Challenging Functional Decline as a driver of care for hospitalised older adults: A discursive ethnography

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DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

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(Photo by Jeannine Moreau)

"Oldness" is evocative of decay and uselessness

…functional decline is not pretty.

ABSTRACT

Functional decline is considered a critical issue in health care incurring significant human and financial cost. In hospitalised older adults' care, functional decline is defined pervasively as decreases in the level of socio-biophysical capacity for activities of daily living (ADL) such as personal care and mobility, that are understood to result in further functional impairment and loss of independence. The health care system is concerned about the associated prolonged hospital stays, diminished outcomes at discharge, and increased dependence and/or mortality.

This thesis uses discursive ethnography to get up close to examine functional decline as a discourse (social practices that produce knowledge) focused on older adults' decreasing capacity in the material actualities of hospital experiences. Seven patients, 75 years or older, hospitalised for surgical repair of a fractured hip due to a fall were followed from admission to discharge. Participant observations afforded a view into performances of care within nurse/patient interactions. Conversations and recorded interviews offering a place for older adults and their nurses to discuss the situation.

Foucauldian discourse analysis explicates how assessment technologies, generated by gerontological research to predict which older adults at greatest risk for functional decline, are constituted by a functional decline discourse based on norms reproduced from ADL technologies. Production and distribution of this discourse in the literature and hospital contexts display how these technologies, when redistributed into hospitals are not benign in their effects, but as functional decline imbued discourses of care produce knowledge that normalises and drives nurse/patient interactions within everyday care: constituting nurse and patient subjectivities contingent on how it is taken up, resisted, or ignored, as nurses and patients position within such interactions.

This thesis exposes how functional decline as a discourse *acted* to effect such positioning, eliding other knowledges, ways of perceiving older adults and enacting care. It provides new understandings that challenge such elisions and singular approaches to provide alternative positions more likely to provide patient centred hospital care for older adults, despite the pervasiveness of the hegemonic discourses that dominate and structure health care systems.

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Key to Transcripts

Symbol or designation	Explanation of symbol or designation
For typewritten Field Notes and audio recorded summative interviews. Each participant has a number; if named a pseudonym is used.	
[ ]	Added to transcribed texts to clarify context or circumstance or meaning in written transcriptions of Field Notes
…	… brief pause; the more dots the longer the pause in written transcriptions of Field Notes
R.	Researcher
HCP#	Health Care Provider participant #
Pat#	Patient participant #
(Field Notes # , page #)	Number of "Field Note set", page number where quote located. Seven Field Note sets total, one for each patient participant (see list below). All Field Notes were anonymised.
(Interview: minute: second) e.g., (123456, 14:10)	Recorded interview #, minute: second. Locates which interview and where located on an anonymised audio recording. All audio interviews were anonymised.
Pseudonyms	Each patient participant was given a pseudonym. Only those HCP quoted in the context of a patient tale, as observational data, are given a pseudonym. No "real" names were used.
	Patient #1 is Gladys = Field Note set # 1
	Patient #2 is Evelyn = Field Note set # 2
	Patient #3 is Mabel = Field Note set # 3
	Patient #4 is Henri = Field Note set # 4
	Patient #5 is George = Field Note set # 5
	Patient #6 is Ruby = Field Note set # 6
	Patient #7 is Bill = Field Note set # 7

Chapter 1: Introducing the thesis: the event of functional decline discourse

> Do not go gentle into that good night,
> Old age should burn and rage at close of day;
> Rage, rage against the dying of the light (Dylan Thomas: 1914-1953).

These words speak to how the event of decline in old age, the dying of the light at the close of day, can be fraught with angst and resistance. In geriatrics, functional decline for hospitalised older adults is predominately defined clinically as a measurable decrease in capacity for the activities of daily living (ADL) such as personal care and mobility, resulting in further functional impairment with losses in independent function. Research indicates hospitalised older adults' functional decline can lead to prolonged hospital stays, poor outcomes at discharge, increased dependence, and mortality; offering myriad technologies such as assessments, pathways, and protocols to measure, predict, mitigate and/or prevent functional decline (Chong, Savige & Lim 2009; Graf 2006; Hoogerduijn et al. 2007; Huang et al. 2013). Functional decline is considered a critical issue in health care as it results in significant human and financial costs (Boltz et al. 2010; Helvik, Selbaek & Engedal 2013; Inouye et al. 1993a). Therefore, functional decline is identified as a common complication, a profound marker of morbidity and mortality (Thomas 2002) and a serious concern for nurses (Resnick, Galik & Boltz 2013). The issue of functional decline in hospitalised older adults is often framed in the literature as a problem compounded by the anticipated grey tsunami, such as claims of a rapidly rising number of Canadians aged 65 years and over projected to be more than 24.5% of the population by 2036, as much as 28% by 2061[1]. Australia is not far behind with statements of alarm over the numbers of people aged 65 years and over, predicted to be more than 22% of the population by 2056[2].

This thesis engaged discursive ethnography to get up close to examine the multi-faceted complex workings of functional decline as a discourse produced, operating, and re/distributed from fields of published research initiatives into material realties of hospital settings. Discourse is defined here as social practices that systematically produce knowledge and reproduce social systems by forming the objects of which it "speaks" (Foucault 1972;

[1&2] Retrieved 12/9/2016 http://www.statcan.gc.ca/pub/91-520-x/2010001/part-partie3-engn.htm and http://www.aihw.gov.au/ageing/older-australia-at-a-glance/ respectively

1981). Discursive analytics provided a means to unpack and examine discourse as events ordered by *a priori* rules of formation that are the actual situation, place and time conditions of possibility for a discourse to exist. Yet discourse is simultaneously constraining and controlling, delimiting what knowledge is to be known or excluded, valorised, subjugated or not heard. Ethnography provided "a way in" to see and hear up close how these 'conditions are constituted by the very concrete discursive and non-discursive practices of a culture' (Mahon 1992, p. 12), in this case the cultures of care for hospitalised older adults. Importantly, ethnography offered opportunity to see and hear how discursive practices operate in everyday hospital interactions. In particular, to hear the voices of older adult patients and the nurses who care for them; voices typically missing in geriatric literature and research that can deeply affect them because such initiatives commonly focus on meeting institutional mandates in search of effective efficient care practices (CIHR 2007; Foss 2011; Jones 2012; Latimer 1999; Leahy, Thurber & Calvert 2005). Discursive ethnography as a methodology informed analysis of how discourse produces knowledge, constitutes and delimits time, space, social realities and subjectivities within and across fields of relations. This methodology enabled exposing the power/knowledge complex of discourse as a discourse produced by knowledge. Yet discourse is simultaneously constraining and controlling, delimiting what knowledge is to be known or excluded, valorised, subjugated or not heard. The thesis as such is not about finding solutions or alternate truths but to unpack and re/think the discursive formations of care practices so as to think beyond functional decline discourse currently formed and enacted to create space for other ways to attend to older adults' care.

In this chapter I introduce functional decline, how it is currently articulated in geriatric literature to show what kinds of knowledges are thought, produced, said, heard and/or enacted in relation to older adults' hospital care. I recognise and describe critical factors of how geriatrics, as a field of practice, became defined with its origins in modernity as a progeny of medicine; how it is delimited by its roots in biomedicine and biomedicalised health care practices; how it can be questioned by drawing from critical gerontology. Subsequently I outline how geriatric practices contextualise the study by describing the four primary prevailing geriatric care technologies and how each is delimited in structure by interrelated discursive formations of functional decline. Further, I briefly outline the

importance and suitability of Foucault's ideas and analytic strategies to render discourse visible and hence analysable. Foucault's strategies, however, do not address the immediacy of immersion in everyday material realities. Hence I sketch out my use of discursive ethnography as a poetic of methods which is about offering in processes of thesis work a place for researcher and reader to engage imagination, to be emotionally moved by and impassioned about how care of hospitalised older adults is driven by the discourse of functional decline. I then move to describing what was closely under study with a synopsis of each chapter to show the coherence of the thesis structure.

Functional decline discourse: an introduction

In contemporary society functional decline in older adults is pervasively taken-for-granted as a reality and defining feature of hospitalised older adult's subjectivity. This thesis reveals how functional decline discourse materialised to define reality discursively, forming objects, concepts and strategies embedded in care technologies that operated to organise, control and manage older adults and their hospital care. Discursive formations so pervasive and common they seemed banal, and assumed natural framing of older adults and their care. What was not recognised or understood about functional decline was how, as an event, it is contingent upon conditions of possibility or enunciative modalities; nor how functional decline discourse prevalent in the field of geriatrics delimited knowledge production; how various discursive formations of functional decline discourse figured, influenced and constrained care practices representing and positioning nurses and patients accordingly. This thesis exposes how functional decline discourse is hegemonic, hence, rarely questioned or critiqued.

Functional decline is examined to reveal how it came to dominate with significant constitutive effects illustrating its power/knowledge complex, disturbing research initiatives conceptualised through the lens of functional decline as an object of concern. This led to questioning how functional decline as a discursive strategy constructed care technologies. These technologies re/distributed into hospital settings mediating hospital care practices, elided other possibilities for framing care of the older person. Such analytics troubled the power and dangerous characteristics of normatively defined functional decline as not only a

clinical phenomenon, but a socio-political force constituting older adults' hospital care, older adults and those who care for them.

Almost all published research (Appendix B.1 outlines how the literature was sourced) on functional decline and hospitalised older adults involves quantitative methods with the aim of constructing measurable, reliable and generalisable technologies to predict, prevent and/or mitigate functional decline. Some studies evaluated or compared how clinimetrics such as ADL technology and assessment are effective or not in managing functional decline. Others evaluated technologies for purposes of determining best practices for screening and risk assessment of functional decline. Some searched for but did not "find" consistently effective and efficient tools to order older adults' care and contain health care costs (cf. Beaton & Grimmer 2013; Hoogerduijn et al. 2014). Studies also focused on assessing how well ADL technologies and other clinimetrics using statistical values could or could not show the extent of older adults' functional decline during or following hospitalisation to categorise and target those most needy and focus health care dollars accordingly (cf. Chodos et al. 2015; Wojtusiak et al. 2016). Some studies wrestled with the value and reliability of screening initiatives to actually measure and predict frailty, aiming for outcomes to manage, mitigate or prevent the *risk* of functional decline associated with frailty and old age (Robinson et al. 2013; Scandrett, Zuckerbraun & Peitzman 2015). Other studies aimed to improve the reach and impact of health assessment technologies or diagnostic accuracy to better detect and/or predict older adults' functional decline (cf. Grimmer et al. 2016; Huang et al. 2013) or did not find any one ADL technology for measuring functional decline consistently reliable (Hoogerduijn et al. 2007). Nursing literature offered various views on how functional decline, as a concept and/or strategy, is considered critical in developing and organising hospitalised older adults' care (Kalisch, Lee & Dabney 2014; Resnick et al. 2016). One study examined mobility, socio-biophysical capacities and hospitalised older adults' functional decline as interrelated objects and questioned care, concluding 'solutions to prevent disability that encompass diverse patient populations and diagnoses have remained elusive' (Graf 2013, p. 5).

Of interest here is the instability of functional decline as a discourse. The above publications revealed the tentative consistency, usefulness and/or effectiveness of discursive formations of functional decline as object, concept, or strategy to reliably

measure, predict, define, manage, and/or contain the deleterious effects of hospitalisation for older adults. Also noted in this literature was a lack of qualitative methods and a rarity of critique. In response, this thesis uses a qualitative methodology of discursive ethnography to examine and critique how as socio/political practices of knowledge production functional decline discourse constitutes older adults and their care; how as a discourse it is 'a violence we do to things, or in any case a practice that we impose on' hospitalised older adults and those who care for them (Foucault 1981, p. 67).

Key to informing the thesis topic organised as a discursive ethnography was to describe how modernity influenced the construction of medicine as a biomedicalised discipline and later geriatrics as a subfield of medicine. Also key was to engage with ideas and debates in critical gerontology to extend ways to analyse and trouble interconnectivities of geriatric medicine and functional decline as a biomedicalised discourse.

Modernity, Geriatrics and Critical Gerontology: key thesis informants

> Medicine remains a bastion of power and privilege, doctors are respected professionals and the public demand for better medical technologies and drug therapies is as great as it was in the 1970s. (Lupton 2005, p. 123)

The thesis is informed by a description of how tenets of modernity continue to inform and structure with evident effects contemporary medicine and geriatrics as a subfield of medicine. Medicine materialised as a discipline out of modernist, grand narratives of the sick with a drive to find scientific truths defining illness, sickness and disease and to discover cures and care procedures accordingly. These grand narratives continue to structure contemporary medicine sustaining it as a 'bastion of power and privilege' (Lupton 2005, p. 123). Further, geriatrics as patterned after medicine is based on biomedical sciences which has led, in the case of ageing, to its biomedicalisation of hospital care practices (Estes & Binney 1989; Kaufman, Shim & Russ 2004). As such tenets of modernity continue to structure geriatric care modalities.

Modern medicine's 'date of birth' is 'the late years of the eighteenth century' (Foucault 1973, p. xii). A time when grand narratives prevailed through valorisation of disembodied reason used to produce accurate and objective accounts written using a 'neutrality of reasoned judgment' for purposes of scientific objectivity (Hartsock 1998, p. 206). Medicine remains primarily structured according to scientific modalities and

persistently engages disembodied reason and the objectivity of biomedical discourse based on biomedicine and notions of transcendent subjectivities (Clarke, Rose & Singh 2013; Foucault 1973). Contemporary medicine as a branch of medical science is founded on the knowledge systems of biology and natural science applied into clinical practice. Integral to medicine as a grand narrative is the conceptualisation of the hospital patient that transcends and effaces the individual through hegemonic homogenising effects where 'biomedicine is often thought to provide a universal, scientific account of the human body and illness' (Good 1994, front page).

The tenets of Modernity are recognisable in medicine through faith in science and technology as critical to knowing *accurately.* For example, care technologies like clinical pathways (CPW) are assessments primarily designed by ADL technology based on norms that result in normalised care practices (Lawal et al. 2016). The focus on calculability, measurability and accuracy makes such technologies amenable to being framed as valid, reliable or effective as per the prescribed rules of quantitative methods with statistical analysis central for objectively producing "hard" facts (Creswell 1994). Geriatrics as a subspecialty of medicine (Achenbaum 2004) is true to medicine's history of bio-physicality and natural sciences, continuing to be 'regulated more in accordance with normality than with health…in relation to a standard of functioning and organic structure, and physiological knowledge' (Foucault 1973, p. 35). The physical concreteness of modern medicine as it socially and politically influences and shapes geriatric practices fosters the biomedical gaze, constituted as a means of observation to empirically know the truth.

The power of medicine and geriatrics rests on scientific validity and authority of biomedical discourse that legitimises both fields as scientific. Biomedical refers to attributes of the 'hard' science of biology as applied to medical theory or practice, the discipline of medicine. It focuses 'on the molecular, physiological and pathological mechanisms believed to form the basis of biological process' (Willard 2005). Biomedical discourse, a social practice that constitutes bioscience as an authoritative field of medical research and development, is the backbone of medicine as a socially legitimised and authorised ensemble of interrelated discourses foundational to health care. The essential traits of biomedical discourse, as one discourse in this ensemble, not only structure medicine and geriatrics as language markings, statements or fragments of scientific discourse, but also legitimise what

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is understood as "in the true" of bioscience within the practices of both fields; marking 'medicine as an institution, system of knowledge and practice' (Kaufman 1994) and geriatrics similarly.

This dominance of biomedical discourse underpins the cultural order of ageing and elides social interpretations of illness in old age. Especially as medicine and geriatrics operate by a scientific authority via prevailing practices of medical diagnoses that inform treatments of illness framed as 'biological deviance' (Freidson 1972) or 'biological pathologies' (Willard 2005). Notions of functional decline follow suit in geriatrics, defined as a bio-physical measurable entity, whether as a state, a concept, or strategy used to mark levels or possibilities of morbidity and mortality in hospitalised older adults (Thomas 2002). Functional decline as a biomedicalised discourse depicts ageing and being old as self-evidenced inevitabilities of biophysical decline. As such the medical model that structures geriatric practices offers only partial knowledge as it operates to 'emphasize disease and disability as inevitable products of old age' (Lupien & Wan 2004) in contrast with social interpretations of illness. This understanding also informs how geriatrics is based on hegemonic notions of objectivity, measurability, normativity and decline, often languaging ideas and concepts in binaries of health/illness, normal/abnormal, standard/deviant, healthy/pathological. Further, such highlighting of biophysical risks in ageing effaces the older adult as a sentient person through erasure of the cultural order (Kaufman 1994). A closer examination of the field of geriatrics illustrates these discursive effects.

Geriatrics, or applied gerontology, is distinguished as 'a medical specialty devoted to older people and their disorders' (Evans 2011, p. 166), focused on pathological notions of ageing and being old via 'highly technical and instrumental, avowedly objective, value-neutral and specialized discourses' (Cole, Van Tassel & Kastenbaum 1992, p. xii). Thus as a set of discourses, an interconnected set of writings and ensemble of social practices, geriatrics produces knowledge about ageing processes and bodily experiences of being old 'in accordance with rules, protocols, and generative formulas… [as an] area of scholarly work…methodically organized expertise' (Green 1993, p. 20). As a health care field defined according to the bio-characteristic of subjects being *over* a certain age, the older adult becomes an object of concern conceptually segregated from society at large. The older person is figured pathologically in decline, an object to be scrutinised by the medical gaze, a

self 'disembodied, separated and distinguished' (Holstein & Gubrium 2000, p. 18) by timeless universals of inevitable deterioration, where functional decline is normalised as 'human nature' (p. 19). Geriatrics mirrors how 'society views ageing through the prism of illness' (Hazan 1994, p. 20). As such, geriatric discursive practices produce delimited formations of what constitutes hospitalised older adults' subjectivities and their care. These formations were analysed using Foucauldian research strategies of archaeology and genealogy as outlined in chapter two.

Critical gerontologists provide critiques with insight into how power/knowledge operates in geriatric literature, research initiatives, care technologies and practices. Their writings aim to expose assumptions, discontinuities and contradictions on ageing and being old; how biomedicalisation is privileged in representing the older body eliding sociological views; how normative practices govern older persons as a population of in-common characteristics in contrast to individuals with a unique mix of characteristics with distinctive "real" life experiences (Powell & Wahidin 2006). Their critiques inform how geriatric practices can be problematic. They question taken-for-granted geriatric practices of assessment and expose how such assessments are focused on pathology, categorising and stereotyping older adults as a population defined and normalised as at risk of biophysical decline. Critical gerontology makes apparent how this form of discrimination based on assumptions of pathology is ageist. As the following descriptions of geriatric practices indicate, a form of ageism so deeply engrained in geriatrics and older adults' care it is hegemonic and unnoticed.

Geriatric practices as functional decline discourse: thesis context

Geriatric practices can be described as 'methodological commitment to scientific inquiry…logical and empirical accuracy of theories, the interpretive adequacy of explanations, and the validity and reliability of measurements' (Green 1993, p. 179). How these practices underpin the development of geriatric technologies imbued with functional decline discourse dominate in contemporary health care and structure hospitalised older adults' care contextualises the study. Acknowledging context enabled deeper understanding of the power/knowledge complex of functional decline discourse, its dominance, taken for granted practices and assumptions in contemporary geriatrics. In chapters four, five, and six

I show *how* functional decline discourse materialised and dominates in such practices, *how* it orders knowledge production and operation of geriatric care, *how* it delimits what is reasonable, comprehensible, or possible to think, say, or do in older adults' hospital care and how it constitutes subjectivities.

These care technologies dominate geriatric practices: 1) assessments; 2) syndromes; 3) teams and units; 4) models of care. Each technology was located in discursive fields of scientific research methods, biomedicalised hospital and health care policies/practices and medicalised techniques of older adults' care. Each was illustrated as a matrix made up of various concepts such as illness, disability, diagnosis, age, ADL technology, functional status, surveillance and/or calculable ordinal assessment techniques. The discourse of functional decline became visible as an object of concern on such grids; conceptualised as measured or levelled decreases in socio-cognitive and/or biophysical performance, determined by objective/ordinal measurements of the older adult's functional capacities, commonly including psycho-socio-and/or-biophysical characteristics. Thus these technologies were perceived as valuable tools in the care of older adults because they provided: 'direct observation of physical function [which] has the advantage of providing an objective, quantifiable measure of functional capabilities' (Reuben & Siu 1990, p. 1105). Although each technology is discussed separately, they are interconnected by matrices of concepts that constitute functional decline, each producing knowledge of the older adult as a measurable object of concern, a targeted subject potentially amenable to respective identified care interventions.

Geriatric assessments

Geriatric assessment became the technology of geriatrics, thus legitimating its existence as a separate and necessary medical field. (Kaufman 1994)

Geriatric assessment (GA), at times interchanged with Comprehensive Geriatric Assessment (CGA), is an ensemble of metric tools used to measure functional status usually including physical, cognitive, and/or psychosocial aspects. GA is claimed to be a discrete technology that affirms and differentiates geriatrics as a medical specialty (Kaufman 1994, p. 432). GA over time has become a valued tool to objectively predict, determine potential or actual decreases in functional status typically labelled as functional decline (Guralnik et al. 1989). GA differs from 'a standard medical evaluation by including nonmedical domains

such as measurements of quality of life like validated screening instruments for depression' (Elsawy & Higgins 2011, p. 48) using ordinal values.

Functional status (FS) was conceptualised as measurable (ordinal values) physical, cognitive, psychosocial capacities for purposes of assessing and depicting an individual's functional abilities (Gilleard 1981). Any measurable decrease in ordinal value, typically by level, was commonly referred to in published literature as functional decline. The older adult's level of FS is, therefore, commonly used to interpret, determine and/or represent their functional capacity and related care needs as illustrated by Guralnik et al. (1989, p. M141):

> By understanding the functional capacities of patients, caregivers are better able to judge disease severity, the impact of multiple morbidity (which is common in older individuals), and the need for rehabilitation and support services.

Guralnik, et al. (1989, p. M141) also argued 'valuation of physical functioning plays a valuable role in clinical geriatrics as well as in aging research'. Their argument continues to be echoed by others such as Cohen, et al. (2002), Hoogerduijn, et al., (2007), Mezey, et al. (2004), Vermeulen (2011) who also valued metric techniques of geriatric assessment to measure, evaluate and predict which older adults are or will likely be in functional decline. Functional decline was a discourse, conceptualised as an assessable and measurable object and effective care strategy integral to GA. As a strategy formed by the way it was talked about as a reliably measurable entity it was recognised as a profound marker of morbidity and mortality, used to identify which hospitalised older adults may worsen or die or likely transfer to a nursing home or need additional community resources (Thomas 2002). Thus functional decline became embedded in geriatric assessment operating as a predictive discourse that produced knowledge not so much of *how* to care for older adults but how to *guide* care based on actualities or potentialities for change in biophysical functional status. Further, as to be discussed in chapter four, entwined with other discourses about risk, desire, investigation and such functional decline as a discourse produces knowledge of potentially more efficient and effective ways to categorise older adults, to group them by assessed care needs around ADLs, targeting health care dollars accordingly.

GA was generally seen as a highly valued multi-dimensional, interdisciplinary diagnostic tool (Ellis et al. 2011) and 'a practical instrument to prevent hospitalization, to

increase survival at home, and to improve functional status in elderly patients' (Sommeregger et al. 1997). Hence GA has been for some time considered crucial in managing hospitalised older adults, in particular by 'detecting treatable functional impairment promptly…for discharge planning and prognostication' (Hoenig & Rubenstein 1991, p. 221). Contemporary studies and literature reviews continue to illustrate how in GA clinimetrics, most focused on ADL technology [a few include socio-cognitive-psychometrics], continue to play a role in the field of geriatrics, engaging social practices of categorising and managing older adults and their care accordingly (cf. Chodos et al. 2015; Warnier et al. 2016; Wojtusiak et al. 2016). As Kaufman observes this 'socially constructed need for patient management lent authority to the concept of geriatric assessment' (1994, p. 433), an observation that persists today.

These two examples of GA illustrate how functional decline was conceptualised as an object of concern and a strategy to frame a population so that assessment, ordering and managing of older adults and their care are normalised. For instance, the Identification of Seniors at Risk (ISAR) tool uses ADL technology and conceptualises functional decline as an adverse outcome in connection with risk (risk of adverse outcomes), safety (identification of risk) and cost (readmission and institutionalisation). ISAR is

> a six-item self-report questionnaire developed to identify persons of 65 years or over in the emergency department (ED) at risk of adverse health outcomes, including mortality, functional decline, readmission and institutionalization'. (Deschodt et al. 2011, p. 422)

Likewise, the Hospital Admission Risk Profile (HARP) also incorporated the understandings of functional decline, risk and safety using ordinal values and is termed 'a simple instrument'. HARP is

> an instrument for stratifying older patients at the time of hospital admission according to their risk of developing new disabilities in activities of daily living…[and is] a simple instrument that can be used to identify patients at risk of functional decline following hospitalization. (Sager et al. 1996, p. 251 & 257)

A study assessing/comparing these two 'instruments for identifying acutely hospitalised older patients at risk for functional decline' (Hoogerduijn et al. 2010, p. 1223) concluded:

> [ISAR's] specificity and positive predictive value are poor, resulting in the identification of too many patients who are not at risk as patients at risk [whereas]…

HARP shows the lowest sensitivity and the highest specificity, leading to possible underestimation of the patients who are at risk and overestimation of those who are not at risk.

This study attested to inaccuracies in the operation of geriatric assessment instruments as does Warnier, et al.'s (2016) systematic review of screening tools for frailty in older adults, concluding 'for no tool, however, is clear evidence available yet regarding validity, reliability and feasibility' (p. 218). When such outcomes are compared to the above comments about GA as highly valued, crucial and important, what counts as GA is contested.

Also contextualising the study are researchers like Avelino-Silva, et al. (2014, p. C122 & 123) who value GA in light of the emergent 'geriatric boom' and make claims such as risk assessment is 'paramount…as old age is a risk'. However, they also claimed the challenge with GA is that it is 'often incompletely executed, therefore, negating the benefits' (p. C125). Such assessment tools used to distinguish and categorise the older person present as objective assessment technologies informing health professionals of the functional status and any declines. Other forms of decline were also highlighted in this science of geriatrics and some have been targeted as germane to geriatric assessment, separated out and incorporated into a technology known as geriatric syndromes.

Geriatric syndromes

The development of geriatric syndromes emerged out of 1980s as strategies to target which older adults were most likely to experience functional decline based on a list of conditions considered specific to old age. Descriptions of these syndromes delineated what was thought particularly important or the most significant geriatric medical problems or symptoms focusing on 'anatomic and/or physiologic abnormalities of discrete organ systems' (Tinetti et al. 1995, p. 1348). Geriatric Syndromes comprised an accounting of such factors as a diagnosed condition, severity of illness in combination of a bio-identifier of age that identified and categorised the older adult according to their failing functional status or level of decline. Such categories conceived of as syndromes rendered the older person visible as belonging to a specific population. Practices that defined older persons by pathology and deemed them incapacitated by symptoms such as delirium or frailty which facilitated targeted treatment of symptoms with care focussed on their relief.

However, despite how common in the geriatric literature, there was no clear consensus about exactly how to describe or determine a Geriatric Syndrome. As Flacker (2003, p. 574) remarked 'what is a geriatric syndrome anyway?' Despite this lack of clarity, Geriatric Syndromes were considered events 'triggered by acute insults, and often linked to subsequent functional decline…[they can] result from the accumulated effect of impairments in multiple domains'. Geriatric Syndromes frame and label the older adult by their functional status in terms of deteriorating health, diminished capacity and increasing dependence which is typically referred to as functional decline. Researchers van der Meide, et al. (2015, p. 860) illustrated this predilection for the biophysical saying 'vulnerability of older hospital patients is increasingly understood in physical terms, often referred to as frailty. This reduces the older person's vulnerability to the functioning body'. Despite such reservations about the impact of the label "frailty", it became a Geriatric Syndrome to 'provide an explanation for the downward spiral of many elderly patients' (Ahmed 2007, p. 748).

Some researchers decided 'to characterize self-neglect definitively as a geriatric syndrome by identifying an association with functional impairment...[claiming it is] often…regarded as a personal preference or behavioral idiosyncrasy that becomes more apparent in older age' (Naik et al. 2008, p. 388 & 392). A Geriatric Syndrome has the discursive effect of labeling and positioning the older adult as responsible for their functional decline with an accompanying moral tone of self-imposed risk.

Geriatric teams and units

During the 1980s in response to the perceived high proportion of older adults entering acute care with some degree of functional disability 'the geriatric evaluation unit and the geriatric consultation team [were]… developed to address the special needs of hospitalized elderly' (McVey et al. 1989, p. 79). Of interest here was how 'improving functional performance and preventing functional decline…was an important objective of these geriatric services' (p. 79) although over time this targeted approach to care was challenged as not economically viable. Thus also of interest was how specialisation cultivated the development of expertise and groups of experts focused not on older adults' care generally but care closely associated with assumed inevitabilities of functional decline linked to old age. As these teams and units became recognised as organised and operated

by geriatricians (experts in their field), their mandated focus on addressing the pathology of ageing and losses in functional status gave authority and legitimacy to functional decline as an unquestionably effective discourse in producing knowledge about older adults and their care.

Engelhardt et al.'s (2006, p. 20) review found consultative work by Geriatric Evaluation and Management (GEM) programs (which can be teams or units) brought better outcomes of 'health care utilization, health care cost, and survival' in targeted care of frail 'elderly' than regular care. Of note was the emphasis on cost effectiveness in contrast to personal effect on the older adult. However, this study had divided results on the benefits of GEM programs overall. Cohen, et al.'s (2002) earlier study of 11 GEM programs also had had mixed results of benefits/no improvement with uncertainty about effects of interventions. These findings echoed some of the already much earlier outcomes by Epstein et al. (1987, p. 299 & 303) who surveyed 104 inpatient/outpatient geriatric assessment units, comparable to the GEM. They found inconsistencies from one unit to the next with mixed results. Hence they claimed a need to evaluate the 'optimal structure, targets, and function' of geriatric assessment units especially because most units 'consume substantial resources… [although] considered a potentially useful but expensive new technology' and questioned 'which types of patients may benefit most from specialized care…which types of assessment and management will be most cost effective for these different patient groups'. As recent as 2011 (Lafont et al., p. 645), a comprehensive international study on functional decline in hospitalised older adults included an examination of teams and units and suggested:

> The process of care reveals shortcomings: lack of geriatric knowledge, inadequate evaluation and management of functional status. The group suggests that interventions must not only identify at-risk patients so that they may benefit from specialized management, but they must also target the hospital structure and the process of care.

What these initiatives made apparent is how the discourse of economic rationalism is entwined with discourses of risk and functional decline to inform expertise in this kind of geriatric care. An expertise focused on delivering greater economic efficiencies for managing, ordering and controlling a defined "at-risk" older adult population. What constitutes knowledge and expertise in these specialised units and teams was delimited and constrained primarily by medical knowledge as noted in other geriatric care technologies.

Knowledge based on functional decline as a calculable and measurable concept, an object of concern amenable to assessments. The knowledge produced by these geriatric teams and units was generally assumed to be expertise, interpretable and accountable for organising and managing efficient and effective older adult care.

Geriatric models of care/programs of care

This type of geriatric technology operated differently than units and teams because it was geared to care for those older adults already assessed as being at some level of functional decline. Acute Care of the Elderly (ACE) exemplified how geriatric models of care operated by combining 'principles of geriatric assessment and quality improvement' in response to the problem of functional decline as 'associated with serious sequelae including prolonged hospital stay, nursing home placement, and mortality' (Palmer et al. 1994, p. 545). Physician researchers (Palmer, Counsell & Landefeld 2003, p. 507) using Randomised Controlled Trials found the ACE approach brought 'improved functional status, lower risk of nursing home placement and higher levels of patient and professional satisfaction with care are achievable with ACE'. They affirmed how functional status is a critical measure/predictor stating 'the importance of functional decline is illustrated by studies of prognosis of hospitalized older patients…the design of the ACE unit intervention was based on a conceptual model for functional decline' (p. 508). Nursing views on ACE (Panno, Kolcaba & Holder 2000, p. 53 & 57) illustrated underpinnings of functional decline, risk and economic rationalism with the claim that ACE 'provides an effective, proactive, inexpensive framework for addressing the complex health needs of older adults…ultimately reduc[ing] costs associated with functional decline'. They noted how 'protocols that will facilitate best practices include assessment of functional status' (p. 57). Others (Jayadevappa et al. 2006, p. 186) using a retrospective case–control design found 'ACE unit patients to have lower medical care cost, shorter LOS, and fewer readmissions', showing an entanglement of functional decline, economic rationalism, risk and managerialism discourses. In a literature review on ACE units Ahmed and Pearce (2010, pp. 219-220) concluded ACE (p. 219) with key factors of 'environmental modifications, nurse led care, and formal daily interdisciplinary team meetings…[is] a valuable alternative paradigm of acute geriatric care'.

Description of these geriatric care technologies vividly illustrated how geriatrics as a subspecialty of medicine and hence geriatric knowledge and expertise embraces a

universalist approach. As important, as critical gerontologist Allen Irving in Powell and Wahidin's (2006, p. 26) edited text explained, geriatrics uses an empiricism engaging a naturalised discourse of aging that 'detaches bodies from their concrete locations…that has allowed us to create bodies through metric, indexical, and quantifiable means…discourses of measurement'. As such these descriptions of geriatric technologies explicated how functional decline as a discourse entwined with discourses of measurement and risk have normalised, standardised and objectified care practices that made it possible to order, manage, and control older adults as indexed objects of care.

Foucault's work was integral to the analysis of how and when functional decline as a discourse materialised in such technologies and to what effect on hospitalised older adults' care. Of importance was how his approach to analysis enabled questioning and problematising the constitutive power of functional decline as a discourse embedded in geriatric expertise, knowledge and care technologies in the context of how hospitals and care systems operate.

Locating Foucault in the thesis

> Knowledge and power are integrated with one another and there is no point in dreaming of a time when knowledge will cease to depend on power; this is just a way of reviving humanism in a utopia guise. It is not possible for power to be exercised without knowledge it is impossible for knowledge not to engender power. (Foucault 1980a, p. 52)

This thesis examined the constitutive effects of the power/knowledge complex inherent in the discourse of functional decline and geriatric practices dominating in hospitalised older adults' care. Knowledge was defined as 'that of which one can speak in a discursive practice… defined by the possibilities of use and appropriation offered by discourse' (Foucault 1972, pp. 182-3). Statements, as the basic unit of a discourse, were located in fields of relations and organised as 'systems of conceptual formations' (p. 60) forming a text containing strands of said discourse materialising as language, symbols, and/or images. Intertextuality referred to an ensemble of texts as located in such fields of relations making up interrelated social structures and processes manifest for example as a field of quantitative research practices, the discipline of medicine or a hospital site (Foucault 1972). Texts therefore in this study were located, accounted for and collected as written, read, spoken, visual and performed; perceived as integrated with or contiguous with other texts.

Texts, therefore, offered a place to locate statements and organise strands of discourse for purposes of analysis, in particular, to expose the power/knowledge complex of discourse.

Many scholars have taken up/interpreted the diverse ways Foucault himself defined discourse, translating his definitions to be suitable for the purposes of what was under study (Mills 2003). Thus as Mills suggests, it is critical in any study to define discourse to make clear how it is being used for what purpose, to find out what and to know what. The definition is as much about the researchers' thinking as the doing of the research. Foucault described discourse as constituted by rules, systems and procedures, the *a priori* rules of knowledge formation, a domain of discursive practices he referred to as the order of discourse (1981). Discourse is more than language or a series of signs or a tight embrace of words and things that come to mean something. It is a system of thought, a framework of discursive practices that capture the objects producing what is visible, doable and sayable, our social realities (Foucault 1972). Hence discourse as social practices of knowledge production is inextricably linked with the exercise of power, generating knowledge as well as being produced by knowledge. As Parker (1992, pp. 18-19) explained 'discourses do not simply describe the social world, but categorise it, they bring phenomena into sight…once an object has been elaborated in a discourse it is difficult *not* to refer to it as if it were real'. This was an important consideration which this thesis aimed to show by revealing how functional decline discourse is material and constitutive with substance of spatial-temporal character. Discourse has a social, cultural and historical existence and embeds what is experienced as real, for example, by nurses and patients in hospital settings. Discourse as such was framed as a trialectic of space/power/knowledge, ruled by *a priori* procedures and considered both productive and delimiting of reality, allowing, constraining or excluding what was sayable, doable and thinkable.

Foucauldian analytics which are more fully detailed in chapter two were used to illustrate how one discourse and not another obtained prominence, produced authorised knowledge and was widely re/distributed. Discursive analytics unpacked the paradox of how such seemingly sedimented discursive authority can waver by revealing how its existence was contingent on current conditions of possibility. Analysis explicated how these conditions of possibility were dependent on where a discourse was uttered, 'who is

speaking, his [sic] position of power, the institutional context in which he happens to be situated' (Foucault 1978, p. 100).

Foucault's work informed how discourse is comprised of tactical elements, fluid, changing, unstable not static. Therefore, discourse was viewed as 'discontinuous practices, which cross over each other, are sometimes juxtaposed with one another…[and can] exclude or be unaware of one another' (Foucault 1981, p. 67). A discourse, therefore is what it is only in the moment of its use as it may or may not continue to exist as in that moment, disappear or change into something with different characteristics or markers (Andersen 2003, p. 21). Hence, in examining the place and power of functional decline discourse in the context of hospitalised older adults' care, it was important to see the instability of its power/knowledge effects due to the tactical nature of its existence in relation to specific conditions of possibility.

Engaging Foucault's way of defining discourse and consequent view of any text or statement was framed by his idea of power/knowledge working together, always in relation, with reciprocal effect on the other. Moreover, this form of analysis viewed each as a transitional set of relations contingent on the space of utterance or appearance. Power could then be viewed as exercised through apparatuses of discursive control such as policies and practices requiring prescribed research methods or enactment of authorised care technologies that operated as 'effective instruments for the formation and accumulation of knowledge' (Foucault 1980a, p. 102). However, despite the authority of these apparatuses acting simultaneously producing scientific and practical knowledges, the contingency and hence uncertainty of the effect of such apparatuses and knowledge production was only a potential.

As this thesis is about functional decline defined by measurable socio-biophysical characteristics (ADL technology) producing knowledge specific to managing older adults' bodies and defining them as a population of concern, Foucault's notion of bio-power was of particular relevance. Bio-power as drawn from Foucault's work entails

> one or more truth discourses about the "vital" character of living human beings; an array of authorities considered competent to speak that truth; strategies for intervention upon collective existence in the name of life and health; and modes of subjectification, in which individuals work on themselves in the name of individual or collective life or health. (Rabinow & Rose 2006, p. 195)

Bio-power relies on established authority to order and manage life via "collective existence" using demographics to define the collective as a statistically defined population for purposes of targeting life and health intervention strategies. Bio-power is therefore a politics of life and death with power not only situated but also exercised at the level of life, governed by strategies of monitoring, organising, and controlling individuals as populations of concern (Rabinow & Rose 2006). In capillary form, bio-power is established in hospitals by techniques of surveillance, discipline and self-discipline and managerialist practices to achieve daily subjugation of patient bodies with the intent to promote recovery from illness, to get patients through the system efficiently and economically and to prevent death. Bio-politics using such techniques to order and manage patients defined hospitalisation as a form of disciplinary power (Foucault 1977) wherein 'the force of bio-power lies in defining reality as well as producing it' (Dreyfus & Rabinow 1983, p. 203). However, any form of power 'exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures' (Foucault 1982, p. 788) .

This way of framing power/knowledge enabled examination of how bio-power operated in the realm of scientific knowledge in research *and* in hospitals; how it has effect but only when exercised. For example, how research initiatives bio-scientifically structured care technologies via norms of measured bio-capacity, normalising assessments, then ordering older adults accordingly. Nonetheless, the power of technologies was only effective to the extent technologies were taken up, resisted or ignored. Only when scientific knowledge was engaged did bio-power play out as mechanisms of power, as 'corporeal rituals of bodily discipline' (Hook 2001, p. 532). Thus, only when exercised does the power of a discourse of assessment materialise as knowledge produced 'generating, enabling, and limiting empowered/disempowered subject-positions' (p. 528) of nurse and patient.

Power, as described by Foucault (1982), was taken up in this thesis as neither a fixed entity nor defined concept but as fluid and changing techniques/mechanisms/strategies manifest in a field of relationships of people and/or things, such as care technologies in fields of research and hospital. Within these fields of relations were shifting configurations of interrelated hospital practices, conduct of care and patient responses. Discursive fields, therefore, were webs of interrelationships involving language, power, knowledge, social

institutions, truth and subjectivities because 'power is not a thing but the name attributed to plural and diffuse strategic relations' (Bacchi 2012, p. 4). A hospital itself is therefore a discursive field of interrelated people and things; a web of policies, practices, procedures, design structures and knowledge operating multi-dimensionally as a network of power relations. Knowledge produced within such webs is distributed via organisational scripts and daily routines (Foucault 1980a) as power is not static, possessed or repressive, necessarily bad or good, right or wrong. Power is relational with reciprocal effects because 'discourse can be both an instrument and an effect of power' (Foucault 1978, p. 101).

Therefore, discursive analytics was not about *judging* what discourse does but making discourse visible to expose what discourse does as social practices of knowledge production and to question 'the way in which knowledge circulates and functions, its relations to power' (Foucault 1982, p. 781). Hence, by making visible what discourse does exposed how knowledge was produced by discourse and enabled seeing consequent powerful discursive effects. However, as with any form of power, the power of knowledge only exists when put into action, especially as knowledge to be heard and taken up must be legitimised and authorised not by an author per se but contingent on the space where enunciated, and who spoke in the name of what credentials to whom (Foucault 1981). Thus some kinds of knowledges were valorised while others subjugated or disqualified as local and specific (Foucault 1980a, pp. 82-83). These insights informed the need to engage discursive ethnography in effort to see up close the working of practices and the power/knowledge of discourse in hospital spaces.

Engaging discursive ethnography as poetic practice

> …the crucial poetic problem for a discursive ethnography becomes how 'to achieve by written means what speech creates, and to do it without simply imitating speech'. (Clifford & Marcus 2010, p. 12)

This discursive ethnography is a poetic practice, imaginatively moving analysis beyond literalness of everyday speech to critically examine the materiality and power of discourse as social practices of knowledge production. Existing studies, many from nursing, influenced and contributed to arguments and thinking of how to use discursive ethnography and get under the skin of the topic, to see what was not obvious on the surface of things. Combining ethnography with discursive analytics provided methods to produce an archive

of textually mediated data that encompassed the voices, performances and views of participants alongside images, words and symbols of geriatric practices and the voices published in written texts offering truth claims, "expert" views and knowledge.

Discursive ethnography exposed the discrepancies between theory and practice as exemplified by Allen's (2004, p. 271) review of nursing literature that revealed a disconnect between nurses' theoretical image of nursing work as 'individualised unmediated caring relationships [and] real-life practice…of [being] the healthcare mediator'. Ceci (2003, p. 61 & 64) raised similar 'questions about nursing, nurses and knowledge' using Foucault's idea of problematising to disrupt thinking *about* nursing knowledge as self-evident and to trouble dominant views of what nursing is, leaving off with a 'lurking' question of what are nurses 'meant to do and be in their practices?' This lurking question suggested a need for discursive ethnography to see up close and to examine discursive practices. Latimer (2000) demonstrated in her ethnography with observations of hospitalised older adults' care the need to discursively examine health policy and institutional practices with actualities of nurses' conduct of care; to gain insight about what nurses accomplish in care delivery and the impact on treatment of older adult patients. Rudge (2003) demonstrated how examinations of everyday material realities of nursing care using discursive ethnography can explicate assumptions, meaning-making, and power relations in the microphysics of nurse/patient interactions exposing the power/knowledge of discourse in the forming of nurse and patient identities. Purkis (1994; 1996) explicated how "the social" in nursing practice is elided by dominant biomedical practices as nurses were observed working in social spaces not technical spaces. These studies, comparatively examined ideology, language and discourse in relation to context, identity politics, power relations and effects of social/temporal/spatial spheres. They explicated what is assumed, absent or invisible in standardised documented care practices and/or research outcomes producing knowledge of care practices in relation to what actually happens when care is observed in clinical settings.

The following views informed the relevancy of discursive ethnography to explicate power/knowledge effects of biomedical discourses of care, to expose how such discourses privilege certain knowledges in hospitals and care practices. For example, Willard (2005, p. 116) drew attention to how interrelationships of biomedical language and biomedicalised discursive practices in the hospital field objectify the individual as a target of assessment

and surveillance; how assessments were structured with emphasis on pathologies in contrast to 'preventing illness or creating the conditions of health'. Anspach (1988, p. 372) showed how figuring "the patient" as an object of concern under the medical gaze represented and positioned the individual as a 'passive receptacle for the disease rather than as a suffering agent'. Holstein and Gubrium (2000) exposed how institutional care systems failed to address issues of older patient's experience by not allowing the patient to be acknowledged as a unique self and/or by ignoring intricacies of what it means to be an ageing person. Their findings supported an argument for discursive ethnography as necessary to look beyond the immediacy of observing in the institutional setting to examining how its organisational systems structure and permit exclusionary practices in the mundane of hospital care. Van der Meide, et al. (2015, p. 860) showed how hospital practices can reduce older adults' 'vulnerability to the functioning body... and ignore the role of the hospital environment [especially as] vulnerability...is increasingly understood in physical terms, often referred to as frailty'. Their outcomes showed how discursively set care practices delimit the constitution of older adult subjectivities. Discursive ethnography goes further to expose how the power/knowledge complex of discourse operates in producing the bodies of older person and the problems that this population will effect.

In this study discursive ethnography as a poetic of methods provided "a way in" (Latimer 2003) to recognise statements of discourse such as inferences, analogies, objects, definitions and blocks of words, single words or phrases and then to organise them as various strands of interrelated discourses. It allowed analysis 'based upon, or infused by, social or cultural meanings: that is by intentions, motives, beliefs, rules, discourses and values' (Hammersley & Atkinson 2007, p. 7). It provided means to trouble interpretations and sense making across seemingly disparate yet inextricably interconnected fields (Latimer 2003; ten Have 2004). Discursive ethnography provided means to be critical, to question what people were writing, publishing, thinking, performing, imaging and saying about functional decline as the topic of interest and what is under study.

What is under study

The thesis question is: In what ways is nursing care provided to hospitalised older adults mediated by discourses of functional decline and how are these processes reflected in everyday nurse/patient interactions?

This study takes up what other studies do not: how functional decline was produced, materialised and operated *as a discourse*, and a network of social practices of knowledge production with constitutive effects on the care of hospitalised older adults. Using Foucauldian discursive analytics the study explicated how functional decline is more than a concept or object of study as framed and talked about in geriatric literature. This Foucauldian approach revealed how functional decline was a discourse produced by certain kinds of legitimised knowledges located in geriatric research initiatives and produces knowledge with constitutive effects in older adults' care.

The research design targeted older adults hospitalised for hip fracture because this population is predicated as at greatest risk of experiencing functional decline. The field, an orthopaedic surgery unit and affiliated rehabilitation unit, was in a mid-size hospital. There are about 4,000 hip fractures each year in the province where the hospital is located with 20% of seniors who suffer a hip fracture dying within one year (Centre for Hip Health and Mobility). Research indicates 75% of hospitalised hip fracture patients are age 75 years and older and functional decline associated with hip fractures in older adults is generally three times greater than for non-hip fracture patients (Bentler et al. 2009). Up to as many as 90% of patients with a hip fracture go to a rehabilitation unit prior to hospital discharge. Wherein rehabilitation occurs along a continuum of care; access to various services is monitored by the Health Authority to mitigate danger of 'periods of potential instability and increased risks of complications, morbidity, and mortality' (Huber 2010, p. 66).

Structure of the thesis

This thesis has seven chapters. Following the introduction is the methodology of discursive ethnography with discussion of ideas and theories informing, influencing, and shaping the thesis. The third chapter, outlines and explains research methods. Both chapter two and three discuss how Foucault along with poststructuralist, feminist and critical social theories, ideas and ways of thinking are integral to the research processes. Chapters four, five and six outline and discuss the analytic outcomes. Chapter four provides a genealogy which is an analysis of the conditions, actions and effects of the discourse of functional decline in terms of the care of hospitalised older adults as located in various fields of relations. Chapter 5 explains and discusses how the motif of mobility in relation to

functional decline pervades literature, care technologies and hospital field sites and to what effect. Chapter six integrates the outcomes from analysis across field sites to describe how patients are moved through the hospital system as affected by the discourse of functional decline. Chapter seven concludes the thesis with a discussion of insights, learning and knowledge gained, identifying challenges, implications and possibilities for nurses and their care for hospitalised older adults in the context of functioned decline.

Chapter 2: Ethnography in discussion with Foucault

This chapter is about writing things into something; the thesis research processes grounded in philosophical underpinnings and ideas, practices for doing research as a discursive ethnography. Foucauldian, postmodernist, poststructuralist and critical feminist ideas and perspectives informed the order of things, the thesis study and structuring of research processes as discursive events. Foucault's ideas, thoughts, writings and analytic strategies were central to the methodology.

Writing the thesis: realisations of suchness

> It is like clouds rising in the sky: suddenly there, gone without a trace.
> And it is like drawing a pattern on water: it is neither born nor passes away….
> When it is enclosed, it is called the matrix of the realization of suchness. (Ma-tsu, c. 960 – c. 987)

Understanding how to assemble thesis elements into a system of methods resembles Ma-tsu's notions of clouds rising, patterns on water; emerging in processes of thinking about things from somewhere to there, but then not *there* until one writes about such things into realisations of suchness, writing the thesis. Theoretical ideas and perspectives for the thesis came by articulating and rearticulating methodological possibilities, backtracking and rethinking/rewriting ideas to avoid the thesis appearing to be 'the leap out of the marked body …a conquering gaze from nowhere' (Haraway 1988, p. 581). Here I tell how I landed there, somewhere; how I theoretically situated the study and myself as researcher and situated the ethnographic gaze so the study comes from "somewhere" based on "situated knowledges" (1988). This is not to transcend objectivity but to be explicit about the subjectivity of the researcher and the particularities of the study and hence, to methodologically construct embodied practices producing embodied knowledge. Ethnography was enacted as a process and practice using the body itself as a tool for reading, observing, interviewing, analysing and writing up. Doing ethnography was as much about "being" a researcher as "thinking about" and "doing" research.

This chapter outlines the use of archaeology, genealogy and ethnography as ensembles of analytic tools informing methods to examine discursive practices in relation to older adults' hospital care explicated from written, read, spoken, imaged, symbolic and performed texts. The theoretical ideas and perspectives, underpinning how this study was

conceived and conducted, were critical to understanding the relevance and effectiveness of this set of tools.

The thesis was situated in ideas of modernity and engaged postmodernity and poststructural frameworks grounded primarily but not exclusively in the theoretical and philosophical work of Michel Foucault. It also drew from others immersed in postmodern and postructural thinking including those who have taken up and/or expanded Foucault's ideas. A Foucauldian philosophical approach provided ways to question and trouble how it is things are as they are and to what effect on how we make meaning and experience our realities, not to discover or produce new truths. Key concepts in this philosophical approach to analysis included power, knowledge, truth, subjectivities, texts and discourse. How I interpreted and understood these concepts informed how I conceptualised the thesis as a study that examines and problematises the powerful and sustaining effects of discourse on what is thought, said and done. These perspectives and concepts situated the thesis historically and culturally yet recognised that contexts are not fixed or stable and discourse is not necessarily all-constraining or defining but contingent on circumstance, time and space of appearance.

Modernity, a 'condition of knowledge' (Lyotard 1984, p. xxiii) from the 17th century was characterised by Hartsock (1998, p. 206) as fixed, 'disembodied reason…objective'; life elements are objects, objectified and portrayed as neutral, humans typecast as universal homogeneous entities. Modernist thinking denies 'the importance of power to knowledge' (p. 206) rendering invisible the powerful effects of knowledge produced and presented, for example, as legitimised by science discourse, subsequently assumed authoritative in health care practices. Modernity as noted in the previous chapter underpins the structure, processes and function of medicine as a dominant discourse in contemporary health care.

Postmodernity was a rupture in and rejection of modernity's homogenising system of organising thought into the grand narratives Lyotard described as "totalizing philosophic positions" (1984; 1993). Being positioned within postmodernity therefore allowed for recognition of the diverse and at times confusing range of theoretical standpoints, the embodiment of who and what we are as unstable subjectivities contingent on circumstance. It offered critique of the inherent rigidity of modes of rational thinking and truth statements framed by positivism and modernity, into a way of questioning the purported neutrality and

universality of knowledge (Macdonell 1986, p. 22). Critique as such is a form of social criticism, viewing the social world as 'contextual, plural, and limited' (Hartsock, p. 170 & 206). Questioning is another technique informing methods exemplified by postmodern feminist gerontologist Ray (1996) who posed several categories of questions that unpack assumptions, and challenge traditions in research on ageing and being old. Hence, tenets of postmodernity were used to disturb assumptions about prescribed scientifically established truth claims rather than offer alternate truth claims. Instead, application of a postmodern stance showed how such truth claims required contexts that operated as social practices of knowledge production. For example, knowledge produced as truth claims was shown to be contingent on how research practices were structured, conducted by whom, published where with which outcomes redistributed for what purpose.

Post-structuralism arose primarily from critique(s) of Saussure's ideas of structuralism that framed language as a 'general system of sounds and meanings [that] underlay the mass of spoken and written utterances' (Macdonell 1986, p. 9), that is, language as transparent structures of fixed meaning. Poststructuralism, a form of postmodernist thinking, rejected static notions of meaning in language, viewing language and texts as not singular but operating intertextually, endlessly referring to each other from the past and possessing implications for future texts. Texts which can be language, images and/or symbols following along the lines of post-structuralist thinking, were therefore understood as containing discursive forms of 'social organization, social meanings, power and individual consciousness'; where subjectivities were constituted, and socio-political consequences were 'defined and contested' (Weedon 1987, p. 21). The power of language then becomes how it 'allows entities and a world to be; it is a condition for the existence of a world' (Mahon 1992, p. 122). These are critical notions informing the relevancy of using archaeology, genealogy and ethnography as a kit of analytic tools using strategies of questioning, troubling and critiquing texts. Thus a poststructuralist approach can problematise hegemony, fixed ideas and universalised norms, to question 'meanings in their material and social construction' (Macdonell 1986, p. 24). As well, these forms enabled methods to see how discourse never operated in isolation but always in relation to other discourses all vying for dominance in thought and ideas which were 'neither denying ambiguity or endorsing it, neither subverting subjectivity nor denying objectivity, expressing

instead their interaction' (Tyler 1986, p. 186). Critical feminist perspectives based on tenets of fairness and social justice informed these methodologies by providing a 'crucial point of entry, a starting point for understanding how social relations are conceived…how they work…how institutions are organised' (Scott 1990, p. 135) and enabled understanding of how discourse operated differently from different standpoints with different outcomes.

As Foucault did in his analytic endeavours, the relationship between methodology and theoretical ideas and perspectives were revisited and revised in the design of this study. Over time Foucault had changed, deleted and modified his ideas according to what he discovered as useful and relevant to his current study (1970; 1972; 1973; 1977; 1978; 1981). Reading Foucault's many books, lectures and interviews informed how to use his work as he did, backtracking, changing one's mind, repeating/discarding ideas, shifting analytic approaches, taking new approaches and rewriting previous ones. Needless to say Foucault is daunting. The fluid nature of his methodological strategies, however, enabled others as myself to do likewise, to adapt methodologies to a study's design to suit current research purposes. The spaces in his strategies provided room in the study design for postmodernist, poststructuralist and critical feminist works to create a more fulsome workable methodology.

Archaeology: explicating structures and powers of discourse

Foucault realised that prior to writing the 'Archaeology of Knowledge' in 1969, the power of discourse was not obvious in his analytic work. His purpose in writing archaeology as a methodology was to more explicitly analyse how power shaped discourse into systems of knowledge and knowledge production. Archaeology, however, was not about determining what was meant by knowledge but about determining the discursive conditions of its existence. The question was what conditions made it possible for what was said, then taken as truth, as reasonable and utterable, authorised and heard as knowledge.

Archaeology then is a dimension of analysis to identify and examine the basic elements formed by a discourse, how these intersect in discursive formations of objects, subjects, enunciative modalities, concepts and strategies. Preliminary to discursive analysis of texts it was necessary to understand how these discursive formations function as sets of relationships and practices immanent to a discourse. It was necessary to understand what *a*

priori rules are present in relation to how they operated as mechanisms, procedures and processes that defined the limits of a discourse, what is thought, sayable and doable, how they were the disciplinary aspect of a discourse with a regulatory function to 'gain mastery over its chance events, to evade its ponderous, formidable materiality' (Foucault 1981, p. 52). Archaeology offered the means to recognise these rules, how they regulated discourse, effect conditions of possibility for a discourse to materialise and operate as a social practice, and then to produce knowledge. Hence, archaeology brought into view how power/knowledge in discourse operated, and how discourses as social practices 'systematically form the objects of which they speak' (Foucault 1972, p. 49). Archaeology uncovered how 'the fields of relations that characterizes a discursive formation is the locus in which symbolizations and effects may be perceived, situated, and determined' (p. 163). Hence archaeological tools made discourse visible and amenable to analysis as 'a complex differentiated practice, governed by analysable rules and transformations' (p. 211).

Archaeology as discursive analytics builds an archive outlined through a system of statements, that appear to regularised and organised as sets of interrelated statements. For a statement to have meaning and recognisable function it had to be located in a set of related statements in reference to a field of truth and knowledge. For instance, in the operating of functional decline as a discourse, this only became apparent when set statements about functional decline were seen in relation to statements on older adults, hospitalisation and measures of their biophysical functional status as truth claims in scientific knowledge, research methods and production of care technologies. The archive therefore was a system of statements, a practice of organising statements according to discursive events and things related to it, that specifically informed, influenced and/or referred to areas or elements within my topic of interest (Foucault 1972). Statements therefore to be recognisable and useable were delimited by where each was situated in a set of relations.

In a "positivity" the accumulation of statements of a discourse were laid bare (Foucault 1972, pp. 125 -128). A positivity 'defines a limited space of communication…defines a field in which formal identities, thematic continuities, translations of concepts, and polemical interchanges may be deployed' (pp. 126-7). In a mass of located texts, to expose a discourse was to organise a set of relations composed in

relation to extra-discursive elements like 'an institutional field, a set of events, practices, and political decisions, a sequence of economic processes that also involve demographic fluctuations, techniques of public assistance, manpower needs, …etc.' (Foucault 1972, p. 157). This discursive field was then amenable to an analysis of how social structures *and* processes of discourse *contain* and *constitute* social practices. For example, the field of geriatrics is a current iteration of previous practices, formed according to *a priori* rules that formed its objects, enunciative modalities, concepts and strategies (1972).

Formation of objects, enunciative modalities, concepts and strategies

Foucault's three principles or *a priori* rules for discursive formations of *objects* are about making visible how discourses systematically constitute the objects of which they speak (1972, p. 38 & 49). These rules render objects manifest and definable hence locatable within a patterned system of communication or discourse. In this study, the object (functional decline) constituted through scientific study was mapped and made visible, as described below, through 1) its **surfaces of emergence** or existence, 2) the **authorities of delimitations** and 3) the **grids of specifications.** These *a priori* rules were used to determine how the object of study (hospitalised older adults' functional decline) was thought of, spoken about and acted upon as an entity. However, not in isolation but as interrelated with other entities or objects of study such as care technologies and hospital practices also formed by these rules.

First, **surfaces of emergence** are conditions of existence facilitating and over time sedimenting materialisation of an object. Which object emerges and how spoken or thought about is contingent on time, place, circumstance and form of discourse. Determining these thresholds of appearance revealed how one object and not another was given status and made 'manifest, nameable, and describable' (Foucault 1972, p. 41).

Second, the **authorities of delimitations** constitute how functional decline is defined, designated, named and established as an object of scientific study. For example, as an object of concern embedded in texts of geriatric literature in an entanglement of various discourses "spoken" with and legitimised by the authoritative voice of biomedical science. Discursive analytics exposed how the authority of such texts restricted what can and cannot be said by whom with what credentials and from what position. These delimitations

ensured functional decline conceptualised as an object of concern not only had credibility but authority in geriatrics. In turn, how this form of expertise based on knowledge about the older person was socially sanctioned through the power of the professionally recognised discipline of medicine.

Third, discursive formations create spaces located within what Foucault (1972, p. 42) called '**grids of specification**' such as bodies of academic literature, health care systems or hospitals. A grid delimits and specifies how differentially presented objects are organised by means of categorisation, division, dichotomies, classifications, levelling and/or derived from one another as objects of a particular discourse (p. 42). Hence, meaning was perceived not by locating such objects in a health care system but by revealing their interrelationships as objects, and the interplay of their correlations within the system albeit on different planes of differentiation (p. 42). Discursively formed objects of institutional arrangements could be on one plane of discursive formations constituting the positioning of patients and nurses by way of a grid of hospital units, rooms and beds, arranged via diagnoses/surgeries, efficiencies of care, infection control, gender and so forth. Another plane could be a grid of technologies of care such as models of care, clinical pathways and care practice routines generated by scientific medical research and organisational policies. Yet another plane could be a grid of the performances, enactments of and responses to such practices.

Thus grids of specification operated like a matrix revealing complex interrelationships of objects and how these objects became meaningful 'as operational rather than conceptual grids of specification' (Green 1993, p. 22). These objects once visible on a grid were amenable to an analysis of how they operated across different planes such as written, read, spoken and observed texts constituting a 'system of formation' (Foucault 1972, p. 43). Grids of specification also helped to determine the organisation and hierarchies of knowledges and voices of authority; for example, how 'medical statements cannot come from anybody; their value, efficacy, even their therapeutic powers…cannot be dissociated from the statutorily defined person who has the right to make them' (p. 51).

The formation of enunciative modalities or function is about the special relations between the author of discourse and the legitimacy, prestige and/or authority of the discourse. Thus *a priori* rules illustrated how it was not an author as person, but as author by position, who established the authority of the discourse as positioned within a field of

relations and domain of conditions (Mahon 1992). A field of relations referred to the speakers, their rights and qualifications to speak a certain kind of discourse with legitimacy contingent on from-where they spoke. The speaker's status attributed in the context of what was spoken to whom and how an author can elicit 'an index of truthfulness' (Foucault 1981, p. 58). For an object to be discursively named, designated and/or described, affirmed or denied value as truth depended on these laws of possibility and rules of material existence (Foucault 1972, p. 91 & 102) ascribed by the history and relations intersecting in webs of fields of relations.

For a discourse to be enunciated as a truth claim was contingent on a web of external factors, that is social, economic and/or political conditions or situations. How a term was used such as functional decline relied on how statements firmed up as truth claims, generated knowledge for the use of experts as authors according to the rules of ways such experts were positioned as able to speak They were an interplay of elements making it possible for functional decline to materialise and operate not only as a discursively formed object but also as discursively formed concepts and strategies.

Foucault did not offer a lot of clarity about formation of concepts. He showed how concepts are controlled by 'principles of classification, of ordering, of distribution' (Foucault 1981, p. 56), the *a priori* internal rules of a discipline that control and delimit discourse in direct relation to how that 'discipline recognises true and false propositions' (p. 60). Thus to delimit a concept was to discern the relations between statements as they figured concepts, and were interrelated in a field of relations such as the discipline of medicine comprised of 'a domain of objects, a set of methods, a corpus of propositions considered to be true…[defined by] rules… techniques…definitions…and instruments' (p. 59).

Concepts were worked in grids, and in systems such as the hospital where they emerged as ways to think about the concept whether in terms of hierarchy or as related to other concepts, how classified and organised for an established purpose. For example, functional decline was not considered as a distinct entity. Strands or statements of the discourse were located in texts where it was entangled or interrelated with other strands of discourses, with concepts such as measurement, assessment, biophysical capacities, activities of daily living, individuality and independence. These concepts were nested within practices of discipline and surveillance that had normalising effects. As such the concept of

functional decline discursively *conceptualised* the older adult as a patient in a delimited way and a particularly defined and contained manner.

The formation of strategies is about how concepts are organised, the re/groupings of objects and types of enunciations that are integral and interrelated processes that bring about certain discursive effects. The diagnosing of effects was therefore, about determining, through analysis, how the strategies were used to define objects, concepts and enunciations. Thus variations and contradictions within a discourse were systematised to differentiate one discourse from other discourses not *a priori* but as strategies, 'regulated ways…of practicing possibilities of discourse' within any disciplinary network (Foucault 1972, p. 70).

What these rules revealed was the prescribed and distinct operation of discourse, how it was produced by authorised and legitimised means that delimited and controlled how it was formulated by truths embedded within the required rituals of a discipline such as medicine. Archaeological tools made visible how *a priori* rules regulated the emergence of a discourse and its manifestation as groupings together that assumed any structure as a formation produced by knowledge and productive of knowledge through operations of power. These archaeological tools were augmented by a set of genealogical tools, outlined below, that provided ways to surface a discourse and critique its constitutive powers to bring a discourse's 'concrete, practical, and historical conditions of existence…into the open…[for] a diagnostic history of the present…to undermine its self-evidences' (Mahon 1992, p. 101). However, before describing genealogy the specific conditions of possibility are explored as entwined discursive events or factors enabling the discourse of functional decline to materialise.

Conditions of possibility: appearance of functional decline as discourse

Understanding the interplays of theoretical, practical factors, social movements, past and current events, as enabling materialisation of discourses, not only contextualised the research study but informed: what questions to ask of the texts, the locations of care such as hospitals as well as how to interrogate the knowledge systems that sustained and produced what counts as health of the older person (Mahon 1992, pp. 105 & 122-3). This socio-historical approach informed how the conditions of its existence were 'inextricably

associated with particular technologies of power embodied in social practices'(p. 104). The relations between power/knowledge and expertise about functional decline as a discourse and older adult subject position defined by the discourse as a health care problem with certain characteristics. This socio-historical approach allowed a Foucauldian critique that did *not* call 'on the past to resolve the questions of the present' (Foucault 1984, p. 250). Rather it revealed how the current reality for hospitalised older adults as constituted by functional decline discourse was not inevitable but a current situation, contingent on conditions of possibility. As critique, this problematised how functional decline as an event for hospitalised older adults became a discourse that took for granted how the declining hospitalised older adult was a self-evident problem.

Mills (2003, p. 51) revealed how problematisation within a Foucauldian approach is a form of scepticism, a kind of questioning to reveal 'the disjunction between intentionality and effect' as located for example, in a hospital's mission statement of aims. Being sceptical was to question what are the possibilities and effects of such conditions enabling a particular disjuncture to be ignored, to see statements of discourse as problematic in contrast to seeing them simply as given or as established belief (Bacchi 2012). Scepticism was to recognise and question the power of certainty or established assumptions, to explain the what, when, and how present in *discursive formations* as organisational systems based on truth claims that may problematically be presented as facts.

In Foucault's work scepticism offered 'revelation of the sheer contingency of the conditions of practices which were the objects of his inquiries. Foucault denaturalizes and de-inevitabilizes' (Koopman 2011, p. 4). For example, to question the scientific assumptions informing contemporary medicine that belong to age-old continuities situated in a field of related discourses that made up what is assumed as naturally the discipline of medicine (Foucault 1972, p. 31). Thus to denaturalise and de-inevitablise required critique that questioned these kinds of familiar and common sense knowledges. It was to engage in questioning how scientific discourse works by 'interconnection, not the primacy of this over that, which never has any meaning'(p. 66). Foucault's critique is not

> a matter of saying that things are not right as they are. It is a matter of pointing out
> on what kinds of assumptions, what kinds of familiar, unchallenged, unconsidered

modes of thought the practices that we accept rest. (Foucault & Kritzman 1988, p. 155)

In this study there were several key elements that were conditions making it possible for the materialisation of functional decline as a discourse. These conditions as practices came to define what was necessary for structuring, informing, and constituting regulatory controls concerning hospitalised older adults and their care. Together they operated as a form of bio-power influencing, shaping and supporting

> the "vital" character of living human beings, in which individuals work on themselves in the name of individual or collective life or health an array of authorities considered competent to speak that truth; strategies for intervention upon collective existence in the name of life and health; and modes of subjectification. (Rabinow & Rose 2006, p. 195)

Although each condition as discursive practice was described separately they were in reality interrelated practices, one influencing the other.

Bio-politics and Alarmist demographics

> The popular and professional discourses that currently accentuate the demographic features of aging populations are characterized by their alarmism. (Katz 1992, p. 204)

Bio-politics as a way to govern populations emerged in the late 18th century with the 'explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations' (Foucault 1978, p. 140). Bio-politics involving alarmist demographics and governmentality by nurses' use of pastoral power in the context of categorisation of patients as geriatric by the sole bio-characteristic of being 60 years or so also enabled managerialist practices. As a condition of possibility for functional decline discourse to be produced and operate, bio-politics functioned as an ensemble of mechanisms of power over bodies and manifested as a

> capillary form of existence, the point where power reaches in the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourse, learning processes and everyday lives. (Foucault 1980a, p. 39)

Bio-politics was particularly evidenced in geriatrics because hospitalised older adults were defined as a distinct population by age and were categorised as noted previously by 'highly technical and instrumental, avowedly objective, value-neutral and specialized discourses' (Cole, Van Tassel & Kastenbaum 1992, p. xii). The materialisation of functional decline was one such discourse enabled by discursively formed subjects, objects and

strategies of bio-power. As a discourse it constituted the hospitalised older adult's subjectivity not only by age but as a way of organising hospitalised older adults via normative ordinal values of functional status. Ordinal values such as socio-bio-capacity for independence formed as pre-determined standards of functional ability normalised as levels of "activities of daily living" (ADLs) deemed necessary for independent living. Covinsky et al.'s (2003, p. 453) quantitative study illustrated such bio-politics by creating and defining functional trajectories of hospitalised older adult's illness recovery based on the number of ADLs, measures of functional status, they could perform independently. Such studies Illustrated how functional decline discourse governed the older adult not as a whole person but a delimited subject, a case of synecdoche, restricted to measured levels of socio-bio-characteristics and categorised accordingly. This was a bio-political, dividing practice that separated out the older adult from the young and healthy. Such a bio-politics depended on the work of functional decline discourse to constitute older adults as a population in the process of becoming a problem due to inevitable decline. The physicality and materiality of functional decline discourse was becoming more than a textual perception of a bio-politically defined problem reality. It was a material reality of the socio-economic practice of bio-power (Hook 2001).

Katz (2000, p. 148), a critical gerontologist, however illustrated a paradox of bio-politics, bio-power in action, by examining how 'production and celebration of an active body in old age is a disciplinary strategy of the greatest value'. Further, he exposed how a discourse of 'alarmist demographics', used statistics to give credibility to statements declaring increasing numbers of declining older adults as problematic and reinforced beliefs in establishing the older adult as a population causing a huge health care crisis (1992, p. 204). Statistics as such are bio-politics not just numbers but an instrument of power to create social facts governing life (Hacking 1991). The enrolment of such statistics used demographic determinism (Katz 1992), a dividing practice used to separate older from younger populations, to position the older as a problematic population on the basis of age, while assuming generalised inevitabilities of declining bodily functions: A kind of categorisation technique similar to how "youth" is homogenised and used to determine a generalised problem of being young and dangerous to public spaces. Such demographics effectively categorised older adults as unduly needy, generalising and stereotyping them as

a population inevitably unescapably and chronically in decline with insatiable needs for care. Alarmist demographics then statistically established the necessity to govern older adult's hospital care economically and efficiently and provided evidence that promoted scientifically produced biomedicalised care technologies promising more efficient hospital care systems (Burgers et al. 2014; Inouye et al. 1998; Rubenstein 1987b).

As a dividing practice alarmist demographics operated as truth claims of scientifically determined "bio-facts". These "facts" derived from statistical analyses were what substantiated older adults as a category of inordinately large numbers of dependent non-productive citizens. Statistics such as these can be used to govern and here became a governmentality used to order, control and manage older adults as a population through practices of self-governance as much as the governing of others. The bio-politics of governing hospitalised older adults as a defined problematic population was instrumental to health care systems and hospital governing practices. This thesis explicated how this was the case for the problematic older person, from the level of organisational models of care to managerialist practices through to quotidian use of care technologies by nurses in their everyday care of older adults. Hence, governmentality became a critical factor in the analysis.

Governmentality

> This contact between the technologies of domination of others and those of the self I call governmentality. (Foucault et al. 1988, p. 19)

Governmentality as the conduct of conduct is a collective and individual relation of power that 'designates relationships between people …an ensemble of actions which induce others and follow from one another' (Foucault 1982, p. 786 & 789). Governmentality is Foucault's analysis of political power framed as techniques and procedures, a governing power to guide and direct people (Rose, O'Malley & Valverde 2006). Power is enacted through relationships, imbricated and reciprocal with the mutual use of each other that involves conduct of self and others within 'emergent understandings…of humans as forming a kind of natural collectivity of living beings' (p. 84). Hence how we govern ourselves and others is by truths built on assumptions about our existence and the nature of who we are. This leads to assumptions about older adults and ADLs that are rarely questioned yet inform the taken for granted nature of governing that gives rise to further production of truths that

often appear as self-evident or necessary (Dean 2010). For example, managerialist practices for governing health care costs have normalised expectations of patients' self-responsibility to prevent functional decline by mobilising post-surgery calculated by levels of ADL function. A time/space calculation documented on technologies like the clinical pathway (CPW see chapter five) that assumed and depended on patients taking self-responsibility to get themselves up, moving from lying in bed to standing and walking, to minimise length of hospital stay. Governmental practices were effected by nurses promoting these calculations inherent in CPW technology and their use to guide care, to mitigate or prevent immobility, implying functional decline. Hence governmentality depended on functional decline discourse as a strategy to not only keep the patient on a trajectory of recovery from illness but for the patient to actively work to keep on the trajectory through self-governance. Functional decline discourse embedded in care technologies provided the normativity, for example the "norms" of expectation of a CPW trajectory to address functional decline to achieve minimal lengths of hospital stays.

Pastoral power, another form of governmentality, was evident in the governing role of medicine/hospital care in terms of its welfare function, a kind of benevolent salvation from illness (Good 1994). Pastoral power with its 'political structures of individualisation techniques and of totalisation procedures' (Foucault 1982, p. 782) can be tricky in its

> role of providing the flock with its sustenance, watching over it on a daily basis, and ensuring its salvation; lastly it is a matter of power that individualizes by granting, through an essential paradox. As much value to a single one of the sheep as to the entire flock. (Foucault 2003c, p. 264)

In an analysis of contemporary western nursing practices Holmes and Gastaldo (2002) showed how nurses operate as agencies of governmentality using 'mutually formative' (Rose, O'Malley & Valverde 2006, p. 88) procedures, strategies and practices of pastoral power to govern the conduct of the patient. Pastoral power was entwined with disciplinary power via surveillance techniques of daily observations, assessments and interventions as caring practices. These practices were seen as productive and assumed to operate from a place of benevolence with intent to comfort or to better the patient's condition. They were productive in constituting patient subjectivities as both beholden to care and co-operating in self-care, represented as objects to be managed, governed and self-governed on a prescribed track of recovery from illness. Holmes and Gastaldo (2002, p.

557) extended pastoral power relations to nurses working in political or management roles of population assessments and dissemination of research outcomes, representing nursing practices as 'means of governmentality of individuals and of the population because… [their] practices contribute to the management of society through a vast range of power techniques'. Where techniques of governmentality involving bio-power become enacted as bio-politics through various forms of managerialist practices underpinning bio-politics were an ensemble of conditions of possibility for functional decline discourse to dominate. Deeply influencing these forms of governmentality was the power of neoliberal governmentality that remains pervasive in the current health care environment.

Neoliberalism

Neoliberalism is an economic discourse of restraint and self-reliance, promoting individual responsibility and self-discipline in 'the context of privatization, free-market regulation, and the devolution of public state services' (Mamo 2010, p. 175). As a political/economic construct, it subordinates social justice and human rights to ideals of consumerism and market justice (Davis & Craven 2011), privileging 'market forces in determining and mediating social relations' (Grant 2014, p. 1280). Further it is about the workings of economy based on fiscal restraint across all spheres transposing

> economic analytical schemata and criteria for economic decision-making onto spheres which are not, or certainly not exclusively, economic areas, or indeed stand out for differing from any economic rationality. (Lemke 2001, p. 197)

The late 1980s encountered several significant economic events with the collapses in western economies and associated sequences of economic processes, a globalising economy reacting to capitalist markets and neoliberal agendas. The most pivotal event was Black Monday 1987 when global stock markets suddenly and unexpectedly collapsed due to a swift and severe record drop in stock market indexes (Albert, Smaby & Wyatt 1993; Economist 2012; Scheier 1987). By 1989 inflation had increased, economic growth had slowed with several years of high unemployment. Massive government budgetary deficits and slow Gross Domestic Product (GDP) growth continued to affect the United States until late 1992 and Canada until 1995 ('Early 1990s recession' 2013) with similar disastrous affects in Europe, Australia and New Zealand (Economist 2012). Economic crisis

exacerbating a situation where 'all industrialized countries have become concerned with health care costs' (Chappell 1993, p. 487).

These historical economic political conditions were concrete, structured outright by the establishment of neoliberalist government agendas in western countries. A neoliberal agenda that reverted back to 18th and 19th century liberal doctrines of *laissez-fair* government as the growing power of national and international corporations reduced state interference perceived as raising costs and reducing profits of industry (Terris 1999, pp. 156-7). Quick recovery from this colossal economic downturn was shown to be illusory which aggravated efforts to manage economies with consequent significant impact on health care in western countries (2012). Subsequent political decisions were driven by this rise in neoliberal politics, profoundly affecting health care resulting in difficult cost-cutting decisions leading to re-engineered health care systems enacted by governing agencies that naturalised managerialist practices of governance as necessary to effect and maintain efficient and effective health care systems and practices.

Managerialist reengineering of health care: governing practices

> Who benefits and who is harmed by prevailing naturalized culturally normative standards? (Holstein & Minkler 2003, p. 789)

Managerialist reengineering of health care, based on neoliberal politics of the 1980s, incorporated business processes and standardisation into health care administration. These practices were used to improve performance using technologies such as decentralisation, clinical resource management (clinical pathways to moderate treatment variations), patient aggregation (combining patients with similar diagnoses and resource needs), downsizing through layoffs involving changes in staff skill-mix ratios and non-core cost savings such as cancelling certain employee benefits (Walston & Kimberly 1997). Martin (1996) tells how the healthcare industry had undergone 'significant changes caused by market-based compensation reform … wherein healthcare executives [were] looking at every function within hospitals… to meet new needs at the lowest possible cost' (p. 27); reengineering focused on function and creativity (p. 30) and promised to fulfil a mandate of leaner offerings yet more effective health care outcomes (Shannon & French 2005). These hegemonic practices were then taken up, taken for granted and assumed to be necessary for smooth running, economical yet effective health care systems. As neoliberal practices

they formed a framework of governmentality used to 'support mechanisms that keep structures of discourse in place…both intrinsic to discourse itself and also extra-discursive, in the sense that they are socio-cultural' (Mills 1997, p. 49).

Managerialist practices as governmentality are a panoptic mode of closely governing what individuals are to do and how to be, often incorporating protocols or work arrangements clustered according to similar required skill sets and/or tasks (Chauvière & Mick 2011). In hospitals, delineated routines, regulations and policies to rule individual captive patients as a population were bio-power practices in action for their 'administration of bodies and the calculated management of life' (Foucault 1978, p. 140). Bio-power as managerialist practices with panoptical effect was also visible as diagnostic tests on body fluids, vital signs, calibrated indexes and scales of measurement, techniques used to assess, order (diagnosis), and manage (treat) patients. These practices governed patients by an all-pervasive medical gaze, biomedically ordering/categorising their body/life processes inside and out according to pre-established norms, normativities and normalising care technologies.

Hospitals subsequently became focused on finding researchers offering simpler more efficient, effective and measurable ways for cost savings such as re-aggregating patients according to similar diagnoses or procedures to focus resources and skills required for targeted patient care (Shannon & French 2005; Walston & Kimberly 1997). Supported initiatives in geriatrics included indexes of independence in ADL for measuring and predicting functional decline and generic severity illness measures to predict care requirements and assure minimally adequate care with least economic cost (Kelleher 1992). Managerialist practices appeared as 'assessments of functional status [that] are a simple, inexpensive measure… [which] may have considerable value' when based on "a minimum data set" for monitoring risk-adjusted outcomes (Davis et al. 1995, pp. 906-7). They concluded 'monitoring risk-adjusted outcomes has assumed central importance in current health policy debates at all levels' (p. 906). Such evidence-based outcomes promised ways to manage economies of care with efficiency.

In summary, reengineered health care and managerialism were shaped by bio-politics and governmentality and influenced by alarmist demographics and contextualised by neoliberal ideologies. The interplay of these discursive practices in fields of relations is

what constituted the conditions of possibility for functional decline discourse to materialise and dominate in geriatric publications and care practices. This understanding of the event of functional decline discourse was foundational to the ensuing discussion of how Foucault's genealogy methodology enabled explicating the production, operation and re/distribution of functional decline discourse; the power/knowledge effect in the doing of discourse.

Genealogy: what the doing of discourse does

Genealogy is a mapping of a history of thought within a realm of discursive practices to explicate the operations of a discourse. Genealogy is about exposing the historical conditions, the concrete and practical existence of a discourse, how it operates, its actions and its effects as power to produce knowledge (Mahon 1992). It is a

> form of history that can account for the constitution of knowledges, discourses, domains of objects, and so on, without having to make reference to a subject that is either transcendental in relation to the field of events or runs in its empty sameness throughout the course of history. (Foucault 2003a, p. 306)

Prior to a methodology of genealogy Foucault had taken great pains in 'The archaeology of knowledge' (1972, pp. 199-200) to dissociate himself from structuralism. He dispensed with the figure of the unitary author as the speaking authority and showed how discourse is only successive events whose meaning is dependent on the conditions of when and where enunciated. He had taken the person out of the research equation and the subject out of the research project to illustrate the power of discourse as an entity in itself, constituting that of which it speaks. Foucault in his genealogy 'The order of discourse' (1981) shifted to subject formation. Although he still referred to discursive formations he involved the effect of person (subjects) and the role of social processes in relation to changing subjectivities but always contingent on positioning. He also attempted to insert the extra-discursive, institutional systems and politics, into his thinking about formations, productions and operations of discourse to reveal how discourse has powerful constitutive effects – that can explain the violence of a discourse.

Foucault in his genealogy outlined elements or functions of discourse as unwritten, unspoken *a priori* rules or principles of discourse, and part of the taken for granted assumptions that make a discourse a discourse. These rules determined how discursive formations constitute humans, effecting various subjectivities in contrast to grand narratives

of a human as transcendent (ahistorical) and universal (totalizing). Instead, subjectivities were contingent on whose will to knowledge or will to truth dominated. Genealogy focused on explicating this ordering of discourse in relation to variable subjectivities and materiality of bodies within an interplay on three axes of truth/knowledge, power and the subject (Mahon 1992).

Genealogy as a critique of systems of power/knowledge built on the archaeology of knowledge. It was not about determining causality or truths or attempting to disprove truths or replace what are considered as truths but to enable recognising and illustrating constitutive techniques of power/knowledge production of truth. For example, constitutive effects of scientific truth claims are embedded in the power/knowledge of functional decline in the field of geriatrics. This genealogy exposed conditions of possibility enabling functional decline discourse to dominate in geriatrics and produce knowledge that structured hospitalised older adults' care. For example, how ideological notions of truth were embedded in scientific knowledge as binaries of true/false, normal/abnormal located in research practices using functional decline discourse to develop best practices authorised as technologies of assessment. This kind of critique enabled recognising how we are 'subjects of what we are doing, thinking and saying…and the possibility of no longer being, doing, or thinking what we are, do, or think' (Foucault & Rabinow 1984, p. 46).

Genealogy is then to 'throw off the sovereignty of the signifier' by explicating truth claims as objects on grids of specification to be known alongside the functions and positions of the author, a knowing subject and 'the technical and instrumental investments of knowledge' (Foucault 1981, p. 54). A critique to problematise both effects of truth claims and paradoxes of discourse, their constitutive power truth despite its uncertainty. As such genealogy also served to recognise occasions for change because discursively set meanings are 'construed historically in different ways and in different settings' (Andersen 2003, p. 21).

One critical and three genealogical sets of analysis

Foucault's (1981) genealogy consists of two sets of methodological practices that alternate, support and complement each other. One set of analytics is *critical* involving the principle of reversal for analysis of discursive control. The other set is *genealogical* involving principles of discontinuity, specificity and exteriority for analysis of the formation of

discourse whether inside or outside the limits of control. These principles were used in concert to recognise how a discourse as 'sets of discursive events' (p. 69), materialises and orders a discourse as systems of knowledge, as discursive formations rendered visible and amenable to analysis. These analytic practices served 'as the regulating principle of analysis' and a compelling way to 'see at once certain methodological requirements' (p. 67 & 72). They enabled explicating and examining the power/knowledge of discourse as an ensemble of discursive formations, how discourse was produced by knowledge and produces knowledge and to what effect. These practices enabled exposing how a discourse is rarefied (p. 58), delimited, ordered and constrained by intrinsic *a priori* rules of formation controlling what can be said where and by whom, not just anywhere by anyone, not open to *ad infinitum* possibilities. For example, not just anybody can write physician's orders or enter interdisciplinary notes on a permanent hospital patient record. At the same time these analytic practices exposed how a discourse, to have effect, must be in circulation in contrast to marginalised, elided or effaced.

Reversal

Reversal 'the critical side of the task' allowed analysis of 'discursive control' (p. 71); the influence and power of a discourse as a social practice to exclude, sanction, limit, and control what is said, thought, and done. Reversal enabled explicating powerful discursive functions of exclusion to see how discourse can be 'both an instrument and an effect of power…a point of resistance…discourses are tactical elements or blocks operating in the field of force relations' (pp. 101-102).

The principle of reversal allowed for examining discourse beyond its immediacy and implicit sense of truth grounded in the power/knowledge nexus of discourse propelled by a will to truth. Reversal elicited the use of scepticism, contingency, problematisation and exposure to call into question the will to knowledge behind the will to truth inherent in the 'swarming abundance' and assumed 'continuity' of dominant discourses (Foucault 1981, p. 67). Foucault (1978) used reversal in an analysis of *heteronormativity* as he questioned how universals and assumptions about sexuality are taken up as necessary and self-evident truths. Reversal as a strategy challenged the notion of self-evident origin 'of a subjectivity which constitutes meanings and then transcribes them into discourse' (Foucault et al. 1991,

p. 61). Applying the principle of reversal was to 'throw off the sovereignty of the signifier' (Foucault 1981, p. 66) by refuting and inverting assumptions of origin to subvert the drive to truth and the realm of technical expertise as given (Hook 2001, p. 531). It was a means to expose the contingency of truth in discourse by revealing its instability, its dependence on 'external conditions of possibility' (Foucault 1981, p. 50).

Reversal was used to expose how the power of a discourse is contingent on *a priori rules* of who gets to speak on the basis of what credentials, where and when; which authors are given authority as expert speaking truths and by whom; how credibility and authority of knowledge was generated by multiple citations in authorised legitimised publications widely redistributed. Hence reversal could expose the 'connections, encounters, supports, blockages, plays of forces, strategies…that establish what subsequently counts as being self-evident, universal, and necessary' (Foucault et al. 1991, p. 76). This strategy could explicate the multiple events and concrete practices that constituted what was truth in a domain of knowledge such as the discipline of medicine. Reversal served to reveal how 'what counts as "the truth" is a product of discourse and power' (Hook 2001, p. 524). For example, rigorous quantitative methods based on truth claims such as assumptive values of validation and generalisability were shown by use of reversal to produce contradictory ambiguous outcomes contingent on circumstance and application.

Hence, reversal was not for purposes of refuting truth claims but rather to make apparent how they are contingent on whose voice of authority and expertise established specific rules of science and legitimated, delimited and constrained which technologies were authorised where and when. Reversal enabled questioning how such technologies were taken up in clinical settings and unproblematically assumed to be scientific knowledge; taken-for-granted as *the* tools for observation, assessment and measurement of functional decline in hospitalised older adults. The principle of reversal provided a means to explore how nurses 'struggle against the coercion of a theoretical, unitary, formal, scientific discourse' (Foucault 1980b, p. 85). It was to make visible the power of discourse to have 'prescriptive effects…what is to be done…and codifying effects regarding what is to be known' (Foucault et al. 1991, p. 75) delimiting and marginalising what others can say and do in older adults' hospital care.

Discontinuity

The principle of discontinuity is never completely separate from reversal but is more about taking a different perspective on the contingency of conditions that enable or disable the power/knowledge rendering it unstable (Foucault 1981). This principle enabled strategies to map out how discourses were interrelated, seemingly entangled across fields of differentiation wherein their effect was discontinuous, shifting and changing contingent on possibilities. It was to see how apparent discursive forms of regularity were in tension with systems of constraint over what could be said or done in material realities of clinical settings. Explicating these complexities helped to inform the questioning of effects of discursive structures on nurse and patient subjectivities as they played out in actualities of care practices within nurse/patient interactions.

The principle of discontinuity by accounting for the entanglement of discourses disrupted the linear notion of "cause and effect" that assumes patterns of continuity. The principle of discontinuity rendered visible entangled discourses that were yet discontinuous in their production of knowledge and constitutive effects. It enabled looking sideways to see how older adults were positioned or represented by discourse contingent on circumstance and situation. It was to see how "things" are not necessarily linear but are within a series versus unity of possibilities as 'familiar functions across a variety of different forms (language, practice, material reality, institutions, subjectivity)' (Hook 2001, p. 534). It was to see how discourses are 'intertwined and often divergent but not autonomous…[to see]…its chance variability, and the conditions of its appearance' (Foucault 1981, p. 68).

Specificity

The principle of specificity is about seeing the physicality and materiality of discourse as practice (Hook 2001, p. 537) rather than as a textual presentation of a factual reality. Discourse is not 'a play of pre-existing significations…we must not imagine that the world turns towards us a legible face which we would have only to decipher; the world is not the accomplice of our knowledge'(Foucault 1981, p. 66). Discourse, as explained above, is an event contingent on the moment of its enunciation in a field of relations, susceptible to change with context and circumstance wherein there can be as with the notion of functional decline a 'great incessant and disordered buzzing of discourse'(p. 66). For example,

discourses of care influenced and are influenced by how nurses were conceptualised in the data and self-identified in the contexts of how hospital spaces/routines would strategically define and organise their care practices, consequently shaping how patients were constituted as objects of care.

This principle offered a broader view of the power of discourse. It revealed the contingency of the power/knowledge effects, how certain truth claims were realised and not others by the specifics of what made a discourse legitimated and authorised. It delineated how the materiality of discourse in scientific research initiatives, specifically structured by biomedical knowledge, were populated with self-evident truths. It provided a means to map internal elements of discourse, established under what conditions to obtain credibility so as to inform and structure protocols, measures, predictors, guidelines and care practices for older adults.

Exteriority

The principle of exteriority moves beyond the content of the text and looking for a hidden nucleus of influence to examine what exterior elements gave rise to its appearance and regularity and fixed its limits as the external conditions of possibility (Foucault 1981). This principle helps 'to entertain the claims to attention of one kind of knowledge against another kind' (Foucault 1980b, p. 83) to illustrate concern 'with the insurrection of knowledges…the effects of the centralising powers which are linked to the institution [in this study, the hospital and health care system] and functioning of an organised scientific discourse' (p. 84). This "wild exteriority" operated as rigorous external factors clearly defining which domain of objects, methods and propositions were accepted as 'in the true', credible contemporary science (Foucault 1981). This principle enabled seeing how credibility is defined by a discipline not one individual "representing" the discipline. The discipline established how validity of truth claims can be verified. Geriatrics, for example, was formed according to principles of biomedicine in the discipline of medicine and remained dependent on extra-discursive elements like alarmist demographics and managerialist practices to obtain its dominance.

Foucault's four analytic principles of reversal, discontinuity, specificity and exteriority provided this study with methodological means to analyse the 'event, the series, the

regularity, the condition of possibility' (Foucault 1981, p. 67) of functional decline discourse as a dominant discourse in hospitalised older adults' care. These principles did not allow getting up close to see how discursive formations of functional decline manifest and to what effect in material realities of hospital settings. Hence I also engaged three ethnographic methodological strategies.

Discursive ethnography: methodological strategies

Discursive ethnography, described in chapter one as a social practice, was enriched by three methodological practices drawn from the postmodern/poststructuralist concepts of "crisis of representation", "panopticon", and "Thirdspace". These concepts as strategies enabled doing ethnography from various perspectives and in multidimensional fields of relations, spaces comprised of various interconnected cultures and perceptions of space and time. As strategies they helped ensure congruence of methods with thesis purpose: to challenge functional decline discourse as a driver of care for hospitalised older adults. As concepts and strategies they enriched the philosophic approach to the thesis informing the practices of ethnography. Such approaches were used to explicate the complexities, contingencies and uncertainties in textually mediated data; to trouble discursive formations of participant subjectivities; and provide frameworks to expose hegemonies of representing subjectivities located in spaces that were rarely questioned, subjectivities, spaces, and perceptions of time commonly understood and naturalised. As methodological strategies each allowed that subjectivities and perceptions of time consisted of multiple meanings and interpretations; how spaces were not contained but overlapping and contiguous, circumscribing a set of in-common experiences.

Crisis of representation

The ethnographic 'crisis of representation' (Marcus & Fischer 1986) questioned how to represent ethnography participants given the fragmented and textual presentation of ethnographic methods. This questioning of representation emerged in the 1980s at least in North America, out of certain postmodern ethnographic circles in response to the work of literary critical theorists. Theorists questioned the credibility of mainstream ethnography's claim to truly represent participants, and the process of using empirical data to produce grand narratives or the product, ethnography. The idea of "true" representation came from

"Enlightenment thinking" of people not as individuals but as typifications from empirical data. In some circles this response was more broadly conceived as part of a more general set of ideas across the human sciences that challenged long-standing traditional beliefs about research offering validated all-encompassing and generalisable (theoretical, methodological, and political) frameworks of empirical research (Marcus & Fischer 1986). Some ethnographers rejected such grand narratives by denouncing them as having constraining and delimiting effects by way of certainties and generalisability of facts, eliding exceptions and bringing totalising fields. This precipitated a move to produce more 'open-ended dialogic works' to engage with 'microsocial description and contextuality' (Marcus 1986, p. 166). As such the thesis used the concept of "crisis of representation" to create methods to capture the uncertainties of the practical world within cultural groups, to see a person's individuality, not as fixed but contingent on circumstance, conditions of the times – to deconstruct the field .

This move, however, from fixities, certainties of representation to a series of variable possibilities had created profound uncertainties in ethnographic circles. A situation due to the up-close 'consideration of such issues as contextuality, the meaning of social life to those who enact it, and the explanation of exceptions and indeterminants rather than regularities in phenomena observed' (Marcus & Fischer 1986, p. 8). Such thinking destabilised the authority of author underpinning the stability and predictability of grand narratives used previously for interpreting ethnographic stories. Hence, Marcus and Fischer (1986) coined the term 'crisis of representation' to illustrate this catastrophic effect of such destabilised representations of culture, capture the perceived calamity that arose in human sciences from a deep 'uncertainty about adequate means of describing social reality' (p. 8). Research outcomes were a postmodern 'incredulity toward metanarratives…dispersed in clouds of narrative language elements…a heterogeneity of elements…[a] rise to institutions in patches - local determinism.…[asking] where…can legitimacy reside?' (Lyotard 1984, pp. xxiv-xxv). This incredulity and questioning aligned with the study's methodological tools of scepticism and problematising informing methods to challenge functional decline discourse.

Theoretical debates emerging out of this 'crisis of representation' included a shift to 'problems of epistemology, interpretation, and discursive forms of representation' (Marcus & Fischer 1986, p. 9). Such debates were represented in classic ethnographic texts such as

'Writing Culture' (Clifford & Marcus 1986; Clifford & Marcus 2010). This ethnography offered post-structuralist perspectives to 'imagine a fully dialectical ethnography acting powerfully in the postmodern world system' (1986, front page). A dialectical ethnography write up in a single text 'local life' contextualised by a global world of systems encompassing it 'by the intended and unintended consequences of factors within them' (1986, p. 171) and around them. As a methodological approach to structuring methods for this study, seeing texts as interrelated enabled capturing the interdependent factors constitutive of discursive formations of subjectivities, concepts, objects, and strategies across fields of relations. The notion of panopticon (following Foucault's (1977) work in his book 'Discipline and Punish') enabled a "way of seeing" this variety of discursive formations from multiple perspectives for a more comprehensive view of what is under study.

Panopticon: metaphor for power and surveillance

The panopticon, as originally designed by Bentham, can effectively induce a sense of 'permanent visibility' that over time those surveilled absorb as continuous, even if not, rendering those in charge an 'automatic functioning of power' as "surveillers", (Foucault 1977, p. 201). In this ethnography, being a "surveiller" took up both senses of the ethnographer and care provider participants as surveillers. Panoptical observation can be adventitious as a strategy to collect as much data as possible from different angles through methods of participant observation, conversation, and recorded interview. Such a gaze can enable gaining multiple perspectives to see the complexities, contradictions and discontinuities. However, ethically taking up methods of panopticism as a researcher required use of surveillance with discretion and respect for participants, ensuring that they were aware of observations done with their consent and in deference to their wishes of when to be observed.

The hospital's panoptic, all-pervasive gaze was spatially constituted architecturally, figuratively and temporally, by means of a floor plan that directs how rooms are organised to accomplish regular regimes of observation and assessment that, in turn structure and/or inform other routine care practices. Ethnographically panoptic surveillance of a space can afford opportunity to see how the hospital site is a heterotopia, a plural and contingent space. It can afford observations of how spaces discursively formed create assemblies of material and abstract representations of what constitutes a patient and a nurse as they

navigated and interacted within the materiality of hospital spaces. The ethnographer if self-positioned strategically can "see" the constraining intersections of time and space of everyday nurse/patient care occasions within the overall busyness of unit activity. This positioning can also render visible disciplinary, organizational and political/economic governmental directives of how hospitals are to be run. It can make visible the complexities of how discourses operate in such spheres. In this study, as an ethnographic tool of observation, the panopticon had powerful effect in creating ways to "see" from multiple perspectives and in various directions, to locate different discursive forms of knowledge production to generate written, read, spoken and performed data for discursive analysis.

This approach to methods in concert with the concept of crisis of representation, as described above, could then expose a braiding of texts to illustrate the intertextual discursive nature of the archived data. For example, the constitution of nurse and patient subjectivities as variable objects contingent on context, circumstance or situation within unstable yet seemingly routine or static temporal/spatial spheres. To *do* this kind of discursive ethnography the concept of a *Thirdspace*, a spinoff of Foucault's notion of heterotopia as taken up by Soja (1996), was used metaphorically as the hyphen or the in-between located in the intersections and interlacing of time/space.

Thirdspace: interconnected spaces as productive of knowledge

Thirdspace is a postmodernist stand of 'multiplicity of perspectives that on first sight seem incompatible, uncombinable' (Soja 1996, p. 5). A point of view that informed my methods of analysis, a critical strategy to see things in 'a recombinatorial and radically open perspective' (p. 5).Thirdspace as a methodological tool was about engaging the notion of 'a continual expansion of spatial knowledge' (Soja 1996, p. 61), in historical context over time and space. As a strategy it informed how to get inside the topic of concern. As Latimer (2003, p. 237) eloquently explained, ethnographers can discern how key cultural materials offer a means 'to get inside' such a topic of concern. I argue that 'to get inside' it was necessary to discern interstices of material realities of hospital spheres concomitantly with mental understandings of time in the space/time nexus of mindscapes as in published literature, places of a 'polycentric mix' (Soja 1996, p. 14). Thirdspace as such was used to see social relations inherent across spheres of varying concepts of time and depictions of space. Soja's work attended to the 'catalytic role of space in the ways human beings construct

knowledge about themselves and the world around them' (Tamboukou & Ball 2003, p. 197). In such an ethnographic space and time were depicted as inextricably linked, unstable, variable and changeable entities contingent on one's point of view. Thirdspace effaced the literature/hospital binary, to expose the in-between by seeing discursive production and redistribution of knowledge happening across planes of differentiation that were interconnected entities in relation to the care of hospitalised older adults.

Also useful to this study was how Soja's Thirdspace (1996) built on Bhabba's work on space as a productive place where cultural differences and subjectivities were constituted potentially outside the controlling and containing constraints of universals; hence producing a Thirdspace that 'explicitly challenges hegemonic historiography' (p. 140). Further, Soja as (1996) explained, Thirdspace can involve a variety of notions of a space described in terms of trialectics, radical openness and hybridity, involving in-between dichotomised ideas or concepts of bicameralised spaces. Soja (pp. 14-15) critiqued this 'bicameralised spatial imagination that can lead us to "Other" spaces quite similar, yet teasingly different' as used in Foucault's (1986) notion of heterotopias. Such a heterotopia simultaneously containing various spaces over and through different modes of time was marked or symbolised by discourses. Complex heterogeneous spaces were where 'we live inside a set of relations that delineates sites which are not irreducible to one another' (p. 23), as evident in sites such as the hospital that contain spaces anywhere from operating theatres and patient rooms to chapels, meeting rooms, gift shops and restaurants – a heterotopia. Further, in this study these kinds of spaces were envisioned as beyond decontextualised binaries because how space was perceived, conjured up multiple interpretations affecting the nature of the space. Spaces, as such, whether material or abstract, were seen as spaces of social struggle, representing the real and imaginary (Soja 1996, pp. 68-9).

This dynamic interconnectivity of a plurality of material elements of time, space, discourse and the production of knowledge reflected Foucault's trialectic of space/power/knowledge. In this trialectic, space influenced the operating power of discourse as a social practices producing knowledge that makes up our everyday lives (1972). The concept of Thirdspace enabled methods to show how certain kinds of knowledges were valorised and others subjugated or disqualified as too common, specific or local (Foucault 1980b, pp. 82-3); how knowledge formations were plural, contingent on

intersecting factors, signalling the power and political nature of discourse (Bacchi & Bonham 2014). These theoretical ideas promoted an exploration of hegemonic effects of unquestioned sedimented knowledges produced and residing in everyday care practices, fixed in binaries of normal/abnormal for the patient. Ideas informing methods for cracking open such dichotomies like care provider/patient, inherently hierarchical as were other binaries such as health/pathology, independent/dependent.

Figuring these discursive practices within a trialectic of space/power/knowledge enabled examination of the in-between spaces of such binaries as dialectical and where knowledge can be produced with plural constitutive effect. It was not to dismiss the binary but to see its power/knowledge function in the hierarchical structure and restructure its meaning by '*selectively and strategically* [drawing] from the two opposing categories to open new alternatives' (Foucault 1980b, p. 5, empahsis in original). In this case within an institutionally organised binary of nurse/patient interactions where care technologies were enacted via knowledge produced by plural and contingent social practices of observation and assessment. It was here where the medical gaze employed with panoptical effect of power and surveillance was located and can be of advantage to the ethnographer as well.

The ethnographer's body: a critical analytic tool

As I worked through ideas, theoretical perspectives and methodologies informing the study design I came to see how the body itself can be considered a critical analytic tool. My body could philosophically demark who I was as author in the context of what I was studying, seeing myself as an ethnographer who subjected myself, my 'body, belief, personality, emotions, cognitions – to a set of contingencies…[to] see, hear, feel, and come to understand the kinds of responses others display (or withhold)' (Van Maanen 2011b, p. 219). I could expose my embodied self to aspects of others' life situations, circumstances and views, in this case those in hospital and those doing academic research writing. Archaeology provided tools to analyse discursive formations of objects, enunciative modalities, concepts and strategies. Genealogy offered tools to make discourse visible and amenable to see the doing of what discourse does, its power/knowledge complex across various texts. Ethnographic methodologies provided material use of the body, to be a researcher physically present in material realities of the field site taken up as a text of

time/space realities. Ethnography offered multiple ways to use the body to view, hear and sense how to conceptualise the complexities and instabilities of participant subjectivities; to gain insight about immediacies of what happens in spaces and different perceptions of time not as separate entities but as interconnected in a Thirdspace; to draw upon notions of seeing from multiple perspectives to enrich ethnographic methods of observation; to gain deeper understanding of how the discourse of functional decline operates embedded in care technologies; how they guided and ordered care by means of the panoptic medical gaze of observation/assessment. From here I move to the next chapter for description and discussion of methods.

Chapter 3: Methods: figuring research practices

Censor the body and you censor breath and speech at the same time. Write yourself. Your body must be heard. (Cixous 1976, p. 880)

Research methods are about practices, strategies and tactics to collect and analyse data for purposes of addressing a research question and writing up the analysis. Qualitative research as a field of inquiry is a discipline, 'a situated activity that locates the observer in the world…a set of interpretive, material practices that make the world visible' (Denzin & Lincoln 2011, p. 3). Discursive ethnography is a critical, qualitative research methodology. It is uncensored body work performed by reading, "doing" interviews, conversations and participant observations. Body work involves concomitant practices of analysing, interpreting, comparing and writing up textually mediated data from a variety of sources so the body can be heard. As an ethnographer I write myself, listening to my body as I observe, read, analyse, interpret, translate and write up what I see, hear, feel, compare and think in relation to field work, data analysis and writing up the thesis. These methods are based on diverse and not easily defined strategies as the intent of discursive ethnography is to evolve with the unfolding of events under study. Such methods are informed by methodological strategies and tools outlined in the previous chapter. They are open to being questioned, challenged and rethought, leaving conclusions open to possibilities as they arise, are recognised and analysed. This approach to methods has 'no theory or paradigm that is distinctly its own' (Denzin & Lincoln 2011, p. 6).

Poststructuralist approaches that informed the study offered ways to engage in questioning, disrupting, and exposing sedimented truth claims and assumptions of inevitabilities in relation to hospitalised older adults and how such claims and assumptions profoundly affect hospitalisation, care technologies, practices, and experiences for patients and those who care for them. Discursive ethnography allowed for troubling assumptions and truth claims by examining 'reality' as uniquely perceived, interpreted, and/or re/presented by participants, to 'hear' participants as 'tellers of experience', to create space for unknowns or the unexpected to emerge not as outlier data but as important data for understanding what is under study and knowing 'every telling is constrained, partial, determined by the discourses and histories that prefigure...[its] representation' (Britzman 1995, p. 232). Thus in collecting and analysing data the aim was to avoid false short cuts,

realising how every 'telling is partial and governed by the discourses of time and place' (p. 232). Recognising such constraints has the advantage of informing how to delimit the study to ensure coherency and cogency between the research question and the study itself, to set out specifics and focus on those discourses germane to the work.

This description of methods as research practices starts with the mechanics of entering the field, ethics approval, construction of field sites, description of participants and recruitment/consent processes. These mechanics are shown to be foundational to and aligned with the research practices described and explained. How data was processed, examined and analysed was set by interconnectedness of elements explained by describing the analytic tools and textual practices used. Methods included addressing anticipated ethical concerns and rigor to maintain thesis consistency and cogency as I positioned as researcher and insider/outsider throughout data collection and analysis. Methods were designed to surface from a web of texts the complexities, messiness, discontinuities and powerful effects of entangled discursive practices to shed light on everyday care of hospitalised older adults in the context of functional decline.

Entering the field: mechanics of the ethnography

Here I describe mechanics of the ethnography. I outline how I entered the field and describe the participants, recruitment and consent processes and details of tools used.

The ethics certificate and amendment approval are in Appendix A.1.1. Details of the processes of ethics are discussed in the following sections to explicate the complexities and ethical sensitivities of concomitantly observing and conversing with staff and patients as well as reviewing unit documents including patient charts. The aim was to be respectful of all participants' perspectives and to maintain their sense of dignity and privacy. Ethical concern was important as I was immersed in hospital life, characteristically a world of human suffering.

Constructing the hospital field site: a discursive affair

Is it surprising that prisons resemble factories, schools, barracks, hospitals, which all resemble prisons? (Foucault 1977, p. 228)

The field site was a mid-late 20th century multi-storied tertiary rectangular shaped hospital built of brick and unpainted cement set in an urban area. It appears quite uninviting

almost distasteful in appearance yet compelling as a necessary place to be when one's health goes awry. It could be most anywhere in a North American or Australian mid-size city – an ambiguous design, yet recognisable as a hospital. A usual first tell-tale sign is a large green H road sign (blue in Australia). Upon entering into the inner sanctums of the hospital units one's nostrils are commonly exposed to a curious mix of smells - stringent antiseptics to foul bodily excretions reflecting the pure to profane embodiment of what is a hospital. Hospitals, however, are part of the health care industry. They resemble an industrial complex of assessment, measurement, cure and remediation, operating by dividing practices that objectify and categorise patients by diagnoses and levels of care required. Discursive analytics problematise in this study how hospitals, as both objects and strategies of the health care industry, operate by way of spatially oriented and time-sensitive practices such as examined in a study on "length of hospital stay" (Heartfield 2002).

Discursively the word "hospital" can depict a hospital site as a heterotopia, a place of intersecting contradictory and paradoxical time/space dimensions. Hospital is an ironic concept hailing from a mix of root-words ranging from hospitality and hostel, to hostile and hostage – a profoundly contradictory mix of meanings for an institution presumably a place of healing or at least of cure. In today's language, hospitals are places of health care services for clients as health care systems are imbricated in a consumerist society immersed in a neoliberal environment, market driven and structured in economic terms (see chapter six). In any event, "hospital" has an apt etymology because hospitals can be as much toxic or cold and calculating places of business as refuges or protections from the spread of communicable diseases and infections, places of cure where surgeries exorcise tumours, fix broken bones, repair defective heart valves amongst other wondrous cures and fixes. Paradoxically, hospitals can be hostile environments harbouring toxic nosocomial infections with medication errors, lack of sleep, falls and other dangers lurking, an ensemble of perils referred to as iatrogenesis or at times 'hazards of hospitalisation' (Rennke & Fang 2011). In contemporary times, as this study revealed, iatrogenesis also known as "hazards of hospitalisation" are associated with functional decline in hospitalised older adults.

This urban tertiary care hospital is one of several in a region of over 2,500 square kilometres comprised of urban, suburban and rural areas in a health authority servicing over 720,000 people where almost 9% of individuals are 74 years and older. This age group

contributes over 24% of all hospital admissions and accounts for over 40% of inpatient days across the health authority where this hospital is located.

The field site, a 25-bed acute surgical orthopaedic unit and affiliated 30-bed sub-acute rehabilitation unit enabled observing care across temporal/spatial trajectories of care. The ideal length of stay for surgical repair of hip fracture in older adults is 5 to 7 days but as many as 80% or more patients may go to an affiliated acute care rehabilitation unit for a further 5 to 7 days. Or these patients may be directly discharged home or be deemed "awaiting alternate placement" receiving rehabilitation on the surgical unit until stable and/or an available bed in a Long Term Care Facility.

The interior geography

The acute surgical and rehabilitation units are on one floor encircled by a hallway; a dividing practice with patient rooms on the outside/window-side of the hall, care providers' work areas on the inside/windowless side. Geographically and symbolically separating patient rooms from care provider work areas used for pouring medications, meetings, charting and handover. Care providers have ready access to patients either visibly, physically or audibly via wireless communication systems, a modern "panopticon" allowing an "all-pervasive gaze" (Foucault 1979) ostensibly to facilitate effective yet efficiently managed care. Both units have rooms configured as single and multi-bed.

The hospital routines and spaces have a totalising institutional effect similar to those Goffman (1961, p. 6) explained as

> all aspects of life are conducted in the same place and under the same single authority... carried on in the immediate company of a large batch of others...[and] all phases of the day's activities are tightly scheduled.

Patients in multi-bed rooms share one bathroom with a sink, toilet and shower, making it temporally and geographically easier for monitoring a scheduled bathing regime. Single bed rooms with a bathroom offer private space but first priority for these rooms is given to patients under infection control regulations, then for patients considered too disruptive or threatening to be anywhere else, those needing palliative or extra complex care and lastly for those willing/able to pay extra for a single room. These spaces are organised according to a 'rational plan purportedly designed to fulfil the official aims of the institution' (Goffman 1961, p. 6).

Staffing

At the time of the study the orthopaedic surgery unit staff ratio mix on day shift, 0700 to 1900, was one Registered Nurse (RN), one Licensed Practical Nurse (LPN or Enrolled nurse) for eight patients or five RNs and two LPNs from 0700 to 1500 for all patients. There was one unregulated Care Aide from 0700 to 1500 who floats helping out where needed. On night shift, 1900 to 0700, were four RNs and no LPNs. LPNs work eight-hour shifts 0700 to 1500. When the LPNs went home at 1500 their patients were cared for by the RN who shared their patient load from 0700 to 1500 with a float LPN from 1500 to 2300 to help where needed. The 1900-0700 unit charge nurse could ask for "extra help" from a hospital wide float pool and *may* get an RN or LPN, if available.

The rehabilitation unit staff mix: for the 0700-1500 and 1500-2300 was one team of two Registered Nurses (RN), two Licensed Practical Nurses (LPN or Enrolled nurse) and one Registered Care Aid (RCA) and the other team was RN, two LPNs and one RCA. The 2300-0700 shift: two RNs, one LPN and one RCA with workload divided up according to an acuity/intensity matrix of the all the patients. An Occupational Therapist (OT) and a Physiotherapist (PT) worked Monday to Friday from 0800 to 1600. However, on the weekends there was a rotation of therapists shared amongst several units and floors.

There were two fulltime Physiotherapists (PT) Monday to Friday 0800 to 1600 for each unit but each unit shared PTs between two floors. An ill PT was not replaced, other PTs rejigged their workload, prioritising who was most urgent, usually the most recent post-operative patients. On weekends and holidays there was a "float" PT from 0800 to 1600 only who was shared between two hospital floors again prioritising urgent physio needs and fresh post-operative patients. When no "PT" was present or available the nurses did the work of "mobilising" patients as per a clinical pathway.

Entering the field

There were no issues encountered in entering the field as hospital administrators and unit staff members were open to my presence, supportive of my research and ready to facilitate the study. I entered the field by discussing the study with the health authority's Nursing Research Facilitator who outlined how to work with the Health Authority on research projects, emailed potential "gatekeepers", orthopaedic surgical and rehabilitation

unit administrators to introduce me and the study including my Executive Summary of the study. All were fully supportive of the study including time lines of expected dates proposed for in-person meetings to set up entering the field.

The administrators I met with on several occasions always supported the study. They introduced me to nurse leaders on the respective units to work as my go-to-persons throughout the field work. While I clearly differentiated past roles with the current researcher role and maintained clarity throughout the field work. These processes were facilitated by my past work with managers as a former liaison between academia and clinical settings.

The participants

The participants were hospital patients, nurses, Physiotherapists (PT) and Occupational Therapists (OT). I followed seven patients from admission to discharge in rather than care providers because my interest was to observe the *trajectories* of patients' hospital experiences; to explore how it is some older adults get worse not better in the context of implied understandings *about* functional decline. My location at the bedside enabled "getting inside" nursing to observe and discern patterns of nursing occurrences with patient participants positioned as "key cultural materials" (Latimer 2003), to understand performances of nursing identities in relation to patient subjectivities. I was therefore interested in how patients responded to and experienced care in this context so as to learn how nurses constituted the older adult as "patient" in the context of functional decline, how they conducted their care and how their practice may be mediated by biomedical discourses of care. I observed and examined discursive events such as variability in nurses' shift rosters, nurses being temporarily off the unit for in-services, working short-staffed, unexpected changes in patient assignments, to see what influenced the conduct of care and patients' hospital experiences. I observed and analysed how nurses' work is structured, organised and/or delimited by organisational policies, practices, routines, environmental impact and contingency factors. Following patients therefore facilitated explication of disruptions, interruptions, continuities/discontinuities, consistencies/inconsistencies in patient care.

Patient participants

As patient participants were potentially vulnerable, being in a state of physical suffering under the effects of a traumatic fall and major surgery, recruitment was done at arm's length by the unit clinical nurse leader (CNL) or designate. This person reviewed the surgical roster to see who met patient participant criteria. Every effort was made to approach whichever patient potentially met study criteria. The CNL affirmed eligibility by consulting the patient's most responsible nurse to decide if cognitively intact and able to actively engage in the study. If satisfactory the CNL described the study and invited the patient to participate and provided information using the Invitation to Participate (Appendix A.2.1). I followed up with the interested patients to answer questions and to gain signed consent. If patients asked to have family present I ensured they were there at the time of signing consent. Seven patients, admitted consecutively to avoid having two patients to observe at the same time, signed consent and remained in the study until discharged from hospital. All seven participants opted to be observed whether or not they could give verbal consent each time they were observed (Appendix A.2.2). Table 3.1 below provides a demographic and clinical summary of the patient participants.

Nurses and other Health Care Provider participants

Health care participants and key informants were initially RNs and LPNs, Clinical Nurse Leaders and Managers, however, Physiotherapists (PT) and Occupational Therapists (OT) on the units wanted to participate in the study. I amended my ethics application accordingly (Appendix A.1.2). Their inclusion contributed to understanding nurses' interdisciplinary teamwork and how it shapes everyday nurses' work. Overall fifty-eight health care provider participants and key informants agreed to participate in the study.

Recruiting health care providers was more complex than patients because their availability was scarce with the busyness and scheduling of their work providing little opportunity to meet as a group. I had to enlist as many as possible to cover which care provider would end up being assigned a patient participant. These health care participants were coded numerically and given a pseudonym.

Patient	Co-morbidities/Brief History	Length of stay
Gladys ~ 76 years old **48 days** in hospital	GERD & COPD so needs walker. She reported as mostly sedentary for last few months. Lives in a suite in a family member and partner's urban home.	**43 days** on acute care unit; **5 days** rehabilitation unit. Discharged to live with family members due to difficult dynamics with previous living arrangements
Evelyn ~ 77 years old **19 days** in hospital	Mild COPD; high anxiety; past alcohol dependency. Does not drive but walked 2-3 kilometres/day for exercise and shopping. Lives alone in apartment in urban area.	**5 days** on acute surgical unit **14 days** on rehabilitation unit ~ discharged to daughter's home for at least 2 weeks before going back home where she lives alone
Mabel ~ 84 years old **5 days** in hospital	Osteoporosis right knee ~ but fractured hip left side. Drives a car and gardens. Lives with family in urban area and helps with child care.	**5 days** on acute surgical unit ~ discharged to live with daughter's family uncertain how long until returns to live with son and child
Henri ~ 86 years old **23 days** in hospital	Left side fractured hip compromised by hemiplegia; type II diabetes; Hx prostate cancer. Urinary incontinence. Chronic constipation. Lives with wife in urban condo.	**23 days** on acute surgical unit. Self-discharged a day early to home with home supports in place
George ~ 80 years old **14 days** in hospital	Type II diabetes; previous knee surgery and suffers chronic knee pain. Lives with wife in interurban house.	**7 days** on acute surgical unit **7 days** on rehabilitation unit. Discharge delayed 3 days due to long weekend
Ruby ~ 93 years old **17 days** in hospital	Scoliosis; fractured left ankle twice (when young and 4-5 years ago) and fractured hip left side. Drives a car. Lives alone in suburban house.	**2 days** pre-operative medical unit; **15 days** acute surgical unit (no beds available on rehabilitation unit) ~ discharged to daughter's for 2 weeks with plan to return home on her own
Bill ~ 84 years old **5 days** in hospital	High cholesterol on Lipitor. Drives a car, lives with partner in urban condo.	**5 days** on acute surgical unit then discharged home

Table 3.1 Elemental characteristics of the patient participants (pseudonyms)

Nurses, physiotherapists (PT) and occupational therapists (OT) were apprised of the study by the unit manager and/or the CNL verbally and by my presentations at staff meetings where several care providers signed consent. Also, staff were informed of the

study by posters (Appendix A.2.3) strategically placed in the units' bathrooms. I met with staff informally on the unit during pre-designated two hour time periods to introduce them to the study. These meetings proved successful as most nurses on shift dropped by to talk or pick up an information sheet (Appendix A.2.4) and several consented to participate or took away a consent form (Appendix A.2.5) and signed it later. There were four regular PT and two OT on the units, others were "casuals". I connected with most in staff meetings or on a one-to-one basis, all consented to participate. By the arrival of the first patient participant I had recruited several nurses, PT and OT. If the care provider for a patient participant had not previously agreed to participate I provided information about the study and a consent form which was usually effective in gaining their written consent to participate.

Doing discursive ethnography

Methods of discursive ethnography required immersion in the everyday of hospital life. Closely listening, reading and observing enabled ways to disrupt "seeing" care technologies and practices presumed as just how it is, banal. The intent was also to make sense of older adult hospital experiences that were at times seemingly so assumed as to be naturalised and invisible. Analysis of data went across texts of field work and published research to explicate operations of discursive formations of objects, subjects, strategies and concepts structuring care technologies, practices and nurse/patient experiences. Combining spheres of hospital unit and publications created a Thirdspace (Soja 1996) (see thesis p. 62) which facilitated taking up simultaneously multiple viewpoints to compare actualities of enacted care practices in relation to what the literature provided about the structure, purpose and intent of such practices. Hence, analysis went over time *and spaces,* revealing how the present recognises itself within embodied experiences. In ethnography one can more or less see, hear, feel and come to question and understand the kinds of responses others display (and withhold) in particular social situations (Van Maanen 2011a, p. 219). Analysis was used therefore to expose discursive contingencies playing out and taking effect over time.

This approach illustrated how field work as an embodied experience of uncertainty was to be embraced. I was dependent on what particular observations and/or conversations with participants came up or were available or not. All was contingent on the nature of

hospitalisation, the disruptions, fractured moments and unexpected changes. I learned that by paying attention to and questioning such contextual factors and contingencies provided insight and understanding of the effects of unexpected events, interruptions and disruptions and how they discursively shaped everyday nurse/patient interactions. I learned the process of organising observations had to be flexible as disruptions and unexpected changes were the norm in hospital and not extraordinary complications interfering with research work.

Participant observations

> …there is also another sense in which seeing comes before word. It is seeing which establishes our place in the surrounding world; we explain that world with words, but words can never undo the fact that we are surrounded by it. The relation between what we see and what we know is never settled…the knowledge, the explanation, never quite fits the sight…The way we see things is affected by what we know or what we believe. (Berger 1972, pp. 7-8)

Berger's words reflect those of Van Maanen (2011b) when addressing the contingencies and ambiguities of doing ethnographic work. I soon realised how it was impossible to observe everything all at once. I learned to make choices of what to focus on from one observation to the next, to plan out anticipated germane events to observe. For example, sometimes I focused on patients' experiences of hospitalisation and other times how nurses talked about, produced and/or conducted their caring practices and identified as nurse. As Berger (1972, p. 4) eloquently articulates, I realised despite what I knew about hospitalisation and hospital spheres I could not possibly capture, believe to know and respectively write all I observed. I needed to unsettle what I saw to shake off assumptions of what I was "seeing" as just how it is. Thus I practised to "see" how, when and what I observed was always contingent on multiple factors, many being unpredictable, unexpected, uncertain or unanticipated.

I experimented with broadening the scope of possibilities of what to observe and hear eventually realising 'there is no pure, objective, detached, observation; the effects of the observer's presence can never be erased' (Denzin & Lincoln 2011, p. 416). At times I took an approach of not knowing, using openness and spontaneity to "see" what would emerge in observations as they arose unplanned. Or I was purposeful with scheduled times to observe specific interactions like observing a patient mobilising for the first then a second time.

I also alternated my focus between actions and exchanges of words to gain insight into likely different aspects of what was going on, to offset the possibility of simply finding what I was looking for. Increasingly detailed field notes moved from emphasis on action to specific words to kinds of language. At times I focused on imagery, stepping back and observing the overall sense or ambience of the interactions taking place. I learned to pick up on key words or actions to minimise note taking, to maximise what I observed. Or to gather information across action and words simultaneously to gain a more fulsome sense of what was taking place. I also learnt to minimise note taking while observing to avoid distracting and/or cueing participants to what I was looking for with them responding accordingly.

Participant observations offered an inductive way to explore my research question as I observed care that involved older adults' ADLs and how ADL status was recorded on hospital care documents in the context of functional decline. Hence, I included observations involving ADLs such as patients mobilising, eating, when and how off to the bathroom, transferring, walking, exercising, dressing themselves or when they took to wearing street clothes, socialising with others including care providers and visitors, friends and family.

I also made observation decisions based on tacit knowledge and spontaneity which enabled capturing for example when a nurse flew into a room, literally taking less than two minutes to get a patient up while she waited for her other patient to finish in the bathroom. Further, if I turned to talk with someone at that unexpected/unplanned moment of nurse/patient interaction I missed the observation. This variety of techniques and strategies as research practices facilitated locating and recognising strands of discourse across the different planes of collected data. Through trial and error I improved my ways of doing ethnography which helped me gain germane insights for how to collect data and do analysis that aligned with my research question.

Field notes

For each patient participant I had a distinct field notebook that easily slipped into my pocket for ready reference to record and describe: observed activities; social processes; how participants made sense of their world and addressed one another such as using gestures, labels, turn taking in their talk; who initiated and/or did what procedures or actions in nurse/patient interactions; how refusal of care unfolded; language used, any

hesitations, body positioning, tropes such as metaphors, styles or unique characteristics and/or euphemisms; what was said and done by participants in nurse/patient interactions of "mobilising the patient" in the context of functional decline. I described patterns of nurse/patient care occasions, their ways of engaging, nurses' explanations of care and use of jargon or medical language or what was inferred or not said; what and how instructions were provided and patients responded; how patients participated or not; how nurses talked about and enacted clinical. I took brief notes in the immediacy of observations and more fulsome notes when out of sight. I aimed for 'thick description' (Geertz 1973) to capture specifics and particulars and to contextualise experiences.

I reviewed field notes to decide what next to observe and for what purpose. I shifted between concentrating on actions, facial expressions and gestures to words and voice intonations or an overall view. Observing is hard work as one never knows exactly what to expect, where to look or what to listen to. Absolute vigilance is not enough; only in hindsight one realises where maybe there was a gap or missing detail never mind at times feeling not able to adequately translate the richness of silent observations into words.

Detailed field notes were carefully recorded during and immediately following field sessions to capture what is seen, heard and felt to understand what was going on. I tried to seize all I was looking at but to be honest my purview often included the patient, family members and at times two or more care providers; the scene was crowded, busy. I took heed of Van Maanen's (1979, p. 539) caution that 'ethnographic research is guided as much from drift as design and is perhaps the source of far more failures than successes'.

I trialled various approaches to working the ethnographic gaze for field note purposes. I experimented with Geertz's (1973, p. 4) thick descriptions, 'sorting out the structures of signification'. I tried to capture in writing the nuances, colours, smells and details to paint a picture of what transpired. However, descriptions and interpretations were always partial as I could only take in the immediate that was in front of me. Emerson et al., (2011, p. 58) offered excellent advice to focus and capture concrete details to evoke sensory imagery such as colour, shape and size along with smell and sound, with 'details portraying gestures, movements, posture, and facial expression'. This was difficult as people simply moved too quickly with some observations merely a minute or two because nurses were usually on the move, often in a hurry. Emerson's et al. (2011, p. 58) advice to select

what I wanted to most vividly and clearly recollect worked well when I knew what I needed to observe that day, to 'simply document the impression' with jottings working as triggers for later notes and possibilities of "seeing" the unexpected.

As a practising nurse I was acutely aware of the danger that what I observed and heard was not taken in or really "seen" or "heard". It was too commonplace and familiar, a case of not seeing the obvious. In deciding what to write I aimed to disrupt my familiarity, purposefully shifting my gaze to see differently for the next observations. In writing field notes I questioned my own assumptions and underlying sensibilities of what to observe, how to record and what constitutes data with sensitivity to unwitting bias.

Recorded audio interviews

I recorded semi-structured summative participant interviews as close as possible to the end of each patient participant's time in hospital. Six patient participants provided 20 to 30 minute interviews within the last day of their hospital stay. The seventh participant promised saying if not in hospital then once discharged home I could interview her. Albeit, she was suddenly discharged instead of going to the rehabilitation unit, so I missed her. I left phone messages twice but she never returned the call so I did not pursue the interview.

I obtained 26 recorded 20 to 40 minute interviews from health care providers who worked with patient participants. These were difficult to get as they fit them in during work hours; reluctant to stay after shift, anxious to get home. I was not able to interview some nurses despite many attempts as we just could not find a few spare minutes of their time. I transcribed or made notes on the interviews myself which provided a way to deepen my familiarity with data and to do preliminary discursive analytics. In experimenting with ways to analyse interviews, for some I re/listened to many times to refresh my memories of the person, to gain a deeper sense of how they talked about their experiences: the nuances, inflections, emotional undertones and such to bring alive again the spirit of who they were and how they portrayed themselves.

I used open ended questions in a semi-structured interview format and worked the tension of guiding questions, followed the lead of the participant, at times allowed silent spaces for possibilities of the unexpected to surface (Kvale & Brinkmann 2009) or pursued a line of thought with spontaneous questions. Each interview carried an undertone of time

constraint but for different reasons. For patients I was acutely aware of their early stage of healing from surgery and how they tired easily. As a nurse I was vigilant about assessing for signs of fatigue making it clear we could end the interview at any time. For health care providers time constraints were stringent. They said things like "it's crazy busy" or did not want to impose on peers covering for them. So I squeezed time in-between their scheduled tasks, honouring their peers who were covering for them. Despite these constraints I got excellent interviews with participants engaged, open to running with questions presented and showing genuine interest in thinking through their words, actions and thoughts.

Conversations in the field and recorded interviews resembled dialogues wherein a 'dialogue is conceived as a crossing, a reaching across, a sharing, if not of a common ground of understanding' (Crapanzano 1992, p. 197). They were active events that became new dialogues with each reiteration, such as the second dialogue was the 'coming together' when spoken texts were transcribed as data, now the written texts of their stories, somewhat decontextualized and reconceptualised as a written text. The next dialogue or 'coming together' will be read as text by the reader of this written thesis text. Crapanzano (1992, p. 196) refers to these secondary and tertiary dialogues as 'shadow dialogues' involving 'thinking that occurs as one engages silently in dialogue with absent interlocutors'. This process revealed discursive instability as created by second and third dialogues which bring an interpretive stance to a previous dialogue with possibility of new reflection and insight (pp. 214-215). Each time there was another 'coming together' or reiterated dialogue, the previous dialogues became re/contextualized; appropriated and oriented to the standpoint of those engaging in yet another version of the original dialogue (1992). This shifting of meaning is captured in Trinh's (1989, p. 79) warning that 'words empty out with age. Die and rise again, accordingly invested with new meanings, and always equipped with a second hand memory'.

The idea of reiterated dialogues aligned with my ethical intent of not taking a stand of authority and creating another fixed truth claim. The discursive meanings in participants recorded stories were contingent on how they were represented and positioned in those moments. Meanings were also contingent on how I reiterated and interpreted their stories when I wrote up data analysis, meanings that will be re/interpreted yet again by the reader.

This tentativeness around meaning offered opportunity to create space for multiple possibilities to bring new insights and understanding with each reiteration.

In recording, listening to and interpreting the recordings I made deliberate effort not to co-opt what each participant was saying and use data for my own purposes. My intent was to keep their stories in context as much as possible noting how I came to know each participant as a unique individual. I also came to know the participants through the eyes of others as I reviewed hospital care documents informing me of how participants were positioned and represented as hospital patients and care providers.

Patient records/other germane documents

Patient care documents/records were comprised of official legal paper charts and electronic health records accessed by a computer in the field. I had ethics approval to access these patient care documents/records and read both paper and electronic while doing field work. The only impermanent part of the "chart" was a pencilled care plan. Expectations were that plans were to be updated regularly with a patient's changing condition and needs. The problem was they were only as "good" as how "up-to-date" making them ambiguous and uncertain references to patient status because updating was not consistent.

Generating/collecting data: across planes of differentiation

Data generation and collection were dynamic processes as I moved back and forth between processes of determining, locating and collecting data in different textual media of written, read, spoken and performed texts. This was a necessary process to see how functional decline was talked about and defined as background to framing questions for challenging usual or common knowledge of functional decline in the context of older adults hospitalised for repair of a fractured hip. I called these planes of differentiation where, for example, objects of functional decline discourse would appear. Texts were considered as embedded in overlapping discursive fields of relations making up different 'textual products' (Atkinson 1992, p. 5); that is segments of text found to be of interest, set aside as data for analytic purposes. This range of texts was necessary for following how discourses were entwined and redistributed across planes of differentiation and hence useable as data for comparative analysis. The comparative piece was to see what discourse does when

redistributed from one location to another under different conditions of possibility or enunciative modalities.

Data were generated through field notes, participant observations and conversations in the field, recorded interviews and published literature. Data was located in documents such as provincial and federal health care reports, my scribblings and self-memos. In these texts I recognised, collected and regularised statements or fragments of discourse that enabled finding discursive formations of objects, subjects, enunciative modalities, concepts and strategies. Further data was generated by asking questions of data:

➢ How are everyday hospital care practices discursively formed across data sets?

➢ What objects are referred to in my data; how would I describe them (diseases, diagnoses, patient, technologies, etc.); how is participant talk an object of research; who is the text addressing? As discourse analysis is about seeing discourse as an object itself (Parker 1992, pp. 9-20).

➢ How does a discourse hail us? What perception of ourselves and/or others does the text discursively invite us to consider?

➢ So, what type of person (doctor, nurse, patient, etc.) is hailed by biomedical discourse and/or is at the same time the object of this discourse?

➢ How does discourse work to constitute subjectivities?

Generating this kind of data was useful 'to unbalance previously accepted notions of naturalness, inevitability, and necessity' (Koopman 2011, p. 5) of hospital experiences, identities and nurses' work. I also located data by recognising how biomedical discourse in terms of language makes

> claims of a unitary body of theory which would filter, hierarchise and order them [scientific claims] in the name of some true knowledge and some arbitrary idea of what constitutes a science and its object (Foucault 1980b, p. 83).

These ways of generating data were intertextual with texts embedded in a 'network of textual relations...[where] meaning becomes something which exists between a text and all the other texts to which it refers and relates' (Allen & MyiLibrary 2000, p. 1), the nature of discourse. Statements were recognised as potentially encompassing current and past ideas making explicit references or allusions or direct quotes from statements in other texts, discursively linking one text to the next in/across fields of relations (Wodak & Meyer 2009).

Tools for doing discursive ethnography

Forget your perfect offering
There is a crack, a crack in everything. That's how the light gets in.
(Leonard Cohen 1934-2016)

My analytic intent was to reveal the cracks, to show discontinuities, lack of stability in discourse as event; as a series of statements across semiotic texts of written, spoken, read and performed discourses to discern what discourse does. These strategies revealed the fragility/contingency of discourse despite its seeming solidity and production of knowledge based on established legitimised truth claims. Discourse was exposed as powerful despite its uncertainty. A discourse, as described here, is what it is only in the moment of enunciation, fluid, changing and contingent on circumstance.

Archaeology: analytic practices/methods to understand how *a priori* rules govern and define internal conditions of a discourse made visible on grids of specification, as objects which are discursive formations of objects, subjects, enunciative modalities, concepts, strategies.	
-Objects **-Enunciative modalities** **-Concepts** **-Strategies**	Discursive Formations (DFs) are manifestations of discourse, statements organised as 'a group of sequence of signs…in so far as they can be assigned particular modalities of existence' (Foucault 1972, p. 107). DFs whether object, subject, enunciative modality, concept and/or strategy are the dispersion and redistribution of a group or series of statements in a field of relations.
Genealogy: Strategies of reversal, discontinuity, specificity and exteriority: informing analysis of discursive events, exposing the conditions of existence and chance events of enunciation made by whom with what credentials, making it possible for a discourse to emerge, operate and be productive. As conditions can vary so can discourses appear and disappear.	
Reversal	Reversal examines discourse beyond its immediacy and implicit sense of truth, to unpack hegemonic assumptions and taken-for-granted notions
Discontinuity	Discontinuity is never completely separate from reversal but more about taking different perspectives on the power of contingent conditions, chance and events enabling/disabling discourse, rendering it unstable.
Specificity	Specificity is about seeing the *physicality* and *materiality* of discourse, as a practice (Hook, 2001, p. 537) rather than as a textual perception of reality. It is about illustrating the power of discourse.
Exteriority	Exteriority is beyond the content of the text and looking for a hidden nucleus of meaning. It examines exterior elements giving rise to the appearance and regularity of a discourse, what fixes its limits and the external conditions of its possibility.

Table 3.2: Archaeology and Genealogy: A recap from chapter two

Table 3.2 above recaps the archaeological methodology discussed in detail in chapter two, that served to inform this discursive ethnography using three analytic tools of statements, events and discourse. These tools made discourse visible, ready for analysis as material realities.

Statements

Discourses are not recognisable as intact systems or whole units but are dispersed in language as statements, the smallest notable nuclear units or fragments of discourse. When assigned or grouped by way of particular modalities statements come into existence as discourse via enunciative modalities, conditions of possibility. Foucault (1972, p. 80) added to existing meanings of discourse by considering it 'sometimes as the general domain of all statements, sometimes as an individualisable group of statements, and sometimes as a regulated practice that accounts for a certain number of statements'. For analytic purposes statements can also be represented as recurring tropes, analogies, images, actions, symbols, values and/or words or phrases that paint a reality that is the material basis of a discourse (Parker 1992). Hence statements are not necessarily a full sentence or separated out as a proposition or delineated argument or theory but recognisable whether as a word, symbol, phrase and/or sentence, by where located and enunciated in relation to what else is located in that space (Foucault 1972). Therefore, whether a statement is a sequence of linguistic elements or an image it is not self-evident, visible only as much as it is enmeshed in an articulated enunciative field of relations appearing as a distinct discursive product. However, statements are interconnected inferring or outright referring to the past as much as the future beyond never free, neutral or independent but playing 'a role among other statements, deriving support from them and distinguishing itself from them: it is always part of a network…in which it has a role' (p. 99).

The statement as an analytic tool enabled recognising how functional decline discourse pervades geriatrics as a series of social practices, discursively forming functional decline as a concept producing "scientific" knowledge about the older adults' loss of capacity for ADLs; in particular in relation to mobility/immobility and risk. As a discursively formed object of research studies functional decline discourse was rendered visible as producing knowledge of how to prevent and mitigate biophysical losses in function, commonly framed as inevitable. When manifest as strategies it produced knowledge of how

to measure, assess and predict such losses in ADL capacity. Hence functional decline discourse was made recognisable by locating statements in research studies on care of hospitalised older adults such as 'functional limitations in older adults, loss of mobility becomes inevitable for many' (Goins et al. 2015, p. 930). This statement clearly referred to functional decline as it is predominately defined in geriatric literature. Similarly, functional decline statements are in the title of a study: 'Understanding and reducing disability in older adults following critical illness' and where the study refers to use of ADL technology to achieve 'modifiable risk factors…associated with improved functional and cognitive outcomes' (Brummel et al. 2015, p. 1265).

Hence, once the nature and work of a statement was understood it could be located, recognised and regularised; made accessible to analysis as discursive formations of objects, subjects, enunciative modalities, concepts and/or strategies. These formations were located as objects on grids of specification such as the hospital system specified by its models of administration, managerialist practices and care technologies and practices. These objects were visible as 'reflexive categories, principles of classification, normative rules, institutionalised types…[as] facts of discourse…[that] have complex relations with each other' (Foucault 1972). The law or rule of existence of statements is contained in the tool of analysis called 'events'.

Events

> The question which I ask is not about codes but about events: the law of *existence* of statements, that which rendered them possible – them and none other in their place: the conditions of their singular emergence; their correlation with other previous or simultaneous events, discursive or otherwise. (Foucault 1991, p. 59)

An event is neither substance, nor accident, nor quality nor process; events are not corporeal (Foucault 1972). And yet, an event is certainly not immaterial; it takes effect, becomes effect, always on the level of materiality and has its place. Events consist in relation to, coexistence with, within dispersion of the cross-checking accumulation, the selection of material elements; occurring as an effect of and in material dispersion (1972). In analysis I organised statements to see patterns of their materiality as events in the context of where and how they existed on grids of specification and to what effect. As in the event of the statement of "mobility", its material emergence in hospital care technologies and practices was not in isolation of the hospital system. Its operation was integral to functional

decline discourse becoming visible as "heard" or "seen" as a legitimised care practice, an authorised object on the hospital's grid of specification. The event of mobility was a recognisable pattern of incrementally mobilising or getting a patient up at the bedside to dangle then stand for a few seconds post-surgery in reference to getting a patient back to their previous level of independence ready for discharge home.

Mobility as such could be seen as part of the hospital's Throughput model organised to achieve a minimal length of hospital stay. As an event I could analyse how "mobility" discursively had effect on the conduct of care and patient experiences. The constitutive power/knowledge effect of mobility as a functional decline discourse event was also rendered visible, recognisable as informed by biomedical knowledge of ADL technology that structured and standardised the CPW technology designed to prevent functional decline post-operatively. By exposing the normalising effects of ADL technology as it operated via the fixed daily requirements of the CPW to mobilise patients, the requirements for conduct of care could be seen as *not* in relation to *who* the patient was but as standardised practices in relation to the type of surgery performed.

Hence, mobility as a discursive formation of functional decline discourse, viewed as an event could be recognised as producing knowledge of how "best" to care for a patient; the power/knowledge of functional decline discourse. This approach enabled exposing the power relations inherent in nurse/patient care occasions as nurses and patients took up, resisted and/or ignored daily care practices as required by the CPW. Further, such analysis could explicate how functional decline discourse was entwined with discourses of safety, desire and risk. Thus the event of a discourse was not necessarily 'divided between accepted discourse and excluded discourse' nor dominant and dominated discourses but as 'a multiplicity of discursive elements that can come into play in various strategies' (Foucault 1978, p. 100). An interplay made up of discursive effects contingent on circumstance and situation contextualised by elements of time/space and power relations.

The discursive work of events is intertextual. Various strands of different discourses within one text appeared bordered by other discourses (contiguous). With the dispersion of events as scattered strands of statements embedded across/within texts, a discourse could refer back to previous texts as well as implicate what is said in future texts working across networks of texts. So 'what is thought within one discourse is an effect related to what is

unthought there but thought elsewhere in another' (Macdonell 1986, p. 47). These elements of discourse attest to its power based on its pervasive and often unwitting presence as they are redistributed across texts, time and space. Thus reading one kind or location of text embedded with webs of statements as event was only an immediate yet partial view of a discourse. Therefore, it was necessary to read, listen and observe widely, to include data from academic publications and germane documents alongside those located in the hospital field. This approach enabled a more comprehensive comparative analysis to ascertain effects of discursive events as written, observed and spoken texts and as such intertextually formed statements of events across planes of differentiation. Spoken texts for example were important because 'talk is interwoven with gesture, facial expression, movement, posture to such an extent that it [discourse] cannot be properly understood without reference to these "extras"' (Fairclough 2001, p. 22). This complex understanding of statement and event was critical to inform how defining discourse is also an analytic tool essential to processes of analysis as outlined next.

Discourse

Incorporating statement and event as integral to the definition of discourse enabled using discourse, statements and events coherently in discourse analysis (Table 3.3 below). Understanding discourse as ruled by certain procedures, *a priori rules*, also helped to make it recognisable, nameable and describable; to examine the production of discourse as simultaneously controlled, selected, organised and redistributed (Foucault 1981, p. 52). Articulating a definition of discourse enabled examining the power/knowledge events of a discourse to reveal how it gains mastery and meaning in older adults' hospital care. Analysis could reveal how discursive meaning-making was transitory, contingent on the event of a discourse: where statements were located and how interrelated with other "things" as social practices. Social practices of health care for example materialised as expertise: admitting a patient, listening to an apical pulse, inserting an intravenous, palpating an abdomen, documenting on patient records, observing/assessing a patient's level of physical mobility, giving hospital discharge instructions, using clinical pathways, validating measures of bio-capacity for ADLs and/or designing instruments to categorise patients for prognostic purposes and so forth. Discourse was shown to operate as ensembles of discursive

formations 'embodied not only in theoretical texts or empirical instruments but also in a whole set of practices and institutions' (Foucault 1994, p. 7).

These Foucauldian tools offered a multi-vocal research approach that could draw from written, read, spoken and performed texts to enhance possibilities of gaining broader and deeper insights. They made the power/knowledge of discourse, discursive practices of knowledge production, visible as embedded in complicated social networks of hospital spaces and research initiatives.

Statement	Event	Discourse
A group of sequenced signs, fragments of discourse representing a discourse's function within an enunciative field of relations that gives meaning to what discourse does, the *doing* and power of a discourse as interconnected webs of statements where, how and when they appear.	The rule of the appearance and existence of a statement. Neither substance, accident, quality, process or corporeal; yet takes effect, becomes effect always on a level of materiality where placed. Recognisable as a *pattern* of statements as to when and where statements are uttered how by whom.	Social practices within language and symbols; a material system of thought productive of knowledge, constitutes what it "speaks". Is recognised by regularity of statements and events that enables "seeing" what a discourse does and to what effect.

Table 3.3: The Foucauldian tools used for discursive analytics

These tools enabled explicating how complex multifarious relations of power 'permeate, characterise and constitute the social body, [how] these relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse' (Foucault 1980b, p. 93). They rendered visible how procedures or rules of discourse are the conditions of possibility for a discourse to materialise and be seen as 'inextricably associated with particular technologies of power embodied in such social practices' (Smart 1985, p. 48). The production and operation of discourse could be examined, how it delimits and controls knowledge analysed, to see why one discourse and not another may appear or disappear.

Textual practices for constructing textual products

Here I outline textual practices of scribbling, self-memos, transcribing interviews and field notes and mind mapping. These practices produced textual products, the discursive

formations of concepts, subjectivities, ideas and strategies. These products were analysed as types of discourse related to discursive formations, how accepted, resisted or made to function as true, to see what techniques and processes led to their acceptance as unquestioned truth claims. Each product was located or referred to in data, organised and constructed according to lines or patterns of analysis in relation to research questions. Textual practices generated textual products enabling discourses to be visible as discussed in chapter two. Table 3.4 below is a description of textual practices and products.

Discursive and Ethnographic Tools	Textual Analytic Practices ~ based on an ethnographic discourse of research practices
1. Scribblings, self-memos, re/reading and re/reading data	Scribblings began with writing the thesis proposal to capture germane ideas, organise my thinking and focus for the study. Scribblings were in the moment of reading and hearing things of interest; spontaneous notes of what surfaced to mind, what struck as germane or peculiar, to disturb my thinking/connect with other less known ideas in re/reading data; concomitant with self-memos and reflective as recursive processes of analysis: fragmenting, sorting, re/organising, looking for patterns, relevance and interpreting.
2. Transcription of field notes and interviews	Self-transcribing field notes and recorded interviews provided familiarity with data and precipitated insights for processing/analysing data. Served to create a re/production of observed, spoken/heard data into re/written data to enrich understanding about what I did, saw and heard in observations, conversations and interview processes.
3. Mind mapping re/reading data	Mind mapping incorporated use of textual products to organise data, insights, imagination and ideas; to figure what was continuous, common, discontinuous and/or disruptive; to sort and organise knowledge produced while continuing to re/read textual products of data: objects, subjects, concepts, strategies, metaphors, synecdoche, other tropes, pronouns, symbols, allusions, allegories, assumptions, self-evidences or inevitabilities and so forth.

Table 3.4: An assemblage of textual practices to construct textual products

Scribbling is usually thought of as done carelessly and hurriedly. However, it can be a "warm-up" exercise, spontaneous writing to loosen up imagination and allow unconscious thoughts to arise naturally while reading; generating creativity, capturing ideas and insights in the moment. Throughout the study I made pencilled scribblings in margins and on post-it notes to inscribe impressions, questions, thoughts, feelings in relation to what percolated into consciousness while listening/reading/reviewing materials. I scribbled away during provocative/evocative conversations with PhD supervisors. I paid attention to things like

tropes and their effect on how I interpreted and understood participants' ways of making meaning and their understanding of performance of subjectivity.

Scribbling, a process of free association, offered things from incomprehensibilities, scratchings later discarded to new ideas and insights informing research "doings". It was a way to access fields of relations and cultural networks that emerged as I looked for themes and patterns in the data (Parker 2004, p. 310). They supported how to judge, process ideas, thoughts and insights, interpret relevancy of what I read/heard/saw in relation to my research questions and purpose. Scribbling in relation to self-memos provided a screening of texts, cultivated intuitive knowing of what texts offered or not as foundational to analysis and assigning meaning or meaning making, locating/recognising statements of discourse, the interconnectivities of statements within/across discourses.

Self-memos were self-reflections on data, insights, questions or comments arising throughout the research processes; thoughts on how and/or what data may be missing, how data could be collected differently or how to make sense of data. A back and forth rhythm between scribblings and self-memos was used to disrupt thinking, avoid seeing what is desired, to problematise my writing. Latimer's (2003, p. 234) idea of getting inside the topic of concern with attention to detail, nuances of language, voice inflections, gestures; to question 'what do we want to get inside' to know and understand how nurses perform their identity, produce and reproduce their realities, their practice, their identity.

Transcription of field notes and interviews as textual products worked to generate ideas and insights, in particular by doing my own transcription. I felt closer to the data listening and reliving what I heard, gaining added perceptions of what was said by whom, when and how for a more fulsome set of textual products, to locate entangled discourses. I experimented with some recordings, not transcribing per se but re/listening over and over to pick up details and nuances generating more self-memos and textual products.

Textual practices were valuable in thinking through, re/organising my mind maps as visuals to establish interrelationships of ideas via various configurations to depict how data and analytic outcomes were interconnected. The study research questions were central to the map organised in relation to the purpose and processes of the study. I depicted spatial/temporal ordering of hospital practices and discourses such as how functional

decline discourse disciplined bodies, scripted patienthood, constituted performances of identities and subjectivities, mediated the nurses' conduct of care. Textual practices mapped out languaging of care, wording as discourses, social practices of power/knowledge that implied, addressed and/or referred to functional decline in relation to observed and heard hospitalised older adults' experiences. The power relations located in these textual spaces, the discursive formations and the operations of discourse power/knowledge effects could be viewed as a trialectic of space/power/knowledge.

I also made up charts, lists and grids to organise data to examine interconnectivities of ideas and insights, to gain new understanding of what the data offered. These textual practices organised how to define and cross reference ideas, concepts, philosophies and ways of knowing, to track where they were located, how used to do what and how redistributed to make meaning of data. These charts contained ideas on problematisation, contingency, knowledge, truth, bio-power, bio-politics, objectification, subjectivity, categorisation, norm, normativity, nursing, patient and more. They enabled locating and organising **statements** and events of discourse to see discursive theoretical and empirical concepts and how they are contingent on context and conditions of possibility.

Nurse researchers like Purkis (2003, p. 34) informed textual products by her way of questioning the divide or distinction between 'nurses in practice and those who write about nursing practice'. Purkis (p. 35) argued theorised nursing practice may not be adequately conceptualising actual everyday nursing practice because nurses in practice although accomplishing nursing as 'knowledgeable actors' may not be particularly adept at describing how they do nursing in terms of what they are accomplishing as nurses. She contended this lack of insight between theoretical (what nurses take to be their work) and empirical (what their actual work is) and how nurses accomplish their identity was problematic.

Textual practices aided identification of the work of discourses: the constitutive effects of labels, categories, stereotypes, endearments, resistance, beliefs, values, assumptions, exclamations, ironies, paradoxes, inconsistencies, allusions, rhetoric, argumentation and power relations (cf. Parker 2004; Wodak & Meyer 2009). I could more readily recognise, locate, and organise signifiers of ageing, definitions, tropes, medical jargon, descriptions of functional capacities and functional status. Textual practices were also guided by questions suggested by Emerson, et al. (2011, p. 177):

- ➢ What are people doing? What are they trying to accomplish?
- ➢ How exactly do they do this? What specific means and/or strategies do they use?
- ➢ How do members talk about, characterize, and understand what is going on? What assumptions are they making?
- ➢ What do I see going on here? What did I learn from these notes? Why did I include them?
- ➢ How is what is going on here similar to, or different from other incidents or events recorded elsewhere in the field notes?

I created these questions:

- ➢ How does a bio/medical discourse draw us in?
- ➢ Who has the right to speak biomedical discourse *and* be heard?
- ➢ What role do we have to adopt to hear the message of this discourse?
- ➢ How does this role reflect the power relations we have with the "author" [where the text comes from] of the discourse?

These questions were also invaluable for generating ideas of what to look for in texts and how to create textual products for specific analytic purposes and helped inform when I had enough data.

How to know when enough data?

There are no stringent or measurable guidelines in qualitative methods concerning how much is enough data to establish trustworthiness and credibility in analytic outcomes. However, I needed enough data for compelling arguments, to gain credibility in how I saw functional decline as an object and a concept that guided treatment and interactions in care of hospitalised older adults. I had enough data when I could interpret the power/knowledge of functional decline discourse, illustrate how it constituted nurse and patient subjectivities and I could support arguments about how the biomedical discourse of functional decline mediated how nurses provided care.

Rigour of methods: ethics and credibility?

> What is philosophy if not a way of reflecting, not so much on what is true and what is false, as on our relationship to truth?...The movement by which...one detaches oneself from what is accepted as true and seeks other rules - that is philosophy. (Foucault 2003b, p. 179)

Rigour of methods in my view involves ethics, to engage in self-reflexivity to discern how methods allow for a coherent and cogent thesis that appropriately addresses the topic of concern and has credibility for the reader. Thus using a stand of self-reflexivity, I questioned how I positioned myself in field work to disrupt assumed truths as I questioned my relationship to truth claims located in the data yet avoided making truth claims myself. As such self-reflexivity was critical to ensure this kind of ethics and rigour when coming to conclusions in the analysis. Textual practices enabled such rigor by helping me to organise, figure out and make explicit my thinking, to keep forefront my research purposes and maintain ethical research practices of honesty and integrity in my explorations, discussion and conclusions.

Ethics is integral to rigor as it necessitated awareness of my own subjectivity, own attributes, experiences and perspectives with clarity in doing the research (Angrosino & Rosenberg 2011). Ethics as self-reflexivity is a Foucauldian notion of freedom generated by taking distance from oneself to observe oneself and what one is doing, thinking and saying from afar, to see differently yet critically; to avoid the dichotomy of resolutely taking a unified position or identity or no particular position or identity. Each year I participated in nursing and interdisciplinary conferences to explore and experiment with these approaches, to invite feedback and keep an open honest yet questioning stance. Ironically ethics was about clarity of position as much as a stand of not knowing with openness to possibilities and contingencies to achieve a rigour in methods yet without set ideas. I accepted shifting insights as new evidence, ideas, thoughts and/or possibilities as they arose; questioning what was self-evident, disturbing what was taken for granted, re-examining my own thinking. The material practices of self-analysis, to think and re/think the conduct of research without preconceived notions of eventualities and/or sedimentary authoritative truth claims was a means to attaining rigour in methods.

Hence rigour involved maintaining clarity about who I am and what I do as researcher, ensured openness about biases and preconceived notions while exploring what was held true and appropriate. It demanded sensitivity to power relations of researcher/participant relationships. As the researcher I designed the project, participants agreed to the design. I questioned my insights and interpretations of their material realities to avoid reinventing or simply replacing already established truth claims and/or seeing things strictly from my perspective. For rigour I cultivated awareness of my own social, economic and political motives, my research interests, values and academic privilege to be transparent in how I represented and positioned myself in the field (Wodak & Meyer 2009, p. 7).

Rigour was not just validating findings, delimiting what was measurable, provable and reproducible as that runs the danger of findings being alternate truths, static and incommensurate with my aim to preserve the uniqueness of participant subjectivities. Rigour involved believability and credibility with consistency between research questions, methods and findings, respect and appreciation toward the social sphere. Field sites were seen as empirical worlds offering places of inquiry with sustained congruence between what and how I queried, described and interpreted the nature of field sites and generated data. Story elements were put together in a congruent way to credibly align the plot of the story with context and circumstance (Hammersley & Atkinson 2007).

Rigour meant to read widely for broad/deep knowledge of the research topic, to gain insight about attendant methodological problems, conundrums, issues and questions. It was to question discursive discontinuities and disruptions in spaces/contexts across data sets. I aimed to consistently see beyond the surface of a discourse that may appear as a unified and permanent object but in actuality was contingent on the space where located and how/when 'continuously transformed' (Foucault 1972, p. 32) as other objects of various discourses appear/disappear within/across data sets.

Insider/outsider: nurse as ethnographer

> If many cultural portrayals now seem more limited than they once did, this is an index of the contingency and historical movement of all readings. No one reads from a neutral or final position. (Clifford & Marcus 2010, p. 18)

I was both insider and outsider, not neutral or in a fixed position. As a registered nurse practising many years in hospital settings and many more as a university nursing professor I came to my PhD student role as a researcher with credentials and experience implying expert knowledge. This drew political and ethical implications as my professional positions implied established authority and legitimation as expert. So, I was always clear about my foregrounded role as nurse researcher and backgrounded my teacher and registered nurse roles. I emphasised I was not judging or evaluating practice. I was learning how to do research by being bodily present in the field, to effect experiencing hospitalisation alongside with participants, not separate by genuinely listening to their talk and trying on their social relations to make sense of what matters most in the immediacy of their hospital worlds (Evans 2012). Despite such clarity, my standpoint as nurse and teacher retained potential for preconceived notions and bias because field sites were familiar territories as were behaviours I observed and what I read in published literature on functional decline imbued with familiarity.

I facilitated rigour in my research practices and addressed being an insider/outsider by adapting ideas and questions from other qualitative researchers (Bradbury-Jones 2007; Bruni 1995; Latimer 2003):

- How do I position and represent myself for objectivity, maintain authenticity and not interfere with nurse performances?
- As a licensed nurse how will I respond if I see untoward, unsafe or unethical practice in the field?
- How will self-reflexive practices enhance credibility, make transparent my subjectivity in the research processes?
- What is my role as researcher and authority of voice in constructing data that stays as close as possible to the "truth" of participants' stories?

Positioned and represented as ethnographer

There is no absolute or universal interpretation of how ethnographers should be positioned and represented in the field. One position is objectivity with intent to not disturb or influence the participants' world; a naturalistic approach 'to reveal the social world in a manner consistent with the participants' image of the world' (Gerrish 2003, p. 81). The

problem is underlying assumption the researcher is value neutral and there is a true realism to be discovered (Hammersley & Atkinson 2007). Or maximise immersion in the field, by taking up active roles in the field site to figure out 'holistically and intuitively' what participants are doing. I positioned myself outside the role of actively participating in activities. I aimed to stand back and observe events of significance and interest, to create time/space to record details, insights, thoughts and ideas as necessary. The intent was to be positioned to see nursing via participants' eyes; to deliberately write what I observed without judgment as insights gained will always be filtered by how I am situated and constituted (Gerrish 2003).

I engaged in ethical reciprocity (O'Neill 2001, p. 223), not standing aloof in the field to avoid an absurd binary of me/participants. This would have created an artificial sense of detachment making participants nervous as I appeared to be an interloper in contrast to researcher. With an embodied sense of representing myself as being a nurse it was uncomfortable to just observe and not reciprocate. Therefore, I offered assistance, did basic tasks of fetching supplies, tidying beds and organising furniture to prepare for patients mobilising, followed them with a wheel chair and other simple/basic tasks contributing to patient care. I did not engage complex nursing skills such as medication administration, adjusting IVs, helping insert NG tubes, skills beyond my scope as researcher at this time.

I decided not to wear a uniform or lab coat to avoid being indiscriminately called upon as nurse. I wore semi-formal clothes. I did not offer advice to care providers. I listened and discussed principles of care, not specifics such as which analgesic would be preferable for a patient. Participants acknowledged and accepted this stand. As a registered nurse I had a duty to report any obvious, non-compassionate, unsafe/unethical practices. I did not witness such practices. My boundaries as researcher were made clear, kept and respected.

Reflections on ethnography using discursive analytic methods

Foucault's principles of discursive analytics: reversal, discontinuity, specificity and exteriority (chapter two) emphasised recognising and revealing how truth claims are legitimised by authorised knowledge using *a priori* rules of author credentials and, epistemological enforcers of what is sayable and heard. These principles informed methods to examine how the power/knowledge of discourse took effect as a will to truth, legitimised

and taken as "in the true". Knowledge as truth claims, whether in legal hospital documents, care practices or authorised journals were always dependent on conditions of existence such as place/time where spoken and/or inscribed by whom. Discursive analytics served to make truth claims and other discursive formations of interest visible as objects on grids of specification used as data sources; grids of hospital systems, routines and spaces not in isolation but in relation to grids or systems of published literature germane to the topic of interest. These data sources held interconnected power/knowledge effects of discourses interiorly and by a "the wild exteriority", *a priori* rules. Hence it was imperative in this study to include both hospital spaces made accessible by ethnography and a body of reviewed literature rendered germane through processes of discursive analytics. As such discursive ethnography could expose the power/knowledge of a discourse wherever it was recognised and located through knowing these *a priori* rules. Analysis could render visible the order of a discourse and its effects within and across different fields of relations, to see how/when re/distributed across literature and hospital spheres. For example, the power/knowledge of biomedical discourse was shown to have similar effect across these spheres, recognised at some level wittingly or unwittingly in hospital as the commentary of the grand narrative of medicine. A commentary that established, authorised and legitimised medicine as a discipline defined and upheld by the delimited domain of the scientific method, 'a corpus of propositions considered to be true, a play of rules and definitions' (Foucault 1972, p. 59).

In doing discursive analytics it was important to treat 'the text itself as the object of study' rather than becoming caught up by what the text 'seems to refer to' (Parker 2004, p. 310). I examined texts for words, phrases, sentences, tropes and chunks of writing to discern how they made sense as statements not in isolation but organised to reveal how as interrelated discursive events they operated to produce knowledge about hospital systems, care technologies, practices and participants. This meant I looked for how such events were enmeshed in webs of conditions contextualised by research protocols, hospital rules, routines and practices. It was by recognising these webs of interrelatedness across texts as objects of study that I could make sense of the ordering of discourse and how one discourse and not another was predominately uttered, the event of a discourse. I examined how statements whether located on the texts of care technologies and/or the texts of care providers' talk they presented as expert knowledge or expertise in tension with subjugated,

local or naive knowledges to reveal how power/knowledge is contingent on the context and conditions of discursive events. Table 3.5 below summarises how I located and recognised texts as **data** in **analytic processes** to figure and determine **what discourse does** and to see what *the doing* of discourse does.

Discursive analytics allowed funnelling ideas progressively by focussing on how patterns emerged in textual spaces across regimes of theory and practice within temporal-spatial spheres of data sets here. I could see a unity of discourse not so much in its permanence and uniqueness but via 'the space in which various objects emerge and are continuously transformed' (Foucault 1972, p. 32) here as discursive formations.

Foucault significantly informed my thinking but is acknowledged as avoiding specific methods to clearly inform data collection, analysis, organising, interpreting and writing up the thesis. He (1994, p. 288) said 'I care not to dictate how things should be' with a purposeful reluctance to prescribe methods claiming he 'tried to reveal the specificity of a method that is neither formalizing nor interpretative...,' (1972, p. 135). Rather, he offered various albeit incomplete frameworks to problematise and question possibilities amenable to his current study. His ideas on methods were simply not too clear or specific never mind shifting and changing as he came upon new thoughts and rejected or abandoned others. The challenge sharpened with trying to follow and understand his broad and diverse synthesis of ideas from social and political studies across many disciplines from the social sciences, literary works, history, philosophy, hard sciences to medicine and psychiatry. I drew from his philosophical, postmodern and post-structuralist approaches to knowledge, power, subjectivity and self-critique.

My methods were not designed to provide solutions as alternate truth claims to already-established health care practices. Methods focused on explicating truth claims for purposes of exposing the constitutive power of knowledge and truth regimes generated by the discourse of functional decline. Discursive analytics revealed how functional decline discourse embedded in the language of scientific study and scientific notions of care imbued care technologies that almost exclusively determined care practices. These methods were used to unpack the effects of the grand narratives of science by examining their discursive effects when redistributed from the literature into hospital systems translated as managerialist practices and embedded in the minutiae of everyday hospital care practices.

Textually mediated data	Analytic processes	What discourse does
Data organised as statements are located as events. Statements can be textual products but only have meaning in the context of where located, their enunciative modality, who is the speaking subject (author function); the conditions allowing the event of a discourse. For example, statements of functional decline discourse can surface as Activities of Daily Living (Katz et al, 1972) when written as scientifically determined and pre-established validated measurements based on norms. Data presents on a patient chart as objectified levels of capacity for mobility ~ useable for deciding what constitutes diminishing capacity, decreasing productivity, increasing illness, and/or recovery; positioning the patient in relation to measurable biophysical elements used to assess discharge status. Data are located and identified elements appearing as events of discourse that structure patient care technologies.	Discursive analytics using Foucault's strategies of reversal, discontinuity, specificity, and exteriority are about locating the character of discourse as event to make visible how discourse is produced as discursive formations and how it operates. The event is *where* a statement is enunciated and located as an artefact of a discourse. Data as a series/ensemble of statements recognised as a pattern of meaning becomes visible as discursive objects, concepts, subjects, and strategies available for analysis, e.g., how items of assessment are enunciated on a patient chart as a grid of specification used to document level of functional status: levels of mobility itemised as dangling at bed edge, standing, etc... Discursive practices can also be the manufacture of tropes such as bed # for patient or idea of assessment as scientific evidence informing the clinical pathway conceptualised as best practices despite being decontextualised and so forth.	Once discursive formations are made visible across interrelated fields of discourse, what they do becomes apparent. For example, how: A patient is formed as object of care is established by the language and structure of patient charts. The discursive formations of charts is about production of knowledge, i.e., biomedical knowledge informing and constituting who a patient is via assessment and documentation strategies. Records of these social practices of hospital care are discursively constructed via tick box format that constitute subjectivities of nurses and patients accordingly, i.e., expert nurse using scientific measures positioning subjugated patients as objects of care. The patient record, as a grid of specification is an enunciative modality for discursive meaning-making about the patient via a series of numeric values used to determine readiness for discharge. The patient becomes objectified as their subjectivity becomes defined by numeric values. Analytic outcomes are how discursive formations of objects, subjects, enunciative modalities, concepts and strategies are constituted and constitute subjectivities as they operate to delimit, guide, and control patient care.

Table 3.5: Organising and working with data for analytic purposes.

My intent with ethnography was to focus on study participants as unique beings without seeing any as outliers. Each was seen as contributing to what constitutes a hospital world for nurses and patients as real people, not normalised subjects, homogenised in a cohort of many as in most quantitative studies. Although my analytic outcomes were recognised to 'always be incomplete, insufficient, lacking in some way,…this is not a defect since it is the means that enables [such] transcendence' (Tyler 1986, p. 186), to see beyond the routinised, normalised and standardised nature of hospital life.

I aimed to be sceptical through practices of self-reflexivity, thinking about my thinking and how that compares to others' thinking in effort to gain focus, clarity and coherency in crafting methods relevant to the study purpose. My methods therefore were relevant to examining functional decline not as a problematised object or concrete clearly defined concept as most geriatric studies do but as a discourse; as social practices to be problematised as delimiting and constraining what can be said and done about older adults' care and older adults themselves. I was keen to not only know what can be said and done when by whom and to what effect in the care of hospitalised older adults but how such practices operate. Ethnography allowed an up close exploration of such things. I could examine the exclusionary practices in action, the modes of delimitation, constraint and discrimination in hospital care policies, models and practices, how such discursive practices problematise the older adult and how they affect the nurses' care for the older adult. The next three chapters illustrate how these methods operated and what I achieved, the knowledge and understanding gained in the "doing" of analysis and the production of analytic outcomes.

Chapter 4: A genealogy of the discourse of functional decline

> You are standing at the edge of the woods at twilight when something begins to sing
> …you are just sinking down into your thoughts. (Mary Oliver 2002)

The genealogy that follows traced the materialisation of functional decline discourse in the context of hospitalised older adults. As a genealogical analysis it incorporated tenets of archaeology of knowledge to enable thinking about and understanding the materialisation, production, dominance and constitutive effects of functional decline discourse so as to reveal its power and violence to constitute that of which it speaks. The analysis explicated from historically archived papers, focused on functional decline and hospitalised older adults, the appearance of functional decline discourse as a series of discontinuous and contradictory discursive formations emerging out of earlier concepts like iatrogenesis. This approach served to reveal the power/knowledge effects of functional decline discourse as it pervaded and dominated contemporary geriatrics and older adults' care.

Integral to analysis here was examination of how activities of daily living (ADL) technology enabled the power/knowledge of functional decline discourse. Analysis will show how health care research initiatives developed assessment tools that linked the measurability of functional decline with ADL technologies that incorporated discourses of risk, safety and economic rationalism. I argue this ensemble of discourses enabled functional decline discourse to be central to the design, structure and enactment of assessment technologies and care practices used to order and manage hospitalised older adults. Analysis will examine how research designs searching to develop trustworthy, reliable yet economic care tools were compelled by health care services' demands to control hospitalised older adults' risk of functional decline in a context of economic constraint. Analysis will expose how despite the perceived taken for granted stability of functional decline discourse, its existence and operation is inextricably linked with contingencies of interior and exterior *conditions of possibility* provided by supporting discourses such as risk. How functional decline is figured, provided the context for two subsequent chapters' analysis of the production, operation and redistribution of the discourse of functional decline and its effect in mediating nurses' conduct of care and older adults' experiences.

A retrospective on the concept of functional decline

Functional decline materialised in published gerontology literature in the late 1980s as language integral to the formation of assessment tools structured by ADL technologies for use in guiding hospitalised older adults' care (Appendix B.1 Sourcing the literature). Prior to the 1980s the notion of functional decline was typically described in terms of disability, dysfunction, or deficiencies in functional capacity. These incapacities were at times measured by ADL technology for purposes relating to the needs of specific types of patients or more often for older adults living in the community or in community care facilities. Discursive formations of ADL technology were therefore organised as measurable objects operating as standardised ordinal values of biophysical capacity. Such uses for these ordinal values were not new though for as early as the 1920s these ordinal measures were used to classify cardiac patients in anticipation of potential declining functional abilities (Guralnik et al. 1989). Later works like Moskowitz and McCann's (1957) 'Classification of disability in the chronically ill and aging' took up ADL technology to 'evaluate and classify their functional capacity' and marked a shift to targeting the 'elderly' population. Although Moskowitz and McCann's (1957) work was evident in the design of various ADL indexes and scales of the 1960s the technology virtually lay dormant until approximately the 1980s (as illustrated by Fig. 4.1's depiction of the citation count for this article) when a re/newed interest in ADL technology in relation to measuring and predicting health decline in hospitalised older adults emerged.
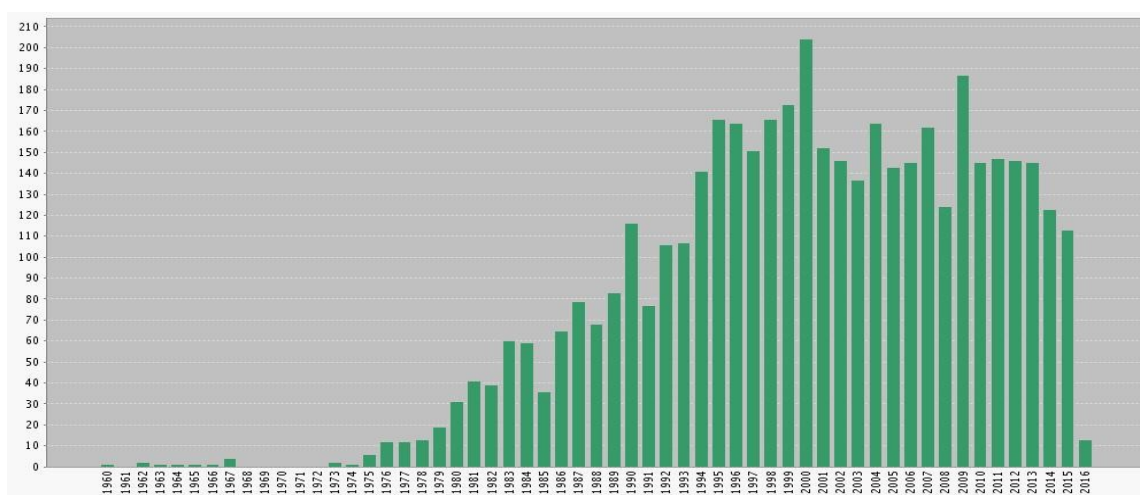

Figure 4.1 Moskowitz & McCann (1957): Citation Count 1960 – March 2016 (Web of Science)

In the 1960s, ADL technology was chiefly used to measure, assess and level functional status focused on how the older adult functioned biophysically outside hospital to inform management of older adults' community care needs. Although the central intent was the well-being of the individual there was an element of economic concern as the tool was designed to assess the older adult's levels of ADL to determine the least expensive, yet most apt and effective level of care. Interestingly the three 1960s ADL technologies described here are still in use and being cited in current geriatric literature. These ADL tools were co-opted as effective and efficient yet economic technologies to order older adults' hospital care by measuring, assessing and/or predicting their functional status, a decrease in functional status over time became conceptualised and typically referred to as functional decline (Gross, Jones & Inouye 2015; Hoogerduijn et al. 2014; Zisberg et al. 2015). Three examples of ADL technologies from the 1960s will illustrate how these technologies are structured and amenable to co-optation for hospital purposes.

'The Barthel Index' (BI) (Mahoney & Barthel 1965, p. 62) targets 'the chronically ill patient', assessing their level of dysfunction and deficiencies by the 'time and amount of physical assistance [they] require' against what has been determined sufficient for 'a state of independence' to perform ADL. It is a normed ordinal scale indicating what *level (not actual function)* of the patient's physical functioning is 'necessary to get along without attendant care…since these [scores will] indicate where the deficiencies are' (p. 62 & 65). It is a scale of *probability*, the *likelihood* of dysfunction not actual dysfunction and implies how over time the "chronically ill" will inevitably *likely* need increasing attendant care. These BI measurements can then also be used for economic purposes, as a predictive measure for savings, in deciding whether or not a "patient" is so dysfunctional they are a 'poor potential for rehabilitation' (p. 62 & 65).

The 'Physical Self-Maintenance Scale' (Lawton & Brody 1969) was designed as a scale for *observers* to *objectively* rate ADL competence in community residents or residential care patients. Its rating of 'physical functioning' provides a 'brief objective assessment… of concrete behaviour' as part of 'routine evaluative procedures' (p. 183). This scale in 'anchoring evaluation to the specifics of actual function serves to minimise distortions and to reduce global, subjective or value-laden judgments' to avoid the possibilities the 'worker, aged client, and family members may be subject to biases' (p. 183). The scale juxtaposes

existing objectified levels of function with potential function to pinpoint discrepancies to inform 'casework process' and indicate 'need or lack of need of services' (p. 186). Objective measures were used as they necessarily 'compel focused attention to the *functioning* of the older person' (p. 183, italics in original). The rationale was 'planning often must take place when the capacities of the elderly person are clouded by acute reality problems and the emotional upset of elderly individuals and family members' (p. 183). Discursive structuring of this ADL technology required objectivity and reliability to determine functional status in order to represent the older adult as 'the functioning human being [who] may thus be assessed by measuring instruments' (p. 179).

The Index of ADL (Katz et al. 1963, p. 914) is a measuring tool designed for assessing *levels* of independence/dependence of 'the aged and chronically ill' in community facilities and is 'based primarily on biological and psychosocial function, reflecting the adequacy of organised neurological and locomotor response'. This index therefore reads as an *objective* measure of *observed* psycho/socio/bio-capacity for independence established by standards and norms which level functional capacity in response to a 'need [for] quantitative information about the natural changes of function in the ill and well' (p. 914) claim 'there is an ordered regression [in loss of function with disability] as part of the natural process of aging' with the index providing 'an objective approach' to study and measure the ageing process. Gilleard (1981, pp. 251-2) saw this ordered 'sequence of dependence' and 'patterns of deterioration' as measured by ADL technology 'a pattern of unidimensionality and cumulativeness' that assumed decline associated with disabilities as linear, inherent, natural and normal in ageing about which most would agree. However, this implies ADL technology figures the ageing person metaphorically as disabled, as a typically ordered regression of functional psycho/socio/bio-capacity or lack thereof, hence a "problem". This is a type of synecdoche, a referential process where functional capacity or its lack represents and stands in for the totality of the ageing person. Functional capacity, at the centre of ADL technology presents as a calculable and objectively measurable construct, clearly commodifying and associating the older adult with the potential for disability and incurring of economic costs. Katz et al. (1963, p. 914) affirmed this position by stating 'administrators could use measures of function to assess the needs for care'.

When these standardised ADL measures (determined by norms) came to be used in hospital as standards of measuring functional decline they were naturalised as relevant measures of loss of functional ability, of what to expect. Hence functional decline became normalised not only as inevitable but, as some argued, objectively and reliably measurable (Covinsky et al. 1997; Pinholt et al. 1987). Naturalising and normalising functional decline as inevitable (objectively and normatively measurable expectations) permits on the basis of ordinal values and statistics the categorisation of older adults as age-related entities of actual or potential levels of chronic illness, disability and/or impairment (Wiener et al. 1990): although such categories are never homogeneous, as characterised by differences such as sense of self and experience. This type of homogenisation points back to the Barthel Index where measuring the observed amount of time and assistance required to perform ADLs used norms to assess an individual's level of deterioration in ADLs. Subsequently, an ordinal value determined the individual's level of independence/dependence and was used to determine if any need for more costly assisted living arrangements. As such, ADL technology reifies and privileges functional capacity. An assessed level of ADL positions and represents the older adult as potentially if not actually or inevitably problematic. Its established place in geriatrics has been legitimised as a validated and authorised way to calculate biophysical functional capacity to determine an individual's level of independence/dependence: a dichotomy that assumes dependence precipitates significant health care costs. The ADL level also pre-figures outcomes of functional status assessments as binaries of function/dysfunction and normal/abnormal.

The numeric value of an ADL measurement became an object, a measured *level* (not actual) of human characteristics and activities. The concept of functional decline thus became a discursive object of ADL technology – a measurable, describable and nameable metaphoric representation of the person. The "elderly patient" became the personification of an object termed functional capacity, represented in one study's outcome as "a decline". A naming that illustrates how the older person as a person is absent in the study despite the focus being "elderly patients" and functional decline. The study states 'the most clinically relevant…outcome for this study was a new decline occurring in hospital and persisting until discharge in any of the five basic-care ADLs' (Inouye et al. 1993a, p. 646).

Two things become evident in older adults' hospital care. First, how the construction of ADL technologies was amenable to interplays of ADL technology, observation, risk, surveillance, measurement and demographics. Functional decline as a measurable marker of deficit in functional status became a way to represent and order hospital care, organisational practices and social representations of the "elderly" and experiences of care for hospitalised older adults. Second, renewed interest in ADL technology was motivated by administrators and researchers seeking economical, cost-effective means to order and manage hospitalised older adults. To these ends research designs such as those authored by Becker and Cohen (1984), Hirsch, et al. (1988), Nelson, et al. (1983), Tulloch and Moore (1979), and Warshaw (1985) connected hospitalised older adults' care needs and older adults themselves to ADL technology and cost savings. They linked the ordinal scales of ADL technologies with older adults' functional status in an effort to produce reliable economic and readily adaptable geriatric assessment. ADL technology could then effectively be used to categorise and target those hospitalised older patients most likely to experience functional decline and become a cost to the health care system.

Warshaw et al. (1982) were some of the first researchers to engage this interplay of ADL, observation, labelling, measurement, demographics and cost savings in terms of assessing functional status to determine or predict which hospitalised older adults were likely to functionally decline, also referred to as functional disabilities. They framed the problem of older adults getting worse not better as *hazards of hospitalising* the 'elderly' who were 'at high risk for medical and iatrogenic complications' (p. 847). Schimmel (1964, p. 58) initially defined the hazards of hospitalisation as 'occurrence of hospital-induced complications' in a study of over a 1000 patients of *all* ages within which 'episodes [of complication] were the untoward consequences of acceptable medical care in diagnosis and therapy' (p. 58). McLamb and Huntley (1967) also using the term hazards of hospitalisation reported 'the population at risk consisted of all patients hospitalized…the episodes observed in this study cover a broad spectrum of drugs and procedures' (p. 469 & 472). In their study "episodes" were 'any response to medical care in the hospital that is unintended, undesirable, and harmful to the patient' (p. 469), the authors concluding these 'hazards [are] inherent in modern hospital care' (p. 472). These hazards of hospitalising were generally included in what was known as iatrogenesis which was, and remains in reference

to hospital induced or acquired diseases or illnesses, consequences or reactions to hospitalisation, hospital acquired, related or associated complications affecting *all* those hospitalised. Hence prior to the 1980s, the terms hazards of hospitalisation or iatrogenesis came with negative inferences for *all* patients, and generally implicated the health care system as prime suspect in the patient's demise as signalled by such terms as hospital-induced and ward accident, each seemingly inherent in modern hospital care practices.. Warshaw et al. (1982) however, called for a focus on older adults as those most likely to be affected by iatrogenic complications and these authors were therefore instrumental in shifting the focus of iatrogenesis from the general hospital population to the "most at-risk", older adult population. Like Warshaw et al. (1982), Becker et al.'s (1987, p. 2313) study was propelled by the idea 'there is increasing evidence that the elderly are at greatest risk for hospital-acquired complications'. Such studies clearly linked iatrogenesis or hospital acquired complications with the hospitalised older adult. This move has wittingly or unwittingly shifted the focus of the problem of iatrogenesis from the problematic health care system to the hospitalised older adult as its foremost problem.

Warshaw et al. (1982) also helped establish the older adult as a health care problem by claiming they use 'a disproportionate share of health resources…more frequently and for longer periods than any other age group' (p. 847). The rationale was older adults had greater potential for functional disability than a younger population because characteristically acutely ill 'elderly' have 'diminished physiological reserve and a decreased capacity to adapt to unfamiliar surroundings' (p. 847). Juxtaposing "the elderly" as a group naturally in higher need of health resources than "any other age group" assumes "the elderly" are problematic and "others" are not. What is not named or qualified is *who* makes up "any other age group" and what they are missing/needing that may be viewed as being of greater priority than the needs of "the elderly".

Several things were happening here, one was the shift in focus of iatrogenesis from being a general issue to a problem focused on the older adult, understood and anticipated in direct relation to the concept of their higher likelihood of functional decline. Functional decline as a concept was therefore also becoming a metaphor representing and being a reference to the hospitalised older adult as a problem. Functional decline was short hand, a motif and symbolic way of depicting hospitalised older adults as inordinately and

undeservedly heavy users of the health care system, and hence a problem. Not only because as mentioned 'at high risk for medical and iatrogenic complications' (Warshaw et al. 1982, p. 847), but also as prone to 'functional decline…[because] hospitalized elderly…[as] functionally dependent patients usually require more intensive nursing care that has an impact on staffing and cost of hospitalisation' (p. 847).

In making their argument Warshaw et al. (1982, p. 847) also increased the focus on older adults as a problem framed in terms of functional decline saying 'more than half of the patients 75 years and older needed assistance with activities of daily living' by recommending controlled trials documenting hospitalised older adults' levels of ADL with other factors such as length of stay as measurable outcomes for purposes of determining efficacy of care (p. 850). The constitutive power of these ideas lies in an objective to produce knowledge for instrumental purposes (Hook 2001) which is arguably "in the system's best interest" as illustrated below.

Researchers in the 1980s (cf. Gilleard 1981; Hogan et al. 1987; Lamont et al. 1983) recognised the prevalence of functional decline also referred to as 'disability' or 'impairment' in older adults, as 'management challenges' (Hogan et al. 1987, p. 713). Hence functional decline was something to be measured for purposes of 'predicting prognosis, planning placement, estimating care requirements, choosing types of specific care' (Feinstein, Josephy & Wells 1986, p. 413). Researchers pursued this purpose by discursively forming hospitalised older adults as measurable objects of concern discernible on grids of specification featuring demographics, length of hospital stay, cost, clinical conditions, age and functional status. Lamont et al. (1983, p. 282) claimed 'use of acute-care hospitals by the elderly is rising rapidly…any changes that will reduce length of stay could result in considerable savings in health care costs', using statistics to evidence the 'steep rise in the 75 and older age group' compared to 'all ages'. They then argued the need to assess, measure, and predict functional status because 'insufficient attention is devoted to functional status' (p. 282) resulting in 'older patients' not being rehabilitated appropriately and causing undue expense of longer hospital stays or discharge to skilled nursing facilities. Note the focus was on economics not how this loss of functionality leads to suffering of the older adult.

ADL tools were seen as effective means to measure, assess and predict the older adult's functional status in order to classify and categorise those determined with a potential for functional decline, as frail, in an effort to target them for provision of care accordingly. Such strategies were perceived to not only *potentially* mitigate functional decline but also save hospital care costs (Lamont et al. 1983; Mackenzie et al. 1986; Nelson et al. 1983; Warshaw et al. 1982). Researchers such as MacKenzie et al. (1986) figured functional status as a valuable measureable outcome of care hence the need to develop a reliable and validated index of patient functional ability. Although functional status is not the same thing as functional decline it was given equal status as an important factor in determining care approaches.

A couple of things were becoming apparent. One, ADL instruments were typically focused on *observing the body in relation to movement, using numbers to rank the older adults' level* of performance according to scores previously established as being necessary for independent living. The score was not a measure of capacity. It ranked where one fitted on a scale of functional status from independence to complete dependence needing full care. Hence ADLs scores were not used to figure actual problems or deficiencies or to offer specific interventions but to determine *potential* care-related implications. Thus ADLs worked as normalising practices to *predict how much care* older adults' would *likely* need (figured as their cost factor), not what care was actually needed under what circumstances (determined as in the best interest of the older person). Commonly ADL indexes used with other ordinal assessments like cognitive functioning, mental impairment, nutritional status and/or severity of illness became valued as aggregated scores of comprehensive geriatric assessments (CGA) were used to categorise and target older adults problematised as requiring more care (Almy & White 1988; Rubinstein & de Medeiros 2015). Most studies did not allow for translation of findings determined under controlled study conditions into the actualities of practice so clinicians could readily and reliably translate assessment outcomes into effective interventions. Some measures assumed applicability to practice saying 'although the scale was designed for use in clinical research, these features are equally attractive for the scale's use in clinical practice' (Mackenzie et al. 1986, p. 1329). Others like Rubenstein (1987a, p. 420) recognised 'it is clearly not enough for an assessment…simply to diagnose functional disabilities. Results…need to be transmitted to the care giver and

translated into improved care'. Likewise McVey, et al. (1989, p. 84) concluded geriatric assessment outcomes as a 'recommendation…did not necessarily mean that the actual care was delivered in exactly the manner desired'.

Secondly, in the 1980s these efforts to contain runaway health care costs incorporating ADLs into geriatric technologies were increasingly rationalised as effective means for managing hospitalised older adults economically, not as individual persons but as categorised targeted populations. Hogan et al. (1987, p. 713) illustrated this when saying 'functional disability is common in elderly patients admitted to hospital' and then use this to rationalise a bio-political strategy of categorising the "elderly" accordingly then targeting them as eligible for a 'geriatric consultation service…with an emphasis on functional assessment'. These bio-political strategies involved determining the administration of life using technologies based on bio-physiology for purposes of social control by practices of categorisation. They engaged economic rationalism to legitimise their strategy as 'a relatively inexpensive… affordable option for hospitals in…[an] attempt to manage elderly patients more effectively' (p. 717) by governing them as a population. Narain et al. (1988, p. 775 & 782) also used bio-politics, economic rationalism and ADL technology by identifying which 'predictors of high risk patients' necessary to assess, order and manage the 'acute care of the elderly patient' effectively targeting 'patients for different specialized geriatric programs' improving 'discharge planning' and 'resource allocation'. McVey, et al. (1989, p. 80 & 84) suggested using bio-political techniques of categorisation to set up more structured settings such as geriatric units to manage those 'patients over 65 years [who] occupy 30% to 50% of all hospital beds annually' with the aim to maintain and improve 'the functional status of hospitalized elderly'. Each initiative approached care of the "elderly patient" with standardised technologies and normalising categorisation techniques for purposes of economic efficiency; not for offering ideas, strategies or suggestions for how to care for older adults as unique sentient persons.

These 1980s initiatives as presented in published research papers revealed how the discursive formations of functional decline materialised in a complex set of relations. The complexity is evidenced by archive data being located in a grid of specification constituted by research outcomes making the interplay of elements of functional decline normalised in ADL technology, demographics, older adults, surveillance, assessments, risks and care costs.

The consistent inclusion of costs as a deciding factor illustrates how assessments were made in the system's best interest, typically for purposes of organising care for the least cost. Functional decline was integral to this set of relations being visible and definable as an observable, measurable object of concern and legitimised by use of ADL technology. Older adults and their high likelihood of functional decline were constituted as a problem authorised by the expertise of research scientists and clinicians. However, formations of functional decline as a measurable object and a problem via use of ADL technology integral to assessment strategies was not straightforward.

Notwithstanding the above research outcomes, claims and recommendations, some hesitations and controversies persisted forming a contested ground that disrupted how functional decline discourse was formed to structure and produce assessments using ADL technology. Guralnik et al. (1989, pp. M145-6), for example, problematised ADL structured tools as having too many variations, questioning both the validity and reliability of methods and the lack of standards in this field. Asserting that 'the assessment of physical functioning status [of older adults]…would be improved if clinicians and researchers began using objective physical performance measures' (p. M145) and recommending that if

> the objective measurement of physical performance can be further developed in a thoughtful, careful and scientifically sound manner, it may well prove to be an extremely important method of assessment in the field of aging. (pp. M145-6)

Such misgivings and cautions illustrated how the integration of functional decline discourse into geriatric assessments was not seamless or continuous. Further, Guralnik et al.'s (1989, p. M145) evaluative outcomes indicated a drive to legitimise the interplay of functional decline and measurement not as a treatment *per se* for functional decline but *only* as 'an indicator of improvement or a predictor of impending decline'. What was unspoken was how such assessments should or could be translated into care practices that prevent or mitigate functional decline.

Some clinicians also realised that accurately measuring functional decline using ADL technology was not going to be simple. For example, there were dilemmas about the use of self-report mechanisms in ADL assessments. Although valued for convenience and economy, Sager et al. (1992, p. 457) found 'self-report measures may have definite limitations when used in evaluation of hospitalized patients'. Also despite being valued for providing insight

into patient views, it was also understood that self-reports on ADL were not consistently reliable. Patients tended to overestimate their abilities when compared to staff assessments using "objective" scales or indexes (Rubenstein & Schairer 1982) or patients tended to claim greater limitations than those assessed by the physician (Rubenstein et al. 1984). In contrast, some researchers found self-report could be informative (Pinholt et al. 1987) providing new insights into patient functioning as they were 'surprisingly accurate' *but only if* using a standardised questionnaire (Solomon 1988). Standardisation implies limiting choice to those things that mattered to the assessment. Guralnik et al. (1989, p. M142) also found 'validity can be compromised in self-report instruments when they do not incorporate strict definitions for the activity being assessed or the possible response categories'. A position paper from the American Medical Association on geriatric assessments captures such controversies (Almy & White 1988, p. 71):

> There is a profusion of scales and tests, and though these are analyzed and compared in literature reviews, clinicians need guidance in selecting tests that are valid, reliable, and appropriate to the individual patient.

Such statements show that despite concerns, admonitions and hesitations about ADL technologies, "truth claims" about functional decline as an important objectively measurable entity persisted. They also showed how questioning and challenging scales and tests was understood as not so much about validity and reliability, the quality of geriatric assessments, but rather the skill and ability of clinicians to select the right tool for the right purpose and correctly use the tool. Further with the incessant demand for objectivity, the older adult as a unique person was moved further and further out of sight and hearing as a person. The older adult was increasingly becoming defined, nameable and represented as an object of care to be economically and effectively managed for the efficient running of hospitals. What also materialised during the period of the 1980s, to further target the older adult, was the biopolitics of organising them as a population of concern to be governed and managed by re/defining the place of iatrogenesis. This happened in relation to designing clinimetrics[3] based on ADL technologies used to assess functional status.

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[3] A framework for objective measurement and assessment of clinical data… emphasises the quantitative measurement of clinical data through accurate measurement and data collection… it relies on a number of established constructs…validity, accuracy, reliability, reproducibility, and usability. http://www.worldwidewounds.com/2006/january/Fette/Clinimetric-Analysis-Wound-Measurement-Tools.html viewed April 14, 2016

Iatrogenesis as described above never left the discussion despite the emerging interplay of functional status, older adult hospital patient, demographics, costs, ADL technology, geriatric assessment, surveillance, risk and functional decline. Its place shifted. It was re/defined, becoming more explicitly associated with hospitalised older adults characterised as the largest percentage of patients. Older adults were framed as most likely to experience iatrogenic illness contributing to their functional decline with consequent results of inordinate health care costs. For example:

> For many older persons, hospitalization results in functional decline…of 60 functionally independent individuals 75 years and older admitted to hospital…75% were no longer independent on discharge…many elderly persons are susceptible to other complications not directly related to the illness or injury for which they were hospitalized [iatrogenesis]. (Creditor 1993, p. 219)

Such views illustrated how the language of care and modes of assessment were inhered with a discourse of risk and the language of iatrogenesis. These views promoted discourses of assessing, predicting and categorising the "at risk" older adult as a problem population to be targeted to enable more cost effective care strategies. These discourses served to enable development of specialty units founded on these kinds of objectivising and dividing practices (Foucault 1982). Specialty units divide older adults as fractured subjects identified by certain bio-characteristics within themselves and from others. Such practices effected dichotomising practices of sorting the older adult according to binaries of independent/dependent, normal/abnormal, able/disabled, non-problematic/problematic.

Other studies also showed how the risk of iatrogenic illness was increasingly associated specifically with hospitalised older adults in contrast to the general hospital population. In a randomised controlled trial[4] of hospitalised older adults it was found 'the elderly are at greater risk for hospital-acquired complications (iatrogenesis)…[suggesting a] focus on patients with more impaired functional status…[who] *seem to be* at higher risk for hospital acquired complications (Becker et al. 1987, pp. 2313, emphasis added). Becker et al. (1987) claimed their work as 'the first study to identify an association between hospital–acquired complications and functional status' (p. 2316). Hoenig and Rubenstein (1991, p. 220) later extended this association stating 'older people frequently incur major functional

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[4] Randomised controlled trials (RCT) are usually about probability sampling and is a common method used in medicine as a putative way of establishing causality and generalisability (Cohen, Manion & Morrison 2007)

setbacks stemming from in-hospital treatment [iatrogenesis]' noting that 'hospital-associated-dysfunction…[in particular] the deconditioning effects of immobilization are often unanticipated and particularly disabling and disturbing'. The problem of older adults' functional decline now linked with iatrogenesis was not only seen as being exacerbated by iatrogenic causes but that a state of functional decline could precipitate such illness; a looping effect of one precipitating or exacerbating the other. Older adults were perceived as likely becoming frailer over time and more vulnerable to things like medication toxicity with increasing dependency on others for help with their ADLs due to *natural* bio-physiological ageing processes (Gorbien et al. 1992; Jahnigen et al. 1982; Schimmel 1964; Woodhouse et al. 1988). Perceived interrelationships of iatrogenic illnesses, *natural* ageing, hospitalised older adults, risk and functional decline further shifted the focus and definition of iatrogenesis from a system's problem to the hospitalised older adult as a problem with more costly 'special care needs' (Becker et al. 1987, p. 2313).

Also more evident was the power/knowledge complex of functional status assessment and functional decline discourse. As illustrated by Reuben and Siu's (1990, p. 1105) truth claims, 'assessment of function has become a cardinal principle of clinical geriatrics…functional status can provide important information about the need for assistance in personal care, ability to live independently, and prognosis'. Such truth claims were supported, and continue to be supported, by commonly used language located in geriatric literature such as "need for assistance", "no longer independent", "functional setbacks", "elderly…as high risk patients" and "elderly are at greater risk for hospital-acquired complications" signalling statements of functional decline discourse constituting the older adult as a problem. Such language displayed an escalating alarm over 'a more rapidly rising rate of acute-care hospitalization by the elderly' (Becker et al. 1987, p. 2313) taking up disproportionate numbers of hospital beds (McVey et al. 1989).

Hence by the mid-to-late 1980s a threshold of concern was crossed with alarm not just over the increasing numbers of hospitalised older adults but how they were highly likely to functionally decline unrelated to the admitting diagnosis precipitating escalating hospital costs (cf. Becker et al. 1987; Nelson et al. 1983; Siu, Reuben & Hays 1990). Further, the problem of the deteriorating rather than improving conditions of hospitalised older adults was defining the researchable problem of functional decline. Studies conducted in the mid-

to-late 1980s responded to this concern by cultivating systems of categorisation for hospitalised older adults using indexes and scales to determine those most likely to experience functional decline. For example, 'the geriatric evaluation unit and the geriatric consultation team…[were established] to address the special needs of hospitalized elderly…one important objective…[was] for improving functional performance and preventing functional decline' (McVey et al. 1989, p. 79)**.** Clinimetrics using ADL technology, i.e., 'comprehensive functional assessments…for determining impairment' (Pinholt et al. 1987, p. 484) were designed to measure, predict and guide how to address potential or actual socio-biophysical functional deficits including susceptibility to iatrogenic illnesses. Assessment outcomes typically targeted 'the elderly population who, in addition to their multiple medical problems, are functionally dependent', a population that became known as the *frail elderly* (Rockwood 1990, pp. 283-4).

Frailty remains a highly contested term, complex, situational and multidimensional with no clear discursive limits of what materially constitutes frailty or being frail (Bergman et al. 2007; Kaufman 1994; Knight & Walker 1985; Pickard 2014; Puts et al. 2009; Rockwood et al. 1994; Tocchi 2015; Woodhouse et al. 1988). The term frail without being defined by material measurable qualities does not lend itself to being assessed using clinimetrics. Despite this, a contested terrain of uncertainty populated by discursive practices of rarefaction (a process of singling out specifics) and delimitation (of who/what to focus on), based on notions of frailty and vulnerability in old age became increasingly associated with notions of functional decline and potential for iatrogenic illnesses. The use of "frail/frailty" was not prevalent in the 1980s, however it was gaining momentum (Goodman 1987; Knight & Walker 1985). By the early 1990s it was rapidly becoming an organising concept in geriatrics (Rockwood et al. 1994), established in the operations of functional decline discourse and unlikely to disappear:

> With the number of Canadians over 65 set to double in the next 20 years and the number over 80 set to quadruple over the next 30 years, a growing number of health care planners and geriatricians think "frailty" should be formally adopted as a clinical concept within elder care. (Webster 2015, p. E311)

There were however discontinuities in determining best assessment/management practices for hospitalised older adults. Lamont et al. (1983, p. 282) in determining patients' pre-illness ADL found 'the most important predictors of deterioration of function are (1)

older age, especially 85+, and (2) abnormal mental status'. There was no clear continuity or consistency with such conclusions. Eight years later Hoenig and Rubenstein (1991, p. 221) called 'attention to function among hospitalized elder patients, ideally through formal functional assessment…[as] crucial if we are to detect treatable functional impairment…for predicting discharge planning location'. They concluded 'better attention to assessing, monitoring, and anticipating changes to patients' functional status should lead to strategies that can usually reduce hospital-associated functional declines in elder patients' (p. 221). Fourteen years after that Ehlenbach et al. (2015, p. 2061) concluded that hospitalisation for older adults 'was associated with clinically relevant decline in gait and chair stand speed and strongly associated with difficulty with and dependence in ADLs' saying this 'underscores the importance of studying in-hospital interventions aimed at maintaining physical function' (p. 2067).

Another play of difference in the contested ground of functional decline discourse were criticisms and disapproval of how functional status assessments were made and/or interpreted in relation to possible biases as 'assessing functional status…may vary considerably according to the informant' (Rubenstein et al. 1984, p. 686) or perhaps contributing to cultural confusion by equating old age with disease (Kaufman 1994), or objectifying the older adult in clinical terms. Feinstein et al. (1986) identified the importance of using disability measurements for clinical practice structured by ratings of ADL. However, with the identification of 43 different versions of ADL indexes they questioned the efficacy of many, concluding that the most common or generic problems with such clinimetrics were that the issues under assessment were: too complex, omitting the patient's role, effort and/or preference about what is important to measure, being unspecific for the purpose of the assessment, ambiguity of aggregated summary of variables and using measures unable to discriminate changes. I interpreted their findings as disrupting assumptions about the reliability and validity of assessment practices by calling into question truth claims as they problematised how metrics did not work despite being distributed as "in the know". Feinstein et al.'s (1986) dispute was not with the production of truth through assessment practices, but the rules used to establish regimes of truth and the potential of these to distinguish true from false statements. They made explicit the confusion of multiple different directions, interpretations and lack of continuity and consistency in the

development of such clinimetrics. They showed how development of ADL technology had many spurs with the variety of metrics that had emerged, then built on another form of measurement that often pointed somewhere else. They clearly illustrated the lack of a single point of origin for such clinimetric determinations of functional status.

These discontinuous, intertextual practices appeared to cross over or be juxtaposed to each other, and could well exclude, contradict or be unaware of one another (Foucault 1981). These challenges illuminate the complexity, ambiguity and uncertainty not often spoken about in the literature on development of metrically devised tools. Despite the problems researchers demonstrated a "will to know" how to create a reliable valid tool as well attested to by Feinstein's (1986) 43 examples of ADL indexes. This drive to know colluded with a "will to solve" the problem of hospitalised older adults and functional decline using clinimetrics that constituted the older adult not the health care system as the problem.

The manifestation of functional decline as a dominant discourse

This retrospective analysis of the constitution of functional decline discourse made apparent how qualitative elements of older adults' functional status, their variable and unique capacities to be independent, were *not* considered in care technologies. Instead the older adult was increasingly assessed and constituted according to a standardised norm of (in) dependence articulated as a definable, measurable, socio-biophysical functional status. This status was made up of ordinal values figured according to pre-established norms of capacity using standardised ADL technology. These discursive practices of measurement and assessment were considered efficient and effective ways to order, manage and control the perceived risks of older adults' functional decline. As important, these practices served to predict which older adults may necessarily be targeted for specialised care to save health care costs. These kinds of discursive practices set the next stage for the materialisation and dominance of functional decline discourse, supported and enabled by a discourse of risk, as a calculable practice to efficiently and effectively manage hospitalised older adults as a risky population.

Of significance in functional decline materialising as a dominant discourse in geriatrics was its entwinement with the discourse of risk. The emergence of a "risk society'

in the late 1980s was founded on the calculus of risk because risk could be anticipated based on probability statistics and was useful for purposes of politically regulating society (Beck 1992). Risk, for example, had 'become a common construct around which health in western society was described, organized and practised…[because the embodiment of risk had become] a political rationality' (Robertson 2001, p. 293) shaped by a neoliberal health care environment as discussed in chapter two. Risk discourse as such enabled functional decline to become recognised and established as a discourse embodying ways to assess, measure and predict which older adults may experience measured decreases in their socio-bio-physical capacity to live independently - a risk to the system. Functional decline as a discourse could then be promoted as a profound marker of potential or actual morbidity. Specifically because major institutions such as the state, health care systems and science increasingly attempted, via decision-making informed by techno-economic probabilities, to anticipate what cannot necessarily be anticipated except as the statistical probability of being at risk (Beck & Ritter 1992). In this case, the risk of functional decline structured as a statistically calculable probability of decreased capacity for ADL, requiring care accordingly in terms of the bio-political ordering of life. However, as Lupton (1999, p. 8) asserted, risk at this time was not just about probabilities but was coming more to mean danger, a harm often framed as negative and undesirable. In health care, as outlined in the previous section, hospitalising older adults was already established as an undesirable hazard, a significant risk to health care budgets reinforced by the use of alarmist demographics. How discursive events braided by the discourse of risk operated as critical factors in the materialisation and production of functional decline as a dominant discourse producing geriatrics and older adults' hospital care will be explored.

Assessment practices of the 1990s increasingly incorporated ideologies of risk and probability using ADL technology embedded by functional decline discourse. These discursive practices became foundational to the use of developing technologies of risk assessment, stratification, adjustment and management used to economically order older adults' care (cf. Howard & Reiley 1994; Iezzoni 1997; Incalzi et al. 1992; Inouye et al. 1993a; Kelleher 1992; Sager & Rudberg 1998). As care practices they built on 1980s research techniques and practices as outlined previously (Bergner & Rothman 1987; McVey et al. 1989; Pinholt et al. 1987) as well as public health policy (Almy & White 1988) that assumed

functional status was effectively and reliably calculable by use of ADL technology. An assumption reflected by Feinstein, et al.'s (1986) review of the scientific and clinical problems with using indexes of functional disability. They indicated the problem was not the use of clinimetrics, *per se*, but the challenge was to get the design of such tools "right" rather than abandon the idea that functional status is reliably measurable. These research practices embedded by a "will to know" the truth about how to construct the "best" clinimetrics set the stage for functional decline discourse as a social practice that promised economic means of incorporating calculability of risk probability. Functional decline discourse was setting the course in geriatrics as the means to get it "right" for measuring, assessing and predicting which older adults were "at risk", needing specialised or targeted care for economic purposes.

How the discourse of risk became entwined with the discourse of functional decline was illustrated by Creditor's (1993, p. 219) truth claim 'hospitalisation is a major risk for older persons' and geriatric assessments should 'identify risk factors' (p. 222). To make his claim Creditor referred back to Hirsch, et al.'s (1990) claims that 'the high incidence of newly acquired functional problems' for 'hospitalized older patients', as determined by using ADL technology, may increase cost of care and length of stay warranting 'greater efforts to prevent functional decline' (p. 1296).

Functional decline in hospitalised older adults was not just assumed highly likely but was becoming discursively formed as an assumption that *risk* of functional decline *always* existed and was calculable. However, researchers were framing the nature of the risk as something needing to be recognised, identified and reliably measured so it could be tamed, predicted to inform the ordering and managing of older adults' care accordingly. Wu, et al. (2000, p. S6) using ADL functional status measurements developed a 'prognostic risk model' for hospitalised older adults to predict 'for severe functional limitations' because 'many conditions prevalent in older patients can threaten their ability to function independently'. Thomas (2002) argued that functional decline was a profound marker of morbidity and mortality in hospitalised older adults and measures of functional decline could be a major predictor of risk for subsequent untoward events and further decline and as such 'predictors at hospital admission is the key to intervention' (p. M568).

Davis, et al.'s (1995) retrospective study illustrated how predicting probabilities of hospitalised older adults' risk of physical impairment, functional decline, was deemed necessary for the purpose of future risk-adjustments. They claimed 'evaluating risk-adjusted outcomes is the centerpiece of ensuring and promoting health care quality in a time of cost constraints' (p. 906). However, there was a discontinuity in their risk discourse as they came to the study with 'the growing realization that gathering data on patient risk factors is expensive' (p. 907). To reconcile the importance of risk-adjustment with unruly costs they rationalised that 'assessments of functional status are a simple, inexpensive measure that may have considerable value…[as a] a "minimum" data set…to risk-adjust mortality rates' (p. 907) across different (ADL) levels of functional impairment and across different facilities. However, all was not straightforward. The study found 'important questions arise about using functional assessment data to risk-adjust outcomes for comparing institutions, because these measures may be more susceptible to manipulation than laboratory data' (p. 918). From such a reckoning, the tools were not a problem rather how tools were used was perceived as problematic. However, a remedy from the 1980s (Feinstein, Josephy & Wells 1986) as noted above was to persevere in improving clinimetrics. Davis, et al. (1995) reflected this "will to solve" by deciding 'to develop functional status measures that are predictive of outcome across diagnoses, and when necessary, to develop diagnosis-specific functional status measures' (p. 919). These researchers did not question how effective are probabilities when the 'risk is assessed prior to and away from where it might appear' (Hardy & Maguire 2016, p. 85). What was becoming clear, as the next studies show, was how functional decline was represented as decidedly risky and costly hence a critical factor to assess and predict if older adults were to be managed and health care costs contained.

At this critical juncture, Inouye, et al.'s (1993a) study illustrated how the discourse of risk was becoming integral to discourses of functional decline and assessment as structured by ADLs. They aimed to effect reliable and valid risk stratification systems for purposes of categorising and targeting those older adults' most vulnerable to, or at risk of, functional decline:

> No risk stratification system currently exists to identify on admission elderly patients at risk for functional decline in the hospital. The purposes of the current study were to determine the incidence of and risk factors for functional decline in an elderly hospitalized medical population to develop and validate a predictive model for

functional decline based on the patient's characteristics at the time of hospital admission (p. 645). The final risk stratification system is based on *simply* adding the numbers of risk factors present. (p. 650, italics added)

Of interest in this study was how the "problem" of functional decline was assumed to be exclusively and immediately associated with "the elderly". Such an assumption seems to be an "of course" as this research started with efforts to 'identify on admission elderly patients at risk for functional decline in the hospital' (p. 645). Geriatric literature as noted previously had already statistically determined hospitalised older adults and functional decline were highly likely, inevitable events. So much so, the events were taken for granted, not questioned but certainly assumed as critical factors causing inordinate healthcare costs. Functional decline discourse as a social practice in the care of older adults had a dominant power/knowledge effect that constituted "the elderly" as a problematic population causing trouble primarily based on age. Singling out "the elderly" as problematic was exemplified by stating 'functional decline…is a common...problem for hospitalized elderly' with the study focus being 'to determine the incidence of and risk factors for functional decline in an elderly hospitalized medical population' (p. 645). Functional decline discourse incorporated risk along with practices of categorisation with individualising and totalising effects as the intent was: 'to develop and validate a predictive model for functional decline based on the patient's characteristics' with age at the top of the list excluding study subjects to those *over* 70 years of age. These practices established systems of exclusion that are ceaselessly renewed (Foucault 1981, p. 70) as Pinholt, et al. (1987, p. 487) had years earlier with their compilation of assessment outcomes already established such thinking concluding 'functional impairment is prevalent among hospitalized geriatric patients…[and] functional assessment instruments greatly increase recognition of these patients'. Inouye, et al.'s (1993a) study engaged ADL technology along with discourses of functional decline, demographics and risk to develop preventive strategies and risk stratification systems (p. 646). Despite the probability of risk outcomes with ADL technology they made a truth claim that 'in-depth understanding of patients at risk for functional decline is necessary before preventive strategies can be developed…[especially as] no risk stratification system currently exists' (p. 645). What seemed contradictory was needing "in-depth understanding" of patients yet their risk stratification system was '*simply* adding the numbers of risk factors present' (p. 650, italics added).

In the Inouye, et al. (1993a) study, discourses of functional decline and risk constituted older adults objectively, quantifying who they "are" for statistical purposes. These discursive practices effaced the complexities of being a sentient person who "is living" being old. As well, the discursive practices of measurement and quantification had normalised the unpredictable nature of hospitalisation and produced knowledge that created and established functional decline as a predictable risk. Functional decline was becoming central to geriatrics as a normal predictable objectivised event, not allowing or accounting for individual differences or the contingent complexities of everyday hospital life. Risk and functional decline as entwined discourses were materialising as proven truth claims of privileged scientific knowledge authorising the constitution of the older adult's subjectivity as delimited by 'age, gender, baseline illness, or functional status….[where] all data were obtained using standard instruments' (p. 646). The older adult in hospital was to be governed by associating functional decline discourse with that of risk and standardised practices which enabled the bio-politics of categorising and targeting 'elderly patients at high risk for functional decline during hospitalisation' (p. 651).

This form of governmentality, through the discursive practices of categorisation and standardisation based on the calculability of risk of functional decline, became dominant practices for purposes of saving health care dollars, formed by economic rationalism; as located in Mukamel, et al.'s (1997) risk management study on functional decline and hospitalised older adults. Study subjects were defined as 'at risk for high costs' then categorised and labelled as 'the high risk group' (p. 784) primarily via ADL technology used in developing an 'optimal screening tool for identification of high cost enrollees' (p. 778). Discourses of functional decline and risk now entangled with a discourse of economic rationalism constituting the hospitalised older adult as a "high cost" problem. This was contested by Mukamel, et al. (1997) who surfaced discontinuities in their study that 'statistical models predicting either utilization or health care costs for individuals based on individual characteristics tend to have limited predictive power' (1997, p. 777). However, they persisted with the dominant thinking of the time by concluding 'further research leading to more accurate tools…[would] increase cost savings' (p. 782). This "will to truth" reflects Feinstein, et al.'s (1986, p. 413) review of ADL technologies as they concluded 'new

indexes can be constructed if the high statistical "reliability" and "validity" of established indexes are not accompanied by satisfactory clinical "sensibility'.

However, it could still be argued that assessments and screening tools to determine which older adults are 'at high risk' of functional decline and categorised for purposes of targeting care are not reliable. Bergner and Rothman (1987) back in the 1980s outlined how research practices to develop health assessments including screening tools must go by prescribed rules to achieve appropriateness, validity and reliability and ensure 'an instrument measures what it is intended to measure'. If such discursively set research practices were not followed, it could lead to clinicians choosing an inappropriate measure of health status yielding 'measures of questionable value' (Bergner 1986, p. 208). What becomes apparent is how such truth claims reveal that the game of tool making is more likely the problem not the tool itself, although this remained unquestioned.

These challenges in tool making persisted as does the "will to solve" how to reliably predict the risk of functional decline in older adults. The "Identification of seniors at risk-hospitalized patients" (ISAR-HS) is an example of contradictions and discontinuities in developing a predictor tool incorporating discourses of risk and functional decline. The ISAR-HS tool was created and considered by Hoogerduijn, et al. (2014) as a best practice technique based on research evidence using researchers like Inouye, et al. (1993a) [referred to above] to recognise and identify risk of functional decline in hospitalised older adults. They also drew from Creditor's (1993, p. 219) list of 'hazards of hospitalisation of the elderly' stating 'both models, Creditor and Inouye, show the complex etiology of functional decline' (Hoogerduijn, Grobbee & Schuurmans 2014, p. 108). However, there was no mention of attending to how the older adult suffers the experience of functional decline, perhaps because this was not predictable or measurable.

All three models, Creditor, Inouye and Hoogerduijn, engaged in the use of bio-politics. They identified and categorised the "high risk" older adults with "high-risk" of functional decline inferring 'a lot of danger' (Douglas 1990, p. 3), which politically positions these older adults as a problem population. The discourse of risk was clearly imbricated with the use of functional decline discourse as evidenced by how "at-risk" was determined by 'estimating the probability of the development of functional decline' (Hoogerduijn, Grobbee & Schuurmans 2014, p. 109). Despite probability being about likelihood not certainty of

functional decline, the researchers proposed to govern the "targeted at-risk" older adults with provision of 'tailored and effective care' (p. 107) made possible through assessment. Their approach to the problem of potential functional decline implied disciplinary measures of pastoral power with no mention of the older adult's voice or sense of agency by way of being actively involved in their own care and decision-making. These discursive practices were not about the person, but to the contrary, they constituted the older adult as a docile body to be 'subjected, used, transformed and improved' (Foucault 1977, p. 136).

Challenges continue in contemporary times with the use of assessment tools structured by ADL technology imbued by functional decline and risk discourses to govern older adults as a risky population. The British National Health Service (NHS) report on risk stratification (Lewis 2015) was to be used for purposes of targeting care to 'high-cost individuals' (p. 7). It stated: 'Risk stratification offers the potential to improve the quality and experience of care for patients whilst reducing costs for the taxpayer' (p. 5) highlighting that 'our populations are ageing and chronic illnesses are becoming more prevalent' (p. 5). These discursive practices of risk management involved an interrelationship of functional decline (albeit implied rather than explicit making it hard to question) and risk discourses using demographics and economic rationalist arguments. These are bio-political techniques with individualising effects where the older adult as an individual is set apart by age. Yet such techniques also have totalising effects as the older adult is homogenised by the dividing practice of being categorised with all of the characteristics of a population at risk of precipitating health care costs. However, the report revealed discontinuities in these discursive practices of risk stratification. Despite certainty, strategies offered had the potential of being unreliable because 'predictive accuracy…[can] potentially worsen health care inequalities…[and cause] increase total costs' (Lewis 2015, p. 5) promoting a call for further research and analysis as a "will to solve" such problems.

Risk discourse had become and remains increasingly lexically associated with functional decline discourse. This occurs via the persistence of demand by health care authorities to assess, measure and predict hospitalised older adults' high likelihood of functional decline; framed as necessary to prevent or mitigate inordinate health care costs. Functional decline discourse as structured, produced and enacted by these kinds of researchers as noted above, was built on merits of calculability, measurement and

quantification which now dominate in geriatrics and the care of hospitalised older adults. Entwinement of functional decline and risk discourses as exposed illustrated how pervasive and foundational these discourses are to the structuring of care technologies, informing managerial practices used to monitor, order and manage how hospitalised older adults are cared for, measurable objects to be surveilled, assessed and categorised. I argue the pervasiveness of functional decline discourse as such has become so naturalised, it is invisible as to how it informs standardised care practices that are done objectively and routinely; practices commonly taken for granted as just how care is organised and performed. These care practices hardly raise an eyebrow or cause concern, and are rarely questioned in figuring the older adult as a risk, a problem and a danger. The violence of such discourse is how it has constituted the older adult as a fractured self, delimited by calculable socio-biophysical characteristics and produced knowledge 'irreducible to the knowledge that any of its members may have of themselves' (Dean 2010, p. 127). The events and procedures enabling the authorised and legitimised dominance of functional decline discourse are *a priori* exterior and interior conditions of possibility as discussed next.

Conditions enabling materialisation of functional decline discourse

The materialisation of functional decline discourse materialised out of perceived need to govern, manage and control a targeted population of hospitalised older adults perceived as risky and at risk, in turn, causing a disproportionate use of the health care dollar. However, a discourse materialises and operates by more than need. A discourse is not happenstance but ordered into existence by exterior and interior *a priori* rules or procedures, conditions of possibility that enable one discourse and not another to appear and dominate (chapter 2). Using an archive made up of research papers informed how such rules, both external and internal to discourse, are events and procedures enabling functional decline discourse to be controlled, selected, organised and redistributed as it informs and structures the discursive practices constituting the older adult to the health care system dominating in geriatrics.

As outlined in chapter two, worries and concerns over health care budgets were escalating in the 1980s and concerted efforts were made to govern, order and control a perceived grey tsunami of hospitalised older adults, to save health care dollars. The demand

to do more for less with deregulation and privatisation, as activated by neoliberal politics, were exterior conditions. These conditions shaped the formation of functional decline discourse as sets of social practices producing efficient/economical care practices for managing older adult health care, as delimited by conditions shaped by neoliberal economic constraint. As such researchers were interpellated to develop sound reliable clinimetrics of clinical utility and effectiveness specific to such a politico-economic climate where the political demands and bureaucracy of hospital systems were linked with achieving greater economic efficiencies in care practices at the bedside (Terris 1999). These demands precipitated discernible shifts in health care administrators' needs and demands which affected research political rationalities (cf. Beaton & Grimmer 2013; Kelleher 1992; Murgatroyd & Karimi 2016). As such researchers were interpellated to produce technologies favoured not just for measuring, assessing, predicting and controlling hospitalised older adults' functional decline but also to be generalisable, economical and efficient when operationalised.

Kelleher (1992) illustrated how prediction is critical for organising patient workload and staffing patterns in these difficult times of economic constraint. She critiqued the inadequacies of patient classification systems used to determine hospital nurses' staffing patterns in relation to prospective payment systems. From an administration viewpoint she suggested expanding the scope of possibilities, to research how viable the possibility of ADL technology for assessing patient needs as a valid and reliable, efficient and effective means to predict workload and costs. She argued the need to quantify, measure and standardise patient nursing needs to inform efficient cost-effective staffing patterns. These kinds of discursive practices create an 'objective reality about which one can have knowledge' about a population's health care needs defined by their bodily functional status, 'known by statistical, demographic, and epidemiological instruments…[and specified by norms establishing staffing patterns to address their] possibilities of pathology' (Dean 2010, p. 127) and respective nursing needs. What gave credibility and authority to Kelleher were conditions interior to discourse, her academic position at an internationally renowned American institution, John Hopkins University School of Nursing and being published in Nursing Economic$. These credentials are examples of *a priori* rules or the interior conditions of a discourse enabling it to be seen and heard. As scripted by Foucault (1984, p.

102) this is referred to as the "author function" of discourse, 'a writing space into which the writing subject constantly disappears'. I would argue this is what happens in scientific initiatives producing functional decline discourse, in the objectivity of science the author as a *person, as subject* disappears. A scientific discourse then loses the people factor, loses the materiality of a discourse as knowledge produced by people not scientific facts.

Author function, however, is a critical factor as a condition of possibility of what is spoken *and* heard as legitimate and authorised dependent on position (Foucault & Rabinow 1984). The status and qualifications of the speaker, the author function in the context of what is spoken, to whom and when are critical considerations in discursive analytics as they signal the chance and event of a discourse; its mode of existence and co-ordinates in a field of time. Author function is an interior rule of discourse effecting how knowledge is put to work, valorised, redistributed and how attributed in society that both enables and constrains what is true or false (Foucault 1981). For an author to be "heard" the interior *a priori* rules of a discourse need to be in place.

In the archive texts the majority of "authors" are typically legitimised and credentialed as medical doctors (MD) or as PhD prepared investigators, many having accomplished post-graduate studies in geriatrics or complementary disciplines of sociology or psychology of ageing. Credentials signify credibility to study and publish in a specific field or discipline. In this case Geriatrics is essentially biomedical science. Statements on functional decline as 'medical statements cannot come from anybody; their value, efficacy, even their therapeutic powers…cannot be dissociated from the statutorily defined person who has the right to make them' (Foucault 1972, p. 51). Table 4.1 data is taken from archive texts and offers examples of how "author function" is achieved by status of credentials.

Table 4.1 below is a grid of specification that reveals the requisites, *a priori* rules for an author to produce and publish new knowledge with credibility, authority and acceptance as being "in the true". The grid contains interactive spaces of social relations where credentials, structures, writings and effects can be located, recognised, and determined. The journals listed in Table 4.1 are well-established regulated scientific, medical and public health academic journals often associated with established public tertiary educational institutions of higher learning. The institutions listed in Table 4.1 are recognised as coherent

Author	Author's institutional roots	Journal of publication
(Gilleard 1981)	Psychiatry, University of Edinburgh, Scotland	Journal of Psychiatric Treatment and Evaluation
(Gillick, Gillick & Serrell 1982)	Internal Medicine, Boston City Hospital, Boston, MS USA	Journal of Social Science Medicine
(Warshaw et al. 1982)	Medicine, Duke University, NC USA	Journal of American Medical Association
(Rubenstein & Schairer 1982)	Sepulveda Medical Centre, Division of Geriatrics, VA, USA	Journal of Medicine & Gerontology
(Lamont et al. 1983)	Family Medicine, Ottawa, Canada & Division of Geriatric Medicine Los Angeles USA	Journal of American Geriatrics Society
(Hogan et al. 1987)	Medicine, Dalhousie University Halifax, NS Canada	Canadian Medical Association Journal
(Bergner & Rothman 1987)	Health Policy & Management, John Hopkins University, Baltimore, USA	Annual Review of Public Health
(Rodgers, Curless & James 1993)	Medicine/Geriatrics University of Newcastle upon Tyne, HH, UK	Journal of Age and Ageing
(Inouye et al. 1993a)	Medicine, Yale University, New Haven, CT, USA	Journal of General Internal Medicine
(Palmer 1995)	Medicine, Case Western Reserve University, Cleveland Ohio USA	Cleveland Clinic Journal of Medicine

Table 4.1 Author function as established by the status of institution & journal

systems operating by *a priori* rules, regulations, and research requirements that enable researchers' credibility as academic investigators with authority and legitimacy in health care fields. University rules and regulations determine who can graduate from academic institutions to protect disciplines from imposters. Similarly, journal standards defend and delimit who has the right to be published in respective academic publications. These highly regulated journals provide a vehicle for new knowledge to be preserved and redistributed. Discursive practices of research, writing, and publication according to such rules and regulations affirm that it does matter who is speaking, how and where one is heard and who is listening; practices constraining, delimiting and/or productive of knowledge.

Further delimitations, exclusions and rules of rarefaction that internally order discourse as authorised and legitimised are an established discipline's political operations. For example how research practices are organised by prescribed principles based on propositions of what is true or false. Quantitative methods are the 'default research modality in the health sciences' (Sandelowski 2008, p. 193). They are established and delimited by rules of objectivity with interconnectivities of measurability, physiology and pathology. These principles of research aim to find cause and effect relationships through for example methods that link measurability of bio-physical functional status, hospitalisation

events, older adults and levelled bio-characteristics of functional decline in the production of reliable valid assessment tools. Such research initiatives, as noted previously, are typically designed to use ordinal measurements with, at times, discussion of outcomes in terms of binaries of independent/dependent, fit/frail or normal/abnormal. Subjects are referred to in third person, a passive tense that objectifies and positions the older adult as spoken *about* in terms of level of functional ability and possibility of decline. These studies are characteristically scientific, conceiving life as science and science as function in concern for the 'pathological phenomenon as a quantitative variation of the normal phenomenon' (Canguilhem 1989, p. 78).

Quantitative methods come in broad and diverse forms based on processes of measurement, quantification and systematic empirical modes of investigation of an observable phenomenon, e.g., functional decline in hospitalised older adults. They use statistical, mathematical or computational techniques making the concept of measurement central with an intention to be free from bias and generalisable to a larger population (Creswell 1994; Given 2008; Vogt 2011). Systematic reviews in geriatrics (cf. McCusker, Kakuma & Abrahamowicz 2002; Vermeulen et al. 2011) include a diverse range of quantitative methods incorporating principles of validity, reliability and generalisability recognisable by criteria such as: 'definition and time of measurement of outcomes and predictors; statistical methods; and results (associations between predictors and outcomes, and performance characteristics of predictor variables or indices)' (McCusker, Kakuma & Abrahamowicz, p. M570). This kind of codification 'provides a mechanism for rendering reality amenable to certain kinds of action' (Miller & Rose 2008, p. 31). Such as older adults are perceived using alarmist demographics as a swarming abundance at risk of functional decline potentially causing inordinate health care costs. Their risk is defined as functional decline, a concept, object and strategy discursively made amenable to be measured and quantified by ADL technology, to determine *how much* the older adult may be a problem. The older adult as a measure of a problem can be more readily costed out, budgeted for on scales of probability, organised by assessment tools of risk stratification for purposes of cost analysis and risk adjustment. Conditions of possibility rendering the older adult definable as a measurable object, categorised for targeted care reflect Engel's law wherein technology

…is *the essence of technique to compel the qualitative to become quantitative*, and in

this way to force every stage of human activity and man [sic] himself to submit to its mathematical calculations. (John Wilkinson in Ellul 1964, pp. xvi, emphasis in original)

Similarly Rodgers, et al. (1993, p. 162) explained in their study the need to appreciate 'these scales [e.g., Katz ADL and Barthel Index] convert descriptive information into numerical scores' and to consider that 'scoring may be location dependent'. They also cautioned 'when selecting any scale it is important to consider the following parameters: validity, reliability, sensitivity, acceptability, responsiveness to change and practicality' to ensure using the appropriate scale for the circumstance. Despite the possibility of 'user' unreliability the authors claim the Barthel Index is easy to administer with high predictive value of functional status as 'scores correlate well with mortality, length of hospital stay and placement' (p. 162). The dominance of quantitative study design for predictability of functional decline for ordering older adults and their care persists in contemporary times as evidenced by Sutton et al.'s (2008) systematic review. They appraised critically screening tools used to identify 'hospitalised elderly patients' at risk of functional decline on the key criteria of 'predictive validity, generalisability, clinical utility and reliability' (p. 1901). Outcomes of the review, although initially referring to evaluating predictions of the qualitative notion of 'likelihood of suffering functional decline following admission to a health care facility' (p. 1901), were restricted to ordinal values to objectively depict *how well* each tool could determine risk of functional decline according to specified criteria. Sutton et al. (2008) followed rules of rarefaction and delimitation with recommendations made according to prescribed criteria. They pursued a "will to solve" not finding a 'most appropriate' or any 'single tool [that] reported sufficiently greater predictive validity to warrant its recommendation over the others…[they recommended] further research needs to be carried out to determine screening tools accuracy' (p. 1907). Likewise Lin, et al.'s (2012, p. 2157) systematic literature review on 'multifactorial interventions to prevent functional decline in older adults' was delimited to quantitative studies (RCTs). They too found discontinuities claiming 'probable heterogeneity of treatment effects for these interventions and inability to understand the heterogeneity of populations studied, and inconsistent reporting' (p. 2162). These studies illustrated how the dominant research modality in geriatrics enabled linkages of functional decline and risk in depicting the older adult as a problem. They revealed how clinimetrics as products of this body of research

were unable 'to draw idiographic generalisations' (Sandelowski 2008, p. 194) to account for older adults' heterogeneities and idiosyncrasies of accumulated life experiences. Despite this shortcoming, Lin, et al. (2012) persisted with a "will to solve" by asking for more quantification and generalisability for 'more-complete and–consistent ascertainment of population function and risk of decline in function in older adults' (p. 2162). The researchers calling for more of the same practices were not benign but hegemonically limiting, constraining and/or reproducing and reaffirming taken for granted meanings of how to produce care technologies incorporating discourses of risk and functional decline.

Another condition enabling the materialisation of the discourse of functional decline were alarmist demographics (see chapter two) that fore fronted the magnitude of the "ageing problem" by way of statistics, presented as social facts. As illustrated by this list of publications (cf. Boltz et al. 2008; Creditor 1993; Doherty-King & Bowers 2011; Fulmer et al. 2002; Hebert 1997; Hickman et al. 2007; Inouye et al. 1993b; Warshaw et al. 1982) statistics, usually at the start of the publication represented the older adult as a problem in terms of real or potential functional decline. Warshaw et al. (1982, p. 847) illustrated this by claiming 'the elderly, 65 years and older, represent 11% of the US population and that persons older than 75 years are the fastest growing age group in America. These elderly use a disproportionate share of health resources' (p. 847). Howard and Reilly (1994, p. 178) similarly claimed that 'Americans are growing older' , their increasing numbers will 'have enormous financial and social consequences'. Palmer (1995, p. 117) likewise claimed: 'although those over 65 years of age are only 12% of the population, they account for 30% of all hospital discharges'. Sager and Rudberg (1998, p. 670) writing in *Clinics in Geriatric Medicine Acute Hospital Care* (the purpose of the 'Clinics' is to summarise current thinking for clinician consumption) framed Warshaw et al.'s 1982 work as germane in establishing the 'high prevalence of disability in hospitalized older patients'. They claimed this problem of functional decline continued 16 years later to cause great social and financial cost, that is a 'dreaded and potentially avoidable consequence of current hospital practices' (p. 669). Alarmist demographics continue with broader statements such as: 'it has long been known that older people admitted to hospital for an acute health problem are at risk of functional decline (Helvik, Selbaek & Engedal 2013, p. 305). These claims of danger delimit and enable

the discourse of functional decline to dominate in geriatrics, shading it with moral values of determining who and what is problematic and what must be done to "right" things.

Alarmist demographics and statistical analysis frame hospitalised older adults as a risk designated by ordinal values, the probability of experiencing functional decline. These claims anchor functional decline as a discourse and a major political economic problem in health care. Older adults have become inextricably linked with the concept of functional decline and as an object of functional decline, socially constructed as a crisis with catastrophic outcomes unless addressed satisfactorily (Hacking 1999). This form of biopolitics gave researchers an argument for their research projects and support evidence to leverage a call to control and manage inordinate numbers of older adults as a defined population using up increasing amounts of health care budgets. As discursive practices alarmist demographics bio-politically reaffirm how the neoliberal socio-economic-political environment is a way to support discursive formations of functional decline as an object of serious concern on a grid of specification. As this object of concern older adults become amenable to the effects of bio-power, classified and categorised as a problem population to be governed through the production of functional decline discourse, 'at once controlled, selected, organised and redistributed by a certain number of procedures' (Foucault 1981, p. 52).

Discussion

This genealogical analysis was *not* conducted to discover the causes of and offer solutions to problems with hospitalised older adults nor to judge established hospital practices as good, bad or indifferent. Functional decline was analysed as a discourse *not* as an object, concept or strategy as is done almost exclusively in geriatric research initiatives. Rather, this analysis exposed the multiple complex relations in the discursive formations of functional decline revealed by tracing out the concrete, practical and historical constructions of functional decline as a discourse. This genealogy showed how such discourse is authored and is unstable as it does not work in isolation but in sets of relations interconnected with other discourses that are contextualised and influenced by ever-changing contemporary socio/economic/political environments. Analytic outcomes revealed how functional decline discourse constitutes that of which it speaks and does.

This kind of knowledge points to the importance of my paying attention, when working in the field, to the power/knowledge of discourse and to examine how it is affected by circumstance, situation and context. Further, knowing that despite functional decline discourse being propelled by a "will to know" how to develop more efficient effective care it can be discontinuous and contradictory; an instability creating space for alternative approaches to hospitalised older adults' care. By understanding the instability of discourse, the possibilities for change are more likely to be recognisable. This knowledge can inform my exploration of where to look and how to recognise functional decline discourse, how it operates and to what effect. In particular, how its operation and effects are contingent on how care technologies in the field are structured, languaged and used, resisted or ignored.

Thus outcomes of this chapter's analysis informed my field work as I examined how older adults are constituted as patients via routinised calculable measurement and assessment technologies and consequent standardised hospitalisation practices. By making explicit how care technologies have individualising effects, signifying the older adult as a patient by their actual or potential for measurable biophysical decline, I enabled seeing how such technologies can operate in practice and to what effect. Such knowledge rendered the possibility of exposing how care technologies can essentially constitute the older adult as an assessable and measurable entity; not a person but a defined and labelled object of concern made amenable to categorisation practices for purposes of targeting their care. Hence, the genealogy illustrated how these practices can have homogenising and totalising effects on the older adult as a normed entity in a designated population. This knowledge embedded in research initiatives informed how care technologies inhered with functional decline discourse are instruments of power; manufactured for purposes of controlling and managing hospitalised older adults efficiently and at least cost (at least in theory) the power/knowledge of discourse. Genealogy also informed how functional decline discourse constitutes the older adult as a normed object of functional decline. A form of stereotyping that is ageist through defining the older adult as one of a homogenised population categorised according to normativities of what it means to age; at the same time effacing the complexities, uniqueness and variabilities of ageing.

Functional decline as such has been rendered as a definable discursively formed object, concept and strategy; a readily recognisable pervasive discourse in geriatrics and

hospitalised older adults' care that is more than an accumulation or culmination of knowledge. Functional decline as a discourse is comprised of sets of relations of social practices, associated activities and outcomes, albeit contingent on interior and exterior conditions of possibility to appear or disappear which make it unstable. However, as a discourse, social practices of knowledge development, functional decline was shown to reach back to what was known and done before, embedded in concepts such as hazards of hospitalisation and iatrogenesis. Simultaneously, it was shown to operate in contemporary geriatrics as its effects reach forward via research practices developing revised/renewed geriatric care modalities, using ADL technology that promises to continue to influence and shape practices of care for hospitalised older adults.

The next two chapters examine the work and effects of functional decline discourse in the hospital sphere; how it is entangled with other discourses across planes of differentiation, not always consistent or recognisable in where/how it is re/distributed and/or re/surfaces in the hospital. Analytic outcomes will illustrate how as such functional decline discourse is produced and operates in various other guises with significant effects on conduct of care, hospitalised older adults and the nurses who care for them. The analysis in the following two chapters served to put actual people into the workings of the discourse of functional decline to illustrate what the doing of functional decline discourse does.

Chapter 5: Talking mobility: where the discourse of functional decline is

> In daily life mobility is an embodied activity, and physical movement is obviously integral to the way in which the world is experienced. (Nicholson 2007, p. 129)

How functional decline discourse operates in terms of hospitalised older adults' mobility is profoundly relevant in contemporary health care (cf. Brown et al. 2007; Kalisch, Lee & Dabney 2014; Mudge et al. 2016; Zisberg & Syn-Hershko 2016). Mobility is the positive side of the mobility/immobility binary with immobility a metonym for functional decline. As such functional decline, depicted as impaired mobility, has by default become the discursive focus of care practices ensuring its place as central to thinking about and structuring care technologies. For example, 'impaired mobility, whether self-or-other-imposed, places the elderly at risk for a multitude of negative physiological and psychological consequences that can affect health, well-being, and quality of life' (Mobily & Skemp Kelley 1991, p. 6 & 10) is *emphasised over and above other potential foci*.

Mobility is commonly referred to as capacity to move, typically recorded by degree, level, amount of ability necessary to stand, sit, transfer, or walk (cf. Kalisch, Lee & Dabney 2014; Ostir et al. 2013; Pedersen et al. 2013; Zisberg & Syn-Hershko 2016) and mobilisation is embedded in care technologies as the process of 'walking, standing or sitting in a chair with or without assistance' (Kalisch, Lee & Dabney 2014, p. 1487). Doherty-King (2014, p. 20) claims 'nurses are in a key position to improve outcomes for hospitalized older patients by engaging them in mobility'. While Doran (2011) frames patient mobility as a measurable "nurse-sensitive outcome" and hence sees is as amenable to accountability within quality monitoring processes with potential for improvement in cost efficiencies and an organisation's performance of health care. Mobility infiltrates nurses' talk of care for hospitalised older adults especially when engaging the unit's primary care technology, the clinical pathway (CPW), which is structured to objectively observe, assess and document a patient's level of capacity for ADLs with emphasis on mobility. Further, mobilising patients is body-work as it is inextricably linked with the physicality of the patient's body and their performance of ADLs and how nurses' work with their own bodies in mobilising patients. Patients too work to make their bodies move knowing mobility is central to their social life and their future quality of life (Ayis et al. 2007) and not just as a measurable biophysical capacity. As expressed by Lawler (2006, Preface) 'nursing practice is essentially and

fundamentally about people's experiences of embodied existence'. Hence this chapter examines how the interconnectivities of mobility, a CPW as structured by ADL technology (Flikweert et al. 2013) and body-work operate discursively and significantly in relation to what the discourse of functional decline does in mediating conduct of everyday care within this patient group.

Clinical pathways: inhering with mobility and functional decline

> Clinical pathways are document-based tools that provide a link between the best available evidence and clinical practice. They provide recommendations, processes and time-frames for the management of specific medical conditions or interventions. Clinical pathways [CPWs] are associated with reduced in-hospital complications and improved documentation without negatively impacting on length of stay and hospital costs. (Rotter et al. 2010, p. 2)

> Clinical pathways are a common component in the quest to improve the quality of health. CPWs are used to reduce variation, improve quality of care, and maximize the outcomes for specific groups of patients. (Lawal et al. 2016, p. 35)

At first read it could be said these renditions of a CPW as authorised care tool offer compelling reasons to consider CPWs as best practices, informing, guiding and organising patient care to achieve anticipated quality outcomes. CPWs have become self-evident truths as evidenced by Rotter et al.'s (2010) report, authored and legitimised as a Cochrane Systematic Review[5], and Lawal et al.'s study (2016). The current analysis, however, problematised CPW design, structure and language, explicating what it presumes, normalises and obfuscates when operationalised, revealing how a CPW as a biomedicalised care tool privileges bio-physiological factors as readily and reliably measurable, promoting 'interventions that treat biological pathologies' (Willard 2005, p. 116) and eliding other possibilities. The bio-politics of the CPW therefore became apparent as the individualising effects of normalised daily expectations and the totalising effects of standardisation, targeting patients as one of a population categorised by symptoms, diagnosis or procedure, much like geriatric assessments (chapter 1).

The unit's full two page "Fractured Hip Clinical Pathway Acute Phase" is included in Appendix C.1. Figures 5.1 and 5.2 below provide key excerpts. On the unit a CPW was the

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[5] **The Cochrane Collaboration** is a global not-for-profit organization that produces the 'gold standard' in systematic reviews. http://www.cihr-irsc.gc.ca/e/40754.html April 18 2017 CIHR = Canadian Institute of Health Research

Interprofessional Practice & Clinical Standards

Title: FRACTURED HIP CLINICAL PATHWAY – ACUTE PHASE

Qualified to Use: Registered Nurses, Physiotherapists, Occupational Therapists, Licensed Practical Nurses

☑ Please check box if core issue met/completed

◯ Circle box = not met/completed

Chart on the Professional Progess Record ☒ N/A

Standard Number:	12.4.7
Effective Date:	February 23, 2009

RIGHT☐ THR☐ Hemiarthroplasty☐
LEFT☐ DHS☐ Cannulated Screws☐
Other: _____

WBAT ☐ FeWB☐ Precautions: _____
PWB ☐ NWB☐

CORE	CARE COMPONENT	Date:			Date:			Date:		
		D	E	N	D	E	N	D	E	N
Cognition	Provide: Glasses☐ Dentures☐ Hearing Aid☐ R☐ L☐ HOH☐ No Aids☐ R = Restless, C= Confused, V= Vague OT Cognitive assessment complete☐ ◆No evidence of Delirium, able to direct care and discharge	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__
Pain	◆Pain rating acceptable to patient

Pain scale 0-10, Assess Pain behaviours | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ |
| Lab | ◆Lab values within acceptable range, not symptomatic | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ |
| Diet | ◆Adequate nutritional support without aspiration

Percentage of Meals Taken | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ |
| NVS | ◆NVS within patient's normal limits | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ | ☐__ |
| CVS | ◆VS within patient's normal limits

IV Site: P= Peripheral C=CVC PI= PICC ◆Hemovac | ☐__ cm ☐ | ☐__ cm ☐ | ☐__ cm ☐ | ☐__ cm ☐ | ☐__ cm ☐ | ☐__ cm ☐ | ☐__ cm ☐ | ☐__ cm ☐ | ☐__ cr ☐ |

Figure 5.1: The unit's Fractured Hip Clinical Pathway acute phase ~ page one of two

CORE	CARE COMPONENT		Date:			Date:			Date:		
			D	E	N	D	E	N	D	E	N
Soc	◆Pt/Family state concerns addressed		□___	□___	□___	□___	□___	□___	□___	□___	□___
	◆Patient / family states continuum of care understood		□___	□___	□___	□___	□___	□___	□___	□___	□___
Nurs Mob.	D =Dangle S=Stand P=Pivot W=Walked										
	Device _____		□___	□___	□___	□___	□___	□___	□___	□___	□___

		D	D	D
Mob/Activity (PT MRC)	Dangle	See PT Initial Assessment □	See PT Initial Assessment □	See PT Initial Assessment □
		Tx explained, consent given □	Tx explained, consent given □	Tx explained, consent given □
		□ Lie⇔sit:: _____ How long? _____ Sitting balance _____	□ Lie⇔sit:: _____ How long? _____ Sitting balance _____	□ Lie⇔sit:: _____ How long? _____ Sitting balance _____
	Sit⇔stand	□	□	□
	T/F chair/ commode	□Assist:	□Assist:	□Assist:
	Mechanical Lift	Stand □ Sling □	Stand □ Sling □	Stand □ Sling □
	Walking aid	2 w/w: □Other: □	2 w/w: □ Other: □	2 w/w: □Other: □
	Up in chair/wheelchair	□ Mins sitting up:	□ Mins sitting up:	□ Mins sitting up:
	Walk to Bathroom	□ Assist:	□ Assist:	□ Assist:
	Standing balance			
	Walked in hall	□ Distance:	□ Distance:	□ Distance:
	Hip exercises	□	□	□
	Delegation to RA	□	□	□
	◆Continue to optimize patient activity/mobility ◆Maximum ROM of unaffected limbs maintained			
ADL (OT MRC)		See initial OT Assessment □	See initial OT Assessment □	See initial OT Assessment □
		Tx explained, consent given □	Tx explained, consent given □	Tx explained, consent given □
	Cognition			
	Eating/Drinking			
	Washing			
	Grooming			
	Dressing/Footwear			
	Transfers			
	Toileting/continence			
	ADL tolerance			
	RA delegated tasks	□	□	□
	Clothing in hospital	□	□	□
	Equipment arranged	□	□	□
	◆ Patient's pre-hospitalization functional status optimized			

Figure 5.2: The unit's Fractured Hip Clinical Pathway acute phase ~ page two of two

primary care tool designed to operate as a technology of assessment and documentation to order and guide care practices.

> Care pathways are used increasingly worldwide to organize patient care….The aim of a care pathway is to enhance the quality of care measured by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction, and optimizing the use of resources. (Vanhaecht et al. 2012, p. 30)

By its focus on mobility, the CPW implicitly addressed assessing and measuring the risk of functional decline. However, as analysis will reveal the focus on mobility objectified the patient as being a measurable care outcome for purposes of optimising resources. Mobilising patients was to prevent functional decline and the potential for extended lengths of stay. The CPW's objective approach inherently objectified patients as it was primarily structured by an algorithm, a prescribed set of sequenced steps for mobilising a patient. It was produced by biomedical knowledge using evidence based understandings such as those underpinning the development of ADLs. The dominance of biomedical understandings in both the language and design of the CPW determined (informed by biomedically supported assumptions) what counts as valid knowledge about the body, in this case mobility. The CPW as discursive event therefore produced knowledge that informed and guided quotidian patient care by only documenting certain standardised objective techniques, which as Lawal, et al. (2016, p. 35) asserted were intended to promote efficient and effective care practices delimited by diagnosis or procedure 'to maximize patient outcomes for specific groups of patients'. Thus the power/knowledge of the CPW was what it *not only included but excluded* as important resting on the assumption that what was included will produce the most efficient and effective care.

 As illustrated in Figures 5.1 and 5.2 above, the CPW was structured and designed to document the patient's functional status thrice daily and organised to image a trajectory from illness to recovery, operating as an account of patient care accomplished over time (Leigheb et al. 2012). The design portrayed as lists of entities to be accounted for did not only guide but determined and delimited what care to provide, what needed to be accomplished directing care in one way and restricting it to a linear depiction. Thus indicating how a managerialist approach of directive governance with monitoring was operating. This authorised form of governance sanctions an anatomo-clinical gaze (Foucault 1973) encompassing both the macroscopic via percentage of meals taken, distance walked

to the microscopic via lab values, vital signs and so forth. A gaze authorised by a statement (see top of Fig. 5.1) ordering which care professionals were qualified and legitimised to use the CPW, and therefore represented as authorities with the expertise to mark the "official" patient record and account for care provided. This was an example of technogovernance where 'quantitative knowledge is engaged and enrolled to guide the management of illness, and is mediated through clinical guidelines' (May et al. 2006, p. 1022). Important here was how this approach reified the patient as an object of care diminishing the subjectivity of the patient as a whole person to a fractured self. This objective representation of the person as "patient" was reinforced by the absence of the "patient" voice from the "official" record. The absence rendered "patient" knowledge as unauthorised and subjugated. As such, effectively effacing the subjective experiences of illness, suffering and emotion and subjugating the epistemological authority of the patient's knowledge to medical knowledge.

Hence the CPW accomplished at least three things: the text delimited patient subjectivity to normalised states of physical attributes and functional ability; the language delimited which observations and actions were to be documented and how to document as objective assessments of measurable objects such as observable functional status; and the structure and design using text boxes and binaries, served to constrain any invitation for care providers to think beyond the options for care contained within the CPW.

The CPW also directed the clinical gaze to documenting within the assumptions of scientific objectivity that underpin assessments restricted to measurable or observable bodily structures and functions. This is illustrated in Figure 5.1 by the tick box structure, binaries such as yes/no, mobilised, normal/abnormal vital signs, acceptable/unacceptable lab values and ordinals to report level of pain. The tick box structure of Figure 5.2 defaults to documenting when a patient is *not* accomplishing desired levels of ADLs or mobility and infers functional decline in its use of minutes (time) and distance (space). The clinical gaze was further directed by the *demands* made in Figure 5.2 for carers too: 'Continue to optimize patient activity/mobility' and ensure 'Patient's pre-hospitalization functional status optimized'. The design and language used in these clinical tools therefore embed discourses of risk, safety, compliance and conformity with motifs of mobility inferring functional decline, a discourse that continues to direct through the interrelated binaries of

mobility/immobility, independence/dependence and optimised/non-optimised functional status.

Such binaries have been used to mobilise the concept of functional decline in myriad geriatric publications from the early 1990s (Hoenig & Rubenstein 1991; Landefeld et al. 1991) and continue today (Wojtusiak et al. 2016; Zisberg & Syn-Hershko 2016). Hence, although not explicit, the language of the CPW represented mobility, as metaphor, and did not just refer to mobility per se but created *implicit* focused understandings of the unspoken immobility side of the mobility/immobility functional pairing. Hence it was the implied dependence and non-optimised flip sides of respective binaries that gave functional decline discourse it power/knowledge effect. Also important to note, however, was how the bio-scientific design, structure and language of the CPW reflected managerialist practices aiming to ensure tasks set out within these documents were efficiently and effectively completed as required to provide for hospital accreditation audits (Rudge 2011). Therefore while these mobility-related words/terms when used in the context of the intent of the CPW to assess and predict they acted as code to mitigate and/or prevent functional decline but were also enrolled in the processes directed towards achieving a minimal length of stay as noted in these publications (cf. Burgers et al. 2014; Castelli et al. 2015; Chong et al. 2013).

Talking mobility, CPWs and care practices: what nurses say

The discourse analysis of nurses' talk and later nurse/patient interactions involved examination and discussion of how discourses embedded in care technologies and practices were not unified, stable, necessarily continuous or clearly articulated. In the analysis I looked for statements of discursive formations and explored possibilities of unpredictability, instabilities and discontinuities to explicate the variable effects of CPW discourses despite the assumed stability of a CPW as standardised practice. I examined its contingent uncertainty and, at times obscure nature, its irruptions and contradictions, how it 'obeys that which it hides' (Foucault 1972, p. 151) to reveal the violence of what a discourse does in the materiality of hospital care.

As her view reflects how other nurse participants referred to or engaged the CPW and the significance of mobility as a factor driving their conduct of care, excerpts of Nurse Reba's data will be used to illustrate how the CPW was incorporated into her thinking about

and understanding of care practices. Mobility/immobility was understood here to include/infer functional decline although not named, indicating the obscured nature of functional decline discourse.

> Umm priorities for someone with a fractured hip is to get them stable, hemodynamically stable and vitally stable and then also mobility because there are so many side effects to not moving with elderly patients who have a fractured hip… ummm controlling delirium if there is any and preventing delirium if there isn't any…umm yeah, that's basically it.
>
> [Documentation of care] We have a hip fracture care pathway that lists some expectations on each day of what the ideal person looks like on paper as far as **things** go…voiding, mobility those kinds of things. (101826, 3:40-4:34)

Reba's use of the pronoun 'we' implied that she was speaking for the hospital organisation and assuming unproblematically that everyone knows that the pathway is *the* guide to care and accepts that it determines the care to be provided without specifying exactly *how* to care. 'What the ideal person looks like on paper' indicated a normative expectation of care which norms what "should be" irrespective of what care actually may be for any individual patient. She inferred 'ideal' as a description of a patient who followed and met the CPW daily expectations. Reba did not stop to explain what to do or what is done with exceptions, idiosyncrasies, or the unexpected indicating how the CPW prescribed and delimited care without providing space for thinking about alternatives. Further, although her hedge, 'as far as things go', was acknowledgement of contingencies or discrepancies that can disrupt the normalising trajectory promulgated by use of the CPW, the complexities of nursing practice seemed hidden or lost in her description. Reba, however, positioned herself as knowledgeable about care practices but this knowledge did not extend to or encourage her questioning the authority or effectiveness of the CPW to guide care.

Reba's prioritisation of "hemodynamically and vitally stable" alongside voiding, mobility, and delirium revealed her preference for biomedical descriptors, objectively inscribed in the CPW as were laboratory values, vital signs (VS), diet and continence. Reba stated her priorities as facts, in a strong voice making no move to substantiate, seemingly assuming agreement. Such prioritisations are common as demonstrated by Siu, et al. (2006, p. 862), a physician led team studying the care of older adults hospitalised for repair of fractured hip listed comparable priorities of 'evaluation of surgical risk and stability, prevention of common complications, pain control, mobilization and physical therapy'.

Maher, et al. (2012), an international team of self-identified nurse-experts using evidenced based knowledge published similar priorities in the care of older adults hospitalised for hip fracture: mobility, pain and delirium management. Reba, Siu, et al. (2006) and Maher, et al. (2012) represented themselves as "in the know" by stating defined priorities which were biomedical elements of the CPW and in doing so demonstrated their affinity with how hospitals and hospital care are highly biomedicalised. While functional decline was not directly spoken about in these priorities it would be necessary to manage and address each priority they listed to avoid, prevent or mitigate functional decline in this patient group.

Reba's comment about 'so many side effects to not moving with elderly patients' also inferred functional decline as does the recording of functional status via tick boxes on the CPW (Fig. 5.1 and Fig. 5.2 above). Her talk, as does that of Siu, et al. (2006) and Maher, et al. (2012), aligned with the objectivity of the CPW as a text offering normalised and standardised disembodied case knowledge about no particular individual's body but rather a normalised decontextualised generic body (Liaschenko & Fisher 1999). Their talk illustrated how the generically designed CPW normatively categorised via surgical repair of a fractured hip exerting a totalising rather than individualising effect for all patients.

Nurse Laurel, who deepens consideration of the effect of documentation, talked quickly and confidently although she hesitated at times using a filled pause "um" (Laserna, Seih & Pennebaker 2014) to seemingly briefly collect her thoughts. Her pauses, however, did not result in taking a moment to question or wonder about the structure, design or language of the CPW as this excerpt shows.

> For the [pre-operative] fractured pathway if the patient is just going for surgery we would document the pre-op sheets. So, if they are acute we would document acute umm acute sheets [CPW Fig. 5.1 & Fig. 5.2] and it has different umm categories that the patient has to meet on a day-to-day basis basically. (152441, 2:16-3:05)

Laurel used "we" as if unproblematically speaking from a position of assumed authority both for the institution itself and those working there. She represented herself as 'in the know' yet compliant with what she figured was required to document despite offering sparse detail or explanation of how the CPW operates. She appeared to assume the CPW was authorised as the unit's care tool ordering what 'the patient *has to* meet' daily. What was unspoken here, was how this pre-established regime determined a trajectory to discharge delimiting a length of stay which was important to the hospital system and

accomplished by mobilising the patient in a clinical context where immobility inferred functional decline. Her use of the discourse management marker (Fraser 2009) "basically" inferred her views were truth claims spoken from a position of nurse "in the know" and therefore common to all. She went on to describe additional documentation practices.

> If they don't meet any of those categories (CPW)…if the patient um got sicker or they are critical…then we would move onto Flow Sheets [Figure 5.3 below] so we can chart a little more about um an event that happened to them. The PPR [Patient Progress Record Figure 5.4 below] is um so that's when you chart like dressing changes or if there is any event or things happen with the patient or any communication with the family, the doctors,…like discharge planning that's where we document it. (152441, 2:52-4:00)

Laurel's assertion that 'if the patient got sicker' and was not meeting 'any of *those* categories' illustrated how categories can delimit thinking about what is important to care while simultaneously obscuring the complexities and messiness of everyday care. Thus seemingly unknown to Laurel was how hospital ordered documentation practices direct what *is to be thought and done,* rather than what care providers' might value, think or would want. Also, how she described the Flow Sheet as being used to account for what the CPW "does not", indicated the presence of functional decline discourse but did not explicitly define possibilities of functional decline. Further, Laurel's understanding of the Flow Sheet as supplemental to the CPW seemed mistaken when the details of the sheet were examined. Her reason to 'move to the Flow Sheet' contradicted its subtitle "For routine recording only" indicating how the discursive formation of the record can be unpredictable and differ in a 'space of multiple dissensions' (Foucault 1972, p. 155).

Figure 5.3: Flow sheet, daily 'routine recording only' (Appendix C.2 full document)

Laurel's understanding of the PPR (Fig. 5.4 below) for "dressing changes…any event or things happen…" vaguely implied functional decline as a potential clinical entity without elaborating much further. Her understanding indicated she has unproblematically assumed this was how documentation practices operate and was unable to provide, despite my asking for it, evidence of how these documents describe clinical care as that was hidden from her. For Laurel the texts of the documents produced knowledge of what was to be done where, when, by whom under what circumstances.

Figure 5.4: Patient Progress Record (PPR)

In the nurses' talk not only was there obscurity and uncertainty of what these documents "do" as discourses of documentation in relation to functional decline, but as illustrated also uncertainty about how care documents constituted what nurses' do and how/what they scribed about the doing of care. A situation further confounded as the process of documentation was contingent on how nurses interpreted or thought how to use the documents. Nurse participant Taylor's ideas, albeit a bit vague, illustrated such contingencies as her ideas contradicted those of Laurel.

> In her case she (patient) was a fracture um we've got our care plans [a CPW] we have expected outcomes which is included in that and any "thing" beyond that we chart on the PPR….we do like our limb assessments that kinda stuff each shift. [Was asked about Flow Sheets and simply said] Yep Flow Sheets yes. [Then asked how the PPR fit in here she said] So for any changes or anything unusual that's not on the expected Flow Sheet. (140731, 6:05-6:40)

Taylor used "we" inferring common knowledge with "everybody knows" not acknowledging exceptions or differences and speaking for the institution and others. Her saying 'any changes or anything unusual' was a coded reference to functional decline, the illegible face of getting worse not better. Her talk positioned her as a "knower in the know" despite offering little detail or clarity of documentation practices. Her use of the metonym

'fracture' in reference to the patient indicated biomedical discourse wherein it was not Taylor herself objectifying the patient but her use of this discourse. Further, despite saying the CPW included 'expected outcomes' how she described *her* conduct of care attested to her resistance to the normalising and standardising discourse of the CPW, as follows:

> I can't say you know on "day 1" you have to be getting the patient up because some people can't um so yah each patient is different in how far and how fast they progress. So I have to take it by each case they give you. (140731, 5:22-5:48)

By using the pronoun "I" Taylor started with a subject position of owning and taking personal responsibility for her ideas as resistant to the "official" CPW trajectory; a resistance to the dominant discourse of care without naming it as such. Her change to "you" signalled a mediated position not hers but a suggested in-common way of doing things. 'Getting the patient up' was reference to mobility followed by 'how far and how fast they progress' indicating how her talk of care remained focused on mobility/immobility 'because some people can't' with a nod to yet never actually naming functional decline.

Surfacing in the nurses' talk were conflicting ideas of what documents were about as documents are a 'space of multiple dissensions' (Foucault 1972, p. 155) while also illustrating the contingency of effective documentation practices. While some nurse participants implied unquestioned compliance in their understanding and use of documentation practices others expressed resistance, serving to illustrate how nurses work with and outside standardised and normalised discourses of care. Their talk more inferred than detailed the complexities and messiness of everyday care with no direct talk of functional decline although it lurked constantly under the surface. Hence the complexities and messiness involved in how nurses are immersed in the suffering and unravelling of lives, as can happen with hospitalisation incurring functional decline, was absent from the "official record" and hence non-existent in understandings of what nurses do.

Mobility, body work and functional decline

The following excerpts of nurses' talk will illustrate their struggles and conflicted thinking about mobilising the patient as the visible discourse where functional decline discourse lurks underneath. What will be explicated is how mobilising the patient drives care and is embodied as difficult work for nurse and patient alike even in the absence of mention of functional decline.

Nurse Lily in her efforts to mobilise a "reluctant" patient, Gladys, struggled to make meaning of her role as nurse and how to conduct care within the tension created by her attempts to respect Gladys as a unique person, while nevertheless keeping the ultimate goal of ensuring discharge to home at the forefront. Gladys was in her late 70s and lived independently in a suite on her own. She had congestive obstructive pulmonary disease (COPD) which was usually managed quite well for the most part. However, now her COPD seemed aggravated by the ordeal of surgery, her anxiety about being in hospital and the uncertainty of her next steps, that were further intensified by her recent pre-hospitalisation decrease in physically active.

> I mean I can see her [Gladys] potential you know for getting better and maybe she just needs more encouragement…that you can be kinda cool about it in your nursing practice…you kinda you tend to encourage them to do better but at the same time you kinda have them lead in their own care especially if cognitively intact… (4:31-4:52). [She goes on to say] With this patient what was difficult was this resistance to care because you know she just didn't want anything, anymore and here we are trying to push her a little bit more (7:20-7:40). [Then later] My priority is first of all comfort for the patient [pause] one big one for me is getting back to mobility. I mean not everyone can get back to how they were pre-op but you know just getting back mobility. The fact is it's one of their big tickets to discharge is for them to be mobile but not everyone can be that you know, get back to the pre-fall, pre-surgery so that's one big thing. (152227, 10:14-10:40)

Despite use of "I" indicating ownership of her thinking, the discourse marker "you know" inferred she expected her ideas were shared common assumptions. Embedded in Lily's notion of needing to mobilise the patient was the assumption immobility leads to functional decline, which is commonly framed in geriatrics as a decrease in capacity for ADLs and loss of independence. Such consequences of inadequate mobilisation are predominately rationalised as precipitating "extra" health care costs. Thus functional decline, when equated with extended length of stay, is known to hinge on assumptions about the likelihood of a nurse not properly mobilising patients, inferring fault with both the nurse and the patient. Hence as Lily explained 'one big [priority] for me is getting back to mobility…you know just getting back mobility…one of their big tickets to discharge is for them to be mobile'. Lily's focus on mobility aligned with nurse "experts" in orthopedic care for older adults such as Maher et al. (2012, p. 179) claim that 'the primary goal…remains to maximise mobility…[as] postoperative mobility is critical to recovery' and Malmgren, et al.'s

(2014, p. 145) emphasis on the goal to 'regain optimal mobility'. In her mobility driven talk and approach to care Lily was practising the discourse of functional decline manifest in her belief in Gladys's 'potential you know for getting better'. Lily's efforts to 'encourage them to do better' implied her understanding patients were dependent on her as they cannot "get better" on their own. Lily's talk therefore positioned her as using pastoral power (Holmes & Gastaldo 2002), making Gladys do it "for her own good". Gladys's resistance revealed the fluid nature of their power relations. Further, in her talk of how she conducted care Lily positioned herself in the empowered positon of "knower"; using discourse markers like "you know" implying an invitation for the listener to come over to her point of view, to consider what she said as knowledge-to-be-known, she a "holder of knowledge" proposing the truth claim 'the fact is it's one of their big tickets'.

Nurse Martha, however, struggled with the perceived need to mobilise Gladys in her conduct of care. She wobbled in her approach and attitude to care, struggling with "getting" Gladys mobile while facilitating her autonomy as patient and her active participation in her own care.

> The most difficult was maintaining her…umm changing her position so that she didn't get bedsores…getting her to change just a little bit and getting her on her side and then next thing you know she's back on her back because that was most comfortable for her, right? So that was hard trying to convince her to move around a bit more (3:00-3:26). [Then concludes] But she is fully intact mentally. She knows the risks. She knows the benefits so she gets to make the choices, for the most part (4:07-4:16). [Yet Martha says] we try and talk it out, work with it. Try and find a compromise, for example sitting up in bed as straight as we can, as opposed to getting fully up….constantly reminding her to move her limbs…to breathe through her nose…sometimes we have to be a little tougher so in her case [Martha's voice dropped to barely audible] it was hard actually she was [long pause and couldn't hear the rest until her voice picked up to as she loudly asserted] **but she knew what she was doing**. (104206, 4:29-5:07)

Martha positioned herself as "in charge" with her words 'sometimes we have to be a little tougher…reminding her' inferring "maintaining her" as if Gladys depended on her with implications of Martha's engagement with pastoral power. Martha also positioned herself as 'responsible nurse' focused on prevention, e.g., of 'bedsores', a marker of functional decline. However, Martha positioned Gladys as obviously and appropriately self-responsible with the words 'She knows the risks. She knows the benefits so she gets to make the choices…she knew what she was doing'. Martha used a technology of responsibilisation, an

individualisation of risk by moving over to the patient the need to self-govern, to take personal responsibility for her own actions (Biebricher 2011, p. 469). Martha's talk included discourses of self-responsibility, risk, desire, moral obligation and functional decline embedded in the conceptual domain of mobility manifest in her drive to have Gladys 'move her limbs'. Martha also struggled with how physically exhausting it was to care for Gladys yet she did not want to show her exhaustion as she practised a discourse of the "morally responsible" nurse in tension with a discourse of denying self-care as she explained:

> I got worn down and ah trying…for me it was hard to maintain an upbeat kind of energy at times and not…its nothing it's not her fault in any way and I am just portraying that to her…I just feel bad when I am tired and other people can see it. (104206, 6:02-6:22)

Martha and Lily's tensions and struggles are captured in Malmgren, et al.'s (2014) study on patient participation of older adults hospitalised for repair of a fractured hip. The authors maintained the biomedical discourse of functional capacity in relation to mobility with their assertion that the aim in care of these older adults is to 'regain optimal mobility' (p. 145). They then reported that nurses found 'it is a challenge to adapt care to both the individual and the organization' (p. 145) and that this was then compounded by the 'challenge for the staff to be not so guided by routines but instead to implement person-centered care'; care 'guided by personal circumstances, needs and desires' (p. 149) of the patient, concluding with a counter argument to economic rationalist discourse with an accounting of personal care:

> By paying attention to patient preferences, the staff have an opportunity to implement changes in health care that will benefit a large patient population. This can lead to patients gaining better functional capacity and quality of life. (Malmgren, Tornvall & Jansson 2014, p. 143 & 149)

The power and danger of these discourses resided not just in their existence as singular entities or events as these discourses were not obvious to the nurses but as entanglements of discourses influencing/covertly driving how nurses think about and conduct care. Rarely did the nurses' talk address of *how* care practices were constrained/delimited by hospital policies and practices that conflicted with their own thinking or how mobility was a driver of care. The nurses' talk did however reveal how the *work of* functional decline discourse as "event" dominated, with unwitting naturalising

effects, and were obscured, despite being ever present in the authorised and legitimised structure, the design and language of technologies of care like the CPW.

Mobilising the patient: how nurses practice functional decline discourse

The discourse analysis here concerned nurse/patient care occasions occurring in the days immediately following the surgical repair of a fractured hip. The assumption as indicated by the CPW was that the patients were to be mobilised incrementally each post-operative day, implying effort to mitigate functional decline. The discursive analytic approach engaged the multi-dimensional conflictual nature, discursive complexities and messiness of hospitalised older adults' care in the context of mobility and functional decline discourse. Analytics facilitated explicating the fluid nature of power relations within nurse/patient interactions; how nurses take charge or stand back; how patients sometimes are compliant, acquiescent and/or resistant in the conduct of care, driven by the concept of mobility with functional decline always lurking nearby.

Nurse Reba and Patient Evelyn: what the doing of discourse does

Reba has worked on this unit since graduating as an RN about five years ago. At times she was a designated nurse leader. One of the unit's Clinical Nurse Leaders commented that Reba is a refreshing no-nonsense highly organised and informed nurse who does well to get things done even when busy. She positioned Reba as someone in the "know" and as an "accomplished responsible nurse" efficiently getting things done properly and on time.

Evelyn, a widower almost 80 years old, lived alone independently in a condominium. She was active, walking her neighbourhood almost daily to do errands or visit friends. Her "official" patient record described her as having a mild case of COPD and a history of high anxiety and fibromyalgia without physically notable symptoms except her own claim to tire easily. She took medication for these health challenges as she decided was necessary. The physician's notes on her "record" stated her co-morbidities were well-managed at this time.

Conduct of care/self-identity as nurse: what Reba has to say

An analysis of Nurse Reba's talk about conduct of care and an analysis of how Evelyn presents as person and patient contextualise a Reba/Evelyn nursing care occasion.

> **Nurse Reba**: I tend to take a bit of a firm approach with patients.
>
> I don't beat around the bush. I push them as far as I think they can go within their limits and encourage as well umm.
>
> ….But I also don't [pause] when it comes to mobilisation specifically give them a lot of choice because I know it's best for them to get up and get moving.
>
> So, we just go in and say "let's do this now or never and we do so"…and we go over risks of not moving, not getting out of bed….
>
> We just have to build their confidence to [pause] keep carrying on, umm, demonstrating with mobilisation that they can do it (101826, 1:28-3:12).

These few words offered a complex view of how Reba constituted her subjectivity as a nurse: her values and beliefs, how she conducted her care, her strategies of care and what she interpreted as knowing and doing the best for the patient. "We", a discourse marker, positioned Reba as "in the know of common knowledge". In saying 'I push them as far as I think they can go within their limits' she identified as critically reflective, a knowledgeable and ethical nurse who knows when and how to 'push'. Seemingly compassionate by figuring *how much* to push yet patronising in her deciding *for* the patient. She presented as a no-nonsense, firm and straightforward nurse: 'I don't beat around the bush' standing her ground to ensure patient mobility. Her stand representing nursing as a moral imperative of beneficence. Her "knowing" stand expressed as 'demonstrating with mobilisation that they can do it' indicated mobility was something natural and obvious which is hard to dispute, particularly for the patient to dispute as the nurse position is one of expertise and authority. Reba was practising functional decline discourse as her "firm approach" ultimately was about mitigating or preventing functional decline by demanding the patient mobilise.

Reba governed the patients. She exercised disciplinary and pastoral power expressed as aiming to 'build their confidence', *do for* the patient and 'I don't…give them a lot of choice because *I know it's best for them* to get up and get moving'; a condescending tone with the moral imperative of knowing what's best, subjugating the patient's self-knowledge. The pronouns "their" and "them" separate out the patient from the nurse manufacturing a space that divided nurse from patient, objectifying the patient in a hierarchical nurse/patient relationship again subjugating patient knowledge to nursing authorised knowledge. A depiction of nurse/patient relationship not uncommon in nursing theories (Alligood 2014; Smith & Parker 2015). This representation of the patient also revealed individualising effects of care constituted by practices of surveillance, guiding and directing

each patient's mobility as produced by the CPW power/knowledge effect. Yet these were also totalising effects as the CPW determined a patient's trajectory of recovery by category of procedure. These care techniques were embedded in Reba's care, securing her position and exercise of hierarchical power within nurse/patient interactions and conversations.

Reba's words "not moving/not getting out of bed" mimicked normative expectations of "progress" driven by the CPW script and represented Reba's care as objectified by the language and design of the CPW, reducing her care focus to what *should/ought* to happen each day as languaged by the CPW (Fig. 5.1 & Fig. 5.2). Reba appeared to unwittingly represent herself as a nurse who unquestionably followed discourses of hospital practices that order what care, when, how which conflicts with her self-identity as "nurse in the know" of what is best for the patient. Reba's language of nursing care was infused by discourses of biomedical knowledge, expertise, nursing knowledge, confidence, moral/ethics, compassion, surveillance, functional decline, risk and normativity, discourses Reba did not name. Further, her documentation practices as noted above minimised, effaced, or erased discursive complexities or messiness in her nursing care that goes beyond the script of the "official" patient record. Reba's ways of self-identity and representing herself incorporated a rhetoric of managerialism, and a reduction of nursing care to instrumentalism which can efface complexities in the conduct of care (Brophy 2008; Comrie 2012; Lindh et al. 2009; Wolf et al. 2012). Her practices were governed by hospital practices and policies focused on patient levels of ADLs, biophysical capacities to progressively mobilise. Hence, despite positioning herself as knowledgeable expert Reba did not question the relevancy, trustworthiness or validity of the CPW to provide appropriate expectations and direction to guide care. Her complicity in accepting the scientificity of the pathway as a regulatory mechanism, as an 'integrated management plan that display[s] goals for patients, and provide[s] the sequence and timing of actions necessary to achieve such goals with optimal efficiency' (Panella, Marchisio & Di Stanislao 2003, p. 509) followed the pathway without challenge.

'Fractured hips are for old people': Evelyn talks of her worries and desires

> Techniques of relating to oneself as a subject of unique capacities worthy of respect, run up against practices of relating to oneself as the target of discipline, duty and docility. (Rose 1996, p. 35)

Each day I came by Evelyn's room she signalled for me to come in, sit down and stay awhile just to talk. In these conversations Evelyn always wove in descriptions of her anxieties about having to mobilise and how much harder it was than she had imagined. She told and retold her nightmare the night of her fall. How in getting up to shake off the nightmare she fell and fractured her hip. With a deepening frown she recounted the struggle to wiggle over to the phone and call for help. She worried that going back to living alone she would have the recurring nightmare, fall again and break another hip. Yet she would talk about being too young for a nursing home and not ready for assisted living despite how it scared her to be going back home, living alone.

In her interview, Evelyn represented herself as conflicted, uncertain and frightened of the future, uncertain how to perform her age exacerbated by lamenting how fractured hips are something that happen to old people and coming to the conclusion she must now be an old person (093648). She was tied to her assumptive world of what it means to age, representing herself as hapless, at the mercy of circumstance, old and alone, implying angst about inevitabilities of functional decline (without actually saying but knowing functional decline). Yet she spoke with a resolve of being 'too young' for dependent living arrangements and with fear of losing her independence (code for functional decline).

Reba and Evelyn: a contested relationship

The setting of the Reba/Evelyn interaction was Evelyn's hospital room. Evelyn's bed was positioned by the window about 19-20 feet walking distance to the room door. The focus of analysis was Reba's efforts to mobilise Evelyn from multiple perspectives including space and time as indicated appropriate by the fractured hip CPW (Fig. 5.1 & Fig 5.2).

> At 0905 on Evelyn's third day post-operative Reba, at Evelyn's bedside, says in a stern commanding yet cheery voice "this morning we are going to walk to the door".
>
> Evelyn responds in a plaintive reluctant voice "I can't go that far", however, she acquiesces and starts to move with a "long face" that expresses her reluctance. (Field Notes #2, p. 4)

Reba's use of "we" had relational value with a tone of authority assuming Evelyn will comply. Within a minute, with Evelyn enrolled in a position of the docile patient, Reba got Evelyn to stand at her walker giving her directions for every step of the process from where to put her hands to how to position her feet. Then once up, with her hand under Evelyn's

elbow without a word Reba started moving her along despite Evelyn continuing to protest expressed in a mournful voice as "I can't do this". Reba's actions were reflective of her earlier remarks on her conduct of care and illustrative of how she practices the discourse of functional decline: 'we just go in and say "let's do this now or never" and we do so' (101826, 1:56-2:00). At this time Reba's face was almost expressionless except for a tightness of resolve and a sense of immovability. However, after a minute or so her disposition shifted and a smile started to creep in as she used words of encouragement, "you can do this". Reba's actions positioned her as the nurse enforcer/encourager of progress discursively articulating the CPW she appeared to follow. Yet she was also represented as persuader by using words to encourage Evelyn to accomplish a level of mobility expected of a patient on their third day post-operative. For Evelyn this meant rising to the norm so as to perform mobility as the pathway dictates, the implicit purposes of staying "true" to the pathway being the prevention of functional decline. The gestures, performances and words used by Reba to keep Evelyn to the CPW showed how power relations were at play here directed by the nurse and the unspoken CPW construction of care driven by mobility: care designed to be *productive not oppressive* despite the underlying message of functional decline discourse, to keep moving or decline. This scenario illustrated how the nurse/patient hierarchy was enacted within the day-to-day by how the nurse talked and "took" authority using words and gesture. Taking Evelyn by the elbow was "allowable" as a legitimised care provider "power effect" for Reba while in the role of nurse. Yet where there is power there is resistance, which as the episode unfolds, Evelyn resisted and produced a reprieve for herself from the nurse-enacted dictates of the CPW.

At this point the physiotherapist Moira arrived (as was expected sometime during the morning - it is usual on this unit, for the physiotherapist to work with patients for the first two-three days post-operative) to assess and document Evelyn's progress in mobilising, following up to keep her on track with the CPW. However, as Moira typically covered for two floors it was not easy for her to come exactly as scheduled. If the nurses had time they would initiate getting the patient up, as Reba did this morning. Such adaptations of work performance reflected the rhetoric of managerialism and demonstrated efficiencies of care dependent on the individual workers doing more with less. Moira, in her professional role as physiotherapist and having worked with Evelyn previously gave many detailed pointers on

how to move, displaying a legitimised air of authority. A position enhanced by her technical comments of praise and encouragement to Evelyn, 'you are doing excellent as your step follows through and you have a good gait' (Field Notes #2, p. 5). This was a hierarchical relationship established in her words of direction and Evelyn's response of a smile and soft thank you. Moira had however, not displaced Reba as the authority. Reba and Moira together now reflected the "we" Reba referred to in later talking about her conduct of care: 'we just go in and say let's do this now…we do so…[talks about confidence] we just have to build their confidence' (101826, 1:54-2:35). The discourse marker "we" established relational value wherein Reba and Moira became the authoritative "we" that reified a care provider hierarchy, positioning Evelyn as beholden patient. This stance left little space for patients like Evelyn to assert their 'knowing' about what was best for themselves. Evelyn's 'say' became subjugated knowledge in deference to the authorised legitimised knowledge of experts: the nurse and physiotherapist.

The configuration of space between Reba and Evelyn had changed with the arrival of Moira who took over from Reba, a change expressed by body movements and gestures not words. As Evelyn neared her bed Reba stepped back and Moira stepped in positioning herself as authoritative guide to Evelyn's last steps to the bedside. Once there, Reba standing nearby with a big smile of satisfaction and approval exclaimed 'you did it', self-positioning as motivator. Evelyn looked a bit pale and not happy, her smile short and weak. Yet as her shoulders shifted downward she showed relief (or perhaps resignation?) at having arrived close to her bed. She stood at her walker in wait mode, not moving, submitting as in previous times to prompts for each step and action to take and representing herself as acquiescent recipient of care despite many claims of protest and hesitation. She was positioned in a binary of authoritative nurse/helpless patient and presented as a conflicted uncertain person, wavering as the next move showed.

At this point, Reba commented to Moira within earshot of Evelyn 'she is a can't-do-it' (Field Notes #2, p. 5), labelling, categorising and representing Evelyn negatively. Her comments intimated that Evelyn was one-of-those patients she had encountered before who needing to be managed through subjugating Evelyn's protest "I can't do it' as irrelevant and inappropriate. This labelling practice engaged categorisation techniques (one-of-those kind) with powerful constitutive effect. In this case, re-scripting Evelyn's subjectivity of

agency expressed by her self-knowledge "I can't go that far" to one of a passive object "can't do" function. However, Evelyn resisted such objectification with a self-justifying response 'it is hard work and hard to do' (Field Notes #2, p. 5), positioning herself defensively despite having acquiesced by continuing to mobilise as Reba had insisted. One possibility was that Evelyn was simply resisting her involvement in an event of asymmetrical power and influence (Latimer 2008). Another possibility was that Evelyn "knows" herself in this context to be *not* as she "normally" knows herself or "knows" her body prior to hospitalisation. Therefore, she was not displaying conviction or confidence in her current self-knowing which was perhaps what allowed her resistance to be overcome by Reba's authority.

Evelyn continued to resist Reba's CPW directed efforts to mobilise by complaining of being hot and nauseated and wanting to return to bed. She refused the chair in contradiction to the CPW which directed that at this stage she *should* stay up in the chair. Reba did not insist or push as before, instead she fetched a cool cloth (no offer of anti-emetic) and placed it around Evelyn's neck affirming she had heard Evelyn's complaint this time as nausea that is a biophysical reaction not to be ignored. In this action Reba presented as the responsible, thoughtful compassionate nurse to which Evelyn as the grateful patient responded with a thank you and saying how it helped. The Reba/Evelyn power relations had shifted with Evelyn's resistance and Reba's concession of "allowing" Evelyn to return to bed. At this point Reba left the room and Moira again took charge, guiding Evelyn via step by step instructions as she moved from standing at the walker to lying flat in bed. Moira, the responsible care provider, practised discourses of mobilisation, comfort, risk and safety as she settled Evelyn in bed with her call bell in reach before leaving.

A few minutes later, Evelyn told me the nausea was wearing off but she was feeling down wondering how she would manage on her own as she saw herself as never being the same and able to do the things as she did before. When asked how she knew this she said 'because this is so hard and difficult and I just know I can't do it like before' (Field Notes #2, p. 5). For her this episode was body work suffused with lamentations and worries, and her words implying her hopelessness were imbued with a sense of impending functional decline with the inevitability and likelihood of deteriorating with age, terminal decline exacerbated by her fractured hip, a discourse of despair and deterioration entangled with functional

decline discourse linked with a failing body and dependence. Later, however, she perked up, denying the impossibility of independence by exclaiming with resolve 'I want to return to my condominium, not assisted living as I want my independence, each day I know I am getting better and coping better because I know I have to' (Field Notes #2, p. 5). Her talk of despair although imbued by the discourse of functional decline also turned to talk of hope and desire infused by a resolve and yearning to be independent again, despite an implicit fear of functional decline. While talking, she had "got busy" under her covers doing leg exercises as directed by the sheet of instructions the physiotherapist had given her the day before. Evelyn's illness had placed her body in the foreground affecting how she positioned and represented as being in a state of unconditional surrender and allowing herself to be managed by mobilisation techniques and protocols fraught with implications which she read as lost functional capacity.

Evelyn's sense of hopelessness was also exacerbated by a haunting fear of losing her independence if she did not exercise and mobilise, as the motif of mobility was not only etched on her body but imbued by functional decline discourse. Her fear then took control, as signified by her fear of losing her sense of self as she knew it, not able to take 'care of my own business, my own life' (093648, 10:01-10:03). Her self-identity, however, was wavering, uncertain and unclear in this liminal time of ambiguous transition from illness to wellness and her sense of identity, governed by fear, frequently compelled her to surrender unconditionally to worrisome demands of mobilisation, with its implied loss of functional capacity.

Upon leaving Evelyn's room I talked with Reba who explained how that morning she considered how they were managing Evelyn's pain, her anxieties about getting up, how many days post-operative she was and acknowledged her co-morbidities before demanding Evelyn walk to the door and back (Field Notes #2 p. 5). Her rationales positioned her as a knowledgeable conscientious nurse who had reasonable expectations of Evelyn that happened to align with the CPW. It was unclear whether or not Reba was consciously practising a discourse of management by objective. She appeared to follow the political rationale of fostering a minimal length of hospital stay by keeping patients to the daily goals of the CPW. In conversation Reba appeared oblivious to the political discursive intent of the pathway. In her talk she positioned Evelyn as the problem for not being self-motivated to

mobilise, neither explicitly framing her resistance to mobilise as caused by deep fears or anxieties nor by the demands of the hospital system. Reba refuted Evelyn's fear of going to "a home" saying that was not the case as she could go back to her own home and function as before, asserting she knew Evelyn better than Evelyn (Field Notes #2, p. 5). Reba had assessed and judged Evelyn as resistant, wanting to be cared for, not independent, but also someone who "should know better" as she was a nurse before. The discourse of "should know better" represented Evelyn as incompetent perhaps irresponsible, positioning her negatively and inferiorly in binaries of expert-nurse/inept-patient, modern nurse/retired nurse. Would Reba have behaved and thought differently if Evelyn was not a nurse? Also important was how Evelyn being a nurse influenced how she positioned and represented other nurses. In her talk Evelyn lamented the "good old days" when she was a nurse which to her meant taking care of patients, giving them bed baths, back rubs, and getting them up with assistance whereas now she was expected to do all these things herself (093648: 6:47-7:13). How much of her resistance to self-efficacy was an embodied desire "to be looked after" as she saw a nurse as one who 'looked after her patients'? How she represented a nurse seemed to contradict contemporary managerialist practices of cost containment, labour constraints and commodification of health care, elements intersecting with current health care system that aim to produce maximum efficiencies of care for the least cost (cf. Gibson 2013; Krol & Lavoie 2014; Miller & Rose 2008; Rudge 2015). As Kirmayer (1992, p. 330) suggested 'the irrational stands for the role of the body in thought: sensuous and emotional'. An idea reflective of Evelyn's view of nursing as affective and caring-for despite how she provided different views in her recorded interview saying

> I can understand why they don't help you because they want you to do it on your own because one day…at least as I understand it to be part of the whole rehab situation is to learn by doing it yourself. If they do it for you they can't come home with you and do it in your home. You have to do it yourself. (093648, 6:07-6:41)

In reverting to rationalism had Evelyn "heard" Reba and re/positioned herself accordingly? Or perhaps she was yet again indecisive and what haunted her was a loss of independence with "having to be looked after". Evelyn's hospital stay was 18 days (13 on the rehabilitation unit) in contrast to the CPW's predicted five day stay for medically stable patients (Waddell 2011). Evelyn saw herself as worse not better. Reba saw her as able to be better but choosing to be worse and according to the system, she was worse still, her stay

having taken over three times longer than the "ideal" proposed by the CPW. I saw Evelyn as a fragmented self, pulled between a number of different discourses of desire, fear, expertise, and states of being. She wanted a nurse/patient encounter of comfort and being cared-for yet knew she had to be self-sufficient in her own care and was all the while anxious about mobilising despite being resistant or hesitant.

In this episode Evelyn's body was self-disciplined and disciplined by observation, assessment and measurement. However, the power relations, in nurse/patient interactions that operated in events of mobilising the patient, played out unevenly and were contingent on an interplay of power techniques. The following analysis of observations and conversations alongside published texts revealed different discursive effects of mobilising in context of functional decline.

Mabel: as the good patient, the docile patient

Mabel personified practising a discourse of "will to health" visible as 'the government of the autonomous self' (Higgs et al. 2009, p. 687). She diligently got herself up and about post-surgery and illustrates the discursive influence of the CPW as a dominant discourse of care that promotes a "will to health" manifested as patient self-responsibility. Mabel demonstrated how individualisation and technologies of responsibilisation for purposes of patients self-governing their care are contingent on norms of self-care. Also exposed is how Mabel's concerted yet unspoken effort to mitigate or prevent functional decline not only inhered with a "will to health" but promised Mabel a social status of independence.

Mabel is in her mid-eighties. She occasionally minds her great grandchildren, does accounts for others and refers to herself as a gardener. Mabel presented herself as independent and strong minded with a twinkle in her eye and ready smile. She was a self that was highly disciplined, regulated and governing with a clear sense of her identity. She told me in conversation 'when you want to do something you tell your brain, not have your brain tell you. Even if you have pain you keep going' (Field Notes #3, p. 5). She was discharged on her fifth day post-operatively in contrast to Evelyn's discharge on her 18th day. Despite this difference they were comparable in age with what appear to be well

managed comorbidities, medically stable with similar levels of physical activity and independence prior to hospitalisation.

Mabel's attitude reflected what the "hip fracture CPW" (Fig. 5.1 & Fig. 5.2 above) required to be done: 'Continue to optimize patient activity/mobility', ensure 'Patient's pre-hospitalization functional status optimized' (Fig. 5.2). Mabel projected an image of what Reba said as 'what the ideal person looks like on paper', a significant contrast to Reba's view of Evelyn as a "can't do it patient".

On the morning of her second post-operative day, Mabel was sitting up in bed vigorously doing foot and leg exercises with the physiotherapist's exercise sheet in hand. She declared adamantly "I am going to get over this" (will to health) deciding she will soon not need a walker as she had a cane at home that would be sufficient for getting around (Field Notes #3, p. 3) despite having osteoporosis in one knee. In the several days I observed I rarely saw a nurse actively interact with Mabel in terms of basic care, teaching or mobilising her except perhaps a moment here or there to enquire how she was doing or to do a standby assist[6] if Mabel needed to walk to the bathroom. The nurses who cared for Mabel told me she was a good patient as she was motivated, always in good spirits and mobilising according to plan. This implied she did not require a lot of their time and effort. As Mabel illustrated saying

> I believe if you exercise as you're told and you continue to do it even if when it's **very** hard for you to **work** with the injured limb it will still work if you have the strength and **will to do it**. (104839, 8:50-9:08)

She positioned herself as an embodied self-motivated self-disciplined/regulated patient who seemed to lack fear of pushing herself to the limits of her strength. She co-operated with the regime of exercises handed to her and her medication record showed minimal use of analgesic while in hospital. She told me she conscientiously followed what nurses and physiotherapists asked of her because what they're 'saying is for the good of me and then I go along' (104839, 10:28-10:31).

Her self-governance was illustrated one morning as a nurse rushed into the 4-bed ward with an armload of clean bedding and towels. From across the room she called to

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[6] Standby assist means the care provider stands by the patient as they mobilise without actively assisting

Mabel "Have you been up to the bathroom to wash yet?" Mabel responded quickly and assuredly "yes, of course". The nurse applauded her and representing herself as "the busy nurse" hurriedly moved on to get beds made with seemingly so much to do (Field Notes #3, p. 4). At various times I observed this kind of Mabel scenario where a nurse praised her with words of well done, confirming her as such a good patient for already accomplishing self-care, then left her to manage. Each implied Mabel as the "good or ideal patient" needing little care and attention taking up little nursing time, appearing to stay on the CPW trajectory. Schroeder (2013, p. 29), a physician lamented, as I suspect would be echoed by some nurses, 'how can we get all our patients to be a "good patient"…as engaged in their care as Alice [pseudonym] is engaged with her own'. The self-governed, docile patient was constituted as the "good patient" whose subjectivity like Mabel was a complex interplay of self-motivation, self-discipline and self-care. They became represented as 'administered, governed, and normalized' (Dean 1994, p. 162) enacting hospital objectives embedded in the CPW designed to minimise length of hospital stay, to reduce costs (Burgers et al. 2014; Roberts, Boldy & Robertson 2005).

For example, by mid-morning, her first day post-operative, Mabel was up with her walker for a 10-step walk with Physiotherapist Liz guiding her more with gestures than words. The day's goal as set by the physiotherapist was for Mabel to be up in her chair for meals. Mabel while waiting for lunch sitting up in her chair was provided a wash basin. She did her own sponge bath. At mid-afternoon she was back in bed talking with me effusing delight about her life with her great grandchildren. While talking she used both feet to push against the over-bed table, moving it back and forth as resistance to build leg strength. She stopped only to use the spirometer saying 'I am working to get strong and have good lungs to get home soon' and as I left she picked up a magazine to read, still moving her legs in the bed (Field Notes #3, p. 3).

The second day post-operative Physiotherapist Liz told her she was doing exceptionally well and likely be discharged home tomorrow. Mabel's nurse that day commented she needed little care as she was very independent, hence a "good patient" (Field Notes #3, p.4). Only once did I observe a nurse follow Mabel as she used her walker to get to the bathroom on her own. Mabel's subjectivity was not only represented by the label "good patient" but embodied by her actions of faithfully keeping to the CPW, mobilising as

expected. Daily she increased her mobility significantly, mostly on her own, appearing ready for discharge well within the norm of five days. In the end she was discharged on day five.

Nevertheless, despite Mabel's diligence and consistent good spirits and ready smile there lurked underneath an unspoken fear of functional decline and disability. Mabel wondered, 'would I come fully back to what you should be and were in the beginning'. Anxieties expressed as, 'because I am a gardener and quite active for my age I wonder if those bones will be as strong as they should be to accommodate what I do' (104839: 9:36-9:47). However, her anxiety seemed dispelled by the end of her hospital stay when asked if she had advice for others:

> I would say that you have to believe in the people who are dealing with you and if they give you advice it is good advice. You ummm ask to take a minute to think about things because it is your life that you're taking about…ahhh…and you mull it over in your mind, consider what's been said to you and then say okay I'll go with what you're saying is for the good of me. (104839, 10:00-10:00)

These words reflected how Mabel, despite her anxieties, maintained a positive attitude with unwavering faith in 'people who are dealing with you' providing 'good advice', propelling her sense of perseverance 'to get over this'. When I asked Mabel how difficult she was finding the exercises she was doing and if she had any pain she replied:

> People on the outside ahhh have always said to me that you go through the greatest pain you'll ever know and it continues for a while when you have a hip operation. But I am not able to say that to anybody because I **did not** experience anything great in pain other than about twice after the operation I have been free of pain. **There is** a bit of discomfort but not pain and immediately that you mention it you are attended to whatever way is necessary to aid you in whatever discomfort there is.'(104839, 7:20-7:48)

She claimed not to have nor appeared to have shortness of breath, pain or nausea when mobilising. Her self-regulation/motivation were reflected by her rarely needing cueing, readily mobilising from her first day post-operatively in contrast to Evelyn who needed constant cueing and struggled with her motivation to move right up until her 12th/13th days post-operatively. Mabel embodied great vigour with strong desire to get better to get home as quickly as possible and had fun in the process. Her daughters teased her about her gorgeous legs as she swung them over the bed edge. Nurses passing by joked about how becoming and "hip" her sandy coloured hair with "roots" showing or how pretty her dazzling azure blue designer pyjama top was when jauntily worn over her hospital gown.

Mabel with a twinkle in her eye would reply with a lively 'yes takes effort to keep up the good looks but gotta keep stylish as I have a few years left' (Field Notes #3, p. 3).

What analysis of observations, conversations and interviews tell us

> The rules of social interaction are not embodied in any one individual; a rule-governed pattern emerges from the fact that each person knows how to play his part (Kirmayer 1992, p. 339).

I contrasted Mabel's story with Evelyn's to show the part the CPW plays in cultivating embodied disparities between one individual to the next that were contingent on how each played their part, in effect compounding complexities of care. How nurse and patient subjectivities were constituted by the CPW and by how the CPW power/knowledge effect was taken up and/or resisted. I also argue the CPW did not necessarily constitute Mabel as "normal" but as normalised in her eagerness to take up and conform to the pathway script. Juxtaposing Evelyn with Mabel illustrated how patients enact or resist discourses of the CPW. Further, how they are positioned and represented by how they take up, resist or ignore the discourses embedded in the CPW, for example "on track and normal" (Mabel as ideal and compliant) or as "off track and abnormal" (Evelyn as resistant and anxious). The work of the CPW, with its embedded discourses showed how the constitution of the patient plays out as unstable and was contingent on complex multi-dimensional ensembles of discursive practices and conditions of possibility. How older adults were positioned and represented as patients depended as much on how nurses identified as nurse, interpreted technologies like the CPW and conducted their care as to how patients were represented and positioned by themselves, as the discursive practices of care informed by the CPW and other technologies of care within nurse/patient interactions. What came into play were the constitutive effects of the CPW; how it was enacted within micro-care situations in relation to the underlying rules of social interaction according to the implicit and explicit discourses, as each nurse and patient played their part within the organisational rules, policies and practices.

Analytic outcomes also illustrated how the unit's CPW for repair of fractured hips was not only presented by research as a series of truth claims based on scientific evidence but was reinforced as a truth when there were "good" or "ideal" patients like Mabel. The CPW therefore not only offered a normalising judgement for mobilising patients, but when

enacted by patients like Mabel, these judgements became normalised as doable without qualification. The patient "on track" was not the exception but one who co-operated and was reified as the docile patient, an object to be 'subjected, used, transformed and improved' (Foucault 1977, p. 136). However, the pathway itself was a text of inert words on a page. Not until enacted within nurse/patient interactions did it discursively operate as a guide to care producing knowledge and tangible "outcomes" products of the health care system. When outcomes were successful as in Mabel's case, this activation of the CPW became self-reinforcing for both care providers and the organisation. This occurred through financial implications for the organisation where a shorter a length of stay brings financial gain for the hospital (Chong et al. 2013). Further, cases like Mabel's, reinforced a normalised illness trajectory that directly reaffirmed the value of organising the delivery of care for all patients via a CPW for a short-as-possible "hospital length of stay", and a significant hospital cost saver (Burgers et al. 2014).

Hence, the pathway per se did not guide or discipline Mabel's recovery. Mabel herself through her enrolment in being the responsible patient used her self-governance and self-motivation to regulate and discipline her own recovery. The pathway both identified and reified what is a "good/ideal" patient as care providers judged/named Mabel a "good/ideal" patient because she stayed on the pathway. Mabel's progress reinforced the efficacy of the pathway, but paradoxically made the pathway problematic because patients like Mabel set up ideal "normalised" standards for all other patients. For example, in Evelyn's case, her resistance and consequent "falling off the pathway" resulted in a negative label of "can't do it patient" and I would argue lengthened her hospital stay. Whether witting or unwitting on the part of the nurses, how they take up, resist or ignore the CPW has significant constitutive effects; not only on how they conduct practice and interact with patients, but also on how they simultaneously present and position themselves as they are represented and positioned by the knowledge produced by the CPW as a discourse of functional decline.

Conclusions

This chapter illustrated how functional decline discourse empowered the orientational metaphor of mobility; a motif used to orient an older adult's hospital recovery

from illness to wellness along a trajectory of care, the CPW. Functional decline discourse was shown to be integral to the notion of mobility as an embodied activity, a physical movement taken for granted as measurable and critical in recovery from surgical repair of a fractured hip. The risk or actuality of functional decline in hospital was shown to manifest when mobility was impaired or absent, i.e., immobility. As such, mobility was interconnected not only with the discourse of functional decline but also discourses of measurement, risk, desire, safety, surveillance and so forth as threads in the fabric of older adults' hospital care. The in-hospital focus on patient mobility was exposed as both explicit and implicit in ADL technology that was the main structure of the CPW. Mobility was revealed in its importance in hospital life, never mind daily life, with its profound effects on how individuals understood and interpreted themselves. In short, mobility was made visible as deeply influencing hospitalised older adults, their experiences of hospitalisation and how functional decline, as a discourse embedded in ADL technology and the CPW, informed, guided and mediated the conduct of their care.

What was absent in the literature and in participant observations, conversations and official patient records was how functional decline discourse is death denying with mortality in hospitalised older adults typically framed as a negative outcome. Functional decline discourse, however, was essentially about social practices concerning death as it was about assessing, predicting, preventing and mitigating loss of capacity for ADLs which would otherwise result in death. Despite life being known to be finite and death inevitable care technologies inhered with functional decline discourse, as noted in chapter four, did not account for or offer guidance for care practices for a patient seen as likely or known to be cascading towards death (unstoppable functional decline).

Analysis exposed how CPWs as written about in published literature were founded on biomedical discourse and have been naturalised and taken up as how care was to be done. These authorised writings legitimised how the CPW prescribed and delimited what care was to be done and officially recorded, while determining a primary focus on mobilising the patient, to have the patient to return to their "normal" level of independence for a timely discharge to home. Analysis not only revealed the governmentality of the CPW, its power/knowledge effects, but how nurses enacted, resisted or ignored the discourses of the CPW and other care technologies in their conduct of care. Juxtaposing these analyses

enabled explicating power relations inherent in care technologies as nurses were both resistant to and complicit with the requirements of the CPW. However, although at times resistant, there was never an indication of the nurses questioning the underlying authority or legitimacy of truth claims structuring the CPW and *how* such claims of what to do, when and how ordered their care.

Inter-linking analysis of literature, nurses' talk and observations of nurse/patient care occasions enabled exposing how mobility is constituted by and constitutive of the discourse of functional decline and *is* a driver of care. Mobility was hegemonically naturalised as well as assumed critical for recovery to achieve a minimal length of stay. Analysis rendered visible the interplays of hospital practices/nurse/patient power relations and taken-for-granted notions of effective and efficient hospitalised older adult care; how despite care practices taken as seemingly stable were always contingent on unpredictable hospital life circumstances and situations. What became apparent was how nurses and patients practised discourses of functional decline, risk, safety and desire. Also, revealed was how nurses' talk and conduct of patient care discursively positioned and represented them accordingly. Next is how such practices were significantly influenced by organisational systems, policies and practices in relation to how nurses moved patients on and out of the hospital system.

Chapter 6: Moving on/moving out: an interplay of discourses

> Going home
> Without my burden
> Going home
> Behind the curtain
> Going home
> Without the costume
> That I wore. (Leonard Cohen, 1934-2016)

The notion of "going home" was taken up here metaphorically as a culminating event, a patient's discharge from hospital following a complex series of discursive events characterised as moving on/moving out of the hospital system. "Going home" was about patients discarding the androgynous costume cum hospital gown and moving out from behind the curtains of the hospital-bed area. Wherein hospital gowns, curtains and beds were not benign entities but discursive practices that served to objectivise the individual as "patient" (Topo & Iltanen-Tähkävuori 2010). Albeit, the older adult, as evidenced by geriatric studies discussed in previous chapters, was not only objectivised by gowns and curtains but also by the panoptic surveillance of care provider observations and assessments, and managerialist practices of monitoring; such care practices were designed to ensure the "patient" continued on a trajectory of recovery according to hospital administrative policies and practices. These standardised care practices will be shown to be based on truth claims, such as the high likelihood hospitalised older adults unless mobilised will experience functional decline; hence the need to predict, measure, assess, prevent and/or mitigate such an event (cf. Ehlenbach et al. 2015; Inouye et al. 1998). The last chapter explicated how functional decline as a discourse permeated everyday care practices constituting an ethic of utility manifest by mobility as a driver of care that suffused the design, structure and language of care technologies. In this chapter, analysis will show how functional decline discourse was not only present within care technologies or lurking in the immediacies of nurse/patient nursing occasions but rather operated at all levels of the hospital system.

Hence, power/knowledge effects of functional decline discourse are shown here operating within the political rationalities, truth claims, structures and discursive practices of the hospital's organisational systems, specifically Throughput (Foy 2010) and Activity Based Funding (ABF) Models (Sutherland et al. 2011). Of interest was how authorised

knowledge was produced by the discursive practices of these models and served to legitimise governmental technologies like the CPW to function as a 'management tool [for]…the efficiency of clinical service delivery' (Tallis & Balla 1995, p. 155). Analysis did determine if these discursive practices of health care systems were good or bad. It revealed how functional decline discourse operated in managerialist practices informed by organisational systems and administrative models for 'the development and control of procedures and injunctions of what to do and how to *be*' (Chauvière & Mick 2011, p. 136, italics in original) specifically via the instrumentalism of the above models.

This chapter provides description of the power/knowledge complex of Throughput and ABF models followed by examination of discursive events experienced by patient participants George and Bill. Analysis will explicate how knowledge produced by these two models operated through managerialist care practices generated by technologies like the CPW that focused care on patient mobility. How then, consequent care practices were inhered with implications of functional decline by the unspoken binary of mobility/immobility.

Throughput and Funding Models: functional decline meets the system

> To analyse political power…is to start by asking what authorities of various sorts wanted to happen, in relation to problems defined how, in pursuit of what objectives, through what strategies and techniques. (Rose 1999, p. 20)

As outlined in chapter four, hospitalised older adults were framed as a problem due to their high risk of functional decline and frequent, inordinately "lengthy" hospital stays. What Health Care Authorities wanted to happen were strategies and techniques to predict and target which older adults were most likely to decline with a political macro-objective of minimising lengths of stay. Hence, there were mandated technologies like geriatric assessments and CPWs to not only order and manage the older adult but also the care provider within the micro-physics of power relations in everyday care provider/patient care occasions. The political power sanctioning such kinds of managerialist practices was via political strategies of hospital systems like Throughput and ABF models founded on tenets of economic rationalism and authorised by health authorities (Sutherland et al. 2011). In this case, these models operated as LEAN production-oriented practices to govern everyday care practices and length of stay.

> LEAN is an approach to systematically eliminating waste in organizational processes in order to improve quality and productivity, and reduce costs. At the heart of LEAN in health care is the mapping of a patient's journey through the system. (Samra 2011)

These discursive practices of mapping a patient's journey were enacted by a CPW used to order and guide care. George and Bill's stories will illustrate how a CPW operated via principles of commodification, objectification and standardisation to order and guide care as goods and services. Incorporation of these principles into everyday care practices was congruent with the Health Authority's mandate to produce efficient and effective services for economic reasons:

> Exploring innovative business models will allow us to meet the ongoing challenge of financial pressures by developing and implementing new service concepts that take advantage of new technologies and apply relevant research results in order to achieve sustainable, efficient and effective services. (The Health Authority (HA) futures plan unnamed for purposes of maintaining confidentiality)

This statement indicated how the hospital espouses corporate and commercial values, as a customer service delivery model focused on technology and structured by marketplace goals of sustainable, efficient and effective services. Such goals commodify patients as objects, quantifiable as products of services through length of stay for purposes of efficiently moving them through the hospital system which elides any sense of person or person-centered care. This kind of corporate model depends on standardised practices like the CPW that languages and structures care practices as commodified measurable outcomes. Attention to these kinds of practices showed how the hospital operated based on LEAN principles, to produce more outputs or profits with minimal resources and least waste. LEAN principles manifest in the hospital's Throughput model and support the central tenets of the ABF model using funding practices that are customer service delivery oriented, designed for efficiency, calculability and predictability. Further analysis revealed how these models operated through technologies like the CPW which were structured by functional decline discourse and served as disciplinary techniques and governing practices (Foucault 1977) in the older adults' hospital care. I observed how such practices can be motivated by safety and quality control in effort to get the patient through the system and discharged home with minimal untoward effects *for the system* not necessarily the patient.

Throughput systems: moving "things" along

> Disability and dependence are, after death, two of the most worrisome health outcomes of all diseases. (Bernabeu-Wittelt et al. 2012, p. 68)

I would assert (as outlined in chapter four) that disability and dependence were also two of the most worrisome outcomes of hospitalised older adults' functional decline that can precipitate extended lengths of stay. I would also argue, that functional decline continues to be understood to be such a worry for the hospital system that it takes a whole range of strategies and techniques to govern a hospital, (an ensemble of practices commonly known as a hospital "Throughput" system) to ensure functional decline is ordered, managed and controlled to 'ensure that the patient flow process continues to run smoothly' (Foy 2010, p. 149).

A Throughput system is a dynamic and complex inventory system organised by a network of policies, rules, forms and practices governed by many levels of decision making, at times based on 'short term subjective demand predictions' (Broyles, Cochran & Montgomery 2010, p. 1645). Demands within a hospital Throughput system may be determined by calculations of immediate staffing levels and resources available, a commodification of health care based on human and non-human factors impacting how patients flow through the hospital system. Within hospitals the metaphoric use of "beds", where a bed becomes an entity discursively formed as a commodity, that is a measureable object of economic value is important for such a throughput system to run smoothly

> Beds are one of the most critical resources in any hospital. Availability of beds may largely affect the access to healthcare facility and patient safety….how to manage beds in a hospital to keep a balance between service level and cost efficiency is an important task to many healthcare service providers. (Zhu 2011, p. 338)

The politics of bed management practices is to balance goods like numbers/types of surgeries with numbers/types of beds available in the right place so care services are maintained by the right staff with the right skill set (Allen 2015). Nurse Myrna, as a unit administrator demonstrated:

> Trying to have beds for all the surgeries coming up with the beds for the ORs in the role I am in now is the most stressful thing there is. You're not supposed to cancel surgeries. Money to hospitals comes in on surgeries. Surgeries run the hospital. They get all this money. I mean hospitals are supposedly a caring place but it is a big

business. [074444, 5:50-6:29] If I had beds every single day everybody'd be happy but that's not the way it is. (074444, 7:11-7:16)

Myrna exemplified why it was considered critical for a Throughput system to facilitate 'getting patients into the right type of bed under the right status and moving them along the continuum in an efficient and effective way' (Foy 2010, p. 148). Myrna's use of the pronoun "I" in describing her role indicated she had taken personal responsibility for the challenge of calculating the right beds at the right time. Management, as a technology of government, in allowing Myrna this freedom to link together 'responsibility and calculation' (Miller 2001, p. 380) had induced her to take self-responsibility for meeting targets as a 'responsible and calculating individual' (p. 380). This is a technology of power at a distance as management 'does not act directly and immediately' (p. 380) on Myrna but holds her accountable as a 'self-regulating calculating person' (p. 381). Likely why she wailed 'coming up with beds for the ORs that is the most stressful thing there is' (074444, 6:00-6:03).

Myrna, however, restricted framing the challenge of beds/surgeries via an economic rationalist lens and a marketing viewpoint: 'you're not supposed to cancel surgeries. Money to hospitals comes in on surgeries'. Beds and surgeries as interrelated goods and services became the desired commodities critical to the economic rationalities of a smooth running Throughput system. Although Myrna also recognised how there were conflicting purposes as she lamented how hospitals were supposedly a caring place but are a big business, demonstrating the power of business priorities overshadowing a nursing ethic of hospital as a "caring place". This conflict was further illustrated by one of the strategies used to keep bed numbers "on track"- the regular "bed meetings. These meetings revealed how 'accountability is defined in terms of counting [where] systems are designed more to reduce costs and control providers than they are to improve continuity and promote quality care' (Armstrong et al. 2000, p. 145). As such patients were constituted as commodities for "care providers" to move through the system as quickly as possible with minimal effort, to be moved along a trajectory of care as objects of economic value, processes aligning with LEAN principles (Foy 2010).

Moving patients through the hospital system by default primarily affects older adults as they form the majority of hospitalised patients as illustrated by alarmist demographics. Further, a large proportion of patients admitted for surgical repair of a fractured hip are

older adults (Wolinsky et al. 2009). Hence technologies of care like the fractured hip CPW although not designated as such primarily address moving the older adult through the hospital system, focused on preventing immobility as discussed in the last chapter. The older adult is also targeted as necessary to be governed because of their high likelihood of functional decline and high risk of extended lengths of stay (Mehta et al. 2011; Mudge, O'Rourke & Denaro 2010). As such functional decline discourse resides in organisational models of governing practices despite unspoken, as a ghost *in* the system yet servant *to* the system. Functional decline discourse resides in practices of surveillance, of measuring, assessing and predicting loss of biophysical functional status that have become legitimised, naturalised and normalised as practices for moving patients through the hospital system. As such functional decline discourse was embedded in the Throughput model of care unvoiced, seemingly unconsidered but *is* there. The invisibility of functional decline discourse was the source of its power and danger because it remained unquestioned, assumed and taken-for-granted as there for efficiencies.

More specifically, functional decline discourse operated as managerialist practices, defined by the authority of the CPW that interpellated care providers to enact standardised daily routines of incrementally increasing patients' mobility, to "optimise patient function", language which implies avoidance of functional decline. The notion of optimising function via mobilising the patient was in the geriatric nursing literature (Maher et al. 2012) and was also embedded in nurse participants' talk of caring for the older adult patient. The nurses implicitly referred to risk of functional decline via metaphors: "not coming fully back to what they should be", "not becoming what they should become", "not returning to normal" or not risking the "side effects to not moving". These ways of *not saying* functional decline were the illegible face of functional decline discourse invisible in the ordering of the throughput system's models and managerialist practices; materialising in the unspoken immobility side of the mobility/immobility binary constituted within the CPW.

The following data extracts illustrated the hegemony of the CPW underpinned by functional decline discourse as Nurse Bridget's struggled with the prescriptive *shoulds and oughts* of the Throughput system that was structured for efficiencies in having patients move along a trajectory of recovery like objects to be managed.

I think sometimes we do push them a little bit too much ummm or maybe even not enough. You know they're in bed for hours and somebody puts them in the chair for 2-3 hours which wasn't our plan….If they get to the point where they're too tired …then they're not going to want to do anything (2:34-3:17)…. [later in talk of planning] I'm always anticipating discharge for patients. I mean that's always our goal. (163854, 8:56-9:01)

The pronouns "we" and "our" as discourse markers positioned Bridget "in the know" of common knowledge of what is assumed necessary to mobilise the patient in tension with how much to keep to the CPW and discharge plans. The "I" pronoun shifted Bridget to a sense of moral, individualised responsibility to get patients through to discharge by her figuring what is 'too much' or 'not enough' for them. She inferred a danger of functional decline by saying 'not going to want to do anything'. The pronouns "them and they" positioned patients in a hierarchy of nurse provider/patient recipient, representing power relations in nurse/patient occasions with nurses in charge/responsible but not indicating how patients were possibly active agents and perhaps resistant to the docile patient role. Saying 'wasn't our plan' spoke to the contingencies of actualities in everyday care with mobilising potentially derailed by functional decline expressed as 'get to the point where they're too tired' yet she persevered with the getting the patient through by 'always anticipating discharge'. Bridget was practising discourses of functional decline, risk, economic rationalism and responsibilisation as she worried about what was best for the patient. However, she continuously framed organisational goals to efficiently move patients through the system without naming a critical barrier, that is, functional decline. Functional decline discourse lurked in her words describing her management of the patient object as 'too tired', 'not going to want to do anything'.

Nurse Randy supported the system with her sense of responsibilisation by aligning her priorities of ensuring the patient 'can get back to their normal daily living' (201549, 4:18-4:19). She talked of getting them up and walking as soon as possible to 'get up and get going…we try to work on that philosophy' (201549, 12:28-12:31). Following institutional policies of assessment she said her documentation

is standard and I think that you document by exception. We have care plans that are um tick boxes and we just chart on the regular normal presentation of what the patient is going through as expected outcome'. (201549, 6:48-7:07)

Later she talked about how 'we rush, rush, rush at the end of our shift to get everything charted (201549, 11:13- 11:19). Her priorities in accomplishing goals of discharge were illustrated by how she took up the practices of the CPW in tension with knowing mobilising patients was also contingent on circumstance and the skill of the nurse.

> Sometimes though patients don't understand why we do things and it takes a lot of explanation as sometimes they think we are mean getting them up to walk…[Randy then gives great detail and examples of what this might look like for patients]… so I emphasize to them how important it is to get back to their normal walking to the bathroom….[After more detail she comes to a conclusion] They need to get back to normal daily living. (201549: 3:28-4:20)

Her aims 'getting them up to walk…get back to their normal' in tension with taking a 'lot of explanation' illustrated the instability of standardisation in the material realities of what it took to mobilise patients. Her practice was driven by a real yet unspoken discourse of functional decline 'get back to their normal' echoing the Throughput model of getting patients through the system. Further, the practices of motivating/encouraging patients reflected the ideological effect of responsibilisation as common sense in disguise (Fairclough 2001), such as of course 'we do things' to get them moving even if 'they think we are mean'. Such techniques of responsibilisation and mobilisation were rarely questioned, appearing naturalised, taken for granted, self-evident and necessary for patient recovery "on time", for getting them through the system.

An exception, Nurse Ben did show how not all nurses hegemonically acquiesced to organisational demands. He resisted techniques of responsibilisation as ordered by hospital systems via the CPW when talking about what was stressful in his nursing practice:

> If there are unexpected events I find it really stressful. If there're, if there's [pause with deep sigh] an organisational push to do things you are not necessarily comfortable with, like discharge people before you think they're ready or their family's not ready that's quite stressful. Um I think [pause] that's probably the biggest one, is if there're things beyond your control that *they* want you to do but you don't feel is necessarily appropriate. You can see how it could be appropriate, but when if you're just not sure that you're there yet, that's the big one. [140944, 13:14-13:56]

Ben, by using the pronoun "I" spoke to his personal uncertainties and conflicts within hospital events bringing ambiguity to his decision-making around "things" mandated by the organisation that were not necessarily appropriate *but could be* appropriate in discharging patients. He illustrated how organisational managerialist practices governed "what to do

how and when" in moving patients, the working of the Throughput system. He struggled with the power of such mandates switching to the pronoun "you" as he questioned and resisted complying although with hesitation. The relational value of the pronoun "you" draws the listener in as an individual and one of his kind, a nurse privy to and with in-common understanding of his stress, 'a status of common experience' (Fairclough 2001, p. 149). He was positioned by the organisation to take up the technology of responsibilisation, to do what is 'beyond your control that *they* want you to do'. Yet his resistance represented him as a knowledgeable nurse, wanting to be responsible for his clinical judgements by thinking through and discerning what may be appropriate when discharging patients 'before you think they're ready'. "Unready" implied there were possibilities of failure to recover according to the timelines of the CPW and thus actual or potential functional decline.

Ben's talk illustrated how the "Throughput" system was a form of governmentality based on managerialist practices ordering conduct of care by 'governing from a distance' (Rose 1999). Governing from afar enabled the unvoiced discourse of functional decline to filter through the system, as illustrated above via standardised tools like the CPW, despite care remaining contingent on circumstance and situation. The Clinical Order Set for Major Orthopaedics provides a standing discharge order: 'Patient may be discharged when meets unit criteria or as per physician's order'. How such standard orders play out however was contingent on how the unit determined their criteria. Other information I gathered about how decisions were made when deciding on discharge plans came from Nurse Nora:

> It all depends as it is a team decision but also depends on person in charge and the nurse leader has been off since last Thursday and is back Tuesday. Last Thursday we figured George still needed help but now Saturday he is refusing the physio help and the OT has things in place for when at home [didn't on Thursday]….Also there are empty beds so no rush to get him out and no one here to assess him for discharge as the team leader, liaison nurse, OT and PT are off for the long weekend. (Field Notes #5: p. 14)

The discharge order was contingent on the co-minglings of decision makers, (such as team leaders, nurses, OT & PTS), assessments of/judgements re patient characteristics, how each thought about and acted in relation to or ignored the unspoken discourse of functional decline. Discharge, therefore, despite being critical to the Throughput system depended on a shifting ground of various interconnections between individuals, circumstances, situations and care technologies. Nurse Jessie expressed how such contingencies were not just rife at

discharge but operated throughout the hospital stay (despite the standardisation and objectivity of models of care and care technologies) to get patients mobilised as scheduled.

> We tended to rush our care getting her up and that sort of thing. So, um I don't think that always works very well for patients. Unfortunately, um that's I don't know how to change it. There's only so much you have to do in a day. Yeah, um it would be nice if you could alter care a bit more to them personally, their likes and dislikes. And I think sometimes we just [pause] "what have you had done?" Then we do our care compared to what they've had not who they are. (174320, 3:27-4:09)

Jessie's talk represented her as responsible nurse by making do within organisational time constraints by doing what 'you have to do in a day'. Her talk positioned her as wrestling with an assumed but unspoken awareness of functional decline as she prioritised 'getting her up', mobilising the patient which did not 'always work very well'. Her sense of responsibility to the personal needs of the patient, implying a kind of person-centered care saying 'would be nice if we could alter care a bit more to them personally, their likes and dislikes' but was overpowered, as she resigned herself to it with 'I don't know how to change it'. "It" seems to refer to the coercive persuasion of the CPW discourse in tension with her workload as mandated by the system. As such managerialist discourses of 'what is to be done' violated her desire to personalise care and as such violated the patient whose care became routinised and depersonalised to avoid the risk of missing required tasks. As Biebricher (2011, p. 470) explains:

> The effect of responsibilization can be summed up…as an individualization of risk involved in various courses of action, i.e. as an obligation to accept personal responsibility for the outcomes related to certain actions.

Ben, Jessie and Sophie expressed resistance to the organisational system governance yet feared to risk not acquiescing to managerial dictates. An unspoken underlying fear of functional decline was the danger of what might happen if *not* following the CPW mandate to: 'continue to optimise patient activity; to optimise to pre-hospital function'. Especially as functional decline as noted in chapter four can result in loss of independence. In western society, independence is a highly valued attribute wherein 'any form of dependence is tantamount to a degrading submission' (Agich 2003, p. 7). The power/knowledge of functional decline discourse lie in its operating via the CPW using the concept of mobility/immobility that inherently meant loss of independence. As such the CPW was a technology instrumental in calculating, rationalising and governing care via mobility to avoid

functional decline to gain minimum lengths of stay. As Nurse Lily claimed 'getting back mobility…is one of their big tickets to discharge' (152227: 10:38-10:41). These nurses reflect how conditions, actions and effects of functional decline discourse were filtered through the system driving care to get patients "through" and thus secure necessary "beds" for a smooth running hospital. This ordering of functional decline discourse was also a critical factor in the effective operation of the ABF model.

Activity Based Funding (ABF) Model: efficiency and value for money

> Accounting practices create a particular way of understanding, representing, and acting upon events and processes….they provide a means for acting upon activities, individuals, and objects in such a way that they may be transformed….By calculating and recording the costs of an activity, one alters the way in which it is thought about and made amenable to intervention. (Miller 2001, p. 393)

Activity Based Funding (ABF) is a goods and services accounting business model 'based on the volume and mix of patients actually treated… [where hospitals] are paid on the number and complexity of activities/interventions, [thus] there is incentive…to increase volume' (Cohen, et al. 2012, p. 25); increased volume indicating the need for a steady supply of empty beds. This section illustrates how the ABF model creates ways of understanding, representing and acting in providing care to hospitalised older adults in relation to functional decline, so the older adults are amenable to move on and move out of the hospital system as expediently as possible.

The ABF model is based on principles of a case mix system that provides 'a means of categorizing patient episodes into payment groups and a measurement that approximates the cost for each episode…[where]the episodes within any case mix group are clinically similar and consume similar health care resources' (Cihi 2010, p. 2). These episodes are treated like 'products' or 'outputs' as the hospital is reimbursed for them according to treating the category-specific case, not for providing a service which means (1) that 'patient episodes are revenue generators' in contrast to 'expenses incurred' and (2) 'payments for unnecessary services or to extend hospital stays longer than needed are no longer provided' (p. 3) indicating length of stay is defined by accounting processes rather than in relation to being "of necessity" as defined by clinical care models. In these ways, ABF aims for efficiency and accountability in targeting and receiving payments according to what is done and predicted as being possible dependent on the smooth running of the hospital throughput

systems: getting patients through the system. By default then ABF efficiency depends on preventing or mitigating functional decline related adjustments to patients predicted lengths of stay. The ABF model and the associated case mix adjustments, adds to the complexity for the unit when predicting its "beds", as each surgical case admitted has to be coded by an estimated length of stay because to obtain adequate funding the length of stay for each "case" needs to stay within an estimated time limit. For ABF to be effective (to generate profit), hospital management needs to figure as accurately as possible how many surgeries can be accommodated daily. Hence the need to ensure timely patient discharges means knowing *and* managing each patient's clinical condition including their the likely impact of functional decline as the surgery scheduling must match beds actually available for fresh post-operative patients. Hence for ABF to profitably operate patients must get through the hospital system efficiently on time for beds to be available for booked surgeries. Thus the ABF model is contingent on discharge/admission policies and practices, the functional status of each patient and resources available such as staff skill mix. Such needs for predictive accuracy indicates how critical it is to assess, measure, prevent and/or mitigate functional decline which, as explained in chapter four, is a primary reason for a patient's unanticipated extended length of stay and the associated reduction in "available beds". Therefore, the ABF model understood here as an example of how the Throughput model operated on LEAN principles and as illustrated was dependent on how functional decline operated as a discourse.

The tales of George and Bill are illustrative of the power/knowledge effects of the Throughput and ABF models and how these models discursively informed and structured governance of care as ordered by functional decline discourse. Analysis here is not about whether the model is good or bad but how the model constitutes care practices in actualities of nurse/patient nursing occasions as patients are moved on/out of the system in the context of possibilities of functional decline. The health authority in this geographic area used ABF as 'remuneration adjusted for the mix of patient diagnoses and the services and procedures to those patients' (Sutherland et al. 2011, p. 3). The 'policy rationale for ABF – [is] to increase hospital efficiency while holding the line on aggregate expenditures' (p. 6). The ABF model operated as an ensemble of discursive practices 'dependent upon technologies for 'governing at a distance', seeking to create locales, entities and persons

able to operate a regulated autonomy' (Rose & Miller 1992, p. 43). For ABF to operate as intended managerialist practices were used to govern care and order how 'people are moved in and out of the system very quickly, so that no beds and no time are wasted' (Armstrong et al. 2000, p. 77).

Zigzagging to discharge: The tale of George

> To be diminished and made an object where identity is authored by others is always dehumanizing. (Latimer 1999, p. 187)

George almost 80 years old as an ardent hiker and recreational cyclist presented himself as a "rebel". He considered himself in the 1% hospitalised who are more reasonably fit and independent than all others. Yet in a resentful voice said 'they treat me like the other 99% and I don't like being classified as just another person especially wrongly' (Field Notes #5, p. 12). On his first post-operative day he complained 'I can't move without first asking the nurse every time I want to move and how much; and that is annoying' (Field Notes #5, p. 1). Then stated with some urgency how he wanted to get himself moving and home as soon as possible (Field Notes #5, p. 1). George took several days longer than the five day length of stay typical for a medically stable older patient admitted for surgical repair of a fractured hip (Waddell 2011).

However, although his subjectivity was politically constituted by care and documentation practices, circumstances informed how he described himself and how he resisted and ignored care regimes. Starting at hospital admission George was objectively constituted as a patient and object of concern by the design, language and structure (tick boxes, binaries, with little space for comment) of the Pre-admission Function Report (Fig. 6.1 below) that constrained who and what he was and how he was to be delimited by his functional status.

The Pre-Admission Function Report restricted what knowledge was to be known of George. It constituted him as a fractured self, a "patient" characterised and accounted for by functional status: information relevant to the running of the hospital system. The report rendered "everything else" about George as absent, not important. It initiated a panoptical effect, where what was known of him and how to care for him was defined by hospital space and time. Enacted via ongoing observations and assessments including routine events like the Pre-admission report itself: normalising George into the role of patient. His

subjectivity was depersonalised, determined by values, beliefs and assumptions integral to the report, the biomedical language, scientific knowledge, stylised vocabulary and content, leaving no space to write what he thought important to know about him. His way of thinking reduced to "intact", countenance restricted to "mood" = "good", status of communication and history of pain left blank (Fig. 6.1).

The report provided a baseline pre-hospital functional status which many studies have claimed as critical for predicting, preventing and/or mitigating functional decline (cf. Inouye et al. 1993a; Sager et al. 1996; Zisberg et al. 2015) and indicative of the unspoken presence of functional decline discourse. Chapter four revealed how such truth claims were

Figure 6.1: The Interdisciplinary Pre-Admission Function Report for participant George

bio-political, realised to 'determine what demographic, medical, and sociologic characteristics of elderly patients recorded at admission would be of value in predicting those most likely to change their functional status…deterioration of function [functional decline]' (Lamont et al. 1983, p. 282). These truth claims therefore have political power as they aimed to make 'changes in the organization of health care that reduce the length of stay [which] could result in considerable savings in health care costs' (p. 282), hence enabling a form of economic rationalism.

This examination of George's recovery trajectory drew on field work, documents of care, Health Authority reports/studies and published literature to present another picture. This section was organised by providing excerpts from field data sequenced from George's 1st post-operative day to discharge. Data focused on George's experiences of pain in the context of being mobilised/self-mobilised to show how functional decline discourse mediated his care.

Field notes and official patient record data: 1st day post-operatively

1. **FIELD NOTES #5, p. 1** The Physio Therapist (PT) and aide helped George up to his walker to take a few steps. He complained with grimaces and groans about how much his *right knee* hurt; that any movement to his *right knee* was pretty painful. The aide brought him ice packs for his knee. (He was in hospital for repair of right fractured hip)
   FIELD NOTES #5, p. 2 Later that morning Nurse Sophie *planned* to get George up to the walker and then sit in the chair as guided by the PT "Initial Assessment" below.
2. **PT Initial Assessment** (done today) is designed as tick boxes with space for brief comment (e.g. as per CPW, Appendix C.1). PT concluded: 'For progressive mobilization as tolerated' and checked the yes box for pain with a comment 'right hip and knee'. (the only reference to knee pain)
3. **Patient Progress Record (PPR):** The only nurse charting for the day on the PPR regarding mobilising was prior to 0700: 'Patient dangled and stood with two person assist. Pt. managed well, but had some discomfort'. All other charting that day focused on George's urinary flow challenges. No indication of whether or not Sophie got George up or further note about his pain
4. **Physician's notes:** Both surgeon and physician commented 'doing well'. (There was no indication throughout the hospital stay that George was medically unstable.)
5. **Acute phase CPW** (Appendix C.1) throughout George's acute post-operative phase the **CPW** did not indicate any issues with pain or mobilisation.

Field notes and official patient record data: 2nd day post-operatively

1. **FIELD NOTES #5, pp. 5-6**: 1000 upon return from x-ray, Nurses Ellie and Martha arrived to help George move from stretcher to walker to chair. He hailed them as 'the professional sadists'. Ellie replied 'you can't afford one of those'.

Although George groaned a lot, breathing heavy while moving, Ellie responded by calmly saying 'breathe easy as you are nervous' followed by praise, 'you did good'. George replied 'if this is good I can't imagine bad'. The nurses however seemed relentless as they continued to have George move using encouragement, praise and humour not asking where or what kind of pain. Upon leaving without consulting him, said 'you'll likely be up for an hour'. Minutes later George disclosed to me when asked how he was: 'it's not good, I can't move it very much. It is very painful. Can't put weight on it with the walker. I was using my arms…[with a big sigh] in time'. George did not specify the pain was primarily in his right knee just referred to his leg.

2. **FIELD NOTES #5, p. 6**: 1620 Nurse Martha commented to me George could likely go home as early as his 4th day post-operatively as it certainly did not seem he needed much longer time in hospital by looking at the initial Physio Therapist (PT) report (see above).

3. **PPR note**: 1400 PT wrote: 'Attempted to ambulate Pt. He had been up in AM to a chair. <u>Was quite tired and sore. Pt. unwilling to go for a walk</u>. Requested by PT to review exercises. Consented. Tolerated well, will continue on his own. (Nothing written by the nurses on pain or mobilising this day.)

4. **Interprofessional Patient Care Plan** - under "Pain" 'Body aches and pains. Right knee multiple ligament symptoms'. The box "no issues identified" was checked. (Never changed over time despite George's complaints although other parts of the plan were updated over time.) 'PT focus is mobility and discharge planning'. (No issues recorded)

For analgesic, as per standing orders, George was receiving Acetaminophen alternated with Dilaudid orally for breakthrough pain, each four times over a 24 hour period.

Despite George complaining, gesturing and signalling how much pain and grief his right knee was giving him care providers not only continued to mobilise him but encouraged him to self-mobilise, to 'continue on his own'. The biomedicalised discourse of mobility evident within the CPW produced knowledge of disciplinary power as to what to expect of patients, each day post-operatively. Such practices also reflected how the hospital system through its models of care were influencing the focus of care, to get the patient through the system using functional decline discourse as rationale. The care providers then represented themselves as responsible by following the CPW ordering of mobility and engaged functional decline discourse by cajoling and encouraging George to discipline his body to keep moving despite his obvious pain. The political rationalities of these models depended on this knowledge of mobility being enacted with a sense of responsibility to stay "on track". These microphysics of care, the discursive practices of mobilising the patient and encouraging self-mobilisation intersected with the macro-level mandate of the organisational system, the model of care that "governs at a distance" (Rose 1999) using the CPW as a technology of power and responsibilisation (Biebricher 2011).

The intermingling of hospital systems' models, functional decline discourse and care technologies were also exemplified by Nurse Martha who predicted George *could be* discharged four days post-operatively, an "on track" were realistic expectations for a medically stable older patient following repair of a fractured hip (Waddell 2011) as long as they mobilise. These were self-regulating, disciplining and governing practices structured by biomedical knowledge generated as truth claims "from afar", in research initiatives, of what was necessary to know and do in conducting the conduct of the hospitalised older adult (Rose 1999). Whereas George's *own* view of his experience of pain and mobilising was not scribed on his patient record, seemingly subjugated as personal knowledge not recognised by the hospital system. Also absent from the patient record was a notation of his knee pain. The PT in the role of expert professional care provider reported 'attempted to ambulate' noting she had performed her part of the responsibility as per the CPW but that George had not performed his, while excusing him as he was 'tired and sore' and 'unwilling to go for a walk'. The PT engaged technologies of responsibilisation in her role of authority *despite* George being 'tired and sore', she requested he review exercises, not only getting him to consent to mobilise but also tolerate and 'continue on his own' with prescribed exercises. The governmentality of the CPW demanded patients mobilise everyday, the Throughput model's need for patients to get through the system had therefore constituted care. In this case, care driven by goals to avoid immobility (code for functional decline), if not one way than another including self-discipline by self-exercising, to be self-responsible, suffering no excuse. The relentlessness of the system's demand as manifest in "care" practices to mobilise the patient can indeed become dangerous to the patient.

Field notes and official patient record data: 3rd day post-operatively

1. **FIELD NOTES** #5, p. 7: The Occupational Therapist (OT) talked with George about going home in a couple days but then realised he could not get needed resources like a raised toilet seat because the shop was closed and he would have to wait until Monday, at least 3 days away. Then she commented he was still having quite a bit of pain and 'perhaps too sore right now for discharge *anyway*'.
2. **FIELD NOTES** #5, p. 7: 0955 PT got George up, he was struggling and grimacing with pain, could only walk with his walker half way across the room then plunked down with a cry of pain into the wheelchair set behind him as a "back up plan". No talk of knee pain.
3. **PPR** 1030 Nurse wrote 'Pt. still increased amount of pain in his right *leg.* Pt. does not express his pain unless asked to rate it on the pain scale. Keep Pt. pain

under a 5/10 and encourage to mobilize. (George's *rate* of pain was never scribed on his CPW in the section on "pain".)

4. **CPW** There is nothing on the CPW pain scale *on any day* as to his "rate" of pain. Each day the 'pain rating at level acceptable to patient' box is checked as acceptable.

The possibility of George being discharged on his 5th post-operative day was contingent on various factors, including the holiday and weekend closures of community resource agencies that the Throughput system and ABF model failed to account for. The problematic nature of this barrier to discharge was quickly dismissed however, when the OT noted he was 'too sore' for imminent discharge '*anyway*'. George was beginning to "fall off the CPW" with 'increased amount of pain in his right *leg'* yet continuing to be encouraged to mobilise (keep functional decline at bay) to keep on the CPW. There was an underlying assumption that pain was an inevitable but not a barrier to mobilising if managed and tolerable. George, however, was held responsible by care providers for exercising but also responsible for expressing his pain on demand: 'Pt. does not express his pain unless asked to rate it on the pain scale'. Discourses of responsibilisation, risk, functional decline and persuasion pervaded the patient record. The implication here being the potential for a Throughput system problem, a problem of bed management imbalance 'between service level and cost efficiency' (Zhu 2011, p. 338) as his bed would not be available "on time" if George did not continuously mobilise and ask for analgesic as needed. To address this the hospital system governed and disciplined from afar via care providers persuasions: 'Needs encouragement to do ADLs and up to BR and chair'. These models of care were commodifying practices used to produce the desired economic outcomes of "empty beds" for the ABF model to operate effectively. A patient discharge was a product of services albeit *dependent on the social relations of care provider/patient*. Or it appears more that the social relations of care were constituted by the hospital system's models.

Field notes and official patient record data: 4th day post-operatively

1. **FIELD NOTES** #5, p. 7: A nurse told me George's knee is causing him more pain than his repaired fractured hip, he tires easily, only walks to the bathroom not going for walks in the hallway as expected by this post-operative day for his kind of surgery. His discharge is likely postponed with talk of him going over to the acute rehabilitation unit.

2. **PPR: Nurse:** 0745 Pt. was slow to mobilize in am. Was able to stand with some assistance getting right leg off the bed.

[No further **PPR** charting today re mobilising or pain but on front of George's chart at the desk was a large pink slip requesting the surgeon to assess George's right knee.]

3. Under **Alert** at bottom of **CPW** PT wrote: 'Pt. complaint of right knee pain worse than hip. RN made aware, note left for MRP.
4. **Daily Patient Worksheet and Summary**: 'Needs encouragement to do ADLs and up to BR and chair. Needs encouragement to take something for pain'. X-rays reviewed: most likely arthritis – needs Cortisone injection – Dr. to do on floor'.

For the first time, a clear acknowledgement on the "official" record of George's right knee pain, separate from his fracture of this admission. However, he continued to be disciplined to mobilise despite hospital procedure incurring a wait for physician authority to order and administer treatment for his pain. George was positioned as an object of hospital governance practices, politically subjugated as a "patient" waiting for treatment. Yet he was encouraged to keep mobilising to enact governmental self-formation imposed by techniques of responsibilisation via relentless reminders to mobilise as organised by the CPW. As Dean (1994, p. 156) explains:

> Governmental self-formation refers to the ways in which various authorities and agencies seek to shape the conduct, aspirations, needs, desires, and capacities of specified categories of individuals, to enlist them in particular strategies and to seek defined goals; ethical self-formation concerns practices, techniques, and discourses of the government of the self by the self, by means of which individuals seek to know, decipher, and act on themselves.

Care providers, by encouraging George to take responsibility to keep mobilising despite his pain, were practising discourses of responsibilisation to avoid the risk of immobility and hence functional decline. These governmental practices imposed on George an ethic of self-care, to self-discipline, to take moral responsibility for one's own recovery, so as to get through the system. These were legitimised, naturalised and normalised care techniques authorised as necessary to address potential/actual functional decline (Roberts et al. 2004) and inhered with the organisation's need to minimise length of hospital stay as cost saving measures (Castelli et al. 2015; Zisberg et al. 2015).

Official patient record data: 5th day post-operatively

1. **PPR charting:** no charting
2. **Physician's Notes** 'Complaint of right knee pain from old meniscectomy. Will try Cortisone injection'.
3. **Physician's *Order***: 'Depomedrol 40mg [Cortisone] for me to inject into right knee. Referral to rehabilitation unit'.

4. **Daily Patient Worksheet and Summary/shift communication**: needs "encouragement" to do ADLs & up to BR + chair – needs "encouragement" to take something for pain.

Field notes and official patient record data: 6th day post-operatively

> **FIELD NOTES #5, pp. 8-11: 1030** Witnessed George moving *on his own* getting up slowly but methodically walked a bit then settled in bed, no grimace or complaint of pain.
> **1100:** his nurse said the <u>Cortisone was on the floor</u> so as soon as the surgeon was able he would do it, but he is <u>in surgery all day so maybe will be later today or tomorrow</u>.
> **1120** George told his nurse Jessie the surgeon suggested the knee pain was from bones rubbing in the joint due to lack of fluid and a Cortisone injection could be most useful. Yet, Jessie encouraged him to be up as much as possible to help his healing and getting "back up to speed". Saying 'if you stay in bed for lunch you will need to get up for a walk in the hallway this afternoon as we want you to be up as much as possible'. He nodded.
> **Later** Jessie wondered to me about his reluctance to mobilise as 'he talks about wanting to move but that does not match what I am seeing and perhaps his knee pain is referred pain'. She will ask the doctor 'for Tramacet instead of Dilaudid for breakthrough pain to see if that makes a difference. At least Tramacet is less sleepy'.

1. **PPR Jessie**: 1400 Writer spoke to Pt.'s wife re Cortisone shot and Pt. pain. Wife reassured Dr. aware the Cortisone is on the floor and he needs to inject Pt.'s knee. Analgesic discussed with wife and Pt. Pt. encouraged to use ice and accept pain analgesic regularly.
2. **Physician's Notes**: Pt. doing well but ↓ motivation to mobilise.
3. **Daily Patient Worksheet and Summary/shift communication:** Cortisone <u>in med cart</u> for MRP to give.

By Day 5 George was held hostage to the bureaucracy of the hospital governing practices of who can give his cortisone injection. The Cortisone was on the unit but *not* the surgeon whose surgeries, of course, take precedence over George's personal need for care but possibly also the system's need for an "available" bed on time. As per standardised protocol the medication record showed George received regular analgesia including oral dilaudid for breakthrough pain but this was not sufficient for his type of pain which was not standard. Although Jessie acknowledged George's persistent knee pain despite the prescribed analgesia and the cause of rubbing bones, she was sceptical saying maybe it was referred pain which would be a more "standard" cause of knee pain in this case. In her role of authority as health care professional she would consult the doctor to change the analgesic but also simultaneously moved responsibility to George by saying he needs to 'accept pain analgesic regularly'. The system protocols had determined what is amenable to be accomplished as care. The doctor too appeared sceptical as he wrote 'doing well but ↓

motivation to mobilise' without acknowledging the knee pain or George's view. The system was dangerous for George as it constrained care providers, who in turn were not able to meet his pain needs. Yet he was represented as a danger to the system, needing encouragement, reluctant and not motivated to mobilise.

Field notes and official patient record data: 7th day post-operatively accepted and transferred over to the acute rehabilitation unit

1. **FIELD NOTES #5, p. 11** the nurse told me when the doctor came in this afternoon to give George his cortisone injection, staff <u>could not find it</u> so it was not given. Later it was found so she thinks George will get it tomorrow when/if the surgeon comes in.
2. **PPR PT**: **Late entry** Initial visit [on rehabilitation unit] Pt. reports significant pain in right femur and knee. Pt. states waiting for cortisone injection right knee. Pt. walked 40 feet with walker, quite slow to move, difficulty moving right leg forward. <u>Spoke with Pt. about importance of mobility</u>.
   Nurse: 1430 'patient complaining of excruciating right knee pain, Dilaudid 2mg PO given, ice to knee, tensor removed' [a half hour later] 'patient reports pain is within tolerable range'.
3. **Physician's Notes**: Pt.'s pain not controlled well. Tramacet may not be effective! Continue with Tramacet and we will review.

"Losing" the Cortisone illustrated the chaos and uncertainty of hospital systems and practices despite the drive for efficiency generated by throughput systems, standardised care technologies and practices. Standardisation did not account for the unexpected: Cortisone not found despite logged as on the "med cart" which would seem standard practice. It was now three days since the decision was made that George needed a Cortisone injection for arthritis in his knee and that other analgesics were not effective. Discourses of mobility, risk and functional decline blinded care providers to potential actions and interactions at this point. George was admonished again 'about the importance of mobility' despite his obvious 'difficulty moving right leg forward' and ineffective analgesics. These practices and discursive events constituted George as a problem needing "speaking to" and "encouragement" not that the system was problematic, never mind dangerous. He was represented as not well-disciplined, resistant to being governed, to taking responsibility and to mobilising as per the CPW standardised regime. His situation illustrated how standardisation can result in 'loss of identity and social power' (Timmermans & Almeling 2009, p. 25) exacerbated by the absence of his voice on the "official" patient record.

Field notes and official patient record data: 8th day post-operatively

1. **FIELD NOTES #5,** p. 11-12: Patient says feeling 'pretty isolated' on this unit as hardly sees anyone 'occasionally the therapist walks in but does not seem to

know what to do'. Says he was up to BR twice with walker and 'now I can lift my right leg without it being too painful which is better than yesterday'. Laments 'feeling a bit down but can't complain because others are worse off. I do have trepidation about getting up because it hurts. It makes me hesitate, a bit anxious. Maybe they'll just kick me out of here'.

2. **Physician's Notes**: Still painful right hip→ knee pain. Worse with activity. ? Cortisone. Continue Tramacet. Looks well.

   No other documentation on patient record specific to George's issues with pain and mobility.

On his 8th day post-operatively George was now indicating he knows his own body and what was doable. In relation to recent events George also indicated he did not have faith in the care providers nor that they "knew" him or his body but as illustrated above, his personal knowledge of self was subjugated to the authorised knowledge of care providers. The physician seemed to question the effectiveness of Cortisone for George without reason or clarifying why he questioned it or did not question why the medication was not yet administered. There was no note of whether or not he consulted with or updated what he knew about George. Tramacet was continued for the second day despite it being questionably effective. Expert knowledge had subjugated George's personal knowledge in effect making its presence or absence invisible. George's view appeared to be unimportant reinforcing a discourse of care provider as skilled knower and patient as subjugated recipient of care.

Official patient record data: 9th day post-operatively

1. **Physician's Notes**: Pain improved today. Mobilizing better. Knee is the worst- OA on x-ray → Ortho was going to inject it – not done yet.
2. No other documentation on record specific to George's issues with pain and mobility

Field notes and official patient record data: 10th day post-operatively

1. **FIELD NOTES #5 pp. 12-13:** 1610 George is wearing shorts and a T-shirt, he has decided to wear street clothes, although his wife, as asked by the PT, brought them in days ago. When asked why the delay George quipped 'I don't like that I am expected to do like everybody else.' George refused to work with physio today (see PPR note below).
   George commented he and his wife had lots of questions about discharge home as they were uncertain and confused but did not think it helped to ask because either the person they asked was too rushed or the answer was just as confusing.
   Later I asked his nurse Nora about discharge home. She said 'it all depends as it is a team decision and the nurse leader has been off since last Thursday and is back Tuesday. Last Thursday we figured George still needed help but now Saturday he is refusing the physio help and the OT has things in place for when at home. I've seen George walking around and he does pretty good so I let him

do what he wants. Also there are empty beds so no rush to get him out and no one here to assess him for discharge as the team leader, liaison nurse, OT and PT are off for the long weekend.'

George told me his knee was feeling better today as he walked 'the loop' (about a hundred feet) on his own initiative with his walker and said he really had no pain. He told of refusing to work with the PT aide saying what 'they don't account for is I am much more active than others in here. They have categorised me and I don't like it. I know how to exercise my leg'.

George did not get his Cortisone injection today. Nora says he refused it but George says 'The doctor who came in today to give the Cortisone shot was a woman but my surgeon is a man so I was confused and not sure I wanted the shot.' Apparently the surgeon said she'd come by tomorrow and see if he'd change his mind.

2. **PPR** PT aide: 1140 Writer was working with patient on bed exercises. Pt. not following direction and stated he had his own way of doing things and would exercise when he got home. As writer went to assist (another patient)...heard him say 'stupid bitch'. (Upon return) to finish assisting with exercises Pt. stated he had done enough and was going for a walk. Pt up walking on his own.
PPR PT: 1540 He reports he is feeling confident in his recovery. He prefers to get up independently with 2 wheel walker and does not want assistance. He refused to get up with writer but was pleasant.
PPR Nurse: (no time): Pt. declined Cortisone injection as feels knee is getting better.

3. **Physician's Notes**: 'Patient very negative about rehab. Doesn't want to do it. Cortisone not done by Ortho yet. Will call tomorrow to arrange. ** Pt. doesn't think he needs it anymore but will decide.'

On Day 9 there was no documentation of George's pain or mobility except a cryptic physician note imbued with the discourse of functional decline, serving the system by objectively without qualifiers accounting for George's pain and mobility. George as a person was absent, represented as a fractured self by mention only of his knee, pain and mobility. Day 10 appears fraught with confusion on a number of fronts without documentation of what actually was communicated and explained between George and the care providers including the physician. A situation antithetic to the intent of hospital systems and CPW technologies designed for purposes of well run, smooth operation of efficient effective care practices. The PPR was written in the 3rd person objectifying George as problematic: 'not following directions', negative name calling (stupid bitch), 'refusing to get up'; without George's voice to provide explanation of the documented behaviours. The care providers' discourse of expertise constituted George as an unruly object, negatively positioning him as a patient to be disciplined. Affirmed by the physician's note: 'patient very negative about rehab. Doesn't want to do it'. George's knowing of his own body and his understanding of how to mobilise on his terms, doing exercises and walks on his own was discounted,

subordinated to the care professionals. The hierarchy of care provider/patient was affirmed by the dominance of their exercise of power in the microphysics of care provider/patient social relationships which elided the practice of person-centered care. Dean (1994, p. 152) refers to such discursive events as political subjectification where "representation" denotes:

> [The] way in which categories of identity and agency are constituted within governmental discourses, it becomes efficacious to the extent that it is inscribed within strategies, policies, and administrative arrangements concerned to promote and transform aspects of the conduct of life…of various groups and individuals, often by means of the implantation of forms of self-relation by the marshalling and training of bodily capacities.

Day 10's events and documentation illustrated how the system rules by way of disciplinary practices authorised by unspoken policies and procedures of what must be done when, how and by which professional health care provider. George would not be disciplined or marshalled by such authority or position hence documented as negative, non-compliant, rude and unco-operative without recourse to provide his perspectives. A situation that changed little from now until his discharge home, at least according to his official record. Any semblance of person-centered care or relational practice if enacted was invisible, and perhaps not valued as it was not accounted for on his official record. George's record remained a cryptic, objective, biomedically languaged report aiming to meet chart audit requirements. What the nurses scribed about George and his care gave little to no indication of how they were caring for him outside the constraints and delimitations of legitimised care technologies and the system's authorised documentation practices.

Official patient record data: 11th day post-operatively

1. **PPR** Nurse: 1200 Pt. states he was misunderstood yesterday and <u>does</u> want knee injection. Sore today - using *Tramacet*. Found doing stairs on his own-asked him to wait for PT but states he's done it already. [No notation Cortisone injection given today]
2. **Physician's Notes**: Pt. says now that he still wants injection. Called Ortho. Doing well with mobility. Disp. Home on Tuesday [will be after the long weekend].
3. **Ortho on Physician's Notes**: Knee pain may be referred pain but Cortisone injection in arthritic knee indicated…Cortisone Depomedrol injected into knee.

Field notes and official patient record data: 12th day post-operatively

1. **FIELD NOTES #5: p.14:** 1600 George says he is 'feeling more benevolent as I am getting along in my healing and moving much better'. He appears more relaxed in his facial features. He told me he got his "Cortisone shot" yesterday and says 'made a difference in degree but always things are generally improving'.

2. **Physician's Notes**: Pt. very pleased with Cortisone injection. Feels that knee is improving.
3. No other recording outside routine of CPW re pain or mobilising – checked off as met

Field notes and official patient record data: 13th day post-operatively

1. **FIELD NOTES #5: pp. 15-16:** George said 'I don't think they will be letting people go today as it is a holiday so I will be going home tomorrow. I still have bad moments for example my knee will buckle when I'm standing with the walker so then I just rest a couple seconds and I'm okay again.' Later: 'They move by rote here rather than assessment'.
2. No other "official" recording except CPW re pain and mobilising: checked off as met.
3. George was discharged next morning, 14 days post-operative– 'without incidence'.

Day 11: Another day of confusion. Tramacet was still used as an analgesic despite days earlier the physician questioning its efficacy and now the nurse indicating with the Tramacet, George's knee was still sore and he was still asking for the cortisone injection. Decision making that reflected George's comment 'They move by rote here rather than assessment'. George was governed by care providers' daily encouragement to mobilise as per the CPW despite the state of his pain indicating how the "rule" to mobilise drove care. Mobilising the patient has been naturalised not only as self-evident but indispensable practice to ensure recovery, a belief reinforced by the structure and language of the CPW.

George's decisions of how to mobilise represented him as knowing himself including the compelling reasons he offered as to why he was resistant to the mobilising care regimes. However, these reasons, mostly captured in field notes, were not scribed on his "official" patient record, effacing George *as a person "in the true"* that is knowing the "truth" about himself. Reports on George's "official" record represented him as a problem to the system, non-compliant and resistant to following exercise and mobilising instructions illustrating how the record is designed to serve the system not the patient. The record was a rigid standardised, objectified and biomedicalised document imposing practices that delimit written nursing knowledge. What and how nurses documented was ruled by the authorised and legitimised biomedical knowledge embedded in the language, design and structure of the record that left no space for nursing knowledge and expertise that recognised the value of paying attention to the nuances of voice and experiences (Pearce 2011). Further these practices were reinforced by objective biomedically focused care practices that were highly valued and reinforced by authorised and legitimised published research outcomes. Such

research initiatives prioritised systematic standardised routine assessment of physical function, observation for surgical complications, pain control and ensuring the patient was mobilised each day to optimise physical capacity and maintain independence (Kalisch, Lee & Dabney 2014; Resnick et al. 2012; Siu et al. 2006).

These publications illustrated how the discourses work via managerialist practices as generated by Throughput and ABF models as material, complex interplays of naturalised, self-evident; seemingly indispensable technocratised and bureaucratised practices for governing care, the patient and those who care for them. Objective care practices were made measurable via standardised daily routines necessitating nurse/patient interactions focused on achieving incremental increases in patient mobility, inherently to keep functional decline at bay. As George's story revealed however, these were unstable discursive practices. Despite care providers ongoing encouragement to self-regulate and discipline his body George did not achieve the desired goal of a minimal hospital length of stay. No matter how coercive, *what ought to be done when*, care practices guided by the CPW did not allow for external conditions of possibility: the unexpected events of George's experiences of knee pain. A saga exacerbated by the interplay of George's subjugated knowledge in tension with care provider expert knowledge, the rigidity of hospital policies and procedures, losing the Cortisone injection and miscommunication. An abundance of discursive practices that prolonged his hospital stay undermining ABF rationalised practices of commodification. The failure with George did not make "beds" available on time as revenue generating goods, where economically effectiveness was contingent on the right number of empty beds for the right number of incoming surgeries as per LEAN principles.

Analysis showed how George, defined and disciplined by care technologies and practices, was represented and positioned as a problem for the staff and to the system. A focus on discursive events of George's experiences of pain when being mobilised or self-mobilised revealed the power/knowledge effects of functional decline discourse as the invisible flip side of the mobility/immobility binary on the CPW. A tale that explicates how it is George zigzagged to discharge. The discursive events of George's hospitalisation contrast with patient participant Bill who moved on and moved out of hospital within five days, on track with the fractured hip CPW. Although Bill was a few years older than George he had a

similar level of fitness as George. Both were considered medically stable when admitted for surgical repair of fractured hip due to a fall.

The paradox of the ideal: The tale of Bill

> When people see things as beautiful
> ugliness is created.
> When people see things as good
> evil is created. (Laozi)

Laozi poignantly yet starkly depicts what happens when representations are figured as positive/negative binaries. In juxtaposing the discursive events of George and Bill there was danger of creating objectifying binaries of acquiescent/resistant or compliant/ornery which some may see as good/bad. As with George, Bill was constituted as a patient, a fractured self, delimited by characteristics of interest to the hospital system. Bill's tale was about governing patients as free individuals "from afar" as he was mobilised via the CPW with the discourse of functional decline operating in the background. As Biebricher (2011, p. 471) explains

> Individuals [are] governed without either resorting to open violence and coercion or to the close surveillance and micromanagement of a police state while still maintaining control over them.

Although some would argue being in hospital is close to the level of police surveillance, not quite in Bill's case as he was a highly motivated patient who unconditionally surrendered to care practices needing minimal cueing or encouragement to mobilise.

Bill, in his mid-eighties, came into hospital self-disciplined saying 'I was very active as I walk several kilometres a day as well as do 40 minutes on a stationary bicycle each day' (Field Notes #7, p. 7). He lived in a condominium with his wife who was partially blind. He often talked about his need to get home to care for her as she was physically active but he needed to ensure the home and everyday life ran smoothly. His two sons, partners and grandchildren visited each day offering to help ensure his wife was cared for and the house would be ready for his return. Bill presented as a rational health-promoting self, reflective of contemporary society's enterprise of body work and self-improvement (Petersen & Bunton 1997). He presented as confident but not arrogant as he told me 'I am not afraid of challenges and hard work as I took up a broad scope of responsibility' defined by his

accomplishments of 'reading all the engineering handbooks in preparing to be a supervisor of all the trades'. He was always polite and respectful with staff acquiescing to staff instructions yet willing to ask questions for clarity.

Bill, was fortunate to have relevant and reliable family support with access to necessary resources that could facilitate a timely discharge. His situation advantaged the hospital system as he had personal goods and services of home and family resources of no cost to the hospital thus providing the health care system with significant cost savings.

First day post-operatively Bill told me about his mobilising: 'I think better than yesterday [day of surgery], although still difficult; you just have to get on with it' (Field Notes #7, p. 7). His use of the pronoun "I" indicated a technology of responsibilisation for self-care, owning his situation. The pronoun "you" implied the listener was in agreement indicating "to get on with it" was common practice, hegemonic, unquestioned, assumed just how it is. The next day his response to how are you was 'terrible' and came with a grimace and reference to the PT as 'torturer' quickly followed by a smile (Field Notes #7, p. 6). His difficulty was not captured by the CPW because pain and struggle with mobilising were expected. On the PPR was a note to remind him to call the nurse when needing to void or if pain increased with a comment 'mobilising better today (five steps and pivot) with no issues'. One nurse commented on how he was doing well on track each day (Field Notes #7, p. 10), representing him as a compliant normalised patient and positioned where he should be on the CPW.

By the morning of his 3rd post-operative day Bill said he thinks he will be ready for discharge by Monday his 5th post-operative day, although also saying 'no one has talked about discharge planning with me' (Field Notes #7, p. 10). Albeit just before noon Nurse Simon told me

> The family has expressed worry about his ability to cope at home so we are waiting until Monday for possible discharge as there is no way in the meantime to organise and book assistance or extra help at home. I'm *not* worried about his mobility or ability to manage, especially as the family says there are no stairs and they have a walk-in bath. So based on that I don't think he needs much extra assistance (Field Notes #7, p. 10).

Simon positioned himself as knowledgeable manager of goods and services and subjugated Bill's common self-knowledge, his worry about his ability to cope by saying 'I'm

not worried about his mobility or ability to manage'. Simon had already made decisions about next steps based not on Bill's views but on his professional assessment of Bill's situation and capacities. At this point Simon invited me along as he went to Bill's room. He greeted Bill casually saying 'Hey Bill want a bit of a walk before lunch?' Bill cheerfully keenly replied 'yes, will be good to loosen up and get up and around'. He immediately efficiently got himself from lying in bed to standing at his walker with no cueing. Nurse and patient appeared to engage like old friends representing themselves as in a trusting established relationship, going out for a stroll. Neither their talk of next steps nor Bill's anxieties as expressed to me appear documented. The PPR records 'mobilising better today' with CPW tick boxes duly ticked representing Bill as clearly "on track", a situation that would make a Throughput model proud.

Bill represented himself as self-governing with little need for services. I rarely saw a nurse in his room when he moved from bed to chair and back on his own. He was enacting the technology of responsibilisation via an ethic of self-care expressed as 'I know the more I do the better it is so I will get up anytime despite it stretches my [affected] leg'. Today Bill managed to walk with a walker about 30 feet at a good clip, no hesitations or signs of pain, except perhaps a grimace at times (Field Notes #7, p. 11). Bill's determination and work to "get better" also implied the avoidance of the unspoken side of mobility, immobility as code for functional decline. Patients like Bill exemplify the possibility 'to govern without governing *society,* to govern through the "responsibilized" and "educated" anxieties and aspirations of individuals and their families' (Rose 1999, p. 88).

However, later that day his disposition changed. He represented as someone stressed despite maintaining a disciplined self-governing/responsible image when he confided to me:

> I'm feeling a bit stressed in that it takes effort and hurts a bit but I have to do this, keep moving if I want to get home and I want to go home as soon as possible. It's good to know my family is there to help me and my son is off for five days now so he can keep in touch with my wife. My grandson is driving our car and he will take her grocery shopping and wherever she needs to go. She drives short distances, a mile or so, but not now as her eyesight is troubling her and she is under care for that (Field Notes #7, p. 11).

Later I caught up with Simon at the desk. He was positioned as expert objective knower saying: 'he will go home tomorrow as he can get in and out of bed himself and if his

wife is at home and can help him then he is good to go' (Field Notes #7, p. 11). However, Simon inserted discourses of safety and risk saying there is a short term community service available to do a home safety check by a community nurse just to be sure [Field Notes #7, p. 13]. Simon's assessment reflected the discourse of commodification of health care, a discourse of devolution of services to the community, home and family contingent on what is available and the volunteer services of family (Armstrong et al. 2000, p. 42). However, there were biomedical facts, clearly deciding factors. Simon explained how Bill's haemoglobin was low and that the physician had ordered two units packed red blood cells. He explained if that went through without any negative side effects by the next day it was in Bill's favour for discharge (Field Notes #7, p. 12).

On post-operative day 4, Bill with his wife next to him, explained how he was about '99% ready to go home', just waiting for his son the plumber to put in grab bars and a shower wand in the walk in shower' (Field Notes #7, p. 12); no mention of previous anxieties of coping and caring for his wife. I went back to Nurse Simon who explained they just received notice of a new admit with MRSA (an antibiotic resistant infection requiring infection control protocol in a private room) and the only private room available was Bill's. Such room decisions were based on the political economy of a hierarchised ordering. According to the hospital "Infection prevention and control manual" a private room was a critical priority based on national and international best practices. The manual stated uncontrolled infections come with high costs, such as requiring specialised equipment and environmental controls with consequent inconvenience and extra time for healthcare workers. Simon explained if necessary Bill could be positioned as "ready for discharge" today (day 4).

> The patient's haemoglobin is now good and we need his room. Technically we have a doctor's order per the clinical order set for discharge. So if nothing outstanding for this patient he could be discharged today. If all works out on our end including the physiotherapist report we will *give him a choice* of either moving back to a multi-bed ward or if his family is prepared for his discharge then he can go home today. If home today, we will organise a home safety check by the community nurse just to be sure (Field Notes #7, p. 13).

Simon talked with knowledge of how things work without questioning the effects of the choice he provided Bill as embedded with discourses of risk and safety. When the family learned discharge today was contingent on their readiness for him to come home with the alternative to move back to a multi-bed ward, they decided on discharge. They were ready

by 1530, Bill's 4th post-operative day. Upon discharge, his chart detailed his patient status as wound looked clean and well-approximated, a positive physiotherapist report (implying no lurking of signs functional decline) and no further concerns *at this time*.

Bill's discharge was a case of bed management to ensure the right patient in the right bed, meeting the targets of the Throughput and ABF models. The bed was a commodity needed for hospital services and Bill an entity that needed to be relocated so the bed was in the right place for the right person. Beds were a complex entity, a commodity of invaluable worth organised ultimately according to illness or procedure and categorised to align with respective care providers' expertise for best practices (Allen 2015). As the unit administrator explained previously, surgeries were monies to the hospital and if the unit was full and no discharges than surgeries were cancelled, 'I mean it would be the worst thing in the world if I had to cancel a surgery' (074444: 7:20-7:30). Although Bill's story reads as a success especially with his "early discharge" to accommodate the system, the violence of the ABF discourse, right bed/right patient, coerced Bill into a position of responsibilisation, having to decide between the multi-bed ward or taking a chance all really was ready at home on short notice.

Of interest was how patients like Bill and of course Mabel who in the previous chapter also had a minimum hospital stay, set the bar high for all other patients. They personified the norm, affirming that the norm was achievable which by default implied others like George or Gladys who were not motivated and/or were uncooperative were deviant, potentially an unnecessary health care system cost.

Conclusions

> Formulas…for all aspects of health care, are based on the assumption of a standard patient, standard provider and a single right way to provide care…. [However] very little is standard in practice. (Armstrong et al. 2000, p. 146)

This chapter set out to reveal how the hospital system operated primarily via Throughput and ABF models inured by functional decline discourse. The operation of these models in the minutiae of everyday care was reliant on standardised managerialist practices enacted primarily via the CPW and care practices predominantly focused on mobility/immobility. However, despite the apparent stability of standardised practices, George's discursive events illuminated how well planned systems can go awry and

functional decline was not necessarily mitigated by rote mobilisation techniques. Bill's events illustrated how personalised care needs were elided by organisational demands managed and made possible by standardised practices. Analysis exposed how such practices were contingent, 'always limited by the conceptual and practical tools for the regulation of conduct that are available' (Rose 1999, p. 22). Further, hospital systems were shown to be constrained by the uncertainty of conditions of possibility, whether or not practices or tools were taken up, resisted or ignored by nurses and/or patients; whether community agencies' practices aligned with hospital practices.

Also illustrated was how technologies of responsibilisation involved practices of governmentality interwoven with practices of self-care and self-formation that led to political subjectification of both George and Bill but in different ways. The political subjectification of these participants took place in relation to governmental practices but did not reduce one to the other (Dean 1994, p. 158). They were instead a complex discursive interplay of subjectivities, models and practices contingent on time, place, situation and circumstance. Further, managerialist practices in constituting the subjectivities of George and Bill were shown to be hegemonic and naturalised as taken-for-granted unquestioned disciplinary techniques determining what is to be done by whom, how and when, that perpetuate 'a violence and coercion on…clients and workers….structural and personalizing in its effects' (Rudge 2011, p. 167).

The hospital was shown to run as an enterprise of customer service exemplifying the marketisation of health care, by way of being a for-profit operation using the ABF model to rationally calculate the most efficient economic way "to do" care; using governance models based on the tenets of biomedical science (Lown 2007) to get patients through the system. The Throughput model was a critical factor. Biomedical science was made visible in the language, design and structure of technologies such as the Pre-function report and the CPW that operated as managerialist practices to order and manage care via quotidian measurements of functional status. This commodification of care masqueraded as observations and measurable assessments of functional status primarily (in this patient group) as levels of mobility. Hence mobility/immobility was implicitly equated with practices for mitigating/preventing likelihood of older adults' functional decline. Clinical governance enabled these social calculations of care by monitoring and determining what was to be

achieved when, how/by whom and how "to be" as care provider for political economic purposes (Chauvière & Mick 2011; Doolin 2002). Hence the Throughput and ABF models as neoliberal driven economic practices provided means to do more for less in health care (Shannon & French 2005), to "spend smarter and spend less" maximising efficiencies in the conduct of care (Armstrong et al. 2000; Austin 2011), reflecting LEAN principles. The power/knowledge effect was 'achievement of acceptable patient outcomes within an effective time frame' (Kowal & Delaney 1996, p. 156) as macro to micro discursive practices inured by functional decline discourse became so dominant and pervasive as to be naturalised and legitimised as just how governance of care was done (Fairclough 1992).

Chapter 7: Concluding the thesis

Like a bird on a wire (Leonard Cohen, 1934-2016)

A primary approach to analysis in this thesis was to position myself like a bird on a wire, to "see" from multiple viewpoints what the "doing" of functional decline discourse does. To provide knowledge and understanding of functional decline *as a discourse*, how it operated as social practices of knowledge production in health care was central to the thesis. Functional decline as a discourse needed to be seen and contrasted with how functional decline continues to be pervasively defined, studied and practised in health care as a concept and an object, calculable and measurable by ordinal values. Thus what was unusual or different here was the use of discursive ethnography with Foucauldian tools of genealogy and archaeology to render visible the power/knowledge of a discourse. This was an analytic approach of critique used to question and problematise how it was that functional decline, and not some other discourse, came to dominate in geriatrics and the care of hospitalised older adults. How as discourse functional decline constituted and delimited time, space, social realities and subjectivities and operated throughout the hospital system via organisational models and managerial practices enacted through care technologies and tools that guided and ordered how nurses provided care was specifically analysed. Analysis generated insights and new knowledge of how nurses talked about and performed care practices including how they organised, normalised and documented their provision of care. Of particular interest was how functional decline discourse produced knowledge that controlled and delimited what is to be known or excluded from the known about hospitalised older adults and their care, notably how it constituted the hospitalised older adult as a problem and in effect influenced how nurses provided care.

My aim in undertaking this research was not to provide solutions to the problem of hospitalised older adults' functional decline as defined in geriatrics or to make judgements about what worked or not to address the problem. My purpose was to analyse and critique constitutive effects of the "doing" of the discourse of functional decline; to point out assumptions and taken-for-granted notions embedded in research initiatives, hospital system's models, managerial practices, care tools and nursing practices. The thesis has therefore been framed by my research question: In what ways is nursing care provided to

hospitalised older adults mediated by discourses on functional decline and how are these processes reflected in nurse/patient interactions. Thus I now share my reflections on the thesis accomplishments, new knowledge produced and implications for nurses, for health care policy, administrative practices and nursing education in relation to future possibilities for hospitalised older adults' care.

Thesis knowledge contributions

Crafting research strategies to render visible for analysis the discourse of functional decline was foundational to generating new knowledge concerning hospitalised older adults and their care. Hence I designed the study as a discursive ethnography using Foucauldian tools. This approach produced knowledge of how functional decline as a discourse is not benign in its influence on the construction and enactment of care practices for the hospitalised older adult. Functional decline discourse was shown to pervade and dominate the field of geriatrics, the research literature and hospital systems right through to nurses' everyday care practices. Functional decline as a concept was shown to have simultaneously reified the older adult as an object of study, which in many ways has become a metonym for the older adult in their engagements with hospitalised care.

The following sections outline three key knowledge contributions, recognising while doing so that they are not in separate domains but interrelated, each informing the other. First and foundational to the study was insight and understanding gained about how functional decline was produced and operated as a discourse. Using this knowledge then led to understanding of how functional decline discourse operated as a biomedicalised discourse, standardising care that normalised practices with depersonalising and dehumanising effects. This understanding enabled generating knowledge of how the older adult was represented as a fractured self, delimited as an object constituted by measurable socio-biophysical characteristics, with profound effects on their experiences of hospitalisation and how nurses provided care. Third is knowledge that pertains to how such understanding of functional decline discourse enabled making explicit how *as a discourse* it tacitly permeated hospital systems. In this domain is knowledge of how functional decline discourse was instrumental to Throughput and ABF models (framed as models of care)

enacted as managerial practices via care technologies serving to guide, order and delimit nurses' provision of care.

Older adults as a health care system problem

First and foundational to the study was insight gained about how functional decline was produced and operated as a discourse, and the consequent knowledge gained of how functional decline when focussed upon as a targeted object of study came to problematise the older adult as a problem for the health care system. In contrast to previous depictions of the system as a problem for the older adult. A critical analytical insight here was the importance, prior to the dominance of functional decline discourse, of the notion of iatrogenesis which framed *any* patient as potentially in trouble *due to hospital system failures*: a concept that problematised the hospital. By the early 1990s functional decline had become established as a profound marker of hospitalised older adults' morbidity and mortality, that was then framed as highly likely to be exacerbated or precipitated by iatrogenic causes. What this thesis makes clear is how subsequently the discourse of iatrogenesis was effectively replaced by the discourse of functional decline, which then became established as organising the thinking about and the naming of the hospitalised older adult as a problem. This shift, propelled by mounting statistics indicating the majority of hospital patients were older adults, consequently led to categorising and labelling them as a population in the greatest danger of decline in functional status. Knowing this enabled seeing the depth and complexity of how older adults were not only pervasively perceived as taking up inordinate amounts of health care dollars but *assumed* to be "the culprit" in taking up disproportionate amounts of health care resources. Analysis explicated how these perceptions allowed the assessment and prediction of functional decline as a measurable entity to become a key strategy for health authorities, to order and manage hospitalised older adults as a measurable and hence controllable population categorised as a socio-economic problem. The analysis then exposing how functional decline discourse was enabled by disciplinary effects of economic rationalism in connection with statistical evidence and knowledge produced by discourses of risk and safety, reinforced by the politics of a neo-liberal health care environment.

The analysis also revealed how this complex ensemble of factors effaced consideration of the older adult as a unique sentient person. How this ensemble, as

interconnected factors set in fields of relations including published studies and the hospital site, had dehumanising and depersonalising effects that elided existential experiences of functional decline; the suffering, fear, anxiety, ambiguity, uncertainty and angst it can bring as expressed by patients in this study. These insights led to examining how functional decline as a discourse is inherently ageist.

Functional decline discourse: depersonalising/dehumanising practices

This study showed *how* the categorising and homogenising effects of functional decline discourse are ageist, a point that is rarely if ever considered in functional decline studies. As a discourse, it was revealed to frame *all* older adults indiscriminately as a *real or potential* health care system problem. It discriminated against the older adult as a stereotype, imaged as belonging to a population of inevitably declining, dependent and needy individuals. Care technologies structured by functional decline discourse were prejudiced by delimiting the sorting and categorising of older adults labelled "frail" to assessments using ordinals and aggregated test scores. These were depersonalising processes dooming the "frail" older adult to being targeted as a problem. Worse, as illustrated in chapter four, many of these assessments were exposed as problematic, erring in validity and/or reliability, measuring the "wrong" thing and creating too many outliers through assessor error or by scores that either missed the "right" older adult or targeted "the wrong" older adult for ordering, managing and controlling.

How functional decline discourse in care technologies operates to get the patient through the hospital system, to minimise length of stay, and then to save care dollars has been exposed here as a form of ageism not previously spoken of in literature or clinical settings. Analysis showed how in such standardised care technologies developed for managing health care dollars in a death denying society, death was elided. Nowhere in the script of care technologies or tools was death or dying mentioned despite the term functional decline implying the not so distant possibilities of death. I refer to this as "backwards" ageism, refusing to admit, consider, talk about, embrace or even look forward to death as the end point of functional decline.

Knowledge generated by this thesis makes clear how functional decline discourse that pervades geriatrics is about preventing or mitigating decline always with undertones of

saving dollars. It also illuminates how functional decline as a discourse, developed to assess and predict socio-biophysical deterioration, by default implies death. Death lurked below the surface of the CPW and other hospital care tools. It was symbolised as the negative side of binaries such as mobility/immobility and met/unmet. This lack of sensitivity to or out and out denial of death reflects how as a society most people are reluctant to openly acknowledge, accept or allow for never mind think about the finiteness of life as they grow into old age (Baars 2016). Although, patient participants shared thoughts about death and possibilities of death with me, it was a rare topic in conversations with nurses. This aspect of functional decline in relation to death triggered insights about how hospitalisation for older adults can be liminal, an initiation into elderliness and facing imminent possibilities of death which could well be a topic for further study.

Another important insight that demonstrated undertones of ageism was how technologies like the CPW and Pre-admission function report mis/represented older adults via stereotyping. Analysis revealed how cohorts of hospitalised older adults studied in the 1980s and 1990s differ from contemporary generations of older adults. An observation prompted by current sociology, psychology, philosophy and critical gerontology writings on the pursuit of agelessness, the "anti-ageing enterprise" and the increasing array of lifestyle choices for example that manifest in myriad ways from denying ageing to halting and reversing ageing (Vincent, Tulle & Bond 2008). This knowledge and understanding provoked questioning of the relevancy and effectiveness of contemporary care technologies like the CPW and Pre-admission function report, especially as they appear to be minimally different in structure, language and design from those of the 1990s. In this study, for example, Evelyn, George, Bill and Mabel in different yet comparable ways demonstrated resistance to ageing, being old and losing their sense of independence. Their determination was expressed by their self-governing of their rehabilitation journey with attitudes ranging from fierce independence and relentless self-discipline to just wanting to "get back to normal". Care technologies and documentation practices did not really fit for them because such tools and practices are standardised and normalised according to what are now clearly outdated age-related understandings. Care for older adults could be enriched by knowing and understanding contemporary ideas of health and wellbeing in old age alongside changing insights on death and dying as expressed and enacted by older adults themselves.

How functional decline discourse mediates nurses' provision of care

The power and the "doing" of functional decline as a dominant and pervasive discourse is rarely if ever located or recognised as embedded in the hospital systems. Analysis here revealed how it operates via the Throughput and ABF models, manifest as managerial practices that materialise through the guiding and ordering of care by technologies like the CPW, that set out daily care requirements. Of particular importance was the exposure of how this ensemble of discursive interconnections has consequent power to mediate nurses' provision of care, to delimit and monitor what, how and when this was to be provided while also eliding other practices such as relational or person-centered care, as described or alluded to by the nurses. This kind of knowledge about the discursive power/knowledge of functional decline discourse was not readily visible, nor written about in nursing literature or spoken about in the clinical setting. The power of discourse is in its invisibility, "inaccessibility" to questioning or troubling.

This thesis exposes the incommensurability of nursing as caring, person-centered relational practice and the hospital when run as an enterprise of goods and services, an economic rationalist business model. Despite how nurse participants expressed desire to provide person-centered care, they were at a loss to clearly articulate that kind of practice. They were not adept at articulating what constrained their practice much beyond listing too many required routine biomedical tasks to be accomplished and documented by shift end. They despaired at not knowing how to change "the system" yet at a loss or reluctant to go up against "management" who were perceived as seeing the world differently from them. This thesis therefore explicates how nurses' laments were intimately interrelated with how functional decline discourses mediated their care practices from afar – how nurses' care is governed from upstream. Nurses were governed by research initiatives responding to demands by health authorities and administrators to develop tools to efficiently, effectively and objectively order, manage and control hospitalised older adults and their care. Thesis findings showed how demands were met by researchers developing care tools located centrally in the functional decline discourse. These tools such as the CPW were shown to marshal nurses' ways of providing care and to focus on mobilising the patient as if on a production line. In turn, nurses rarely questioned how the CPW guided their practice as *standardised* care strategies. They did not appear aware of how they should do this or why

they assumed such tools are reasonable and technically proven as providing for effective trajectories of recovery. Nor how such trajectories have normalised their practices based on ADL technology that drives care by the mantra of "mobilise the patient". I argue these discursive formations of care practices underlie an unwitting depersonalisation of care that some of the nurses struggled to offset.

What this thesis makes obvious is the lack of conversation between researchers and subjects. Notwithstanding the fact that they are real people, researchers are typically abstracted as faceless legitimised scientists and their subjects effaced as ordinal values. This points to how such research erases the fact discourse is made by people but is I would argue in the case of functional decline, a discourse *not* about or for people. Especially as shown here, researchers did not at any time or in any way discernible within the literature, acknowledge the significance and meaning of functional decline and the tools produced for those most intimately involved, patients and nurses. Such researchers could not because they almost exclusively used quantitative research methods to develop such tools structured by practices of objectivity, calculability, normativity and measurability. The thesis demonstrates how such research modalities consistently produce care technologies with dehumanising and depersonalising effects. If nurses wish to mitigate the incommensurable nature of their practice with organisational demands to use such tools, they need to understand how the interconnectivities of technology and people are *effected* at all levels of the organisation, not just in the immediacy of nurse/patient care occasions incorporating CPW requirements.

Thoughts on doing the research and being a researcher

What this thesis accomplished by crafting a methodology and methods of discursive ethnography was to generate knowledge about how to render discourse visible and to expose the power and violence of such discourse. As stated, if discourse is unseen/unheard it cannot be questioned or troubled. I suggest that the value of the research practices outlined here is not only about the kind of knowledges generated but also that such knowledge is amenable for application and use elsewhere. How I crafted, organised and outlined methodology and methods can be translated, for example into a framework to make accessible to those interested, ways to render visible any discourse across written,

read, spoken and performed texts. I have also provided information and strategies to generate knowledge that enables "seeing" and understanding the dialectical nature of discourse in its production of knowledge.

Such frameworks could be appropriated to review and examine how current hospital policies and practices discursively operate and to what effect at a variety of levels and for different purposes. For example, how care practices are organised and ordered by the health authority's LEAN principles and to what effect; how such principles can appear contradictory to the hospital mission statement and strategic plan espousing patient-centred care. The framework could also be used to expose how seemingly benign policies and practices are held up as legitimised and authorised science, taken-for-granted as common knowledge and just how it is. The framework could organise ideas and strategies to challenge naturalised and inevitablised familiar and common sense knowledges operating as discourses in the mundane of everyday care practices. By providing knowledge and understanding of the power/knowledge of discourse, such frameworks could be purposed to guide reflective practices. For example, to facilitate how nurses think about, question and trouble *how* they talk about and enact what can be contradictory or misaligned and/or constrained care practices and how come. In addition, such frameworks could benefit nurses in their decision-making roles to address how to treat patients as people by examining the discursive effects of hospital models, policies and practices on patients and those who care for them.

Discursive ethnography as structured by this thesis enabled locating myself "in-between" the structures, patterns and products of discourses and people's experiences. Spheres of analysis I combined into a "thirdspace" to facilitate capturing the seemingly incompatible and incommensurate nature of written and bodily expressions, the in-betweens of this and that, here and there of the data archive. This kind of discursive ethnography allowed for immersion in the interstices of everyday material realities juxtaposed with the spaces of written and published texts to engage a fulsome critique. I argue this approach could prove valuable in nursing research for analysis and critique of complex situated issues involving hospitalised older adults in ways a quantitative approach could not accomplish.

From an educational standpoint, study outcomes illustrate that if nurses desire to perform "relational person-centred care" (as espoused by nurses in this study and promoted in contemporary nursing theories), it is necessary to learn, know and understand the power and violence of any discourse. Nurses whether educators, administrators, researchers or clinicians need to be able to recognise how a discourse constitutes that of which it "speaks" as articulated in this study. Without such knowledge and understanding, the dominance of biomedically framed discourse, such as functional decline will persist unremarked in the system: naturalised, unquestioned and unproblematised. Biomedical discourse will continue to "silently" rule everyday care practices hegemonically assumed as based "in the true" authorised and legitimised science; rarely questioned as being naturalised and normalised, just taken-for-granted as how care is to be done. Biomedical discourses as such mediate the "conduct of care" and as illustrated in this study delimit nurses and patients alike as political subjects amenable to self-responsibilisation, governable by "the system" operating as a business. This study offers nurses means to learn how to see such discourse in action and to make informed professional/clinical decisions about what it "does". This kind of learning needs to start in the early days of a nursing education program so that critique by way of questioning and problematising is socialised into how one thinks about, knows and *does* nursing. Questioning and troubling *how* health care practices, policies and procedures are presented and hospital systems organised can be enabled and fostered by having critical and radical pedagogies central to the nursing curriculum and reflective of a philosophy of *how to do* nursing education. It is for nurses to learn the art of questioning along with learning and building capacity to have a voice in decision-making and to take relevant action.

How this thesis approached examining discourse in relation to nurses' provision of care offers knowledge of how to learn about, to understand the interconnectivities of discourse, knowledge production and nursing practice. The thesis informs how discourse operates with knowledge production, meaning-making and effect dependent on where a discourse appears, how it appears and uttered by whom, contingencies creating possibilities for change. This study offers ways of creating such change as it illustrates how nurses are positioned in the material realities of hospital care to see, figure and enact care practices that embody older adults as unique fulsome persons, not objects delimited by

biomedicalised care technologies. Noting however that change is not necessarily about replacing biomedicalised care technologies, which have their value, but for nurses to learn how to critique them and to articulate how such technologies need to be understood discursively. They need to see such technologies as guiding their practice and clinical judgements not determinants of them. At the same time nurses need to be mindful of what the doing of technology does to the person. Hence, knowledge generated by the thesis can help nurses to learn how to take more deliberate charge of their conduct of care, to create space for their moral agency. This thesis is a call to nurses to think about, actively engage in and effect change such as taking charge of developing tools, policies and practices that are to the benefit of the older adult as a highly valued member of society.

This thesis provides a plethora of insights and analytic outcomes not as answers but as new knowledge. For example, how the biomedicalised discourse of functional decline that pervades geriatrics and mediates the nursing care of hospitalised older adults is essentially ageist. Thesis knowledge generated as such can serve to promote researchers to consider taking up discursive ethnography, as a methodology outlined here, to get up close to see the "doing" of any discourse. Discursive ethnography can conceivably provide counter discourses to the current discourses dominating in older adults' care. I suggest that the foundational knowledge provided by this thesis can fuel future studies centred on the needs and desires of hospitalised older adults as sentient persons not objects of care. These studies would actively include the voices of the older adults and the nurses who care for them. Discursive ethnography however not only generates knowledge but also generates questions. Here I leave with a particularly poignant and important question: What would nursing care of hospitalised older adults look like without ageist undertones?

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Appendices

Appendix A 1.1 Ethics Certificate

Jeannine Moreau

From:	Human Ethics <ro.humanethics@sydney.edu.au>
Sent:	November 21, 2012 7:14 PM
To:	Trudy Rudge
Cc:	Jeannine Moreau
Subject:	20121121 14769 Rudge Correspondence Noted
Attachments:	JMoreau ethics amend approval Nov'12.pdf

Dear Professor Rudge,

Title: Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care.
Protocol No: 14769

Thank you for your correspondence dated 15 November 2012 enclosing the modification approval letter from the Health Authority/University of Victoria and the modification submission documents (as attached).

The Executive Committee of the Human Research Ethics Committee at its meeting on **21 November 2012** has noted your correspondence.

Yours sincerely

Human Research Ethics Committee
The University of Sydney

1

Appendix A

THE UNIVERSITY OF SYDNEY

RESEARCH INTEGRITY
Human Research Ethics Committee
Web: http://sydney.edu.au/research_support/ethics/human/
Email: ro.humanethics@sydney.edu.au
Address for all correspondence:
Level 6, Jane Foss Russell Building - G02
The University of Sydney
NSW 2006 AUSTRALIA

MF/KR

20 April 2012

Professor Trudy Rudge
Sydney Nursing School
The University of Sydney
Email: trudy.rudge@sydney.edu.au

Dear Professor Rudge

Title: Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care [Protocol No. 14769]

PhD Student: Ms Jeannine Moreau

The Executive of the Human Research Ethics Committee (HREC) has reviewed your study to include the PhD student – Ms Jeannine Moreau and acknowledges your right to proceed under the authority of University of Victoria   Health Authority Joint Research Ethics Sub-Committee.

The Human Research Ethics Committee advises that you consult with The University of Sydney **Audit and Risk Management Office** (http://sydney.edu.au/audit_risk/) to ensure that University of Sydney staff/students and premises are adequately covered for the purpose of conducting this research project.

Any modifications to the study must be approved by University of Victoria/█████████Health Authority Joint Research Ethics Sub-Committee. A copy of the approved modification, approved progress report and any new approved documents must be provided to The University of Sydney HREC for our records.

Please do not hesitate to contact Research Integrity (Human Ethics) should you require further information or clarification.

Yours sincerely

██████████

Dr Margaret Faedo
Manager
Human Research Ethics Committee

cc   Ms Jeannine Moreau [Email: jmoreau@uvic.ca]

Appendix A1.2 Ethics Modification Approval – November 20xx

University of Victoria

Joint UVic/ [health authority]
Request for Amendment of an Approved Project

health authority

Instructions:
1. Download this application and complete it on your computer. Hand written applications will not be accepted
2. Submit one (1) original and one (1) copy of this completed, signed application with all attachments to:
   Joint UVic- [ ] Subcommittee

   Victoria, BC
3. If you need assistance, contact the UVic HRE Assistant at (250) 472-4545 or ethics@uvic.ca
4. Please note that incomplete applications cannot be processed and will be returned to the applicant.

Current Protocol Approval Number
Use the most recent Protocol No. for this project _____

Applicant Information

Principal Investigator	Jeannine Moreau		Department	Nursing at University of Sydney Australia
Phone	250-477-6529		Fax	250-721-6231
Email	jmoreau@uvic.ca			

Mail correspondence and approval to:	Department ☐	Home **X** *Complete the address section below.*

Mailing address	

Position	Faculty ☐	Staff ☐	Master's Student ☐	Undergraduate Student ☐
			Ph.D. Student **X**	Post-Doctoral ☐

Student Supervisor (if applicable)

Name	Dr. Trudy Rudge	Email	

Co-Investigator(s) – Identify those *collecting* **raw** data. (Name, position [eg., Graduate Student] and department)

1.		***Others*** (eg., Grad supervisor, committee)	
2.		1.	
3.		2.	
4.		3.	
5.		4.	

Title of Project

Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care

Updated April 4, 2011
Page **1** of **2**

Request for Amendment

X There will be changes to the protocol design or research materials – adding 2 field sites and a group of participants.
See attachment for details that includes list of the necessary forms to go with the changes ~ also attached

Attach details and rationale for the changes along with a brief synopsis of progress to date with an emphasis on any problems encountered during the conduct of the research. Submit this form with copies of any revised forms, tests, advertisements or questionnaires.

Signatures

Signature of Student Supervisors indicates that they undertake to respect and abide by the statements of protection of confidentiality of data and anonymity agreed to by subjects/participants in the Letter of Informed Consent. When Chair/Director is the Principal Investigator, signature of Dean is required.

Signature of Principal Investigator	Signature of Supervisor	Signature of Chair/Director/Dean
Date: JULY 29th	Date: July 28th	Date: Aug 13th

Signature of _____ Administrator
Date:

For UVic Ethics Use only:		New Approval Number:	
HREB Chair Signature	Approval Date:	Start Date:	End Date:

Jeannine Moreau ▬▬ **UVic Ethics approval #J2012-02 March 12th** ▬▬

Attachment to the ▬▬/UVic Request for Amendment of Approved Project #J2012-02

Project title: Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care

These are the two proposed amendments to this research project following meetings with staff and unit managers related to this project:

1. **Addition of field sites**: ▬▬ has requested that patient and nurse participants also be included in the study from her orthopedic surgery unit at ~ ▬▬. This will complement my already approved field site at ▬▬ acute rehabilitation. There is also the possibility that patient participants may go to the ▬▬ for rehabilitation and in the event that I may need to follow them there I need to include it as a field site.

2. **Addition of group of participants**: At the ▬▬ study field site ▬▬ and ▬▬ field site ▬▬ Occupational Therapists (OT) and Physiotherapists (PT) attended information sessions and requested to be participants in the study. My PhD committee agreed that they could contribute to the study in meaningful ways as these health care providers explained that they contribute to addressing issues of functional decline in hospitalized older adults and collaborate with the nursing team. I plan, as necessary, to also include OT and PT at the ▬▬ and have their Manager's and Coordinator's support for this.

Attached are:

1. Emails of support for the amendments from the ▬▬ orthopedic services manager and ▬▬ orthopedic services manager
2. The amended Appendices that accommodate the additional field sites and participants as outlined above. This is a list of the attached amended Appendices

Appendix B   Nurse Participant Poster Invitation to study - **revised**
Appendix C   Nurse Participant Invitation/Introduction to study - **revised**
Appendix D   Patient Participant Consent Form - **revised**
Appendix E   Nurse Participant Consent Form - **revised**
Appendix F   Patient Participant Profile and Schedule of Observation Sessions - **revised**
Appendix G   Nurse Participant Profile and Schedule of Observation Sessions - **revised**
Appendix I   Nurse Participant Interview Schedule - **revised**
Appendix K   Occupational Therapist and Physio Therapist Participant Interview Schedule - **new**
Verbal Consent Scripts – **revised**

Potential need for renewal of ethics application in 2013: Delay in data collection

A challenge encountered during my research project was my health and subsequent need for open heart surgery booked for August 2012. This means I had to postpone entering the field sites to collect data. I have suspended my PhD candidature until January 2013 for my own healing and rehabilitation. Therefore, the earliest I can enter the field sites to obtain consents and collect data is January 2013. This potentially means I will need to submit a request for renewal of my ethics approval, unless I can collect all necessary data by March 11th 2013 when my approval expires.

---

[1] Please see attached email from ▬▬ Manager Rehabilitation Services at ▬▬ and one from ▬▬ Manager, Orthopaedics, Subacute Rehabilitation, Surgical Relief Pool at ▬▬

Page **1** of **1**

This list indicates which appendices to the   /UVic Ethics Approval #J2012-02 need to be revised to accommodate the Approved Ethics Amendment submitted in July 2012

Appendix A   Patient Participant Invitation/Introduction to study- **not necessary to revise**

Appendix B   Nurse Participant Poster Invitation to study - **revised**

Appendix C   Nurse Participant Invitation/Introduction to study - **revised**

Appendix D   Patient Participant Consent Form - **revised**

Appendix E   Nurse Participant Consent Form - **revised**

Appendix F   Patient Participant Profile and Schedule of Observation Sessions - **revised**

Appendix G   Nurse Participant Profile and Schedule of Observation Sessions - **revised**

Appendix H   Patient Participant Interview Schedule – **not necessary to revise**

Appendix I   Nurse Participant Interview Schedule - **revised**

Appendix J   Contract for Transcription of Audio-recorded Interviews **not necessary to revise**

Appendix K   Occupational Therapist and Physio Therapist Participant Interview Schedule -**new**

Budget – **not necessary to revise**

Verbal Consent Scripts – **revised**

Page **1** of **1**   Researcher: Jeannine Moreau, RN, PhD (c)   Revised July 26th 2012

Appendix A2.1 Patient Invitation

Health Authority logo

INVITATION TO PARTICIPATE (PATIENTS)

You are invited to participate in a study: *Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care,* conducted by Jeannine Moreau. Ms. Moreau is a PhD candidate in the nursing program at University of Sydney, Australia and faculty member, University of Victoria (Nursing).

Ms. Moreau's PhD Supervisor is Dr. Trudy Rudge, RN, PhD, faculty member, University of Sydney (Nursing) and co-supervisors Dr. Andre Smith, PhD and Dr. Karen Kobayashi, PhD, faculty members at University of Victoria (Sociology).

This research project is in fulfillment of the University of Sydney Nursing School PhD thesis requirement.

What is the purpose of this study?

The purpose of the study is to gain understanding of patients' (who are older adults) and nurses' perspectives and experiences with patient care on an acute orthopaedic (bones or joints) surgery hospital unit and linked acute rehabilitation hospital unit (to prepare for discharge). Therefore, there will be over the course of your stay a series of short nurse/patient observations as nurses provide everyday care. Research shows that a common complication for hospitalized older adults following hip fracture is a decrease in their capacity to undertake personal care and mobility, a kind of diminishment usually coined *functional decline*. This study proposes to gain insights into how nurses and patients work together to foster/bring about progress back to independent care and activities. This is not about assessing nursing practice but about gaining deeper insight into dynamics of care. The purpose of the patient taking part in this research is to gain patients' perspectives to

further inform nursing practice of what works and does not work for patients in their healing and striving to regain their former independence. The intent is that knowledge gained can potentially offer insights that support hospitalized older adults in their healing and ability to accomplish more positive outcomes around activities of daily living.

Why is it important?

Research of this type is important as health professionals caring for people with surgical repair of hip fracture, are instrumental in working with these people in their process of healing and regaining previous capacities in activities of daily living. This study aims to examine the dynamics of hospital care, the process of healing and rehabiliation to be able to contribute to improving outcomes for people with hip fractures. It is anticiapted that findings gained through this study will provide insights to help inform nursing practice, policies and guidelines to support nurses in their practice and people in their healing so they can regain, as much as possible, their previous capacities in activities of daily living.

Who can participate?

People 75 years or older, admitted to the orthopaedic surgery unit for repair of hip fracture due to a fall, willing and able to communicate their ideas, and would like to share their experiences of healing and rehabilitation following surgery. You are under no obligation to participate in this study and may withdraw at any time without any explanation or any consequences.

How can I learn more about this study?

For more information or to learn how to participate, please call:

Jeannine Moreau, RN, PhD (c) **250-721-7959** or email jmoreau@uvic.ca.

Thank-you

Appendix A2.2 Patient Invitation

Health Authority logo

Research Study Title: *Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care.*

You are being invited to participate in a study entitled, *Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care,* that is being conducted by Jeannine Moreau, a PhD candidate in the nursing program at the University of Sydney Australia and faculty at University of Victoria (Nursing). Her PhD supervisor is Dr. Trudy Rudge, faculty at University of Sydney, Australia (Nursing)

Principle Investigator: Jeannine Moreau, RN, PhD candidate.

Ms. Moreau can be reached at 250-721-7959; jmoreau@uvic.ca

Who can participate?

You are being asked to participate because you are over 75 years of age and have been admitted to an orthopaedic surgical unit at the Regional Hospital or the City General Hospital for repair of a fractured hip due to a fall. The researcher is interested in seeing and hearing peoples' experiences of healing and rehabilitation following their hip surgery. You are under no obligation to participate in this study and you may withdraw at any time without any explanation or any consequences.

What is the purpose of this study?

The purpose of this study is to gain understanding, by observing health care provider/patient interactions, of the experiences of patients and nurses/occupational therapists/physio therapists on acute orthopaedic and acute rehabilitation hospital units. Specifically understanding how care is provided when patients are in the process of healing and engaged in daily activities following surgical repair of a hip fracture due to a fall. The

intent is twofold: 1) to gain an understanding of actual health care practice in relation to the perspectives and experiences of patients and health care providers concerning dynamics of care following hip surgery, and 2) to gain knowledge that can provide direction for interventions, education, and supports so older adults can maintain as much as possible their activities of daily living while hospitalized.

Why is it important?

Research of this type is important because older adults with the repair of hip fracture are vulnerable to losing their previous physical capacities for day to day activities such as mobility (e.g., transferring from bed to chair) and personal care. These kinds of loss or decline in capacity often result in further impairment and increased dependence. This study aims to examine the dynamics of health care practice in relation to health care providers and patients' perspectives on processes of healing and rehabiliation to be able to contribute to improving outcomes for people with hip fractures. It is anticiapted that findings from this study will provide insights that can offer new knowledge to inform policies, education, and interventions that support best outcomes for people with hip fractures.

What do I have to do? In giving my consent I acknowledge the following:

1) If you agree to voluntarily participate in this research, your participation will include 5 to 15 minute observations once or twice per day and/or afternoon shift of interactions between you and your nurse or occupational therapist or physio therapist for that day. These observations will take place while you are on the acute orthopaedic unit and then again in the follow up rehabilitation unit.

2) In addition, there will be a 20-30 minute audio-recorded summative interview at the end of your hospital stay wherein you will be asked some questions about how health care was for you. For example questions may include: Can you tell me what health care was like for you? What went well? What was most difficult? What was most helpful? Any surprises?

3) Agree to give the researcher permission to access your hospital care records to see how recordings of care provided match with what the researcher observes in the patient/health care provider interactions. This may include review of information such as diagnosis, treatments, nursing observations of patient's status, and test or assessment outcomes to aid in monitoring the patient participant's illness in relation to functional decline, e.g., any indications of increasing frailty. All details are collected anonymously as each participant is given a code number.

4) If you are interested, you will be given a summary of the report that can be mailed to your home address.

5) Your participation in this research must be completely voluntary. You may withdraw at any time without any consequences or any explanation. If you do withdraw from the study you will be asked if you would like to have your data removed from the study. If you wish to remove your data all efforts will be made to respect this choice. However, if analysis of transcripts has begun this may not always be logistically possible. Nevertheless, every effort will be made to respect your wishes.

6) If for some reason during the study it is determined that you cannot give a yes or no verbal consent to participating in a health care provider/patient observation session (you will give a verbal consent prior to each health care provider/patient observation session) you have two options:

   a) You can indicate on this written consent that you will still remain in that part of the study despite temporarily not being able to give consent. Or,
   b) You can appoint a proxy (somebody authorized to act for another person) now to give verbal consent for you each time you are not able to give verbal consent yourself. That person will be apprised of the study and sign on this written consent that they are willing to be a proxy for you when you cannot give a yes or no verbal consent and indicate understand what the study is about.

Are there potential risks and benefits?

There are no known or anticipated risks to you by participating in this study. However, reflecting on emotionally sensitive experiences may evoke psychological discomfort or emotional distress. If this occurs, adequate time and support will be provided by the researcher who has skill as a health care professional to help you address your emotional or psychological concerns that may arise; or if necessary negotiate with you as to how you see best to address your distress including permission to notify your primary nurse for that day. Given the expertise of the researcher as a health care professional in nursing no untoward situations are anticipated.

The potential benefits of your participation in this study may include having time to reflect and discuss your experiences with a researcher who is educated in this field.

Is this confidential?

All efforts will be made to ensure your anonymity and the confidentiality of the data. Identifying information will not be released without your consent. Anonymity will be protected by removing all personal identifiers from field notes and transcripts. Numeric

codes will be used on all notes, audio recordings, and transcriptions. For the purposes of published reports, personal names will be replaced with fictional names. All field notes, digital recordings, and transcription data will be kept in a locked metal cabinet in the researcher's office. Any person hired for transcription purposes will sign a confidentiality agreement with the researchers. Confidentiality will be retained in any publication and presentation.

Field notes will be shredded and digital audio recordings will be erased after data analysis is complete. Transcribed data will be kept for purposes of secondary analyses for 7 years from the completion of the thesis in a secure facility in the Sydney Nursing School, the University of Sydney, Australia. Data may be shared for learning purposes, as this study is a PhD thesis requirement. It is anticipated that the results of this study will be shared with others in the following ways: published in scholastic journals, presented at academic and public forums. Additionally, research findings will be shared with research participants.

There is a remote possibility due to the relatively small sample size that you may in some instance be recognized despite the cautions outlined above. This possibility will be offset by weaving various pieces of each observation and interview into new narratives in the writing up of the data for publication and presentation purposes. Exact names of the location, hospitals and units where the research took place will also be fictionalised.

Who do I contact with questions or concerns?

You may contact Jeannine Moreau by calling 250-721-7959 or emailing jmoreau@uvic.ca. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting Dr. D. Michael Miller the Associate Vice-President, Research at the University of Victoria (250-721-7971), ethics@uvic.ca. Or you may contact the Health Authority Ethics Co-ordinator [name] at [phone #] or email address.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Participant Printed Name _____

Signature _____Date _____

For some reason during the study it may be determined or affirmed by your primary nurse that you cannot give a yes or no verbal consent to participating in a particular health care provider/patient observation session. For example, hospitalization and surgical interventions can be stressful and for some patients these stresses can lead to interim or temporary spells of confusion, usually referred to as delirium or it may be other circumstances such as unbearable pain at that particular time. In the event that it is determined by your primary nurse that you cannot provide your own consent, you have two options:

1) I hereby give consent to continue to participate in the study despite temporarily not being able to give a yes or no consent immediately prior to a nurse/patient observation session.

Signature _____Date _____

Or

2) I hereby appoint a Proxy of my choosing in the event I cannot give a yes or no consent to a nurse/patient observation session.

Proxy understands the nature of this study and the duties as proxy. The proxy may be contacted and may give consent by telephone.

Proxy Printed name _____

Signature _____

Date _____

Researcher Printed Name _____

Signature _____

Date _____

A COPY OF THIS SIGNED CONSENT WILL BE LEFT WITH YOU, AND A COPY WILL BE RETAINED BY THE RESEARCHER

PARTICIPATION IS VOLUNTARY AND NO PENALTY FOR WITHDRAWING AT ANY TIME

Individual confidentiality will be protected through the use of codes on all field notes, audio recordings, transcriptions, CD computer disks; all names and identifying information will be removed and substituted with fictional identifiers (i.e. ABC) where needed. For the purposes of published reports, personal names will be replaced with fictional names.

PARTICIPANT CODE NAME: _____

VERBAL CONSENT FOR SUMMATIVE INTERVIEW   YES   NO

DATE:_____ TIME:_____ PLACE:_____

Appendix A2.2 Patient Consent Form

Health Authority

Research Study Title: *Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care.*

You are being invited to participate in a study entitled, *Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care,* that is being conducted by Jeannine Moreau, a PhD candidate in the nursing program at the University of Sydney Australia and faculty at University of Victoria (Nursing). Her PhD supervisor is Dr. Trudy Rudge, faculty at University of Sydney, Australia (Nursing)

Principle Investigator: Jeannine Moreau, RN, PhD candidate.

Ms. Moreau can be reached at 250-721-7959; jmoreau@uvic.ca

Who can participate?

You are being asked to participate because you are over 75 years of age and have been admitted to an orthopaedic surgical unit at the Regional Hospital or the City General Hospital for repair of a fractured hip due to a fall. The researcher is interested in seeing and hearing peoples' experiences of healing and rehabilitation following their hip surgery. You are under no obligation to participate in this study and you may withdraw at any time without any explanation or any consequences.

What is the purpose of this study?

The purpose of this study is to gain understanding, by observing health care provider/patient interactions, of the experiences of patients and nurses/occupational therapists/physio therapists on acute orthopaedic and acute rehabilitation hospital units. Specifically understanding how care is provided when patients are in the process of healing and engaged in daily activities following surgical repair of a hip fracture due to a fall. The

intent is twofold: 1) to gain an understanding of actual health care practice in relation to the perspectives and experiences of patients and health care providers concerning dynamics of care following hip surgery, and 2) to gain knowledge that can provide direction for interventions, education, and supports so older adults can maintain as much as possible their activities of daily living while hospitalized.

Why is it important?

Research of this type is important because older adults with the repair of hip fracture are vulnerable to losing their previous physical capacities for day to day activities such as mobility (e.g., transferring from bed to chair) and personal care. These kinds of loss or decline in capacity often result in further impairment and increased dependence. This study aims to examine the dynamics of health care practice in relation to health care providers and patients' perspectives on processes of healing and rehabiliation to be able to contribute to improving outcomes for people with hip fractures. It is anticiapted that findings from this study will provide insights that can offer new knowledge to inform policies, education, and interventions that support best outcomes for people with hip fractures.

What do I have to do? In giving my consent I acknowledge the following:

1) If you agree to voluntarily participate in this research, your participation will include 5 to 15 minute observations once or twice per day and/or afternoon shift of interactions between you and your nurse or occupational therapist or physio therapist for that day. These observations will take place while you are on the acute orthopaedic unit and then again in the follow up rehabilitation unit.

2) In addition, there will be a 20-30 minute audio-recorded summative interview at the end of your hospital stay wherein you will be asked some questions about how health care was for you. For example questions may include: Can you tell me what health care was like for you? What went well? What was most difficult? What was most helpful? Any surprises?

3) Agree to give the researcher permission to access your hospital care records to see how recordings of care provided match with what the researcher observes in the patient/health care provider interactions. This may include review of information such as diagnosis, treatments, nursing observations of patient's status, and test or assessment outcomes to aid in monitoring the patient participant's illness in relation to functional decline, e.g., any indications of increasing frailty. All details are collected anonymously as each participant is given a code number.

4) If you are interested, you will be given a summary of the report that can be mailed to your home address.

5) Your participation in this research must be completely voluntary. You may withdraw at any time without any consequences or any explanation. If you do withdraw from the study you will be asked if you would like to have your data removed from the study. If you wish to remove your data all efforts will be made to respect this choice. However, if analysis of transcripts has begun this may not always be logistically possible. Nevertheless, every effort will be made to respect your wishes.

6) If for some reason during the study it is determined that you cannot give a yes or no verbal consent to participating in a health care provider/patient observation session (you will give a verbal consent prior to each health care provider/patient observation session) you have two options:

   a) You can indicate on this written consent that you will still remain in that part of the study despite temporarily not being able to give consent. Or,
   b) You can appoint a proxy (somebody authorized to act for another person) now to give verbal consent for you each time you are not able to give verbal consent yourself. That person will be apprised of the study and sign on this written consent that they are willing to be a proxy for you when you cannot give a yes or no verbal consent and indicate understand what the study is about.

Are there potential risks and benefits?

There are no known or anticipated risks to you by participating in this study. However, reflecting on emotionally sensitive experiences may evoke psychological discomfort or emotional distress. If this occurs, adequate time and support will be provided by the researcher who has skill as a health care professional to help you address your emotional or psychological concerns that may arise; or if necessary negotiate with you as to how you see best to address your distress including permission to notify your primary nurse for that day. Given the expertise of the researcher as a health care professional in nursing no untoward situations are anticipated.

The potential benefits of your participation in this study may include having time to reflect and discuss your experiences with a researcher who is educated in this field.

Is this confidential?

All efforts will be made to ensure your anonymity and the confidentiality of the data. Identifying information will not be released without your consent. Anonymity will be protected by removing all personal identifiers from field notes and transcripts. Numeric codes will be used on all notes, audio recordings, and transcriptions. For the purposes of published reports, personal names will be replaced with fictional names. All field notes,

digital recordings, and transcription data will be kept in a locked metal cabinet in the researcher's office. Any person hired for transcription purposes will sign a confidentiality agreement with the researchers. Confidentiality will be retained in any publication and presentation.

Field notes will be shredded and digital audio recordings will be erased after data analysis is complete. Transcribed data will be kept for purposes of secondary analyses for 7 years from the completion of the thesis in a secure facility in the Sydney Nursing School, the University of Sydney, Australia. Data may be shared for learning purposes, as this study is a PhD thesis requirement. It is anticipated that the results of this study will be shared with others in the following ways: published in scholastic journals, presented at academic and public forums. Additionally, research findings will be shared with research participants.

There is a remote possibility due to the relatively small sample size that you may in some instance be recognized despite the cautions outlined above. This possibility will be offset by weaving various pieces of each observation and interview into new narratives in the writing up of the data for publication and presentation purposes. Exact names of the location, hospitals and units where the research took place will also be fictionalised.

Who do I contact with questions or concerns?

You may contact Jeannine Moreau by calling 250-721-7959 or emailing jmoreau@uvic.ca. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting Dr. D. Michael Miller the Associate Vice-President, Research at the University of Victoria (250-721-7971), ethics@uvic.ca. Or you may contact the Health Authority Ethics Co-ordinator [name] at [phone #] or email address.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Participant Printed Name _____

Signature _____Date _____

For some reason during the study it may be determined or affirmed by your primary nurse that you cannot give a yes or no verbal consent to participating in a particular health care provider/patient observation session. For example, hospitalization and surgical interventions can be stressful and for some patients these stresses can lead to interim or temporary spells of confusion, usually referred to as delirium or it may be other circumstances such as unbearable pain at that particular time. In the event that it is determined by your primary nurse that you cannot provide your own consent, you have two options:

1) I hereby give consent to continue to participate in the study despite temporarily not being able to give a yes or no consent immediately prior to a nurse/patient observation session.

Signature _____Date _____

Or

2) I hereby appoint a Proxy of my choosing in the event I cannot give a yes or no consent to a nurse/patient observation session.

Proxy understands the nature of this study and the duties as proxy. The proxy may be contacted and may give consent by telephone.

Proxy Printed name _____

Signature _____

Date _____

Researcher Printed Name _____

Signature _____

Date _____

A COPY OF THIS SIGNED CONSENT WILL BE LEFT WITH YOU, AND A COPY WILL BE RETAINED BY THE RESEARCHER

RESEARCHER'S RECORD OF VERBAL CONSENT FOR HEALTH CARE PROVIDER/PATIENT OBSERVATIONS

SUPPLEMENT TO CONSENT FORM TO OBTAIN VERBAL CONSENT AT TIME OF EACH OBSERVATION AND SUMMATIVE INTERVIEW NOTING PARTICIPATION IS VOLUNTARY AND NO PENALTY FOR WITHDRAWING AT ANY TIME

Individual confidentiality will be protected through the use of codes on all field notes, audio recordings, transcriptions, CD computer disks; all names and identifying information will be removed and substituted with fictional identifiers (i.e. ABC) where needed. For the purposes of published reports, personal names will be replaced with fictional names.

PARTICIPANT CODE NAME: _____

VERBAL CONSENT FOR EACH OBSERVATION – DATE AND TIME

VERBAL CONSENT FOR SUMMATIVE INTERVIEW   YES   NO

DATE:_____ TIME:_____ PLACE:_____

Health Authority logo

A research study about the complexities of care of hospitalized older adults

You are invited to participate in a study entitled: *Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care.*

This study is conducted by Jeannine Moreau, a PhD candidate in the nursing program at University of Sydney Australia and a faculty member, University of Victoria (Nursing).

Ms. Moreau's PhD Supervisor is Dr. Trudy Rudge, RN, PhD, faculty member, University of Sydney (Nursing) and Associate Supervisors are Dr. André Smith, PhD and Dr. Karen Kobayashi, PhD, faculty members of the University of Victoria (Sociology). This research study is in fulfillment of the University of Sydney Nursing School PhD thesis requirement.

This study aims to examine dynamics of hospital care and processes of healing and rehabiliation for older adults who are admitted for surgical repair of fractured hip and subsequently transferred to an acute rehabilitation unit. The purpose of the study is to gain deeper understanding of what happens for older adults when hospitalized in direct relation to their capacities for activities of daily living (e.g., personal care, mobility) including their sense of independence.

Research of this type is important as health professionals caring for people with surgical repair of hip fracture are instrumental in working with these people in their process of

healing and regaining previous capacities in activities of daily living. The intent is to be able to contribute to improving outcomes for people with hip fractures.

There are information sessions offered to provide more details of the study and how you as a nurse caring for patients on this unit can become a participant. All Registered Nurses, Licensed Practical Nurses, Registered Care Aides, Occupational Therapists, and Physio Therapists are encouraged to participate.

Dates   Times   Places

Appendix A2.4 Nurse/OT/PT Participant Invitation/ Introduction to Study

Health Authority logo

You are invited to participate in a study entitled, *"Problematising the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care"* that is being conducted by Jeannine Moreau. Ms. Moreau is a PhD candidate in the nursing program at the University of Sydney Australia and faculty member, University of Victoria (Nursing).

Ms. Moreau's PhD Supervisor is Dr. Trudy Rudge, RN, PhD, faculty member, University of Sydney (Nursing) and co-supervisors Dr. Andre Smith, PhD and Dr. Karen Kobayashi, PhD, faculty members of the University of Victoria (Sociology).

This research study is in fulfillment of the University of Sydney Nursing School PhD thesis requirement.

What is the purpose of this study?

The purpose of the study is to gain understanding about the complexities of care of hospitalized older adults in direct relation to patients' activities of daily living (e.g., personal care, mobility). Research shows that a common complication of hospitalized older adults is a decline in their capacity to do activities of daily living, also coined as *functional decline*. The sites for this study are acute orthopaedic surgery unit*s* and linked rehabilitation unit*s* because research has found loss of ability in activities of daily living is a common complication following hip fractures; losses that often lead to further impairment, dependence, and other devastating consequences including mortality. The intent of this study is to better understand how health care practice takes place concerning this problem of patients' decline in capacity (*functional decline*) by observing health care provider/patient interactions. This is not about assessing health care practice but about gaining deeper

insight into dynamics of care to see how health care providers take up and interpret their ideas and experiences within everyday patient care. The study includes how patients respond to care and the effects on their capacities in activities of daily living. The aim is to learn about dynamics of health care as a means to offering insights about how care works well or not in addressing problems concerning hospitalized older adults' *functional declines*.

Why is it important?

Research of this type is important as health professionals caring for people with surgical repair of hip fracture, are instrumental in working with these people in their process of healing and regaining previous capacities in activities of daily living. This study aims to examine the dynamics of hospital care, the process of healing and rehabiliation to be able to contribute to improving outcomes for people with hip fractures. It is anticiapted that findings gained through this study will provide insights to help inform health care practice, policies and guidelines to support health care providers in their practice and people in their healing so they can regain, as much as possible, their previous capacities in activities of daily living.

Who can participate?

Nurses, Occupational Therapists, and Physio Therapists who work on the orthopaedic surgery unit or rehabilitation unit at the City General Hospital or the orthopaedic surgery unit or the rehabilitation unit at the Regional Hospital or the Activation Program and would like to share their experiences of caring for older adults following their hip fracture surgery or acute rehabilitation. You are under no obligation to participate in this study and may withdraw at any time without any explanation or any consequences.

How can I learn more about this study?

For more information or to learn how to participate, Please call Jeannine Moreau, RN, PhD (c) **250-721-7959** or email jmoreau@uvic.ca . **Thank-you**

Appendix A2.5 Nurse/OT/PT Participant Consent Form

THE UNIVERSITY OF SYDNEY   **Health Authority logo**   University of Victoria

Research Study Title: *Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care*

You are being invited to participate in a study titled, *Problematizing the concept of functional decline in hospitalized older adults: An ethnographic study of nursing care* that is being conducted by Jeannine Moreau, faculty at the University of Victoria, Nursing and in fulfillment of her PhD thesis requirement at University of Sydney Australia, Nursing School. Her Supervisor is Dr. Trudy Rudge, RN, PhD University of Sydney Nursing School.

Principle Investigator: Jeannine Moreau, RN, PhD candidate.

Ms Moreau can be reached at 250-721-7959; jmoreau@uvic.ca

Who can participate?

You are being asked to participate because you are a nurse (Registered Nurse, Licensed Practical Nurse or Registered Care Aide) or you are an Occupational Therapist or a Physio Therapist who works on the orthopaedic surgery or rehabilitation unit at City General Hospital or the orthopaedic surgery or rehabilitation unit at the Regional Hospital or the Activation Program, all of which are in the Health Authority, Canada. You are under no obligation to participate in this study and you may withdraw at any time without any explanation or any consequences.

What is the purpose of this study?

The purpose of this study is to gain understanding, by observing specific health care provider/patient interactions, of the experiences of patients, nurses, occupational therapists and physio therapists on acute orthopaedic surgery and rehabilitation units. Specifically

understanding how care is provided when patients are in the process of healing and engaged in activities of daily living following surgical repair of a hip fracture due to a fall. The intent is twofold: 1) to gain an understanding of actual health care practice in relation to the perspectives and experiences of patients and certain health care providers concerning dynamics of care following hip surgery, and 2) to gain knowledge that can provide direction for interventions, education, and supports, with a focus on nursing practice, so older adults can maintain as much as possible their activities of daily living while hospitalized.

Why is it important?

Research of this type is important as health professionals caring for people with surgical repair of hip fracture are instrumental in working with patients in their process of healing and regaining previous abilities in activities of daily living, such as personal care and mobility. Studies indicate that despite research and policy initiatives people do not always regain as much capacity for activities of daily living as anticipated or desired. This study aims to examine the dynamics of health care practice in relation to nurses, occupational therapists, physio therapists and patients' perspectives on processes of healing and rehabiliation to be able to contribute to improving outcomes for people with hip fractures. It is anticipated that findings from this study will provide insights that can offer new knowledge to inform policies, education, and interventions that support best outcomes for people with hip fractures.

What do I have to do? In giving my consent I acknowledge the following.

1) If you agree to voluntarily participate in this research, your participation will include 5 to 15 minute observations of interactions between you and your patient during everyday care approximately once or twice per shift. These participant observations will take place while you are on the acute orthopaedic surgery unit or the follow up rehabilitation unit.

2) In addition, there will be a 30-45 minute audio-recorded summative interview at the end of the study wherein you will be asked some questions about your experiences related to the observed health care provider/patient interactions. There will be open-ended questions that may include asking you about your practice, what resources you rely on, what you believe you are achieving in your care, what kind of relationship you have with the patient. The study is about describing health care practice in the context in which it takes place and not judging practice.

3) Be aware that the patient participant's hospital records will be accessed to see how recordings of care provided match with what is observed in the health care

provider/patient observations, e.g., information such as diagnosis, treatments, and test or assessment outcomes reviewed to aid in monitoring the patient's illness in relation to functional decline, for example, any indications of increasing frailty. Data will also be gathered as to how this information is recorded and organized in the chart and what particular systems of notation such as BID, OD, vitals, et cetera are used as another way to describe health care practices. All details are collected anonymously as each participant is given a code number.

4) If you are interested, you will be given a summary of the report sent to your mailing address.

5) Your participation in this research must be completely voluntary. You may withdraw at any time without any consequences or any explanation. If you do withdraw from the study you will be asked if you would like to have your data removed from the study. If you wish to remove your data all efforts will be made to respect this choice. However, if analysis of transcripts has commenced this may not always be logistically possible. Nevertheless, every effort will be made to respect your wishes.

Are there potential risks and benefits?

There are no known or anticipated risks to you by participating in this study. However, reflecting on your work as a health care provider may evoke psychological discomfort or emotional distress. If any emotional or psychological concerns arise the researcher will take time to discuss with you what options are available so together you can determine next steps. For example, encouraging you to identify who would be best to further discuss your issue with on the unit, such as the Clinical Nurse Educator, Clinical Nurse Leader, or your Manager. Another option to reduce/attend to psychological discomfort or emotional distress that may arise due to participation in this study is the Employee and Family Assistance Program (EFAP) that you are eligible to access as a Health Authority staff member as part of your employment in the Health Authority. The researcher will have cards on hand with information of how to access the EFAP.

The potential benefits of your participation in this study may include having time to reflect and discuss your experience with a researcher who is educated in this field.

Is this confidential?

All efforts will be made to ensure your anonymity and the confidentiality of the data. Identifying information will not be released without your consent. Anonymity will be protected by removing all personal identifiers from transcripts. Numeric codes will be used

on all audio recordings and transcriptions. For the purposes of published reports, personal names, units, hospital names and geographic locations will be replaced with fictional names. All field notes, digital recordings, and transcription data will be kept in a locked metal cabinet in the researcher's office. Any person hired for transcription purposes will sign a confidentiality agreement with the researchers. Confidentiality will be retained in any publication and presentation.

Field notes will be shredded and digital audio recordings will be erased after data analysis is complete. Transcribed data will be kept for legal purposes or for secondary analyses for 7 years after the completion of the research in a secure facility in the Sydney Nursing School, the University of Sydney, Australia. For instance, after agreement, data will be anonymised and taken out of context (details of circumstances and settings altered to maintain confidentiality) and may be shared for learning purposes in the UVic Grounded Theory Research group. It is anticipated that the results of this study will be shared with others in the following ways: published in scholarly journals, presented at academic and public forums. Additionally, research findings will be shared with research participants.

There is a remote possibility due to the small sample size that you may in some instance be recognized despite the cautions outlined above. This possibility will be offset by weaving various pieces of each narrative into new narratives in the writing up of the data for publication and presentation purposes. The exact location of the study will not be disclosed in any publication or presentation.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Who do I contact with questions or concerns?

You may contact Jeannine Moreau by calling 250-721-7959 or emailing jmoreau@uvic.ca. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting Dr. **D. Michael Miller** the Associate Vice-President, Research at the

University of Victoria (250-721-7971), ethics@uvic.ca. Or you may contact the Health Authority Ethics Co-ordinator [name] at [phone #] or email address.

Participant Printed Name

_____

Participant Signature _____   Date _____

Researcher Printed Name _____

Researcher Signature _____   Date _____

A COPY OF THIS SIGNED CONSENT WILL BE LEFT WITH YOU, AND A COPY WILL BE RETAINED BY THE RESEARCHER

PARTICIPATION IS VOLUNTARY AND NO PENALTY FOR WITHDRAWING AT ANY TIME

Individual confidentiality will be protected through the use of codes on all audio recordings, transcriptions, CD computer disks; all names and identifying information will be removed and substituted with fictional identifiers (i.e. ABC) where needed. For the purposes of published reports, personal names will be replaced with fictional names.

PARTICIPANT STATUS AND CODE NAME: _____

VERBAL CONSENT FOR SUMMATIVE INTERVIEW   YES   NO

DATE:_____ TIME:_____ PLACE:_____

Appendix B.1 Processes for locating and sourcing the literature

Locating and sourcing the literature as textual data was a critical piece of ethnographic discursive analytics in this thesis. Sourced literature are figured as cyberspace documents as most are accessed from "on-line" which as such became a part of the ethnography coined as a cyberspace field site. This collection of literature was sourced to provide data for analysing how functional decline as a discourse is produced and operates in published research then redistributed as technologies of care like the Clinical Pathway (CPW) in the ethnographic field. This approach to research enabled analysis of how research outcomes such as technologies of care operate in the hospital field site as discourses of care. Discursive analytics of this ensemble of textual data enabled explicating how science treats 'social facts as things…[with] the "mute solidity" of the modern individual [resulting in the] instrument-effects of power' (Dreyfus & Rabinow 1982, p. 143).

My initial review of literature in preparation for this study used several combinations of keywords: functional decline, old age, old, gerontology, older adults, hospitalisation, and nursing practice using search engines Web of Science (the sciences, nursing, medicine, social sciences, arts, and humanities), CINAHL (***Cumulative Index to Nursing and Allied Health Literature) and PubMed (***biomedical literature from MEDLINE, life science journals, and online books)***. Results provided a relevant scope of materials for locating the dominance and pervasiveness of functional decline discourse in relation to hospitalised older adults. This literature provided a rich source of data*** for understanding complexities in my field of interest ***and informed*** examination of the concept of functional decline as a discourse emerging in the early 1990s; how it was produced, operated and came to dominate in the field of geriatrics. This study is designed using discursive analytics of such written texts as a method to understand the effects of discourse as systems of knowledge (e.g., quantitative research studies, hospital policies and practices) in socio-political contexts. Further, these particular keywords were chosen in effort to find publications with potential to make discourse visible as they offered discursive formations of objects and strategies such as care technologies for hospitalised older adults. I could see how functional decline as a discourse intersects in language with other discourses to form truth claims concerning care of hospitalised older adults and how such truths mediate nursing practice.

I focus on functional decline in relation to older adults' hospital care using keywords 'functional decline', 'old', and 'hospital' on Web of Science. These keywords provided literature on how functional decline as a discourse of care is produced and operates and how it mediates hospital and nursing practices. Nursing practice is seen as art and science comprised of knowledges, ideas, experiences, ways of knowing, alongside skills and abilities from across several disciplines and fields of study in the realms of human health, suffering, and illness care (Risjord 2010; Rolfe 2005; Sherwood & Barnsteiner 2012). So, I read widely across published literature including humanities, social sciences, nursing, and medicine to gain greater depth and breadth on the topic of functional decline in the *context* of ideas, discussions, and research initiatives relative to ageing, growing old, being old and hospitalisation. I pursued reference and citation lists from readings and works concerning older adults, articles recommended by colleagues and peers, and what I came across at academic conference proceedings. I also drew from literature on older adults I use in my theory and clinical teaching practices. Besides these sources many of which are located in library databases I included various organisations' publications and on-line documents such as hospital mission statements and recent annual reports, national reports and government studies on *the* older adult population such as 'A portrait of seniors in Canada' (Turcotte et al. 2007) and 'Best of care getting it right for seniors'(Ombudsman 2012).

The graph (Fig. B1.1 below) was generated by three key words "functional decline", "old", and "hospital" starting in 1990, when functional decline appears in the context of all three keywords to 2016. It depicts numbers of publications naming functional decline in relation to older adults and hospital in contrast to providing details of what each publication is about. In reviewing publications from the graph I noted the majority came from gerontology, geriatrics, psychogeriatric, medicine, nursing, physiotherapy, occupational therapy and nutrition health. All referred to functional decline in terms of functional status and/or concepts of functional disability, geriatric conditions or syndromes, many on measuring, developing, assessing, testing out, and/or reviewing instrumental ways to predict, assess, manage, control, and/or mitigate one or more kinds of bio-physical and/or bio-social functional deterioration in relation to older adults as a population of interest. Although not inclusive or exhaustive of all possibilities this selection of literature illustrated how many publications in this database were available for examining emergence,

production, operation, and redistribution of functional decline discourse in the context of older adults and hospital care. Functional decline was typically defined by normativities, i.e., scientifically established levels of biophysical capacities constituted as necessary for independent living (Bruett & Overs 1969; Katz et al. 1963; Lawton & Brody 1988).
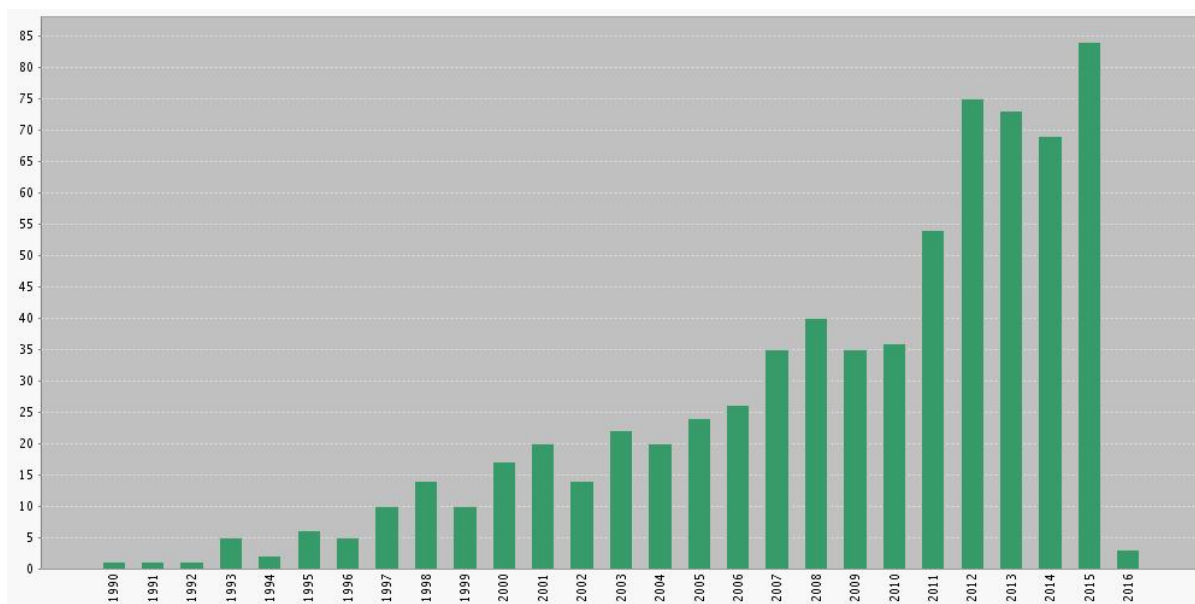

Figure B1.1 March 2nd 2016 Web of Science database search 1900 to 2016 using three key terms 'functional decline', 'old', 'hospital' showing the distribution of 702 *published* articles.

Figure B1.2 below is another Web of Science graph. It illustrates the number of citations from Figure B1.1 publications. These numbers also increased exponentially over time. Both graphs track use of the term functional decline and its ascendency with indication of how it became a dominant concept in the realm of hospitalised older adults' care. As I reviewed publications from both graphs I could see how functional decline as an abstract concept was becoming increasingly prevalent as a concrete measurable entity used in various tools or technologies of measurement/assessment to order, manage, and control older adults as a population represented by either their likelihood of or actual state of functional decline.
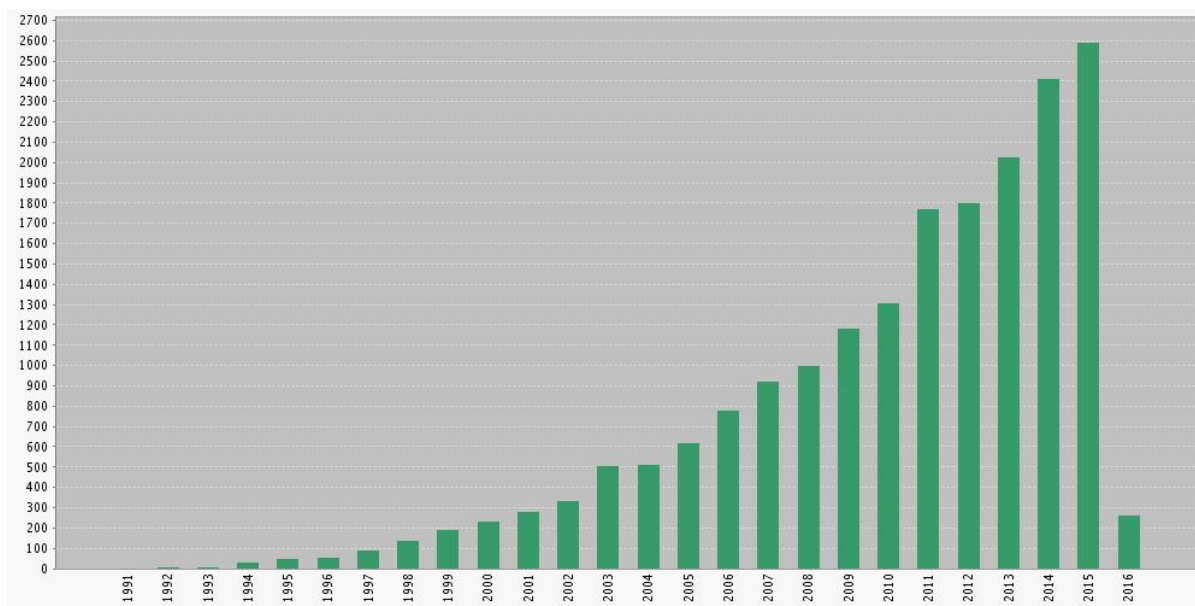
Figure B1.2 March 2nd 2016 Web of Science database 1900 to 2016 using three key terms "functional decline", "old", "hospital" showing the distribution of 13,360 *citing* articles.

I used discursive analytics to question how this predominant way of defining and categorising hospitalised older adults via functional status excluded other ways of positioning and representing the older adult in hospital. I found for example publications typically focused on defining hospitalised older adults biomedically by way of particular diagnoses or chronic conditions for purposes of categorising them to determine production of geriatric care models, consultation teams and/or units, and geriatric assessment technologies such as accelerometers and other clinimetrics aiming for best practices. There were publications on cognitive decline with several articles discussing effects of dementia, delirium and/or frailty in the context of functional decline, some on the prognostics for end of life, others on effects of certain kinds of physical training and exercises in older adults' rehabilitation with some studies referring to lab results and treatment outcomes. There was little to nothing on what the embodied experience of functional decline meant to the older adult as a sentient being.

These sources of textual data led to locating and generating data from organisations' publications, government reports, and on-line writings from disciplines or fields of study such as sociology, anthropology, sociology of medicine, and economics including critiques of biomedicalisation, economic rationalities and political economies of health care. I located

numerous ways to speak *about* functional decline such as functional status, functional disability, functional impairment, physical functioning, deconditioning, hazards of mobility, hazards of hospitalisation, and physical functional capacity. All these terms are associated with older adults' biophysical characteristics in relation to levels of capacity for independent living as noted above embedded in technologies of care. I looked at the surfaces of emergence of such terms to locate where strategies, objects, and concepts of functional decline discourse appeared, such as technologies for assessment and management of functional decline, i.e., protocols, predictors, assessments, clinical pathways, care models. Although not inclusive or exhaustive of all possibilities these sources of literature were relevant for examining emergence, production, operation, and redistribution of functional decline as a discourse as well as respective discursive formations of objects, subjectivities, strategies, and concepts.

This ensemble of textual data was used for comparative analysis of discursive formations in relation to functional decline in the context of hospitalised older adults as located across ethnographic fields containing written, read, spoken and performed texts of research/health care initiatives/reports and material realities of older adults' hospital care.

Appendix C.1 Clinical Pathway for surgical repair hip fracture: acute phase

Interprofessional Practice & Clinical Standards

Title: FRACTURED HIP CLINICAL PATHWAY – ACUTE PHASE

Qualified to Use: Registered Nurses, Physiotherapists, Occupational Therapists, Licensed Practical Nurses

☑ Please check box if core issue met/completed

Ⓞ Circle box = not met/completed

Chart on the Professional Progess Record   ☒ N/A

			Standard Number:	12.4.7	
			Effective Date:	February 23, 2009	

RIGHT☐ THR☐ Hemiarthroplasty☐
LEFT☐   DHS☐ Cannulated Screws☐
                Other: _____

WBAT ☐ FeWB☐ Precautions:_____
PWB ☐   NWB☐

CORE	CARE COMPONENT	Date:			Date:			Date:		
		D	E	N	D	E	N	D	E	N
Cognition	Provide: Glasses☐ Dentures☐ Hearing Aid☐ R☐ L☐ HOH☐ No Aids☐ R = Restless, C= Confused, V= Vague OT Cognitive assessment complete☐ ♦No evidence of Delirium, able to direct care and discharge	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__
Pain	♦Pain rating acceptable to patient / Pain scale 0-10, Assess Pain behaviours	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__
Lab	♦Lab values within acceptable range, not symptomatic	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__
Diet	♦Adequate nutritional support without aspiration / Percentage of Meals Taken	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__
NVS	♦NVS within patient's normal limits	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__
CVS	♦VS within patient's normal limits / IV Site: P= Peripheral C=CVC PI= PICC ♦Hemovac	☐__ / cm / ☐	☐__ / cm / ☐	☐__ / cm / ☐	☐__ / cm / ☐	☐__ / cm / ☐	☐__ / cm / ☐	☐__ / cm / ☐	☐__ / cm / ☐	☐__ / cm / ☐
Resps	♦Chest clear, afebrile O₂ rate ___/min NP=NP M=Mask R/A=R/A ♦O₂ Sats ≥ 92% or normal range for pt DB& C Encouraged, Incentive spirometry ☐	☐__ / ☐__	☐__ / ☐__	☐__ / ☐__	☐__ / ☐__	☐__ / ☐__	☐__ / ☐__	☐__ / ☐__	☐__ / ☐__	☐__ / ☐__
GI	♦Nausea and vomiting controlled / BM	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__
GU	♦Pt output ≥ 30cc/hr or >120cc in 4 hrs I = Incon B =Bedpan C= Commode F= Foley	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__
Wound /Skin	SIRA form completed within 24 hours☐ Heels☐ Coccyx☐ Other☐:_____ ♦Incision care maintained/Skin Dry and Intact	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__
Safety	♦Patient safe from risk of falls 1HEP4	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__	☐__

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3

Author(s): Fractured Hip Collaborative

Issuing Authority: Quality Council - Surgical

Date Last Reviewed/Revised: February 23, 2009

CORE	CARE COMPONENT		Date:			Date:			Date:		
			D	E	N	D	E	N	D	E	N
Soc	♦Pt/Family state concerns addressed ♦Patient / family states continuum of care understood		❑___ ❑___	❑___ ❑___	❑___ ❑___	❑___ ❑___	❑___ ❑___	❑___ ❑___	❑___ ❑___	❑___ ❑___	❑___ ❑___
Nurs Mob.	D =Dangle S=Stand P=Pivot W=Walked Device _____		❑___	❑___	❑___	❑___	❑___	❑___	❑___	❑___	❑___

		D			D			D		
Mob/Activity (PT MRC)	Dangle	See PT Initial Assessment ❑			See PT Initial Assessment ❑			See PT Initial Assessment ❑		
		Tx explained, consent given ❑			Tx explained, consent given ❑			Tx explained, consent given ❑		
		❑ Lie⇔sit: _____ How long? _____ Sitting balance _____			❑ Lie⇔sit: _____ How long? _____ Sitting balance _____			❑ Lie⇔sit: _____ How long? _____ Sitting balance _____		
	Sit⇔stand	❑			❑			❑		
	T/F chair/ commode	❑Assist:			❑Assist:			❑Assist:		
	Mechanical Lift	Stand ❑ Sling ❑			Stand ❑ Sling ❑			Stand ❑ Sling ❑		
	Walking aid	2 w/w. ❑Other: ❑			2 w/w. ❑ Other: ❑			2 w/w. ❑Other: ❑		
	Up in chair/wheelchair	❑ Mins sitting up:			❑ Mins sitting up:			❑ Mins sitting up:		
	Walk to Bathroom	❑ Assist:			❑ Assist:			❑ Assist:		
	Standing balance									
	Walked in hall	❑ Distance:			❑ Distance:			❑ Distance:		
	Hip exercises	❑			❑			❑		
	Delegation to RA	❑			❑			❑		
	♦Continue to optimize patient activity/mobility ♦Maximum ROM of unaffected limbs maintained									
ADL (OT MRC)		See initial OT Assessment ❑			See initial OT Assessment ❑			See initial OT Assessment ❑		
		Tx explained, consent given ❑			Tx explained, consent given ❑			Tx explained, consent given ❑		
	Cognition									
	Eating/Drinking									
	Washing									
	Grooming									
	Dressing/Footwear									
	Transfers									
	Toileting/continence									
	ADL tolerance									
	RA delegated tasks	❑			❑			❑		
	Clothing in hospital	❑			❑			❑		
	Equipment arranged	❑			❑			❑		
	♦ Patient's pre-hospitalization functional status optimized									
Alert										

INITIAL	NAME & DESIGNATION	INITIAL	NAME & DESIGNATION

Appendix C.2 Flow Sheet Record

PATIENT CARE FLOW SHEET

FOR ROUTINE RECORDING ONLY

ENTRIES REQUIRING ELABORATION ARE DOCUMENTED ON PATIENT PROGRESS RECORD

		DATE	DATE	DATE	DATE	DATE	DATE
		SHIFT	SHIFT	SHIFT	SHIFT	SHIFT	SHIFT
HYGIENE	SELF / ASSIST / TOTAL						
	ASSIST (type/amt)						
	OTHER, e.g., oral, hair, peri, foot						
ACTIVITY	UNASSISTED						
	ASSIST (type/amt)						
	BED REST						
	TOLERANCE						
MOBILITY/ POSITION	REPOSITIONING						
	SELF / PARTIAL / COMPLETE						
	ROM						
PAIN / COMFORT	PATIENT STATED PAIN LEVEL 0 = NO PAIN 10 = EXTREME PAIN						
	PATIENT STATED COMFORT LEVEL 0 = NO PAIN 10 = EXTREME PAIN						
NUTRITION	TYPE						
	% TAKEN (0 - 100%)						
	SELF / ASSIST / TOTAL						
SLEEP / REST	OBSERVATIONS INTERVENTION						
	DELIRIUM CONFUSION ASSESSMENT METHOD (CAM) SCORE +/-						