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# Resisting the 'mask' of old age?: the social meaning of lay health beliefs in later life

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***ABSTRACT***
While the substantial literature on lay health beliefs gives some consideration to older people's conceptions of health and illness, it is material which has yet to be examined from the perspective of postmodern theory. This article, therefore, critically examines the value of using ideas from postmodernism in such a context and focuses on data obtained from a series of in-depth interviews with a sample of fifteen older people. During the interviews they were asked to talk about themselves in relation to issues which included health, illness, disease, death and dying. What they said revealed that, while medicine remained a location of power and knowledge, many of their health beliefs were nonetheless at odds with conventional medicine and indeed with the traditionally passive role of the NHS patient. In conclusion, we suggest that, whilst not always in an explicit or conscious sense, interviewees were discovering self-empowering strategies by questioning the meta-narratives through which the social world is fabricated.

***KEY WORDS*** **–** postmodernism, health, illness, medicine, empowerment.

## Introduction

The burgeoning literature on lay health beliefs suggests points of both conflict and synergy between medical and lay health knowledge (Calnan 1987; Currer and Stacey 1986; Helman 1986, 1990). However, that which focuses on older adults often centres around rather narrow conceptions of health, despite the fact that older people are a social category for whom bodily change, in a broad sense, represents a key focus for attention and activity (MacDonald with Rich 1984). As Sidell (1995) points out, later life and health are more likely to come together either in the literature which concerns itself with

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what is often seen as the plight of sick elderly individuals from a 'humanitarian perspective' or in the policy-oriented literature which represents older people as a burden for health and welfare services. Both of these literatures neglect older people's health beliefs. Consequently, the meaning and experience of 'health', 'illness' and 'health care' is assumed to have an unproblematically universal, often medicalised, nature.

It is this deficit which the article addresses via research oriented specifically towards the lay health beliefs of older adults. In this respect we echo the focus on health which is beginning to be more fully addressed by other writers within their analysis of people's strategies of survival in later life (Bury and Holme 1990; Kaufman 1986). In particular, Cornwell's research in the East End of London depicted intriguing and complicated patterns of links between individual biography and health beliefs (1984). In focusing particularly on the relationship between medical and lay health knowledge, our data show that, as in the case of their younger counterparts, older interviewees' beliefs and practices are sometimes in conflict with a medical approach. However, within the context of old age as a social category, such conflicts carry particular implications in relation to questions of power and resistance. To make sense of them it is important to examine the relationship between 'health' and 'old age' itself. Sidell identifies a 'medical myth' which makes ageing synonymous with disease. This myth draws upon the implicit ambiguity of the term 'old age' which refers to both a stigmatised bodily condition and a temporal period within the life course. Unlike childhood, adolescence and mid-life, old age is the one period of the life course which is both the cause as well as the time of ill health. As a result, throughout the period of old age, individuals with health problems are less likely to have specific causes attributed to their illnesses; and more likely to be told that such conditions are 'due to your age'. What we are arguing here, then, is that if 'ill health' and 'old age' tend to be seen as synonymous, we may need to recognise older people's health beliefs and practices as representations of something more far-reaching than just a bout of flu or an attack of rheumatism. For 'health' and 'illness' we should perhaps read 'age', 'time of life' and 'embodiment' when these terms manifest themselves within accounts of the kind presented in this article.

If older people's beliefs and practices are at odds with the ways in which medicine frames health in later life, we can therefore ask if they constitute a form of resistance not just to discriminatory medical frameworks, but also to the wider set of ageist beliefs and practices through which the category 'old age' has been constructed (Bytheway 1995). Thus, 'illness' stands as a cultural icon for the all-encompassing conditions of old age itself. This may help explain the paradox that while older people experience higher levels of morbidity than people in mid-life, particularly if they are women, research consistently demonstrates that they perceive themselves to be in good health (Sidell 1995). One explanation posited is that such individuals are drawing upon an alternative notion of health, perhaps one which is more holistic or psychological in nature. However, in this article, we suggest that when older people lay claim to 'good health' during a research interview, they may also be engaging in an act of resistance to a stigmatising social identity. Thus, if ageing and disease are made synonymous, denial of the evidence of disease also represents a refusal of old age itself. In the data which follow 'health' and 'illness' appear to constitute an apparently uncontentious focus within talk between older adults and a younger researcher. Once unpacked, however, we discover them to be concepts which not only encompass interviewees' broader strategies of self-empowerment and experiences of powerlessness, but also provide a key site within which their agency is mobilised.

The question of how such material should be understood is not entirely resolved in the limited though valuable work which exists in this area (Williams 1983, 1990). For example, a possible synergy between lay health beliefs and the general growth this century in the questioning of traditional sources of authority or 'meta-narratives' such as bio-medicine, have not become a focus up until now (Lyotard 1984). While a Parsonian model of the 'sick role' usefully takes account of the interaction and indeed bargaining which goes on between patient and doctor, it assumes, ultimately, the compliance of the patient with the authority of the doctor (Parsons 1951). Similarly, Zola (1972) highlights the place of negotiation within the medical encounter, but gives insufficient attention to resistance to medical power. Indeed, if anything, existing work on lay health beliefs in later life has flown in the face of postmodern thinking, in emphasising the way meta-narratives such as the Weberian 'Protestant ethic' can shape, or even constitute, the perceptions of older people themselves (Williams 1983). Furthermore, no analysis has as yet been placed within the political context of the so called 'grey power' or agency of older people. Thus, the twin aims of the paper are to ask first whether the interview material represents a questioning of the authority of meta-narratives such as bio-medicine, and secondly whether interviewees' accounts constitute aspects of broader strategies of self-empowerment or forms of agency within an ageist society.

Alongside indications of resistance, the data also show evidence of subordination to the powerful discourses of medical and indeed religious 'experts'. There appears, therefore, to be a complex power relationship between the authority of meta-narratives and the way in which individuals make sense of them in their everyday worlds. This article investigates, in particular, the workings of power in the empirical area of older people's accounts of health and illness. In theoretical terms, both the tension between resistance and acceptance and the sheer heterogeneity of lay knowledge, make it difficult to understand this material using traditional structuralist sociology such as that deriving from Durkheim, Marx or Parsons. Rather we draw on ideas from postmodernism in an effort to distance the analysis from 'non-reflexive folk systems' which 'explain' the world – whether they be science, magic, religion, traditional politics or structuralist sociology (Fox 1993). We seek to 'understand' in a way which is open to further development and interpretation, rather than 'explain' in a way which implies any finality of problematisation and theorisation. Grounded in the challenges posed by social anthropology and interpretive sociology to the influence of objectivism, the reflexive character of postmodernism is used here to make sense of heterogeneity, diversity, difference and the de-centring of the subject; that is, the rejection of the idea that individuals contain essential human characteristics. We therefore follow what Fox describes as

> refusing to accept a human subject as interior, an 'essence' of a human, and replacing this idea of subjectivity with one fabricated by knowledge, expertise and power, including the professional knowledge of medicine (Fox 1993:v).

In this way, the article explores the value of ideas from postmodernism in making sense of the research data. In particular it draws upon the notion of intertextuality, which we would describe as the process of fabricating a social reality through the juxtaposition and interplay of diverse genres for understanding.

## Data and method

The research presented in this paper builds upon a questionnaire survey of health care need which was commissioned by a local District Health Authority. The DHA project took place on a working-class council estate. One hundred and twelve households were surveyed and 50 per cent of these contained members aged 65 years and above.

Those findings which related to perceptions of health and health care need provided a heterogeneous pattern of responses that was framed more in terms of health need than health care need. For example, most people answered 'don't know' to questions about the provision of health services. Self-assessments of health were largely contradictory and diverse. The meaning of this pattern could not be expressed through the quantitative methods required by the DHA. It could therefore be argued that the DHA project was framed more in terms of the requirements of health care providers, and less in terms of the needs of potential users. While the project produced a wealth of fascinating data, its methodological limitations made it impossible to work with this material.

Building upon this data, the study reported here gathered additional material using qualitative methods and a more sensitised approach, one which sought to locate health beliefs within the biographical contexts of the people being interviewed. This further stage of field research involved biographical interviews and a group discussion which in total involved 15 retired people aged between 50 and 81 years, 13 of whom were over 65 years. This was carried out over a period of ten months. In broad terms, eleven people could be described as working class (seven women and four men) and four as middle class (all women).

The group discussion took place in an Age Concern Centre in Hull. It involved nine people plus a younger researcher and lasted for one hour. Talk centred around the themes of ageing, illness and death. It was stimulated by open-ended questions from the researcher such as 'what's it like to be retired?', 'do you feel the same or different now compared to when you were younger?', 'hands up those who would say they are healthy!' and 'hands up those who would say they are not healthy!', 'why do you say that?', 'what does being ill mean to you?', 'why do you say that?'. Where necessary, prompts were used. These were derived from the general literature on health beliefs – particularly Stainton-Rogers' Q Set (1991) and Williams' study of older Aberdonians (1990) – and from themes which were emerging in the biographical interviews which took place during the same period.

Eight people were each interviewed on two separate occasions by the same researcher using a biographical approach (in one case illness prevented the interviewee from taking part in a second interview). Two of the eight people had also participated in the group discussion. The interviews took place in their own homes, mainly in either middle class areas of the town of Beverley or working class areas of the city of Hull. Approximately two to four hours was spent with each person on each occasion. The first interview was intended primarily to establish rapport, in order that material relating to health beliefs might be framed by an understanding of the individual's personal biography and self identity. Thus the general format of the interview drew on the principles of a biographical approach which contends that:

> the beliefs and ideas that people have about health and illness... will be connected in some way to their own lived experience and therefore our understanding of their views will be improved by knowing something about the contexts from which they have emerged. (Cornwell and Gearing 1989: 36).

Data were thus derived from two sources, both of which were tape recorded: a group discussion and biographical interviews. Notes were also taken during telephone calls, and from conversations with the respondents immediately prior to and following the tape recorded interview. These provided an additional source of data which were used to inform the overall process of the research. Access was gained through request letters sent to people from the previous DHA sample, through a homeopath, Age Concern, a local office of the Council for Voluntary Services, and through a snowball technique where respondents introduced the researcher to a friend. In all instances the study gained the fully informed consent of respondents. Table 1 provides information on pseudonyms, access, age, social class, and type of interview.

Since this body of data is relatively small, the theoretical themes raised by older people themselves – agency, empowerment and choice – remain non-generalisable on an empirical basis. However, it does not represent exclusive experience. Rather, these are themes which resonate with other social science which explores resistance to power in the context of the insider's perspectives on ageing (e.g. Matthews 1979; Hockey 1989). The intention is to provide analysis and discussion which is theoretically generalisable beyond the empirical confines of the research. In other words, as Geertz argues, 'small facts speak to large issues' (1975: 23) and our data provide an opportunity to see the general in the particular (Wright Mills 1959).

Viewed as a whole, the content of this material constitutes a set of statements about something which both interviewee and interviewer recognise as 'health'. It would seem at first glance, therefore, that they share a common understanding of this concept. However, careful examination reveals that, for the older people surveyed and interviewed, the notion of 'health' stands more broadly for the conditions of later life itself. In this respect they are illustrative of Armstrong's analysis of the processes involved in the rise of the 'geriatric gaze' (1983): through geriatric medicine the chronologically determined category of 'old age' came to be defined scientifically as an illness. In light of this

TABLE 1. *Sample breakdown by pseudonym, method of access, age, social class, and type of interview*

| pseudonym | age | access | class* | type of interview |
|---|---|---|---|---|
| Cheryl | 64 | Age Concern | working class | group discussion |
| Delia | 66 | Age Concern | working class | group discussion |
| Elspeth | 68 | snowballed from Hettie | intermediate class | biographical |
| Emma | 69 | Age Concern | working class | group discussion |
| Evelyn | 71 | Age Concern | working class | group discussion /biographical |
| Fred | 78 | Council for Voluntary Services | working class | biographical |
| Harry | 69 | Age Concern | working class | group discussion |
| Hettie | 78 | Homeopath | service class | biographical |
| Joyce | 52 | Homeopath | service class | biographical |
| Paula | 50 | Council for Voluntary Services | working class | biographical |
| Ros | 69 | Homeopath | intermediate class | biographical |
| Tim | 70 | DHA research | working class | biographical |
| Vera | 71 | Age Concern | working class | group discussion |
| Will | 81 | Age Concern | working class | group discussion /biographical |
| Winifred | 67 | Age Concern | working class | group discussion |

* The unit of analysis is either the individual or the household – whichever is the highest. The social class categories are based on a scheme devised by Goldthorpe (Edgell 1992: 29).

interpretation we first consider the ways in which interviewees talk about medicine.

## Meta-narratives and 'health' and 'illness' in later life

The data indicate that medicine, particularly when combined with other meta-narratives such as religion, represents a powerful framework for both making sense of and managing health and illness. A veneration of medical knowledge ranged from:

Will: When you are ill, you can't do a thing about it. You have to rely on medical attention…

to the more circumspect:

Joyce: You don't want to get on the wrong side of them…

All those who were interviewed expressed, in one way or another, deference to the specialised knowledge of medical professionals and its scientific basis. Will, cited above, had worked for most of his life as a supervisor in residential social care. He had recently suffered a severe heart attack and was physically dependent on conventional medication. Of all the accounts gathered, his demonstrated the most deference to scientific medicine. To his strong assertion that 'you have to rely on medical attention', the interviewer replied:

SC: Do you think so?

Will: (forcefully) I am certain you have.

SC: Do you always go to a doctor when you are ill?

Will: I have got to attend a doctor because I am ill. I am seeing a doctor.

For Will, then, illness needs to be regulated by doctors. Indeed, biomedicine is represented as expert knowledge, something which is beyond the grasp of lay understanding:

SC: What about complementary medicine, what do you think about that?

Will: No. I leave it up to the experts.

SC: What about reading books on health?

Will: (smugly) The more you read the more you think you have got, and the more it will worry you because you can't do anything about it…

Even though Fred, an ex-shipyard worker, still very active in the Trade Union Movement and also involved in pensioners' rights organisations, was very critical of medical power, he nonetheless expressed deference to medicine. His reluctance to use the NHS was less a critique of its practices than a fear of wasting its valued resources. This is evident in the following exchange regarding a hearing problem:

SC: When did you first go to the doctors' about your ear?

Fred: (nonchalantly) Oh, about a couple of years ago.

SC: How long had you been having problems with your ear?

Fred: Every time I got a cold.

SC: So how long was that?

Fred: Oh, early days. After the war mainly.

SC: Why didn't you go to the doctor's about it?

Fred: I just thought that this was a cold and all I should do was get rid of the cold. That's what people do… I hope… I have never been one to dash off to the doctor's… most things you can treat yourself. In the old NHS, in the early days, everybody flocked in for Aspros, Anadins, I was never like that. (Smiles) Our doctor said, if there was more people like our family, the health service would be able to concentrate on people who really needed it.

Fred's sustained refusal is thus not a rejection of doctors as such. Rather, as he points out, it was a choice for which his family doctor provided medical legitimation. Nevertheless, Fred asserts the particular lay belief that 'most things you can treat yourself'. This sustains a view of himself and his family as both self-reliant when compared with the people who 'flocked in for Aspros', and in good health when compared with the people who 'really needed' the health service. As a lay health belief, however, this does not stand in opposition to medical knowledge. Indeed, it would seem that medicine represents a source of regulation and restraint, since Fred goes on to talk of the need to consult a medical 'expert' and of the complexity of the workings of his ear. However, he does partly modify this view by stating a preference for the term 'specialist' rather than 'expert':

SC: You said you like to read. Do you ever read anything about health?

Fred: (gasps) No. I mean, it's so complex…something like my ear, it is very difficult to know what's the matter with me. So, therefore, you have got to see an expert. They will decide… (raises eyebrows). You can take their advice or leave it.

SC: Would you ever not accept the advice of an expert

Fred: Well it's a funny word is expert (laughs)…I don't call anybody experts…I would rather call somebody…a specialist. I have never been one to visit the doctor…

In order to fully grasp the position of bio-medicine as one of contemporary society's meta-narratives, we also need to recognise the wider field of narratives which can be drawn upon to reinforce its position. For example, Williams has already shown how Calvinist values such as stoicism are clearly discernible in the health beliefs of older Aberdonians (1990). In our data we find the narratives of Christianity and the British tradition of individualism as manifested in the 'stiff upper lip'. The value attached to scientific knowledge and progress is similarly in evidence. The interviewees, then, drew upon all these narratives to explain and justify medical power and expertise. Thus four interviewees, all over 65 years old, drew on religious beliefs in a significant way. Tim, a retired storeman, referred to miracle cures for which there was no scientific explanation:

…you can't have an answer for everything…there are a lot of inexplicable things that happen…What about those kids with leukaemia…who suddenly get better? You can't say why that happens… You do read about these miraculous happenings.

By contrast, Hettie, a retired professional civil servant, uses religious faith to explain progress in medical science:

I believe God parts the veil for doctors so they will be able to heal… In the past it was tuberculosis and they found a cure for it. This is why cancer is

> incurable at the moment… I believe God will part the veil and…we will be able to cure cancer. Then of course we have got AIDS to deal with. As we get more mature the veil parts a little bit…

Elspeth, a former nurse, mystifies the causes of illness by referring to the workings of the physical body as 'beyond comprehension'. It represents 'God's work':

> …we are made beyond the comprehension of which any of us can understand. The complexity of any system of the body…they are all incredibly complicated. It's miraculous really…and I think we can't understand because it's God's work…

Evelyn, from a working-class background, explained how religion helped her cope with cancer of the bowel. She received blessings from members of her church saying she still had more time to continue 'God's work':

> I knew that I could go through with the operation and beat the thing alright after I had received the same blessings.

Thus, for these four interviewees, the Christian tradition was drawn upon to explain: inexplicable cures as miraculous; the progress of medical science as a result of God parting 'the veil' to give divine enlightenment; the body as a complex creation of God (and therefore beyond complete comprehension, with the result that the causes of illness cannot always be discovered). Finally, religious beliefs were drawn upon as a source of moral strength and a purpose to fight illness. Thus, while religious practice did not predominate among the majority of those interviewed, for a minority residual religiosity is a source of explanatory frameworks.

What we see demonstrated in this material is the importance of medical knowledge and expertise and also religion within the lives of a group of older people. In the following section we show how, in broader terms, 'old age' takes on a negative, illness-based aspect which is often internalised by older people. Like doctors, they too understand their age – the temporal period reached within the life course – as the cause of their poor health. As a result, their age-based social identity, in being meshed with the expectation of deterioration and death, takes on increasingly negative qualities.

## Ageism, the body and dependency in later life

The idea that later life is a period of the life course when dependency and social inequality are to be anticipated has been shown to rest upon sets of social, economic and symbolic constructions (Bond and Coleman

1990; Phillipson 1982; Phillipson *et al.* 1986). This paper argues that dominant conceptions of health and illness in old age are cornerstones within this particular set of beliefs and practices. They contribute to a negative representation which can be internalised by older people themselves. As Coupland *et al.* (1991) point out, age is recognised by both children and older people as a marker of social identity, and this is evident in the sometimes ageist language they use. Interestingly, the work of these authors shows that when older people were asked about their health they give their age as a sign of being above average. In other words, they too understand poor health to be synonymous with later life, a belief which distinguishes their own bodily well-being from that of younger people:

SM: ... as well as I can be ... I'll tell you first I'm going on ninety

CH: Oh no, very good ... Well I'm almost eighty and I can't expect as much

MM: Not on top of the world but ... when you come to eighty-three years of age you can't expect to be like a spring chicken can you?

GT: I haven't been too well ... because ... of course I'm getting on now, I'll be eighty next year.

(Coupland *et al.* 1991: 138)

Therefore a broadly negative cultural representation of later life can be reflected in the specific notion that good health is inevitably a scarce resource for 80 to 90 year old people. In a circular fashion, this then feeds back into a more general perception of later life as a period of disadvantage and dependency. Illness as an objective category, can be both expected and accepted after a certain age and, as we have argued, ill health comes to stand for old age. Material similar to that presented by Coupland and his colleagues was gathered as part of the present project. For example, during the group discussion at the Age Concern Centre, a participant provoked lively discussion by asserting that the health of a person was due to divine intervention or the 'will of God':

Several people together (turning to the speaker, some shaking their heads, smiling, frowning, arms being crossed): No; naa; course not.

Delia: I just think it's old age.

Winifred: I think it's age.

SC (surprised): Age ... Now you are the ones who are calling yourselves old.

Winifred (calmly): Well, we are old.

Here we see age being cited as the cause of illness and, as such, helping to make sense of poor health. This relieves the individual of any sense of blame or responsibility – though it does require people to take on the social identity 'old'. Interestingly, both Delia and Winifred also refused the notion of old age as an inferior social category. Other interviewees, however, resisted age as a marker of social identity.

It is not just the health of the body but, more broadly, what could be called the body's condition or appearance that is the site within which social identity comes into being. The body is a crucial space or interface which links self-identity and society (Shilling 1993). Thus, we found that the identity which individuals felt would be read off from their bodies was not always one which matched their sense of self. For example, Tim described the previous disjunction between his age and his sense of identity, and how that disjunction has been undermined after a heart attack:

SC: When you said that you were now feeling your age, can you remember how long you have been feeling like that?

Tim (matter of factly): Just this last year… 18 months, possibly.

SC: Why do you think that has happened?

Tim: Well, I felt too young before. I should have felt like this previously. Talking to one of the few chaps who is still alive… they have felt like this for years – and it's just come on for me. As I say, I am 71. (frowns) How are you expected to feel when you are 71?

Before the heart attack there was a feeling of tension or difference between a set of external bodily symbols which indicated decline – wrinkles, grey hair, slack flesh – and his subjective sense of an ageless self located within his body. There was a conflict between self-identity and the 'mask of old age'; that is the negatively perceived external appearance of the ageing body (Featherstone and Hepworth 1990). While the positive re-presentation of the body via the 'mask' of cosmetics and clothing is a possibility for some older people, this was not the case for those interviewed here. For example, Ros, a retired small-businesswoman, also described her experience of a disjunction between her body and mind.

Ros… As you get older, your body gets older, and you look older. But, if you had no mirrors and no clocks you would never know that you are getting older, because the inside of your brain is still exactly the same. It doesn't get any less. You think exactly as you thought… fifty years ago.

SC: And do you feel like that?

Ros (sighs): Oh yes. The only trouble is that you can't do what you could do fifty years ago and that is the frustrating part about it.

SC: So do you feel young inside?

Ros (sighs): Oh yes. You do. You do. (pause) But you get a shock when you look in the mirror… and you expect to see – well I expect to see – a dark

> vivacious face looking at me… and I get a grey wrinkled face looking back and I think, 'Well, oh God'… and there's not much you can do about it… everybody is getting younger and you are getting older.

Hettie echoes this sense of a divergence between self and body:

> The thing is that bits of your body wear out, but inside, the essential me is still the same. The physical me is the envelope in which the letter is, and the envelope gets worn out.

Later life, then, can be experienced and perceived by older people themselves as an externally imposed masking of their sense of self. There is a cultural strategy which prioritises the body and its appearance over the *person* in the body. In this way the body is made to stand for, and indeed becomes, the self. Normative ideas of beauty, health and interaction in the everyday world are drawn upon in such a way that the older person is excluded or marginalised in relation to younger people. As a woman who had worked for most of her life as a mother, wife and part-time shop assistant, said:

> (sighs)… and everybody is younger… the policeman, the bus conductor, the people in the shops… they are all younger… it makes you feel strange.

In this way tension, even anomie, is experienced as a result of the difference between that which is internally located – emotions and the mind – and the outward signs of bodily decline (and their association with culturally constructed dependency). The author, J. B. Priestley, described the experience in the following way:

> It is as though walking down Shaftesbury Avenue as a fairly young man, I was suddenly kidnapped, rushed into a theatre and made to don the grey hair, the wrinkles and the other attributes of old age, then wheeled on stage. Behind the appearance of age I am the same person, with the same thoughts as when I was younger (Featherstone & Hepworth 1990: 148).

In some ways this experience parallels Goffman's dramaturgical model which makes a clear distinction between the presentation of self and role in everyday life (Goffman [1959] 1990). However, both Goffman's model and the notion that older people can be marginalised as a result of negative readings of their bodies, risks obscuring these individuals' alternative representations, responses and indeed their agency. In the following analysis we examine data which demonstrate the resistance of older people to generalised assumptions about their incompetence and lack of social value. Significantly, as we have already argued, medical beliefs and practices play a key role as a meta-narrative. This reflects the primacy of the body as a signifier of social identity and, as we go on to show, it is therefore the body in health and illness which becomes a key site for resisting dependency and marginalisation in later life.

## Resisting the mask of old age

The following extract comes from the group discussion:

SC:…just to talk about things that you think could affect your state of health…

Cheryl: Oh, I know, when people treat you as if you are daft because you are old. I know because I am in Pensioners' Rights and we get MPs talk down to us as if we are daft.

Two other voices: Umm, daft. Yes.

Cheryl:…and we get them saying, (sarcastically) 'oh we will take you into the restaurant for a cup of tea and a sticky bun'…

Two other voices: (in chorus) Yes.

Cheryl:…(getting angrier) and we say, 'we do not want a cup of tea and a sticky bun, our brains are the same as what yours are'. We go to talk about pensioners' rights and they talk to you as though you are a baby…

Other voices: They do. It's not right.

Cheryl (very angry):…and you're not. Mind you, it doesn't just happen there, it happens all over the place…they think pensioners and they think you are stupid. They do.

Winifred (sharply): They do.

Delia (defiantly): They think we are up agin wall and that we are on way out…well I can tell them that we are not going (laughs)

Being talked down to in a child-like way is being subjected to processes of 'infantilisation' (Hockey and James, 1993). As well as perpetuating powerful negative stereotypes, it clearly annoys older people themselves. Resentment and hostility towards being marginalised is evident in the following extract

Fred (angry):…when you get old, they push you to one side… The people ruling us…have no respect for us. I fought the war for this country…and what do I get back in return now? Nothing! I think it is a disgrace that old people have to buy secondhand clothes in charity shops. We deserve better after all we have done for this country…I…I…(shaking his head, sighing and then eventually going quiet).

People in old age are discriminated against in terms of not only health but also body image, participation in production and consumption, and thus in collective social life. For example, consumer culture's emphasis on youthfulness – 'the body beautiful' – is increasingly excluding and marginalising people in later life. Enforced retirement also bars a substantial number of people from a major area of social life. Thus, 'consumer society' and the 'work society' both reinforce and create negative language and images of later life. In turn, this can produce a slide into symbolic or social death (Baudrillard 1993). Generally speaking, there is an inverse relationship between growing old and participating in social life or, as Turner (1987: 122–125) puts it, between 'maturation' and 'reciprocity'. It is through this process that old age comes to be marginalised and stigmatised. Hence, the negative 'downhill all the way' or 'time's-up' narrative which, whilst not entirely all-powerful, certainly underpins the dominant conception of old age. This ageist conception of later life is reinforced by the way health care services are provided for 'the elderly'. The threat of health-based forms of discrimination is evidenced in a recent report by the Royal College of Physicians. It highlights age bars for certain treatments and the implicit view that younger people should be given priority (Mihill 1994). Age is therefore not only the cause of illness but a constraint on its treatment or cure. The outcome is not only increased dependency (Phillipson 1986) but also unnecessary death (Mihill 1994).

In the face of marginalisation, however, older people are challenging ageism. Indeed, age-based politicisation is taking place internationally; for example, the Gray Panthers, the American Association of Retired People, European pensioners' political parties, the UK Pensioners' Rights Campaign and the University of the Third Age. Featherstone and Wernick (1995: 6) note that such organisations have sought to 'combat age discrimination in labour markets, the reversal of the mandatory retirement age, as well as ageist language and negative stereotypes of the aged in general'. As yet most commentators seem to agree that the tide has not completely turned. However it is clear that the 'time's up' narrative is being resisted, and that this resistance is growing. Thus, while vulnerable to the power inscribed in dominant social categories such as doctors, social workers and younger family members, older people appear to have access to alternative sources of power. Here 'health' and 'illness' become key contested sites.

## Challenging medicine

The District Health Authority survey of health care need generated largely contradictory and diverse self-assessments of health. As noted, its quantitative methodology did not represent a useful framework for making sense of this fragmented, discursive body of data. Similarly, structuralist sociology, whether Marxist or functionalist, gives few insights into interview material characterised by contradictions and heterogeneity. We contend that postmodern perspectives have yet to be drawn upon in making sense of the health beliefs of older people. In this section we look in some detail at the ways in which our interviewees have drawn upon a range of discontinuous and interrelated narratives and texts. As we will show, they come together in the following accounts as a form of intertextuality, the practice of fabricating the social world.

We begin by acknowledging the importance of historical continuity in the way traditions from the past are called upon to make sense of the present. It is, however, also important to note that their role is not always deterministic. Thus, following postmodernism, we also emphasise discontinuity, rupture and breaks with the past. Two important theoretical perspectives can be considered here. First, Lyotard's argument that this century has seen the demise of 'meta-narratives' (Lyotard 1984). As already argued, this has confronted medicine with challenges. Here we focus on the agency of older people for whom 'health' may constitute not just a bodily condition but an entire social identity. Second, intertextuality is a mechanism by which the social world is fabricated, and this explains why 'ideologies' of the powerful continually break down and fail to achieve hegemony. Thus, medicine as an ideology can never achieve absolute power; instead it is subject to a continuous process of re-constitution via the play of intertextuality.

Those who were interviewed for this project challenged medicine as a meta-narrative on a wide range of grounds. Contradictions were also apparent, however, in that respect and criticisms were simultaneously present as explanatory orientations (or 'pragmatic valencies' or 'paralogy'). These seemed to reflect the experiences and perceptions of those concerned. What was said, therefore, represented intertextual readings or 'intersections' of contrasting social narratives. For example, in relation to ill-health Ros was critical of 'greedy doctors at the top'. However, she goes on to absolve the government and to include the 'undeserving poor' as the other guilty party:

> Oh no, it's not the government's fault... It's those doctors at the top... [and those] seamy people [who] must have their pint of beer... no matter how little they have got.

Three narratives seem to be important here: (i) greed is wrong and 'greedy doctors at the top' are to blame; (ii) more pragmatically, ill-health is not a government responsibility; and (iii), perhaps indicating political beliefs, maintaining health is a personal responsibility neglected by the 'undeserving poor'.

By contrast, Fred implied that 'the powers that be' were responsible for inequalities in health, and that health care providers were having to respond to social causes which they were powerless to control: 'It's unemployment and poverty what causes ill-health.'

Ill health is being put into the context of a more far-reaching criticism of social inequality. There is a slippage of meaning whereby 'health' becomes a concept which extends beyond a narrow medicalised focus on the body. By recognising the 'undecidability' present in the reading and writing of texts (and in language itself), we gain access to the social meaning of the interviewee's lay health beliefs (Fox 1993). Thus, postmodern perspectives allow us to address the presence of vastly different explanations of the same thing. In each interviewee's account, a number of different texts and narratives are being traded off with each other in intertextually constructing another narrative.

Within the group as a whole, the way medicine was challenged can be divided into four main areas: (i) using alternative medicine; (ii) questioning the merit of medical knowledge in their personal health care; (iii) unhappiness with health service practices and organisation and (iv) the way these challenges are combined with other texts and narratives to form an intertextual challenge.

### *Using alternative medicine*

Four people used homeopathy. Interestingly, all were women and all were in high income brackets. They all expressed incredulity and disdain towards the meta-narrative of biomedicine. For example, Joyce turned to homeopathy because of the perceived failure and unsympathetic attitude of the GP to the problems she was having with her son, Malcolm:

> …this is why I have got into homeopathy… (sharply) he never seemed to be all that sympathetic. He would never listen, because I kept saying to him, whilst Malcolm was still young, what terrible problems we were having. He seemed to think that I was exaggerating, I used to say, (pleading voice) 'can't we just find out if he is allergic to anything?' I thought something was upsetting his brain and (sharply) he wouldn't hear anything of it. And blow me, it did turn out years later, we found out that Malcolm was very, very, allergic to milk. He has been addicted to milk. He used to drink it by the gallon. So, whilst clearly he did have emotional problems, I think the whole thing was being made worse than it need have been. I think a lot of it came from him drinking milk… So that made me seek advice from alternative practitioners, because, when I started irritable bowel syndrome and I had years suffering from that… and again I was under the impression that there was an allergy involved in it, but I didn't know where to begin to find out what I was allergic to.

This can also be read as an intertextual challenge, as feelings of responsibility towards her son were played off against ideas implying that 'doctor knows best'. Eventually, feelings for her son led her to question the credibility of the GP's expertise and to seek help from an alternative practitioner.

Right at the beginning of the interview, without any prompt from the researcher, Joyce had emphatically rejected medical knowledge and power.

> (very calmly) I hate to feel that I am totally in somebody else's hands. That is why I hate going into hospitals… When you are in hospital you are supposed to lie in bed and let them make all the decisions, and they don't even explain what they are doing. You don't know if they are making mistakes or what… I do not like that. I would like to know what is wrong with me, what the treatment they are giving me is and how it is going to work, what might go wrong, what is the cause of what is wrong with me… (sternly) I just don't like to be in anybody else's power (laughs)… I don't know how else to put it… I just don't like to feel helpless and being dominated by someone else, and my life in their hands completely.

This forceful statement clearly questions the power of medicine and firmly rejects the disempowering experience of becoming a 'patient'. There were also clear misgivings among this group about impersonal bio-medical treatment regimes. This included general criticisms of the over-prescription of drugs and of the lack of time and explanation given by medical practitioners:

> Elspeth (getting angry): This is how they are, if they can't do anything they just won't bother to explain to you… they don't explain anything really; they just put satisfactory… and, really, it's all over in a flash.

Here, the impersonal and production-line nature of health care is rejected. The logos, or the heart of the matter, seems to be a call for a more conciliatory approach, which includes more explanation and more time.

Alternative medicine also seemed to offer empowerment. As one woman, who said that she read about and practised homeopathy, concluded: 'so I do think you can help yourself'. In all cases, the use of homeopathy was an obvious resistance practice. This was clearly related, however, to an ability to pay, in that all of those using alternative practitioners were in high income groups.

### *Questioning the merit of medical knowledge in personal health care*

Ros, talking about the health care received after a heart attack, remarked:

> Well you don't know what you feel. But I felt frightened, (pause) frightened… I think they try and frighten you to take the pills. I told them that they did not agree with me whatsoever – but I felt if I didn't take them,

> (sighs) I would probably die. I took the pills and they didn't agree with me. I think they caused me the second illness, which was double pneumonia, which nearly lost me my life. I was in a coma for four days.

Clearly this account refers to disempowerment and the fear that was induced by the perceived consequences of not adhering to medical discipline. There is also an expression of dissatisfaction, in that the cause of the 'second illness' is attributed to the medical treatment received for the first. Many of the group regarded expert knowledge with scepticism. For example, Tim, who was mostly deferential to bio-medicine, also questioned the authority of experts:

> You can't take any notice of the experts because they all contradict each other. One says do this, that and the other – and the other one says don't do that, do this.

In terms of drug prescription, many people were critical. For example, the first thing Evelyn said, without any prompt from the researcher, was:

> I think that when you go to see a doctor they are writing a prescription before you know it.

Winifred commented:

> I think people take too many tablets. I stay up in bed till three o'clock in morning and I read. If you take too many tablets, it's no good. You just have to do it yourself and not rely on tablets.

Paula, when describing how divorce had effected her health, had found herself on the receiving end of gender- as well as age-based discrimination:

> My new doctor is very good, he will sit there and listen to me. Whereas the one I had in Hull he was awful… he said… (adopts blasé voice) 'all you women who get divorced, you get all these problems. You will just have to learn to live with them'. I said, (adopts hurt voice) 'well, I didn't plan it, I didn't set about to get divorced, it wasn't my fault'. All he said was, 'you will just have to learn to live with it'… I don't know why he treated me like that, I was so upset… it made things worse. I just couldn't seem to communicate with him.

There was also a comment on the unequal relationship. Joyce, feeling a lack of power in the consultation, implied that resistance could only take place in a safer setting:

> Joyce: Although I was very annoyed with him, I couldn't do anything at the time. You don't want to get on the wrong side of them, do you?

Overall, therefore, four forms of contestation seem to be important. The first concerns expertise, the second relates to drugs, the third to gender, and the fourth to medical power generally. In relation to personal health care, there is a challenge to the authority of biomedicine in the form of a general scepticism about expert knowledge: 'experts…contradict each other'. Drugs are seen to be harmful: 'I took the pills and they caused me the second illness'. They are an easy option for doctors: 'they are writing a prescription before you know it'; and for patients: 'If you take too many tablets, it's no good. You just have to do it yourself'. Gender is used to sustain power inequalities: 'all you women…get all these problems. You will just have to learn to live with them'. Finally, even when 'very annoyed', the power of a medical practitioner is recognised: 'You don't want to get on the wrong side of them'.

The text of personal experience was also drawn upon to express a challenge towards health service practices and organisation more generally, one which constitutes an important aspect of older people's agency.

### *Discontent towards health service practices and organisation*

A number of people seemed to resent the ethos of the NHS as expressed in the organisation and delivery of health services. Many also felt that, other than as a source of symptoms, they were not being listened to and that this was wrong. Doctors were seen to engage in language games, to gain the authority of expertise in relation to the physical body:

> Joyce: All it is, is that quite often you know what it is, but you do not know what the medical term for it is; and the doctor would say, 'you don't know what you are talking about, I am the expert.' They oppose it; and really, I do not think they should. I think they should listen to you more.

Or put another way, doctors draw on scientific texts, using 'medical terms', to gain the logos, or truth claim, of expertise. An epistemological challenge to the Cartesian duality of mind and body was also evident:

> Joyce: I do think instinct plays a part in illness. It's probably because it is your body, not the doctor's, and you know instinctively what it is and what the cause of it is; because your body is connected to your brain, isn't it?

This can also be read as an example of how lay knowledge is rooted in the text of experience, whereas medical knowledge is derived from the concept of disease. Although there can be an interchange between the two, the narratives of most of those interviewed were rooted primarily within their own experience. Thus, bio-medical practices such as taking drugs, and explanatory frameworks which separate mind and body are called into question.

A firm criticism was also evident of the ethics of technical rationality (or what Weber calls *zweckrationalitat*) where action is guided by considerations of ends, means and secondary consequences which can be subjected to calculation rather than by any absolute values (Runciman 1978: 28–30). For example, all those interviewed were opposed to age bars in health care on moral grounds, and some were critical of NHS medical consultants for working part-time, and of 'modern day' doctors for 'empire building':

> Ros: ... The doctors I think they are empire building ... The doctors at the top, they don't do enough work ... Every time the government step in to do something, they can't put it right because of those at the top. You see our old-fashioned doctors ... you see, like when we were kids, the doctors were very kind. When somebody didn't have enough money to pay, the doctor would let them off ... People were different then. I think people nowadays are more interested in money and things like that ...

Others were critical of NHS organisation, in particular of the abuse of power by medical elites, and of new managerialism:

> Fred: ... It is just not right that consultants can work part-time ... (frowns) I mean, it's not on, is it? You wouldn't get it anywhere else ... You wouldn't get somebody coming in to a firm to do their job part-time and then going off somewhere to run their own business ... That is what they are doing ... It is not fair on the doctors and nurses who know about health and how to care for somebody properly, to be told that they have to work on business lines and make a profit. I don't like all these managers who are running the health service like a business; you can't do that. It is just not right. I don't agree with those Trusts. They should get rid of them straight away ... The problem with the Trusts is that you have all these business people talking about cash going in and cash going out. You have got no lay people on there who are actually going to have the treatment in hospital.

Deprivation and power are key themes for Fred, and he is very critical of the individualising discourse of 'looking after yourself':

> Fred: It's all right them in health service going on about looking after yourself. What I think what causes ill health today is unemployment and poverty. The thing is that it is the powers that be that will not recognise it. If they did they would have to say it was their fault. Then they would be in a right state ... because they would have to do something about it ... When I hear that Virginia Bottomley going on about looking after yourself, I think what a load of rubbish. It's unemployment and poverty what causes it.

The main narrative here is that looking after yourself is only part of the story. For Fred, 'health' includes more than just the maintenance of bodily well-being. It encompasses the entire socio-economic positioning of older people within society. The political discourse of individual responsibility is faulted because it side-steps the social causes of 'unemployment and poverty'. This seems to suit the needs of more powerful groups because they can disclaim responsibility: 'the powers that be' will not recognise it because they would have to do something about it.

In sum, therefore this third set of criticisms contained an epistemological critique of the objectivism of scientific medicine. This was also seen as a sign or icon for contemporary society, a reflection of rationalisation. The latter view, therefore linked into the notion that we live in mechanistic or uncaring times. Thus, a considerable number of interviewees pointed to exogenous causes of ill-health such as poverty, pollution, unemployment and iatrogenic health care.

### *Intertextual challenge*

Overall, then, in that they were based in a number of texts, the interviewees' health-related criticisms were constructed via the practice of intertextuality. This was demonstrated by the way each person in the group drew on a wide range of narratives and texts within the interview. This included:

- 'greedy doctors at the top';
- the government is not responsible;
- the 'undeserving poor' will not change their lifestyles;
- 'poverty and unemployment' cause ill health, and responsibility for this lies with the 'powers that be';
- medicine affiliates itself with more powerful interests; for example, individualising health care obscures inequalities in health;
- expert knowledge can be challenged from the basis of experience; for example, the experiential text of responsibility towards other family members can overrule biomedical discourse;
- those with higher incomes use texts from alternative medicine and they also consult alternative practitioners;
- the logos of equity is asserted; for example, medical practitioners fail to explain 'what they are doing'; they purposefully disempower patients by claiming the authority of expertise over the physical body;
- ageist health care is firmly rejected;
- doctors should not exploit gender inequalities to maintain power and control;
- the cultural construction of later life through the mask of old age is a false construction;
- over-prescription of drugs is firmly rejected;
- scientific approaches within *zweckrational* health care are rejected.

This, we would suggest, implies that the ways in which medicine was challenged represent different forms of resistance to a single, negative, age-based, social identity. Interviewees were claiming other identities which were not totally controlled by either medical discourse or any other source of power and knowledge.

## Conclusion

Postmodern perspectives have facilitated an understanding of how older people intertextually re-construct narratives to explain health and illness, thereby allowing us to address the heterogeneity of interview data. The friction between experience and the negative 'mask of old age' alerts us to issues of self-identity and, as we have argued, is closely connected with interviewees' resistance to the objectivist or scientific approach of medicine. Their reaction can, therefore, be seen as a challenge to the homogeneity of the social category 'elderly' as an embodiment of the 'time's up' narrative. In addressing the issue of 'health' in later life, it is useful to note Foucault's contention that there has been a growth in locations of power and knowledge that seek to inscribe physical and social bodies or communities with discourses of normality and self-government (Foucault 1977). In the data presented here, self-identity, in terms of the privileging of experience, can be seen as a form of empowerment which conflicts with inscriptions of power and expertise that shape and target 'the elderly' as a social body. A range of inscriptions ran through the interview data, some of which were deferential to sources of power and knowledge such as medicine, religion and science, whilst others were not. On balance they give clear evidence of the questioning of authority, or the rejection of totalising theory (Lyotard 1984).

As medical power is threatened by marketisation and de-professionalisation, contemporary health care has become even more of a battleground for status and control. As many have noted, Western medical power has drawn its knowledge base from the scientific tradition (Doyal 1979; Turner 1987). A relapse into the knowledge and practice of objectivist science must, then, seem attractive to medicine. Yet, in the interviews, it was the scientific approach which was almost universally criticised.

'Older people' being defined as a residual group, coupled with cuts in real terms to health service resources, has produced further ageism in health care. However, the possible synergy between this and the epistemological and political challenges from other people, is not being studied. As de Swaan points out:

> …medical intervention has expanded greatly over the last half century, including areas where medical expertise can offer no conclusive answers and where other approaches are conceivable (1990: 58).

As with any age group the interviews show heterogeneity. Nonetheless, there was also a clear theme of resistance to negative notions of dependency and towards biomedicine. All of the people interviewed were unhappy to varying degrees with the imposition of child-like identities or the practice of infantilisation, and all were unhappy with *zweckrational* health care. Significantly, two out of the fifteen were involved in political lobby organisations.

Finally, we return to this paper's twin aims. In gathering material about the health beliefs of older people we have highlighted the local significance of more generalised terms such as 'health', 'illness' and 'healthcare'. We have challenged the narrow assumption that older people inevitably have (a) different kinds of health problems by virtue of their age, and (b) homogeneous responses to them by virtue of the explanatory frameworks of their generation. Instead, we suggest, the concept of 'health' itself may take on particular sets of meanings for an age-group whose *subjective* interpretation of health conflicts with the *objective* bio-medical definition. In terms of the latter, the explanatory frameworks derived from bio-medical discourse help to reinforce the stereotype that later life is synonymous with, and indeed caused by, being old.

It would be determinist to forecast that, as more people live longer and as the health service continues to discriminate against older people, we can anticipate major conflict. Nevertheless it should be noted that the discussed accounts contain considerable resentment and hostility towards negative representations of ageing and towards biomedicine. While the findings from an in-depth study of this kind are not empirically generalisable, the theoretical approach we have followed is one which can be fruitful in a range of similar research settings. We would argue that the postmodern concepts we have used have helped us to both recognise and theorise *agency*. In this article, we have examined the intertextual strategies adopted by the interviewees to show that, in effect, there is a plurality of forms of knowledge open to them (Foucault 1973). The genealogical approach of Foucault (1980) calls for a methodology that brings out narratives that have been previously hidden by totalising theory. We have tried to achieve this by bringing to the fore some of the multiplicity of texts and narratives drawn on by the people interviewed. It is this material which provides insights into their individual agency. For many powerful interests, oppressed groups are not seen to have agency, they are thought of as not capable of it or not worth it. Not only health care providers but also researchers need to listen carefully to the accounts of their clients and their interviewees. If their agency is denied, dependency will continue to be fostered, both on conceptual as well as practical levels.

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