Older Adults’ Risk Practices From Hospital to Home: A Discourse Analysis

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Abstract

Purpose: To understand risk-related practices of older adults returning home posthospitalization.

Research Design: Qualitative methods informed by critical discourse theory, designed to uncover linkages between broader social practices and peoples’ talk and stories, were used.

Methods: Eight older adults, screened as high-risk from an inpatient cardiology unit, and six partners were interviewed face-to-face within three weeks of discharge. A discourse analysis of participants’ accounts of risk was conducted: the cultural and social understandings or conceptual frameworks used to understand risk were identified.

Results: Ableism, a discourse in our society that privileges abledness, was found to permeate the data. Participants underscored that being abled was normal and being disabled was abnormal. Ableism, as a discourse or conceptual framework, compelled participants to appear and act abled, or to perform “compulsory abledness.” That, in turn, produced their responses to risk: a pressure to preserve abled identities created internal and external tensions related to objects and situations of risk and forced participants to use strategies to diminish and minimize risk. Participants created a new response—a position of “liminality” or in-between—where their accounts portrayed them as neither abled nor disabled. This discourse of liminality allowed them to reconcile tensions associated with risk.

Implications: Critical discourse analysis sheds new light on older adults’ risk practices. This approach challenges accepted ways of acting and thinking about what constitutes risk and produces possibilities for alternate ways of representing the same reality.

Keywords: Risk, Discourse, Ableism, Compulsory Ableism, Disability

Among Canadians aged 65 years and older, cardiovascular (CV) disease accounts for the highest number of hospital days (Public Health Agency of Canada, 2009). Discharge from hospital to home is a critical transition for older adults (Boltz, Capezuti, Shabbat, & Hall, 2010; Halasyamani et al., 2006), with rehospitalization more likely to occur during the first 2–3 weeks following discharge (Bixby & Naylor, 2009). During this time, older adults may be at greater risk of negative outcomes due to physical weakness, functional deficits, new and unfamiliar treatment and medication regimes, and psychosocial distress (Altfeld et al., 2013). Yet, it is not known how older adults understand and give meaning to risk in the immediate posthospitalization period.

The discourse approach informing this research takes the position that as people give account of their experiences through the language they use (people’s talk and narrations of experiences and the meaning they attribute to these experiences), their accounts do not just mirror the social world but also help construct it (Holloway & Wheeler, 2010). In the case of risk and older adults, society often constructs older adults as “at risk” and positions them as responsible
for identifying and managing their personal risks through avoidance strategies such as curtailing activities. This may create enormous tensions and contradictions, especially following a period of hospitalization, and compete with older adults’ deeply held value of autonomy (Powell, Wahidan, & Zinn, 2007; Wilson, Burgess, & Hernandez, 2001).

Discourse analysis from a critical perspective makes linkages between how older adults talk about and describe risk and the broader social context in which these stories are produced. In so doing, it contributes to an understanding of how discourses operate to produce ways of thinking and acting in relation to risk. In turn, this can help those working with older adults to better understand and support the choices older adults make that may increase or decrease their risk. The purpose of this study was to understand the risk-related practices of older adults returning home following hospitalization. Discourse analysis is a method of examining how discourses, as part of the broader social context, influence the way people make meaning of their experiences. Such an approach offers opportunities to interrogate wider social practices and the taken for granted. The research question guiding this exploration asked, “What are the discourses that shape, discipline and produce older adults’ meanings, understandings and practices of ‘risk’ posthospitalization?”

Literature Review and Background

The immediate post-hospital discharge period is a time of high risk for older adults, yet gaps in preparing older adults for discharge home have been well documented (Bixby & Naylor, 2009; Popejoy, Moylan, & Galambos, 2009). A body of research has reported inadequate communication of information at the time of discharge to direct care at home and lack of individual and family/carer engagement (Guerin, Grimmer-Somers, Kumar, & Dolej, 2012). An extensive review of research related to discharge planning with older adults revealed a lack of quality content, such as activity resumption, that led to difficulties with self-management during posthospitalization recovery (Popejoy et al., 2009). Similarly, other researchers described “missing pieces” during post-discharge for vulnerable older adults, such as attention to social support and functional limitations (Greysen et al., 2014).

Within the pervasive hospital safety discourse, safety practice is directed toward assessing, predicting and managing risk (Rowland & Kitto, 2014). Yet risk has been addressed to only a limited extent in the hospital-to-home transition literature. Huby, Stewart, Tierney, and Rogers (2004) found risk defined narrowly in terms of safety that promoted a medicalized focus and resulted in attention to older adults’ abilities, limitations, and function. The recurring lack of older adult participation in transition planning, and in some cases a silencing of their voices and preferences, might be expected to result in poor risk management during recovery at home (LeClerc, Wells, Craig, & Wilson, 2002; Popejoy et al., 2009). However, two British studies found that following hospital discharge, older adults made ongoing adjustments and reassessments in managing everyday risks in order to lead a normal life (Mitchell & Glendinning, 2007). Furthermore, McMillan, Booth, Currie, and Howe (2013) found that older adults discharged after a hip fracture achieved a risk balance (through protective guarding and following orders) that was facilitated through discharge information.

Few studies have used a discourse analytic perspective to study risk in older adults during transition from hospital to home. Hicks, Sims-Gould, Byrne, Khan, and Stolee (2012), in their discourse analytic study, found disparities between health care providers’ (HCP) discourse of “giving options and being realistic” at discharge and the experiences of hip fracture patients having no choice and yielding to HCP decision making. The illusion of choice in discharge options for older adult patients positioned them as dissenters, risky, and unrealistic when they challenged the discharge options of expert authority. This contrasts with other research in which older adults identified risk, health, and independence as more important than safety and supervision and better reflecting the realities of their life context (Huby et al., 2004; MacCourt & Tuokko, 2010).

Theoretical Orientation

In understanding older adults’ experiences and practices of risk within the context of transition from hospital to home, this study was guided by critical discourse theory informed by poststructural ideas (Cheek, 2000; Foucault, 1980; 1994). Central to such an approach is an understanding that what is known about the social world is contingent on the existing conceptual frameworks (e.g., theories, ideas, understandings that create and explain the social world) and categories that are available in any given culture or society. As Burr (2003) explains, human beings acquire explanatory frameworks as they develop, and these frameworks are reproduced everyday by everyone through language, stories, and texts. These frameworks become institutionalized (e.g., policies, laws) and become the taken for granted. For example, prominent societal discourses of disability construct impairment and illness as something negative that should be cured, eradicated, or at least its effects minimized. Such a frame of reference has implications for how individuals in society understand and respond to disability and influences how individuals understand who they are in the world (e.g., as abled or disabled) and the meanings attached to these identities. As such, the approach we’ve taken shifts the focus onto the discursive practices (the conceptual and explanatory frameworks available to us in our social and cultural contexts) that shape the ways people actively produce social and psychological realities, and through which they position themselves and are positioned (Burr, 2003; Cheek, 2000; Davies & Harre, 1990). Discourses are the assumptions, words, language, text, and images that produce, shape, and inform peoples’ understandings, meaning-making.
activities, experiences, and practices (Cheek, 2000; 2004; Foucault, 1980). According to Foucault (1972; 1980), discourses produce and reproduce particular representations of reality by positioning people and/or groups in ways that can be both constraining and productive. It is within the context of interaction and everyday talk that people form and often navigate contradictory positions and discursively produce a diversity of selves (Davies & Harre, 1990) while seeking to maintain a coherent identity (Bamberg, 2011).

Such a theoretical perspective seeks not to advance linguistic determinism but rather to complement other ways of knowing and researching, by shifting the analytic gaze to discursive practice. Thus, rather than accepting the reality of risk practices as a given, poststructural perspectives, such as discourse analysis, seek to understand the ways through which “risk” and responses to “risk” come into being—are attributed meaning—and seek to identify how discourses shape these understandings and their political consequences, as well as sites of resistance and subversion.

**Methods**

**Design**

A qualitative research design that utilized a poststructural and critical discourse analytic framework guided the study.

**Sampling and Recruitment**

Study recruitment began following joint ethics approval [H12-00002] by the University of British Columbia Okanagan and Interior Health. The setting for recruitment was an inpatient cardiology unit in a tertiary, acute care center in a Western Canadian urban city with a high percentage of seniors compared to other areas of the country (Statistics Canada, 2011). The cardiology unit served as the site for recruitment because it was not participating in a telephone discharge follow-up study in process at the same time. Over a 4-month period, the Clinical Nurse Specialist (CNS) in Geriatrics consulted with the Patient Care Coordinator on the unit to identify patients who were 65 years of age and older and had a written doctor’s order for discharge to home. The CNS approached a total of 14 patients, gave a brief explanation of the study, and obtained their permission for screening to determine if they qualified for the study. Two patients declined. The 12 consenting patients were screened using Bixby and Naylor’s (2009) Hospital Screening Criteria for High Risk Older Adults, consisting of 10 inclusion criteria (see Table 1), with the presence of two or more of these criteria representing high risk. As per the screening tool, patients were excluded if they were participating in an in-hospital dialysis program, had a primary cancer or neurological diagnosis, or lived further than 30 miles from the admitted facility, as these required specialized follow-up (Bixby & Naylor, 2009). All screened patients met the inclusion criteria, gave consent to be contacted, and received an Information and Consent Form to take home.

A member of the research team followed up with those who agreed to be contacted, to provide additional details of the study, answer any questions, and coordinate a time for a face-to-face or telephone interview. During this follow-up, two patients declined to participate and two others who agreed to interview withdrew—one because of unstable health and the other due to a change of mind. Interviews were scheduled with the remaining eight patients within 2–3 weeks posthospitalization, the time frame when rehospitalization is most likely to occur (Bixby & Naylor, 2009).

**Data Collection**

Prior to data collection, participants reviewed details about the study and completed consent and demographic forms. Data were obtained through individual interviews in participants’ homes. A semistructured interview guide was used to elicit older adults’ perceived risks generally, and specifically related to hospitalization, in anticipation of returning home, and at home, and how they were managed and supported. Partners were included in the scheduled interview with their written consent and that of the patient participant. Interviews took from 1 to 1 ½ hr, were digitally recorded, and transcribed verbatim.

**Data Analysis**

A discourse analysis was used to make sense of the data. In this kind of analysis, the focus is on the broader context: for example, the ways discourses (the assumptions, words, language, text, and images that produce, shape, and inform peoples’ understandings, meaning-making activities, experiences, and practices) influence how people give account of their experiences. Specific to this study, attention was on the ways participants constructed risk in the stories they shared during the interviews. Hole’s (2007a,b) four interpretive readings, a specific approach to discourse analysis, guided the analytic process. An outline of these readings follows. The first reading was an accuracy check of the transcripts and a reading for content. The research

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<thead>
<tr>
<th>Criteria</th>
<th>Frequency</th>
<th>Percentage</th>
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<tr>
<td>Age 80 or older</td>
<td>6</td>
<td>75</td>
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<tr>
<td>Moderate-to-severe functional deficit</td>
<td>1</td>
<td>12.5</td>
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<tr>
<td>Active behavioral or psychiatric illness</td>
<td>1</td>
<td>12.5</td>
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<tr>
<td>≥4 active coexisting health conditions</td>
<td>6</td>
<td>75</td>
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<tr>
<td>≥6 prescribed medications</td>
<td>6</td>
<td>75</td>
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<tr>
<td>Hospitalizations within past 6 months</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>Hospitalization within last 30 days</td>
<td>8</td>
<td>100</td>
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<tr>
<td>Inadequate support system</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Cognitive impairment</td>
<td>3</td>
<td>37.5</td>
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question was the focus of the second reading and asked the following questions: How did participants’ representations of posthospitalization risk influence self-identity? What meaning did they make of their posthospitalization experiences? What metaphors did they use in making meaning? What is not said or implied? The third analytic reading directed attention at how participants located, constructed, and presented themselves in their interviews in relation to risk. What tensions did they experience? What meanings were they trying to convey? What parts of the self did they share? The fourth reading centered the analytic lens on the discourses of “risk” in the participant interviews. Initially, all three researchers coded two interviews and met to discuss and develop a preliminary coding schema that was then used to analyze the remaining interviews. The researchers met regularly to discuss and monitor coding consistency in achieving consensus, and to address internal consistency and analytic validity (Morse & Richards, 2002), and ensure that the data supported the analysis (Sandelowski, 2000). Direct quotes and selective interactions between patient participants and their partners are included to enable readers to evaluate the interpretations.

Findings

Sample Description

Eight older adults and six partners participated in the study. Seven participants had been hospitalized with a primary cardiac condition; one had a fractured wrist with a coexisting cardiac condition. Hospital stays ranged from 48 hr to 5 days, after which patients were interviewed within 2–3 weeks of discharge. A description of older adult patient participants appears in Table 2. The six partners ranged in age from 77 to 84 and were all living with one or more chronic illnesses (e.g., diabetes, atrial fibrillation, stroke).

Responding to Questions About “Risk”

Participants found risk a challenging area for discussion. Older adults and their partners identified common risks such as falling, bathing, and showering resulting from changes in physical strength, balance, and/or dizziness (e.g., medications). Additionally, they described health and treatment-related risks including recurrence (e.g., heart attack), complications (e.g., Stroke), and multiple medication use. More prevalent than commonalities were variations in participants’ responses to risk from those who were evasive and dismissive to those who readily acknowledged the reality of risk in their daily lives. Between these extremes were those who remained tentative, struggled to grasp risk, or reluctantly admitted to its presence. This variability prompted our curiosity about the discursive production of participants’ responses to risk. Findings revealed that participants constructions of risk were: (a) shaped by dominant discourses of ableism, (b) produced compulsory ableism that created internal and external tensions and was

<table>
<thead>
<tr>
<th>Table 2. Description of Sample (n = 8)</th>
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<tbody>
<tr>
<td>Age (X ± SD)</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
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<tr>
<td>Marital status</td>
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<tr>
<td>(Re)married</td>
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<td>Widowed</td>
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<td>Type of residence</td>
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<td>Detached home</td>
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<td>Condominium</td>
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<tr>
<td>Living arrangement</td>
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<td>Lives alone</td>
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<td>Lives with partner</td>
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<tr>
<td>Reasons for hospitalization</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
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<tr>
<td>Myocardial infarction</td>
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<td>Congestive heart failure</td>
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<tr>
<td>Fractured wrist</td>
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<tr>
<td>Quality of life</td>
</tr>
<tr>
<td>Excellent</td>
</tr>
<tr>
<td>Very good</td>
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<tr>
<td>Good</td>
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<td>Fair</td>
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performed in several ways; and (c) and created a new liminal identity. These will now be elaborated.

Discourses of Ableism

Participants’ constructions of risk were shaped and influenced by discourses of ableism that produced the able, strong, and productive self/body as normal and its opposite (disabled, dependent, and unproductive) as abnormal. In this binary, abledness was privileged, assumed normal, and taken for granted, while disability/impairment was different/othered.

This binary was evident in participants’ construction of risk as a disruption to life as they knew it and threatened their taken-for-granted abledness—their ability to be normal and healthy. Participants privileged and took up discourses of ableism, taking great pride in their normal/“usual” age-related prowess, independence, and confidence in being active, doing, and going. Their internalized abledness was manifested in a prehospitalization array of normative activities (e.g., driving, shopping, gardening, and golfing) that were at, or in some instances above, others their age. At the same time, it produced risk as inherently negative in its life-changing disruption, as a 79-year-old
woman captured, “You know you’re so used to go, go, go and then something comes and stops you from doing all that stuff and it’s just... it’s devastating.”

Abled discourses further produced risk as dependence, fledgling vulnerability, and vulnerable. This construction of risk created subject positions of different, dependent, incompetent, disabled (and the counter positions of abled, independent, and competent), and “other.” The accommodations that participants made in response to their health conditions and age produced them as visibly dependent and other. For example, rest and slowing down were common, yet unnatural, accommodations that reinforced their feelings of disabledness, as a male participant revealed, “I’ve been able to slow down pretty good but I don’t like it, you know.” Dependence on others to do what they normally did before hospitalization and in their younger years, such as driving others, also reinforced vulnerability and dependence.

Spouses, too, engaged in “othering” their loved ones as they were transformed from healthy, active, and vibrant into different people. One husband described how his wife’s subject position changed, “Then when she came home, when we got her home... (long pause) she was not the same person. She moved around... she became an old lady all of a sudden.” One wife’s uncertainty led her to reconfigure her husband from healthy to disabled other and ask, “What am I suppose to do with this patient?”

Compulsory Abledness

As participants internalized ableist discourses, they were compelled to act as normal and abled, or to perform compulsory abledness in response to disability and impairment, to avoid being different. This need to appear and identify as able and normal drove participants’ responses to risk, creating internal and external tensions related to situations and objects of risk, and forcing their use of strategies to diminish risk.

Internal and External Tensions

Participants’ internalized, compulsory abledness led to their responses to risk that produced internal and external tensions. At the same time they were forced to exercise caution due to physical symptoms (e.g., fatigue, tiredness, weakness), and others’ sanctions (e.g., doctors, spouses), participants experienced the internal pressure to be productive and doing. An 80-year-old male patient with a myocardial infarction and aortic aneurysm wrestled with this tension, “There are things I should be doing... but at the same time you know, the other part of your brain says, “Don’t do that ‘cause you never know what is going to happen if you do.”

Discourses of abledness produced tensions with others in relation to risks associated with specific activities or objects in the environment. External tensions occurred most often with spouses who thwarted or undermined patient participants’ efforts to perform normality. “Acceptable” activities were one of the areas of greatest tensions between partners. Tensions related to activities, such as stairs, carrying heavy things, lifting, and even walking were intensified when discharge communication was lacking, received second hand, or interpreted differently between partners. Activity uncertainties led a wife partner to default to activity restriction that created enormous tensions for the couple:

X: No, they said walk for 10 minutes only...
Y: Ya and you told me that.
X: That’s what he [cardiologist] told me!
Y: Did he say anything about lifting?
X: No he didn’t say anything about lifting or going up and down stairs or anything else.

Stairs created considerable tension for couples, a symbol of abledness for husbands and a source of risk for wives. A male participant with end-stage heart failure who admitted the stairs were a greater risk than his daily stationary cycling was willing to take the risk, resisting his wife’s suggestion that the bicycle be brought upstairs. Similarly, another wife viewed the stairs as a risk regardless of age while her husband denied the risk, adamently justifying his ableism,

I don’t know why you [wife] get so concerned about the stairs or going down stairs! There is a railing there and you can you know, it’s easy to walk down the stairs sideways you know!” and “If worst got to worst I could sit on each seat and get down there. That’s easy! You’re concerned, I’m not!

External tensions occurred with friends and golf buddies who unwittingly created pressures for participants to resume normalcy. Several participants who golfed four to five times a week had golfing buddies who reinforced compulsory abledness when they communicated an unwillingness to accept the disability. One male participant’s golf partner refused to believe there was anything wrong with his heart, another’s social circle couldn’t believe he could no longer golf, and a female participant’s group of golf friends questioned what was wrong and what she had done.

Performing Compulsory Abledness

Discourses of ableism compelled participants to perform compulsory abledness to counter the unacceptable alternative of performing disableism. Participants performed compulsory abledness in four ways to normalize, reduce, or hide risk. These included: normalizing risk, maintaining business as usual, diverting from physical to cognitive competence, and passing.

Normalizing risk. Compulsory abledness was at work to produce risk as normal. Participants normalized risk by making it inclusive of people, places, and things; this served to minimize, even silence their personal vulnerability to risk. Participants living at great risk with CV disease and who had been “through this [hospitalization] so many times” constructed risk as normal and as bad as it could...
get. A male participant with end-stage heart failure with an inoperable leaky valve asserted, “Everything is a risk actually at this stage. Every day is a risk but nothing out of the usual.” One spouse participant spoke of the normality of risk-taking, “Otherwise, it’s normal you know. Everybody is taking risks every day. But we don’t do it purposely.”

Maintaining “Business-as-Usual”. Participants enacted compulsory abledness by maintaining “business-as-usual” as another way to minimize risk. More typical of male patients and partners, this involved carrying on with daily activities as if nothing had happened. In one couple, the husband said, “we generally don’t let our inability to do what we could do before slow us down. We support one another and don’t let the other stumble too often.” Others were not deterred from travel plans despite some family reservations. They had worked out strategies to continue with travel plans out of province or country. For another participant with several cardiac comorbidities, risk was not an issue 2 weeks posthospitalization, as he had returned to normal activities (e.g., shopping, walking), “I would say things are on the plus side. The risk part… I don’t know how to explain that but I don’t really feel that there is any great concern.”

Diverting From Physical to Cognitive Competence. Participants took up compulsory abledness by diverting attention from their declining physical ability and function to their cognitive competence that they described as still having their “wits” or “marbles” about them. This diversion minimized risks as one participant illustrated: “Risks means a lot of things but I don’t have great worry about it because I think I still have my marbles, even though the rest of my body doesn’t work well.” Cognitive abledness was viewed as important in managing their chronic diseases and multiple medications that in some cases exceeded 10. As one widow describes,

That was sort of upsetting to figure that out [medications], and once you get it that’s fine. I just wrote it all out for myself. But imagine other people who have Alzheimer’s or something and you give them that amount.

Passing . Participants performed compulsory abledness by passing as normal, to minimize, disguise, and/or hide difference. Both patient participants and some spouses passed by limiting disclosure of potential dangers or risks, leading others to think all was normal. Passing involved concealing information or activities from family members such as a 79-year-old female living in her own home “not tell[ing] them [her grown children] everything,” and saying “ya I’m fine” or male participants who tried to conceal their engagement in restricted activities (e.g., sweeping the deck, gardening) but were discovered by their partners or neighbors. Passing was evident in another participant’s initial denial of conversations about risk during his hospital stay but eventual reluctant and “minimizing” admission during an interaction with his wife.

Interviewer: While you were there [hospital] did a nurse or a doctor talk to you about risks that you should look out for in coming back home?
X: Nope.
Y: Well who told you no gardening for the rest of your life?
X: Oh uh, I guess it was Dr. (name).
Y: It was the doctor.
X: Ya, but she wasn’t there that long.
Y: No, but she did … ya the cardiologist told him that.
X: She said to forget the shovel.

Performing compulsory abledness while experiencing disability led participants into a liminal space. It created a hybrid other that involved a merging of the abled–disabled binary.

Liminality

Despite the disruption in their normal, competent, abled body identities, participants resisted subject positions of “disabled” and “impaired.” This rupture between the binaries, in which older adults were neither abled nor disabled, led them to occupy liminality, a hybrid space of being “in-between” two otherwise distinctive entities. In light of their current health status, participants constructed new subject positions—a liminal, “in-between” that resisted a devalued disabled/impaired subject position while holding onto the highly valued abled subject position. They described being in limbo between “I can’t right now” but “I will get back,” making no commitment to disableism, regarding it as a temporary state of affairs, while looking with anticipation, hope, and optimism to restored ableism. Taking up this liminal identity allowed participants to navigate risk by resolving these two contradictory subject positions of disabled and abled and relegating risk to the background.

Within this liminal space, older adults resolved contradictory identities (of being both abled and disabled) by shifting their subject positioning between overcomer and complier. Older adults positioned themselves as overcomers, confident that as in the past they would “overcome,” “beat it,” and “not giv[e] in.” Some expressed “planning on it” and even projected specific time frames, 2 weeks often signifying being “almost back to normal” or “able to go golfing.” One couple exemplified a confidence in a return to ableism, “We’ll rest a while but look out, we’re coming back and we are. There is no doubt about it.” A male participant recovering from a second heart attack similarly communicated confidence, “I tell everybody I’m going to be golfing when I’m 100.”

At the same time, as they presented themselves as confident overcomers, participants positioned themselves, as did...
their partners, as compliers who engaged in risk reducing self-protective activities. These included complying with medical regimens, “behaving” themselves, pacing their activities, staying within acceptable limits, and resting in a variety of ways. This shift in positioning between confident overcomer and restrained complier (good patient) allowed participants to sustain their ableist identities in the face of change and preserve a sense of normalcy and same-ness despite their current realities characterized by difference—difference in activities, routines, self—that served to accommodate risk.

Discussion

This is one of the first studies to explore posthospitalization risk in older adults from a poststructural perspective. Therefore, it offers unique insights into how discourses of ableness produced compulsory abledness and shaped older adults’ particular accounts of risk. Theorizing risk post-hospital discharge from a poststructural standpoint shifts the analytic spotlight away from the individual and toward the discourses (processes and practices) that produce people in particular ways with particular capacities. In this case, ableism, which is embedded deeply and subliminally within Western culture (Lupton, 2013), produced risk as disability, a diminished state of being human, threatening older adults’ ableist identities. Everyday objects and activities became sites where discourses of ableism were taken up in responding to risk but created tensions particularly with partners and family. Tensions and differing views of risk have been reported between older adults and their families, with one study showing that older adults but not family members acknowledged fall risk (Kilian, Salmoni, Ward-Griffin, & Klosek, 2008).

Researchers in the United Kingdom have observed older adults’ tendency to adapt and accommodate to changing circumstances following hospital discharge in self-managing and balancing risks to lead as “normal” a life as possible (McMillan et al., 2013; Mitchell & Glendinning, 2007). Current findings revealed that older adults were driven to return to normal but illuminated the underlying driver as the system of compulsory abledness that left participants without alternatives; assuming normalcy was their only choice. The compulsion to return to normal led participants to minimize, hide, and mask risk by passing: activities, staying within acceptable limits, and resting in a variety of ways. This shift in positioning between confident overcomer and restrained complier (good patient) allowed participants to sustain their ableist identities in the face of change and preserve a sense of normalcy and same-ness despite their current realities characterized by difference—difference in activities, routines, self—that served to accommodate risk.

Theorizing risk post-hospital discharge from a poststructural standpoint shifts the analytic spotlight away from the individual and toward the discourses (processes and practices) that produce people in particular ways with particular capacities. In this case, ableism, which is embedded deeply and subliminally within Western culture (Lupton, 2013), produced risk as disability, a diminished state of being human, threatening older adults’ ableist identities. Everyday objects and activities became sites where discourses of ableism were taken up in responding to risk but created tensions particularly with partners and family. Tensions and differing views of risk have been reported between older adults and their families, with one study showing that older adults but not family members acknowledged fall risk (Kilian, Salmoni, Ward-Griffin, & Klosek, 2008).

Researchers in the United Kingdom have observed older adults’ tendency to adapt and accommodate to changing circumstances following hospital discharge in self-managing and balancing risks to lead as “normal” a life as possible (McMillan et al., 2013; Mitchell & Glendinning, 2007). Current findings revealed that older adults were driven to return to normal but illuminated the underlying driver as the system of compulsory abledness that left participants without alternatives; assuming normalcy was their only choice. The compulsion to return to normal led participants to minimize, hide, and mask risk by passing: maintaining business-as-usual and normalizing risk. Unlike other studies, older adults performed compulsory abledness not to accommodate risk but to disavow risk as disability/impairment (Campbell, 2009), by seeking to fit in and appear normal. Although researchers regard normalization as a positive adaptive coping mechanism for people with chronicity (Joachim & Acorn, 2000), the current study found that the many ways older adults (passing as normal) performed ableist normativity were used to cover risk and resist difference. However, in passing, or failing to disclose perceived or actual danger (Leary, 1999), patients were putting themselves at risk. This self-protection hid valuable information that had the potential to decrease risk.

Discourses produced older adults’ responses to risk as disability yet were used to negotiate new subject positions (Davies & Harre, 1990). Subject positioning is an entry site for considering how individual accounts are constituted from social, cultural, and historical discourses and how people dialectically move between different, even contradictory positions (Davies & Harre, 1990; Hardin, 2001). Older adult participants created a new hybrid liminal identity (Campbell, 2009) in which they moved between the subject positions of overcomer and complier. This positioning allowed participants to preserve a futuristic ableism without yielding to disableism when they occupied neither the world of the abled or disabled. Liminality has been observed in other older adult and “at risk” populations as occupying a space in between health and illness and characterized by ritualized degrees of separation from society (McKechnie, Jaye & MacLeod, 2010). Navon and Morag (2003) found that men with prostate cancer, taking hormonal therapy, assumed liminality because of their inability to classify themselves into culturally available categories.

Despite their varied responses to risk, all older adult patient participants had been screened as high risk using Naylor and Bixby’s screening tool with four factors primarily accounting for their risk status: hospitalization within the past 30 days, age 80 or older, four or more comorbidities or six or more medications. Of these risks, participants identified the management of complex regimens of six or more medications following discharge home as a risk that was offset by their cognitive competence. Although patient participants used their cognitive competence as a diversion from physical ableism, it became an imperative in medication self-management following hospitalization. Yet, in another study, patients with suspected cognitive impairment were found to manage five or more medications alone, without help from family or caregiver (Mehuys et al., 2012). Polypharmacy and cognitive impairment are among several risk factors that warrant careful attention as part of standard hospital discharge that was absent at the time of this study, possibly reinforcing compulsory ableism, and creating tensions for older adults and their partners.

Limitations

Older adult participants took up discourses of ableism in constructing their accounts of risk and created their subjectivities within a specific historical context and culture at a particular moment in time (Foucault, 1972). As such, these discourses are subject to change and are not generalizable. Further, constructions of post-hospital risk were based on a small sample of older adults with cardiac conditions and may limit transferability to other health conditions. Findings are not meant to be authoritative but to give a likeness to the truth, since the analytic focus was not on which account was “true,” but how they performed
“truth,” which is constantly under construction (Hardin, 2001; Hole, 2007a). Although partners were included in the study and their voices heard, they were not part of the original design, and only limited demographic details were obtained from them. Approaching risk from a dyadic perspective could be strengthened in future work.

Implications
Recognizing the binary of abledness/disabledness in producing risk helps to consider possibilities for new ways of thinking about supporting older adults in the liminal space where they create hybrid identities. Traditionally, there have been correct or accepted ways of thinking about and acting toward risk in the health care arena. The over-riding “avoid and contain” approach to risk positions individuals as responsible for making rational and autonomous decisions in managing and controlling risk, or else becoming targets of criticism. The current findings challenge this dominant approach that situates risk within the individual, by revealing the powerful social practices and discourses that act within the individual to produce their responses to risk. For older adult participants, discourses of ableism produced risk as disability threatening the “continuation of a pattern of living that has been carried out over many years” or what Chater (1998, p. 146) refers to as risks associated with aging. Supporting older adults’ ableism during this critical transition might begin with providers being sensitive to the meaning that risk has for older adults at this time when functional abilities are decreased and identity threatened. Further, framing conversations about risk within the language and discourses of ableism (e.g., Abilities, strengths) rather than disableism (e.g., Losses) may counter older adults’ tendencies to hide, cover, or minimize risk and promote honest discussions about safe and realistic risk self-management posthospitalization. The way communication is framed has been shown to influence patients’ risk perceptions and decisions (Edwards, Elwyn, Covey, Matthews, & Pill, 2001).

At the same time, through poststructural analysis, dominant discourses may be challenged and reshaped to produce new knowledges and remake boundaries that better serve the needs of older adults and ensure smoother transitions from hospital to home. For example, risk constructed as disability and a departure from ableist normativity led older adults to minimize risk to assimilate to the normal, to fit in, and to avoid being different, reflecting society’s marginalization of diversity. Given the considerable energy and effort that accompanies trying to be normal, drawing on discourses of difference that promote liminal identities and a space for recovery may better serve the needs of older adults especially in the immediate posthospitalization period.

Tensions between partners especially related to activities were often heightened by the lack of discharge communication or communication that failed to involve the partner. Planned discharge communication involving standardized instruction with family units is imperative to ensure smooth transitions from hospital to home. Other researchers have similarly found gaps in communication, with inadequate information to direct ongoing care following discharge, and lack of individual and family/carer engagement in the process (Guerin et al., 2012; Lee, McDermott, Hoffmann, & Haines, 2013).

In summary, discourses of ableism worked to construct risk in older adults accounts of transition from hospital to home. They compelled participants to conceal risk that paradoxically increased risk. Older adults created liminal identities, a safe space for recovery and where they can best be supported.

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