Why older women do or do not seek help from the GP after a fall: a qualitative study

Joanne Dollard\textsuperscript{a,}* , Annette Braunack-Mayer\textsuperscript{b}, Khim Horton\textsuperscript{c} and Simon Vanlint\textsuperscript{a}

\textsuperscript{a}Discipline of General Practice and \textsuperscript{b}School of Population Health, University of Adelaide, Adelaide, Australia and \textsuperscript{c}School of Health and Social Care, Faculty of Health and Medical Sciences, University of Surrey, Guildford, UK.

*Correspondence to Joanne Dollard, Discipline of General Practice, School of Population Health, University of Adelaide, Level 11, 178 North Terrace, Adelaide 5005, Australia; E-mail: joanne.dollard@adelaide.edu.au

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Abstract

Background. It is recommended that older people report their falls to their general practitioner (GP), to identify falls risk factors. However, many older people do not report falling to their GP. Little is known about the reasons why older people do and do not seek help about falling.

Objective. To explore why older women do or do not seek GP help after a fall.

Methods. A qualitative study, using semi-structured interviews with 11 community-dwelling women aged $\geq$65 years, living in Adelaide, Australia, who had fallen in the last 12 months. Interviews focused on women's experience of falling and seeking GP help. Interviews were analysed using constant comparison.

Results. Four women sought GP help when they believed their fall-related injury was serious enough. Family and a bystander persuaded three women to attend for a fall-related injury. The four women who did not seek help believed their fall or fall-related injury was not serious enough to seek help and justified this by using internal rationales (they monitored and managed the outcome of falling, they wanted to be associated with a positive image and attitude, and they recognized and interpreted the cause and control of falling) and external rationales (they did not want to waste GPs' time for trivial reasons and they believed they did not have timely access to their GP).

Conclusions. Given the reasons why some older women do not seek help for falling, GPs should routinely ask older women for their 12-month fall history.

Key words: Accidental falls, general practitioners, health services for the aged, health care seeking behaviour, qualitative research, women.

Introduction

Approximately, one in three community-dwelling people aged 65 years and older (older people) fall at least once a year (1). Falls can affect quality of life, independence, morbidity and even cause death (2,3). As a history of falls is the strongest predictor for future falls, it is recommended that older people report all falls to their general practitioner (GP), so that risk factors can be identified and addressed (4). Few (21–38\%) older people who have fallen present to their GP (5,6). The reasons why older people present to their GP after falling remains unknown, as approaching help seeking from this perspective does not reveal complexities of older people's experiences and decision making.

The literature finds a range of factors influence why people do or do not seek help. Recognizing and interpreting symptoms is necessary for help seeking to occur (7), however, this may not be sufficient to trigger seeking help even if symptoms are interpreted correctly (7). Particularly for older people, symptoms can be minimized or attributed to ageing. Older people may not
want to present for seemingly minor symptoms to be told nothing is wrong, as this could cause embarrassment (7–9).

No studies explored why older people do or do not seek GP help about falling. Research suggests help is sought from GPs when medical treatment is needed for an injurious fall (10). Older people have disclosed falling to their health professional when attending for another reason (11). Personal reasons for not seeking help could be older people’s causal attribution (believing falling was accidental and unpreventable or a result of their behaviour); negative feelings (embarrassment (12) or fear of the consequences (13)) and concern to present as the type who fall (14). Other reasons might include concern that the GP would attribute falling to ageing, or their concern about using the GP’s time for something perceived as non-medical or minor (10,11). Financial disincentives are not as relevant in Australia, as 82% of patients have no out-of-pocket expenses (15).

Knowledge about how community-dwelling older people make help-seeking decisions following falls is incomplete. In light of the potential consequences, much could be gained by a greater understanding of older people’s perspectives on seeking medical help about falling. Greater insight may increase reporting to GPs of injurious and non-injurious falls and trigger falls prevention strategies. This study focuses on women as they are more likely than men to fall and be hospitalized (3,16) and because we know that some help seeking is gendered (7). This study explores why older women do or do not seek GP help after falling, focusing on the initial medical contact with a GP.

Four women were recruited via university colleagues and personal contacts and seven via a general practice (to aid recruiting women who had sought help after falling). Of the 15 GPs working in the general practice, seven GPs consented to their patients being invited to the study. A research practice nurse extracted a patient list of community-dwelling women aged ≥65 years who had presented to the general practice in the last 12 months and selected every third patient (n = 137). GPs excluded 16 patients (moved to residential aged care, deemed too ill or had deceased). The general practice posted an invitation letter to 121 patients. Patients were invited to post the form to the first author (JD) if they ticked ‘yes’ to the following questions: were female, aged ≥65 years, had fallen in the last 12 months and sought help from their GP after falling.

JD received 31 responses and screened these via telephone, to ensure women met the eligibility criteria: women aged ≥65 years, community dwelling in Adelaide, had fallen in the last 12 months, had not attended accident and emergency or been hospitalized, could independently get out of a chair, able to participate in a face-to-face interview and spoke English. Twenty-one women had not fallen in the last 12 months and three women were not interested or did not meet other criteria. Information was posted to the remaining seven women prior to interviewing. One of these women said her GP organized for her to receive the invitation, after learning that she had fallen.

Data collection
JD conducted face-to-face, one-to-one semi-structured interviews in June and July 2009. Interviews took ~1 hour. One woman chose to be interviewed at the university and 10 were interviewed in their home. All interviewees gave written informed consent.

Falls were defined at the start as a ‘a slip or trip in which you accidentally lose your balance and land on the floor or ground or lower level (18)’. The interview guide explored: women’s experience of falling and subsequent actions, experiences of help seeking and disclosure of falling to health and non-health professionals and their expectations of the GP’s role. JD collected demographic information, use of mobility aids and field notes. Interviews were digitally recorded and transcribed verbatim soon after the interview.

JD sent the interview transcript and a summary to the women for member checking to ensure that meaning was not lost in the transcription, enhance the content validity and trustworthiness of the data (19). As a quality check, after the four pilot interviews, one member of the research team (ABM) experienced in qualitative interviewing reviewed the transcript, the interviewer’s interview technique and interview guide in gathering quality data, all of which were satisfactory.
Data analysis

Data analysis was guided by grounded theory methodology. Nine of the 11 interviews were coded by phrases and sentences to generate categories (open coding). Axial coding was used to develop relationships between codes and subcodes. Constant comparison was used throughout open and axial coding, seeking similarities and differences between codes. JD and ABM met frequently to discuss, review and agree on codes. Constant comparison was used throughout open and axial coding, seeking similarities and differences between codes. JD and ABM met frequently to discuss, review and agree on codes. JD developed this process into a hierarchal coding scheme through a process of coding interviews, writing memos, drawing diagrams and reviewing the help-seeking literature. Later stages of the coding scheme were reviewed and refined by JD, ABM and KH, resulting in an agreed coding scheme. Coding the last two interviews resulted in minor refinement and confirmed coding. Negative case analysis was conducted throughout coding. Data saturation was achieved with this sample.

Demographic variables (age, marital status, educational level and source of income) were compared between those who received help and those who did not, and between those who sought help and those who were persuaded by other people to seek help.

An audit trail was maintained throughout the research process. A notebook was used to document sampling, coding, analysis and interpretation. NVivo 8 (QSR International Pvt Ltd) was used to manage data analysis and to document analysis and interpretation, memoing about codes and linking memos with nodes. Powerpoint 2007 was used to diagram relationships between codes. A range of strategies was used to maintain rigour (including an audit trail), conducting deviant case analysis, member checking with respondents for the transcript and multiple authors agreeing on the codes and coding scheme.

Table 1. A summary of women’s characteristics and initial medical contact about fall

<table>
<thead>
<tr>
<th>ID</th>
<th>Age</th>
<th>Marital status</th>
<th>Mobility aid</th>
<th>Received medical help</th>
<th>Initial medical contact</th>
<th>Reason to seek help</th>
<th>Time after falling received help</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>75–84</td>
<td>Widowed</td>
<td>No</td>
<td>Yes</td>
<td>Usual GP</td>
<td>Painful injury</td>
<td>10 days</td>
</tr>
<tr>
<td>02</td>
<td>85+</td>
<td>Widowed</td>
<td>Used walker outside</td>
<td>Yes</td>
<td>Locum</td>
<td>Persuaded by other people</td>
<td>Within 12 hours</td>
</tr>
<tr>
<td>03</td>
<td>75–84</td>
<td>Widowed</td>
<td>No</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>04</td>
<td>65–74</td>
<td>Widowed</td>
<td>No</td>
<td>Yes</td>
<td>GP clinic</td>
<td>Painful injury</td>
<td>2 days</td>
</tr>
<tr>
<td>05</td>
<td>85+</td>
<td>Widowed</td>
<td>No</td>
<td>Yes</td>
<td>GP clinic</td>
<td>Persuaded by other people</td>
<td>2 hours</td>
</tr>
<tr>
<td>06</td>
<td>65–74</td>
<td>Widowed</td>
<td>No</td>
<td>Yes</td>
<td>Nurse in GP clinic</td>
<td>Visible injury</td>
<td>&lt;1 hour</td>
</tr>
<tr>
<td>07</td>
<td>65–74</td>
<td>Married</td>
<td>No</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>08</td>
<td>65–74</td>
<td>Married</td>
<td>No</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>09</td>
<td>65–74</td>
<td>Married</td>
<td>Supported by husband when out</td>
<td>Yes</td>
<td>Specialist physician</td>
<td>Persuaded by other people</td>
<td>Within 12 hours</td>
</tr>
<tr>
<td>10</td>
<td>75–84</td>
<td>Married</td>
<td>No</td>
<td>Yes</td>
<td>Usual GP</td>
<td>Painful injury</td>
<td>5 days</td>
</tr>
<tr>
<td>11</td>
<td>65–74</td>
<td>Married</td>
<td>No</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

*Eldest women aged 87 years.

Results

Six of the 11 women were aged 65–74 years, and five were aged 75–87 years (see Table 1). Women discussed 18 falls (six women discussed one fall, three women discussed two falls and two discussed three). Three falls occurred inside the women’s homes, 5 in the women’s gardens and 10 in a public place. Seven received medical help (for one fall only) and four did not (see Table 1). Of the six widows, five received medical help, and of the five who were married, two received help. Of the six aged ≤74 years, three received help, and of the five aged ≥75 years, four received help. Of the three women who were persuaded to seek help, two were aged ≥85 years, the only two in this age group in the sample. There were no notable differences for marital status, source of income and educational level.

Reasons for seeking help

Perceived fall-related injury as serious

Women sought medical help because they perceived their fall-related injury was serious and required a medical examination. The key indicators of seriousness were pain and visible injuries. Three women sought help for a painful injury. They tried to manage the pain and sought help between 2 and 10 days after falling when pain impaired mobility and everyday activities, continued longer than expected or worsened, or they believed the pain might mean something insidious was developing internally. One woman sought help because of a new visible injury. She had not received first aid and presented to a medical clinic shortly after falling to have her laceration reviewed (see Table 2 for illustrative quotes).
Why older women do or do not seek help from the GP after a fall

Younger female family members persuaded two women to seek help and a bystander persuaded another woman to seek help. Negotiation was used in two instances and coercion in one. Family members and the bystander saw the older women, who all had visible facial injuries, within a short time of sustaining the injury, and organized the medical appointment and/or transport within 12 hours of the injury occurring. Suggestions to seek help were not sufficient to persuade women to seek help.

### Table 2. Reasons older people do and do not seek help about falling

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Quotes from participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For seeking help:</strong></td>
<td></td>
</tr>
<tr>
<td>Perceived fall-related injury as ‘serious’</td>
<td>Pain impaired mobility: I just couldn’t do my normal activities [10]. Well I was limping a lot and I could see I did enough [04]. Pain endured or worsened: I thought this has gone on too long [01]. Pain worried them: I started to worry that I might have something through the knock, that I might have something starting to grow there, and I got a bit of a fright thinking about [01]. New visible injury: I thought something might have needed a stitch because there was blood [06].</td>
</tr>
<tr>
<td>Persuaded by other people</td>
<td>She [bystander] came in and rang an afterhours number for a doctor. ‘Cause she said “Your eyes are all starting to go,” because there was blood here [02]. I didn’t think it was important to see a doctor but my husband called my daughter who was here and I was rushed away to see somebody to which they said they hadn’t seen a black face like that for a long time [09].</td>
</tr>
<tr>
<td><strong>For not seeking help:</strong></td>
<td></td>
</tr>
<tr>
<td>Perceived fall or fall-related injury as not serious</td>
<td>Internal rationale: Monitored and managed the outcome: I thought about going, and I thought ‘oh well there is nothing much he [the GP] can do anyway. I have got a black eye, I think it is just a case of go quietly’ [01]. I was home by myself at the time, so yes, I got up and moved around, stretched myself and sat down for a bit, and felt okay again [08]. Wanted to be associated with a positive image and attitude: Well, I suppose it’s like the little old jokes with the little old ladies having a fall over this and that, … and you’re very aware of the age [10]. Recognized and interpreted the cause and control of falling: No, he [GP] can’t do anything about the pavement. It’s not that I have blackouts or anything like that. If I would be giddy or something like that, yes, but not what’s on the ground when you trip over [05]. But after an hour or so, the pain had gone, so—I’m pretty tough! [08].</td>
</tr>
<tr>
<td>External rationale</td>
<td>GP’s were busy. They did not want to waste GP’s time for trivial reasons: Well, I think, otherwise you sort of feel sometimes it’s a bit foolish; things are not had enough to worry the doctor about [10]. I have always been reluctant to go to the doctor unless I really needed it, more because I think they are just so busy, all the time [01]. Believed they did not have timely access to their GP: As sometimes happens, … by the time you do go, you are getting better, … you feel a bit stupid then [01]. If you ring up she’s a one doctor practice so you will wait a week anyway before you get in to see her … unless it’s desperate and you say ‘I really need to see her’ and then you might get put in but apart from that you will wait a week to get in to see her. So I just didn’t bother [03].</td>
</tr>
</tbody>
</table>

### Reasons for not seeking help

**Perceived fall or fall-related injury as not serious**

The major reason to not seek help was that women perceived their fall or fall-related injury was not serious. Women used three internal rationales to justify self-management.

**Monitored and managed the outcome of falling**

Women consciously monitored themselves and managed (often by resting) the physical and emotional effects of the fall.
They believed they could manage the outcome from falling, as they knew what to do. They also believed that the GP could do no more than what they were already doing. They expected to recover within a time period. Some falls had minor physical or emotional effects and women saw no reason to seek help or report the fall to their GP.

**Wanted to be associated with a positive image and attitude**

Women presented themselves as being strong, independent, self-sufficient and coping. They did not want to ‘make a fuss’ by going to the GP for what they believed they could manage. Some preferred to manage themselves rather than admit to having fallen because of the strong negative association with ageing and decline.

**Recognized and interpreted the cause and control of falling**

Women attributed their fall to extrinsic factors (e.g. uneven footpath) or to their behaviour (e.g. hurrying), which they believed they had control over. Some were aware of their own actual or potential intrinsic risk factors (e.g. giddiness, blackouts, leg weakness, poor balance) but discounted them. They believed they could prevent further falls by ‘taking care’ (e.g. by watching where they were walking or slowing down). Lastly, women acknowledged a loss of function over time, such as leg weakness, unrelated to recent injury and compensated for loss of function, for example, by taking care.

Women used two external rationales to justify self-management.

**Not wanting to waste GPs’ time for trivial reasons**

Women believed GPs were busy and did not want to waste their time for trivial reasons (i.e. fall-related injury). They avoided potential embarrassment by not seeking help.

**Believing they did not have timely access to their GP**

Women believed that they would have to wait for a GP appointment unless they had an urgent reason. This perceived delay was a reason not to seek help when unsure if their fall injury was serious enough. Women did not want to wait for their appointment, to find their injury already resolved, thus wasting the GP’s time.

**Discussion**

Older people are encouraged to report falls to their GP (20) so that the GP can assess the risk of falling with a view to prevent falls, yet only 21–38% of older people who have fallen present to their GP (5,6). These quantitative studies were not designed to explore why people did or did not present to their GP. This is the first study to specifically explore why older women did or did not seek GP help after falling. This study found that older women who sought or received help had a ‘legitimate’ reason—a serious injury as perceived by self and/or others. Conversely, the major reason for not seeking help was perceiving their fall or related injury as not serious.

There were two main reasons for seeking help. First, sustaining a fall-related injury perceived to be serious mostly because of pain. Women tried to manage the pain and sought help when self-care failed, consistent with help-seeking literature (16–21). The key finding that women needed a serious reason to seek medical help (16) (p. 177) was also reported by other studies.

The second reason was the role that sanctioning and instrumental support played in facilitating older women’s medical review. Zola (21) (p. 684) refers to this pattern of help seeking as sanctioning, with ‘one individual taking the primary responsibility for the decision to seek aid for someone else’. Sanctioning has not been highlighted in falls prevention literature; however, help-seeking literature reports that family have been vital in persuading some people to seek help, with the emphasis on other people organizing (or threatening to organize) medical review (7,22–24). For example, Tod et al. (22) found that families legitimized help seeking and made medical appointments for a family member, which overcome delay in help seeking for lung cancer. Our study found that when other people sanctioned help seeking and made the appointment or provided transport, women overcame barriers to seeking medical help. In our study, family and a bystander organized medical review after seeing the women had recently sustained fall-related facial injuries. The two women aged ≥85 years were persuaded to seek help. Therefore, two intertwining explanations for this phenomenon may be that women with a facial injury felt more vulnerable and inclined to accept help; and, those that intervened may have perceived the women with new facial injuries as particularly vulnerable and in need of help. The observed link of being aged ≥85 years (and widowed) and receiving help may well reflect the exponential increase in association of age with fall-related injuries. Cripps and Carman (3) found a 9-fold increase in rate of hospitalization due to accidental falls between ages 65 years and ≥85 years.

The major reason for women to self-manage instead of seeking help, as also found in the help-seeking literature, was that women believed they did not have a serious reason (the fall or injury) to seek help (25,26) and used three internal and two external justifications. Women consciously monitored and managed physical and emotional impacts (25), relying on personal knowledge. Such behaviour contrasted with that of men, Smith et al. (25) found that men sought factual information from various sources to make an informed decision about seeking help. Women self-managing used commonsense, maybe because there was no mystery for explaining vague symptoms that can accompany other conditions. Women wanted to be self-reliant and not make a fuss for something they believed they could manage and wanted to be associated with a positive image and attitude.
(22). Recognition and interpretation of symptoms is a well-documented barrier (7). Older people’s attribution of falling to non-intrinsic factors (14) and beliefs such as taking care and the desire not to waste GPs’ time by presenting with a trivial reason has been documented (7). Some women believed, based on self-appraisal, they might have something wrong, but considered it minor or were unsure and delayed attending a GP.

Many women do not voluntarily report falls and this study showed that women received medical help when they or others perceived they had a legitimate reason—a fall-related injury requiring medical assessment. If older people only present with an injurious fall, then a trigger to implementing falls prevention strategies is missed. Health promotion messages urging older people to report all falls to their GP (20) are unlikely to convince women because as we found in this study, falling alone is not considered a legitimate reason to seek help. We need to increase awareness that all falls are legitimate and worth discussing with the GP. If we can link falls reporting with independence and autonomy, health promotion messages could promote that GPs can help prevent falls and this may sustain a healthier and more independent lifestyle. If GPs ask older women if they have fallen, women might volunteer this information. Therefore, GPs should routinely ask older women in their care whether they have fallen in the last year (4).

A limitation of the study was that the small, gender-specific sample was relatively homogenous, with interviews conducted at one point in time. As the focus of this study was on urban-dwelling older women, it would be informative to conduct comparative qualitative studies with older men to help explain any influence of gender and rural-dwelling older women. Further, we need to know more about the role of people sanctioning seeking help: how prevalent it is and when is sanctioning successful?

Older women sought or received GP help about falling when they had a legitimate reason as perceived by themselves or others. The main reason for women to not seek help was their perception that their fall or fall-related injury was not serious enough. GPs should routinely ask older women in their care for their 12-month fall history.

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Declaration

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