional.

In addition, few of the participants had elected to be interviewed in private, and there was therefore the potential for their contributions to be overheard, which could also influence the decisions others made about them.

For these reasons, then, it is suggested that the service user accounts were designed to convince me that they would be able to return to their lives prior to their admission. Some service users talked about experiences during the war, the view from a window at home and family. Initially such passages seemed rather peripheral to the main issues being explored within the interviews. However, within the context of the developing analysis, they began to assume a greater significance. Through their stories, they constructed vivid images of previous and existing roles and responsibilities such as

'employee', 'mother' and 'grandmother'. The accounts often illustrated how service users belonged to informal social networks of family and friends. These stories had the effect of countering their current predominant identity as 'patient'; passive, immobile and dependent.

5.10 Summary

In this chapter, the process and analysis of an initial study designed to explore service user and therapist accounts of falls has been presented. It was suggested that the therapist accounts were influenced by a 'risk discourse', premised on an understanding of a fall as a predictable and preventable occurrence. Within a risk discourse, therapists possess the necessary expertise to assess degree of risk and advise on precautionary action. Health service users are represented as vulnerable, and in need of such advice.

Older health service users with fracture hips tended to talk about themselves and their experiences with reference to a 'moral discourse', in which they described themselves as of good character, appreciative of staff efforts, and working hard to overcome their 'temporary' disabilities. They demonstrated how their falls were not due to their carelessness or diminishing capabilities, and invoked their lives and roles outside hospital as a contrast to the identity of 'patient'.

It was argued that the persona(s) of the interviewer were integral to explanations about what these accounts were trying to achieve. The therapist accounts appeared to reinforce competent professional identities based on specialist knowledge, skills and awareness of responsibilities. It was suggested that the persona of the researcher as an occupational therapist, lecturer and postgraduate student was implicated in the production of these accounts. The interview responses of older health service users with fractured hips seemed designed to convince the researcher that these people were deserving, hardworking, independent and ultimately capable of returning home. It was suggested that the researcher was perceived as one of a number of health and social care professionals encountered by these older people, to whom they had to prove their capabilities.

The following two chapters describe a subsequent study which aimed to further explore how risk was constructed within a health care environment for older people. An alternative identity of the researcher within the research as 'student' is introduced.

6. Chapter Six: Theoretical perspectives on risk.

6.1 Introduction

In an initial study exploring accounts of older people and therapists about falls, risk was shown to be a key concept in making sense of how therapists described their work with older people who fall. However, risk did not appear to be understood in the same way by older people who had fractured their hips, nor specifically mentioned in their accounts.

This chapter provides a brief overview of some current theories of risk as a prelude to a second empirical study which focuses on risk in a health care setting. A traditional perspective on risk is initially introduced. This is followed by a brief discussion about how risk has come to be seen as a defining characteristic of the late 20th century, focusing on the work of Giddens (1991) and Beck (1992) (in Annandale 1998, Bury 1997, Lupton 1999 and Scott and Freeman 1995). Next, sociocultural determinants of perceptions of risk are briefly discussed, introduced through the writings of Douglas, the major theorist in this area (Douglas 1966/1969 in Lupton 1999, Douglas 1986, Douglas 1992 in Lupton 1999, Douglas and Wildavsky 1982 in Gabe 1995 and Lupton 1999). Risk and health is then considered in more detail. Through the work of Lupton, Ogden and Petersen (Lupton 1993, 1999, Odgen 1995, Petersen 1996, 1997, Petersen and Lupton 1996), health promotion and health psychology activities and theories are critically examined to illustrate how they exemplify notions of the rational, controlling self. The ideological and moral nature of public health is also highlighted. Finally, risk is discussed through a consideration of Green's work on risk and accidents (Green 1995, 1997a, 1997b). Throughout this chapter, the major theories are critically evaluated and their contribution to this thesis explicitly highlighted, through application to the literature on falls and falling.

6.2 Traditional perspectives on risk

Risk has been defined as follows:

"*n* hazard, danger, chance of loss, failure or injury; the degree of probability of loss; a person, thing or factor likely to cause loss or danger. - *vt* to expose to risk; to incur the chance of unfortunate consequences, loss or danger by (doing something)" (Schwartz 1992; 935).

Most definitions, such as this one, draw attention to the current association of risk with negative or undesirable outcomes. However, this association is a relatively recent phenomenon, where once it was equally concerned with both positive and negative outcomes (Douglas 1990, cited in Carter 1995). The other aspect of this definition worthy of note is the pairing of risk with probability and chance. Risk has come to assume an actuarial sense, with risk assessment seen to be a skilled technical task which is the preserve of scientists (Gabe 1995). Within health, the discipline concerning itself most with the calculation of risk is epidemiology, with quantification and use of statistics the methods of choice (Petersen and Lupton 1996). Estimates of risk for particular diseases are calculated on the basis of populations and presented as neutral epidemiological facts, unconcerned with the personal experience of illness, and often difficult to interpret on an individual basis (Green 1995). The 'translation' of such findings into health promotion advice in relation to individuals is therefore problematic, and population based information about risk factors is also difficult for individuals to understand (Adelswärd and Sachs 1992, Davison, Davey Smith and Frankel 1991, Parsons and Atkinson 1992, Sachs 1996). As has been illustrated in chapter two, one of the recent trends within the falling literature has been the identification of risk factors for falling. Epidemiological initiatives look to determine the relative risk posed by various agents, and to establish the sub-groups within the population of elderly people for whom such factors represent a hazard (Gillespie et al 1998).

Within a traditional perspective, then, risk can be objectively known, is potentially calculable and therefore controllable. This approach to risk has dominated health research into disease and illness. However, work from within both the social and natural sciences has challenged this supposedly neutral and objective approach to the research of risk. The literature review of falls in chapter two illustrated how much work in this area to date is premised on three key assumptions which were

shown to be problematic; namely that a fall is a serious event for an older person which warrants investigation, that a fall is an event for which there are objective antecedents and consequences and that a fall can be prevented.

6.3 Risk society

Skolbekken (1995) reported the results of MEDLINE database searches for articles including the term 'risk' in either the title or abstract between the period 1967 to 1991. He illustrated a rapid increase in the frequency of such papers over the last five years, particularly within epidemiological journals. One of Skolbekken's conclusions was that the 'epidemic' of risk papers could be viewed reflexively to reveal current cultural preoccupations and beliefs, such as a decline in attributions of health events to fate and destiny.

This view of representations of risk as reflective of modern society echoes work by social theorists Beck (1992) and Giddens (1991), (both cited in Annandale 1998, Bury 1997, Lupton 1999 and Scott and Freeman 1995). For Beck and Giddens, risk has assumed a central significance in late modernity. Globalisation has led to the erosion of social structures which at one time provided a sense of security, and both science and technology have created new types of risk of uncertain scale, such as those posed by Bovine Spongiform Encephalitis (BSE) and nuclear energy which cut across social boundaries such as class or ethnic background.

In relation to health, Beck (1992 in Annandale 1998) argues that 'medical sub-politics' have created a market for products to protect against risks which both medicine and science have themselves constructed as a problem.

For Beck and Giddens, science also facilitates the management of risk. Through reflexivity and the use of scientific information about the nature of risks, individuals can make decisions about their lifestyle and their environment which reduce potential danger. For Giddens, a 'risk society', in addition to possible hazards, also provides exciting opportunities for innovation.

The work of Beck and Giddens finds many resonances in public health theory and policy in the United Kingdom, including work on prevention of falls. In recent years, reports in the media have been dominated by risks to health of unknown scale, which extend to other countries and continents. Many of these, such as BSE and risks from toxins in pesticides, are seen to have arisen as the result of increasingly sophisticated technology. Public health has informed the debate by identifying a host of risk factors for illness and disease relating to lifestyle and environment. Over four hundred factors have been identified as potentially associated with falling, for example (Gillespie 1996, cited in Nuffield Institute for Health and NHS Centre for Reviews and Dissemination 1996). A reliance on the use of scientific information about risk factors is a prerequisite for health promotion work, such as interventions to reduce the number of falls.

The invention and use of hip protectors (Lauritzen 1996, Wallace, Ross, Huston, Kundel and Woodworth 1993) for older people at risk of falling might be regarded as one of the products of 'medical sub-politics' about which Beck writes. Hip protectors are pads worn under outer clothing which are designed to disperse shock of a fall, thus preventing hip fracture. Having identified a health risk, in this case hip fracture as the result of a fall, a product was designed, by sources closely allied to medicine, to counter this risk. Hip protectors are currently being tested both for their efficacy in reducing hip fractures, and for their potential acceptability to older people. This risk could therefore be viewed as having been constructed by medical science, which then manufactures a product from whose sale it profits financially, in order to reduce this risk.

The perspectives of Giddens and Beck are therefore useful in reflecting on the current preoccupations with risks for health. However, a number of shortcomings have been identified in their work, which limit their potential contribution to this thesis. Firstly, there is a tendency in their writing for risks to assume the status of objective, although not necessarily consensually agreed, facts. Reflexivity with regard to risk might help us to understand the modern condition, and 'new' risks such as those from genetically modified foods might appear uncertain and unpredictable. However, risk is always potentially calculable for both Beck and

Giddens - its contested nature is not a subject of interest in its own right. Secondly, their central appeal to an "autonomous rational ego" (Petersen 1997: 190) to understand and manage risk, uncritically accepts modernist notions of a thinking, self determining individual.

6.4 Sociocultural determinants of perceptions of risk

The major theorist within this neglected area is the anthropologist, Mary Douglas. Her major contribution to the study and understanding of risk is her assertion that the identification and privileging of particular risks over others is dependent on the cultural context in which they are located. The ways in which these risks are responded to cannot be explained by 'lay' ignorance or models of individual behaviour, but by reference to cultural explanations about danger and 'otherness' (Douglas 1966/1969 in Lupton 1999). Douglas and Wildavsky (1982 in Gabe 1995 and Lupton 1999) developed a 'group-grid' explanation of cultural explanations of risk, which has also been used by others to explore cultural behaviour in relation to perceptions of risk (eg Bellaby 1990).

As Lupton (1999) contests, Douglas' position is also that of 'weak' social constructionism, in that real and absolute dangers are recognised, although understandings of and responses to these are culturally mediated. As was the position with the theories of Beck and Giddens, Douglas' contributions are not therefore wholly convincing to those adopting a more relativist perspective. However, the substantive body of work produced by Douglas has helped to encourage a contextualised perspective of risk, enacted through rituals, habits and practices.

6.5 Perspectives on risk in health

The identification, assessment and control of risk has become a major priority within health services in the United Kingdom (Gabe 1995). Petersen and Lupton have noted a concurrent increase in the influence and visibility of public health and health promotion activities (Lupton 1993, Petersen and Lupton 1996, Petersen 1996, Petersen 1997). Both Petersen and Lupton take as their project the ideological and moral nature of 'the new public health', arguing that health

promoters work together with a variety of different institutions to produce the 'at-risk' individual (Petersen and Lupton 1996). The management of this 'at-risk' status is achieved through the willing participation of the public, who view it as a duty and moral obligation to participate in the maintenance of their own health. However, the current interest in identifying risk factors for health, plus the extending influence of public health into an increasing number of spheres such as leisure activity, food and sex means that the potential number of 'risky' individuals and activities, far from decreasing, is growing.

Ogden (1995), from the discipline of health psychology, has argued that health psychology theories can themselves be viewed as data. Using examples of stress, pain, and behaviour, she illustrates how over a number of years, psychological theories in these areas have reconstituted the individual from passive responder to external events, to the inter-active individual, to the 'intra-active' individual. The intra-active individual is self controlling and self-regulating, with the environment increasingly disappearing in psychological explanations and theories. Ogden parallels this change in the constitution of the individual within psychological theory, with similar changes occurring within other disciplines, using risk as an example. With regard to risk, Ogden shows how in recent years the individual within medical and health care theory has come to be viewed as at risk from themselves - the "risky self" (Ogden 1995: 262). The risk of health events such as heart disease and cancer rests on the ability of the individual to attend clinics for screening, modify their diet, exercise regularly and desist from such practices as smoking. One of the consequences of this shift to the intra-active individual is that the management of risk also becomes the main responsibility of that individual, achieved through self-discipline and self-regulation.

These critical perspectives of both public health and health psychology have important implications for work in the area of falls and falling, and for theory, practice and research in health more generally. Firstly, it is suggested that to view the corpus of knowledge about falling as objective facts devoid of the context in which they are constructed and located is to privilege rationalist explanations, ignoring both their reflexive potential and their relativity, dependent upon culture.

Secondly, these critical perspectives imply that the current preoccupations and directions of work in the area of falls have something to reveal about how 'fallers' are constituted, how health care workers perceive their professional roles and responsibilities with regard to prevention of falls and how health services define their objectives and priorities. Thirdly, this critical work has implications for the methodologies used to research falling, and also for the relative positions of 'researcher' and 'researched' in terms of expertise and knowledge. Much of the work to date within the field of falls and older people has involved the testing of *a priori* hypotheses based on the prior knowledge and assumptions of the researcher. The understandings and explanations of older people about falls have not been seen as worthy of inquiry, nor having anything to contribute to theory and practice in the prevention of falls.

6.6 Risk and accidents

Work in falls prevention in the United Kingdom has in part been stimulated by the identification of targets within the Department of Health document, 'The Health of the Nation' (Department of Health 1992). One of these targets was the reduction of deaths resulting from accidents for older people aged 65 and over by 33% by the year 2005. The inclusion of this target in papers about falls is often used to provide a context for work reported subsequently, and, by inference, suggest that falls are of enough concern to warrant government policies and targets (eg Nuffield Institute for Health and NHS Centre for Reviews and Dissemination 1996). The literature on falling and older people therefore makes explicit an association between falling and accidents. This section considers the contribution that work into risk and accidents makes to the current thesis, through a focus on the arguments proposed by Green (1995, 1997a, 1997b).

As Ogden (1995) has argued for risk, Green (1997a, 1997b) illustrates how explanations about the causes of accidents cannot be separated from their historical and cultural context. A misfortune, such as death from a fall, could in the 14th century be attributed to an inanimate object, such as a stair or step. This was possible because the prevailing interest at this time was not about punishment,

responsibility or prevention, but rather compensation to God for death, a principle known as 'deo dandum', in which the object 'causing' death was forfeit to the Crown to be used for pious purposes.

Green (1997a) links the rise in importance of the category of accident to the dominance of rationality in Western thought from the 17th century onwards, when it became increasingly necessary to identify a category for those incidents with as yet unexplained causes. Within medicine, she argues that accidents represent the "leftovers of a rational medical discourse" (Green 1997a: 70). As such, accidents have not been a focus of interest, rather viewed as a provisional and unsatisfactory category of events, awaiting better explanation and clarification. Once better epidemiological information has been obtained, the expectation is that "accidents ... should no longer happen" (Green 1995:117). The literature review in chapter two reveals that the objective of much research in the area of falls is to identify their antecedents, and to prevent them from reoccurring, thus removing them from the category 'accident'. For social scientists, the study of the marginal category of accidents could reveal much about the ontology and epistemology underpinning practice in medicine and health (Green 1997a).

Green makes two further important contributions to the current work from the perspective of research into accidents. Firstly, in investigating the persuasiveness of education as an accident prevention strategy given its apparent lack of success, she suggests that its value may be as 'talisman' (Green 1995, 1997a). Secondly, she argues that talk in children's stories about accidents provides a resource for the construction of group and social identities (Green 1997b). She also suggests that one of the attractions of educational accident prevention strategies is their appeal to a competent, rational view of self, also implicating social identities in the success or otherwise of accident prevention work (Green 1997b).

From a discursive perspective, Green's discussion about social identity in terms of gender and 'occupational class' has a tendency to reify such concepts, although she does acknowledge that "such social factors may be constructed through talk about risk" (Green 1997b: 476). The reliance within social identity theory (eg Hogg and

Abrams 1988, Tajfel and Turner 1986) on cognitive processes is also regarded with suspicion by those working from discursive positions (Edwards 1997). However, Green (1997b) makes a major contribution to risk theory as one of the first to suggest that talk about risk and accidents can be used to create images of self by those who are very often the passive objects of a risk discourse.

Further reference is made to social identities in relation to the second empirical study in the following two chapters, and discussed more generally in chapter nine. However, the following definition is proposed, which alludes both to the relativity and action orientation of social identities, in line with discussion by Wetherell (1996):

Social identities are created by oneself or others through the representation of affiliation to or distance from categories or groups of people. Both these identities and categories or groups to which reference is made are flexible, contingent and are invoked to perform particular tasks.

6.7 Summary

This chapter has provided a brief overview of a variety of theoretical perspectives on risk, with a particular emphasis on health. These perspectives have encompassed a broad span of positions, ranging from a rationalist view of risk as representing the numerical odds of a population becoming diseased or ill when exposed to particular risk factors, to a reflexive view of risk as revealing predominant beliefs and values in modern society, and 'risk talk' as a resource for the construction of social identities. The relevance of these perspectives for research into falling in older people has been highlighted, and the potential contributions of the major theorists to the current thesis discussed. This chapter therefore provides a broad theoretical framework for the second empirical study reported in the following two chapters.

7. Chapter Seven: Context, procedure and descriptive findings of study exploring risk in a day hospital for older people.

7.1 Introduction

Having explored theoretical perspectives of risk in the previous chapter, a second empirical study, designed to investigate approaches to and management of risk in a day hospital, will be described. Initially, this chapter will commence with some contextual information concerning day hospitals for older people, and rehabilitation theory and practice. The procedure used in carrying out the study will then be described, including details of process of analysis and interpretation. The concluding section will provide details about the research participants and a description of the day hospital in which the research was carried out.

7.2 Background information

7.2.1 Geriatric day hospitals

Geriatric day hospitals make a substantial contribution to the health care and rehabilitation of older people, their central goal being to enable older people to remain living in their own homes (Royal College of Physicians and British Geriatrics Society 1994). They traditionally include input from a variety of health professionals (not necessarily on a full-time basis) which may include doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, dieticians, podiatrists and social workers. The objectives of geriatric day hospitals generally include some or all of the following: functional assessment, rehabilitation, delivery of medical or nursing procedures, physical maintenance and respite or social care (Corner, Curless, Parker, Eccles, Gregson, Bond and James 1998), although the Elderly Care Research Unit (1998) suggests that the latter two now account for far fewer attendances in day hospitals than previously. There is very little evidence comparing different types of day care provision for older people, or evaluating the effectiveness of day hospitals (Corner et al 1998, Stephenson, Wilson and Gladman 1995). As requirements to demonstrate cost and clinical effectiveness become more imperative, however, purchasers of day hospital provision have become more critical of perceived shortfalls in services. Particular targets have been unreliable transport arrangements, time spent waiting for

transport and unoccupied time during the day (Royal College of Physicians and British Geriatrics Society 1994, Zeeli and Issacs 1988).

Partly in response to these criticisms, the Royal College of Physicians together with the British Geriatrics Society have produced consensus guidelines regarding standards of good practice in day hospitals for older people (Royal College of Physicians and British Geriatrics Society 1994). These include:

- clarification of role and relationship with other types of provision
- situation on NHS sites
- high quality transport arrangements
- clearly defined clinical manager
- access to a range of health professionals
- a written statement of goals and objectives
- multi-disciplinary assessment, core objectives and negotiated goals of treatment
- opportunities for recreation, socialising, health promotion and health education.

There has been a limited amount of research investigating older peoples' and carers' perceptions of and satisfaction with day hospital provision (Elderly Care Research Unit 1998, Stephenson et al 1995, Zeeli and Issacs 1988). Whilst, in general, high levels of satisfaction have been indicated, reasons for satisfaction may not concur with the main objectives of day hospitals in providing treatment. Stephenson et al (1995), for example, found that whilst 51% of older day hospital patients interviewed felt they were not able to do more at home as a result of attending the day hospital, 97% enjoyed meeting other people. Similarly, whilst most carers agreed that their friend or relative benefited from attending, there was almost universal agreement about the personal benefits provided by a break from caring. Zeeli and Issacs (1988), reflecting on their findings of relatively modest achievement of objectives set within day hospitals, commented that patients appreciated even small gains in function, and carers appreciated the relief from caring. In the Elderly Care Research Unit (1998) study, the fifty patients attending

the day hospital tended to target improved mobility as their principal aim in attending the day hospital, although the reasons identified by staff were more diverse. In addition, some of the patients were uncertain about why they were attending. Seventy nine per cent of patients felt they had fully or partially attained their goals, often including 'social contact' with improved mobility at this later stage of questioning.

Whilst day hospital provision appears to be appreciated by older people and their carers, then, there seems to be a diversity of views about why people attend, why they enjoy attending and what the perceived benefits are.

7.2.2 Rehabilitation

The 1991/2 national survey of 384 Geriatric Day Hospitals which formed the basis of the Royal College of Physicians and British Geriatrics Society (1994) report and guidelines found that 98% of those surveyed provided rehabilitation. The same report also cites two other large studies which identified rehabilitation as the major reason for patient acceptance at Geriatric Day Hospitals (Brocklehurst and Tucker 1980, Cohen and Schwartz 1985). This section therefore provides some background information regarding definition and principles of rehabilitation.

Rehabilitation is a relatively new discipline, achieving recognition during World Wars One and Two for work carried out with injured soldiers (Nolan and Nolan 1997, Ward and McIntosh 1993). It is perhaps for this reason that theorising within this field is in its infancy. At present, there is relatively little literature detailing the process and philosophy of rehabilitation in general, and there have been calls for the development of a clearer conceptual framework for rehabilitation (eg Robinson and Batstone 1996). Whilst the term 'rehabilitation' is used in such diverse fields as mental health (Hume and Pullen 1986) and the care of older people (Squires 1996), its application in the field of neurology has perhaps been the most extensively documented (eg Greenwood, Barnes, McMillan and Ward 1993, Carr and Shepherd 1998, Wade 1992).

Whilst various definitions of rehabilitation have been proposed, the following are perhaps two of the most widely recognised:

"A process of active change by which a person who has become disabled acquires the knowledge and skills needed for optimal physical, psychological and social function" (McLellan 1997:1)

"The application of all measures aimed at reducing the impact of disabling and handicapping conditions and enabling disabled and handicapped people to achieve social integration" (Wood [1980] cited as World Health Organisation [no date] in Department of Health 1997:6)

This latter definition is reliant on the International Classification of Impairment, Disability and Handicap as described by the WHO (Wood 1980 cited in Pfeiffer 1998) (see appendix 16).

The identification of goals which form the focus for intervention is a widely recognised principle of rehabilitation practice (Robinson and Turnock 1998, Sinclair and Dickinson 1998, Ward and McIntosh 1993). The goals or foci of rehabilitation are often described as being directed at all three levels of the framework described by the WHO (1980), that is impairment, disability and handicap (Department of Health 1997, Sinclair and Dickinson 1998).

Another tenet of rehabilitation is that it involves multidisciplinary teamwork which includes a variety of differently trained health professionals (McLellan 1997, Robinson and Turnock 1998, Ward and McIntosh 1993). The need for a leader of this team is acknowledged, but it may not be appropriate for this to be the medical practitioner, who may have minimal input (Ward and McIntosh 1993). A widely invoked principle of rehabilitation practice is that it is 'client-centred' ie it acknowledges the rights of the disabled individual to make choices about the goals of rehabilitation and to control their own lives (Department of Health 1997, McLellan 1997, Robinson and Turnock 1998, Ward and McIntosh 1993).

Whilst various approaches or strategies to rehabilitation interventions have been described (eg Department of Health 1997, McLellan 1997), the specific details of components of different interventions are often lacking in descriptions of rehabilitation (Ballinger, Ashburn, Low and Roderick 1999, Sinclair and Dickinson 1998). This means that it is sometimes impossible to replicate the interventions briefly described in research papers focused on rehabilitation, and it is also unclear whether like is being compared with like, for example, in comparisons of 'stroke rehabilitation'. Another specific criticism of rehabilitation is that it has been difficult to define its practice so that the perspectives of service user, family, professionals and agencies are all accommodated (Nolan and Nolan 1997, Robinson and Batstone 1996, Robinson and Turnock 1998).

7.3 Procedure for study aiming to explore risk within day hospital for older people

The remainder of this chapter will detail the procedure employed in setting up and carrying out this study, and will report on preliminary findings, in the form of a description of the day hospital (specific details about and rationale for the methods used in this second study are discussed in chapter four). This information will thus provide a context for the major interpretative work of this second study, which will be reported and discussed in chapters eight and nine.

7.3.1 Research questions and study aim

Whilst explicit mention of risk was made many times in the therapist accounts within the initial study, it was not specifically alluded to by older service users. It was unclear whether service users recognised the same types of objects and activities as 'risky' in relation to falling as the therapists, and whether they perceived themselves to be at risk in the same way as the therapists appeared to. Research questions to be explored in the second study therefore included the following: how is risk constructed in a community health care setting for older people? Are particular types of risk recognised and privileged by health care professionals? How is falling manifest in configurations of risk in this setting? Do older service users prioritise the same risks as health care professionals? How does

risk relate to how the self is perceived and represented? All of these questions were subsumed within the following, general, study aim:

- to explore how risk was invoked, communicated and managed within a day hospital setting for older people.

The definition of risk was kept deliberately vague at the start of this study, in order that a range of possibilities could be included and considered. The rationale for selection of a community health care setting is explained in the following section.

7.3.2 Rationale for design of study and choice of site

As discussed in chapter four, one of the potential strengths of research loosely based on ethnographic principles is that the research design evolves over the study period, being dependent on emerging themes and issues of interest. In the current work, decisions regarding the aim and focus of this study were based on the outcomes of the initial study, and the focus evolved during the process of the research.

With risk as a specific focus, I was interested to learn more about how older people living at home, who had not very recently faced a traumatic health event, but who had been deemed to require some health care intervention, experienced the provision of this service. I also wanted to investigate how health care workers viewed their responsibilities to older people, and how a group of older people were 'managed' in a community health environment. I felt that a combination of participant observation would enable me to investigate the culture of the day hospital, followed by semi-structured interviews to explore in more detail individual accounts of giving and receiving health care. Although identified for the purposes of gaining ethical approval, and access, the aim for this second study was deliberately vague as I was anxious not to formally incorporate my untested preconceptions into the design of the study.

The original idea of selecting a day hospital for older people had come from a discussion with a therapist participant from study one. She had confirmed that

many of the older patients in the community setting in which she worked had experienced a fall, knowing that this had been a particular focus for my first study. On visiting her several months after the conclusion of the initial study, she explained that she was to be involved in a 'Fallers Clinic' which was to be set up within the auspices of the day hospital in which she worked, with additional central government money, known as 'Winter Pressures' money. This money has been allocated for the past two winters to provide some relief for the National Health Service at a time of increased demand from older people. The 'Fallers Clinic' was due to commence at the time when I hoped to be starting data collection for a second study.

The design and choice of site were therefore determined by theoretical considerations (in broadening the context of the research, and exploring conceptions of risk more generally), practicalities (proximity of day hospital to workplace, access facilitated through therapist), serendipitous good fortune (in the creation of the 'Fallers Clinic') and ethical and access considerations (described later in this chapter).

7.3.3 Preparation as researcher

One of my criticisms of my first study was that, in spite of my best intentions, I had still approached the research, and particularly the data analysis and interpretation, with the assumptions and understandings of an occupational therapist and health care worker. This had caused difficulty in the execution of the project (particularly in selecting the patient interview questions), and in interpreting the accounts of the service user participants. I therefore felt that in this second study I particularly wanted to avoid this identity, although was aware that the extent to which I could assume alternative identities would be limited, and were partly dependent on my own preconceptions about how participants were making sense of me and my mission. Prior to starting, I therefore deliberately avoided obtaining a large amount of formal or written information about the day hospital, such as its stated purpose, or activities, believing that this would allow me to experience the day hospital from more of a service user perspective, in preference to that of a health worker.

The only information obtained prior to the study was the approximate numbers of staff and service users, and how medical cover was provided, which was required for completion of the ethics form. I also confirmed that people attending were 'older', and asked about their diagnoses and method of referral to the day hospital, in order to confirm that they were not in need of acute health care. I did not keep written records of the responses to these inquiries as I felt these might serve to reinforce a health professional perspective of service users which I particularly wanted to avoid in this second study.

Prior to the period of participant observation I had several practices at observing and recording social practices in various different settings, on the advice of my supervisor. I also spoke to some colleagues with experience in this research method regarding techniques and advice.

7.3.4 Access and ethical approval

The processes of gaining access and ethical approval in order to carry out the research reveal much about the culture of the day hospital, and health care for older people more generally, and as such constitute 'data' which I have included in developing theoretical reflections about 'frames' and risk in chapters eight and nine. At this point, however, a fairly unreflexive, although detailed, account of the processes is provided, in order that they might be considered analytically in later chapters.

After completion of my first study, and whilst planning the second, I went to see a therapist colleague, to discuss basing the research within the environment in which she worked, and how this might be facilitated. She was enthusiastic, and agreed to negotiate a meeting for me with the day hospital Manager, by background a nurse, from whom she suggested I needed to seek permission. This meeting was arranged very shortly afterwards, and I visited the Manager, also at the day hospital. My identity as a Lecturer in Occupational Therapy was known to the therapist participant, and I deliberately elected to introduce myself in this capacity to the Manager, in the belief that it might reassure her about my capacity to carry out research. Thereafter, I reverted to an identity as 'student' during the period of

observation. She also had no objection to my carrying out the study, but wanted to confirm permission with the Service Manager (her line manager), and also said that everyone, 'including the housekeeper' who constituted 'the team' needed to agree to my presence and project. She invited me to attend a team meeting, at which I presented my research, handed out information sheets to all people present, and was willing to answer any questions that people had. The meeting was held on a Wednesday, when service users do not attend the day hospital, and none of the doctors or volunteers attended this meeting. No objections to my research were raised at this meeting. I also explained that I needed to obtain approval from the Joint Ethics Committee before proceeding with the study.

In the submission to the Joint Ethics Committee, I stated my intention to obtain verbal (rather than written) consent for both participant observation and interviews. My rationale for this was that the process of gaining written consent had felt intimidating to participants in the first study. I also explained that I had received permission from the Manager of the day hospital to proceed with the study, and confirmed my intention of informing consultants who provided medical cover about the study, prior to starting.

Several weeks after submitting the form to the Joint Ethics Committee, I received a letter informing me that my project had been granted conditional approval, but that several additions were required:

i) the committee felt that the project should be discussed with medical staff
ii) subjects (sic) should be made aware of how and when the taped interviews would be destroyed
iii) formal (ie written) consent should be obtained at the taped interview stage

Whilst I did not necessarily agree with the steps proposed, I carried out the additional steps required, by discussing the project with one of the doctors with input into the unit (who was quite happy for the project to go ahead, particularly as it involved interviews which he felt were 'non-invasive'), making changes to the information sheet, and drafting a formal consent form to be signed by participants

before interview. I received a letter confirming full approval one month later, and commenced data collection at the end of January 1998.

7.3.5 Decisions regarding participant observation

7.3.5.1 Persona of researcher and how to observe

As previously stated, I was particularly anxious to avoid an identity of 'health worker', 'therapist' or 'occupational therapist' in this second study. In addition to the preparation detailed in section 7.3.3, I therefore deliberately adopted the following strategies in an attempt to promote an identity as 'student'. I introduced myself verbally and on my written information sheet (appendix 17) as a student at the University, to both staff and service users. In line with this identity, I elected to wear casual clothes, usually trousers and a jumper or shirt, and avoided carrying a briefcase, or large bag. I hoped that in selecting this identity for myself, people would recognise my role as a 'learner', and not look upon me as a source of experience, or respond to me as a health worker. This, in fact, accorded much more with the way in which I thought of myself within this setting, and I found this identity easy to maintain. In expressing my gratitude to the participants who had agreed to be interviewed later in the study, several spontaneously volunteered that they had agreed in order to 'help you learn'.

Although I had previously met the staff at a staff meeting before the observation period began, I deliberately avoided becoming close to, or associating with any staff member initially. I felt that this was necessary in order that none of the staff should make particular efforts to accommodate me or introduce me, thus helping to differentiate my position from that of the service users attending the day hospital, as I perceived it.

In applying for Joint Ethics Committee approval for this second study, I decided in consultation with my supervisor not to ask for permission to refer to patients' medical notes. The rationale for this was twofold; firstly I didn't want service users or staff to see me accessing medical information about patients, which I felt would reinforce my status as a health worker, from their perspectives. Secondly, I

wanted to avoid constructing the older individuals I would be observing as primarily patients with medical problems, as documented in their medical records.

I was also anxious to avoid being seen writing notes about my observations, either by staff or service users, as I felt this would also impact on the nature of what I observed, and also the relationships established with study participants. In the case of service users, I felt that this would again potentially reinforce my status as 'health worker'. I therefore developed techniques to enable me to record my observations covertly. These included frequent visits to the toilet, where I could make notes in private, use of a small tape recorder on which to record points of interest on the car journey back to my workplace, and purchase of a newspaper, on which I jotted letters which would act as later memory cues, under the guise of completing the crossword.

These reminders were all used to write notes of each period of participant observation on the wordprocessor, usually completed shortly after arriving back at my work base from the day hospital. Each note started with a filename, day, date and time in and out of observation period and whether or not a diagram (for example of who sat where in the day room, or within a staff meeting) was included. The filenames used were either 'dhvis' (day hospital visit) followed by a number, representing the number of the visit, or 'fclinic' (fallers clinic) followed by the number of the clinic. The notes were printed out and filed in chronological order, interspersed by other sheets ('memos') containing reflections, ideas and thoughts arising from supervision or reading. The memos also constituted data, were coded and contributed to the analysis. Memo files were called 'fnotes', also followed by a number, indicating order of completion. The different files from which excerpts shown in chapter eight have been taken are indicated by use of the file name, followed by the line numbers of the excerpt, having been converted to an 'Ethnograph' file. Documentary sources were also collected during period of participant observation, and filed in chronological order along with hard copies of word processed notes and memos. These included policy documents, leaflets and copies of posters.

7.3.5.2 When to observe

In deciding when to observe, my aim initially was to spend as much time as I could in the day hospital, whilst allowing time to type up notes, reflect on what I had observed and keep records of emerging ideas and theories to test out with further observation. The dates and times selected, particularly at the beginning of the data collection period, reflect a spread of times and days during which the day hospital was open. I was also anxious to record as many details as I could of what I saw, and tended to restrict the time spent observing to a maximum of around three hours. This was particularly important initially, when my observations were very unfocused, and I was inexperienced in the use of participant observation as a data collection method. The dates and times of participant observation periods are shown in the table below:

Table 13: Periods of and details regarding participant observation in second study

Week starting	26/1/98	2/2/98	9/2/98	16/2/98	23/2/98	2/3/98	9/3/98	16/3/98	23/3/98	30/3/98	6/4/98
Mon	2.45pm - 4.05pm	1.20pm - 3.00pm		3.25pm - 4.30pm				3.35pm - 3.50pm	1.40pm - 3.20pm	1.40pm - 2.40pm	
Tues	8.40am - 10.40 am		2.30pm - 3.40pm	8.55am - 11.30 am	1.45pm - 3.20pm			9.30am - 11.15 am	**11.00 am - 12.00 1.50 pm - 3.35 pm**	10.50 am - 11.20 am	**10.30 am - 11.00 am**
Wed	11.45 am - 2.40pm	8.40am - 9.00am 1.15pm - 2.50pm	10.20 am - 1.20pm	10.45 am - 1.05 pm	9.15am - 11.45 am						
Thurs	11.45 am - 2.00pm	8.05am - 10.15 am 2.50pm - 4.15pm	10.30 am - 12.30 am					1.35pm - 2.45pm	**10.05 am - 11.50 am**	11.50 am - 12.25 pm	**10.30 am - 11.45 am**
Fri		9.15am - 10.05 am	9.20 am- 11.30 am		9.15am - 10.15 am				10.50 am - 11.45 am	10.15 am - 10.45 am	

Key: Light shading: 'Fallers Clinic'
Dark shading: Time away for initial coding and interpretation
Bolded characters: Observation period which included interview carried out in the day hospital environment

The total amount of time spent carrying out participant observation was 50 hours, 15 minutes, of which four hours included a semi-structured interview in the day hospital, and seven hours, 50 minutes was spent within the context of a 'Fallers Clinic'.

7.3.5.3 Where to observe

Choices about where to carry out the observations within the day hospital reflected my decision to orientate myself with the service users, and to deliberately distance myself, initially at least, from staff, in an effort to promote an identity as 'student' and not 'health worker'. I also wanted to try and experience the day hospital in as similar a fashion to the service users as possible, in order to help me to understand and interpret the accounts they provided for me. I therefore elected to spend long periods of participant observation in the day room, the large room where patients spend the majority of their day, when not receiving treatment or therapy. My

ventures into other rooms in the day hospital used for therapy or assessment often occurred when the individual with whom I was conversing was asked to go into one of these rooms for treatment. I took advantage of such opportunities to ask if I could accompany them, and was usually answered in the affirmative. Access to areas utilised solely by staff was often determined by necessity such as the need for somewhere private to record notes, use of the toilet, access to a hot drink and a relaxing space to eat my lunch. The differential use of space within the day hospital by service users and staff is further reported later in this chapter.

7.3.5.4 Whom and what to observe

Selection regarding whom and what to observe and record were also linked with my desire to gain an insight into the experience of being at the day hospital primarily from a service user's perspective. I therefore spent most of participant observation periods with service users, in order to counter what I perceived as my pre-existing health professional orientation.

This was particularly evident during the initial few weeks, when I only attended meetings/treatment sessions/other activities as I learnt about them through my observations, rather than purposively enquiring about them or seeking them out. As I had expected, the first few days of observation were overwhelming. I felt bombarded with information, and had difficulty in attempting to remember all that I had seen. As the study progressed, I gradually became more focused and selective, both about what I selected to observe and what I chose to record. I kept records in the form of memos about ideas for future observation and a rationale for working in the way I did.

7.3.6 Interviews

7.3.6.1 Rationale for interviews with service users

As already indicated, one of the attractions of utilising ethnographic principles in the current research was the possibility of an emerging research design, which could accommodate shifts in focus. In applying for approval from the Joint Ethics Committee, in discussing the study with the day hospital Manager and in the

information sheet, the possibility of interviews at a later stage in the project had been included. It was originally envisaged that these would take place with both staff and service users, once the initial period of observation had occurred, and a perspective on the culture of the day hospital and an understanding of risk within this was starting to emerge.

After five weeks of participant observation, a considerable amount of data had been generated, and the decision was taken to take time away from the site to begin a preliminary coding of these data. After discussion with my supervisor, I felt that interviews with patients would provide additional perspectives to supplement the observational data in making sense of the day hospital world. I also felt at this point that I would be able to accommodate possible challenging and puzzling views which might conflict with my initial impressions and developing theory, which would have been difficult at an earlier stage.

I decided in the interviews to focus exclusively on service users as I felt my health professional training and orientation and my growing understandings of the way in which the day hospital functioned meant that their perspectives were at that time the most difficult to access. Reasons for this included the emerging dominant explanations regarding the purpose of the day hospital, the potential variability of accounts of service users and lack of opportunity they had to speak freely and privately in a context of their own choosing.

7.3.6.2 Design of interview schedule

One of the most critical issues to emerge for me from the first study was the importance of reflexivity in exposing one's own prejudices and assumptions, when trying to make sense of data generated from interviews. I came to realise the futility of trying to ask the 'right' questions, and the importance of focusing on the meanings generated by the participants. In developing the interview schedule for the second study, therefore, I aimed to ask fairly brief questions, broadly relating to my interests in the day hospital, falling and risk, but which would also enable the interviewees to express their views and concerns.

I drafted out a set of questions which, after discussion with my supervisor were modified just once, and which I then used for the entire set of fifteen interviews (see appendix 18). In the first study, I had also included an additional questionnaire (see appendix 11) in which I had asked for information such as the type of accommodation the participant had lived in prior to admission. In retrospect, these questionnaires had not added much to the analysis and as I understood more about the constructed nature of 'objective facts' (such as the number of previous falls someone may have had), the less useful such data appeared. Consequently, I kept the number of additional questions to a minimum (see appendix 19).

7.3.6.3 Procedure for interviews

One of my early impressions of the day hospital, recorded in my notes, was that it was very difficult to remember names and faces of the many service users who seemed to attend. As the initial five weeks of participant observation proceeded, I began to recognise and get to know more of the service users. Returning from the two week break that I had taken in order to do some preliminary analysis of the observational data, I realised that I had an opportunity to recruit some of the people whom I had begun to know better for the semi-structured interviews. There was a widely shared understanding amongst staff that the service users tended to attend the day hospital for between six and eight weeks. If I therefore was to capitalise on the relationships that I was beginning to establish, and to maximise recruitment rate, I needed to begin recruitment fairly promptly.

Whilst initially, during the observational phase, I had been very methodical in handing out information sheets about my study to service users attending the day hospital, I found that this had detracted greatly from the focus of my observation, forcing upon me a much more active role, which I felt was not desirable. I had also become preoccupied with trying to remember to whom I had given an sheet, and who was a new attender, a particularly difficult task when patients' identities were concealed in all my notes for sake of confidentiality. During the observational period, therefore, I decided to stop handing out information sheets about the study

as a matter of course, although provided information if people asked about the study.

However, the issue of informed consent was important to participation in the interviews, and I adopted a procedure, described below and summarised in the flow chart, to ensure that all patients I approached about participating in interviews had received written information about the study, and been given the opportunity to think over whether they would like to take part.

Each day during the recruitment phase, (between 16/3/98 and 3/4/98, with exception of participant 15 - see section 7.5) I obtained a list of names of people attending the day hospital on that particular day. This list was produced by the administrators for the Report meeting at the beginning of the day, and included names of all attenders, in alphabetical order, plus people attending for the first time ('First assessment') and those for the second time ('Second assessment'). I then systematically approached each attender to ask if they had received an information sheet, and if not, to give them one, and explain that I would be seeking volunteers for interviews.

I then allowed a break of between three days and a week to elapse before again approaching individuals, to inquire whether they had any questions about the study and to ask if they would be willing to be interviewed. I gave people a choice of venue for the interview. In light of difficulties with privacy experienced during the first study, and how I felt the medical experience and environment influenced the patient accounts, I wanted to interview service users in their homes, where I felt that they might have more autonomy and control. However, I was also aware that some participants might feel safer being interviewed in the day hospital, in preference to giving me their home addresses, or being visited alone at home by a relatively unknown researcher with no responsibility for their treatment or care. Once they had agreed to be interviewed and we had discussed the venue, we agreed a time and date for the interview, and I wrote this information on a compliment slip with my contact details which I gave them, should they change

their mind about participating. In general the interviews then took place a few days later.

At the start of the interview, the participants were asked to sign the consent form (see appendix 20) before the tape recorder was switched on and the interview began. In general the interviews lasted around half an hour, and concluded with a few questions detailing demographic data such as date of birth (see appendix 19).

Notes pertaining to the interview were written shortly afterwards, and became part of the corpus of data, and the interview tapes were given to one of two clerical staff to transcribe. The detail paid to the interview tapes in transcription by the two support staff was slightly different. However, experience with interpretation in the initial study suggested that the level of analysis was such that this would not pose a problem (ie 'macro' rather than 'micro' or 'conversation analysis style' analysis). Word processed files of interview transcriptions were called either 's2p' ('study 2 participant') or 'ints2p' ('interview study 2 participant'), depending on which of the two clerical staff were completing the transcription, followed by the number of the participant (from one to fifteen). Additional interview notes were either included as 'dhvis' ('day hospital visit') files (see observational data) if the interview was carried out in the day hospital, or 'intnot' ('interview note'), followed by number of interview to which they corresponded. As with the observational data, any excerpt from interview transcripts or interview notes in the subsequent chapter is followed by the file name, plus line numbers of the excerpt from the converted 'Ethnograph' file.

Letters of thanks were then written to the participants and sent either to their home, if the interviews had taken place there, or to the day hospital, if they had preferred to be interviewed in this environment.

This process is demonstrated in the flow chart below:

Figure 9: Procedure for recruitment and execution of semi-structured interviews with service users in second study

Week 1	Specific mention made of study to service user, and information sheet provided if not already received.
	⇓
Week 2	Service user approached again and asked if they would be willing to be interviewed. Venue, date and time agreed and compliment slip provided with details of interview time and contact details.
	⇓
Week 2 or 3	Interview takes place. Notes about interview completed shortly afterwards.
	⇓
Week 2 or 3	Letter of thanks sent to participant. Interview tape passed to clerical staff for transcribing.

7.3.7 Data analysis

7.3.7.1 Activities which assisted in process of analysis and interpretation

The act of typing up notes shortly after each period of participant observation served not only to record what was observed, but also to allow continuing reflection and possible alternative interpretations of the events which had been witnessed. Notes written after each interview also facilitated this process.

I had kept a research diary since the start of the research studentship in which I recorded impressions, thoughts and emerging ideas regarding my research. During the course of the participant observation, these entries became more formal memos, being wordprocessed rather than handwritten and formatted in order that they could be coded using 'Ethnograph', as was all raw data. During the course of writing both notes and memos, I had ideas for further observation, of which I kept a record, and which then informed how I proceeded with the participant observation. Hard copies of all computer data files were printed and stored in chronological order in two folders. The first contained observational data, which were interspersed with handwritten notes with ideas for further observation, agendas for supervision and diagrams of layout of particular rooms within day hospital. The second contained transcriptions of interviews, together with interview notes and additional questions completed at time of interview.

Regular supervision allowed for testing of emergent ideas and discussion about possible relevance of different activities witnessed. I was able to benefit from my supervisor's insights derived from her work in similar fields of interest, and also from her experience in the use of qualitative research methods and interpretation.

'Ethnograph' proved a useful tool for structuring the mass of data that were being generated. Whilst the subsequent overarching theory is more complex and sophisticated than the codes developed for the observational and interview data, these codes provided a way of managing, organising and initiating interpretation of these data.

7.3.7.2 Coding of the observational data

During the initial five weeks of data generation, through participant observation, the activities identified above provided a useful means of managing and starting to interpret the many notes and memos, namely those computer files named 'dhvis', 'fclinic' and 'fnotes'. After five weeks I felt it would be useful to spend more time working closely with the existing data in preference to generating more. I therefore took a break of two weeks from the period of observation, during which time I read through notes and memos recorded, jotting down ideas and potential codes and points worthy of interest in the margins of the hard copies in line with criteria suggested by Parker (1992, 1994) and Potter and Wetherell (1995), as discussed in chapter three. An example of manual marking of interview data can be seen in appendix 21. The data were then formatted for entry into 'Ethnograph' and coded using the schedule in appendix 22.

The coded data were then read again during the two week break, parameters of each code specified, and comments and thoughts noted. Shortly after participant observation resumed again and recruitment for interviews began, several of the codes were modified a little, as in appendix 23, and the data recoded.

These codes were subsequently retained for the observational data. Participant observation continued for another four weeks, alongside semi-structured interviews. The second corpus of data was coded in early June using the slightly modified codes. Appendix 24 shows an example of interview data which has been coded in 'Ethnograph'.

7.3.7.3 Coding of the interview data

The audio-tape recorded interviews were transcribed as detailed in appendix 6 and hard copies of the transcripts and interview notes read and manually coded using criteria identified in the previous section. I had originally envisaged that I would develop one set of codes which would be used to analyse both the observational and interview data. However, as I read through the interview data, different ideas and themes seemed to emerge, and I decided to develop a separate set of codes.

The interview transcripts and notes were prepared for entry into 'Ethnograph' when the last interview had been completed, and coded according to the schedule shown in appendix 25.

The following flow chart illustrates the sequence of coding both the observational and interview data:

Figure 10: Flow chart illustrating sequence of coding of observational and interview data in second study

Weeks 1-5	Initial period of participant observation with recording of notes and memos
	⇓
Weeks 6-7	Manual coding of observational data, formatted for entry in 'Ethnograph'. Coding in 'Ethnograph' with original set of codes. Re-reading of coded data and parameters of codes specified.
	⇓
Weeks 8-11	Modification to original set of codes and recoding of observational data using 'Ethnograph', continued participant observation (with recording and coding of notes and memos) and commencement of interviews with audio-recording, transcription and interview notes
	⇓
Weeks 12-17	Manual coding of interview data, formatting of interview data for entry into 'Ethnograph'. Coding of interview data in 'Ethnograph', reading, discussing developing ideas with supervisor

The codes identified for both observational and interview data were viewed as being exploratory and as such, rigorous definitions, which might inhibit further creativity and understanding of the phenomena being studied, were not provided. The parameters of the codes were written retrospectively, shortly after the original coding was carried out, in order to provide an opportunity to reflect on how the codes were being used and understood. As such, therefore, the codes were not

subject to any reliability checks, such as asking independent assessors to identify themes and comparing number and type identified. This work is located in a discursive tradition which celebrates diversity and multiplicity of perspectives. Any appeals to positivist notions of reliability are therefore rejected. However, the process of identifying codes and coding data was described to and shared with my supervisor, herself an experienced qualitative researcher. This ensured that the alternative criteria proposed for evaluating this thesis in chapter three (namely rationale provided for data source(s), data generation method(s) and interpretation, reflexivity, plausibility and accounting for detail and volume of data) were addressed.

7.3.7.4 Inclusion of documentary sources in the analysis

Documentary sources were collected and filed throughout the period of participant observation. However, they were viewed as a secondary source of data, to supplement primary data from observation and interviews. Initially, therefore, they were not formally included in the analysis, and their status and value as data were unclear. As the analysis developed, however, their potential contribution to the interpretation was recognised, and a limited form of discourse analysis was carried out these sources. This was based on the criteria identified by Parker (1992, 1994), with particular emphasis on the first few stages. The process of this analysis was not formally recorded, but written into the account of this study described in the following section, and in chapter eight.

7.3.7.5 Writing account of second study

The process of moving from coding data with two relatively simplistic coding sets to producing a theoretical overview which accounts for the data in detail is very difficult to describe. The process of analysis and interpretation utilised in this current study did not, for example, follow the prescriptive sequence often identified as 'Grounded Theory' (eg Charmaz 1995). However, some of the major activities will be identified in this section.

Throughout both studies, the process of writing and redrafting an account has proved a key activity in the developing analysis. The task of producing a version

of this second study began whilst coding of the data was underway, and a first draft of this study was completed in a few weeks. This draft focused heavily on methods and methodology used, and provided a preliminary descriptive account of the day hospital. At this stage, the relationship between the account provided and the original research aim was rather tangential, although further directions for exploration and interpretation were identified.

In subsequent months, the following activities were undertaken, which all contributed to a deeper theoretical understanding of risk, and enabled a more coherent understanding of the culture of the day hospital and the ways in which risk was constructed to begin to develop:

- holiday (in which risk of attack from wild animals led to productive reflection!)
- review of risk within social sciences literature
- production of paper from initial study, revision following rejection from one journal and subsequent resubmission to another
- presentation of methods and data from second study at several seminars
- production of outline plan(s) of thesis
- re-reading of all coded data

The following written material, illustrating the development of theory, is available, and provides a chronological account of how this work evolved, thus enhancing plausibility of the final account:

- daily diary containing brief notes about activities undertaken throughout studentship
- reflective diary, containing longer passages which record thoughts, developing ideas, problems, blocks, strategies and plans
- all previous drafts of chapters filed in chronological order, kept within reflective diary.

The figure in appendix 26 provides a graphic representation illustrating the relationship between some of the original codes and part of the interpretation presented in chapter eight. It's purpose is not to provide an exhaustive or definitive explanation, but to illustrate the complexity of developing theory informed by an initial coding scheme. The chart illustrates how different data and codes were used in the formulation of the 'rehabilitation frame' and risk within this frame, described in chapter eight.

7.4 Description of day hospital

The following two sections, 7.4 'Description of day hospital' and 7.5 'Characteristics of service users participating in interviews' are derived from data generated through the research; observation, interviews and documentation. As such, they therefore constitute a preliminary level of analysis. Whilst the artificiality of dividing 'procedure' from 'findings' has already been discussed, a rationale has been provided for doing so, in that this facilitates a reading of the research. This preliminary analysis is presented here, however, both because it provides contextual information which sets the scene for subsequent interpretation and also because it constitutes another set of data which are further analysed and discussed in subsequent chapters.

7.4.1 Service aim, service users and staff

The aim of the day hospital, as stated in the Service Profile and Operational Policy, was to 'promote independent living and good health'. Service users were accepted if they were aged over 65 years, and required medical, therapy or rehabilitative nursing assessment or treatment. The clinical team included doctors, nurses and therapists. More details about the aims of the service, the service user group and personnel can be found in appendix 27.

7.4.2 Fallers Clinic

The following information is based on informal discussions with various members of staff about the way in which the Fallers Clinic operated, and observational data, as formal written information about the Fallers Clinic, although requested, was not forthcoming.

The clinic had clinical assistant, occupational therapy and physiotherapy input, and a part-time dedicated nurse was allocated to the project. Occupational therapy cover for the project came from another part of the OT service on the site. The aim of the service was to provide rapid response multi-disciplinary assessment and treatment for older people who had fallen. Attendance at the clinic involved a thorough medical examination and physiotherapy assessment, and generally lasted between two and three hours. Outcome depended on the nature of the problem(s) identified; patients could be referred to the day hospital or to other agencies; action, such as change of medication, could take place within the clinic; or occasionally no further action was deemed necessary.

7.4.3 Daily routines

As previously discussed, one of my objectives in carrying out this second study was to enable me to gain a greater insight into the perspectives of older people themselves. To this end, I deliberately chose to orientate myself with service users in the day hospital during participant observation, and therefore gained a greater insight into their daily routines than those of the staff. For reasons also explored elsewhere, the staff had greater choice over the extent to which their actions were viewed by others, and for much of their day they were not visible either to myself or the service users. The practices in the day hospital also meant that the service users were often perceived as an homogenous group, whilst the activities of the staff were more disparate, being partly dependent on their professional role. For the above reasons, it is more easy to characterise the daily routines and activities of the service users in a table, than to represent those of the staff in this way. The table below therefore illustrates a typical service user's day on a Monday, Tuesday, Thursday or Friday. Additional information is included regarding the different routine on Wednesdays.

The times in the table are approximate, and additional information clarifying activities is provided under the tables.

7.4.3.1 Daily routine of service users

Service users usually attended the day hospital for two or three days per week. A typical day for a service user is shown in table 14, below:

Table 14: Daily routine of service users in day hospital (second study)

TIME	ACTIVITY
8.30 am	Collected by day hospital ambulance for transportation to day hospital
9.30 am	Arrive at day hospital, coat collected, labelled and hung up, receive name badge, helped to day room, receive hot drink
10.00 am	Sit in day room, participate in assessment/therapy/treatment on an individual basis, often in one of the peripheral rooms
12.30 pm	Lunch in dining room
1.30 pm	Return to day room, period of rest
2.00 pm	Continued assessment/therapy/treatment. Sometimes game* (in day room), church+ (in dining room) or audiologist appointment (in audiology room)
3.00 pm	Receive hot drink, move into corridor, collect coat and wait for transport
3.30 pm	Collected by transport

Key: * game: sometimes organised by volunteer in the day room, usually word game taken from daily newspaper, involving creation of words using letters from a matrix, or bingo, using pack of cards

+ church: occasional service conducted by chaplain which took place in dining room

Service users in general did not attend on Wednesdays, unless they had been referred to the Fallers Clinic, or were receiving individual treatment or therapy, by virtue of their expressed preference.

7.4.3.2 Daily routine of staff

For reasons previously explored, the daily activities of the staff are difficult to characterise succinctly. During the period of participant observation, however, it became apparent to me that regular meetings took place for staff, the most frequent being the Report meeting. These meetings, which service users did not attend, seemed to provide a framework which helped 'clinical' staff to structure their day. These meetings, and the times when they occurred, are described below.

- Report meeting which generally occurred between 9.00 am and 9.30 am every morning in the Sister's Office, for therapy, nursing and medical staff. Daily lists of names (hereafter 'daily sheets') were available for this meeting, indicating names of patients attending, and separately identifying those who had been asked to attend again after a prespecified break ('Recalls'), those who were attending for the first time ('Assessment') and those for the second time ('2nd visit'). The staff discussed each patient in turn, often reminding themselves of the goals identified for the patient and identifying tasks that needed to be completed during their day's visit.

- Goal setting meetings which were held for approximately 1 ½ hours after lunch on Wednesday. Reports on individual service users (identified on a circulated list) were fed back by the staff member allocated to that individual. Problems were identified, and a list of goals were agreed by the team and recorded. The team also discussed for how long the individual should attend, and also the frequency with which they should attend the day hospital.

- Staff meetings seemed to occur once a month on Wednesday mornings for discussion of general issues relating to staff. I was invited to attend a staff meeting prior to starting my study in order to explain my research to the staff and to obtain their consent to carry out the project in the day hospital.

The daily activities of other staff, such as housekeepers and therapy helpers, were linked to the daily routines of the service user group. For example, the two therapy helpers met service users on their arrival at the day hospital, and the housekeepers provided hot drinks and lunch.

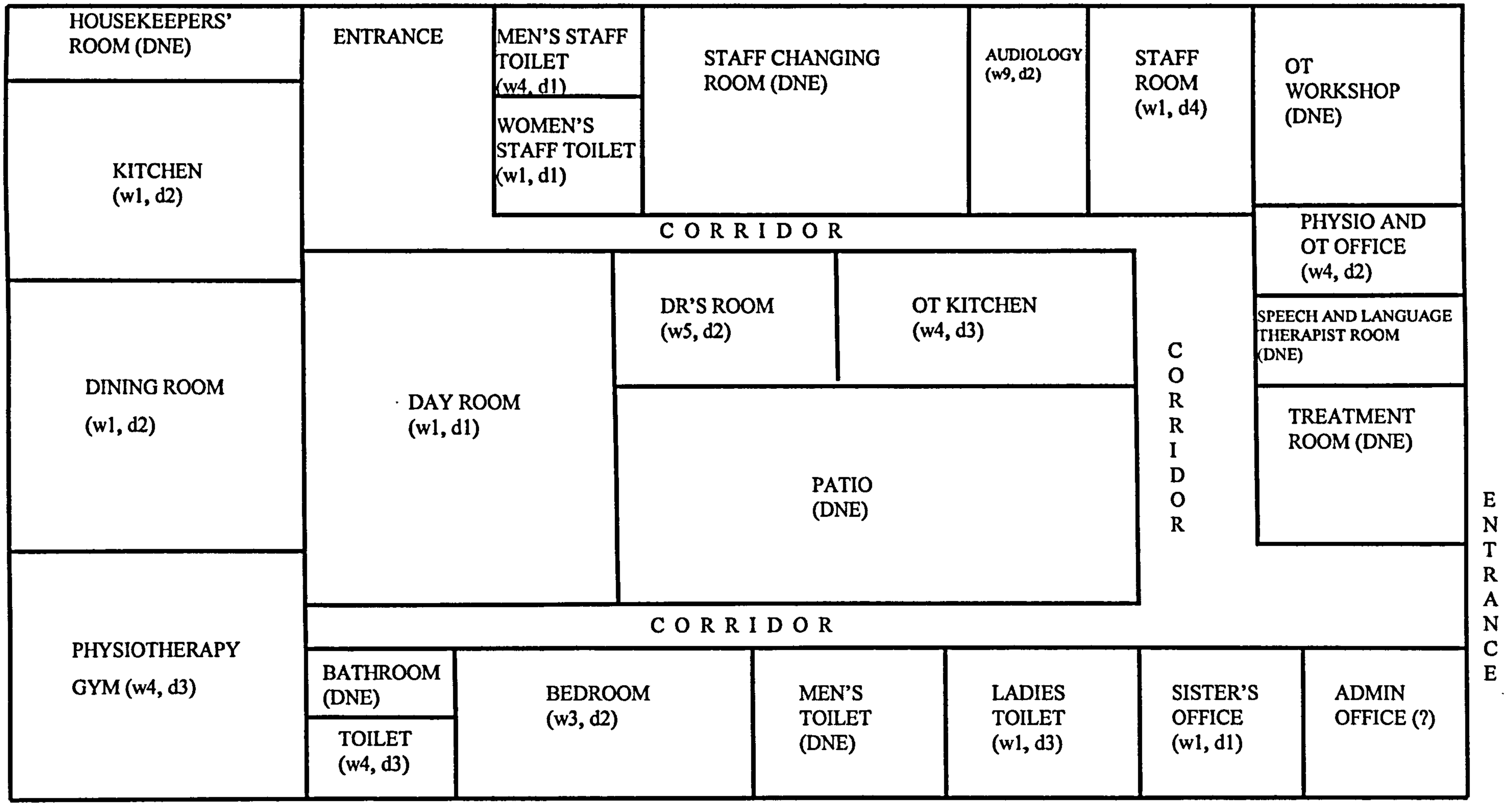
7.4.4 Location and space in the day hospital

The day hospital provided places for around twenty five service users per day, with the exception of Wednesdays.

The day hospital is situated in a suburb of a large city in the South of England, within the grounds of a large hospital for elderly people, formerly a workhouse. Other services included on the same site are in-patient facilities for older people, day provision for people with mental health problems and a community learning disability team. The day hospital is a single storey building located near to the entrance of the site. A plan is shown overleaf, based on a line drawing found on the notice board in the administration office and photocopied.

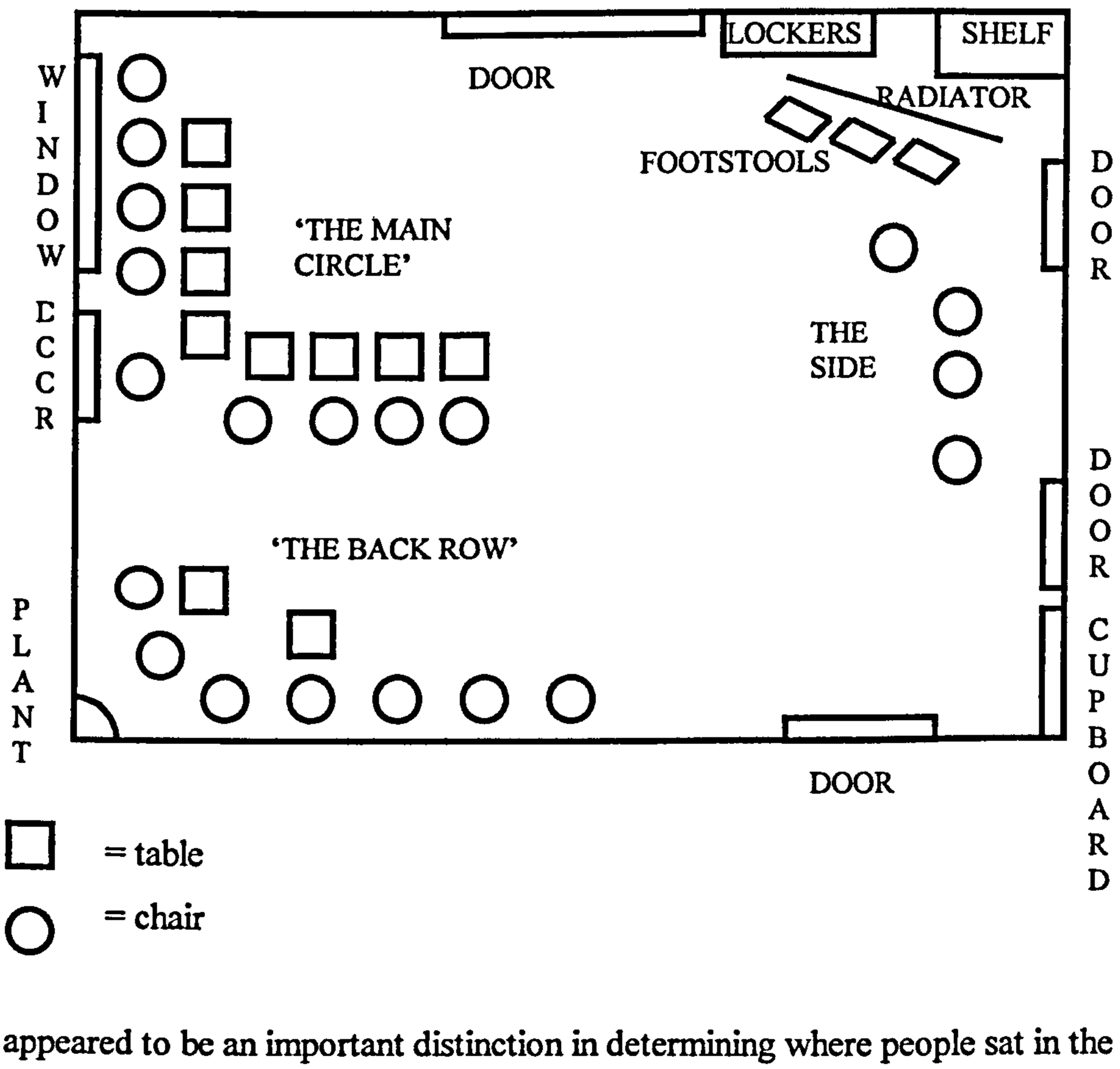
As researcher, I originally located myself with service users in the day room. Of interest during the course of the observational period were the points at which I gained access to other peripheral rooms, which are indicated in brackets on the figure (the observation took place over eleven weeks, of which weeks six and seven were spent coding and analysing data).

Figure 11: Plan of day hospital for older people, site of the second study
Key: brackets indicate when accessed w = week, d = day, ? = unrecorded, DNE = did not enter during study period



The figure below is a plan of the day room, reproduced from a sketch made during the second visit for purposes of data collection to the day hospital. It has been included both to help with subsequent interpretation (for example, reference to 'the back row'), and also because the ways in which the physical space in the day room was utilised also constitute data which are important in subsequent interpretation in the following chapters.

Figure 12: Plan of the day room in the day hospital (second study).



Gender appeared to be an important distinction in determining where people sat in the day room: the 'main circle' was usually occupied solely by women, whilst the male service users tended to sit on the side.

Service users tended to prefer to sit in the same seat throughout the day, expecting to return to 'their' seat after therapy in the physiotherapy room, for example. The way in which the seats were occupied within the day room also appeared to be an important

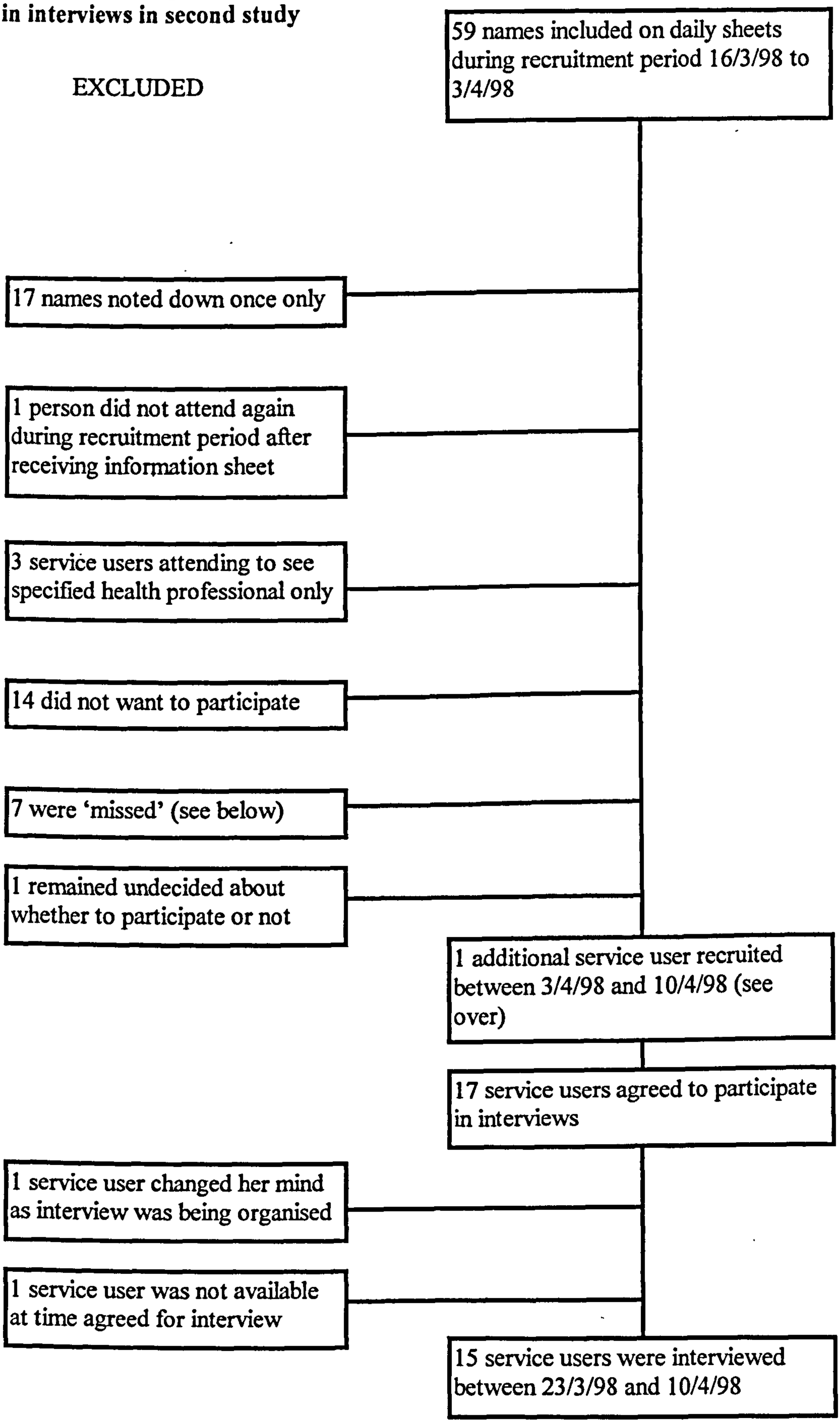
determinant of status, with those who had been attending for some time sitting in the 'main circle', or on the side, and the new attenders sitting in the 'back row'.

The 'main circle' was almost exclusively occupied by women who had been attending for some time, and who tended to be the focus of most conversation or laughter, although this was dependent partly on the presence of particular people. Activities, such as the games previously mentioned, tended to be located with this group primarily in mind, and the board (on which the problem was displayed and solutions recorded) was occasionally positioned so that the men on the side were unable to get a clear view, whilst the people in the 'back row' were probably too far away to see clearly.

7.5 Characteristics of service users participating in interviews

The chart below illustrates numbers of service users potentially able to participate, and reasons for non-inclusion. All older service users attending the day hospital during recruitment period were viewed as potential participants. The daily lists prepared for the morning Report meetings were used to determine those attending the day hospital (and therefore those who potentially could be interviewed), although names included indicated only intention to come, rather than confirmation of attendance. Service users named only once, and those whose names did not appear on the list again after they had received the information sheet were not eligible to participate, as they would not be present to indicate their intention. Those service users attending to see a health professional specified on the daily list (eg occupational therapist, speech and language therapist, physiotherapist) were more difficult to access, attending for a limited appointment period only, and not necessarily coming into the day room where recruitment took place.

Figure 13: Figure illustrating numbers of service users agreeing to participate in interviews in second study



The one individual who was still unsure about whether to participate or not did not attend again. Reasons for the seven 'missed' service users were varied: they may not have attended, although the sheets record their names, or have attended very infrequently, which provided limited opportunity to discuss the study and arrange the interview. Participant 15 was recruited slightly later than the cut off point of 3 April, because she was the sole interviewee who attended the Fallers Clinic, and it was felt that her account would add to the developing theoretical base. The characteristics of the interview participants are shown in the table below.

Table 15: Characteristics of service user participants interviewed in second study

Participant number	Age at time of interview	Gender	Venue of interview (DH = day hospital, H = home)
1	77	Male	DH
2	66	Male	H
3	76	Female	DH
4	77	Female	H
5	89	Female	H
6	86	Female	H
7	67	Male	H
8	78	Male	H
9	66	Female	H
10	76	Male	H
11	83	Female	H
12	89	Female	H
13	82	Female	DH
14	75	Female	H
15	71	Female	DH

Those interviews carried out in the day hospital were generally conducted in private. However, interview with participant 13 was interrupted by presence of other people in spite of reassurance of privacy.

7.6 Report for Manager of day hospital

At the conclusion of this second study, the Manager of the day hospital requested some feedback about the findings of the research. Following discussion regarding the three frames and perceptions of risk within these three frames, presented in the next

chapter, she felt that it would be of more direct relevance to the day hospital staff to have information about three points:

a) why interview participants thought they were attending the day hospital
b) aspects of the day hospital which participants liked, or found useful
c) aspects of the day hospital which participants disliked.

Whilst these issues were not the focus of the interviews, I agreed to analyse the interview transcripts and elicit this information from them. Whilst from a discursive perspective, the accounts gained from participants in an evaluation of the day hospital would in probability have been different to those provided for the purposes of the current research, I also felt it was imperative to respect the relationship established with the day hospital Manager and staff. The day hospital had been the focus of several research projects, and the Manager had the perception that these had yielded little information that was either clinically relevant or useful. I therefore agreed to scan the transcripts for information pertaining to the above points, whilst respecting the anonymity of the participants. The report also makes clear that this information was derived from data generated in the context of another study. The full report can be seen in appendix 28.

7.7 Summary

This chapter has provided the context and some of the preliminary findings of the second study, aiming to explore how risk was invoked, communicated and managed within a day hospital for older people. The chapter commenced with general information about both geriatric day hospitals and rehabilitation. The processes used to carry out both participant observation and semi-structured interviews were then described. The chapter concluded with a description of the day hospital, and a profile of the interview participants.

The following chapter will extend the analysis and interpretation of this second study by describing the three frames through which action and talk in the day hospital can be constituted. It is argued that different types of risk are present according to the frame being employed.

8. Chapter Eight: Three frames for understanding risk within a day hospital for older people.

8.1 Introduction

This chapter further develops the main theoretical propositions deriving from the second empirical study, which aimed to explore how risk was constructed and enacted within the day hospital.

Risk did not appear to be a unified entity or concept, perceived in the same way by all those associated with the day hospital. Rather, different types of objects and activities were deemed 'risky', according to the perspective, or 'frame' adopted. It is proposed that there are three 'frames', which may be used to make sense of and describe the day hospital, and activities associated with it. These three frames; 'medical', 'rehabilitation' and 'social', comprise a resource upon which service users and providers draw, when 'doing day hospital business'. Each of these frames differs in terms of priorities and foci, and it is argued that the nature of and response to risk also varies correspondingly, depending on whichever frame is being utilised. This chapter will describe each of these frames, and provide examples of risk within each. The objective is not to classify different types of risks, but rather to illustrate how the same set of circumstances may be viewed as risky or not, or recast as posing different types of risk within each frame. This is further clarified by an example of the different risks leading to, and associated with a fall.

More general implications of the propositions asserted here are discussed in the final chapter, with specific reference to falls prevention programmes for older people, and more generally to health promotion activities.

8.2 Use of the term 'frame'

The choice of the term 'frame', in preference to 'discourse' has already been alluded to in chapter three. Within discourse analysis, particularly within the Loughborough School, the term 'discourse' has been closely associated with talk

and texts, as illustrated in the definition of discourse analysis proposed by Potter and Wetherell (1995):

'... it is concerned with what people *do* with their talk and writing ... and also with the sorts of *resources* that people draw on in the course of those practices'

(Potter and Wetherell 1995:80-81)

As previously described, however, this study utilised several different methods, including participant observation, in which fieldnotes and written memos comprised the raw data to be analysed, alongside interview transcripts and documents. The term 'frame' was chosen in preference to 'discourse' because such world views or perspectives are not realised solely through texts, but through interactions including non-verbal communication, architecture, design and use of space, and non-verbal practices. The act of turning these into texts constitutes a level of interpretation. The term 'frame' (as in window frame, spectacle frame or picture frame) incorporates the visual sense through which such knowledge constructions are apprehended, and included a feel for what is permitted or bounded by each view. Many of the metaphors used in discursive work, such as 'world view' or 'perspective', also allude to this visual capacity, making this choice of term doubly fitting. However, the use of 'frame' in this thesis also concurs with more general descriptions of 'discourse' within social constructionist work, such as this from Lupton (1999:15):

'A discourse may be understood as a bounded body of knowledge and associated practices, a particular identifiable way of giving meaning to reality via words or imagery'.

8.3 The Medical Frame

Within the medical frame, the focus of attention is the organic body of the service user, labelled 'patient', as constructed in microscopic detail through medical texts and practices. These bodies comprise cells, invisible to the naked eye, tissues, organs and body systems. The premise for the existence of such bodies is their material reality, apprehended with the aid of technology if necessary.

These bodies are subjected to scrutiny, both within and without, for the purpose of detecting any organic malfunction. This following excerpt details part of a conversation I had with a new patient, during one of my observation visits to the day hospital:

'She told me that it was her first day, and a doctor had examined her very thoroughly "There was not a part of my body that wasn't asked about"' (dhvis22 lines 105-109)

Within the medical frame, the purpose of intervention is to halt and reverse any abnormality caused through disease or trauma, once it has been discovered. The physical corpus is therefore prioritised, and there is no place or need for recognition of the individuality of the patient; the corpus is passive and cannot think, speak or feel. Some of the practices in the day hospital exemplify this construction of the patient as a passive body, to be examined and checked. On attending both the day hospital and the Fallers Clinic, the patients are routinely assessed by the doctor. They are prepared for this assessment by the nurse, who helps them to strip down to their underwear, put on a gown, and lie in wait on a bed for the doctor to arrive, behind closed curtains. Little explanation is provided about the nature of these examinations, and the patient is often not involved in discussion about the outcomes of these explorations. The possible embarrassment or vulnerability experienced by the patient, unclothed and supine, in the presence of several health professionals whom they have not met before, is not recognised within the medical frame.

With no requirement for the recognition of the uniqueness of each individual, the patients become an homogenous group, to be assessed, monitored and processed. Large numbers of service users come to the day hospital, and there is a rapid throughput. Initially, during the period of participant observation, I tried hard to record and remember each individual's name, but reluctantly realised the futility of this enterprise. The following extract is from my fieldnotes, recorded during the second week of participant observation:

'I wasn't concerned with trying to catch and remember everyone's names today, which I tried to do last week. I recognised some people, and generally felt that I would remember those who would be coming for several weeks. Maybe this reflects the impossibility of trying to meet and remember everyone who attends. Other staff don't seem embarrassed by having to ask people's names (eg J, who asked one lady for her second name, then 'first name'). However, this lack of concern maybe reinforces the homogeneity of patients as a group, rather than individuals. If you can't name people, they become one of a crowd. I felt like I lacked the energy today, and it seemed rather pointless, as I can only remember a few people from day to day.' (fnotes3 48-57)

With a code named 'collective', I identified examples of practices in the day hospital from the period of participant observation in which service users appeared to be grouped together, either for purposes of receiving services, or in descriptions provided by others, and sometimes myself. These included moving to and from the dining room at lunchtime, and recording of my initial attempts to talk and observe 'them', the patients. This following example illustrates the construction of patients as objects waiting to be processed, within the medical frame (from fieldnotes recording observation of discussion between two physiotherapy staff):

'She had put initials by the names of the people to be treated by the physios and told (the senior physiotherapist) *"I've done Mrs X"* (a patient)*'* (dhvis15 lines 443-447).

Another characteristic of the medical frame is the description of problems or difficulties experienced by the patients in terms of the epistemology of medical practice; as symptoms, signs or conditions of the body. In this following extract, one of the physiotherapists is trying to help me to recall a particular service user, Mrs X:

'We went to the physio room, and she asked me if I knew Mrs X: "She's nil by mouth"' (dhvis15 lines 305-307).

Initially my expectation, and preliminary theory development, constructed the medical frame as a resource used solely by staff to understand and describe patients and the business of the day hospital. However service users also made use of the medical frame. This example, from an interview, illustrates the orientation of the medical frame to curing, through reversal of the pathological processes occurring in the body:

'*I feel my sort of prognosis is very poor no I honestly don't feel I shall ever recover I'm not really I suppose accepted that yet*' and later '*So what lies at the root of all of this is sort of damage to my brain has occurred when the stroke occurred and of course the tissue of the brain doesn't regenerate itself ... so as far as I'm concerned there is no hope in that so if I have in any have any hope I invest it with the pharmaceutical companies somebody'd do a bit of research which would trigger the brain off to repairing itself so that it would regenerate*' (ints2p2 lines 470-486)

With the objective of the medical frame being the remediation of damage to the body, the outcomes of treatment for many users thus defined within the medical frame were likely to be disappointing, as many had chronic or deteriorating conditions, such as stroke, Parkinson's disease and arthritis.

Within the medical frame, the knowledge and expertise of the doctor is pre-eminent, with other health care workers supporting this central role. The doctor is ultimately responsible for diagnosis and treatment, assisted in this task by other health professionals. Two of the medical staff at the day hospital emphasised to me, on two separate occasions, the importance of obtaining a 'good history' from the patient, and stated that if they were unable to ascertain what the problem was after talking in some detail to the patient, that their examination had failed in some way. In this example, the doctors position themselves as solely responsible for diagnosis on the basis of good assessment skills, without recourse to the skills or input of other professionals.

The role of the nurse in preparing the service user for assessment by the doctor has already been illustrated. In this following example from a service user interview, the physiotherapists are also described as working with the patient in preparation for a meeting with the doctor:

'*because they* (ie the physiotherapists) *said they'd let me practice the lot so that I could walk if the doctor wanted me to ... he didn't ... he just felt my knee or worked my knee and inspected inspected the scar and he said everything was fine ... and I've had x-rays and he said they were good so I didn't have to walk for the doctor after all*' (s2p3 lines 292-311)

In this extract, the authority of the doctor is absolute: the physiotherapists rehearse skills with the patient for the benefit of the doctor, the patient may be required to demonstrate these skills at the request of the doctor, and the word of the doctor is final regarding progress.

The importance of observation and surveillance within the medical frame has already been alluded to, with examples of assessments performed by the doctors. The nurse also has an important surveillance function within the medical frame, a role described in the information booklet prepared for patients who attend the day hospital. In response to the question '*Who may be involved with my treatment?*', the section describing the nurse is as follows:

'A **nurse** will be involved with specific nursing care such as well-person checks, monitoring of blood pressure, management of continence, and monitoring of medication' (bold text in the original)

The role of the nurse in the medical frame is therefore described in terms of checking and monitoring performance of the physical body, and managing agents prescribed for treatment. The medical frame does not recognise or acknowledge the functional, emotional or spiritual needs of the service users, nor the role of the nurse in meeting these.

The surveillance role of staff extends to the collective body of the patient group. The day hospital is designed and built so that continual observation of the service users is facilitated. The day room, in which the patients spend the large proportion of their time at the day hospital, is located in the centre of the building, with multiple windows and doors allowing views into the room. The reception area, also with large glass screens allowing a clear view of the corridor, is located beside the main entrance, and is occupied by one of the administration team during most of the day. In addition to enabling assistance to be provided promptly for new visitors, this also enables patients leaving the building to be noted.

In order to carry out this surveillance role satisfactorily, staff must be proficient in administering the technology developed to monitor physical functioning of the body; using sphygmomanometers to measure blood pressure, BM sticks to detect the presence of sugar in the blood and stethoscopes to determine if atherosclerosis is present. They are also required to interpret the results of such monitoring, for example, blood tests to detect IgM globulin in serum indicating rheumatoid arthritis and x-rays to check fractures and osteoporosis. In explaining her role, the housekeeper draws on the medical frame in the following excerpt, from my fieldnotes. Her technical and monitoring responsibilities are emphasised.

'(The housekeeper) *asked if I had been at the X* (large general hospital), *and explained that her role as housekeeper was different to the cleaners at the X. She has responsibility for checking people in, doing things with their food; she explained that it was difficult to get the thickener right and she had to note if they were diabetic'*. (dhvis2 lines 70-79)

For the nurses, talking or socialising with patients is not regarded as legitimate work within the medical frame. During word games organised by the volunteer, nursing staff sometimes stopped to contribute a suggestion. However, this is not regarded as appropriate use of time, as this excerpt from fieldnotes illustrates:

'(The nurse) *felt the need to tell* (the senior nurse) *that "I am working really", having stopped to add some words to the board ie the game didn't constitute 'work'.* (dhvis5 lines 238-243)

In summary, then, the focus of the medical frame is the material body of the patient, to be passively monitored and checked by health care workers using a range of technologies, under the ultimate direction of the doctor. Problems experienced by the patient are understood in terms of medical explanations about underlying diseases and pathologies, and progress is also understood as the remediation of these abnormalities. Emotional, spiritual and social needs are not recognised within the medical frame, and patients are viewed, described and treated collectively, with no necessity for acknowledging individuality and uniqueness.

8.4 Risk within the medical frame

Within the medical frame, with its focus on the material corpus, risk is therefore constructed as the potential threat which objects or agents pose to the body. The consequence of unchecked risk is physical harm or damage to the body. The medical frame does not recognise the mental life of service users, and they are not acknowledged as possessing the capacity to think and reason. Consequently, responsibility for the management of risk within the medical frame is located with staff; they must prevent physical harm from occurring to patients and are held accountable for accidents that do occur. With no need for the recognition of individuality, prescriptive rules and routines are therefore the methods of choice to deal with such risks. Monitoring and surveillance help to ensure that such rules are adhered to, and ensure early detection of problems if they do occur.

One such example within the day hospital of a physical agent perceived as a risk is food, which has the potential to cause harm to those service users with diabetes. Such food includes the usual desserts prepared for and eaten by service users without diabetes at the day hospital, ordinary biscuits and chocolate. As a consequence, routines have been developed within the day hospital to avoid the possibility of people with diabetes being given the 'wrong' food. At lunch times, separate desserts are prepared for people with diabetes, who are served before

other people. A list of people with diabetes is written on the white board near the hatch in the kitchen, a means of checking which food people should be receiving as the housekeeper passes food through to the dining room. Service users remain seated throughout the meal, and are served by the day hospital staff, who also stand watching as people eat their meals.

Another example of the staff's role in protecting people with diabetes from consuming the wrong food is illustrated in the routine for the awarding of prizes following card games which take place in the day room. These games are organised by one of the volunteers who is responsible for purchasing the prizes for the winners. I recorded the routine for awarding the prize in my fieldnotes:

'People who won were given the option of 'Chocolate or something else'. (Patient) *won, and it transpired that she was diabetic.* (The volunteer) *made a point of saying to her 'You've got to have something else, haven't you?' several times, meaning that she couldn't choose the chocolate prize'* (dhvis11 lines 75-83).

In order that a mistake should not occur, the prizes were conceived of and organised in terms of those which were suitable for people with diabetes, and those which were not. Those service users who won the card game were theoretically given a choice regarding their prize, but those with diabetes were not 'allowed' to select the chocolate option.

Medication is also perceived within the day hospital as posing a potential risk, within the medical frame. One of the requirements of patients attending the day hospital is that on arrival they surrender any medication they are taking during the day to the nursing staff, who keep it in a locked cupboard and administer it to them at regular times throughout the day. All patients are expected to adhere to this rule whether or not they are responsible for taking their own medication at home, as many of them are.

Tablets are therefore perceived as 'risky' within the medical frame, and a routine had therefore been established whereby the staff assumed responsibility for managing this 'risky' substance.

The potential for physical harm to service users through involvement in a road traffic accident whilst travelling to or from the day hospital is recognised as a risk. As a consequence, all service users are required to wear seat belts in the mini-bus used to transport them, an expectation uncritically accepted by them. This requirement didn't appear to extend to me on the occasion when I travelled in the mini-bus, as my fieldnotes record:

'I sat in the front initially, but then moved to the back, I think after our first visit (to collect patient). *I asked if I needed to wear a seatbelt, but was told that I didn't'* (dhvis8 lines 82-86).

Later I noted:

'At this point, or after we collected the next patient, I started wearing my seat belt, feeling awkward that patients were expected to, and I was not' (dhvis8 lines 177-181).

One final example which illustrates the authority of the medical profession concerning the management of risk within the medical frame can be seen in the response of the Joint Ethics Committee to my submission to carry out this second project within the day hospital. Prior to this submission, I had received permission to proceed with the project from the day hospital Manager (a nurse by profession), also from her manager, and had discussed the project with the multi-disciplinary team within the day hospital, who had raised no objections. This information was included in the submission to the Joint Ethics Committee, but I was still required to discuss the project with medical staff (as detailed in chapter seven). In this instance, authority with regard to the management of risk to patients through involvement in my study was located with the doctor. His response (that interviews were 'non-invasive' and that he was happy for the project to proceed)

confirms the construction of risk as threat posed by material objects causing physical harm within the medical frame. Because he perceived that involvement in my study did not pose risks of this nature to patients, he was happy to allow me to continue, without checking on procedures for obtaining consent, storage of data or guarantees of confidentiality.

There are a number of problems with the construction of risk as articulated within the medical frame. The first is the inflexibility of the categorisation of physical agents as either 'risky' (or 'bad') or 'not risky' (and therefore 'good'). As previously demonstrated, within the day hospital, chocolate was labelled as a 'bad' or 'wrong' food for people with diabetes. However, current thinking about control of diabetes through diet favours a more sophisticated approach, which encourages individuals to take responsibility for monitoring their own food intake. This approach permits the consumption of foods such as chocolate in moderation, provided that intake of other foods is adjusted to accommodate this. As a consequence, 'Boots plc', a UK pharmaceutical company and the largest manufacturer of 'diabetic foods' have stopped producing their diabetic range, which included 'diabetic chocolate' and 'diabetic jam' ('You and Yours' programme, 2.4.99, BBC Radio Four). Many 'diabetic foods' contain sugar substitutes such as aspartame which can also be harmful to health. The classification within the medical frame of chocolate as a 'bad' food, and 'diabetic chocolate' as a 'good' food for people with diabetes is shown to be problematic.

Another consequence of the construction of risk within the medical frame is the reinforcement of dependency and passivity of the service users in the day hospital. Without recognition of the capacity of older people to exercise autonomy, and the positioning of both expertise and responsibility with staff, service users are expected to be compliant with procedures carried out by staff for managing risk. My fieldnotes record how some service users had difficulty in fastening and unfastening their seatbelts on the mini-bus. However, no-one opted not to wear one, or challenged the rationale for doing so. On arrival at the day hospital or returning home, some service users raised their arms, as if through force of habit, in the expectation that the driver would come to release them from their seat belt.

The objectification of service users through management of risk in the medical frame thus had the effect of encouraging them to view themselves in the same passive light, dependent on others for initiation of action and management of their safety.

Within the medical frame, responsibility for risk management and prevention of accidents is located solely with staff, with the threat of heavy penalties for those who make errors, such as litigation, disciplinary action and accusations of professional misconduct. Cheek and Gibson (1996), using the administration of medication as an example, demonstrate how, in the same way as has been argued for physical agents of risk, nurses who commit errors become labelled as 'bad nurses'. Nurses themselves are complicit in this construction, and may choose not to report small errors in order to remain 'good' nurses. Cheek and Gibson (1996) argue that nurses have learnt to accept the blame for medication errors when they have little influence over those factors which cause such errors to occur. Examples of such factors might be heavy workloads and fatigue through long working hours. Thus management of risk in the medical frame is perceived as a matter of individual professional practice and standards, rather than an inherently social matter, in which factors such as structure, organisation and communication are implicated.

The responses developed to manage risks within the medical frame have been shown often to involve inflexible routines, applied uniformly to all service users. Cheek and Gibson (1996) cite some of the 'correct' procedures evolved to minimise the chance of error in medication administration, such as the 'five rights', and argue that such procedures have become ritualised. In the day hospital, the nurses appeared to hand out medication at particular times of day, but the routine was such that it was unable to accommodate service users requiring medication at other times, as this interview participant suggests:

'but code codeine I took those to take for my arm ... ah for the pain in my arm one two every four hours ... and half the time they didn't bring them round or anything or ask you if you want it' (s2p14 lines 1139-1151)

In the day hospital, the location of responsibility for medication administration with the nursing staff failed to prevent the occurrence of mistakes. On one occasion during my period of participant observation, one of the service users mentioned to the nurses that he hadn't received his medication, although the nurse concerned was sure that she had given the tablets to him. Eventually, another service user with communication difficulties managed to convey that he had swallowed these tablets in error, as they had been left on the table between the two men, and he had believed them to be his.

With the possibility of a patient's mental or social life excluded in the perspective of the medical frame, the possible consequences of some of the strategies used to manage risk for service users' self esteem or social identities are similarly not acknowledged. The practice of giving medication to staff to hand out was commented on extensively by one of the interview participants, p14, who commented that this procedure meant that patients were treated *'...like like children you know'* (s2p14 line 1164). She cited this practice as one of the reasons why she disliked coming to the day hospital, and had indicated that she wished to stop attending. The insistence on selection of the 'correct' prize by people with diabetes, following the card game, can be viewed as the public labelling of a condition which some people might perceive as stigmatizing, as could the receipt of a dessert ahead of everyone else at lunchtime. Also, the manner in which the prize was offered did not respect the dignity or the autonomy of the service user concerned.

8.5 The Rehabilitation Frame

Within the rehabilitation frame, the focus remains on the service user, labelled 'patient' or sometimes 'client' within this frame. However, the nature of the patient has changed. No longer the passive objectified body of the medical frame, the service user is now conceived of as an active, rational being, capable of making decisions and interacting with the environment. Performance and function are prioritised, particularly with regard to activities of daily living (adl), a set of tasks carried out on a regular basis which are required in order that the service user can continue to live satisfactorily at home. Such tasks are usually said to include

personal hygiene, dressing, cooking and cleaning, amongst others. This excerpt from my fieldnotes records my observation of an initial assessment carried out by the designated key nurse for a new male service user at the day hospital, using the standard day hospital initial assessment form:

'(The key nurse) *asked him about cleaning his bungalow, washing etc, and it seemed he does most things himself with a minimum of help'* dhvis13 lines 186-90.

This illustrates the focus within the rehabilitation frame on function and action, and also highlights the major objective within this frame; the performance of tasks with as little assistance as possible, or 'independently', a term which is commonly used within this frame.

The above description of the rehabilitation frame draws attention to three aspects necessary for the successful performance of activities of daily living; an active, functional body, a mental capability which is orientated towards performance of these tasks, and an environment which facilitates this activity. Within the rehabilitation frame, epistemologies for each of these three areas have been developed, which enable each to be understood and evaluated, as a prerequisite for the identification of targets or goals within treatment. These three different areas are often perceived as the domains of different health professionals, and there is variation in the complexities of the epistemologies of these areas, with the environment perhaps having the least sophisticated explanation. The following sections describe and illustrate each of these three areas.

The physical body remains important within the rehabilitation frame. However, the nature of this body has changed from passive to active, and the epistemology used to describe it focuses on performative aspects, understood in action, rather than on the static, internal structures of the body, described in microscopic detail as in the medical frame. The following example, from fieldnotes written after observation during one of the 'Fallers Clinics' at the day hospital, illustrates how a physiotherapist constructs walking, or 'mobility' as it is usually referred to within the frame, as an activity combining many other skills, within her assessment:

'Physio assessment was orientated towards muscle strength, righting and saving responses, balance, sway and gait. (The physiotherapist) *worked her way through a sheet ... involving standing, sitting, resisting being pushed, standing on one leg, reaching, walking'* (fclin1 lines 270-277).

Walking, then, is not simply a product of muscle operating on bone, but a complex combination of functionally orientated skills, such as balance. These are assessed with the active involvement of the patient, for example, by pushing against him or her to see how successfully they are able to resist displacement of their centre of gravity.

In addition to the active body, the rehabilitation frame allows the patient a mental life, in contrast to the medical frame. The mind, often characterised as 'psychological functioning', is constructed as a group of domains of varying complexity. 'Cognitive abilities', for example, may be broken down into various subcategories including attention, problem-solving and memory, which themselves may be composed of smaller elements (memory, for example, is often described as encompassing both 'short term memory' and 'long term memory'). Cognitive abilities enable the patient to comprehend the tasks which need to be done, and how to structure them in order to ensure their successful completion. 'Mood', by contrast, remains a fairly general, non-specific category, or may be broken down into 'anxiety' and 'depression'. Performance in each of these mental domains can be measured. This excerpt, from fieldnotes, details an account by a new patient about an early contact with staff from the day hospital:

'She had been visited at home by a doctor from the day hospital, to her surprise. She had been asked "all sorts of questions"; "to spell a word backwards", asked something and then half an hour later asked if she remembered. She was also asked if sometimes "You wish you weren't here" ... ' (dhvis22 lines 75-84).

Whilst these questions seemed strange and unexpected to the woman concerned, they may be recognised by rehabilitation professionals as derived from standardised

assessments checking 'mental state functioning' and 'depression'. Motivation is also seen to be a critical mental characteristic within the rehabilitation frame, a prerequisite for successful intervention and outcomes, as illustrated in the following excerpt, taken from a service user interview ('P' is the interview participant, 'R' the researcher):

P: 'It's it's a damn thing good thing for anyone (ie day hospital) *although I know two or three that have been gone there only one day and then packed it in*

R: Right why do why do you think that is?

P: Well because work yeah work it's to too lazy ...

R: Right right yeah so some people don't don't like having to work is that what you're saying?

P: Yeah they get so used to being done things for them they they get into the habit ...'

(ints2p10 lines 628-652)

As illustrated in this excerpt, service users also make use of the rehabilitation frame in their accounts about the day hospital and their experience there. As with use of the medical frame, this confounded my original expectations that the rehabilitation frame would mainly be used by health professionals. Use of this frame seemed to be particularly evident in the accounts of interview participants three, six and ten, although they did also make use of the medical and social frames in their responses to interview questions. These participants had had extensive experience of rehabilitation services, and one had a daughter who was a rehabilitation professional.

The third component relating to the performance of activities by individuals, the priority of the rehabilitation frame, is the location within which activities are carried out, usually referred to as 'environment'. Whilst people visit a large number of different places in the course of their daily lives, for example, the supermarket to purchase food, or leisure facilities such as cinemas or restaurants, the 'environment' is usually considered to be the home, within the rehabilitation frame. The initial contact, carried out prior to attendance at the day hospital, usually takes

place in the patient's home, and the home itself may be the subject of a separate assessment. Interview participant five, for example, described the purpose of coming to the day hospital as being '*to see if I was able to manage by myself at home like'* (s2p5 lines 26-27).

With 'independence' in the performance of daily living activities the goal within the rehabilitation frame, progress is determined through the extent to which external help is required in carrying out these activities, either in the form of assistance from carers, or through use of assistive devices. In this following excerpt from an interview, the carer ('C') orientates the interview participant ('P') away from indicators of performance of body systems (from within the medical frame) to independent capacity in an activity of daily living, dressing (from the rehabilitation frame), as a mark of progress (as before, 'R' is the researcher):

R: 'Right right what sorts of things um help you know that you're improving what what would you what kinds of things do you notice

P: Well they're very good in checking your blood pressure

R: Mm mm

P: I would have sat down and stood

C: Yes but what what do you notice you're up

P: Yes

C: I'll tell you that I think she's starting to dress herself better

R: Right

C: You could mention that you you say that' (interview notes s2p4 lines 845-868)

In the following excerpt, from an interview with participant three, who makes frequent use of the rehabilitation frame, a reduction in use of assistive devices is illustrative of progress within this frame. Of note is that the walking aids she describes appear to be organised in a type of hierarchy, indicative of amount of help required. When asked about the kinds of things that she does at the day hospital, patient three described walking as follows:

'Oh I'm I have walked oh I have to walk I'm now I was on a walking frame ...then I progressed from that to crutches last week' (s2p3 lines 277-284)

and a little later in the interview:

'And next week I have got to bring in my Fisher sticks[1] that I used to use ... um for the physio to put a try and put a larger base on them because they're very small based ... so she's going to try and put a bigger base on them so that I can exchange them for that ... and sort of use them intermittently I've still got my walking frame at home and my wheelchair ... and er there are days when I just have to use the frame I can't can't face using those' (s2p3 lines 317-358)

The construction of the service user as in possession of rational thought, capable of exercising choices and making decisions, has important implications for the location of responsibility for progress and recovery, as defined within the rehabilitation frame. In contrast to the medical frame, in which service users were perceived as no more than their passive malfunctioning bodies, for which staff had to take responsibility, service users in the rehabilitation frame can now be held accountable for their own recovery, in terms of their decisions, choices and behaviour. The nature of the intervention itself has shifted from the monitoring of and administration to passive bodies within the medical frame, to a process in which the health worker and patient must work together on the project of improved function. The role of the staff therefore becomes one of enhancing patient performance through teaching and facilitating. Whilst expertise and knowledge is still located with the health professionals, assistance is proffered in the form of advice, with the patient responsible for acting upon this advice. In this example, from fieldnotes, the patient acknowledges this educational role of the therapists:

'I asked about her therapy. She said how when she was wearing slippers she would look down and the slipper would be off or trodden down, but that the

[1] Fisher sticks: walking sticks of hip height with moulded 'platforms' for the hands

physios had "taught me how to walk on the front of my foot" and also taught her not to rush so much' (dhvis20 lines 132-139)

This emphasis on education was also evident from some of the literature that was available to patients, either in the form of leaflets or posters, such as the 'Nutrition' poster stuck on the wall of the dining room (dhvis2 lines 97-99).

A corollary of the rational, autonomous patient constructed within the rehabilitation frame is that they will understand what is required of them in terms of participation in treatment, and will treat the enterprise of their rehabilitation with the gravity that it deserves. This expectation is illustrated in the following excerpt from a patient interview:

'It was very funny this week I suppose I shouldn't record this really but er I went in a velvet suit and (physiotherapist) *said to me have you come to work and I said yes well she said you look as though you're going to town well I said I wear this at anytime you know ... it's not it's not sort of a picked thing well she said on Friday we'll come in tracksuits and track shoes ... because they don't approve of my shoes at all I like high heels'* (s2p11 lines 884-903).

Within this example, the staff member draws a contrast between 'coming to work' (ie rehabilitation within the day hospital) and 'going to town'. This patient had previously worked as a health professional, and perhaps therefore there was a particular expectation from staff that this woman would know what was required of her in terms of preparation for treatment. The clothes that are associated with a willingness to 'work' are those associated with sporting activities, in contrast to smart clothes and high heels, worn to 'town'.

Another assumption predicated on the sensible, rational patient within the rehabilitation frame is that they will follow advice to practice skills that they learn at the day hospital at home, away from the supervision or assistance of rehabilitation staff. Evidence that they are doing so is an indication of their commitment to the cause of their functional recovery. The following examples

illustrate both the anticipation that this will occur, and the belief that in following this advice, there has been some improvement in performance:

'(A physiotherapist) *at the same time was working with someone I hadn't seen before, and suggested some exercises that she could practice at home'* (dhvis 14 lines lines 244-247).

'(The physiotherapist) *was very pleased with the progress that she said* (a patient) *had made, and* (the patient) *confirmed that she had practised at home in the kitchen'* (dhvis 15 lines 335-338).

To summarise the rehabilitation frame; the focus remains with the patient, but now constructed as a rational, autonomous being, striving for independence as they go about the tasks of every day life in the environment of their own homes. Successful performance of these tasks is dependent on intact cognitive function and motivation, an able body, and an environment that will facilitate such activity, or can be modified to do so. Within the rehabilitation frame, patients assume responsibility for their own recovery, in terms of reduced dependency in adl, with staff having an educational and advisory role.

8.6 Risk in the Rehabilitation Frame

With self sufficiency in every day activities the goal within the rehabilitation frame, risk within this frame is conceived of as a threat of loss of independence in the capacity to perform these activities. Awareness of this threat is evident in this excerpt from an interview conducted with a service user ('P') and her sister who was also present ('S') ('R' is the researcher, and bracketed initials indicate difficulty in identifying from the audio recording whether the speaker was the service user or her sister):

R: 'Right ... are there other things that worry you about about getting older ...
(S): I think we're both the same when we said I wouldn't like to get old that I couldn't keep myself clean
R: Right

(P): No I wouldn't like that

(S): That is is a worry that I have got deep down 'cos as long as I can keep myself nice and clean ... 'cos I can still bath myself I feel ... but I wouldn't like to be that I couldn't (do anything)

(P): No I wouldn't like that

(S): That would worry me

(P): If I couldn't keep myself clean ... but we can do that see and my daughters even change the sheets in my bed ... you see so they I don't know what well I wouldn't be able to manage without me daughters I'd have to have outside help'

(s2p6 lines 421-481)

Previously attributable to a tangible object within the medical frame, risky situations now occur through the activities of the service user. Physical damage to the body is still one of the consequences of unchecked risk, as in the medical frame, but brought about through the actions of the patient within a particular environment, usually the home. However, the construction of risk within the rehabilitation frame focuses on the consequence of this physical harm; the possibility of increased dependency and ultimately inability to remain in one's own home and institutionalisation. Knowledge and expertise both about the presence and level of risk, and about how accidents might be prevented remains with those individuals recognised as 'staff', as in the medical frame. The major strategy for informing service users about the risks they face is through education.

One of the documents collected as data from the day hospital is a leaflet produced by 'Help the Aged' and the Office of Fair Trading entitled 'Be Sure Who's at the Door'. This leaflet was one of a number left on a stand near the entrance for service users of the day hospital. The purpose of the leaflet is described as explaining 'how to deal with doorstep salesmen so that you do not fall victim to the conmen' and includes advice such as checking who is outside the door before opening it, checking caller's identification, and not handing over cash in advance of having work done. Thus the act of opening one's own front door is described as a risky activity, within the rehabilitation frame, and service users are positioned as

vulnerable, ignorant of the risks which they face, and needing to be informed by knowledgeable experts.

However, whilst experts, including health professionals, possess knowledge about what constitutes a risk, the responsibility for management of this risk, particularly back in the home environment, becomes that of the service user. They are expected to take heed of advice offered, and carry out the necessary changes in order to make performance of every day activities safe. One example of location of this responsibility was evident in a poster pinned to the notice board in one of the kitchens used by service users entitled 'How to avoid falls'. This poster was produced by the Royal Society for the Prevention of Accidents (RoSPA) and included a section on 'Temporary loss of balance'. Readers are told 'You need to plan to avoid temptation' (to bend too low, stretch too high etc), and 'Simple solutions' include the repositioning of power points to a comfortable height and the use of 'proper lightweight step ladders for high level jobs'. Having been alerted to possible dangers, individuals themselves are expected to remedy them.

Within the rehabilitation frame, service users who do not follow expert, professional advice about reducing risk may be perceived as ignorant and unaware of the need to do so, as illustrated in this excerpt from fieldnotes:

'I asked them why they thought people fell; (first service user) *replied that it could be dizziness, or Parkinson's, and* (second service user) *thought it might be to do with the ear.* (A volunteer) *had joined us, and also said that she thought it was sometimes to do with people's homes and that they didn't realise they were dangerous'* (dhvis 2 lines 256-264)

Alternatively, they may be represented as lacking the mental, or cognitive, capabilities to respond to such advice, or in possession of some character defect such as 'stubbornness' or 'lack of motivation' which means that they wilfully and perversely pay no heed to such advice. In this example from an interview, the service user is talking about another patient encountered whilst she herself was an inpatient:

'... and yet you get another one who wouldn't do a thing she was told ... one fell because she was told not to get out of the chair on her own and she deliberately got out ... she fell ... I don't know' (s2p3 lines 1350-1362).

Whatever the explanation, the blame for any subsequent accident can be attributed to the service user, and the actions that they have, or have not performed.

As with risk in the medical frame, there are a number of problems inherent in the way that risk is conceptualised in the rehabilitation frame. The focus on every day activities, and the home environment in which they are carried out, requires that those perceived to be 'at risk' within the rehabilitation frame view their usual routines and surroundings in a new, self-conscious light. Service users are expected to examine the way that they perform particular tasks, which have become familiar habits. Their homes, in which most spend a large proportion of their day, must now be viewed as potentially hazardous and in need of modification. As alluded to by Oliver (1996), the symbolic significance of such activities and the place in which they are carried out is ignored in this construction of risk, as is the shift in meaning required in order to now perceive them as potentially 'risky'.

This construction of risk also requires that the recipients of risk prevention messages view themselves simultaneously in two contradictory ways. Firstly, they must perceive themselves to be vulnerable, frail and 'at risk'. In order to take advantage of the advice proffered, they are then expected to behave as active agents, with the necessary control over resources to change the way in which they carry out daily activities, and the environment in which they are carried out. Such contradictions are apparent in the following excerpt from one of the interviews with a service user from the day hospital ('P'). She has learnt to recognise that she is now 'at risk' of falling, and the natural corollary would therefore be to reduce the extent and distances she travels. However, her sister ('S') recognises that to do this would limit some of the social opportunities that they both enjoy, and perhaps feels that such caution is unjustified. She therefore encourages the

interview participant to view this new perception of 'going out' as risky as a challenge to be overcome, and expresses her admiration of her sister in doing so:

'P: I don't go out at all now unless one of my daughters can take me because I'm afraid of falling now I lose me balance you see ...
S: See when we goes to the Fellowships I'm with her
P: She always comes with me yes
S: As I said I admire the way me sister do go out and get on the bus ... yes she do she says it's not going to get me down she says to me and we do go out and she do get on the bus' (s2p6 lines 397-417)

Representation of expertise in detecting risk and suggesting solutions in the rehabilitation frame as lying with expert professionals ignores the capacity of individuals to do so for themselves. As has been shown by Roberts, Smith and Bryce (1993), 'lay' people may be able to conceive of a greater number and variety of risk factors than professionals. The capacity of day hospital service users both to recognise and act upon perceived dangers, without the benefit of professional advice, is demonstrated in this excerpt from my fieldnotes, in which I recorded part of a conversation with a man new to the day hospital, to whom I had given an information sheet relating to the research project:

'It seemed to me that my information sheet had prompted him to tell me about his fall. He said how on one occasion he had fallen very close to his electric fire, although hadn't hurt himself on it. After this, he had replaced it with a convection heater with enclosed elements, to make himself safer'. (dhvis12 lines 218-227)

The rehabilitation construction of risk attributes problems to specified individuals, and suggests that they should also be responsible for the solution of these problems. However, this ignores societal and structural barriers to the prescribed solutions for reducing risk. Whilst the solution to 'Temporary loss of balance' (as suggested in the poster 'How to avoid falls') might be the use of 'proper lightweight step ladders', the means to purchase these or the method of

transportation of step ladders from point of purchase to home are not discussed. Similarly, the repositioning of power points as a means of avoiding falls, a solution from the same poster, doesn't address how architects and builders could work together to create safe environments, not just for older people prone to falling, but also for those with children (see Roberts et al 1993).

8.7 The Social Frame

Within the two frames discussed previously, the role of the service user has been the focus of attention, and described in relatively static and prescriptive terms; as passive bodies, the objects of testing and monitoring, and as logical, reasoning beings, striving to be as independent as possible in their everyday lives. Risk is generally perceived in negative terms, and steps to avoid risk, in terms of physical harm and loss of independence, realised formally within practices (such as the routine for medication) and interventions (such as the information leaflets concerning doorstep salesmen and falls).

The third frame to be discussed differs from the other two in several important respects. Firstly, it acknowledges the capacity of all those within the day hospital to be self defining, and capable of being constructed by themselves and others in a multiplicity of different ways. As a consequence, the focus of attention within this third, alternative, frame, broadens to include those previously assigned unproblematic and self-explanatory roles within the medical and rehabilitation frames, namely 'staff' and 'researcher'. One other consequence, distinguishing this third frame from the medical and rehabilitation frames, is that risk no longer remains solely an issue for 'patients'; everyone is now potentially vulnerable. However, what is constituted as 'risky' and what is at risk is dependent, as before, on the priorities of the frame.

Social identities, then, are the focus of interest in this frame, as defined in the relativistic and flexible sense described in chapter six. Of interest also are the social groups of family, friends, colleagues, communities and cultures invoked to illustrate these. This frame is therefore described as the 'social frame'. The means

by which particular identities are achieved, and the reasons for selecting them are also of interest.

With the creation of social identities a key task within this frame, the position and role(s) of the researcher are also highlighted. The selection of identities chosen by the researcher herself is an issue to be reflexively considered. Similarly, the way in which these identities impact on those with whom the research is being carried out is an important factor in interpreting data generated through participant observation and interviews.

The different interpretations which a variety of people might bring to ostensibly the same identity, such as 'patient', also adds an additional dimension of complexity. For some people at a particular moment in time, to be a 'patient' might represent an opportunity to gain approval from others of valued social status ('staff') through adherence to treatment, being undemanding of staff time and recognising pressures on staff. The social identity of 'patient' might also indicate a desire to be cared for, as an object of concern. In either of these formulations, the identity of 'patient' might be perceived in a positive light. For others, to be a 'patient' might be an undesirable position, suggesting passivity, lack of control, dependence and vulnerability.

Whilst the conventional use of designations of 'staff' and 'patient' has be shown to be problematic in the social frame, distinctions will be made between these two groups for the purposes of interpretation, on the basis of material differences. These differences, which for example include the difference in average chronological age, mean that the identities to which claims are made may be different, and also the means available to people to do this. For this reason therefore, these two groups will be considered separately. The position of the researcher will also be discussed.

Within the social frame, service users create a variety of identities for themselves as spouses, members of families and communities, including the day hospital. Eleven of the fifteen service user participants elected to be interviewed at home, and of

these, six were interviewed with a friend, spouse or relative present. This had the effect of providing me as researcher with tangible evidence of identities other than that of 'day hospital patient'. Talk about family and friends also featured prominently in many service user interviews, recreating supportive social networks, of which the interview participants were a part.

Participant six, interviewed with her sister who lived nearby and who contributed freely to the conversation, spoke at length about her large family, evidence of which was visible in terms of the many family photographs on the walls of the flat. During the interview, both the participant and her sister provided similar examples of times when each had been concerned about the others' well-being. The accounts differed in terms of how responsibility was allocated; both provided examples of how they had on separate occasions each been concerned because the other sister had apparently not woken and risen, evident from such cues as curtains pulled back, or answering the doorbell. However, the sister was represented as the sensible careful partner, who had previously mentioned to her sister that she was planning to leave her flat early that day, and consequently wouldn't be there to welcome her for her usual cup of tea. The interview participant, on the other hand, appeared in the joint account as the foolish, forgetful relative, who had not only forgotten this particular piece of information, and became unnecessarily worried, but on another occasion had taken a sleeping tablet, causing her to oversleep, and thus caused her sister legitimate and justified anxiety, through some misfortune which had apparently happened during the night.

Together, however, these particular examples helped to create a picture of a mutually dependent pair, who were aware of each other's needs, and had access to a wide variety of sources of support, such as the warden in the sheltered accommodation in which they lived, on which to call in times of difficulty.

The interview questions (see appendix 18) asked service users about their reasons for attending the day hospital, and how their lives were being affected by their perceived problems. Thus it was difficult for service users to refute the implicit assumption that they were experiencing some current difficulties. However, many

interviews included discussion about social identities in detailing how social relations had been or would be affected by these problems. Having spoken about his medical condition which includes Parkinson's Disease, epilepsy and heart failure, this service user commented:

'... but generally I mean I don't worry about it it's just that um my real concern is the fact that it puts such a load on my wife and a um not just sort of keeping an eye on me but doing the things that I would be doing and um particularly uh you know business things, money things you know that sort of thing that she has to busy herself with (w)hat I used to do before' (ints2p1 lines 214-224)

This service user speaks about not only the increased burden that his physical problems cause for his wife, but also about how roles within their relationship must change to accommodate such problems, and alludes to how his own identity is challenged by these changes.

Another woman patient ('P') and her partner ('C'), who were interviewed together, talked about her discomfort at the prospect of using equipment which could help her mobility following her stroke. This discomfort appeared to focus on the way in which she would be perceived by others if she chose to use a wheelchair, again drawing attention to the social meaning that this would have in terms of her identity:

P: '... and I think I mean I using a wheelchair I wouldn't like to do that in case
C: Ah she feels sort of embarrassed doing that you know
P: In case I meet a friend' (s2p4 lines 426-431)

As previously discussed in chapter seven, gender appeared to be an important determinant of seating positions both in the day room, and in the dining room. Thus within the social frame, the social identity of man or woman was of importance in describing the social experience of being at the day hospital, from the perspective of a service user. Social comparison (Festinger 1954) was also used in order to construct identity, as in this excerpt from an interview with a service user:

'The social side er er helps it helps very much as I said about talking to other people ... meeting other people and seeing people that are worse off than you ... they they they are you know and you see some people er come in and you think to yourself oh my God and here's me moaning about mine you know and and they're they're much worse off so it does help to er bring you back into perspective things into perspective you know' (s2p15 lines 1015-1037)

As discussed, service providers are also potentially drawn into focus within the social frame, as previously uncontested designations such as nurse or therapist become one of a number of potential social identities. However, the act of including service providers also highlights one of the differences between the different social groups within the day hospital. While service users were visible to me as a researcher for much of the period of participant observation, service providers had more control over whether or not they were observed. They had free access to a greater area within the day hospital, and could also exclude both service users and myself, through closing doors to their offices, for example. For much of my observation, then, the identity of 'staff member' seemed natural and straightforward for most service providers; they understood the expectations of this selected identity, and seemed at ease with the apparent status it conferred. However, those for whom this identity perhaps posed more problems were also generally able to remain unavailable to me as a researcher. Therefore, those who were the most confident in this identity were the most highly visible. This is discussed in more detail in the following section ('Risk in the social frame'). The point is made here, however, to explain why there are few examples of contested identities illustrated with examples including members of staff. Because the identity of 'staff' was often not negotiated or disputed in public, there are fewer examples of how it was challenged or achieved, available within the data.

However, some aspects of being a 'staff member' are highlighted by focusing on a volunteer, for whom this title was perhaps more tenuous. The volunteer, on the days when she came to the day hospital, was very apparent to me as a researcher, spending much time in the day room, and often organising social activities in the

afternoon. However, her title was included under the title 'Support Facilities' rather than in the list of the 'Clinical Team' in the Service Profile and Operational Policy of the day hospital. She did not attend either the Report or Goal Setting meetings, which other staff did. It appeared, then, that her role was perceived within the formal organisational and management structure as rather peripheral to the main business of the day hospital.

She therefore had a delicate task to perform in illustrating to me, a newcomer, what the social identity of 'volunteer' involved, and how it was valued in the day hospital. The following excerpt is from my fieldnotes, and illustrates some of the ways in which this was achieved:

'I heard (the volunteer) *asking* (a housekeeper) *who I was. I hadn't yet given her a copy of my information sheet and I introduced myself and told her about myself and my study. She explained that she has been coming for three years since her husband died and works in different places on the site. She wears a tabard and seems to be a motherly figure;* (the locum nurse) *who didn't seem to have much to do with anyone, gave her a hug at one point and joked with her. I felt that she had been a little put out that no-one had told her who I was, and that when I spoke to her she was placated. She mentioned that there were some 'characters' (amongst the patients) and joined in my conversation with some of these 'characters' later'.*
(dhvis2 lines 168-188)

In this, my first encounter with the volunteer, she indicated that she has been involved with the day hospital for a significant period of time, and seemed indignant that no-one had thought to inform her about who I was. This suggested either that she thought she had a right to be informed, rather as other staff members had been, or that I should have recognised the requirement to explain myself and my presence to her, in deference to her status. Her wearing of a tabard identified her more closely with staff, who wore uniforms, and clearly distinguished her from service users who did not. She appeared to have an important social function within the day hospital, supportive of the locum nurse, whose contested position as a member of staff was perhaps also more obviously apparent. The

volunteer described herself as an authority with regard to the social character of service users, being able to distinguish 'characters'.

Of interest also within the social frame are the social identities which I selected and constructed for myself within the day hospital. The rationale for my choice as inexperienced 'student' has been discussed in chapter seven. Whilst I selected this as an identity with which I felt comfortable, and which I felt suited my purposes, fieldnotes recorded during my early days in the day hospital note my discomfort, indicative of problems in clarifying who I was, what my purpose in the day hospital was, and how I conveyed this. This is discussed more fully in the following section. On several occasions, I also assumed other identities, when they appeared to serve a particular purpose. This excerpt from my fieldnotes documents one example:

'(A service user) *came and sat down, accompanied by* (a nurse*). He asked her who I was, she laughed and I said I would come and talk to him, to explain. I collected the footstool to sit on and he asked if I was to be his footstool. I explained what I was doing, and gave him my sheet. He asked me if I was studying for an MSc or a PhD, and I replied a PhD. He then asked who the prof in my department was. I was aware that I was potentially blowing my cover as a naive student with some of the other patients, but was enjoying talking with someone who knew a bit about the university system'.* (dhvis19 lines 52-68)

8.8 Risk in the social frame

Within the social frame, social identities and the resources drawn upon in their construction are prioritised. Previously unproblematic within the medical and rehabilitation frames, the identities of 'staff' and 'researcher' are highlighted, and rendered complex within this frame.

Risk within the social frame, therefore, constitutes a threat to social identities which are valued and respected by self and others. Risk is also heightened before such identities can be represented and shared, for example through introduction to a new social environment. The consequences of unchecked risk include social

embarrassment, shame and loss of self esteem and can result in stereotyping, stigma and social exclusion. Reference to the role of the day hospital in supporting or challenging social identities were not acknowledged in policies or formal procedures, as risk in the medical frame appeared to be, for example through routines established for administering medication. However, there did appear to be a covert acknowledgement amongst some staff of the potential for this risk in the way that the day hospital functioned, discussed later in this section.

As argued in the 'Social frame' section, reflexivity regarding the role of myself as researcher is critical in interpreting data relating to risk and social identities, and fruitful in terms of understanding the experiences of service attenders particularly. As a new person at the day hospital, the potential for disruption of the *status quo* balance seemed great. In this extract from my first set of fieldnotes, I describe the process of introducing myself to patients, and giving them an information sheet about the research project:

'I had a feeling of interrupting people to talk to them, rather as if they would normally mind their own business unless spoken to. This felt a bit strange, and not in keeping with my intended agenda of being with people on their own terms. In that row of people, I finally spoke to (service user), *another man, who after reading my sheet, asked me what I wanted to do next - what did I want of him next'* (fieldnotes dhvis 1 lines 94-106).

The suggestion that service users might like to participate in my study about risk and falling in older people seemed offensive to some people, who distanced themselves from the implicit assumptions about them contained in my information sheet. The response of one woman is recorded in my fieldnotes:

'She said that the project 'is for older people' and 'my husband read it (the sheet) and said 'it's not for you'' (dhvis22 lines 130-133).

Some staff also seemed to find my presence a challenge to their identities as competent health workers, as discussed later in this section, although this was not my intention.

The necessity of approaching service users in order to provide them with an information sheet and tell them about my study, as required by the Joint Ethics Committee, also felt like a challenge to my own chosen identities as unobtrusive participant observer, inexperienced young student and pleasant, personable woman. The potential for unpleasant and unwanted connotations associated with the role of researcher seemed confirmed by a comment from a service user, recorded in my fieldnotes:

'I handed out some more of my sheets to women in the main circle, and one of the women who I knew joked about the fact that this explained what I was doing and that I wasn't just 'a nosy parker'' (dhvis16 lines 196-201)

The work that I did through my talk and action in constructing particular representations of myself and my role at the day hospital, were therefore not only for the purposes of the research in terms of researcher position, but also related to my view of myself. I found it difficult to be perceived as an interfering and authoritative individual.

The service users had many potential challenges to their preferred identities in attending the day hospital, which were often particularly acute during their first few visits. As this excerpt from fieldnotes detailing a discussion with a new female service user, the potential for mistakes was great:

'She referred to the women in the main circle as a 'cackling load of old devils' and said that she had 'put her foot in it' with them and had asked the nurse not to put her by them when she arrived that morning. She returned to this topic again, and said that last week she had been talking to one of the men who had become upset and she had put her hand on his arm to comfort him. It was this that she felt had upset the other women' (dhvis12 lines 124-136)

One of the major challenges for service users at the day hospital was an assumption that they were 'old', a perception powerfully voiced by the second interview participant during the course of the interview:

'You know sometimes in the afternoon they'd all fall asleep I thought my God thought it'd never come to this I'd look round the room and see old people propped up in the same sort of chairs all saying very little, all the men too and all the women too. One of two would be there and their heads would fall back and their mouths would open with a vacant look on their faces' (ints2p2 811-822).

As has been illustrated, this challenge was at times resisted by some service users, particularly those who were chronologically younger, usually in their sixties, such as interview participant nine. In this excerpt, this service user appears to distinguish herself from 'the older people' in the day hospital:

(speaking about the day hospital staff) *'And um well they seem to be rather nice to people individually you know they sort of don't mind a joke and that sort of thing it's really it's very helpful to the older people I feel ... and it you know they're they're in a safe environment just for a few hours before they go back to to their homes or wherever they're going'* (s2p9 lines 547-563)

Another threat to the preferred perspectives of self of the service users was the supposition that because they were attending the day hospital, they were incompetent or vulnerable, and in need of some help or assistance. In answer to the question 'Why was I referred to the Day Hospital?' the response contained in the Information Booklet prepared for service users mentions the need for 'assistance to regain further independence' and 'investigations, to try to find out what may be causing an illness or difficulty'. In discussing with me their reasons for attending the day hospital during interviews, the majority of interview participants identified that they were coming to the day hospital for therapy, or physiotherapy, in order to improve their walking. Of all the potential activities that took place under the auspices of the day hospital, such as relaxation classes, home

assessments, audiology assessments and bathing, perhaps this identification of the need to improve one's walking was the least personal and threatening.

Potentially one of the most powerful strategies used by patients to avoid these implicit challenges was the decision to stop attending the day hospital, although discussion about this seemed difficult, perhaps because it challenged the whole project of the day hospital. The day hospital records, however, illustrate a low but consistent level of non attendance. There did appear to be a tacit recognition by staff that some service users found the social environment of the day hospital difficult. One of the women participants I interviewed had made the decision to stop attending for a variety of reasons, including the lack of conversation with other people, the food, being treated as a child and the cold environment. When I first started interviewing her, I understood that she was still coming to the day hospital on a regular basis, but she explained the staff response when she stated that she no longer wanted to attend ('X' here is the participant's first name):

'When I they did everything to change my mind ... they were ever so sorry that I was so that I wasn't coming anymore and they were sorry that I felt the way I did ... but I think they understood ... um oh they didn't say so but I think they did you know sat around hours ... she went away and she said I'll see you in a minute X she came back and told me she said what about you coming on a Wednesday when it's only a a little while and just have your treatment and home for dinner' (s2p14 lines 1449-1478)

This woman goes on to say that she was unable to sort out transport arrangements, but that this was also managed by staff. This interview took place during the final week of data collection, and this concession was the first acknowledgement I saw that service users might find the social environment of the day hospital difficult, but would still benefit from treatment. The other patients I spoke with seemed unaware that special arrangements could be made which would allow them to receive treatment, but avoid much contact with other patients.

In addition to stereotypes about being old and disabled existing in the wider community, new service users also needed to learn and assume a position with regard to the norms and values particular to the group of people within the day hospital, in respect of social identities. The practices linked to gender have been mentioned: for females to be overfamiliar with male service users, as previously illustrated, seemed to be suggestive of a particular social identity which was not popular at that particular time with the group of women in the 'main circle'. As a person at the day hospital who was not a staff member, but clearly not a service user, I had limited access to these practices, and the assumptions about different social identities that underpinned them.

Although unintended, my presence as a researcher in the day hospital also seemed occasionally to highlight a potential threat to the social identity of some members of staff as competent and knowledgeable within their area of expertise. An example of this is illustrated in the following extract:

'*I sat down again by* (service user), *and* (physiotherapy worker) *brought a zimmer frame to her. It seemed that people waited until approached by a member of staff to go out to the transport at the end of the afternoon.* (Service user) *was the last to leave the day room.* (Physiotherapy worker) *talked her through getting up, at the same time as telling me that she had been involved in a research project and had enjoyed it. On* (service user's) *rising from the seat, she commented that 'it wasn't very good'* (ie manner in which this woman had stood up), *but took some of the blame for that. It seemed to me that she felt aware of me appraising somehow'* (dhvis1 lines 188-203)

In this example, the physiotherapy worker's need to comment on an aspect of this patient's performance indicates that she is able to assess the quality of the movement employed in rising from a seat, and thus demonstrate her own skill in recognising that more rehabilitation was still required.

As discussed in the previous section, the staff were able to exercise greater control over how frequently they were observed by me, and were perhaps able to use this

as a strategy to avoid perceived challenges that I posed to their social identities as competent health workers. The following excerpt details part of a conversation that I had with one of the health workers during my first observational visit to the day hospital. I had known this woman prior to the research project, and she spent twenty minutes talking with me on this first occasion. However, during the subsequent nine weeks of data collection I saw her very infrequently, and did not have the opportunity to see her working with a service user. This following excerpt from fieldnotes details part of our conversation about the 'Fallers Clinic' (in this excerpt, 'X' represents the profession of which she is a member):

'She felt that the Xs had had to push quite hard to be included, but identified that the home environment is where falls happen and that 'home visits are our thing'. She herself wasn't involved anymore - she described the potential contribution as 'technical' whereas she was 'practical', and said that she would find it difficult limiting her intervention to the areas specified for the Xs. She indicated that she liked to work more broadly, to include 'psychological' factors, which didn't seem to be possible in the context of the falls clinic, where the X had to focus on two or three 'risk' areas? factors?' (dhvis1 lines 242-261)

Whilst her decision not to be involved in the Fallers Clinic is constructed as a choice, the conversation recorded in this excerpt may also represent an attempt to assure me of her valid and comprehensible reasons for not having an input into this new service. As I was known to her as a health worker with research interests in falling, it was conceivable that I could ask challenging public questions about the absence of this professional from the team. This section of the conversation may then have been designed to assure me of her social identity as a skilled health care specialist, who valued her professional autonomy to work in the way that she felt appropriate.

8.9 Summary

This chapter has described three frames which it has been suggested may be used to construct and interpret explanations about the purpose and activities of a day hospital for older people. A description of these three frames; medical,

rehabilitation and social, is a prerequisite to understanding the different ways in which risk is invoked, communicated and managed within the day hospital, the aim of the second study described in this thesis.

As has been argued, these three frames are used interchangeably by staff and service users within the day hospital, and can be combined within action and talk. In addition, the three frames are not mutually exclusive. Several service users, for example, described themselves as working hard at their therapy, practising techniques and exercises they had been taught at home and comparing themselves favourably to their less motivated companions. Such descriptions draw on ideas of agency and patient responsibility promoted within the rehabilitation frame. However, such descriptions also construct a social identity of a 'good' patient, adhering to treatment, deserving and appreciative, which utilise processes such as social comparison.

The following table illustrates how the different constructions of risk within the three frames can each potentially be apparent within a single event, in this example, a fall in an older person. The context of a day hospital has been used to allow for the suggestion of specific examples, some of which are evident in the data generated as a result of the study reported in this chapter. This example is provided to illustrate the different preoccupations and foci within each frame, and how risk is consequently realised.

Table 16: Risk in the medical, rehabilitation and social frames in relation to the event of a fall in an older person within the context of day hospital service provision.

	MEDICAL FRAME	REHABILITATION FRAME	SOCIAL FRAME
What is deemed risky?	Agents acting on the body: combinations of medications, leading to polypharmacy obstacles which cause falls to occur (eg unused walking frames)	Functional activities (eg hanging curtains), particularly if in interaction with unsafe environment, or ignorance of danger	Being seen to fall, or fall being discovered
What is the consequence of unchecked risk?	Physical injury and trauma, death	Loss of independence, institutionalisation	Embarrassment, stigma (eg to be described as frail, vulnerable, needy), prejudice
How is risk managed and who is responsible?	Staff monitor prescribing of medications Staff remove dangerous objects to place of safety (eg walking frames removed from proximity of day room to corridor)	Staff suggest avoidance of unsafe performance (eg 'wandering around'), work with service users to enhance safe performance, through improved skills (eg improved balance) and suggest ways of modifying environment. Service users adhere to advice, practise skills to enhance performance and make changes to home	Event of fall is concealed or minimised (eg described as a 'slip')
Focus of risk within frame	Physical body of service user	Functional performance of service user	Social identities of service user

9. Chapter Nine: Discussion

9.1 Introduction

This chapter commences with a discussion of the findings of the two empirical studies. The criteria proposed earlier in this thesis for evaluating discursive research are next revisited, and this work discussed in light of these suggestions. The broader implications of this work are then considered. Initially the methodological implications for both discursive research, and health research more generally are discussed. This is followed by consideration of the implications of this research for health promotion, therapy and rehabilitation, including work focusing on falls in older people. Limitations of the work are addressed before recommendations for both further research and practice are identified. The chapter concludes with a summary.

9.2 Discussion of the findings of the two empirical studies

9.2.1 Discourses and frames: resources for constructing meaning

The interpretation of the initial empirical study described in chapter six suggested that in talking about falls and falling, therapists tended to make use of a 'risk discourse' whilst older people in hospital with fractured hips employed a 'moral discourse'. In exploring risk further in the second empirical study, it was proposed that within the context of a day hospital for older people, risk could be constructed and understood variously within three different frames: the medical, rehabilitation and social frames.

The identification of resources through which meaning is constructed is a prime objective within discourse analytic work, particularly within the Manchester School. The descriptions of the discourses identified in the first study are similar to findings from other discursive work, and more broadly in critiques of public health. Lupton amongst others, for example, has written about both the 'moral dimension' of illness (Lupton 1994), and the 'risk discourse' (Lupton 1993), both of which share similar characteristics with those identified within the first study.

However, no work has been located which specifically utilises discourse analysis as the primary methodological framework for research into falling. Only one very recently completed study (Martin 1999) has argued more broadly for the possibilities introduced by the adoption of a social constructionist perspective within the area of falling amongst older people.

The use of the term 'frame' in preference to 'discourse' was justified in relation to the second study in order to accommodate those non-textual means, such as practices, non-verbal aspects of communication and environments, through which meanings are created. The use of the term 'frame' is similarly not new within the context of research in health care. Coupland et al (1994), for example, use this denotation to refer to aspects of communication within doctor-patient interaction, and Peräkylä (1989) describes four 'frames' of staff identity within palliative care. However, the use of frames within both Coupland et al (1994) and Peräkylä (1989) is described in terms of the adoption of interactive styles and communication strategies, rather than a more discursively orientated perspective of a frame. Within this thesis, frames are created through and constitutive of larger social and cultural resources (Stainton Rogers 1996) or ways of making sense of the world which are not wholly dependent on speech and interaction, and in which the observer or reader is also implicated.

Characteristics from the perspective of medicine and the medical practitioner have been described variously as the medical model (eg Brisenden 1986), medical discourse (Parker 1992, 1994) and medical frame (Coupland et al 1994, Peräkylä 1989). Similarly, the 'social model' has been extensively documented (eg Oliver 1996, Shakespeare and Watson 1997) and the lay frame described both by Peräkylä (1989) and Coupland et al (1994) shares some characteristics with the 'social frame' described in chapter eight, such as the dissolution of identities of 'patient' and 'staff'. However, whilst there are similarities between the 'medical', 'rehabilitation' and 'social' frames in this thesis, and the way in which these terms have been used in other work, the adoption of a discourse analytic framework, together with the rationale for the term 'frame', allows this work to make a novel contribution to research into health explanations.

9.2.2 Contribution of this work to different understandings of risk

As was discussed in chapter 6, risk has come to be a major preoccupation in Western society in the late twentieth century (Hart 1999). Risk features increasingly in explanations about health (eg Skollbekken), although relatively little work has focused on what Tansay and O'Riordan (1999) have described as the 'social or perceptual' analysis of risk as opposed to the 'technical' perspective, particularly in the area of falls and falling in older people.

Blaxter (1999) also drew attention to the frequency with which risk is associated with health outcomes, arguing that this limits both what is regarded as 'risky', and what is at risk, within the context of 'social research'.

This thesis aims to both recognise these existing representations through an explanation of risk in the medical and rehabilitation frames, and also expand and transcend them in considering risk in the social frame. Within this construction of risk in the latter frame, social relations, the self and identity are all implicated in terms of both what is risky and what is at risk. Whilst previous work on risk in health has acknowledged social and cultural constructions of risk (eg Bellaby 1990, Brown, Chapman and Lupton 1996, Davison, Davey Smith and Frankel 1991, Metcalfe 1993), there has been comparatively little work which has attempted to combine different constructions risk in one explanatory framework, as this work does. Within work focusing on falls in older people, the development of theory about risk has almost exclusively focused on 'technical' analysis (Tansey and O'Riordan 1999), or risk in the medical and rehabilitation frames. This thesis therefore represents a timely addition to work in this area.

Another feature identified by Blaxter (1999) in the 336 grant proposals submitted in response to the ESRC programme 'Risk and Human Behaviour' (which formed the raw data for her exercise in the 'sociology of social research') was that they tended to be located within single disciplines, again limiting development of theory about risk through cross fertilisation of perspectives from a multiplicity of disciplines. This thesis, and the empirical studies, has deliberately combined a

discourse analysis perspective from social psychology in the United Kingdom with risk theory from both social psychology and sociology in an area which has been dominated by biomedical and more recently public health/rehabilitation explanations. This combination of methodology and theory base employed in the area of health practice selected as an exemplar, falling in older people, has not been attempted before.

9.2.3 Action orientation of 'risk talk'

The previous section has been concerned with the resources drawn upon in constructing and recognising different types of risk. In keeping with the dual orientation of discourse analysis alluded to in the description by Potter and Wetherell (1994), reproduced in chapter three, this section discusses the function of talk about risk in relation to previous work. In the first empirical study, it was suggested that talk about risk serves to legitimate therapists' roles in health care settings as expert assessors and advisors about risk, with older patients/clients as vulnerable and in need of their services. In the second study, the case was made for an expanded construction of risk, beyond the threat of bodily harm and loss of independence, to include a challenge to preferred social identities. The two empirical studies in this thesis have thus illustrated how talk about risk may be used to construct social identities, and also how talk invoking social identities can also be indicative of previously unrecognised constructions of risk.

Green (1997b) has previously identified how children's talk about risk and accidents can construct gendered identities, with girls describing themselves as responsible and sensible, whilst boys were adventurous and brave. Green is also one of the first to explicitly recognise the possibilities for social identities in talk about risk, although this is implied in other work. Parsons and Atkinson (1992), for example, suggest that some women who are carriers of the Duchenne Muscular Dystrophy gene describe themselves as 'spoiled' and undesirable.

One of the more salient issues in construction of identities through talk about risk in this work appeared to be position as professional or patient within the healthcare system, particularly in considering the initial study. This is in contrast to the issue

of gender identified by Green (1997b), although gender was also implicated in the alternative construction of risk proposed in the second study. An example of this can be seen in the comments of the female service user who felt she had antagonised other women in the group through being overfamiliar with a male service user.

This work therefore shares much in common with Green's (1997b) contribution in illustrating how social identities may be created through 'risk talk'. However, it also extends the possibilities with regard to the types of identities which might be constructed.

9.2.4 Discussion of empirical studies in relation to other studies focusing on experience and understanding of falls

A total of six studies were found which considered the personal experience of and understanding about falls. These have been reviewed in chapter two (see table 4). These six studies do not share a theoretical framework in common with this thesis. As a consequence, possibilities are raised for alternative interpretations of findings in these papers, particularly those which appear similar to observations reported here. These similarities are discussed in this section.

One of the possibilities highlighted within this thesis is that older people have an interest in presenting themselves in a manner which appears consistent and counteracts possible stereotypes about frailty, incompetence and confusion in old age. Weinburg and Strain (1995) adopt more of a realist position in exploring one of the strongest associations between poor self rated health and attribution of fall to own limitations, in their study of older people's fall attributions. However, this association could also be explained by the desire to demonstrate that, in the face of apparent evidence, one does not hold unrealistic perceptions about what one is able to do, thus compounding possible negative perceptions of the older person's frailty and vulnerability on the part of the researcher. Furstenburg (1988) also identified how expressed expectations were modified in light of what health professionals say. This same desire not to appear overoptimistic and foolish in light of views

expressed by those who are seen as 'expert' would also account for this apparently powerful effect.

Borkan et al (1991) commented that older people with fractured hips tended to adopt the language and explanatory models of the surgeons with whom they had contact. Whilst different in terms of content, this tendency to use language more usually associated with health professionals was also highlighted within the second empirical study as a characteristic of the rehabilitation frame. Rather than indicating an increased understanding of the problem as commonly interpreted, however, an alternative explanation within the social frame might be that participants are desirous of appearing more knowledgeable. The use of such language therefore might serve to redress some of the perceived imbalance in terms of power and authority within the therapeutic relationship.

The importance that people attach to social identities was noted in the social frame, and some examples were given about how people distanced themselves from those they perceived as having undesirable identities, such as 'being old'. This theme is strongly represented in the study by Braun (1998), in which people distinguished risk of falls for themselves as much less than for those of the elderly population in general. This suggests that some 'older people' do not perceive of themselves in these terms, a finding also noted in the second study reported in this thesis. Whilst commenting that these findings are of interest, however, Braun (1998) does not develop a strong theoretical explanation for them.

Another finding resulting from the first study was that moral descriptors were invoked in the older patients' accounts of themselves and their experience of a fall and hospital. Borkan et al (1991) also report on moral attributions related to falls in their study of blue collar factory workers who sustained hip fractures. However, as an alternative to the defensive work in terms of protecting social identities advanced here as an explanation for this finding, Borkan et al (1991) suggest that use of these moral descriptors were reflective of deeper religious beliefs. As briefly discussed in chapter three, those using discourse analysis as an underpinning methodology for their research find such explanations for talk unconvincing.

One of the reported findings from the first empirical study here was that patient accounts of the fall event and admission to hospital were very detailed and recounted in chronological order, suggesting that narrative might be a productive theoretical framework to adopt in considering this aspect of these accounts further. Furstenberg (1988) also reported on the depth and detail with which older people experiencing a fall resulting in hip fracture talked about their experience, providing additional support for this suggested use of narrative.

In discussing possible reasons for adoption of particular attributions for cause of fall, Furstenberg (1988) makes an interesting point which is in contrast to the interpretation advanced in chapter six. She suggests that, in contrast to having a negative impact on identity, the assumption of responsibility for a fall may actually serve a positive function in terms of taking responsibility and exercising control. However, the first study here suggests that acknowledging that one might be responsible for one's own fall within the environment of an acute orthopaedic trauma ward may be a 'risky' activity, in terms of implication for maintenance of independence and social identity.

9.3 Appraisal of own work in light of alternative criteria proposed in Chapter 3.

The criteria against which it was proposed that this thesis be judged in chapter three were as follows:

- rationale provided for data sources, data generation methods and interpretation
- reflexivity
- plausibility
- accounts for detail and volume of data

This section briefly considers this work in light of these proposed criteria, and illustrates where evidence in support of each may be found.

The reasons for selection of sample, and sampling strategies employed in the two empirical studies are described in chapters five and seven. In retrospect, the utilisation of inclusion and exclusion criteria and dependence on nurses as gatekeepers with regard to patient participants in the initial study were perhaps over-reliant on positivist biomedical assumptions about who would be fit and able to participate in this study. However, the strategies employed in the second study were aimed at maximum inclusivity, aiming to encourage creativity in theory generation. Issues concerning generalisation on basis of samples have been addressed in chapter four. Whilst these propositions are perhaps rather tentative, they do acknowledge the importance of one's ontological and epistemological position in considering possibilities for generalisation, and also acknowledge the differences between empirical and theoretical generalisation after Mason (1996) and Yardley (in press). The rationale for data generation methods used has been addressed in chapter four, with explicit recognition of the challenges posed by use of participant observation within a discourse analytic framework revisited later in this chapter. A rationale for interpretation within a discursive framework is provided in chapter three, with details regarding how interpretation was carried out provided in chapters five and seven. A specific example of how different types of data were combined and contributed to theory development is illustrated in appendix 26. In addition, the case was made in chapter three for inclusion of research diaries in providing an explanation regarding how interpretation developed, a suggestion which was adopted throughout the studentship period in which this research was carried out.

Reflexivity as a criterion is specifically discussed in chapter three, but the persona of the researcher is acknowledged throughout this thesis, mainly through the intermittent use of the first person. The critical importance of reflexivity in justifying use of participant observation within a discursive framework is discussed in this chapter. One of the criticisms of this work might be that the presence of the researcher is too keenly felt throughout, particularly for those of a more positivist and less critical perspective. However, as a researcher new to discourse analysis and qualitative methods more generally, the insights and interpretation generated through reflexive practices have proved powerful learning experiences. It would

be possible to rewrite this thesis with the researcher less visible within it, but whilst this might prove aesthetically more satisfactory, it would be less representative of the experience of carrying out this work and also make the process of interpretation less transparent.

The third criterion against which it was proposed this work be judged was plausibility. As was noted in chapter three, appendix two details opportunities taken to test the credibility of emerging theoretical propositions in public. The acceptance of abstracts of papers resulting from this work through peer review systems suggests that the explanations proposed seem feasible and of interest to some audiences.

One of the possible arguments challenging this as a criterion of quality and rigour is that new and novel explanations might sound strange and contrary to common sense understandings and thus threaten plausibility. The assertion that risk might be constituted as a threat to social identity is perhaps more easily challenged within this context than more usual understandings of risk as a physical threat to body. However, as already noted, commentators such as Blaxter (1999) have argued for greater recognition of different types and forms of risk. The criterion of plausibility thus appears to militate against more radical and original explanations. However, in evaluating the usefulness of this criterion, one might also consider the account of the process whereby the particular interpretation was reached and how it was warranted; the care taken in detailing each step and the way in which the developing theory was tested, for example. Viewed in this way, plausibility refers to the conduct of the research as whole, in preference solely to the resultant interpretation. It is suggested that, in these terms, this work meets this standard.

The final criterion suggested in chapter three for evaluation of discursive research is that the explanation accounts for the detail and volume of the data. In both empirical studies detailed in this thesis, data from the majority of different participants in the semi-structured interviews has been included to support the theoretical explanations. In the second study in chapter seven, effort has been expended to illustrate how the three different types of data were integrated within

the interpretation, and examples from all three data generation methods have been included. Examples of 'negative cases' in which data appear to initially contradict preliminary interpretation have been included in the accounts of both studies in chapters five, seven and eight. The initial interpretation has been modified and refined to account for these examples, demonstrating attention to detail in the data.

9.4 Implications for research

9.4.1 Implications for discursive research

Because interviews and documents have more usually been the source of data for discursive analysis, there has been little debate within discursive psychology about the viability of participant observation as a method within a discourse analytic framework, nor the particular challenges that use of this method would raise.

One of the first is that one must necessarily be selective about what one records during observation. As Potter (1998a) states about the ethnographer, they will usually concentrate on a few themes which are either deemed most important, or relate to prior questions. The *a priori* research question in participant observation may not therefore focus on interactional practices (Potter 1998a), or appear, initially at least, to address Parker's concerns about how subjects are constituted within discourses (Parker 1992), the more usual reasons for carrying out a discourse analysis. In the second empirical study, my aim was to explore how risk was realised in the setting under consideration, according more closely with Parkers' and the Manchester School's focus. However, many of the initial fieldnotes concerned use of space, discomfort on my part as the researcher in a new environment, and difficulties in recalling people's names. At times, a risk focus seemed in danger of being superseded by other more immediate and superficial concerns. Questions about the unfolding direction and focus of the research are usually not pertinent in discourse analysis because data has already been generated before analysis begins. However, use of participant observation foregrounds the researcher's role in generating data as the research evolves. Within my work, I continued with the loose theme of risk, and through continued reworking, reading and interpretation, constructed a theory of the three frames,

with risk realised differently in each, which integrated this initial data. This decision was an intuitive one, based on a conviction that these different issues were linked, and that apparently superficial detail such as which service users sat where in the day room of the day hospital could contribute to a more theoretical understanding of risk.

A second challenge present in the use of participant observation within a discursive framework is that the researcher is the sole producer of the raw material under study. The 'sense-making' carried out by the researcher is reliant on the ways of understanding the world, or discourses, which she brings to bear on what she sees. Written material accords with existing patterns of understanding, or is self-consciously identified as something that does not, to serve to stimulate thought and theory generation at a later time. Within participant observation, any potential material for analysis is mediated by the discourses employed by the researcher in order to bring them into being as texts.

However, there are a number of reasons why it might prove useful and insightful to carry out a discourse analysis on texts produced by oneself, as in participant observation. Firstly, Yardley (1997) and others have argued that objects, including the body, do have a material reality, although they may be constituted in a variety of different ways, or not visible at all, within different discourses. The reality of an 'impaired body' is beginning to feature again in writing about disability (eg Hughes and Paterson 1997) which for a long time has focused on the social meanings and construction of the term, for example. Fieldnotes and memos generated in participant observation do therefore contain examples of phenomena which have a material reality, albeit mediated through the researcher's fieldnotes, which can as a consequence be studied by both the person generating the data, and others.

A further reason for an analysis of one's own texts is that the ways in which the researcher makes sense of the world, and of the situation being observed, is not always accessible even to the researcher. The act of carrying out discourse analysis clarifies this, and perhaps influences and alters this over the course of the interpretation. My early coding of the data, for example, included a category

which I called 'risk'. The parameters of this code were kept deliberately vague, and the category included examples of anything that seemed to relate to risk at this early stage of analysis. I was aware that my developing explanation was at this time partial and incomplete, but felt that a closer examination of data I had included in the 'risk' category could help clarify and develop my thinking. On reflection, items included in this category tended to be derived from what I later termed the medical and rehabilitation frames, emphasising my enculturation as a health professional regarding types of objects or activities understood as 'risky'.

Another example from my own work which illustrates that the frameworks used to make sense of experience in participation observation are far from clear to the researcher at the time of observation, is apparent in development about theory regarding the three frames. This hypothesis of the three frames emerged at a relatively early point in this analysis. However, the use of these frames, and how they accounted for some aspects of the data, required much reworking, thinking and re-reading. The use of the medical and rehabilitation frames by service users to enhance their social identities was an insight which occurred fairly late on during interpretation and writing.

Another methodological implication of this work is that further analysis of the explanation provided, or discourses identified, in discourse analysis work can reveal preoccupations of the researcher and concerns of the discipline. As Ogden (1995) has argued for psychological theories, discourses can also illustrated how what passes as knowledge is constructed. In this work, for example, a single 'medical' discourse has been identified. However, some commentators have subdivided this further. Lupton (1994), for example, includes under the rubric 'medical discourses', 'public health and the body', 'the sexual body' and 'the commodified body'. The reason why I have identified just one discursive resource, which I have labelled the 'medical frame', when others have subdivided this into several discourses perhaps indicates something about the explanatory power and saliency of professional roles and identities for me in determining how health events are understood, and health services provided. Many occupational therapists tend to contrast occupational therapy with medicine, both in terms of practice (eg

Craddock 1995, Creek 1997) and research (eg Wright 1998). In chapter three, I argued that my own lack of grounding in a discipline with a rich and diverse theory base possibly had adverse implications for the level and sophistication of my interpretation. However, the particular value and significance of my work may lie in those characteristics which initially appear to limit my analysis; my identity as an occupational therapist. The theory I have generated and the frames I have identified may be viewed reflexively to reveal the relatively simplistic ontology and epistemology of occupational therapy, a comparatively new profession and a new academic discipline. This will also impact on the ways in which service users are understood by therapists and health professionals more generally, and how services are constructed to meet their perceived needs.

9.4.2 Implications for research in health

The work in this thesis also has implications for health research more generally. One of the main findings is that in talking to others about the experience of providing health care (in the case of staff), or experiencing a health event and treatment (as a service user), interviewees are mindful of their social identities in the accounts they provide. They draw on a variety of resources to construct diverse identities including medical and rehabilitation frames, talk about risk, professional responsibilities and social relationships. The perceived position of the researcher is also important in the construction of these accounts. In an acute setting working with older people who have experienced recent trauma and major surgery, for example, the researcher may be seen as another health professional. This may be particularly true in settings in which the service user is exposed to a variety of different health personnel within a short period. This therefore challenges the perspective that in interviewing individuals, or conducting surveys, one is accessing relatively stable attitudes and beliefs, or neutral accounts of experiences (eg Moser and Kalton 1993, Oppenheim 1992).

This attention to social identity will therefore have implications for surveys designed to test patient satisfaction with a particular service, health professionals' descriptions of their role, or service users' experience of an illness or treatment. This is not to suggest that participants are lying, or not telling the truth, but rather

that the researcher should be sensitive to power relations in both health and research scenarios. The location, context and timing of the research will also influence the responses generated. In the second empirical study, for example, service users were given the option of participating in an interview in their homes. This decision was taken because I felt that the environment of the ward, the setting of interviews in the initial study, had emphasised the identities of participants as 'patients' and reinforced perceptions of me as a health professional. The environment had therefore impacted on the accounts which the service users provided.

The potential multiple constructions of an event or experience perhaps suggest a shift in focus, as advocated by proponents of discourse analysis. In preference to asking questions about how satisfied patients are with their treatment and care, for example, a more fruitful approach within a qualitative tradition might be to focus on how the accounts are constructed, for example; the types of items mentioned; their nature (eg material and tangible, like food, or social, such as relations with key nurse); implications of the accounts for the social identities of the service users (eg compliant and grateful, or angry and misunderstood); concurrence between criteria invoked by service users when considering 'satisfaction' and those deemed relevant by managers of the service.

Similarly, in investigating 'fear of falling', the researcher might consider how perceptions of herself might influence responses generated. Is she viewed as a figure of authority, to whom it might appear foolish to state that one is more concerned about keeping clean than falling? Might she have influence over discharge plans, in which instance to admit to being afraid might be to invite ascriptions of frailty, neurosis or charges of potentially not coping at home? Does she seem young and vulnerable, and that to challenge the premise of her questions or answer in the negative might cause her embarrassment or loss of face?

9.5 Implications for health services

9.5.1 Implications for practice in working with older people who fall or are seen to be at risk of falling

One of the most important findings of this work is that older people may not share the same perspectives as health care professionals about the causes of falls, the seriousness of a fall, or their own role in preventing a fall. This diversity of views may have implications for the degree to which older service users adhere to advice proffered by health care professionals for preventing a fall, such as the recommendation to exercise regularly, or to modify one's home environment. The motivation with which service users approach therapy may also be affected. Whilst therapists and rehabilitation professionals tend to assume that they are working in partnership with older service users towards shared goals, this research has also illustrated that older people may not view the process of therapy in this way. It may therefore be necessary to make explicit such assumptions, and check whether they accord with patient/client agendas and priorities.

9.5.2 Implications for health promotion material about falling, and falls prevention programmes.

The results of this work suggest that in planning health promotion campaigns, it is important to attend to images presented in materials such as leaflets and posters, and to implied identities of those who might use such materials. Findings from both empirical studies illustrate that older service users distance themselves from association with 'old people' and work hard to refute suggestions of culpability for falls. Both of these findings are replicated in a newly completed study (Martin 1999), which also suggests that older people are mindful of self in language used to talk about falls: 'falls' happen to other people who are old and frail, whereas the person themselves might acknowledge that they 'trip' or 'slip', but may minimise the significance of this.

Whilst the new Department of Trade and Industry campaign (Department of Trade and Industry and Health Education Authority 1999) acknowledges this to a limited extent in the title of the campaign, the leaflets it has produced include 'Information for older people on how to avoid accidental falls in the home'. It is suggested that

whilst people may acknowledge that some of the measures proposed are useful, they may be unlikely to apply this information to themselves, and the leaflets will therefore not be used on the scale envisaged. The photographs used in the campaign literature include a picture of an older man from an ethnic minority. The campaign is apparently targeted at all 'older' people, regardless of gender, ethnic background or chronological age. However, there is evidence to suggest that some people from ethnic minorities may have different perspectives about the desirability or otherwise of dependency and sense of personal risk (Martin 1999), and several service users aged in their sixties in the second empirical study did not identify, or want to be associated with other 'older people'. There is no acknowledgement of such differences in perspectives within the campaign material.

The lack of acknowledgement of varying social and cultural perspectives is also apparent in many of the falls prevention programmes now being designed. Following the apparent success of an American study utilising an exercise programme based on Tai Chi, also one of the FICSIT interventions (Wolf et al 1996), Tai Chi has been recommended as a type of exercise which may be particularly helpful in preventing falls (eg Nuffield Institute for Health and NHS Centre for Reviews and Dissemination 1996, Department of Trade and Industry and Health Education Authority 1999). However, this recommendation appears to be based solely on the balance training aspects of this particular activity. As Wolf et al (1996) report, Tai Chi is a martial art, and whilst it has been used as a form of exercise in the USA 'predominantly by older individuals of Asian heritage' (Wolf et al 1996: 489), the acceptability of this form of exercise, and implications, in being invited to learn a martial art, for views of self of older people in the UK have not been investigated.

Some of the interventions suggested do not appear to acknowledge the potential impact on personal and social identity. Hip protectors are increasingly being advocated as a measure to prevent fracturing the hip in the event of a fall (Nuffield Institute for Health and NHS Centre for Reviews and Dissemination 1996, Department of Trade and Industry and Health Education Authority 1999). The possibility of issues relating to the reluctance of older people to wear hip

protectors appear to have been anticipated in the overall design of the FICSIT series of studies (Ory et al 1993). The intervention at site seven, involving wearing of hip protectors, was the only non randomised controlled trial in the series, and the study consisted of a period of observation designed to determine compliance in the wearing of hip pads. However, the reasons for this possible reluctance do not appear to have been discussed in detail, nor has any work been found which investigates older people's perceptions of hip protectors. Women appear to be particularly targeted (a woman is shown wearing the hip protector undergarments in the Department of Trade and Industry and Health Education Authority [1999] information leaflet, for example), but it is suggested that the addition of extra padding around the area of the hips is not a measure that most women would welcome. These garments appear to conform to ageist stereotypes of older people as non-sexual beings, unconcerned about their shape or body image, who are prepared to sacrifice femininity and 'sex-appeal' for increased safety.

The acceptance of a social identity of oneself as 'someone who falls, or is likely to fall' is a prerequisite for many of the falls prevention and management measures discussed, particularly because of the necessity for individuals to take active responsibility in maintaining their own safety. This work suggests that strategies based on this assumption may fail, a proposition strongly supported by Martin (1999).

9.5.3 Implications for the therapy professions and rehabilitation

Therapists are increasingly involved in health promotion and education activities, in which risk assessment and management have a growing role. As has been illustrated in chapter two, therapists are taking the lead in some aspects of falls prevention work, furthering knowledge particularly in the area of balance and environmental hazards. As yet, however, there has been little discussion in the therapy literature with regard the theoretical base of health promotion, how the core skills and values of the therapy professions mesh with this, or the specific roles which therapists might play within the broad spectrum of public health.

Of the two therapy professions specifically included in this research, occupational therapy has in recent years expended the most effort in exploring and describing its defining characteristics and frameworks (eg Hagedorn 1992, Kielhofner and Forsyth 1997, Young and Quinn 1992). Whilst there is a growing body of research to support the claims made for the profession of occupational therapy, many of these remain unsubstantiated. However, they have provided explanatory power in describing and defining professional activity. Physiotherapists, in contrast, have appeared to have had less difficulty in identifying their core activities. This may be because physiotherapists' practice draws more directly from the medical tradition (Thornquist 1994) and their role is therefore perhaps more easily understood by medical and health professional colleagues.

However, both professions in the UK have been required to respond to calls for increased clinical effectiveness (NHS Executive 1996) , and practices based on evidence, rather than anecdote (Department of Health 1995). As a relatively new discipline which is very much in tune with current constructs of lifestyle, health and the self (Department of Health 1999), public health is a powerful and attractive ally. In locating their activities within a health promotion framework, the therapy professions stand to gain status and authority.

In an unusual example of a paper focusing on the philosophies of both therapy and health promotion, Thibeault and Hébert (1997) claim that the tenets of occupational therapy and health promotion are very similar, being based, amongst other points, on empowerment, social justice and respect for cultural diversity. Seymour (1999) in a survey of senior occupational therapists working with older people in Wales found the they felt their profession and health promotion shared an holistic approach to work with older clients/patients, and felt that occupational therapists should have a greater role in health promotion activities. However, as illustrated in chapter five, commentators of a more critical persuasion have challenged these apparently benign intentions of the public health movement (Metcalfe 1993, Petersen and Lupton 1996). Lupton (1993: 425) claims that the 'risk discourse' in public health serves the function of laying blame on the victim,

displacing the 'real reasons' for ill-health on the individual, and exercising control over socially questionable behaviour.

Without a thorough reappraisal of its relationship with public health, it appears that occupational therapy in particular may be at risk of jettisoning some of its espoused values in a desire to ally the profession with public health. In viewing risk assessment and management as objective and technical skills (Thom and Blair 1998), occupational therapists are at odds with their commitment to client centred practice (Young and Quinn 1992), in which different types of risks might be acknowledged, negotiated and prioritised.

Two definitions of rehabilitation were provided at the beginning of chapter seven, which both acknowledge the importance of social integration and social functioning. However, the rehabilitation frame described in chapter eight suggests that the practice of rehabilitation tends to focus on performance of activities of daily living within the context of health service environments and the home, to the exclusion of more socially aware or orientated interventions. In addition, the construction of the service user within the rehabilitation frame as a rational, functioning agent ignores the social and cultural communities within which the service user is located, and from where they derive their perspectives and identities. It was also suggested that particular service users with more extensive experience of rehabilitation tended to acquire and use terms more commonly associated with rehabilitation professionals, and that 'working hard' and 'motivation' were important concepts in making sense of their presence at the day hospital. Maclean, Pound, Morgan and Rugg (1998) have also reported the saliency of the concept of motivation for rehabilitation professionals, but noted that this characteristic, or lack of it, tends to be implied, sometimes erroneously, by behaviour of patients. They also drew attention to the differences in meaning that this term had for various different members of the rehabilitation team. There is a paucity of work researching the social practices and meanings of rehabilitation, but this work suggests that this would be a fruitful area to explore. As rehabilitation professions, it is proposed that therapists should be aware of the social habits, traditions and mores of the cultures from which their patients and clients originate.

9.6 Limitations of current work

This section considers some of the limitations of the current work. One of the potential criticisms of the first empirical study is that whilst contrasts are drawn between the discourses employed by the therapists and the older service users in their accounts, these two samples do not bear direct comparison. The therapists were asked about their work with, and approach to, older people who fall, whilst the older service users with fractured hips were questioned about their personal experience of a fall. In order to truly compare like samples, it could be argued that one should ask the same set of questions of both therapists who have sustained fractured hips as the result of a fall, and service users in the same position. Alternatively, in light of problems in finding therapists in this category, one could interview older people and therapists with experience of a fall. This, however, introduces the potential difficulty of degree of severity of fall, and whether the experiences of the two groups are truly equivalent. Whilst the differences between the two groups of participants are accepted in part as an explanation regarding the ways in which the accounts differ, it is also argued that the choice to focus on these two groups was valid. Therapists provide services for older people on the bases of their professional education and current priorities and policies in health care. These same factors influence the accounts they craft about the work that they do; the requirements to demonstrate clinical effectiveness and evidence based practice, the need to show the value of and the potential contribution that the therapy professions can make in the area of falling. Older service users speak from their experience of a fall and their perceptions about requirements of them as patients; these influence the way that they as patients respond to treatment. The differences between the two samples do not invalidate the interpretation, therefore, but further explicate the different pressures and motivations to talk about falls and falling in the way that the two groups did.

From a positivist perspective, it could be argued that one of the more obvious methodological limitations of both empirical studies are the small sample sizes; twenty therapists and eight service users in the initial study, and a single day

hospital and fifteen service users in the second. In addition, the participants were not randomly selected from wider populations of therapists, older service users or day hospitals. This has obvious limitations for 'empirical generalisation' (Mason 1996). However, as research within a qualitative tradition, this work is aiming to provide theoretically plausible explanations about the particular contexts, people and processes studied, which may find wider resonances in other situations, the 'theoretical generalisation' (Mason 1996) or 'vertical generalisation' (Yardley in press) already discussed. Such generalisation is possible through the detail of the explanation, use of a range of data sources and methods, clarification of the theoretical framework in which the research has been conducted and demonstration of rigour of both process and analysis within research (Mason 1996, Yardley in press). These criteria overlap with those proposed for the evaluation of qualitative research in chapter three. The ways in which this thesis meets these criteria have already been discussed, and clarification of the theoretical framework of the research, an additional criterion, is also provided in chapter three of this thesis. The interpretations provided in this work should therefore be pertinent within other contexts.

However, in being too prescriptive about the extent and nature of this generalisation, it is possible that some of the potential contribution of this work may be missed. The issue is not perhaps solely in the interpretation and how it is warranted, but also in the theoretical position of the individual looking to generalise to other contexts. The possibilities for applicability beyond the immediate contexts studied are therefore offered as tentative suggestions within this chapter. It is hoped that these will stimulate creative thought, and promote multiple and negotiated perspectives of health events and health care interventions.

From a discourse analytic perspective, a constant tension present throughout this work is on the one hand the need to acknowledge that realities are multiple, flexible and constantly shifting, and on the other a requirement to assume a position with regard how falling in older people is currently viewed within health services, and the implications of this perspective. This latter requirement is particularly keenly felt because this work was funded through an NHS Research Studentship,

and a priority of the funding body will be the practical implications of this work for services. My position as an occupational therapist also means that I have a desire to see services 'improve', and feel more than an academic obligation toward those formerly positioned as 'my patients'. This tension reproduces the relativist/realist arguments debated more widely between discourse analysts (eg Edwards, Ashmore and Potter 1995, Gill 1995, Potter 1998b).

Once again, the very recognition of this tension encourages reflexivity and constant re-evaluation of one's own work. This work recognises differences between the two groups described as 'older service users' and 'staff' in terms of authority and capacity to shape health services and construct identities within those services. The unequal ways that power is played out in the current structure and organisation of health services are therefore acknowledged. However, the potential for different and multiple constructions is also recognised through a critical focus on the meanings that have come to be associated with these labels, and the consideration of other possibilities, and how people might actively become involved in selecting and creating these. Both these perspectives are represented in the recommendations to follow. This apparent lack of commitment to a single position with regard to relativism or realism is therefore proposed as a strength, the focus being on the utility which different positions can offer.

9.7 Recommendations

9.7.1 Recommendations for future research

In view of the heavy reliance within discourse analysis on talk and texts, those using discursive approaches need to further develop methods and theoretical explanations that account for non-textual materials. Further use of participant observation as a means of generating data which could form the basis of a discourse analysis is suggested. The position of the researcher within such research would also require further theoretical consideration and explanation.

The wider adoption of critical research approaches more generally, and discourse analysis in particular, is advocated within the therapies and rehabilitation, as a

means of exploring alternative constructions of health and illness. The use of such approaches can highlight implicit assumptions in clinical practices and health services, and expose service users' perspectives which are currently underrepresented in health research. More specifically, the establishment of a critical forum and journal within rehabilitation is proposed. It is suggested that the capacity of a discipline to include a critical and reflexive function is a sign of its maturity. Such a forum would be a timely addition to academic rehabilitation.

In focusing on falls in older people more specifically, a number of possible directions for further research are proposed. The use of longitudinal designs to explore how the accounts of older people change over time following a fall is suggested. Such work could investigate how different contexts inform accounts, how the use of discursive resources vary and how accounts change over time.

Although included in the first study, the accounts of therapists about falling have not been a particular focus of this work. Further research exploring variation within and between therapists' account of their work with older people who fall is suggested. Inclusion of therapists who work with other groups deemed to be 'vulnerable', such as children and people with learning difficulties, would allow a focus on rhetorical devices which position particular groups in this way, and allow further theoretical exploration of how particular groups come to be described as 'at risk'. Investigation into how falls in younger people are represented by therapists, other health professionals and the 'lay public' might help to clarify how and why falling in older people has been identified as a particular priority.

Observational work both within and outside the theoretical framework of discourse analysis could provide more information about the take up and use of health promotion materials in which falls are targeted. Observation of the selection of health promotion leaflets in a library or general practitioner's waiting room, for example, could reveal whether older people find such materials relevant and potentially useful, particularly if followed with interviews. Investigation of older people's responses to specific initiatives such as the 'Avoiding trips, slips and broken hips' campaign (Department of Trade and Industry and Health Education

Authority 1999), both within the context of individual interviews and focus groups, would also allow for further exploration of this issue.

9.7.2 Recommendations for therapy professionals, health services and clinical practice

As a consequence of this work, it is recommended that therapists working with older people who fall take time initially to gain an understanding of the service users' perspectives about falls: why they occur, whether and how one might prevent them, and also the role of therapy. The therapist could also use this initial discussion to make explicit some of the tenets underpinning therapy intervention, such as the expectation that the service user will actively participate to effect improvement in their function. Such discussion also provides an opportunity to check whether such means of working are acceptable to the patient/client, and to negotiate direction and goals of therapy. Such practice reinforces the importance of the relationship between the therapist and service user, and could serve to challenge some of the perceived imbalance in authority and control which seemed particularly evident in ways in which older patients represented themselves in the initial study. In viewing the therapist as an ally, advocate or facilitator, the service user may represent areas of difficulty such as repeated falls, or anxiety about falling, with greater ease, less concerned about possible implications for their perceived abilities, competence and identities.

One of the findings of this research is that older people may not identify with or want to be included in services which are described as being 'for older people'. Whilst 'older people' is now generally used in preference to 'the elderly ' or 'geriatric' when describing services for this age group, none of these descriptors appears to be very attractive to those at whom these services are targeted. Some of the service users in the second study, for example, whilst meeting the criteria for inclusion in the day hospital, drew distinctions between themselves and older people around them. In view of the fact that services provided and resourced on the basis of age might alienate those for whom they are provided, it is suggested that a focus on perceived need (for example, for monitoring medication, or

podiatric attention to feet), or geographic location might prove a more acceptable basis on which to organise health provision.

In respect of the therapy professions, it is suggested that a clearer theoretical explanation is required with regard to the position and contributions that occupational therapy and physiotherapy should make within the arena of public health. Occupational therapists in particular need to ensure coherency between their espoused professional values and health promotion and falls prevention initiatives.

One of the practical applications of discourse analytic work suggested by Willig (1997) is discussion of alternative representations and constructions of disadvantaged and disenfranchised groups. Whilst criticism has been levelled in this thesis at some health promotional material for its simplistic and individualistic representation of health problems and their solutions, some do provide examples of active older people involved in activities which may not be associated with those of more advanced age, such as exercise classes and line dancing (Department of Trade and Industry and Health Education Authority 1999). Such material could prove a useful stimulus, perhaps within the context of a day hospital for older people, for example, in discussion about representations of older people in the media, and how one might choose to be portrayed.

9.8 Summary

This thesis began with a focus on falls in older people. Previous research in this area was shown to be based on 'taken-for-granted' assumptions about the gravity of a fall for an older person, and the possibility of prevention of a fall. The perspectives of older people themselves about the significance of a fall were largely absent from this literature. An initial empirical study illustrated how therapists and older people with fractured hips used different explanations in their accounts about falling. For therapists, risk appeared to be an important feature in talking about their work with people who fall. Older people with fractured hips as the result of a fall, however, were primarily concerned with representing themselves as being of 'good' character, and able to take care of themselves at home. A second empirical

study considered risk more broadly, within the context of a community rehabilitation service for older people. It was suggested that the 'medical', 'rehabilitation' and 'social' frames served as explanatory resources for constructing risk in contrasting ways in this environment as threat of bodily harm, loss of independence and challenge to preferred social identities.

Thus falling in older people has been used in this thesis to illustrate how current health practices and research focus on risk within medical and rehabilitation frames, to the exclusion of risk in the social frame. As a consequence, it was suggested that interventions in this area may be under utilised, and possibly cause further jeopardy through advocating the use of potentially stigmatising solutions for the prevention of falls and hip fractures. More broadly, the use of discourse analysis as an underpinning methodology in health research is advocated as a means of encouraging reflexivity, and exploring alternative, under-represented perspectives of health events.

REFERENCES

Adelswärd V and Sachs L (1996) 'The meaning of 6.8: numeracy and normality in health information talks' *Social Science and Medicine* **43** 1179-87.

Alexander B, Rivara F and Wolf M (1992) 'The cost and frequency of hospitalization for fall-related injuries in older adults' *American Journal of Public Health* **82** 1020-3.

Anderson S, Tobin A and Sealey C (1999) 'The National Collaborative Audit for the rehabilitation of elderly fallers' *Final Programme and Book of Abstracts 23rd Annual Conference College of Occupational Therapists* London: College of Occupational Therapists.

Annandale E (1998) *The Sociology of Health and Medicine* Cambridge: Polity Press.

Apley AG and Solomon L (1993) *Apley's System of Orthopaedics and Fractures (2nd edition)* Oxford: Butterworth-Heinemann.

Ashley MJ, Gryfe CI and Amies A (1977) 'A longitudinal study of falls in an elderly population: II. Some circumstances of falling' *Age and Ageing* **6** 211-20.

Askham J, Glucksman E, Owens P, Swift C, Tinker A and Yu G (1990) *A Review of Research on Falls Amongst Elderly People* London: Age Concern/Instutute of Gerontology.

Atkinson RL, Atkinson RC, Smith EE and Bem DJ (1993) *Introduction to Psychology (11th edition)* London: Harcourt Brace Jovanovich.

Audit Commission (1995) *United They Stand Co-ordinating Care for Elderly Patients with Hip Fracture* London: HMSO.

Ballinger C, Ashburn A, Low J and Roderick P (1999) 'Unpacking the black box of therapy - a pilot study to describe occupational therapy and physiotherapy interventions for people with stroke' *Clinical Rehabilitation* **13** 301-9.

Banister P, Burman E, Parker I, Taylor M and Tindall C (1994) *Qualitative Methods in Psychology A Research Guide* Buckingham: Open University Press.

Barnitt R (1999) 'Reflect, research, revise' *British Journal of Occupational Therapy* **62** 405-412.

Bellaby P (1990) 'To risk or not to risk? Uses and limitations of Mary Douglas on risk-acceptability for understanding health and safety at work and road accidents' *Sociological Review* **38** 465-83.

Bennett GCJ and Ebrahim S (1995) *The Essentials of Health Care in Old Age (2nd edition)* London: Edward Arnold.

Blake AJ, Morgan K, Bendall MJ, Dallosso H, Ebrahim SBJ, Arie THD, Fentem PH and Bassey EJ (1988) 'Falls by elderly people at home: prevalence and associated factors' *Age and Ageing* **17** 365-72.

Blake C and Morfitt JM (1986) 'Falls and staffing in a residential home for elderly people' *Public Health* **100** 385-91.

Blaxter M (1999) 'Risk, health and social research: lessons from the ESRC programme on risk and human behaviour' *Health, Risk and Society* **1** 11-24.

Bogle Thorbahn LD and Newton RA (1996) 'Use of the Berg balance test to predict falls in elderly persons' *Physical Therapy* **76** 576-83.

Borkan JM, Quirk M and Sullivan M (1991) 'Finding meaning after the fall: injury narratives from elderly hip fracture patients' *Social Science and Medicine* **33** 947-57.

Braun BL (1998) 'Knowledge and perception of fall-related risk factors and fall reduction techniques among community-dwelling elderly individuals' *Physical Therapy* **78** 1262-76.

Brisenden S (1986) 'Independent living and the medical model of disability' *Disability, Handicap and Society* **1** 173-8.

Brown J, Chapman S and Lupton D (1996) 'Infinitesimal risk as public health crisis: news media coverage of a doctor-patient HIV contact tracing investigation' *Social Science and Medicine* **43** 1685-95.

Buchner DM, Cress ME, Wagner EH, de Lateur BJ, Price R and Abrass IB (1993) 'The Seattle FICSIT/Moveit study: the effect of exercise on gait and balance in older adults' *Journal of the American Geriatrics Society* **41** 321-25.

Bull R (Ed) (1998) *Housing Options for Disabled People* London: Jessica Kingsley Publications.

Burman E and Parker I (Eds) (1993) *Discourse Analytic Research: Repertoires and Readings in Action* London: Routledge.

Bury M (1997) *Health and Illness in a Changing Society* London: Routledge.

Byers D and Parker M (1992) 'Early home rehabilitation for the patient with a hip fracture' *British Journal of Occupational Therapy* **55** 351-54.

Campbell AJ, Borrie MJ and Spears GF (1989) 'Risk factors for falls in a community-based prospective study of people 70 years and older' *Journal of Gerontology Medical Sciences* **44** M113-M117.

Campbell AJ, Borrie MJ, Spears GF, Jackson SL, Brown JS and Fitzgerald JL (1990) 'Circumstances and consequences of falls experienced by a community population 70 years and over during a prospective study' *Age and Ageing* **19** 136-41.

Campbell AJ, Reinken J, Allan BC and Martinez GS (1981) 'Falls in old age: a study of frequency and related clinical factors' *Age and Ageing* **10** 264-70.

Campbell AJ, Robertson MC, Gardner MM, Norton RN, Tilyard MW and Buchner DM (1997) 'Randomised controlled trial of a general practice programme of home based exercise to prevent falls in elderly women' *British Medical Journal* **315** 1065-9.

Carr J and Shepherd R (1998) *Neurological Rehabilitation Optimizing Motor Performance* Oxford: Butterworth-Heinemann.

Carter S (1995) 'Boundaries of danger and uncertainty: an analysis of the technological culture of risk assessment' in Gabe J (Ed) *Medicine, Health and Risk Sociological Approaches* Oxford: Blackwell Publishers.

Carter SE, Campbell EM, Sanson-Fisher RW, Redman S and Gillespie WJ (1997) 'Environmental hazards in the homes of older people' *Age and Ageing* **26** 195-202.

Charmaz K (1995) 'Grounded Theory' in Smith JA, Harré R and Van Langenhove L (Eds) *Rethinking Methods in Psychology* London: Sage Publications.

Cheek J and Gibson T (1996) 'The discursive construction of the role of the nurse in medication administration: an exploration of the literature' *Nursing Inquiry* **3** 83-90.

Clemson L, Cumming RG and Roland M (1996) 'Case-control study of hazards in the home and risk of falls and hip fractures' *Age and Ageing* **25** 97-101.

Clemson L, Fitzgerald MH and Heard R (1999) 'Content validity of an assessment tool to identify home fall hazards: the Westmead Home Safety Assessment' *British Journal of Occupational Therapy* **62** 171-9.

Clemson L, Roland M and Cumming R (1992) 'Occupational therapy assessment of potential hazards in the homes of elderly people: an interrater reliability study' *Australian Occupational Therapy Journal* **39** 23-6.

Clemson L, Roland M and Cumming RG (1997) 'Types of hazards in the homes of elderly people' *Occupational Therapy Journal of Research* **17** 200-13.

Close J, Ellis M, Hooper R, Glucksman E, Jackson S and Swift C (1999) 'Prevention of falls in the elderly trial (PROFET): a randomised controlled trial' *Lancet* **353** 93-7.

Coffey A and Atkinson D (1996) *Making Sense of Qualitative Data* London: Sage Publications.

Collin C, Wade DT, Davies S and Horne V (1988) 'The Barthel ADL Index: a reliability study' *International Disability Studies* **10** 61-3.

Collins HM and Pinch T (1982) *Frames of Meaning: the Social Construction of Extraordinary Science* London: Routledge.

Connell BR and Wolf SL (1997) 'Environmental and behavioural circumstances associated with falls at home among healthy elderly individuals' *Archives of Physical Medicine and Rehabilitation* **78** 179-86.

Corner L, Curless R, Parker S, Eccles M, Gregson B, Bond J and Oliver J (1998) 'Developing guidelines for day hospitals for older people: adaptation of national guidelines for local use' *Journal of Clinical Effectiveness* **3** 10-3.

Coupland J, Robinson JD and Coupland N (1994) 'Frame negotiation in doctor-elderly patient consultations' *Discourse and Society* **5** 89-124.

Craddock J (1995) 'Adopting a social model of disability' *British Journal of Occupational Therapy* **58** 487.

Creek J (1997) '... the truth is no longer out there' *British Journal of Occupational Therapy* **60** 50-2.

Cummings S, Nevitt M, Browner W, Stone K, Fox K, Ensrud K, Cauley J, Black D and Vogt T (1995) 'Risk factors for hip fractures in white women' *New England Journal of Medicine* **332** 767-73.

Cummings SR, Nevitt MC and Kidd S (1988) 'Forgetting falls The limited accuracy of recall of falls in the elderly' *Journal of the American Geriatrics Society* **36** 613-6.

Cwikel J and Fried AV (1992) 'The social epidemiology of falls among community dwelling elderly: guidelines for prevention' *Disability and Rehabilitation* **14** 113-21.

Cwikel JG, Fried AV, Biderman A and Galinsky D (1998) 'Validation of a fall-risk screening test, the Elderly Fall Screening Test (EFST) for community dwelling elderly' *Disability and Rehabilitation* **20** 161-7.

Cwikel J, Kaplan G and Barell V (1990) 'Falls and subjective health rating among the elderly: evidence from two Israeli samples' *Social Science and Medicine* **31** 485-90.

Davison C, Davey Smith G and Frankel S (1991) 'Lay epidemiology and the prevention paradox: the implications of coronary candidacy for health education' *Sociology of Health and Illness* **13** 1-19.

Department of Health (1992) *The Health of the Nation: a Strategy for Health in England* London: HMSO.

Department of Health (1994) *Research and Development in Occupational Therapy, Physiotherapy and Speech and Language Therapy: a Position Statement* Leeds: Department of Health.

Department of Health (1995) *Research and Development Towards an Evidence-Based Health Service* London: Department of Health.

Department of Health (1997) *Rehabilitation - A Guide* Leeds: Department of Health.

Department of Health (1999) *Saving Lives: Our Healthier Nation* London: HMSO.

Department of Trade and Industry (1998) *Home Accident Surveillance System: Twentieth Annual Report* London: Department of Trade and Industry.

Department of Trade and Industry and Health Education Authority (1999) *Avoiding Trips, Slips and Broken Hips* London: Department of Trade and Industry and Health Education Authority.

Doolittle ND (1991) 'Clinical ethnography of lacunar stroke: implications for acute care' *Journal of Neuroscience Nursing* **23** 235-40.

Douglas M (1986) *Risk Acceptability According to the Social Sciences* London: Routledge and Kegan Paul.

Downton JH (1993) *Falls in the Elderly* London: Edward Arnold.

Downton J (1998) 'Falls' in Tallis R, Fillit H and Brocklehurst JC (Eds) *Brocklehurst's Textbook of Geriatric Medicine and Gerontology (5th edition)* London: Churchill Livingstone.

Downton JH and Andrews K (1991) 'Prevalence, characteristics and factors associated with falls among the elderly living at home' *Aging* **3** 219-28.

Drew P (1995) 'Conversation Analysis' in Smith JA, Harré R and Van Langenhove L (Eds) *Rethinking Methods in Psychology* London: Sage Publications.

Edwards D (1994) 'Script formulations: a study of event descriptions in conversation' *Journal of Language and Social Psychology* **13** 211-47.

Edwards D (1997) *Discourse and Cognition* London: Sage Publications.

Edwards D, Ashmore M and Potter J (1995) 'Death and furniture: the rhetoric, politics and theology of bottom line arguments against relativism' *History of the Human Sciences* **8** 25-49.

Elderly Care Research Unit (1998) *Goal Negotiation in Three Models of Day Care: a Study of Relative Effectiveness and Cost Effectiveness Project Report* Southampton: Elderly Care Research Unit, University of Southampton.

El-Faizy M and Reinsch S (1994) 'Home safety intervention for the prevention of falls' *Physical and Occupational Therapy in Geriatrics* **12** 33-49.

Erasmus Fleming B and Pendergast DR (1993) 'Physical condition, activity pattern and environment as factors in falls by adult care facility residents' *Archives of Physical Medicine Rehabilitation* **74** 627-30.

Festinger L (1954) 'A theory of social comparison processes' *Human Relations* **7** 117-40.

Fetterman D (1989) *Ethnography Step by Step* California: Sage Publications.

Folstein MF, Folstein SE and McHugh PR (1975) 'Mini mental state: a practical method for grading the cognitive state of patients for the clinician' *Journal of Psychiatric Research* **12** 189-98.

Fox D and Prilleltensky I (Eds) (1997) *Critical Psychology An Introduction* London: Sage Publications.

Franzoni S, Rozzini R, Boffelli S, Frisoni GB and Trabucchi M (1994) 'Fear of falling in nursing home patients' *Gerontology* **40** 38-44.

Furstenberg A-L (1986) 'Expectations about outcome following hip fracture among older people' *Social Work in Health Care* **11** 33-47.

Furstenberg A-L (1988) 'Attributions of control by hip fracture patients' *Health and Social Work* **Winter** 43-8.

Gabe J (Ed) (1995) *Medicine, Health and Risk Sociological Approaches* Oxford: Blackwell Publishers.

Garfinkel H (1967) *Studies in Ethnomethodology* New Jersey: Prentice-Hall.

Gill R (1995) 'Relativism, reflexivity and politics: interrogating discourse analysis from a feminist perspective' in Wilkinson S and Kitzinger C (Eds) *Feminism and Discourse* London: Sage Publications.

Gill TM, Robison JT, Williams CS and Tinetti ME (1999) 'Mismatches between the home environment and physical capabilities among community living older persons' *Journal of the American Geriatrics Society* **47** 88-92.

Gillespie LD (1996) *Risk Factors for Falling in Community Dwelling Elderly: Quality of the Literature and Role of Muscle Strength* (thesis in preparation) for submission to the University of Newcastle, New South Wales, Australia in Nuffield Institute for Health and NHS Centre for Reviews and Dissemination (1996) 'Preventing falls and subsequent injury in older people' *Effective Health Care* **2** 1-16.

Gillespie LD, Gillespie WJ, Cumming R, Lamb SE and Rowe BH (1998) 'Interventions to reduce the incidence of falling in the elderly (Cochrane Review)' in *The Cochrane Library Issue 4* Oxford: Update Software.

Green J (1995) 'Accidents and the risk society Some problems with prevention' in Bunton R, Nettleton S and Burrows R (Eds) *The Sociology of Health Promotion* London: Routledge.

Green J (1997a) *Risk and Misfortune The Social Construction of Accidents* London: University College London Press.

Green J (1997b) 'Risk and the construction of social identity: children's talk about accidents' *Sociology of Health and Illness* **19** 457-79.

Greenwood R, Barnes MP, McMillan TM and Ward CD (1993) *Neurological Rehabilitation* Edinburgh: Churchill Livingstone.

Grimley Evans J (1988) 'Falls and fractures' *Age and Ageing* **17** 361-4.

Grisso JA, Schwarz DF, Wolfson V, Polansky M and LaPann K (1992) 'The impact of falls in an inner-city African-American population' *Journal of the American Geriatrics Society* **40** 673-78.

Gryfe CI, Amies A and Ashley MJ (1977) 'A longitudinal study of falls in an elderly population: 1. Incidence and morbidity' *Age and Ageing* **6** 201-210.

Guba EG and Lincoln YS (1982) 'Epistemological and methodological bases of naturalistic inquiry' *Educational Communication and Technology Journal* **30** 233-52.

Guba EG and Lincoln YS (1998) 'Competing paradigms in qualitative research' in Denzin NK and Lincoln YS (Eds) *The Landscape of Qualitative Research Theories and Issues* London: Sage Publications.

Hagedorn R (1992) *Occupational Therapy: Foundations for Practice* London: Churchill Livingstone.

Hagedorn R, McLafferty S and Russell D (1998) *Focus on Falls Project Manual One Falls: Screening and Risk Assessment for Older People in the Community* Worthing: Worthing Priority Care NHS Trust.

Hammersley M and Atkinson P (1995) *Ethnography: Principles in Practice (2nd edition)* London: Routledge.

Hart G (1999) 'Risk and health: challenges and opportunity' *Health, Risk and Society* **1** 7-10.

Hayes WC, Myers ER, Robinovitch SN, Van den Kroonenberg A, Courtney AC and MacMahon TA (1996) 'Etiology and prevention of age-related hip fractures' *Bone* **18** 1 supplement 77S-86S.

Heitmann DK, Gossman MR, Shaddeau SA and Jackson JR (1989) 'Balance performance and step width in noninstitutionalized, elderly, female fallers and nonfallers' *Physical Therapy* **69** 923-31.

Henwood KL and Pidgeon N (1992) 'Qualitative research and psychological theorizing' *British Journal of Psychology* **83** 97-111.

Hindmarsh JJ and Estes EH (1989) 'Falls in older persons Causes and interventions' *Archives of Internal Medicine* **149** 2217-22.

Hogg MA and Abrams D (1988) *Social Identifications A Social Psychology of Intergroup Relations and Group Processes* London: Routledge.

Hollingworth W, Todd CJ and Parker MJ (1995) 'The cost of treating hip fractures in the twenty-first century' *Journal of Public Health Medicine* **17** 269-76.

Hughes B and Paterson K (1997) 'The Social Model of Disability and the disappearing body: towards a sociology of impairment' *Disability and Society* **12** 325-40.

Hume C and Pullen I (Eds) (1994) *Rehabilitation for Mental Health Problems: an Introductory Handbook (2nd edition)* Edinburgh: Churchill Livingstone.

Josephson KR, Fabacher DA and Rubenstein LZ (1991) 'Home safety and fall prevention' *Clinics in Geriatric Medicine* **7** 707-31.

Kannus P, Parkkari J, Sievanen H, Heinonen A, Vuori I and Jarvinen M (1996) 'Epidemiology of hip fractures' *Bone* **18** 1 supplement 57S-63S.

Keilhofner G and Forsyth K (1997) 'The Model of Human Occupation: an overview of current concepts' *British Journal of Occupational Therapy* **60** 103-10.

Kellogg International Work Group on the Prevention of Falls by the Elderly (1987) 'The prevention of falls in later life' *Danish Medical Bulletin* **34** supplement 4 1-24.

Kisely S (1996) 'Broken hips - background' *Bandolier* **3** 3-4.

Kuhn TS (1970) *The Structure of Scientific Revolutions (2nd edition)* Chicago: University of Chicago Press.

Lach HW, Reed AT, Arfken CL, Miller JP, Paige GD, Birge SJ and Peck WA (1991) 'Falls in the elderly: reliability of a classification system' *Journal of the American Geriatrics Society* **39** 197-202.

Langlois J, Smith G, Baker S and Langley J (1995) 'International comparisons of injury mortality in the elderly: issues and differences between New Zealand and the United States' *International Journal of Epidemiology* **24** 136-43.

Lauritzen JB (1996) 'Hip fractures: incidence, risk factors, energy absorption and prevention' *Bone* **18** 1 supplement 65S-75S.

Lilley JM, Arie T and Chilvers CED (1995) 'Special review Accidents involving older people: a review of the literature' *Age and Ageing* **24** 346-65.

Lincoln YS and Guba GG (1985) *Naturalistic Inquiry* California: Sage Publications.

Lord S, Sambrook P, Gilbert C, Kelly P, Nguyen T, Webster I and Eisman J (1994) 'Postural stability, falls and fractures in the elderly: results from the Dubbo Osteoporosis Epidemiology Study' *The Medical Journal of Australia* **160** 684-91.

Lord SR, Ward JA, Williams P and Strudwick M (1995) 'The effect of a 12-month exercise trial on balance, strength and falls in older women: a randomised controlled trial' *Journal of the American Geriatrics Society* **43** 1198-206.

Lucht U (1971) 'A prospective study of accidental falls and resulting injuries in the home among elderly people' *Acta Socio-medica Scandinavia* **3** 105-120.

Lupton D (1993) 'Risk as moral danger: the social and political functions of risk discourse in public health' *International Journal of Health Sciences* **23** 425-435.

Lupton D (1994) *Medicine as Culture Illness, Disease and the Body in Western Societies* London: Sage Publications.

Lupton D (1999) *Risk* London: Routledge.

Luukinen H, Koski K, Kivela S-L and Laippala P (1996) 'Social status, life changes, housing conditions, health, functional abilities and life-style as risk factors for recurrent falls among the home-dwelling elderly' *Public Health* **110** 115-8.

McIntyre A (1999) 'Elderly fallers: a baseline audit of admissions to a day hospital for elderly people' *British Journal of Occupational Therapy* **62** 244-248.

McKee KJ (1998) 'The Body Drop: a framework for understanding recovery from falls in older people' *Generations Review* **8** 11-4.

McLean D and Lord S (1996) 'Falling in older people at home: transfer limitations and environmental risk factors' *Australian Occupational Therapy Journal* **43** 13-8.

McLellan DL (1997) 'Introduction to rehabilitation' in Wilson B and McLellan DL (Eds) *Rehabilitation Studies Handbook* Cambridge: Cambridge University Press.

Maclean N, Pound P, Morgan M and Rugg AG (1998) 'The "motivation" of stroke patients for rehabilitation: a qualitative study of stroke professionals' attitudes' *Proceedings of the 30th Annual Conference BSA Medical Sociology Group* York: Medical Sociology Group.

Martin M (1999) *The Construction of the Risks of Falling in Older People: Lay and Professional Perspectives Final Report* Edinburgh: Scottish Health Feedback.

Mason J (1994) 'Linking qualitative and quantitative data analysis' in Bryman A and Burgess RG (Eds) *Analyzing Qualitative Data* London: Routledge.

Mason J (1996) *Qualitative Researching* London: Sage Publications.

Meeds B and Pryor G (1990) 'Early home rehabilitation for the elderly patient with hip fracture' *Physiotherapy* **76** 75-7.

Meldrum D and Finn A (1993) 'An investigation of balance function in elderly subjects who have and have not fallen' *Physiotherapy* **79** 839-42.

Metcalfe A (1993) 'Living in a clinic: the power of public health promotions' *Anthropological Journal of Australia* **4** 31-44.

Meyer HE, Tverdal A and Falch JA (1993) 'Risk factors for hip fracture in middle-aged Norwegian women and men' *American Journal of Epidemiology* **137** 1203-11.

Miller J and Glassner B (1997) 'The "inside" and the "outside" Finding realities in interviews' in Silverman D (Ed) *Qualitative Research Theory, Method and Practice* London: Sage Publications.

Moser CA and Kalton G (1971) *Survey Methods in Social Investigation* Aldershot: Dartmouth Publishing Company Limited.

Murphy J and Issacs B (1982) 'The post-fall syndrome A study of 36 elderly patients' *Gerontology* **28** 265-270.

Myers AM, Powell LE, Maki BE, Holliday PJ, Brawley LR and Sherk W (1996) 'Psychological indicators of balance confidence: relationship to actual and perceived abilities' *Journal of Gerontology Medical Sciences* **51** M37-M43.

Myers AH, Young Y and Langlois JA (1996) 'Prevention of falls in the elderly' *Bone* **18** 1 supplement 87S-101S.

Nevitt MC (1991) 'Ascertainment and description of falls among older persons by self-report' in Weindruch R, Hadley EC and Ory M (Eds) *Reducing Falls and Frailty in Older Persons* New York: Charles C Thomas.

Nevitt MC, Cummings ST, Kidd S and Black D (1989) 'Risk factors for recurrent nonsyncopal falls A prospective study' *Journal of the American Medical Association* **261** 2663-8.

NHS Executive (1996) *Promoting clinical effectiveness: a framework for action in and through the NHS* Leeds: Department of Health.

Nikander P (1995) 'The turn to the text: the critical potential of discursive social psychology' *Nordiske Udkast* **2** 3-15.

Nolan M and Nolan J (1997) 'Rehabilitation: realizing the potential nursing contribution' *British Journal of Nursing* **6** 1176-80.

Norton R, Campbell AJ, Lee-Joe T, Robinson ER and Butler M (1997) 'Circumstances of falls resulting in hip fracture among older people' *Journal of the American Geriatrics Society* **45** 1108-12.

Nuffield Institute for Health and NHS Centre for Reviews and Dissemination (1996) 'Preventing falls and subsequent injury in older people' *Effective Health Care* **2** 1-16.

O'Brien K, Pickles B and Culham E (1999) 'Clinical measures of balance in community-dwelling elderly female fallers and non-fallers' *Physiotherapy Canada* **50** 212-17.

O'Connell DC and Kowal S (1995) 'Basic principles of transcription' in Smith JA, Harré R and Van Langenhove L (Eds) *Rethinking Methods in Psychology* London: Sage Publications.

Ogden J (1995) 'Changing the subject of health psychology' *Psychology and Health* **10** 257-65.

Oliver D, Britton M, Seed P, Martin FC and Hopper AH (1997) 'Development and evaluation of evidence based risk assessment tool (STRATIFY) to predict which elderly inpatients will fall: case-control and cohort studies' *British Medical Journal* **315** 1049-53.

Oliver M (1996) *Understanding Disability From Theory to Practice* Basingstoke: Macmillan.

Oppenheim AN (1992) *Questionnaire Design, Interviewing and Attitude Measurement* London: Pinter Publishers.

Ory MG, Schechtman KB, Miller JP, Hadley EC, Fiatarone MA, Province MA, Arfken CL, Morgan D, Weiss S, Kaplan M and the FICSIT group (1993) 'Frailty and injuries in later life: the FICSIT trials' *Journal of the American Geriatrics Society* **41** 283-96.

Parker I (1992) *Discourse Dynamics: Critical Analysis for Social and Individual Psychology* London: Routledge.

Parker I (1994) 'Discourse analysis' in Banister P, Burman E, Parker I, Taylor M and Tindall C *Qualitative Methods in Psychology: A Research Guide* Buckinghman: Open University Press.

Parker I (1997) 'Discursive psychology' in Fox D and Prilleltensky I (Eds) *Critical Psychology An Introduction* London: Sage Publications.

Parker I and Burman E (1993) 'Against discursive imperialism, empiricism and constructionism: thirty two problems with discourse analysis' in Burman E and Parker I (Eds) *Discourse Analytic Research: Repertoires and Readings in Action* London: Routledge.

Parker MJ, Tremlow TR and Pryor GA (1996) 'Environmental hazards and hip fractures' *Age and Ageing* **25** 322-5.

Parsons E and Atkinson P (1992) 'Lay constructions of genetic risk' *Sociology of Health and Illness* **14** 437-55.

Peräkylä A (1989) 'Appealing to the "experience" of the patient in the care of the dying' *Sociology of Health and Illness* **11** 117-34.

Perry BC (1982) 'Falls among the elderly: a review of the methods and conclusions of epidemiologic studies' *Journal of the American Geriatrics Society* **30** 367-71.

Petersen AR (1996) 'Risk and the regulated self: the discourse of health promotion as politics of uncertainty' *Australian and New Zealand Journal of Sociology* **32** 44-57.

Petersen A (1997) 'Risk, governance and the new public health' in Petersen A and Bunton R (Eds) *Foucault Health and Medicine* London: Routledge.

Petersen A and Bunton R (Eds) *Foucault Health and Medicine* London: Routledge.

Petersen A and Lupton D (1996) *The New Public Health Health and Self in the Age of Risk* London: Sage Publications.

Pfeiffer D (1998) 'The ICIDH and the need for its revision' *Disability and Society* **13** 503-23.

Piotrowski Brown A (1999) 'Reducing falls in elderly people: a review of exercise interventions' *Physiotherapy Theory and Practice* **15** 59-68.

Potter J (1996) *Representing Reality Discourse, Rhetoric and Social Construction* London: Sage Publications.

Potter J (1998a) 'Qualitative and discourse analysis' in Schooler N (Ed) *Comprehensive Clinical Psychology Vol. 3: Research Methods* Amsterdam: Elsevier Science.

Potter J (1998b) 'Fragments in the realization of relativism' in Parker I (Ed) *Social Constructionism, Discourse and Realism* London: Sage Publications.

Potter J and Wetherell M (1987) 'How to analyse discourse' *Discourse and Social Psychology - Beyond Attitudes and Behaviour* London: Sage Publications.

Potter J and Wetherell M (1994) 'Analyzing discourse' in Bryman A and Burgess RG (Eds) *Analyzing Qualitative Data* London: Routledge.

Potter J and Wetherell M (1995) 'Discourse analysis' in Smith JA, Harré R and Van Langenhove L (Eds) *Rethinking Methods in Psychology* London: Sage Publications.

Potter J, Wetherell M, Gill R and Edwards D (1990) 'Discourse: noun, verb or social practice?' *Philosophical Psychology* **3** 205-17.

Province M, Hadley E, Hornbrook M, Lipsitz L, Miller J, Mulrow C, Ory M, Sattin R, Tinetti M and Wolf S (1995) 'The effects of exercise on falls in elderly patients A preplanned meta-analysis of the FICSIT trials' *Journal of the American Medical Association* **273** 1341-7.

Prudham D and Grimley Evans J (1981) 'Factors associated with falls in the elderly: a community study' *Age and Ageing* **10** 141-6.

Reason P and Heron J (1995) 'Co-operative research' in Smith JA, Harré R and Van Langenhove L (Eds) *Rethinking Methods in Psychology* London: Sage Publications.

Reece AC and Simpson JM (1996) 'Preparing older people to cope after a fall' *Physiotherapy* **82** 227-35.

Richards L and Richards T (1994) 'From filing cabinet to computer' in Bryman A and Burgess RG (Eds) *Analyzing Qualitative Data* London: Routledge.

Roberts H, Smith S and Bryce C (1993) 'Prevention is better ...' *Sociology of Health and Illness* **15** 447-63.

Robinson J and Batstone G (1996) *Rehabilitation A Development Challenge* London: Kings Fund.

Robinson J and Turnock S (1998) *Investing in Rehabilitation* London: Kings Fund.

Royal College of Physicians (1989) *Fractured Neck of Femur: Prevention and Management* London: Royal College of Physicians.

Royal College of Physicians and British Geriatrics Society (1994) *Geriatric Day Hospitals Their Role and Guidelines for Good Practice* London: Royal College of Physicians.

Rubenstein LZ (1999) 'The importance of including the home environment in assessment of frail older persons' *Journal of the American Geriatrics Society* **47** 111-2.

Rubenstein LZ, Robbins AS, Josephson KR, Schulman BL and Osterweil D (1990) 'The value of assessing falls in an elderly population A randomised controlled trial' *Annals of Internal Medicine* **113** 308-16.

Sachs L (1996) 'Causality, responsibility and blame - core issues in the cultural construction and subtext of prevention' *Sociology of Health and Illness* **18** 632-52.

Schwartz C (Ed) (1992) *Chambers Maxi Paperback Dictionary* Edinburgh: W and R Chambers Ltd.

Scott S and Freeman R (1995) 'Prevention as a problem of modernity: the example of HIV and AIDs' in Gabe J (Ed) *Medicine, Health and Risk Sociological Approaches* Oxford: Blackwell Publishers.

Seidel J, Friese S and Leonard DC (1995) *The Ethnograph V4.0 Software Package* Massachusetts: Qualis Research Associates.

Seymour S (1999) 'Occupational therapy and health promotion: a focus on elderly people' *British Journal of Occupational Therapy* **62** 313-317.

Shakespeare T and Watson N (1997) 'Defending the Social Model' *Disability and Society* **12** 293-300.

Shumway-Cook A, Baldwin M, Polissar NL and Gruber W (1997) 'Predicting the probability for falls in community-dwelling older adults' *Physical Therapy* 77 812-19.

Simpson JM, Harrington R and March N (1998) 'Guidelines for managing falls among elderly people' *Physiotherapy* 84 173-77.

Simpson J and Mandelstam H (1995) 'Elderly people at risk of falling: do they want to be taught how to get up again?' *Clinical Rehabilitation* 9 65-9.

Simpson JM, Marsh N and Harrington R (1998) 'Guidelines for managing falls among older people' *British Journal of Occupational Therapy* 61 165-8.

Sims D, personal communication, 2.3.97.

Sinclair A and Dickinson E (1998) *Effective Practice in Rehabilitation The Evidence of Systematic Reviews* London: Kings Fund.

Skelton DA and McLaughlin AW (1996) 'Training functional ability in old age' *Physiotherapy* 82 159-67.

Skolbekken J-A (1995) 'The risk epidemic in medical journals' *Social Science and Medicine* 40 291-305.

Smith JA (1995) 'Semi-structured interviewing and qualitative analysis' in Smith JA. Harré R and Van Langenhove L (Eds) *Rethinking Methods in Psychology* London: Sage Publications.

Smith JA, Harré R and Van Langenhove L (Eds) (1995) *Rethinking Methods in Psychology* London: Sage Publications.

Squires AJ (Ed) *Rehabilitation of Older People A Handbook for the Multidisciplinary Team* Edinburgh: Chapman and Hall.

Stainton Rogers W (1996) 'Critical approaches to health psychology' *Journal of Health Psychology* 1 65-77.

Stephenson C, Wilson S and Gladman JRF (1995) 'Patient and carer satisfaction in geriatric day hospitals' *Disability and Rehabilitation* 17 252-5.

Tajfel H and Turner JC (1986) 'The social identity theory of intergroup behaviour' in Worchel S and Austin WG (Eds) *Psychology of Intergroup Relations* Chicago: Nelson Hall Publishers.

Tansey J and O'Riordan T (1999) 'Cultural theory and risk: a review' *Health, Risk and Society* 1 71-90.

Ten Have P (1995) 'Medical ethnomethodology - an overview' *Human Studies* 18 245-61.

Thibeault R and Hébert M (1997) 'A congruent model for health promotion in occupational therapy' *Occupational Therapy International* **4** 271-93.

Thom KM and Blair SEE (1998) 'Risk in dementia - assessment and management: a literature review' *British Journal of Occupational Therapy* **61** 441-7.

Thornquist E (1994) 'Profession and life: separate worlds' *Social Science and Medicine* **39** 701-13.

Tideiksaar R (1984) 'An assessment form for falls' *Journal of the American Geriatrics Society* **32** 538-9.

Tinetti M (1994) 'Prevention of falls and fall injuries in elderly persons: a research agenda' *Preventative Medicine* **23** 756-62.

Tinetti ME, Baker DE, McAvay G, Claus EB, Garrett PG, Gottschalk, M, Kock ML, Trainor K and Horwitz RI (1994) 'A multifactorial intervention to reduce the risk of falling among elderly people living in the community' *The New England Journal of Medicine* **331** 821-7.

Tinetti ME, McAvay G and Claus E (1996) 'Does multiple risk factor reduction explain the reduction in fall rate in the Yale FICSIT trial?' *American Journal of Epidemiology* **144** 389-99.

Tinetti ME, Mendes de Leon CF, Doucette JT and Baker DI (1994) 'Fear of falling and fall related efficacy in relationship to functioning among community living elders' *Journal of Gerontology Medical Sciences* **49** M140-M147.

Tinetti ME, Richman D and Powell L (1990) 'Falls efficacy as a measure of fear of falling' *Journal of Gerontology Psychological Sciences* **45** P239-P243.

Tinetti ME, Speechley M and Ginter SF (1988) 'Risk factors for falls among elderly persons living in the community' *The New England Journal of Medicine* **26** 1701-7.

Todd CJ, Freeman CJ, Camilleri-Ferrante C, Palmer CR, Hyder A, Laxton CE, Parker MJ, Payne BV and Rushton N (1995) 'Differences in mortality after fracture of hip: the East Anglia audit' *British Medical Journal* **310** 904-8.

VanSwearingen JM, Taschal KA, Bonino P and Yang J-F (1996) 'The Modified Gait Abnormality Rating Scale for recognising the risk of recurrent falls in community-dwelling elderly adults' *Physical Therapy* **76** 994-1001.

Vellas B, Cayla R, Bocquet H, de Pemille F and Albarede JL (1987) 'Prospective study of restriction of activity in old people after falls' *Age and Ageing* **16** 189-93.

Wade D (1992) *Measurement in Neurological Rehabilitation* Oxford: Oxford Medical Publications.

Walker JE and Howland J (1991) 'Fear and fear of falling among elderly persons living in the community: occupational therapy interventions' *The American Journal of Occupational Therapy* **45** 119-122.

Wallace RB, Ross JE, Huston JC, Kundel C and Woodworth G (1993) 'Iowa FICSIT trial: the feasibility of elderly wearing a hip protective garment to reduce hip fractures' *Journal of the American Geriatrics Society* **41** 338-40.

Ward CD and McIntosh S (1993) 'The rehabilitation process: a neurological perspective' in Greenwood R, Barnes MP, McMillan TM and Ward CD (Eds) *Neurological Rehabilitation* Edinburgh: Churchill Livingstone.

Weinburg LE and Strain LA (1995) 'Community-dwelling older adults' attributions about falls' *Archives of Physical Medicine and Rehabilitation* **76** 955-60.

Wetherell M (Ed) (1996) *Identities, Groups and Social Issues* London: Sage/Open University.

Wetherell M and Potter J (1992) *Mapping the Language of Racism Discourse and the Legitimation of Exploitation* New York: Harvester Wheatsheaf.

Whitney SL, Poole JL and Cass SP (1998) 'A review of balance instruments for older adults' *The American Journal of Occupational Therapy* **52** 666-71.

Wickham C, Cooper C, Margetts BM and Barker DJ (1989) 'Muscle strength, activity, housing and the risk of falls in elderly people' *Age and Ageing* **18** 47-51.

Widdicombe S and Wooffitt (1995) *The Language of Youth Subcultures* Hemel Hempstead: Harvester Wheatsheaf.

Wild D, Nayak US and Issacs B (1981) 'Description, classification and prevention of falls in old people at home' *Rheumatology and Rehabilitation* **20** 153-9.

Willig C (1997) 'Discourse and practice: how DA can inform sex education' Lecture on Discursive Practice Workshop, Bolton Institute, 17.4.97 (unpublished ms).

Willig C (1998) 'Social constructionism and revolutionary socialism: a contradiction in terms?' in Parker I (Ed) *Social Constructionism, Discourse and Realism* London: Sage Publications.

Wolf M (1992) *A Thrice Told Tale: Feminism, Postmodernism and Ethnographic Responsibility* California: Stanford University Press.

Wolf SL, Barnhart, HX, Kutner NG, McNeely E, Coogler C, Xu T and the Atlanta FICSIT group (1996) 'Reducing frailty and falls in older persons: an investigation of Tai Chi and computerized balance training' *Journal of the American Geriatrics Society* **44** 489-97.

Wolf SL, Kutner NG, Green RC and McNeely E (1993) 'The Atlanta FICSIT study: two exercise interventions to reduce frailty in elders' *Journal of the American Geriatrics Society* **41** 329-32.

Wright R (1998) 'Research pathways for occupational therapists: taking our own road' *British Journal of Occupational Therapy* **61** 418-22.

Yardley L (1997) *Material Discourses of Health and Illness* London: Routledge.

Yardley L (in press) 'Dilemmas in qualitative health research' *Psychology and Health.*

Young ME and Quinn E (1992) *Theories and Principles of Occupational Therapy* London: Churchill Livingstone.

Zeeli D and Issacs B (1998) 'The efficiency and effectiveness of geriatric day hospitals' *Postgraduate Medical Journal* **64** 683-6.

APPENDIX 1

Text used by Parker (1994) to illustrate mode and focus of analysis within Manchester School of discourse analysis.

Directions for use

Choose a children's brush that has a small head and add a pea-sized amount of Punch & Judy toothpaste. To teach your child to clean teeth, stand behind and place your hand under the child's chin to tilt head back and see mouth. Brush both sides of teeth as well as tops. Brush after breakfast and last thing at night. Supervise the brushing of your child's teeth until the age of eight. If your child is taking fluoride treatment, seek professional advice concerning daily intake.

Contains 0.8% Sodium Monofluorophosphate

APPENDIX 2

Dissemination of research

The following list provides details of opportunities I have taken to present my work in public:

Ballinger C and Payne S (1997) 'Falls and elderly people - can discourse analysis contribute to understanding?' College of Occupational Therapists 21st Annual Conference, 25-27 June, Southampton.

Ballinger C and Payne C (1997) 'Falls and falling; a preliminary study of accounts of therapists and elderly people' Proceedings of British Society of Gerontology Annual Conference, 19-21 September, Bristol (poster).

Ballinger C (1997) 'Elderly people and falling: can discourse analysis contribute to understanding?' Nottingham Stroke Research Unit, Lunchtime seminar series, 2 June, Nottingham.

Ballinger C and Payne S (1997) 'Falls and falling; accounts of therapists and elderly people with fractured hips' Proceedings of Health Care Development Group Annual Conference, 12 November, Southampton.

Ballinger C (1998) 'Falls and falling: accounts of occupational therapists, physiotherapists and older people with fractured hips' MSc in Psychology and Health, Middlesex University, Lunchtime Seminar Series, 20 January, Middlesex.

Ballinger C (1998) 'Falls and falling: accounts of occupational therapists, physiotherapists and older people with fractured hips' University Rehabilitation Research Unit, Lunchtime Seminar Series, 17 March, Southampton.

Ballinger C (1998) 'Researching risk in a day hospital' School of Health Professions and Rehabilitation Sciences, Internal Seminar Series 21 October, Southampton.

Ballinger C and Payne S (1999) 'An investigation of perceptions of risk in a day hospital' 23rd Annual Conference College of Occupational Therapists, 20-23 July, Liverpool.

APPENDIX 3

Interview schedule developed for service users in initial study investigating accounts about falls and falling.

1. Can you tell me about your fall?

2. Why do you think your fall happened?

3. What sort of effect do you think your fall might have on your life?

4. Had you ever thought this might happen?

5. Can you tell me about the different staff you've seen while in hospital?

6. Do you know anybody else who has fallen? Why did they fall?

7. If you had a friend in the same situation (they'd had a fall, broken their hip), what would you tell them about being in hospital?

APPENDIX 4

Interview schedule developed for therapists in initial study investigating accounts about falls and falling.

1. Can you tell me about your work with people who have fallen?

2. What sorts of people have falls? What kinds of problems do they have?

3. What effects do falls have on people's lives?

4. Why do you think falls happen?

5. Do you find that people talk about falling in different ways, for example, depending on the situation or who they are talking to?

6. Why do you think you have the views you do about falling?

7. What kinds of challenges or difficulties do you experience in your work with people who have fallen?

8. Are there other ways of looking at falls and falling?

APPENDIX 5

Two systems of transcribing conventions tested during the pilot phase of initial study, investigating accounts of falls and falling

EXAMPLE ONE (REDUCED TRANSCRIPTION SYSTEM)

Conventions:

- Initials to left indicates person speaking ('T' is 'therapist', 'R' is 'researcher')
- hyphens indicate when words have been broken off
- use of square brackets indicates overlapping speech
- 'best guess' of unclear speech indicated by use of brackets

T: in an abnormal way um are are more at risk of falling so the study is not about trying to understand y- necessarily wh- why the turning has happened because I think thats much more a- breaking down the pathology and the physiology of it
[but its
R: [Right
T: really trying to look i- i- in a functional behavioural sense (of) what a- u- the their strategies of movement um uh and are these people wh- a- risk of actually falling

EXAMPLE TWO (EXTENDED TRANSCRIPTION SYSTEM)

Conventions:

- Initials to left indicate person speaking ('R' is researcher)
- Extended sounds indicated by colons
- pauses indicated by number of seconds in brackets
- in breaths indicated by '.hh'
- hyphens indicate when words have been broken off

R: Ri::ght (0.2) its very sensitive sh- so it it it should be (0.1) OK now .hh right OK .hh just to start then um I wonder if you could tell me a little bit about somebody that you've worked with that has had a fall (0.2) um (0.10) just a little bit about them the sort of work that you did with them

Both methods deliberately avoided use of punctuation.

APPENDIX 6

Transcription conventions used in the two empirical studies described in this thesis.

- Initials to left denote person speaking: 'T' is 'therapist participant', 'P' is 'patient participant' and 'R' is 'researcher'. Initials representing other speakers are explained in the text.
- Dots or text within parentheses, eg (...), indicate unintelligible speech, or 'best guess' at unclear speech
- Use of square brackets ([) indicates overlapping speech (confined to first study only)
- Dash (-) indicates broken off word
- Use of dots eg '...', indicates that material has been omitted.

APPENDIX 7

Information about the ward profile, taken from documentation produced for the launch of the new orthopaedic trauma elderly care ward, the site of the initial empirical study.

'Ward X is a 22 bedded orthopaedic trauma ward ... Patients are admitted to the ward who have suffered traumatic events involving any structure of the musculoskeletal system, such as bony, mechanical or soft tissue injuries. Staff groups who compile (sic) the orthopaedic multidisciplinary team on the elderly care ward include:

- patients and their families, friends and carers
- nurses; ward X staff are led by two Ward Sisters and comprise nurses of varying grades of qualification and experience
- doctors; nine orthopaedic Consultants have access to beds on ward X; they each head a team of a Senior Registrar, Registrar and Senior House Officer. Ward X also has daily input from Dr Y, an Elderly Care Physician, who advises on specific medical issues
- clerical staff
- domestic staff
- physiotherapist
- occupational therapist
- dietician
- social worker
- pharmacist'

APPENDIX 8

Introductory letter and consent form for therapists in initial study

DATE

Dear *X*

I am writing to ask if you would be willing to be involved in my research project: 'Falls and falling; perspectives of elderly people with fractured hips, occupational therapists and physiotherapists'.

I am an occupational therapist, previously working as a Lecturer in Occupational Therapy at the School of OT and PT, University of Southampton. I am currently a full-time postgraduate student at University of Southampton, having been funded by South and West NHS Research and Development Directorate, to carry out a three year study into therapy and falls in elderly people.

During the first phase of my project, I would like to talk to OTs and PTs who potentially might work with elderly people who fall or who are at risk of falling (although this may not necessarily be the main focus of your work eg in learning difficulties). The interview would last approximately half an hour, would be scheduled at your convenience and includes a short questionnaire. I would like to tape record the interviews; however, if this is likely to be a problem, please do let me know.

Approval for the project has been granted by the local Research Ethics Committee and Therapy Managers have given me permission to carry out this study. All information will be treated as confidential, and you can withdraw from the study at any time.

If you require more information, please do contact me on (01283) 712 455. If you are interested in taking part in this project, please detach and complete the form below and return to me. Thank you for your interest.

Yours sincerely

Claire Ballinger
POSTGRADUATE STUDENT

---

*PLEASE DELETE AS APPROPRIATE

- I work with elderly people who fall or who are at risk of falling *often/sometimes/ occasionally/never
- I am willing to be interviewed about my views on falls and falling as part of the project 'Falls and falling; perspectives of elderly people with fractured hips, occupational therapists and physiotherapists' *YES/NO
- I am happy for you to tape record the interview *YES/NO

NAME:_____ DATE:_____ *OT/PT

CONTACT ADDRESS AND PHONE NO:

_____

_____

_____

PLEASE RETURN TO: CLAIRE BALLINGER, SCHOOL OF OT AND PT, UNIVERSITY OF SOUTHAMPTON, HIGHFIELD, SOUTHAMPTON, SO17 1BJ. ***THANKS VERY MUCH!!***

APPENDIX 9

Service user information sheet for initial study

FALLS PROJECT!

My name is Claire Ballinger, and I have been funded to carry out a three year project into therapy and falls in elderly people. I am hoping that my research will help improve therapy treatment to people who have fallen, or are at risk of falling.

For the first part of my project, I want to talk with some people who have been admitted to hospital with a fractured hip following a fall. These talks will probably last not more than half an hour, would be focused on your views of falls and falling and will include a short questionnaire.

I would like to tape record the discussion - however, if you do not want this to happen, please let me know. All information you give will be treated confidentially.

Please note the following:

- **you can refuse to take part without giving a reason - this will not affect your treatment or patient rights in any way**
- **you can withdraw from the study at any time without giving a reason**

If you want more information, please call me on (01283) 712 455, or write to me at: School of OT and PT, University of Southampton, Highfield, Southampton, SO17 1BJ

APPENDIX 10

Service user consent form for initial study

FALLS PROJECT: CONSENT FORM

Please read and complete the following questions.

Please cross out as necessary

1. Have you read the Patient Information Sheet ('Falls Project')? **YES / NO**

2. Have you had the chance to ask questions and discuss this study? **YES / NO**

3. Have you had satisfactory answers to all your questions? **YES / NO**

4. Have you received enough information about the study? **YES / NO**

Do you understand that you can decide that you no longer want to take part in the study:

- **at any time?** **YES / NO**
- **without having to give any reasons?** **YES / NO**
- **and without it affecting your future medical, nursing or therapy care or treatment?** **YES / NO**

Signed:..... Date:.....

(Name in block letters):.....

Signed (researcher):..... Date:.....

APPENDIX 11

Self administered questionnaire - service user participants (initial study)

Code:..... (researcher only)

FALLS PROJECT
SELF ADMINISTERED QUESTIONNAIRE - PATIENT

Please complete the following sheet by writing or circling the correct answers. All information will be treated confidentially.

1. What is your age? .....

2. What is your sex? Male/Female

3. Which ward are you currently staying on? .....

4. Before you came into hospital, what type of accommodation were you living in?

.....
.....
.....

5. Were you living on your own before coming into hospital? Yes/No

6. If no, who were you living with?: .....
.....

7. How many times have you fallen in total, including the fall which led to this hospital stay?:

once / twice / three times / more than three times

8. Is there anything else that you feel is important (eg in terms of your self, your experience, current events) that you feel might help me understand and interpret what you have said during the interview?:.....
.....
.....
.....
.....
.....(*please continue over the page if more space needed)*

MANY THANKS FOR TAKING THE TIME TO TALK WITH ME AND COMPLETE THIS QUESTIONNAIRE! PLEASE HAND THIS BACK TO ME BEFORE LEAVING!

APPENDIX 12

Therapist information sheet for initial study

FALLS PROJECT!!

My name is Claire Ballinger, and I am an OT funded by South and West NHS Research and Development Directorate to carry out a three year project into therapy and falls in elderly people.

For the first phase of my project, I want to talk with a variety of OTs and PTs who might work with elderly people who fall or who are at risk of falling (- this need not be the main bulk of your case load eg in learning disabilities). These interviews would last for around half an hour and would be focused on your views of falls and falling. A brief questionnaire will also be included.

I would like to tape record the interview - however, if you do not want this to happen, let me know.

Approval to carry out this study has been granted by the local Research Ethics Committee and OT and PT managers have agreed to my carrying out this project.

Please note that you are not under any obligation to take part in this study.

If you want more information, please call me on (01283) 712 455, or write to me at: School of OT and PT, University of Southampton, Highfield, Southampton, SO17 1BJ.

THANKS IN ANTICIPATION OF YOUR HELP!!

APPENDIX 13

Self administered questionnaire - therapist participants (initial study)

Code:..... (researcher only)

FALLS PROJECT
SELF ADMINISTERED QUESTIONNAIRE - THERAPIST

Please complete the following sheet by writing or circling the correct answers. All information will be treated confidentially.

1. What is your age? .....
2. What is your sex? Male/Female
3. Are you an occupational therapist or a physiotherapist? OT/PT
4. Please state the year in which you qualified as an OT or PT .....
5. Please list your professional qualifications, and any academic qualifications gained since leaving school (it would be helpful if you could write them out in full):.....
   .....
6. Please describe your current job, including grade, client/patient group with whom you work, name of specialty, location, how long you have been working in this area plus anything else that you feel is important:
   .....
   .....
   .....
   .....
7. Briefly describe your last three therapy jobs, using the table as a guide:

	From (year)	To (year)	Specialty	Grade
Last job				
Previous job				
Job before that				

8. Is there anything else that you feel is important (eg in terms of your self, your experience (clinical and/or personal), current events) that you feel might help me understand and interpret what you have said during the interview?:.....
   .....
   .....
   .....
   .....
   .....
   .....
   .....(*please continue over the page if more space needed)*

MANY THANKS FOR TAKING THE TIME TO TALK WITH ME AND COMPLETE THIS QUESTIONNAIRE! PLEASE HAND THIS BACK TO ME BEFORE LEAVING!

APPENDIX 14

Codes and definitions developed for coding of data from therapist interviews in initial study.

'Being done to': service users described in passive terms, or activities involving service users undertaken without reference to them.

'Controllable (or not)': description of fall as event which is potentially preventable, or not preventable.

'Environmental': reference to environment and surroundings, such as home, or specific objects within environment, such as stairs or rugs.

'Therapists as expert': inference of therapists as experts by virtue of their knowledge, skills, techniques etc.

'Patient voice': representation of service user views, desires or expectations.

'Moral': involving judgement, for example of character or conduct, or using terminology which suggests that such a judgement is implied.

Later in the analysis, these initial six codes were included under the theme 'Risk'.

'Fall as signifier': implication of fall as indicative of other problems or resulting in wider difficulties.

'Humanistic': use of terms or concepts suggestive of humanistic psychology or holistic approach to treatment, for example in terms of lifestyle, respecting individual's right to choose.

'Personal stories': including personal details, for example of therapists' families or relatives, or incidents related from a primarily personal perspective.

'Truth': invocation of truth or reality, for example in terms of patient accounts, or cause of fall.

APPENDIX 15

Codes and definitions developed for coding of data from service user interviews in initial study.

'Staff evaluation': evaluation or judgement of staff in either positive or negative terms

'Blame for fall': reason(s) why fall occurred

'Proving OK/deserving': information illustrating that service user is not impaired either mentally or physically, or information suggesting that they are deserving of praise, admiration etc.

'Overcoming weakness': illustration of service user overcoming weakness, temptation, illness etc.

Later in the analysis, these initial four codes were included under the theme 'Moral'.

'Metaphor': use of metaphor, in particular relating to feet, walking and falling.

'Stories': inclusion of personal details, for example about families, or perspective, for example, detail in recounting experience of fall which emphasises personal view of event.

APPENDIX 16

The International Classification of Impairments, Disabilities and Handicaps (Wood 1980 cited in Pfeiffer 1998).

Handicap: 'A disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual' (Wood 1980:183)

Disability: 'Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being' (Wood 1980: 143)

Impairment: 'Any loss or abnormality of psychological, physiological, or anatomical structure or function' (Wood 1980: 47).

APPENDIX 17

Information sheet for second study

REF. 318/97

RISK PROJECT

My name is Claire Ballinger, I am a student at the University of Southampton and I have been funded to carry out a three year project into therapy and falls in older people.

The purpose of this study is to understand how both people attending a day hospital and the staff working there talk about risk, particularly relating to falls and falling in older people. I am hoping that one of the outcomes of this study will be improved services for older people who are likely to fall.

This study will involve observation over twelve weeks. During this time I will be coming to the day hospital (although not every day) in order to learn as much about what usually happens as I can. I will also be hoping to talk to both staff and patients individually, and will need your permission to do so. I would like to tape record these talks with your agreement. I hope to start this study in January 1998. The audio tapes of the interviews will be kept in a locked cupboard when not in use, and will be deleted on successful completion of the study of which this project is a part.

You are free to decide that you do not want to take part or to talk to me without explaining why, and also to change your mind about taking part at any time. This will not affect your treatment/work rights in any way. Your identity will be concealed in records of any information you give to me.

Approval to carry out this study has been given by the local Research Ethics Committee.

If you would like more information or have any questions, please contact Claire Ballinger, School of OT and PT, University of Southampton, Highfield, Southampton, SO17 1BJ Tel. (01703) 595260 (work switchboard) or (01283) 712455 (home 24hrs).

Thanking you for your time and help!

APPENDIX 18

Interview schedule developed for service users in second study

1. Can you tell me about how you came to attend the day hospital?
2. What sort of things do you do at the day hospital?
3. What is different about being in the day hospital to being at home, or doing what you usually do?
4. Are there things that worry or concern you about growing older?
5. If so, what do you think can be done about these concerns?
6. Does the day hospital help you deal with these concerns?
7. I'm particularly interested in falling amongst older people - have you had a fall, or know anyone at the day hospital who has?
8. What sort of things happen to people who've had a fall when they go to the day hospital?
9. How much longer are you going to come to the day hospital?

MANY THANKS FOR YOUR TIME AND HELP!

APPENDIX 19

Service user information recorded for second study.

1. Venue for interview:.....
2. Date and time:.....
3. Code:.....
4. Date of birth:.....
5. Gender:.....
6. How long have you been coming to the day hospital?.....

APPENDIX 20

Service user consent form - second study
REF. 318/97

RISK PROJECT

Please read and complete the following questions: **Please cross out as necessary**

1. Have you read the Patient and Staff Information Sheet ('Risk Project') **YES / NO**

2. Have you had the chance to ask questions and discuss this study? **YES / NO**

3. Have you had satisfactory answers to all your questions? **YES / NO**

4. Have you received enough information about the study? **YES / NO**

5. Do you understand that you can decide that you no longer want to take part in the study at any time, without having to give any reasons and without it affecting your future treatment/work rights? **YES / NO**

Signed:..... Date:.....

Name in block letters:.....

Signed (researcher):..... Date:.....

APPENDIX 21

Example of manual marking of observational data from second study in preparation for entering and coding in 'Ethnograph'.

dhvis:4

date:29.1.98

day:Thursday

time in:11.45 a/m

time out:2.00 p/m

diagram attached?:

Wanted to see how people went to sit down at lunch time particularly today. As I went into the day room, I recognised several people, to my relief, including G1, who was sat in a different position to Tuesday. I sat beside her and chatted to her. She joked about my newpaper being la-di-da (the Independent). Later it appeared that she had damaged her knee. J came to have a look at it and asked G1 to walk, although it appeared painful. She went to sit back down again, with Z's help. He said something like 'I had to make you walk so I could see'. He caught me eye once or twice, and I had the impression that possibly some of this was for my benefit? He was working in the room marked 'Medical Officer' and for the first time today I was the engaged sign removed. Z and U came to see G1 to discuss her knee further. At lunchtime, she ate in the day room, and there was joking about her elevated status in being able to do this.

I also spoke with E1 who remembered what I was doing. She felt that people fell because they got older, and said that I wouldn't have experienced that.

A1 called 'How are you, Claire?' and I went over to talk to him. The side of the room seems to be where the men sit. He talked to me about the fact that he was feeling down, and wanted to improve. I recognised H1 and possibly M1 and met N1 for the first time. H1 told me again about his falls - and how it had been impossible to save himself when falling backwards. N1 was telling H1 how he had been in hospital for seven days. He said that he wanted to walk again, and that if someone could chop his legs off at the knee (and replace them?) he would be able to walk.

During this conversation, I met B who said that she only comes on Thursday mornings. I think she had a red t-shirt on, possibly with words embroidered on, rather than a tabard. She spent a lot of time with the patients, and checked with A1 particularly to see that he had access to a newspaper. When talking about her work, she said something like 'As long as everyone's cheerful, we're alright'.

APPENDIX 22

Initial coding schedule with parameters developed for coding of observational data in 'Ethnograph' in second study.

'space': reference to part of the day hospital in relation to who uses it, who has authority in it, what kind of things go on in it. Concerned with rooms, but also smaller spaces, and objects within spaces.

'fallclinic': any reference to the Fallers clinic (not including data recorded whilst observing Fallers clinic, which have discreet filenames)

'evaluating': includes assessment (eg formal procedures, standardised tests) and statements indicating judgement of more infomal kind

'risk': occasions or activities which are very overtly concerned with risk eg someone mentions risk, or behaves in a way which indicates they are aware of it, or I am very conscious of it as an issue

'passive': concerned with service users being treated or spoken about without regard to personal views or choice. Also includes examples where this is resisted by service users.

'practices': procedures carried out by health staff, usually with co-operation of service users, to do with the business and running of the day hospital

'accounting': examples of staff or service users justifying or explaining themselves or their actions to me, or to each other

'me': any reference to consciously noted personal thoughts, reflections and actions

'individual': characteristics of service users which cause them to appear distinct and memorable

'collective': reference to speech, routines or activities in which service users are treated as one body, without regard to personal preferences

'age': any explicit reference to age or about being old, or to youth, as opposed to being old

APPENDIX 23

Modified coding schedule with parameters developed for coding of observational data in 'Ethnograph' in second study.

1) 'evaluating' subdivided into 'evaluating' and 'assessing'

where

'evaluating': subjective judgements about people realised in speech

'assessing': procedures and tests carried out during course of treatment at day hospital for purposes of measurement

2) 'practices' subdivided into 'pracpers', 'pracadl', 'pracrout', 'pracmove', 'pracname' and 'praccost'

where

'pracpers': practices relating to individual people

'pracadl': practices relating to activities of daily living

'pracrout': practices relating to routine

'pracmove': practices relating to moving around

'pracname': practices relating to names and naming

'praccost': practices relating to cost and saving.

Other codes from appendix 22 (ie 'space', 'fallclinic', 'risk', 'passive', 'accounting', 'me', 'individual', 'collective' and 'age') all remained the same.

APPENDIX 24

Example of observational data entered and coded in 'Ethnograph' from second study.

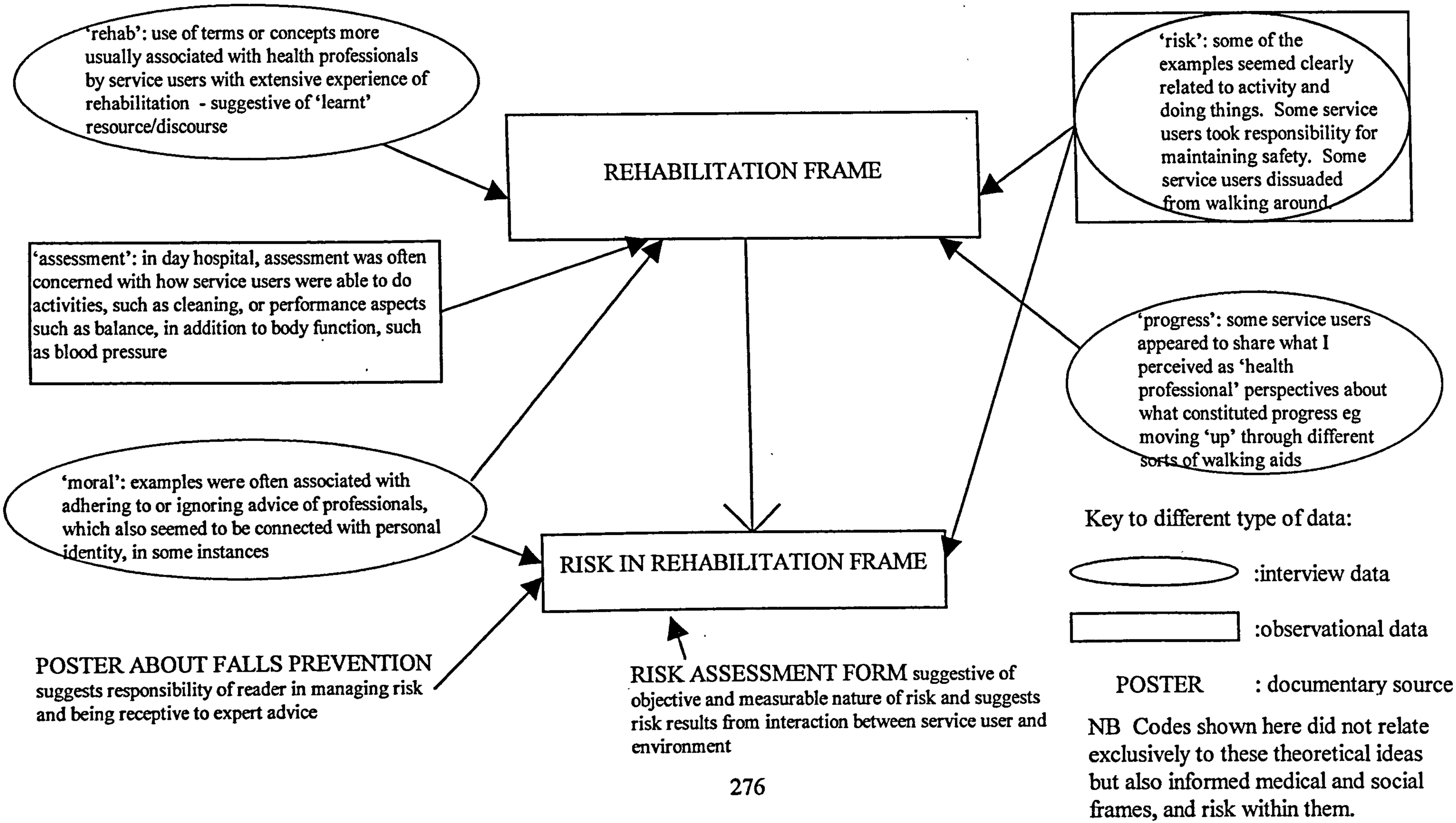
```
Coded Version of DHVIS3   2/12/1999  08:11   Page
-------------------------------------------------------------------------------
     dhvis:3                                                    1
     date:28.1.98                                               3
     day:Wednesday                                              5
     time in:11.45 a/m                                          7
     time out:2.40 p/m                                          9
     diagram attached?:yes                                     11
     Hadn't anticipated going at                               13
       lunchtime, but A was not around for                     14
#-COLLECTIVE
       the run that we'd agreed, so at                         15  -#
       last minute decided to go for lunch                     16   |
       rather than during the afternoon,                       17   |
       as I had wanted to see people                           18   |
       moving around.  Just before I                           19  -#
       arrived, I remembered that patients                     20
       don't come to the day hospital on a                     21
#-SPACE
       Wednesday.  Went into the building,                     22  -#
       and saw most people sat in the                          23   |
       dining room at a meeting.  I didn't                     24   |
       feel I could join them - where I                        25   |
       feel 'allowed' to go at the moment                      26   |
       is difficult, particularly without                      27   |
       asking beforehand.                                      28  -#

#-SPACE       $-ME
     I didn't want to sit alone in the                         30  -#-$
       dayroom where I would be clearly                        31   | |
       visible, looking uncomfortable and                      32   | |
       with nothing to do, so decided to                       33   | |
       sit in the corridor.  Felt                              34  -# |
       extremely uncomfortable.  Walked                        35    -$
```

APPENDIX 25

Coding schedule with parameters developed for coding of interview data in 'Ethnograph' in second study.

'rehab':	passages which illustrate particular perspective of rehabilitation, (subsequently described as the 'rehabilitation frame') including use of particular vocabulary associated with rehabilitation professionals
'progress':	passages indicating progress or recovery in terms of service user's impairment or disability. Also includes passages indicating lack of progress.
'time':	any reference to time passing (for example, quickly or slowly) whilst at the day hospital
'food':	any reference to food or drink consumed whilst at the day hospital
'risk':	passages illustrating an overt awareness of risk, or safety.
'moral':	passages in which moral judgement is inferred, or people are represented in such a way that a moral judgement from me as listener is expected
'care':	reference to actions or talk illustrative of caring attention or disposition

APPENDIX 26 **Figure illustrating how coding scheme informed development of theory relating to the rehabilitation frame and risk within this frame in the second study.**



APPENDIX 27

Service aim, client group and personnel of day hospital for older people, site of the second study.

Service aim

The aim of the service as stated in section 1 of the Service Profile and Operational Policy of the day hospital was 'To promote independent living and good health'.

This is further clarified in section 2.2 ('Service Provision') which states that the 'purpose of the Day Hospital is to complement the inpatient and outpatient services for the elderly by:

a) providing an individualised and coordinated multiprofessional approach to rehabilitation of the older adult with physical disabilities not requiring an in-patient stay in hospital
b) providing patients with prompt assessment and/or treatment which may reduce admissions to in-patient care or support earlier discharge from hospital
c) advising patients and/or referring them to appropriate statutory and voluntary services available to older adults'.

Client group and referral system

The following is taken from the Service Profile and Operational Policy:

'Appropriate referrals will be accepted if patients:

a) require - Medical assessment, diagnostic or therapeutic intervention
Therapy assessment and/or treatment
Rehabilitative nursing assessment and/or treatment
b) are over the age of 65 years and live within the area of (the City and seven other specified surrounding areas).

The service is **not** appropriate for

a) older persons whose principal problem is a behavioural one associated with severe mental illness

b) older persons requiring only a bathing service'

The policy states that patients may be referred to the day hospital after admission to hospital by the multidisciplinary team, following a domiciliary visit or out patient attendance, or by a member of the primary health care team or community staff, in consultation with the patient's General Practitioner.

Personnel

Information requested by me from the administrator detailing the staffing compliment included the following, described in the Service Profile and Operational Policy as the 'clinical team':

Medical consultant (1)
Clinical assistant (2)
Sister (also the Manager) (1)
Staff Nurse (3)
Nursing auxiliary (1)
Occupational Therapist (1)
Occupational Therapy helper (1)
Physiotherapist (2)
Physiotherapy helper (1)
Speech and Language Therapist (1)

The team also has access to: Dietetics, Social Work, Orthotics, Patient Counselling, and an Audiology out patient clinic is held every week. Under 'Support facilities', the policy lists the ambulance service, hospital chaplains, volunteers, activities coordinator and hairdresser. Additional staff, not mentioned in the 'Resources' section of the Service Profile and Operational Policy include an administrator, two housekeepers and a secretary.

APPENDIX 28

Report for Manager of day hospital for older people, based on data generated for second study.

1. INTRODUCTION

This report is derived from data generated through semi-structured interviews with fifteen participants attending X Day Hospital. The interviews were carried out between 24 March and 9 April 1998.

The participants were interviewed in connection with a study exploring perceptions of risk with a day hospital. The exploration of patient views about the day hospital was not the main purpose of this study, and have therefore been determined through secondary analysis of the data, at the request of the day hospital Manager.

The participants comprised ten men and five women, aged between 66 and 89 years, with a mean age of 77 years. Participants were given a choice regarding where they wanted to be interviewed; four opted to be interviewed at the day hospital, and eleven at home. Of those interviewed at home, six had relatives present, and three were in residential accommodation of some type.

All participants received written information about the study, and were given the opportunity to consider whether they wanted to participate, and ask questions before being interviewed. The interviews were audio tape recorded and transcribed, and a thematic analysis carried out for the purposes of this report.

The findings are presented under three headings:
1. reasons why participants thought they were attending the day hospital
2. aspects of the day hospital which participants liked or found useful
3. aspects of the day hospital which participants did not like

In reporting numbers under each of these three headings, many participants identified several points.

2. REASONS WHY PARTICIPANTS THOUGHT THEY WERE ATTENDING THE DAY HOSPITAL

The great majority of the interview participants identified that they were coming to the day hospital for therapy, or physiotherapy, in order to improve their walking. Some people identified specific aspects of mobility that they were receiving help for, such as balance, exercises to strengthen muscles in the leg, and to get the hip working.

The opportunity to meet people was mentioned by two participants. Other reasons that people gave included being assessed to see if they could manage on their own, respite for carer, speech therapy, therapy for hands and to assess reasons for falls.

3. ASPECTS OF THE DAY HOSPITAL WHICH PARTICIPANTS LIKED OR FOUND USEFUL

Most people mentioned that they found the staff caring and attentive. Participants seemed to appreciate the fact that they were able to joke and have fun with the staff, and several people particularly liked the way that they were recognised and treated as individuals. The ambulance drivers were specifically mentioned, and participants also appreciated the lunches.

Just over half of the interview participants said that they either enjoyed their exercises, or were now able to walk 'properly', which included walking downstairs. Several people specifically found the encouragement provided whilst exercising useful, contrasting this with the difficulties they had carrying out their exercises at home.

Slightly fewer than half of the interviewees also appreciated the opportunity to meet people, and enjoyed 'a day out'. A couple of people mentioned that they felt their confidence had improved since attending the day hospital.

The following aspects were identified by individual participants:

- providing opportunity for carer to relax
- being provided with specific ideas to work on at home
- improving hand function
- receiving correct diagnosis
- receiving equipment to help in everyday activities

4. ASPECTS OF THE DAY HOSPITAL WHICH PARTICIPANTS DID NOT LIKE

A variety of different issues were identified under this heading. The most frequently discussed aspects which people did not like were the hours spent sitting doing very little, and the fact that people felt they were either not making any progress, or their condition was getting worse (mentioned by four people each).

Two participants were unhappy about having to get up so early to be ready for the transport, and the long wait between getting up and being collected. Food in the day hospital was included in this category by two people.

The following dislikes were mentioned by individual participants:

- lack of conversation
- lack of improvement in confidence
- insufficient therapists
- no books or newspapers
- having to hand tablets in
- felt cold
- not provided with targets or goals for treatment

One person mentioned several times during the course of the interview that she was disappointed that she had to stop coming to the day hospital.