

The construction of the risk of falling among and by older people

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ABSTRACT

Risk is frequently invoked in contemporary accounts of ill health, but its construction is often constrained by a rationalist perspective that focuses on physical causes and functional outcomes, and that presents risk as external to the self and predictable. This paper describes an empirical study of the ways in which risk was realised and managed in a day hospital for older people. An ethnographic approach, with participant observation and semi-structured interviews, and discourse analysis were used to explore these issues with the staff and fifteen users. Whilst the service providers were orientated to the management of physical risk, as through the regimes for administering medication and their attention to risk reduction in the physical environment, the service users were more concerned with the risk to their personal and social identities, and they more frequently described its manifestations in interpersonal exchanges, sometimes as infantilisation and stereotyping. The paper develops this understanding of the potential for falls among older people to elucidate a broader interpretation of risk, and reveals that it is commonly constructed as a challenge to a person's self-image and identity. Such constructions help to explain older people's responses to complex health problems and to the services and treatments that attempt to solve them.

KEY WORDS – falls, falling, risk, discourse analysis, ethnography, social identities.

Introduction

Risk is prominent in explanations of health and illness (Gabe 1995; Petersen and Lupton 1996). Skolbekken (1995), for example, has described a recent 'epidemic' of research papers that explore risk in medical journals. With a few exceptions (*e.g.* Bellaby 1990; Davison *et al.* 1991; Parsons and Atkinson 1992), these studies have neglected the

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social context and the conceptual construction of risk, and instead focus on the personal characteristics, behaviour and the environmental attributes which predispose individuals to ill health. Using the example of falls by older people, this paper will argue that a broader conception of risk can make a significant contribution to the understanding of complex health issues.

The paper begins with brief reviews of the literature on both health risks and falling among older people. Professional behaviour and codes of conduct are also addressed. It then describes an empirical study which explored the constructions of risk of service providers and users at a day hospital for older people. The ethnographic methods and the findings of the discourse analysis are then described, and the discussion explores the ways in which alternative constructions of risk, that feature the social milieu in which behaviours and inter-personal interactions occur, help to challenge conventional representations of health problems such as falls.

Risk and health

The complex nature of risk becomes immediately apparent when one considers a definition. Most dictionary definitions allude to the negative or undesirable nature of risk, as in the following:

noun: 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. *verb transitive*: to expose to risk; to incur the chance of unfortunate consequences, loss or danger by (doing something) (Schwartz 1992; 935).

These associations are relatively recent. As Green (1997) points out, in the past risk was as frequently associated with both good and bad outcomes and more synonymous with chance. In her article on the 'sociology of social research', Blaxter (1999) comments on the high frequency with which risk was associated with health outcomes in the proposals submitted to the British *Economic and Social Research Council* programme, 'Risk and human behaviour'. She argues that the preoccupation with predominantly physical and individual outcomes limits what is viewed as both 'risky' and 'at risk'.

The conventional view of risk (Tansey and O'Riordan 1999) is actuarial, with the risk assessment seen as a skilled professional and technical task which is the preserve of experts (Gabe 1995). In medicine and health, the disciplines most closely associated with the estimation of risk are epidemiology and public health, and the methods of choice include large randomised controlled trials, population databases and advanced statistical analysis (Petersen and Lupton

1996). Another strand of risk research in health is its exploration in the social context. Writing in this field is dominated by Beck (*e.g.* 1992) and Giddens (*e.g.* 1991), who argue that the preoccupation with risk is a distinctively modern phenomenon, brought about by the erosion of social structures which once provided stability and security, such as the family and the state. Their work elucidates the intricate links between social forms and the level of orientation to risk, the type of risks that are described, and the extent to which they are perceived to pose a threat. Scott and Freeman (1995) illustrate these connections through the specific example of HIV and AIDs.

The psychological approach to risk in health focuses on the relationship of individual characteristics and behaviours to health outcomes, the territory of the rapidly expanding sub-discipline of health psychology. Much of this is based on models which explain and predict health behaviour, such as the 'health belief model'. In such models, the individual is characterised as a conscious and rational actor, making decisions on the basis of perceived vulnerability, risk and predictable outcomes (Lupton 1999).

Another and neglected theoretical approach to risk is the sociocultural perspective as advanced by the anthropologist Mary Douglas. Her major contribution to the study and understanding of risk is the assertion that the identification and privileging of particular risks above others is dependent on the cultural context in which they are located. The ways in which these risks are responded to are dependent on cultural explanations about danger and 'otherness'. The 'grid-group' model of cultural explanations of risk advanced by Douglas and Wildavsky (1982) has been used by Bellaby (1990) to explore health and safety at work.

The identification of and protection from risk are often explicitly addressed in professional codes of conduct such as that issued by the *United Kingdom Central Council for Nursing, Midwifery and Health Visiting* (UKCC) (UKCC 1992). Hussey (1996) has identified some of the problems inherent in too rigid an interpretation of professional codes of conduct, and highlights a broad range of functions which such codes can serve, including guidance, information, proclamation and negotiation. He argues that professionals need the skills and ability to become 'enhanced moral agents' (Hussey 1996: 251), and that codes of conduct should aim to assist complex decision making, rather than being interpreted as sets of prescriptive rules. The different theoretical approaches to the consideration of health risk that have been described, and a review of health professionals' codes of conduct, have provided the conceptual framework for our empirical study. The next section

introduces falls as a problem of older age, and summarises the pertinent literature.

Falling as a health problem of older age

Falling in older age has become an important issue for the health care services in many developed countries. In the United Kingdom (UK), it is estimated that around 30 per cent of older people living in the community aged 65 years and over fall each year (Campbell *et al.* 1981), rising to around 40 per cent in those over 75 years (Downton and Andrews 1991). The physical consequences of falling have been well documented. It is estimated that over 1,500 people aged 65 and over die each year in the UK as a result of a fall at home (Department of Trade and Industry 1998). One of the well publicised consequences of a fall is hip fracture, shown to occur in around 1 per cent of older people who live in the community who fall. Other physical trauma resulting from falls include fractures to other bones, and soft tissue injury (Gryfe *et al.* 1977; Tinetti *et al.* 1988).

In response to the perceived problem of falling in older age, falls have featured regularly in health policy, research programmes and health promotion campaigns initiated by successive British governments. Targets for reductions in number of falls and accidents experienced by older people were present in both the 1992 and 1999 health White Papers (Department of Health 1992; 1999), and were also included in the recent *National Service Framework for Older People* (Department of Health 2001). Interventions to prevent falling in older people have been the focus of an 'Effective Health Care Bulletin' (Nuffield Institute for Health and NHS Centre for Reviews and Dissemination 1996) and a Cochrane Review (Gillespie *et al.* 1998), both of which were initiatives to improve the evidence base that underpins health services in the UK. Many dedicated falls prevention services have also been developed in response to this perceived health threat.

The governments of many other countries have responded to the challenge of falling in their older populations with research and practice initiatives. In the United States, for example, a major programme of research known as the 'Frailty, and Injuries: Co-operative Studies of Intervention Techniques' (FICSIT) programme was funded throughout the later 1990s, the objective being a meta-analysis of seven different falls prevention programmes (Ory *et al.* 1993). In Australia, falling also features prominently in both health research (*e.g.* Lord *et al.* 2001) and clinical practice (*e.g.* Clemson *et al.* 1999; Hill *et al.* 1994).

A consistent theme of the reviews of this emerging research field is the neglect of psychological and social factors in the aetiology of falls (*e.g.* Askham *et al.* 1990; Lilley *et al.* 1995). They also identify inconsistency in both the definition of a fall and in the methods of reporting, which include older people's self reports through diaries and postcards, carers' observations, and institutional incident books. Variable reports of incidence have generated inappropriate explanations, as with 'the notorious forgetfulness of the elderly' (Gryfe *et al.* 1977: 207). Throughout, the dominant perspective is a positivist construction of an objective event, the occurrence of which many older people may not recognise or may deny. This encourages investigators to 'blame the victim' for any differences between the anticipated and the reported incidence, when it is actually a consequence of their own methodological inadequacies.

Although not a major theme in the literature, some studies have taken older peoples' experiences of a fall and of a (closely associated) hip fracture as a topic worthy of investigation in its own right. Borkan *et al.* (1991) interviewed 80 older people admitted to hospital with hip fracture and gathered the subjects' own narratives of the event. They found that different explanatory models were employed by older people to account for their falls, namely the body as machine (which might break down), and the body as an organic structure (prone to illness or disease). Additional analysis suggested that those who described their hip fracture in a mechanistic fashion or by reference to external agency achieved better ambulation outcomes at three and six months post-fracture. This suggests that differences in people's narratives are both grounded and may be related to the success of rehabilitation.

The dissociation of the self from the likelihood of falling was observed by Braun (1998) from a survey of older people living in residential accommodation in the United States. The respondents were more likely to identify other people as at risk of a fall than themselves. This suggests that rather than the risk being independent of the person (or neutral for affect), individuals are strongly motivated to underplay their personal susceptibility. Braun's work also draws attention to the different ways in which health professionals and older people view and represent falling. Such differences were explicitly investigated using a social constructionist framework by Martin (1999). This work suggested that falling is an emotive and loaded topic, and that the language used to describe falls by older people avoids connotations of personal vulnerability. Martin (1999) also found cultural variations in the description of falls.

The study of health professionals' and lay perspectives of falls

To investigate these issues further, the authors' first study examined the ways in which health professionals and older people who had fallen represented falling. A full account is found in Ballinger and Payne (2000). Over nine weeks in 1997, eight people with fractured hips aged 65 years and over were recruited from an orthopaedic trauma elderly care ward of a large general hospital in the south of England. In addition, 20 occupational therapists and physiotherapists were recruited from two local NHS trusts. The data were generated through semi-structured interviews with questions that focused on the reasons for, the predictability of, and the consequences of falls. The therapists constructed a fall as a predictable event which health professionals had a duty to try and prevent, and they identified many personal characteristics of older people that they believed were implicated in the causes, including physical problems, cognitive deficits such as senility and confusion, 'neurological events', 'blood pressure problems', and personal habits and behaviour, such as wearing inappropriate shoes. The home environment was also mentioned many times. The occupational therapists and physiotherapists represented themselves as knowledgeable experts whose role it was to teach their older patients and clients how to remain safe.

In contrast, the responses of the older service users focused on their commendable personal attributes, and many refuted negative assessments of their mental state, moral characters, and capacity to take care of themselves. With respect to the perceived reasons for the fall which caused their hospital admission, the older people were reluctant to assume responsibility for the event, and some attributed their accident to the carelessness of other people. Many spontaneously affirmed that they had not been drinking at the time of the fall. The two sets of interviews clearly established differences in the perspectives of health professionals and older people on not only the vulnerability to falls but also the consequences and preventative strategies. This initial study provided an impetus and direction for the research reported here, which has examined a broader range of perceptions of risk.

Representations of risk in a day hospital for older people

The introductory sections have established that although alternative frameworks for understanding risk have been proposed, in health research a positivist perspective has predominated, and research has

neglected its psychological and social aspects. Nonetheless a few studies have shown that falling might be an emotive issue for older people, and suggested that there are differences in the ways that it is represented by health professionals and by those who have experienced a fall. We now discuss the merits of the methodology that was selected to investigate these variations and broader dimensions of the risk of falling.

Discourse analysis as the underpinning methodology

‘Discourse analysis’ is used in many academic disciplines, but this study borrows most closely from the methodologies developed in British social psychology (Nikander 1995). This form is particularly appropriate for this study because of the action orientation in its approach to talk and texts, in contrast to the orientation in other disciplines towards beliefs, attitudes and the identification of facts (Potter 1996; Potter and Wetherell 1987). The attention in discourse analysis to the wider resources (or ‘interpretative repertoires’, *cf.* Potter 1996), that are employed in the construction of everyday life creates the critical potential of the methodology (Parker 1992; 1997). It enables us to see how dominant ‘common sense’ understandings manifest in the construction of meaning about the social world and, by extension, helps us to identify those perspectives which are not represented or are deliberately silenced.

The use of discourse analysis as a framework for exploring risk in a day hospital for older people therefore had the potential to clarify how service users were viewed, how the purpose of the service was identified, and how interactions between service users and providers were framed and managed. It also facilitated access to the service users’ perspectives. We selected the following principles to guide the data interpretation:

- attention to the detail and construction of the text (Potter and Wetherell 1995)
- focus on contradictions and disjunctions in texts (Potter and Wetherell 1995)
- identifying objects and subjects, and how texts are rhetorically constructed around and through them (Parker 1992)
- examining the ways in which specified institutions and categories of person are reinforced or disempowered in texts (Parker 1992)

The use of a discourse analytic methodology also focuses attention on the criteria that are employed to determine rigour in the work. Following other researchers that have used discourse analysis (and

several other 'critical' qualitative research methods), positivist markers of quality such as 'reliability' and 'validity' were believed to be inappropriate. Instead, we favour the provision of a detailed rationale for the research design, sample construction and methods, and an emphasis upon ensuring that a sufficient volume of data is examined to achieve 'stability' in interpretation, reflexivity and plausibility (Mason 1996; Potter 1996; Potter and Wetherell 1994).

Design and methods

An ethnographic approach using participant observation was adopted (Fetterman 1998; Hammersley and Atkinson 1995). The benefits of this approach include the study of a naturalistic setting and a flexible design, which enables the researcher to shift the focus or adopt new methods to investigate emerging topics of interest. Three specific data generation methods were employed: participant observation, semi-structured interviews, and the analysis of documentary sources. Participant observation was carried out for five weeks, followed by a two week break and then four weeks further field work, during which time 15 semi-structured interviews were carried out. Field notes were gathered for just over 50 hours, of which semi-structured interviews carried out in the day hospital setting took four hours.

Recent work (*e.g.* Atkinson and Hammersley 1998) has drawn attention to the need to clarify and justify the role of the researcher in observational work, as critical perspectives have criticised the objective of ethnographic studies as simply recording 'what is there'. For this study, the first author and researcher, whilst neither a service provider nor user in the health facility, actively engaged and interacted with the people she observed. The presence of the researcher inevitably influenced the 'social action', and therefore it cannot be claimed that *non*-participant observation strictly occurred.

During the participant observation, the researcher orientated herself as closely as possible with the older service users for several reasons. As a young health professional, she expected to identify more easily with those providing the service than those receiving it; and having a health professional background, there may be a tendency to explain structure and action in a health facility in service provider terms. She therefore deliberately avoided accessing large amounts of formal or written information about the day hospital before the study began, and purposefully avoided collecting 'medical' data about the participants (*e.g.* diagnosis) or accessing their medical records. For most of the observational periods, she placed herself in the central day room where

service users were for most of the day. She introduced herself as a student to both service users and providers, and dressed informally. The peripheral treatment rooms (such as the physiotherapy room) were entered only in the company of and with permission from the service users with whom she was interacting.

The fifteen interviews with service users were carried out during the last four weeks of observation. Of the fifteen participants, five were male and ten female, and the age range was from 66 to 89 years (median 77 years). Participants were given a choice of venue for the interview: four chose the day hospital, and eleven their homes. The interview questions focused on the reasons for attending the day hospital, activity there, the participants' views and concerns (if any) about growing older and whether the day hospital addressed these, and a specific question about falling. Information about recruitment procedure is included in 'Sample' below.

Some analysis of documentary sources was also carried out, including the 'Service Profile' and 'Operational Policy' of the day hospital, an information booklet about the day hospital prepared for new service users, and the information leaflets and health promotion posters displayed on the walls. Some of these texts were freely available to service users, and others were requested from staff. Ethical approval was obtained from the joint local research ethics committee, and permission to collect data in the day hospital was sought from the manager and, at her suggestion, from the staff group. A condition of ethical approval being awarded was that the medical consultant providing medical cover also gave his permission.

Sample

Selecting the users of a day hospital permitted access to older people who had regular contact with health professionals and were still living at home. Service users of such facilities are therefore usually more independent and have better health than those in hospital, although have some health care needs, such as functional assessment, rehabilitation, or physical maintenance (Corner *et al.* 1998). Day hospitals may be viewed as providing a service to older people at the margins of the health care spectrum, and their users may be experiencing a transition in health status. Such a setting may be more apposite to a study of the constructions of risk than, for example, an acute hospital in which there may be more of a consensus about risk status and management.

The day hospital was located in the grounds of a large hospital for elderly people, and a newly established service called a 'Fallers clinic' provided rapid response multi-disciplinary assessment and treatment for older people who had experienced a fall. This clinic was however a separate service with dedicated staff time, and whilst the service users could be cross-referred, few of the day hospital attenders were aware of the clinic's existence. The day hospital was in a single storey building, with a day room and patio at the centre. Surrounding this central area were individual treatment rooms, toilets, staff offices, kitchen and a dining room. The clinical team in the day hospital included doctors, nurses and therapists. Service users were accepted if they were aged 65 or more years and required medical, therapy or rehabilitative nursing assessment or treatment; and they generally attended for either two or three days per week.

The names of possible participants were obtained from the daily lists of attenders. The recruitment procedure required that the service users were first provided with verbal and written information about the study, and approached at a later time with the invitation to participate. Of the 60 names on the lists over three weeks, 22 could not be approached a second time, *e.g.* because they only attended once during the recruitment period, 16 declined to participate, and seven could not be identified. Written consent was gained immediately prior to the interview and confidentiality promised to participants.

Data analysis

The tape-recorded interviews were transcribed immediately after they took place, along with notes of the researcher's thoughts and impressions. The data from the first five weeks' observation sessions were entered into the 'Ethnograph' qualitative data analysis software package. The initial coding scheme was then developed, and the refinement procedures began. Later observation and interview data were subsequently analysed using the refined coding system. The coded texts were repeatedly re-read to develop the theoretical framework, while the documentary sources were filed throughout the period of analysis and contributed to the emerging interpretation. This process was facilitated by the production of iterative accounts, further literature searches, and the preparation and discussion of interim reports.¹

Findings

Service providers' orientation to physical risk

The service providers' discourse focused on physical safety and the well being of the older people who attended the day hospital. On initial referral to both the day hospital and the fallers' clinic, the users were given a thorough physical examination by a physician, which involved the removal of outer clothes and lengthy and systematic testing of the various systems of the body. As a new patient commented about her initial interaction with the doctor on her first day at the facility, 'There was not a part of my body that wasn't asked about'. The assessment role of the nurse was emphasised and formalised in the information booklet provided to new attenders with the following description:

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.

The overall aim of the day hospital was described in the 'Operational policy' as to 'promote independent living and good health'. However, the initial experience of service users attending the day hospital was of passive examination aimed at detecting physical malfunction.

The architecture and design of the day hospital ensured that service users were easily visible to staff. The large day room could be seen through glass panels which ran from waist height to ceiling in the corridor leading to the main entrance and exit. Staff offices and treatment rooms were situated peripherally, and so staff approaching the day room had a clear view of the service user group. The two clerical staff worked in an office beside the main entrance, and so could greet people as they arrived, but also check on those who were leaving. The design of the day hospital therefore also enabled easy observation of the patient group, and detection of risks and untoward events such as a fall, the entry of an unauthorised person into the building, or a confused individual wandering. Other rules and practices were designed to reduce physical risk. The day room and main passageways were kept free of obstacles, and larger mobility aids such as walking frames were stored away from thoroughfares. At least one member of staff was normally present in the day room at any time, and at those times when the users were required to move to another area, as at lunchtime, other members of staff would collect mobility aids and wheelchairs and escort the attenders to the dining room. Once seated, they were served their meals by the staff.

Through the study period, the incidence of accidents was low, for

example, no falls were observed. The diligent management of risk had however other consequences which seemed at odds with the promotion of independence, one of the primary objectives of this service. Service users who required a mobility aid to walk had to request help from a member of staff to fetch their aid, as when they wanted to use the lavatory. With a few exceptions, the service users, particularly if new, were discouraged from 'wandering around'. On one occasion, an older woman who had recently begun to attend was uncertain whether she was 'allowed' to use the bathroom unless invited to do so. The teaching of specific mobility techniques, and practice of the techniques, occurred during the treatment sessions by the physiotherapists, usually in the physiotherapy treatment room and surrounding corridor. But the focus on physical risk meant that the skills learnt during these sessions were generally not reinforced or practised in the day hospital without supervision, which was usually provided at specified times. On very few occasions were the service users encouraged to initiate action, for example, to make a cup of tea or coffee or to prepare their own lunch.

Another illustration of the negative consequences of the primary requirement for physical safety was the approach to medication administration. On arrival in the morning, the users were required to hand their tablets to one of the nursing staff who locked all medication away. At regular intervals during the day, a registered nurse would carry out a drug round in which medication would be dispensed, ostensibly to reduce the likelihood of mistakes. Many of the service users were however responsible for taking their own tablets when at home. One participant, Amy, commented extensively on day hospital practice during the course of the interview. She elected to be interviewed at home, and said that the way in which the staff assumed control of her medication was one of several reasons why she disliked attending. To her, this procedure meant that service users were treated 'like children, you know'. She also raised other objections:

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.

Her comment illustrates the awareness and sensitivity of some service users to the social implications of the routines in the day hospital. For Amy, the medication routine resulted in both humiliation and an inflexible practice that denied her access to relief from pain.

Service provision in the day hospital also appeared to prioritise biological function, and risk was therefore recognised as the agents or events that threatened physical harm, such as a fall or a medication

overdose. This risk was managed by the imposition of rules and routines, such as the list of people with diabetes in the kitchen, and at mealtimes by serving specially prepared 'diabetic meals' to this group before the others.

The service users' perception of challenges to self and identity

The service users' conversations, their comments during the interviews, and our observations of them suggested that they orientated to the social nature of the day hospital. In reflecting on her own positive experience of the day hospital, for example, Ella said:

the social side er er helps very much, as I said about talking to other people ... meeting other people and seeing people that are worse off than you ... 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.

From the participant observer's perspective, many implicit rules of social behaviour appeared to govern interaction in the day room. The seat that a service user occupied for much of the day, for example, appeared to be determined both by gender and the accumulated duration of attendances. An area termed the 'main circle' was almost exclusively occupied by women who had been attending for a relatively long time and who initiated most of the conversation and laughter. Group activities, such as the board games organised by a volunteer, tended to be oriented towards this group, the board being placed in their clear view but less visible from other areas of the day room. The 'back row' was used in contrast by people who preferred less interaction or who were new attenders to the service.

The users' orientation to social behaviour enabled them to perceive other manifestations of risk. May, newly referred to the day hospital, during a period of participant observation described the other women in the main circle as 'a cackling load of old devils', and implied that she had 'put her foot in it' with them (Visit 12). She later revealed that during the previous week she had been seen talking with a male service user who had become emotional and upset. In response, she had placed her hand upon his arm to comfort him. May felt that this action had been interpreted as 'familiar' by some of the other women service users, and had upset and annoyed them. Ignorance of the social code in the novel situation constituted a risk, of behaving in an inappropriate or socially unacceptable way.

The role of staff and others with authority to determine appropriate social behaviour was evident in some of the service users' accounts. In

the following excerpt, Irene, whose daughter was a health professional, comments negatively about the actions of a fellow patient who acted against the advice of the senior nurse. Her account invokes shared social judgements about what constitutes ‘good’ patient behaviour (*i.e.* that one is compliant) through use of such terms as, ‘wouldn’t do a thing she was told’, and ‘deliberately got out’, and in the details of the disastrous consequences when one ‘misbehaves’:

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’.

During the interviews, some participants alluded to the broader social risks in the wider community of being perceived as disabled. Pat (P) is the service user in the following extract, who was interviewed with her partner, Colin (C):

P: ... and I think I mean ... 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.

As a service user, to be in attendance at a facility providing health services specifically for older people requiring rehabilitation created risks to personal identities that were valued and synonymous with independence and a general capability in society. Michael powerfully reflected on this during the course of an interview:

You know sometimes in the afternoon they’d all fall asleep [and] I thought, My God, [I never] thought it’d [n]ever 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 or two would be there and their heads would fall back and their mouths would open with a vacant look on their faces.

Sandra, who was in her sixties and had experienced a stroke, when speaking about the day hospital staff, distinguished herself from ‘the older people’ in the day hospital, apparently to distance herself from the negative stereotype of the service user:

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.

These examples suggest that attention to the social milieu of the day hospital permits the construction of a broader view of risk in which personal and social identities are implicated. This alternative view may

better reflect the day hospital experience of the service user, and also illustrates how the identification and management of apparently 'objective' risks, such as the possibility of a fall, may inadvertently create other risks, such as increased dependence and loss of dignity.

Discussion

Across the range of the health services, Petersen and Lupton (1996) have noted the increase in the influence and visibility of health promotion activities. They particularly critique the ideological and moral content of the 'new public health', arguing that health promoters and various institutions work together to produce the 'at-risk' individual. The management of the constructed '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. It is in such ways that the current enthusiasm for identifying the risk factors for health, with the extension of the influence of public health into new spheres such as leisure, diet and sex life, means that the number of 'risky' individuals and activities, far from decreasing, is growing.

The findings of the empirical study illustrate the extension of health promotion principles into community services for older people, as with the fallers' clinic and in many patient information posters and leaflets. The principles of rehabilitation emphasise the responsibility of individuals to participate actively in their treatment, to hasten a return to optimal function (Department of Health 1997; McLellan 1997; Robinson and Turnock 1998). But the service response to the signs of physical risk in the day hospital resulted in an environment in which people were dissuaded from independent activity, and in which normal daily activities such as having meals and drinks were organised and delivered by staff. Service users were sometimes unnecessarily provided with personal help and guidance to carry out daily routines. Ironically, this resulted in a health facility in which some people were less mobile and used fewer life skills than in their own homes. The focus on physical activity and risk, and the staff's role in limiting 'inappropriate' patient behaviour, reinforced passivity among the service users, and also meant that the potential for psycho-social interventions, for example to promote self esteem or confidence, was not recognised and under-utilised.

It also appears that the increasing focus on the health professional's responsibility to maintain the safety of service users, partly through the

rigid interpretation of professional rules of conduct, may also contribute to a conservative approach to service provision in which patient-initiated activity is seen as potentially challenging and dangerous. Additionally, service users may not be aware of, or share, a perception that they can be participants in the maintenance of their own health and function, and may have different priorities. This latter point is reinforced by the apparent orientation of service users to risks of a social rather than physical nature, as in the day hospital but also in the wider community. This tendency has been exemplified in the expressions of the risk of being ostracised through unexpected or unconventional behaviour, the risk of infantilisation on the part of health professionals, and the risk of being stigmatised in one's local community.

It is suggested that the identification of falling as a significant health problem for older people is predicated on positivist perspectives of risk that prioritise the reduction of physical injury or trauma. This positivist construction of a fall as an objective event, which can be prevented and has identifiable precursors and predictable consequences, is problematic for several reasons. Firstly, it isolates the event from its social context. Ballinger and Payne (2000) suggest that for many older people falling is an emotive topic, and that many are anxious to distance themselves from such events to avoid being negatively stereotyped as frail and vulnerable. Other research evidence suggests that older people tend to under-estimate the occurrence of falls, and may be reluctant to disclose their occurrence (Lilley *et al.* 1995). This has obvious implications for the manner in which the issue of falling is approached and discussed with older people. It also suggests that sensitivity is required when recording falls.

A second problem with the positivist construction is the neglect of the contingent and negotiated nature of the risks. Green (1997) showed that the meaning of 'accident' has evolved historically, and that lay and professional attributions of the causes frequently differ. Participation in many health promotion activities, such as falls prevention programmes, is based on shared assumptions about the causes of accidents and how they can be prevented. The common preventive interventions are exercise programmes and modifications of the home environment. If an older person views a fall as a matter of bad luck, does not believe that improvements in muscle strength or balance will reduce their likelihood, and cannot accept that their home is a risky environment, they are unlikely to see the advocated preventative interventions as relevant or necessary. Whilst there is scanty information about adherence in most of the reports of falls prevention trials, the variation in adherence has been recognised (Shah *et al.* 1997).

A third issue raised by the reductionist explanation of falls is that some of the proposed measures either to prevent falls or to minimise their impact create social risks. Participation in falls prevention initiatives means that one is easily identified as an individual with problems. Similar labelling if not stigmatisation occurs with hip protectors, under-garments with soft pads over the proximal ends of both femurs that are designed to prevent fractures. Whilst the evidence suggests that when worn they do reduce the incidence of broken hips, Green (2000: 471) reports that many accident prevention professionals reject the use of what they describe as ‘padded knickers’ because they compromise the dignity and respect of older clients. Non-adherence is recognised as an important influence on the effectiveness of hip protectors (Cameron and Quine 1994).

The prevalence of and harm caused by falls has led to a plethora of information leaflets about their prevention, as produced by *The Royal Society for the Prevention of Accidents*, the *Department of Trade and Industry* and the *Health Education Authority*, and individual health professionals. The effectiveness of such leaflets is contingent on older people recognising their vulnerability, engaging with the contents, sharing their assertions about the causes of falls, and having the resources to follow their recommendations. These presumptions remain untested. In conclusion, we argue that health professionals who work in services for older people should consider the adoption of alternative approaches that emphasise opportunity and valued social identities, such as the ‘Five service accomplishments’ model (O’Brien 1987). Whilst acknowledging the need to be cognisant of risk, we argue that rigid definitions that are defined purely in physical or functional terms produce services which do not address older people’s concerns and in which they will be reluctant to participate.

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NOTES

- 1 Whilst the analysis of documentary sources and semi-structured interviews are usual methods in discourse analytic work, the use of a discursive (or interactive)

methodology in ethnography is less common but has been described by Humphreys (1999).

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