

Talking about frailty: health professional perspectives and an ideological dilemma

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Abstract

Frailty is increasingly used in clinical settings to describe a physiological state resulting from a combination of age related co-morbidities. Frailty also has a strong 'lay' meaning that conjures a particular way of being. Recent studies have reported how frail older people perceive the term frailty, showing that frailty is often an unwanted and resisted label. While there are many scores and measures that clinicians can use to determine frailty, little has been published regarding how healthcare professionals use and make sense of the term. This paper reports the findings of a qualitative study that explored how health professionals perceive frailty. Forty situated interviews were conducted with healthcare professionals working in an emergency department in the English Midlands. The interview talk was analysed using discourse analysis. The findings show that the health professionals negotiate an 'ideological dilemma'—a tension between contradictory sets of meanings and consequences for action—based on their 'lay' and clinical experience of the term frailty. It is concluded that this dilemma could have a negative impact on the assessment of frailty depending on the system of assessment used.

Key words

Frailty, health professionals, perceptions, ideological dilemma, discourse analysis.

Introduction

The term frailty is increasingly used in clinical settings in countries with ageing populations. Concurrently, frailty is often used uncritically in clinical language and academic research addressing medical issues, despite mounting research to suggest that it is a problematic term

(Pickard 2014). While a growing number of research studies exploring older people's perceptions of frailty have been published (for examples, see Grenier 2006, Warmoth et al 2016, Britain Thinks 2015, Grenier 2017), to our knowledge only two studies address the perceptions of healthcare professionals (Shaw et al 2018, Gwyther et al 2018). To our knowledge, there has been little consideration of how health professionals practising in an emergency department make sense of frailty despite growing demands on this area of healthcare to address frailty effectively (NHS 2019a). In light of this, how health professionals talk about and make sense of frailty in an emergency department forms the focus of this paper.

There is no universally agreed definition of frailty as used in clinical settings. Most clinicians, however, agree that frailty comprises three fundamental elements: that it is a condition or syndrome rather than a disease; that it 'results from a multi-system reduction in reserve capacity'; and that this failure results in the decline of physiological systems (Campbell and Buchner 1997). Numerous scores and measures are now available to aid the assessment of frailty (Fried et al 2001, Rockwood et al 2005, Gilbert et al 2018). Healthcare organisations in OECD countries have largely embraced the Fried et al (2001) or the Rockwood et al (2005) models. The Fried model suggests that there are specific observable characteristics, a "phenotype", for frailty that include loss of weight, loss of muscle strength, poor mobility and generalised weakness. These characteristics are positioned as the result of the complex interaction between the genetic makeup of an individual and their physical and social environments (Fried et al 2001). In contrast, the Rockwood model suggests that everyone accumulates deficits as we go through life and frailty is a continuum based on how many of these "deficits" are developed over time (Rockwood et al 2005). Increasing longevity, therefore, raises the risks of developing frailty, although the subsequent progression can be

slow or fast. Individuals thus move from being fit towards severe frailty as their functional state deteriorates due to cognitive and physical impairment. The cognitive aspect features more strongly in some assessment approaches than others. In the Rockwood scale an individual with dementia and inability to remember to cook, get dressed or washed, despite not displaying Fried's phenotype, may well be moderately frail. In short, clinical frailty comprises a collection of variable co-morbidities in older age, dependent in part on the model used to define it. The clinical assessment of frailty, moreover, has moved from subjective opinions based on clinical and personal judgement towards reliance on more objective, evidence-based scales.

Regardless of how frailty is determined, however, the term is now increasingly used in clinical and health research settings in nations with ageing populations (Rahman 2018). The general practice contract in England's National Health Service (NHS), for example, now specifies that people aged 65 and over should be routinely screened for frailty; many NHS hospitals also use a variety of assessment tools when treating older patients (Rahman 2019). There is also an increasing number of practice guidance documents to support the care of frail older people in NHS settings (NHS 2019b, NHS 2014, NICE 2016, NICE 2015). In addition to this, the NHS Long Term Plan (NHS 2019a) outlines that all major emergency departments in NHS hospitals should aim to provide an acute frailty service to ensure rapid and appropriate care for frail older people.

It is important to note that this application of the term is a relatively recent development that coincides with ageing population trends and the production of frailty assessment tools (Pickard et al 2019). In contrast to its clinical usage, frailty has a long history as a 'lay' term, dating back to Middle English when frailty was used to refer to weak morals. Indeed, the Oxford

English dictionary (2019) defines frailty as ‘the condition of being weak and delicate’ and lists synonyms such as weak, weakened, feeble, enfeebled, debilitated, incapacitated, crippled, and wasted. In many Western countries, particularly those characterised by neoliberal political economies, these synonyms invoke a stigmatised way of being that implies dependence and uselessness (Scambler 2009). While the ageing process has been repositioned through affirmative discourses associated with the third age, deep old age still carries the stigma of bodily decline (Grenier et al 2017). Indeed, deep old age has been positioned in terms of a fourth age, associated with the medicalisation of older bodies and the shared social disgust associated with this (Gilleard and Higgs 2013, Pickard 2014, Grenier et al 2017).

It is not surprising, therefore, that studies that have addressed older people’s perceptions of frailty have found it to be a term that is generally unwanted and resisted. Age UK’s report *Frailty language and perceptions* (Britain Thinks 2015); for example, identifies resistance to the label ‘frail’ among older people, concluding that so-called ‘frailty services’ could be off-putting for older people. Similarly, Warmoth et al (2016) found that a ‘frailty identity’ could be accepted and performed or resisted and rejected, leading to the conclusion that the ‘frailty identity’ is a potentially important factor in the health outcomes of older adults. Likewise for Grenier et al’s (2017) participants, frailty was associated with declining physical and cognitive ability and feelings of powerlessness and fear.

While several studies have now addressed how older people perceive frailty, little has been done to explore how healthcare professionals themselves perceive and use the term. Given the NHS Long Term Plan’s (NHS 2019a) recommendation that emergency departments ensure rapid and effective care for frail older people, it is important to consider the perceptions of

frailty among healthcare professionals in this setting. This paper aims to explore how key stakeholders in the delivery of emergency healthcare understand and make sense of the term frailty. The findings from 40 situated interviews with healthcare professionals working in a busy NHS emergency department to explore perceptions of frailty are presented and discussed.

First, however, it is important to outline our position regarding the term frailty. Throughout the paper, we recognise the increasing general acceptance of the term in practice and research. Here we argue for a more critical approach. Our use of the term frailty acknowledges that frailty represents a real bodily state, but also positions the term critically and suggests the need for reflexivity to account for social, cultural, and economic factors as well as individual lived experience.

Stakeholder perceptions of frailty in the existing literature

As stated, a number of studies have explored how older people perceive the term frailty and considered the implications for practice (see Grenier 2006, Grenier et al 2017, Warmoth 2016, Britain Thinks 2015, Shaw et al 2018, Nicholson et al 2013, Skilbeck et al 2018 for examples). In these studies, the term frailty is generally positioned critically based on patients' negative perceptions of frailty (Nicholson et al 2017). While the participants in many of these studies reported instances of feeling frail, the majority of participants worked hard to dissociate themselves from a frail identity (Nicholson et al 2013, Warmoth 2016, Skilbeck 2018). Less attention has been paid to how health professionals and other stakeholders involved in frailty care perceive frailty. The studies that have explored this show a trend towards scepticism and uncertainty. Gwyther et al (2018), for example, report findings from interviews with seven

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European healthcare policy makers regarding their attitudes towards the management and screening of frailty, focusing on seven themes identified across their talk. Their participants felt frailty screening was an effective tool if combined with proactive interventions. Key to their findings, however, was the perception of a knowledge gap and the need to devolve ownership of frailty from clinicians to a wider healthcare and patient base. It was generally thought that despite ageing populations and the increasing clinical use of frailty in European healthcare settings, those using the term frailty and those referred to as frail lack an adequate understanding of what frailty actually is. This limited knowledge was thought to have consequences for the care of people deemed frail, including the implementation of recommended clinical and self-management approaches. Devolved ownership of the management of frailty was suggested as a solution to this problem, to encourage shared learning. Overall Gwyther et al (2018) recommend a campaign to raise awareness regarding the malleable nature of frailty among health and social care professionals in order to instigate a culture shift regarding the inevitability and negativity that is often associated with frailty.

Similarly, Shaw et al (2018) examine European stakeholders' perceptions of frailty screening, including healthcare professionals, social care providers, older people, and family carers. Focus groups were conducted to assess the acceptance of frailty screening. Shaw et al's (2018) participants' perceptions of frailty reflected dominant stereotypes associated with older people. Additionally, when discussing their personal experiences of frailty, their talk focused on the impact of social and environmental factors and their protective and preventative effects. Shaw et al (2018) conclude that screening for frailty must be accompanied by care pathways that take account of these factors and that the screening and prevention of frailty must be coupled with a proactive and multidisciplinary approach to management.

Key to these studies is a focus on perception of frailty screening as a preventative measure, either to reduce the likelihood of frailty or to manage the experience of frailty. In both studies, while the term frailty is acknowledged to be associated with stigma, frailty is used within the discussion and conclusions with relatively little critique. While participants in Shaw et al's study were asked to discuss how they understand and use the term frailty, despite identifying a degree of discomfort associated with stigma among their participants, the implicit connotation of their discussion and conclusion is that frailty is an acceptable term. Indeed, their approach is explicitly framed in terms of increasing the acceptability of the term, and thus of interventions designed to address it: Shaw et al (2018, p.1226) state 'if people do not believe that frailty is malleable they may be reluctant to participate in screening programmes or interventions. Ensuring that screening and interventions are viewed positively will assist with uptake and a healthy ageing process'. This observation is not limited to Shaw et al's (2018) study, indeed, frailty is increasingly used unproblematically, despite growing research to the contrary (Pickard et al 2019). As Tomkow (2018) suggests, frailty is more than a clinical buzzword: it is an objectifying label that has life-shaping consequences for those so labelled.

Although frailty is typically used without question, critical discussion is increasing. It has been noted that frailty tends to be rejected by those so labelled due to its negative lay connotations; consequently, it is claimed, services using the term may do more harm than good (Warmoth et al 2016, Britain Thinks 2015). Grenier (2017) tellingly associates the term frailty with 'failed' old age. The findings of the study outlined in this paper indicate a critical awareness among healthcare professionals using the term frailty that highlights some of its potential unintended consequences, and shows the importance of applying the term cautiously and reflexively.

Research design

The study took place in a busy emergency department in an NHS hospital in the English Midlands. This emergency department had been experiencing increased numbers of frail older people accessing emergency care, and consequently had instigated the voluntary use of the Clinical Frailty Scale (CFS) (Rockwood et al 2005) to aid decision-making and person-centred interventions. At the time of interview, four months after the introduction of the score, the majority of staff were using it to categorise patients, communicate information among colleagues, and inform clinical decisions and care pathway choices. To provide some context, this emergency department sees over 48,000 older people a year and the majority arrive by ambulance. The CFS is generally calculated in the ambulance assessment area. This information is shared with the staff and senior clinicians are typically positioned in the ambulance assessment area to support proactive care of frail older people with early access to a multidisciplinary team during the daytime. Surveillance data show a mean completion rate of 65% for patients who do not have an existing CFS on the system. The CFS was chosen after carrying out a feasibility study of several risk-stratification tools (Elliot et al, 2017). Since its digital introduction in October 2017, the completion, accuracy and use of the CFS in decision-making has been subject to rigorous improvement science methodologies, which are still ongoing (Aijaz et al 2018, Mitchell and Banerjee 2019).

In order to further understand the use and experience of the term frailty, the project asked two research questions:

1. How do key stakeholders in the delivery and receipt of emergency care understand frailty?

2. How do key stakeholders in the delivery and receipt of emergency care experience the emergency care of frail older people?

This paper focuses on research question 1 only. A qualitative research methodology was chosen to answer the research questions. Situated interviews were used as the most appropriate research method given the constraints of the emergency department setting and the needs of the participants. Situated interviews bridge the gap between traditional semi-structured interviews and ethnographic approaches in that observation and place is included as part of the interview 'talk' (Gale and Sultan 2013). This was particularly important in this project because we were interested in how frailty is understood when used in a healthcare setting.

In total 70 situated interviews with 100 participants (30 patients, 30 carers and 40 staff) were conducted over a three-month period. Staff participants, the focus of this paper, included healthcare professionals such as doctors (n=10), student doctors (n=2), nurses of various grades (n=15), healthcare assistants (n=6), allied health professionals (n=1), and ambulance staff (n=6). Situated interviews with staff ranged from five minutes to 40 minutes. Owing to the busy nature of the emergency department, on occasion interviews were interrupted and picked up again later. Sampling was opportunistic, based on who was in the emergency department and able to participate at the time. The primary researcher (first author) stopped interviewing staff when saturation point had been reached. All participants were asked the following pre-set questions: what does frailty mean to you? How would you describe a frail older person? What factors do you think contribute to frailty? These questions were deliberately general and were designed to begin a conversation about frailty. Using an interview guide is typical, although not an essential element of the situated interview approach (authors forthcoming). Due to the fast-paced environment of the emergency department, pre-set questions were useful

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to allow conversations to cover key issues; however, the primary researcher used these questions flexibly and asked other relevant questions based on individual participants' talk.

All participants provided informed, written consent prior to the start of the interview. The researcher did not take note of any personal details but did record each participant's job title. Due to the high turnover of staff and the number of healthcare practitioners employed in the emergency department the collection of this minimal detail ensured anonymity. The interviews took place in the emergency department itself and were conducted in empty corridors, in empty bays and at staff workstations. All interviews were audio recorded and transcribed verbatim. Transcriptions ranged from three pages to 22 pages. The project was granted Health Research Authority approval by the Brighton and East Sussex Research Ethics Committee.

Discourse analysis was used to analyse the participant talk addressing experiences of frailty. Broadly described, discourse analysis looks at patterns of language within and across texts as well as taking account of the social and cultural contexts in which the texts occur (Wetherell 2001). Potter (1996) outlines two primary assumptions within discourse analysis: that discourse is a social practice; and that linguistic resources facilitate this social practice. Rather than simply reflecting reality, language, via the use of linguistic resources, is seen as having an active role in its construction (Bowker and Tuffin 2002). As Tuominen et al (2002 p.273) identify, discourse analysis focuses on 'discourse as the vehicle through which the self and the world are articulated and on the way different discourses enable different versions of selves and reality to be built'.

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There is no one prescribed method of discourse analysis. The approach taken here involved the identification of interpretive repertoires based on Potter and Wetherell's (1987) framework. Potter and Wetherell (1987) use the analogy of a ship in a bottle to describe their approach to research. Like ships in bottles, people's worlds are made up of parts – society, selves, material objects etc. – that are taken for granted as having always been there, 'their presence is unquestioned and miraculous' (Potter and Wetherell 1987 p.181). In this way, discourse analysis renders the process of 'manufacture' important. Frailty, as highlighted above, is a material and social reality that is often used unproblematically in discourse. Like the ship in the bottle, understandings of frailty are not just there: they are manufactured by discourses that are part of social life that in turn is impacted upon and produced by material frail bodies.

Interpretive repertoires are linguistic resources that allow the speaker/writer to construct meaning and consequently manufacture subject positions, identities, selves, and understandings of the world. Consequently, interpretive repertoires can change, overlap, and conflict (Vehkakoski 2007). As linguistic resources, moreover, interpretive repertoires allow speakers to traverse the ever-changing and contradictory landscape that is shared cultural and social knowledge. In summary, this approach enables the complexity of shared social and cultural knowledge about frailty to be acknowledged and reveals how this knowledge comes to structure the understandings of frailty outlined here.

Potter and Wetherell's (1987) flexible ten-step guide to conducting discourse analysis was followed in order to organise the participants' talk into consistently used repertoires. The ten steps include: 1. Research questions, 2. Sample selection, 3. Collection of documents, 4. Fieldwork, 5. Transcription, 6. Coding, 7. Analysis, 8. Validation, 9. Writing up, and 10.

Application. For step 7, analysis, Potter and Wetherell (1987, p.169) stress ‘it should be clear there is no analytic method, rather there is a broad theoretical framework, which focuses attention on the constructive and functional dimensions of discourse coupled with the reader’s [researcher’s] skill in identifying significant patterns of consistency and variation’. Based on this and given limits of space, here we outline our approach to coding (step six) and analysis (step seven).

Potter and Wetherell (1987: 167) tell us the aim of coding is “not to find results but to squeeze an unwieldy body of discourse into manageable chunks.” The codes developed should reflect the research questions, and can be as broad as necessary. Unlike thematic analysis, owing to the range of linguistic resources available to speakers and the acceptance that speakers may shift between compatible and incompatible repertoires to construct meaning, paradoxes, anomalies and borderline issues can be coded. To begin, the first author organised the interview talk into broad codes using qualitative data analysis software (NVivo 12). Coding was an iterative process that involved re-reading transcripts to identify specific topics discussed and linguistic resources used in similar and different ways. With the research questions in mind, the transcripts were organised into 32 codes.

Step seven, analysis, has two aims: to establish functions of the discourse and to highlight patterns and inconsistencies. As outlined, Potter and Wetherell (1987) provide no specific method for achieving these aims; rather they relate the process to the overall theoretical basis of discourse analysis. The first author re-read codes and transcripts many times, searching for patterns across the talk, particularly instances of similarity and contradiction where participants used similar patterns of words and phrases to make sense of what they were talking about,

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consistent with the characteristics of interpretive repertoires. Emergent patterns were then related to the codes previously generated. From this, six interpretive repertoires organised as three pairs were identified to be used consistently throughout participants' talk:

1. Frailty is a clinical issue / frailty is world changing
2. Perception of frailty / reality of frailty
3. Frailty is useful for staff / frailty is a negative label

The six repertoires were organised into pairs to reflect the participants' varied talk about frailty. The two repertoires in each pair are co-dependent; the participants used them to do different things, oscillating between them to make sense of frailty. While the pairs may appear to be contradictory, this is often the case when talking about uncertain and emotive topics (Billig et al 1998). In drawing on different repertoires at different times according to context, speakers can make themselves understood to their audience and can associate and dissociate themselves with particular identities (Davies and Harre 1990).

Findings

1. Frailty is a clinical issue / frailty is world changing

This repertoire pair underpinned the staff talk. The belief that frailty has a medical origin was implicit and explicit throughout their talk. When asked what frailty means to them, to describe a frail older person, and what factors can contribute to frailty, as might be expected, the participants framed their answers in terms of medical issues, drawing on their expertise and experience to do so. Their understanding of frailty and the descriptions of frail older people

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they gave were based upon the notion that frailty represents a form of ill-health such as an ‘illness’, ‘disease’, or ‘syndrome’, as seen in the extracts below.

S16 (Doctor): It’s a multi-factorial syndrome that describes someone’s ability. So someone who is unable to recover from disease completely or efficiently or is likely to end up worse off after they have recovered.

S25 (Nurse): My opinion, frailty is a new illness but more than illness, is a lot of co-morbidities. All the body will be affected from the brain, heart, the joint, everything. They will be more prone to get an infection, they will be more prone to get unwell.

The use of the *frailty is a clinical issue* repertoire might be expected, given the healthcare professionals’ clinical expertise and the location of the interviews. In contrast, however, the staff also positioned frailty as an experience with wider implications and consequences, such as occupational health support and home adaptations, using the *frailty is world-changing* repertoire to do so. In this way frailty was constructed as having a clinical origin but a social impact. Participants used this repertoire to show the social consequences of frailty, and to offer non-clinical solutions to frailty that would decrease admissions to hospital and emergency care, seen in the extracts below.

S1 (Paramedic): So they can be in hospital for months and if they do, they may not get back home or if they do, they end up, they go back to somewhere that’s been, had adjustments, stair lifts and they have carers coming in, literally who are essentially invaders into their own private space that they’ve had complete control over. Some people won’t go home at all, they’ll go back to care homes

instead. I've met a lot of them who go downhill because their world changes when they leave it.

S27 (Ambulance Technician): They're more likely to use walking aides with other aides as well such as raised chairs, electric chairs, electric beds in the front rooms, that sort of thing. So some things that sort of adapt their daily lifestyle.

In these extracts, participants acknowledge the individual and social impact that frailty can have for those experiencing it. Frailty is framed here as imposing a way of being that diverges from what the now-frail body once experienced. This changed bodily state results in both individual and social impacts that require support such as: 'carers coming in' who are 'essentially invaders into their own home' [S1], 'walking aides', 'raised chairs', 'electric chairs', and 'electric beds in front rooms', and the possibility of moving into a care home [S1]. Being frail, moreover, was said to bring with it a state of change whereby previous independence and capacity decline into dependence and incapacity; lifestyles are adapted [S27] and individual worlds change.

This repertoire pair reflected the participants' clinical knowledge of frailty and their role managing it in a healthcare setting. While frailty was undoubtedly constructed as a clinical issue, its social and individual impacts were thought to require social and individual intervention: non-medical solutions in the main, as seen below.

S6 (Doctor): So we have got points of access that we can tap into, whether that be our primary care team who can assess them which is a physio, OT and see if there's any increased requirements in package of care they can sort out social workers.

Overall, *the staff used this repertoire pair to construct frailty as a clinical and embodied condition that can have social and individual consequences that are better addressed outside a hospital setting.* Tension between this pair and the participants' use of 'lay' language as well as clinical language is seen in the use of the next two repertoire pairs.

2. Perception of frailty / reality of frailty

While frailty was framed as a bodily issue associated with a clinical origin that requires social solutions, participants also talked about their personal perceptions of frailty. Indeed, this repertoire pair reveals a disconnect between the *frailty is a clinical issue* repertoire and the social construction of frailty that the participants' talk revealed when talking about their lay perception of frailty, whereby frail older people were associated with a particular stereotype.

While participants' clinical knowledge and expertise underpinned their professional understanding of frailty, this did not eliminate the influence of the socially constructed stereotype of frailty. When asked to describe a frail older person, participants diverged from their use of the *frailty is a clinical issue* repertoire and instead talked about a particular visual image: that of a weak, unsteady, older person, as seen in the extracts below.

S7 (Nurse): Looking old, looking frail, not able to get around themselves, maybe. Sitting, you know, difficulty with independence, not able to do anything

for themselves on the bed, you'd think "Oh, they're frail". I think that most people in society, you look at somebody like that and you say frail.

S27 (Ambulance Technician): It [frailty] primarily conjures an image of an elderly person, the first person you think of when you think of frailty is an older person, sort of hunched over, you've got a typical stereotype in your head.

Here the participants refer to the 'lay' perception of frailty that 'conjures an image' and a 'typical stereotype'. When S7 says, 'I think that most people in society, you look at somebody and you say frail, the word frail', she acknowledges the lay meaning of the word frail and the distinct image that this conjures that results in the assumption of frailty based on initial appearance. Constructed in this way, the participants' 'lay' understanding of frailty mirrors the phenotype approach to frailty, whereby frailty is positioned as a syndrome diagnosed on the basis of five largely visual characteristics. This interesting relationship is examined further below.

Participants often followed their descriptions of frailty with an acknowledgement of the tension between their clinical experience and 'lay' stereotypes.

S28 (Medical Student): You kind of get a vision in your mind what that person looks like, a little old lady kind of walking down the street or something like that, which may perhaps not be the most useful

thing because it may mean that actually you may miss people who are actually are frail.

Here, S28 acknowledges that her lay perception of frailty ‘may not be the most useful thing’ and follows this by demonstrating that she knows professionally that frailty doesn’t present in terms of a stereotypical image, and by highlighting the problems this can cause, such as missing people ‘who are actually frail’. This tension is further illustrated in participants’ use of the *reality of frailty* repertoire discussed next.

The participants used the *reality of frailty* repertoire to acknowledge the subjective basis of the term and the tensions that this can bring. When talking about their experiences of frailty, participants often referred to their surprise when older people turned out not to be frail. Their clinical experience, however, led them to reassess their understanding of frailty based on lay stereotypes and reflect on the conflict between their lay and professional perceptions. The extracts below show how the participants constructed this tension and the conflicts it can bring.

S7 (Nurse): We might have had them down in our heads as frail but the score allows us to ask about their situation and we might find that even though they are 80s 90s they are not actually frail.

S11 (Healthcare Assistant): Sometimes it’s a bit deceiving. Some people may look at age and think ‘Oh, this person’s like 92 so they must be frail’ but we get people older than that who are not frail necessarily.

S13 (Nurse): It’s difficult because when I get patients in here, they look very frail you know, but they are very independent so it’s difficult.

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Each of these extracts demonstrates the tension between a lay stereotype of a frail older person and the clinical assessment of frailty. In all of the extracts, the social construction of a particular image of a frail older person based on stereotypes can be problematic in reality. When encountered in the emergency department, the socially accepted image of a frail older person as thin, weak and old, is said to be potentially ‘deceiving’. The participants discuss the difficulty they have experienced when this tension arises in their practice. While people may ‘look frail’ and staff members may ‘perceive’ them to be frail or ‘have them down in their heads as frail’, each staff participant here gives an example of when this sometimes is not the case in reality.

Overall, *the staff used this repertoire pair to show the difference between lay and clinical understandings of frailty and the tension this can create.* One potential implication of this finding is that some frailty measures such as the Clinical Frailty Score (CFS) (as used by the participants in this study) (Rockwood et al 2005), where patient ability two weeks prior to assessment is the focus, might encourage staff to think beyond the immediate appearance of the patient they are assessing, and to question their ‘lay’ understanding of frailty based on a stereotypical image. Measures that rely on this image for assessment of frailty based on presenting phenotype could reinforce the stereotype of the frail individual, which may result in both false positives (individuals who look frail but are not) and false negatives (individuals who do not appear to be frail but suffer from some of the less visible features of frailty). The stereotype implicit and explicit within the lay conception of frailty is further seen in the discussion of the final repertoire pair, *frailty is useful for staff / frailty is a negative label.*

3. Frailty is useful for staff / frailty is a negative label

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As with the previous repertoire pair, the staff drew on this pair when making sense of their use of frailty as a term that has clinical and lay meanings. The staff were generally uncertain as to whether frailty represented the most appropriate term to use when addressing older people with multiple morbidities. The lay connotations of the term frailty, and the associated stigma, formed the basis of their uncertainty. The repertoires in this pair were used closely, often following on from each other. The participants tended to supplement their acknowledgement that frailty is a useful term with an acknowledgement that it may also be a negative label for others.

The vast majority of participants considered frailty to be a useful term in a clinical setting.

S26 (Nurse): It helps us to know quickly what sort of patient needs there are.

S1 (Paramedic): It guides our treatment, it also guides on who to involve, you know because we work like a multidisciplinary team so I think it kind of aids with that. We all know what it is we are talking about, just using an easy term.

S23 (Ambulance Technician): It describes all manner of things. It's probably why we use it so abundantly.

In these extracts the participants draw on the *frailty is useful for staff* repertoire to show their use of the term in their clinical roles. Frailty is considered to be a useful classificatory term to describe 'all manner of things', an 'easy' term that can 'quickly' convey information about a patient's needs across a 'multidisciplinary team'.

The participants tended to follow up this talk by drawing on the *frailty is a negative label* repertoire. In doing so, the participants acknowledged the tension between the clinical use of the term frailty and the lay connotations and stigma that this term carries. This interchange between repertoire use is demonstrated in the extract presented below.

S20 (Nurse): I suppose it describes what it is supposed to describe. So for that, although people may not want to be described as frail, for clinicians maybe it's helpful, especially when we're looking at, you know, long-term prognosis, you know when someone's been diagnosed with something, their frailty may have an impact on how likely they are to recover and how well they're going to recover.

S20 begins and finishes by addressing why frailty is a clinically useful term. 'It describes what it is supposed to describe' and 'for clinicians maybe it's helpful' when considering 'long term prognosis'. In the middle of the extract, however, S20 acknowledges that 'people may not want to be described as frail'. Here S20 shows awareness of the stigma associated with frailty, framing it as an unwanted term among patients.

Unease characterised the staff participants' talk about their feelings towards the use of the term frailty in a clinical setting. The extracts below show the staff members attempting to make sense of their unease regarding their use of a term that they understand to be unwanted by patients.

S23 (Ambulance Technician): I think you just have to be careful sometimes of using the word frail, isn't it, you know, obviously where you might class somebody as being frail

doesn't necessarily mean they'd feel themselves,
or want to think that.

S20 (Nurse): It's not something we talk about that much with the patient themselves, if we're assessing someone's frailty, that's because they're elderly and potentially at risk, we don't want to make them feel bad about themselves, so we often don't actually discuss it with them.

S12 (Ambulance Technician): Well, maybe it's just my personal choice but I suppose I've maybe seen it as a negative word to use and so often coming into hospital is quite overwhelming anyway, and to then sort of, to then say, 'Oh, by the way, we think you're extremely frail'. It might not go down very well.

Here the participants refer implicitly to the stigma associated with a frail way of being and the tension this creates in their clinical use of the term. Frailty is thought to be 'a negative word' that should be used with care. To call a patient frail could result in them 'feeling bad about themselves' and add to their already vulnerable position in hospital.

Some participants went on to consider alternative terms that could be used, and discussed how they manage using the term frailty with patients.

Interviewer: Would you use the word frailty with patients?

S23 (Ambulance Technician): I don't think I would actually, I would probably avoid or just say something along the lines of

older people... so for instance, if I'm to take somebody in but consider their frailty, I would say, you know, it's not as good for an older person to go into the hospital because they are more likely to contract illnesses and stuff like that, so I wouldn't necessarily say frail.

S23 (Ambulance Technician): I tend not to use labels with patients at all. I try to take an empathetic approach and will probably just use their names.

Here the staff participants express how 'hard' it is to negotiate the tension between the clinical use of the term frailty and the translation of this to the patient. This tension is underpinned by the lay conception of frailty and the stigma associated with it. Acknowledging this stigma, the staff state that they 'tend not to use labels', that they 'wouldn't necessarily say frail' and that 'there could be a better term'.

Despite the participants' reports of discomfort in using the term frailty among patients, though, they were uncertain how else to refer to this way of being.

S24 (Paramedic): I think there could be a better term to be used. But I don't know what that term would be.

Interviewer: Are there any other terms you think could be used instead?

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S19 (Deputy Sister): I don't know, multiple morbidities maybe, elderly. It's hard because frailty sums up a lot of different things but it's probably not what the patients want to hear.

Both S24 and S19 'don't know' how else to phrase frailty and S18, above 'wouldn't necessarily say frail' but instead would 'say something along the lines of older people'. This uncertainty was again underpinned by the shared knowledge that the lay conception of frailty implies a stigmatised way of being, as when S19 states 'it's probably not what the patients want to hear'.

Overall staff used this repertoire pair in order to make sense of their conflicted use of the term frailty. While the staff acknowledged the clinical benefits of using the term frailty between themselves for purposes of effective communication and care, when used with patients the term could take a more sinister role that the participants were uncomfortable with. The staff participants were aware of the stigmatised connotations associated with frailty's 'lay' use. Consequently they perceived (accurately, according to previous research such as Britain Thinks 2015, Warmoth 2016 and Grenier 2017) frailty to be an unwanted label among patients and used various strategies to avoid using the term with patients.

Discussion

Overall, the participants' use of all three repertoire pairs is permeated by the tension between clinical and lay conceptions of frailty. The staff themselves occupy both lay and professional roles, and consequently have a working appreciation of both conceptualisations. When the staff discussed their lay perception of frailty, their descriptions mirrored patient perceptions

detailed in some other studies (see Grenier 2007 and Warmoth et al 2016), conjuring the image of a weak, thin, old person who lacks mobility and requires much support. In contrast, the staff also discussed their clinical understanding of frailty, framing frailty as an individual, physiological issue and constructing it as a clinical condition as opposed to a way of being or appearance. In this way, frailty was thought to be a useful term to inform clinical decisions.

The two conceptions of frailty held by the staff came into conflict in the emergency department in that staff reported the need to put aside their lay conception of frailty when using the term in their professional practice. The staff, however, were aware of the 'lay' interpretation of frailty when using the term with their patients, sometimes choosing not to refer to the specific term frailty with patients due to these connotations. They acknowledged that the lay use of frailty carries a shared social stigma associated with old age. It was this stigma that resulted in participants' unease regarding the term. While they could not think of another word to capture the variety of conditions and their consequences encapsulated in frailty, they recognised the difficulties associated with the term that render its use in practice problematic.

The tension between the lay and clinical understandings of frailty, and participants' use of the repertoires to manage this tension, represent an 'ideological dilemma' (Billig et al 1988). Like interpretive repertoires, ideological dilemmas are reflective of shared social and cultural beliefs and the history that has produced them. Such shared beliefs contain contrary ways of understanding the world; it is when two contradictory themes conflict that an ideological dilemma arises (Billig et al 1988). Ideological dilemmas create a situation in which 'people are pushed and pulled in opposing directions' (Billig et al 1988, p.163) – in this case reflecting the appropriation of the lay term frailty within clinical discourse and practice. Rather than

inhibiting thinking, however, Billig et al (1988) show how the negotiation involved in an ideological dilemma is creative and productive, in that the back and forth consideration allows the speaker to think meaningfully about both the topic under discussion and their self-identity. Here, the participants were aware of the competing understandings of frailty within the emergency department, and indeed themselves. The participants used the repertoires to negotiate this tension and to position themselves within this tension. Both the repertoires and the ideological dilemma they are used to manage are products of frailty's social and cultural past and present and the dominant shared discourses that preside at the time.

As Edley (2001, p.202) tells us, 'people are encultured into particular, even partial ways of understanding the world'. The participants have lay and professional understandings of the term frailty that conflict in practice within this is also a conflict between their lay and professional identities. They acknowledge the usefulness of the clinical definition of frailty within clinical settings but struggle to apply this beyond communication and decision making with their clinical colleagues. The participants draw primarily on the *frailty is a clinical issue* and the *frailty is a useful for staff* repertoires to do this but also use the *frailty is world changing*, the *frailty is a negative label* and the *perceptions and reality of frailty* repertoires to show that they also perceive frailty to be a stigma-laden term that is unwanted by many patients.

The repertoires also highlight the internal conflict the staff encounter when using the term frailty. As stated, in this emergency department, the assessment of frailty using the CFS was a relatively new development. Their negotiation between the clinical understanding of frailty, as prescribed by the CFS in this case, and their lay understanding of the term was, moreover, a recent experience. Prior to the use of the frailty scale, staff had tended to use the term frailty in a way that resembled its lay understanding – relating frailty to patients who looked old and

weak. The participants' use of the *perception of frailty* and *reality of frailty* repertoire pair highlights this internal negotiation associated with appropriation of a lay term into clinical usage.

In order to negotiate the ideological dilemma involved in the clinical use of the term frailty, the participants utilised the repertoire pairs to construct frailty as a double-edged sword: something that could be useful clinically but can also have unwanted consequences for the patient. This is echoed in the literature addressing the perception of frailty among older people, which argues that a 'frailty identity' is potentially damaging in terms of health outcomes for frail older people (Warmoth et al 2016 and Britain Thinks 2015).

A number of alternative or equivalent terms to frailty have been proposed based on the negativity associated with the term, and clearly demonstrated in the participants' talk presented here. When talking about managing frailty, Bujinowska-Fedak et al (2019, p.202-3) use the term resilience, stating 'understanding frailty as a loss of resilience with the ensuing opportunity to build resilience in one of the key frailty deficit areas, perhaps in terms of improving physical health, cognitive health issues or social connectedness, may mean that people are more likely to take action, than if they perceive pre-frailty and frailty as an end-of-life state'. Similarly, Nicholson et al (2017, p.351) recognise the benefits of the clinical use of the term but suggest a reflective approach to its use, acknowledging its limitations and the things that frail people *can* do. They conclude: 'we should be seeking to find ever more inclusive ways to define the population most likely to benefit from the inclusive, broad, detailed, interactive approach to healthcare for which geriatricians advocate'.

More critically, Laceulle (2017) chooses the term vulnerability as opposed to frailty. Arguing that frailty suggests adverse outcomes, she suggests that the term ‘existential vulnerability’ brings elements of frailty/vulnerability to the fore that cannot be adequately addressed through typical clinical approaches to frailty. Existential vulnerability, moreover, relates specifically to ‘elements of our lives that intrinsically belong to the human condition, such as our sociality, our embodiment, and our inclination to strive for transcendence and meaning in our lives’ (Laceulle 2017, p.2). She further suggests that approaching frailty from a virtue ethics perspective positions the frail person as a moral agent with capacity to ‘successfully age’ through the adoption of acquiring wisdom as life progresses. In doing this, Laceulle seeks to broaden the impact of gerontology by widening the understanding of frailty. For Laceulle (2017, p.6) ‘The scientific study of aging seems to stand rather empty handed in the face of existential issues that touch upon questions of meaning, values and consequences’.

In acknowledging and understanding the presence of the existential issues identified in the study, such as age-related stigma, and the negativity associated with a frail/failed identity, those who care for people experiencing frailty may be able to contribute to the rebranding of frailty as a ‘successful’ rather than ‘failed’ way of being. It is important to note that ‘successful’ is not used here to gloss over the individual difficulties associated with frailty. Rather it is used to refer to frail people as active agents, and to position frailty as part of what Laceulle (2017) calls ‘the human condition as an existential reality, rather than an unfortunate situation that needs an instrumental remedy’. As Nicholson et al (2017) point out, a more ‘nuanced’ conversation about what frailty means is required between practitioners and patients.

Strengths and limitations of the study

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This study contributes to the increasing body of literature addressing perceptions of frailty by adding much-needed empirical evidence of how healthcare professionals understand and make sense of frailty. The findings are based on a robust and transparent methodology that is rooted in a social constructionist ontology and epistemology. We acknowledge that while highlighting unquestioned use of the term frailty in other studies, we ourselves use the term in this study. Our use of the term frailty acknowledges that frailty represents a real bodily state and lived experience, but also positions the term critically and suggests the need for reflexivity.

While the findings are based on a credible and transparent methodological approach, the study setting was limited to a single emergency department. The findings therefore may not be generalisable beyond healthcare practitioners working in an emergency department. The fact that the emergency department is often the first point of contact with the healthcare system at a time of crisis, and that the participants were using the CFS to assess frailty, may also have influenced both their understandings of the meaning of the term and their characterisations of frail people. Further research addressing staff perceptions might explore how healthcare professionals in other settings understand frailty.

Conclusion

In summary, the appropriation of a lay term into clinical practice with a specific clinical meaning has, here, resulted in the creation of an ideological dilemma that the clinical staff sought to overcome by constructing frailty through multiple discursive repertoires. The increasing prevalence of the term in geriatrics and other clinical disciplines demands careful

attention to its multiple meanings, and the potential unintended consequences of using it unreflectively.

Rather than recommend a campaign to raise awareness regarding the malleability of frailty, as Gwyther et al (2018) do, we recommend that frailty at the very least be used with a critical appreciation pertaining to its lay connotations and its impact as a negative label. Appropriating a lay term with shared negative connotations rooted in stigma and stereotypes of older age problematises the use of frailty in clinical practice. As Nicholson et al (2017, p.350) warn, the use of particular tools and definitions of frailty risks viewing ‘an entire person through a particular lens’.

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