

OLDER PEOPLE AND 'PERSON-CENTRED' PODIATRY: A CRITICAL EVALUATION OF TWO MODELS OF CARE

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ABSTRACT

Older people and 'person-centred' podiatry: a critical evaluation of two models of care.

Older people are often portrayed as a disadvantaged and silent group in society, whose views have been largely ignored. Demographic studies suggest the number of people over 75 years of age, as a percentage of the population in coming years is likely to substantially increase, which will place greater demands on healthcare services. In the last two decades, health policy has focused on delivering high quality services based on individuals' needs, with a greater emphasis placed on individuals being involved in decisions about their care. This policy direction has facilitated a change in power relationships between patients and professionals and will require providers of healthcare to focus on delivering '*patient-centred*' care at times and places that meet individual's needs and expectations.

The aim of this research was to evaluate the current medical model provision of NHS podiatry with the biopsychosocial model which claims to provide 'holistic', patient-centred care. An important aim of this research was to provide a greater and more informed understanding of what older people communicate about their 'lived' experiences, the significance of those experiences on care-seeking and their expectations of appropriate podiatry care.

The research was undertaken with older people living in east Gloucestershire, who were 75 years old or over, and had requested NHS podiatry. The study was underpinned by a qualitative methodology, strengthened by a desire to change current clinical practice and inform health policy. The research methodology included involvement of participants in an innovative reminiscence technique, and as a consequence the '*podiatry patient career*' was constructed. The texts generated from the participants were examined using an interpretative phenomenological analysis to ensure a '*person-centred*' focus because it was imperative to hear the voices of the '*participants*' and not just the medical model '*patients*' narrative.

A portrait was revealed of older people who were conscious of their position in the life course and their own mortality, together with the effect this had on how they conducted their lives. The participants' raised consciousness of their 'self' affected their expectations, feelings, and interaction with others. For many of the participants there appeared a vicious circle of impending frailty that led to a diminishing circle of contacts which had an effect on their wider social activities and relationships. At this stage, participants perceived a resolution of their foot-care needs to be of great value and importance in maintaining their well-being which, assisted by the podiatrist, resulted in a handing over of the responsibility for their care.

The conclusion is that neither model delivers '*person-centred*' care to meet participants' expectations and foot-care needs. A new model is presented where differing and changing priorities, at different times of the participant's lived world will be relevant to meet their expectations and needs. The research concluded that the requirement for podiatry care can be taken as an early indicator of failing independence. The importance of the participant-podiatrist relationship was also identified as central to the delivery of 'person-centred' podiatry. The research findings depict older people who want to be involved in their care rather than being '*a burden to the state*'. Recognition is also given to the changing nature of caring relationships in the next decade, and how NHS podiatry services will have to profoundly transform if they are to deliver a holistic, person-centred service in the future.

I declare that the work in this thesis was carried out in accordance with the regulations of the University of Gloucestershire and is original except where indicated by specific reference in the text. No part of the thesis has been submitted as part of any other academic award. The thesis has not been presented to any other education institution in the United Kingdom or overseas.

Any views expressed in the thesis are those of the author and in no way represent those of the University.

Signed.....Chris Boden..... Date...31st May 2007.....

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A huge heart-felt thank you to you all.

“When your feet hurt, you hurt all over”

**(Quote attributed to Socrates
Greek Philosopher
470-399 BC)**

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List of Abbreviations

CPSM	Council for Professions Supplementary to Medicine
DOH	Department of Health (more recently, the Department of Health has been abbreviated in official documents to DH but for the purpose of consistency DOH has been used throughout the dissertation)
GP	General Practitioner
HPC	Health Professions Council
NHS	National Health Service
NHSE	National Health Service Executive
WHO	World Health Organisation

Chapter One

Introduction

1.1 Introduction

Podiatry and older people are not perhaps the two most exciting topics to research. Yet, significant numbers of older people are reliant on interventions from NHS podiatry services each year. Perhaps surprisingly there is little empirical evidence to support the benefits of podiatry. Older people express great dissatisfaction with podiatry services, not with the interventions provided, but about frequency of interventions (waiting times), and restrictive access criteria to NHS podiatry.

1.2 Purpose of the Dissertation

The purpose of the dissertation is therefore to critically evaluate two models of care provision. The current care framework within which NHS podiatry services are delivered: the medical model will be critically evaluated alongside the biopsychosocial model framework which claims to provide a ‘person-centred’ approach.

This had led to the construction of the research question:

“Would older people receive foot care services more relevant to their needs, if NHS Podiatry Services adopted a different approach?”

1.3 Summary and Structure of the Dissertation

This dissertation is therefore a critical evaluation of the medical and biopsychosocial model frameworks to ascertain which model will deliver a 'person-centred' approach to meet older peoples' foot-care needs. The remaining chapters of the dissertation are therefore set out as follows:

Part One – Setting the context of the dissertation presents the background context within which the research is situated. This will be established by describing podiatry, older people and NHS policy through the 1990's and early part of twenty first century. In **chapter two** the concept of podiatry is introduced. This will include a description of the profession of podiatry and its development through a brief socio-historical biography. It will be argued that throughout its development, the profession of podiatry has attempted to achieve a higher level of status within a hierarchy of health professions, but still remains subservient to medicine. Portrayed will be a podiatry profession that has struggled to elevate its status in relation to the medical profession, and this perception of lower status continues to be the view held by the medical profession and the wider general public. Since 1974 when podiatry services first became part of the National Health Service (NHS), a greater focus on operating within a 'medical model' framework will be demonstrated. Throughout the period that podiatry services have been free at the point of delivery, demand for foot-care from the general public has continued to outstrip supply. A tension therefore exists between a 'patient-led' demand and a 'profession-led' supply and it is felt that the continued focus by the podiatry profession on a 'medical model' approach to the delivery of its services is a cause for public dissatisfaction with NHS podiatry services. Podiatry services are therefore failing to deliver a public service to adequately meet the wider general publics' demands and expectations of foot-care services.

Chapter Three describes ‘older people’ in homogenous terms, but with a focus on the relevant issues of individuality of older people related to the undertaking of the research. In describing older people, links will be made with their relationship to NHS podiatry services. Despite changes to access criteria to include all age groups, older people remain the single largest group of people requiring NHS podiatry services. The target group of older people for this research will be older people, 75 years and over and the reasons for this will be elaborated on in chapter nine – research methodology. A hierarchy in the provision of services for older people will be identified. With the proportion of older people in the general population predicted to increase in the next decade, negative stereotypes of older people being portrayed as a burden to health and social agencies have arisen. This has led to older people receiving lower priority in terms of provision of services and application of resources to meet their healthcare needs.

Chapter Four examines the implications for NHS podiatry services and the effects on older people of health policy over the period 1987-2004. Health policy during this period has seen a shift to a focus on ‘clinical’ needs (which are derived by health professionals) and a greater push for the involvement of ‘the patient’ in the decision making about their care and how they receive it. This clearly leads to tensions between healthcare professionals and ‘patients’ about the amount of care that is delivered by the National Health Service. Yet, ‘patient empowerment’ has remained a central focus of both Conservative and Labour governments during this period as it is perceived as the appropriate method to challenge the dominant role of healthcare professionals. Across the three chapters, three interlinking themes of hierarchies, status and issues of power emerge. As a result it will be demonstrated that older people and podiatry are usually situated in lower positions of the hierarchy of healthcare provision, with low status and little power.

Part Two – Contextual frameworks provides a critique of the two central models to be evaluated in this research. This commences with a critical examination of the medical model. **Chapter Five** portrays the medical model as ‘reductionist’ and ‘mechanistic’ with the healthcare professional assessing and diagnosing the diseased part rather than considering the individual person as a whole. Power relationships leading to hierarchies in the participant-professional relationship are identified which do not allow the professional to appreciate the ‘lived’ world of the participants. The medical model therefore ignores the participants’ subjective feelings and expectations, and concentrates on objectively measured signs and symptoms related to the organ or disease.

Chapter Six describes General Systems Theory. This theory is presented as the unifying theory between the medical and social models (Bertalanffy, 1968) and led to the development of Engel’s (1977) biopsychosocial model. **Chapter Seven** critically examines the biopsychosocial model because this is the model selected for comparison with the medical model. The biopsychosocial model has been claimed by Engel (1977, 1980) to provide a ‘holistic’ or ‘patient-centred’ approach to the delivery of healthcare. The biopsychosocial model contains three separate entities, the biological (or biomedical) the psychological and social elements. It will be shown that the biopsychosocial model was developed by the profession of psychiatry to elevate its status to that of other medical specialties however, it will be demonstrated that the biological element is usually the dominant element in a hierarchy within the biopsychosocial model. This therefore questions the claim that the biopsychosocial model is truly holistic.

Part Three – Methodological issues of the dissertation develops the research methodology to uncover the answer(s) to the research question. **Chapter Eight** commences with the development of the ‘podiatry career’ a new concept for the ‘journey’ the participant takes as they pass from the recognition of their foot-care needs to the outcome of the podiatry intervention. In **Chapter Nine** an innovative research method is developed in order to reveal the participants expectations and feelings about their foot-care needs. In order to understand the older person’s view of their foot-care needs the study will follow a qualitative research methodology. This places a challenge to the research as medical model studies routinely require an objective approach to the methodology. The reasoning and justification for the selection of a qualitative approach for this study is examined in detail in this chapter. An innovative reminiscence technique is demonstrated through the use of a reminiscence book. The reminiscence book allowed the participants to provide a background history to their lives which had the added advantage of building a relationship of trust between the participant and the researcher. The texts generated by the participants are examined using an interpretative phenomenological analysis within both a medical and biopsychosocial model framework.

Part Four – Reflections from older people presents the findings from the interpretative phenomenological analysis of the participants’ texts. **Chapter Ten** will present specific findings relating to the participants in the study as a homogenous group of older people. **Chapter Eleven** introduces the findings from a medical approach to the participants’ texts. The texts reveal an approach where the participants perceive the podiatrist to have a greater skill than the participant in performing a task to meet their foot-care need(s). Following the performing of the task there ensues a handing-over of the podiatry care to the podiatrist. It will be demonstrated that the participant-podiatrist relationship is an uneven power relationship, in which the participants’

collude with the podiatrist to ‘medicalize’ their foot-care need. **Chapter Twelve** describes the findings from the participants’ texts within a biopsychosocial model framework. The texts will be examined to ascertain whether the provision of a ‘patient-centred’ approach is possible within a biopsychosocial model framework.

Part Five – Evaluation of the models contains an evaluation of the models from the findings that were described in chapters eleven and twelve. In **Chapter Thirteen** a discussion of the evaluation takes place. The evaluation uncovers issues with the participant-podiatrist relationship and the operation of the medical and biopsychosocial models. The final chapter of the dissertation, **Chapter Fourteen – Conclusions**, takes the issues identified from the critical evaluation of the two models and develops them into a new model of podiatry provision. Following the examination of the application of both models, recommendations on how future ‘patient-centred’ or more importantly ‘person-centred’ podiatry care for older people is provided are made. This will be linked to current and future health policy which leads to suggestions for new participant-professional relationships. The new model of podiatry care delivery will be one based on a person’s needs, with their full involvement and thereby delivering truly, ‘person-centred’ care. The implications for health policy, the development of new methods for understanding older peoples’ foot-care needs, and finally implications for podiatry and its traditional caring roles are made.

PART ONE: Setting the Context

Chapter Two

Podiatry

2.1 Introduction

Podiatry is a profession associated with the treatment of foot problems. When individuals are asked the question “what do you think of your feet? “...eeuuh horrible!” is probably the first reaction that comes to individuals minds. There are several reasons for this: personal, cultural and psychological. As Borthwick (1999) states:

“...the foot is difficult to glamorise and has symbolic associations with dirt, smell and impurity which renders the foot unattractive within dominant cultural norms.” (p.26)

Foot problems occur across the general population but their prevalence increases in older age groups. Foot problems are the cause of discomfort, immobility and are recognised as a contributing factor to the loss of independence in older age (Clarke, 1969; Kemp and Winkler, 1983; Cartwright and Henderson 1986; DOH 1994). Bowling and Grundy et al (1997) state that foot problems are the single, physical health symptom consistently associated with chronic difficulties of daily living. They also found that foot problems contributed to physical difficulties and to poor mental well-being in older people.

However, modern society’s view of the foot and foot-care services still remains a low priority with frequently heard comments from carers and other healthcare professionals of “this is something I could not possibly do” [or would not do?] as if it were something beneath them. As George (1995) comments:

“...with the growing need for foot-care services nurses might find they are expected to take on this *additional burden*”. (p.22) [*Author’s italics*]

This negative view of the foot can be traced back through history, from Christ demonstrating humility by washing the disciples’ feet at the Last Supper (Gledhill, 2003). Biblical imagery suggests “...feet are not normally considered particularly attractive and may be thought of as inferior” (1 Corinthians, 12:15, 21, cited in Ryken and Wilhoit 1998), and more recently, Borthwick (1999) states “...association with the foot as an entity demonstrates a diminishing of the individual”.

Negative images of the foot have undoubtedly influenced the provision of NHS services dedicated to foot-care, and services for older people, as Harvey and Frankel (1997) conclude both are viewed as “...low priority, low status and are less glamorous aspects of healthcare provision”. Borthwick (1999) suggests the reasons for this may be lost in history but are firmly embedded in modern Western culture. Later in this chapter, section 2.4 is dedicated to a brief history of the podiatry profession which supports the concept of podiatry being of low status and this historical account goes some way towards explaining why. More recent recognition of the neglect of podiatry services comes in the form of a recommendation from the Commission for Healthcare Audit and Inspection (2006):

“The Department of Health could support improved access to good quality podiatry and general foot-care services by requiring Primary Care Trusts to commission adequate provision of these Services” (p.21)

This negative representation suggests that older people and foot-care services are perceived as a burden and of low status. Older people who require foot-care therefore find themselves seeking

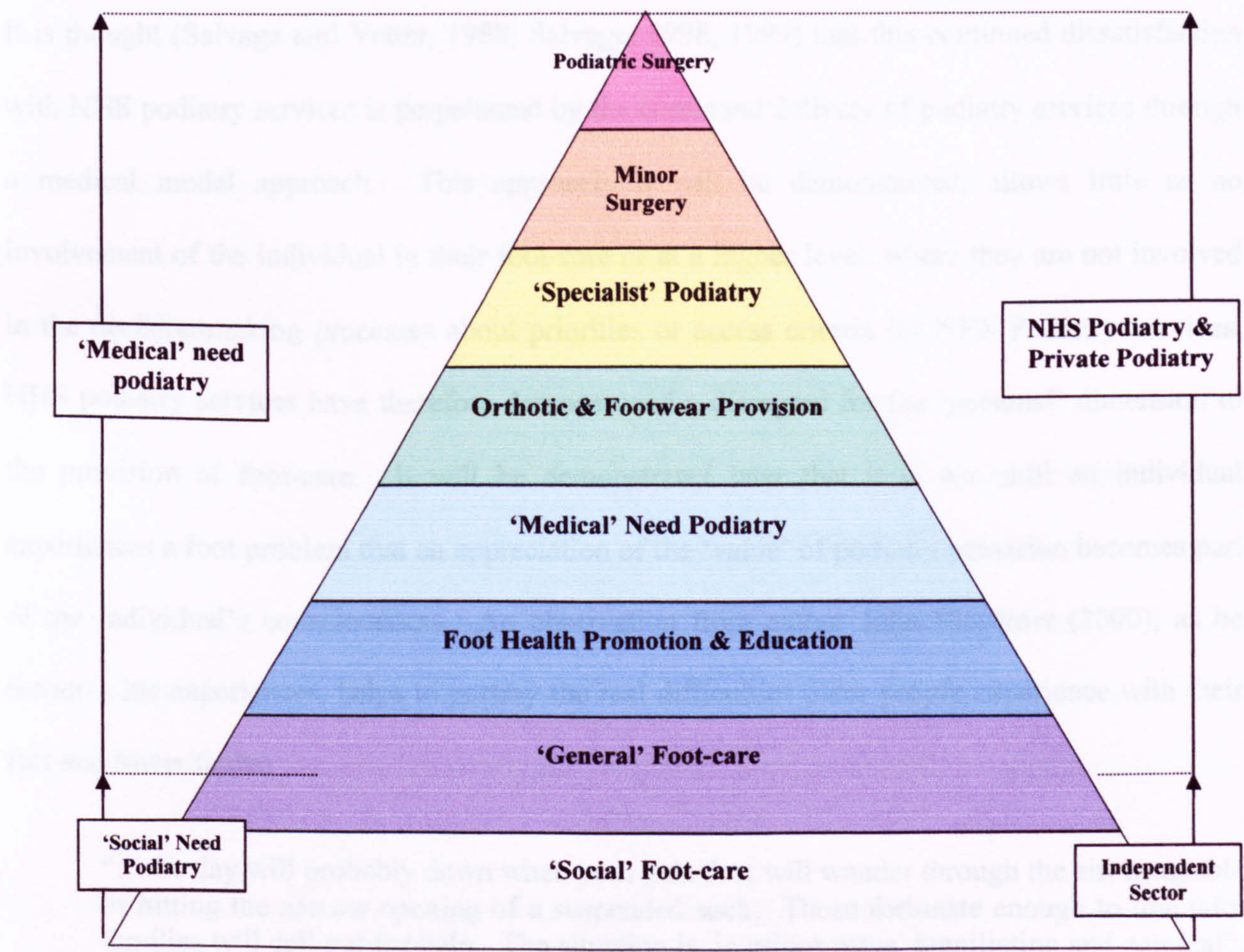
podiatry services that struggle to secure adequate healthcare funds to meet demands, in a healthcare system that is expected to deliver more, year on year within finite resources. Limited resources and lack of specific government policy on foot-care services have resulted in a number of NHS Trusts' Podiatry Services being forced to 're-profile' their provision by reclassifying foot-care needs. This has led to specific aspects of foot-care for older people being reclassified as "social foot-care" and therefore no longer the responsibility of the NHS (Tippins 1998, Lever and Shearer 1999, Campbell and Bradley et al 2000, Campbell and Patterson et al 2002).

There is no national classification of foot-care needs. Although attempts have been made, (Kemp and Winkler, 1983, NHS Executive - 'Feet First', 1994) there remain differing levels of NHS foot-care provision across the United Kingdom. This suggests that as a result of the lack of national guidelines, individual Health Authorities continue to apply inconsistent resources to NHS podiatry services. This in turn leads to inequities in NHS podiatry provision for older people. The differing levels of NHS foot-care provision have not been previously described. Overleaf is a diagrammatical representation of the researcher's view of the current provision of foot-care services and their hierarchy (Figure 2.1). This diagram (Figure 2.1) represents this spectrum of NHS podiatry provision - the 'Spectrum of Podiatry Care'.

The Podiatry Spectrum of Care is presented as a hierarchical pyramid, with podiatric surgery at the pinnacle and 'social' foot-care at the base. While specific numbers are not offered in this diagrammatic representation, there remains increasing demand for foot-care services from across all age groups. It is felt that the diagram is however representative of the perceived demand for the various types of foot-care services, i.e. there is greater demand for 'social' foot-care, than 'medical need' foot-care. As the prevalence of foot problems are greater in older people there is

increasing demand from this group of the population despite the perceived low status of foot-care services provision and the resources they attract.

Figure 2.1: “Spectrum of podiatry care”



While the provision of podiatry remains an essential service for maintaining older peoples' mobility, independence and well-being, older people continue to have little influence in the decisions taken on what foot-care priorities will be provided for by NHS podiatry services. The combination of differing levels of NHS foot-care services provision, growing demands from older people, coupled with current government policy focusing on meeting 'patients needs' has led to national public dissatisfaction with NHS podiatry services.

It is thought (Salvage and Vetter, 1988; Salvage, 1998, 1999) that this continued dissatisfaction with NHS podiatry services is perpetuated by the continued delivery of podiatry services through a medical model approach. This approach, it will be demonstrated, allows little or no involvement of the individual in their foot-care or at a higher level, where they are not involved in the decision-making processes about priorities or access criteria for NHS Podiatry Services. NHS podiatry services have therefore demonstrated a disregard for the 'personal' dimension to the provision of foot-care. It will be demonstrated later that it is not until an individual experiences a foot problem that an appreciation of the 'value' of podiatry provision becomes part of the individual's consciousness. An observation from author John Mortimer (2000), as he recounts his experiences, helps to portray the real difficulties older people experience with their feet and lower limbs:

“...the day will probably dawn when your pale foot will wander through the air, incapable of hitting the narrow opening of a suspended sock. Those fortunate enough to live with families will call out for help. The situation is, in minor ways, humiliating and comical”.
(p.1)

Mortimer's personal view begins to provide an insight into what some older people experience when normal everyday tasks become difficult to undertake. Feelings of humiliation and

frustration at such a perceived minor issue can cause older people to feel reluctant to seek help or to discuss their foot-care needs with others.

The purpose of this research is therefore not to focus on, or glamourise the foot, but to examine the perspectives and experiences of older people who perceive they have foot problems using a comparison of two different conceptual models of care. The first conceptual model is the ‘medical model’ (current model of NHS podiatry provision). The selection of the comparative model has been made on the basis of a model that proposes to take into consideration the individual’s view, the ‘biopsychosocial model’. A detailed examination and discussion of these models is undertaken in Part Two of the dissertation.

2.2 Podiatry – What is it?

Throughout this dissertation the terms ‘podiatry’ and ‘podiatrist’ will be used to describe the ‘profession’ and ‘professional’ identified with providing NHS foot-care services in the United Kingdom. These terms provide consistency, but it is recognised that other terminology is used throughout the U.K. i.e. chiropody, chiropodist, foot health specialist, pedicure and pedicurist. As a result, where the term has been changed to podiatry from its original, it will appear in italics.

The profession of podiatry was not fully regulated until July 2005, and the scope of NHS podiatry provision continues to remain unclear. Within current NHS provision of foot-care services it has been demonstrated that there is a spectrum of care provision (Figure 2.1: Spectrum of podiatry care) from highly specialised ‘medical interventions’ through to less specialist ‘social care interventions’. This distinction is an important factor, as NHS podiatry provision over the

last decade has tended to focus more closely on 'medical intervention' on the basis that this is meeting the populations 'clinical needs'. This 'clinical' distinction is significant, as it has appeared only recently in health policy documents and implicitly allows rationing of healthcare by placing health professionals, unwittingly perhaps, in the position of defining 'clinical needs' because they are perceived to be the 'experts' with the 'knowledge'.

The 'profession' of podiatry remains undefined and it is questionable whether podiatry is a profession. It will be suggested in this chapter that podiatry is attempting to elevate its 'professional' status, as Larkin (1983) suggests, many podiatrists view themselves as 'Cinderella' figures and that the profession still lacks a credible scientific theoretical basis underpinning its practice. Borthwick's (1999) Weberian perspective of the profession views podiatrists as, "acting in their own self interest to enhance their own social status by creating a need for their services and in developing a monopoly of provision by excluding any competitors". (p.21)

To date, there is still no requirement for regulation of practitioners in the private sector unless they wish to use the title 'chiropodist' or 'podiatrist'. The NHS however, only employs practitioners who are 'registered' with the regulatory body, the Health Professions Council (HPC). Prior to April 2002 NHS podiatrists were required to be 'State Registered' and this was gained by three years' full-time study and the successful completion of examinations that led to practitioners being able to register with the Council for Professions Supplementary to Medicine (CPSM).

The professional body representing the majority of Registered Podiatrists, the Society of Chiropodists and Podiatrists (2000) describes podiatry in the following terms. From these

descriptions it can be demonstrated that the professional body identifies itself as operating within a medical framework and aligning itself with the medical profession (author's italics to highlight medical model focus).

“The profession of podiatry has developed from its origins in chiropody to become *a medical speciality dealing with assessment, diagnosis and treatment* of the lower limb”

“Podiatry has developed a broad scope of practice focussing on *the scientific principles* of a wide range of lower limb disorders”

“Podiatry continues to be *a developing progressive profession* enhancing patient mobility and quality of life”

“Podiatrists are *autonomous professionals* who may also work as part of *a multi-disciplinary team within health-care*. They are enthusiastic, independent professionals who are able to adapt to *working in a variety of clinical environments* both within the National Health Service (NHS) and the private sector”

So how did the podiatry profession come to have such a medical model focus? As suggested in the introduction, the reasons for podiatry's attachment and operation within a medical framework are many and complex and can be traced from a historic context.

2.3 Historical development of podiatry

It was suggested in the previous section that the historical development of the medical and podiatry professions, and later the NHS, have had a profound affect on the way in which podiatry services are delivered today. This next section highlights the important historical references relevant to this research. (For a wider history of the profession see Brodie 1989, Dagnall 1995a, 1995b, 1995c, and Borthwick 1999a, 1999b, 2005)

The profession of medicine has a history of practice that covers hundreds of years. The podiatry profession however, originated more recently, in France in the eighteenth century and was closely

followed by development in Britain (Dagnall, 1995a). At the end of the eighteenth century, Armstrong (1987) suggests, that two important concepts within the medical profession emerged: (i) symptoms and history and (ii) signs and examination, terminology that is associated with a medical model approach. These concepts led to the theory of the 'medical model' with its focus on the disease/lesion/organ rather than on the individual. The body of knowledge that developed is one reason for the superior position the medical profession commands within the provision of healthcare. This body of medical knowledge is discussed as part of the critique of the medical model in chapter five.

The beginnings of the podiatry profession come from 'humble corncutters' (Dagnall 1995a). Thomas Nashe (1593 cited in Dagnall 1995a) described the individuals who provided foot-care as "broome boyes and corncutters (or whatsoever trade is more contemptible)". The demand for 'corncutters' came about because physicians and surgeons, then two separate groups (and even barbers), regarded the treatment of corns beneath their dignity.

"A Treatise on Corns, Bunions, the diseases of nails and the general management of feet" (Durlacher 1845, cited in Dagnall 1995a) helped establish podiatry as a branch of medicine and surgery. It helped 'able and ethical practitioners' to be considered as professional men and women. Interestingly, Durlacher's book noted that the part of the population most in need of podiatry services were the lower classes, especially servants. As this section of the population was generally poorer and at the lower end of the social hierarchy, they were unable to pay for professional assistance, and at the same time were not eligible for hospital treatment until the disease had advanced enough to cause serious problems that required 'medical' attention.

In the period leading up to the First World War, podiatrists were few in number and continued to largely serve the upper classes. Podiatry practices were situated mainly in larger cities, in locations that reflected the upper classes, with practices usually being passed from one generation to another (Dagnall 1995c).

The economic depression after the war saw the development of an increasing number of correspondence courses offering training to become a podiatrist. This was partly as a result of the requirement to meet the needs of the country's many unemployed people (Dagnall, 1995c). In 1933 the establishment of the National Register of Auxiliary Medical Services saw podiatrists gain their first recognition when they became registered Medical Auxiliaries. The register however, was created by the medical profession and remained under the direction of doctors.

A British Medical Association (BMA) meeting in 1934 discussed the recognition given to podiatrists. While medical and surgical specialists were largely sympathetic to the move to a national register, they still required a strict definition of the podiatrist's role. General Practitioners however remained largely unsympathetic. A doctor who led the opposition stated that:

“...*podiatry* was either an aesthetic enterprise or a therapeutic method, and he thought it was the former.” (Dagnall, 1995a)

From 1948, podiatrists lobbied the government about its failure to provide a national podiatry service. In a report entitled, “The Social Medicine of Old Age”, Sheldon, (1948, cited by Dagnall 1995c) commented on the needs of older people as:

“...there is little doubt that the two measures which at the present time would give the greatest relief to old people are adequate provision of *podiatry* and the supply of spectacles. By no means all the afflictions of the feet would be relieved by *podiatry* assistance, but many would derive great help. Such assistance would be much easier to provide than physiotherapy for rheumatic disorders and there can be no doubt as to the gratitude with which it would be met. Pain in the feet is worthy of special attention for two reasons: (a) it is apt to render the subjects immobile to a degree out of all proportion to the seriousness of the condition and, (b) it is almost the only physical complaint which caused great resentment in the sufferers, the other being the incontinence of old women. Seeing that it affects women so much more than men, and that women have put such a constant strain on their feet in shopping and housework, there is much to recommend an extension of the facilities for *podiatry*”. (p.178)

Despite the somewhat ‘politically incorrect’ statements above, the views expressed are representative of the era and reflect the stereotypes that the medical profession used to categorise the general population. It could also be suggested that this ‘feminization’ of foot-care provision was discriminatory and kept foot-care provision as a lower priority.

A recommendation by the Guilleband Committee in 1953 confirmed that local authorities [not the NHS] should be allowed to develop podiatry services. These services were still not free at the point of delivery, as a small charge was made unless an individual could demonstrate they were on state benefits. However, it was not until December 1956, and despite Treasury objections, that the introduction of a national podiatry service was announced. The timing coincided with an increase in the prescription charge, and it could be suggested that the introduction of a national podiatry service was used to deflect complaints from older people about these increased charges.

Regardless of this announcement it was not until 1958 that an extension of podiatry services through health departments in local authorities, that a national podiatry service was established (personal informant). This initial development of podiatry services was however limited to

specific 'priority groups' rather than based on needs, (Boden, 1997). These groups were: people aged 65 years and over, the physically and mentally handicapped and expectant mothers [*Author - it is recognized that some of the terms used in the 'priority groups' are no longer politically correct*]. A small number of local authorities also included children in their priority groups. As Boden (1997) suggests, this led to assumptions and expectations that anyone of 65 years old or over had 'a right' or 'entitlement' to subsidized foot-care provided by the State. This left access to foot-care provision based primarily on age, rather than any defined need.

The next major defining event in the development of podiatry services took place in 1974. Following a major review of local authority and national health services the responsibility for the provision of podiatry services transferred to the National Health Service, though the Local Authority eligibility criteria remained in place. These criteria however, were at odds with NHS policy on access to services which in theory were free at the point of use and provided on the basis of need (Boden, 1997). It was not until the 1990's that podiatry services began to challenge the Local Authority 'Priority Groups' and moved towards a model of provision based on 'medical' and 'podiatry' need. This saw a challenge to the universal acceptance of older people being 'entitled' to free podiatry treatment. It is not clear whether the move to change podiatry access criteria was driven by the podiatry profession elevating its status, or the drive from numerous Health Authorities wishing to decommission specific aspects of traditional podiatry care in order to make financial savings.

What is clear is that the development of the new access criteria were based on medical and podiatry needs (Tippins 1998, Lever and Shearer 1999, Campbell and Bradley et al 2000, Campbell and Patterson et al 2002). These criteria were also based on professional opinion and

not based on the foot health needs of the local population. The re-defining of podiatry access criteria led to specific aspects of foot-care provision being redefined as 'social care' i.e. the cutting of non-pathological toenails (see Spectrum of podiatry care, Figure 2.1) and as a consequence, no longer the responsibility of the NHS. This medical model approach has led to many older people with 'social' foot-care needs being disadvantaged, as a greater focus on 'medical conditions' related to an individual's foot problems have been implemented. This supports the suggestion that the podiatry profession is attempting to elevate its status by aligning itself with the medical profession, rather than focusing on meeting the foot-care needs of older people who continue to be perceived as a 'low status' care group. It can also be suggested that the development of the podiatry profession has been hindered by its own belief that it should be of the same status and standing as that of dentistry or the medical profession, whereas Macdonald and Capewell (2001) contend that podiatrists feel NHS podiatry services are burdened with low skill tasks that impede the use and development of their professional training. Yet, the podiatry profession continues to try to extend its professional knowledge base and encompass new, more technical and specialist roles at the same time as still jealously guarding its right to accept, diagnose and treat people without reference to the medical profession.

The dental profession has perhaps been more successful in increasing its status. It has gained greater autonomy and status because of its symbolic importance at a 'vulnerable margin'. As Borthwick (1999) observes, podiatry has been unable to match this development because of its symbolic insignificance:

“...the symbolic significance of the mouth and teeth as the 'vulnerable margin' of the body through which communicable diseases gained entry thereby preventing epidemic diseases and maintaining healthy bodies.” (p.26)

The podiatry profession's strategy to enhance its professional status has therefore been to leave behind the image of 'cutting older people's toenails', in order to assist its own development and recognition. However, this 'podiatric gaze' is resulting in specific groups of the population (i.e. older people) with no state provision to meet their 'social' foot-care needs, which were previously defined 'general foot-care', (Figure: 2.1, Spectrum of podiatry care). The podiatric gaze is explained in more detail in chapter 5, section 5.2. The undertaking of this element of foot-care provision has now been transferred to carers and various voluntary organisations. Therefore, while the podiatry profession attempts to elevate its professional status it can be accused of neglecting the unglamorous and more vulnerable members of society who require more basic foot-care services. Macdonald and Capewell (2001) suggest that alternative sources of basic foot-care provision are not acceptable and older users of NHS podiatry services feel that involving relatives is demeaning and that using voluntary organisations who charge is 'paying twice'.

2.4 Podiatry epidemiology

From the 'Podiatry Spectrum of Care' it has been suggested that there are significant numbers of older people who have basic foot-care needs. Unfortunately, there are few scientific studies on podiatry services or foot-care needs. The lack of a knowledge base is perceived as a source of weakness for the podiatry profession especially when compared to 'the power' of the medical profession's evidence base. Scientific evidence based on randomised controlled trials, is presented as a 'gold standard' of medical research evidence, but unfortunately podiatry has currently very little quantitative research evidence.

In the USA, podiatry is perceived to have a higher status and this is in part due to its scope of practice (greater focus on medical aspects i.e. surgery) and its knowledge base. Two National American studies have demonstrated that considerable numbers of people require the services of podiatrists’, (Greenberg, 1994), see Table 2.1

Table 2.1: Number of people requiring podiatry

	Males per '000 popn	Females per '000 popn
NHIS	194	224
Brimm Comm	205	310
In the over 65 year olds 10:1000 had toenail problems, 124:1000 had corns and callous, 47:1000 had foot infections and 56:1000 had bunions.		

Studies in Britain have tended to focus on the ‘priority groups’ and therefore specific groups of older people. However, a small number of whole population studies have demonstrated that problems with feet are more common in older people (Clarke, 1969; Vetter, 1985; Salvage, 1999).

Macdonald and Capewell’s (2001) study suggested 45% of all people over 65 years old receive NHS podiatry and that 87% of NHS podiatry was provided to pensioners. In Vetter’s (1985) earlier study, 53% of participants admitted to some form of foot trouble that required professional help. This compared with 30% of over 65 year olds in an even earlier, large national study conducted by Clarke (1969), but over a third of people in the study were under seventy years of age and thereby missing a larger group of older people who potentially had greater need for podiatry services. Macdonald and Capewell, (2001) suggest almost 50% of people over 75 years state they need better foot-care and for older people as a whole, podiatry is the most important NHS service after General Practitioners. A study by George (1995) identified that amongst

disabled people, who stated they needed more care, podiatry was the single most important health service requested.

In studies looking at specific foot problems, Benvenuti and Ferrucci (1995) found that foot pain was associated with a higher prevalence of disability, especially people who were affected by callous, corns, hallux deformities, hammer toes and other recognised foot conditions. They went further to state:

“...adequate foot-care provided for subjects having difficulty in coping with the basic needs of their feet or reporting foot pain can be an important strategy for prevention of disability in older persons”. (p.484)

Hadbridge's (1993) previous study led to similar conclusions:

“Adequate foot care services would not only lessen the pain and discomfort of large numbers of older people, but would increase the mobility of many, probably around 700,000, thus preventing dependence and the ensuing demands on other services”. (p.23)

Harvey and Frankel (1997) in their study found that 53% of over sixty year olds had three or more recognised foot problems and that two fifths of those assessed as needing podiatry care did not receive it. Bowling and Farquhar, et al (1994) highlighted that 30-45% of their study group of older people with chronic disabilities did not receive podiatry services.

The General Household Survey carried out in Britain in 1994 (ONS, 1996) and the follow-up survey of the health of people aged 65 years and over (OPCS, 1996) highlighted the high prevalence in older people of disabilities affecting hearing, sight and mobility. Problems with feet were identified as one of the major causes of walking difficulties in older people. This suggests a connection between maintaining mobility and independence in older people which is

an area that has not been explored in detail in any podiatry studies. This may relate to the podiatry profession's, continued 'gaze' on the foot inhibiting its recognition of the wider benefits of podiatry provision for users of its services.

Wallace (1991) identified sharp increases in disability in people aged 75 and 80. This disability related particularly to the ability to cut toenails. From the 1994 General Household Survey (OPCS, 1996), the following differences in abilities to cut toenails by age and gender have been identified (see Table 2.2 below).

Table 2.2: Percentage of population experiencing difficulty cutting toenails by age/gender (GHS, 1994)

Age/Sex	65-69yrs	70-74yrs	75-79yrs	80-84yrs	85+yrs	All over 65
Males	14	16	25	46	57	23
Females	17	31	39	60	60	36
All elderly	16	25	34	54	60	31

An important point to note is that the General Household Survey only includes those living in private accommodation; it does not include people living in institutional settings. As a significant number of older people reside in institutional settings, and there are greater numbers of older women than men, this could further support Arber and Ginn's, (1991) suggestion that the inability to cut toenails in women and older people in general is greatly underestimated. This evidence also supports the earlier assertion of a 'feminization' or discrimination against older women in the provision of NHS podiatry services.

The above statistic implies a subtle inequality in provision of podiatry services and that current ‘medical model’ podiatry provision does not allow an equitable distribution of resources to this older female age group. However, the proportion of women in older age groups does get larger as age rises, suggesting greater numbers of older women will require podiatry services than men. This is reflected in the current age/sex mix of people attending podiatry services locally and nationally (DOH Statistics Division 2001, 2002, 2003, 2004, 2005). In East Gloucestershire twice as many women attend for podiatry treatment in the over-eighty year old age group (see Table 2.3).

Table 2.3: Age/Sex profile of older people attending NHS podiatry in East Gloucestershire (1999/2000)

Gender/Age	0-64yrs	65-74yrs	75-84yrs	85+yrs	Total
Female	2309	1722	3047	1999	9077
Male	1950	1129	1564	717	5360
Total	4259	2851	4611	2716	14437

Inequalities in healthcare are described by Townsend and Davidson (1992), who suggest that working class people make less use of dental and *podiatry* services. Whilst they admit that many of the studies are old, they feel that in the absence of later evidence to the contrary, a clear relationship between social class and the use of preventative services seems to have been demonstrated. The implications of social class were identified in the historical context of podiatry provision and are therefore a relevant issue.

This section on podiatry epidemiology has identified foot problems to be highly prevalent amongst the older population. After the age of 65 years the incidence of foot problems increases with each decade. Foot-care provision for these groups of people is not universally available, but

studies have shown that foot-care services are greatly appreciated by those receiving the service and are the most frequently requested after General Practitioners.

2.5 Podiatry Needs

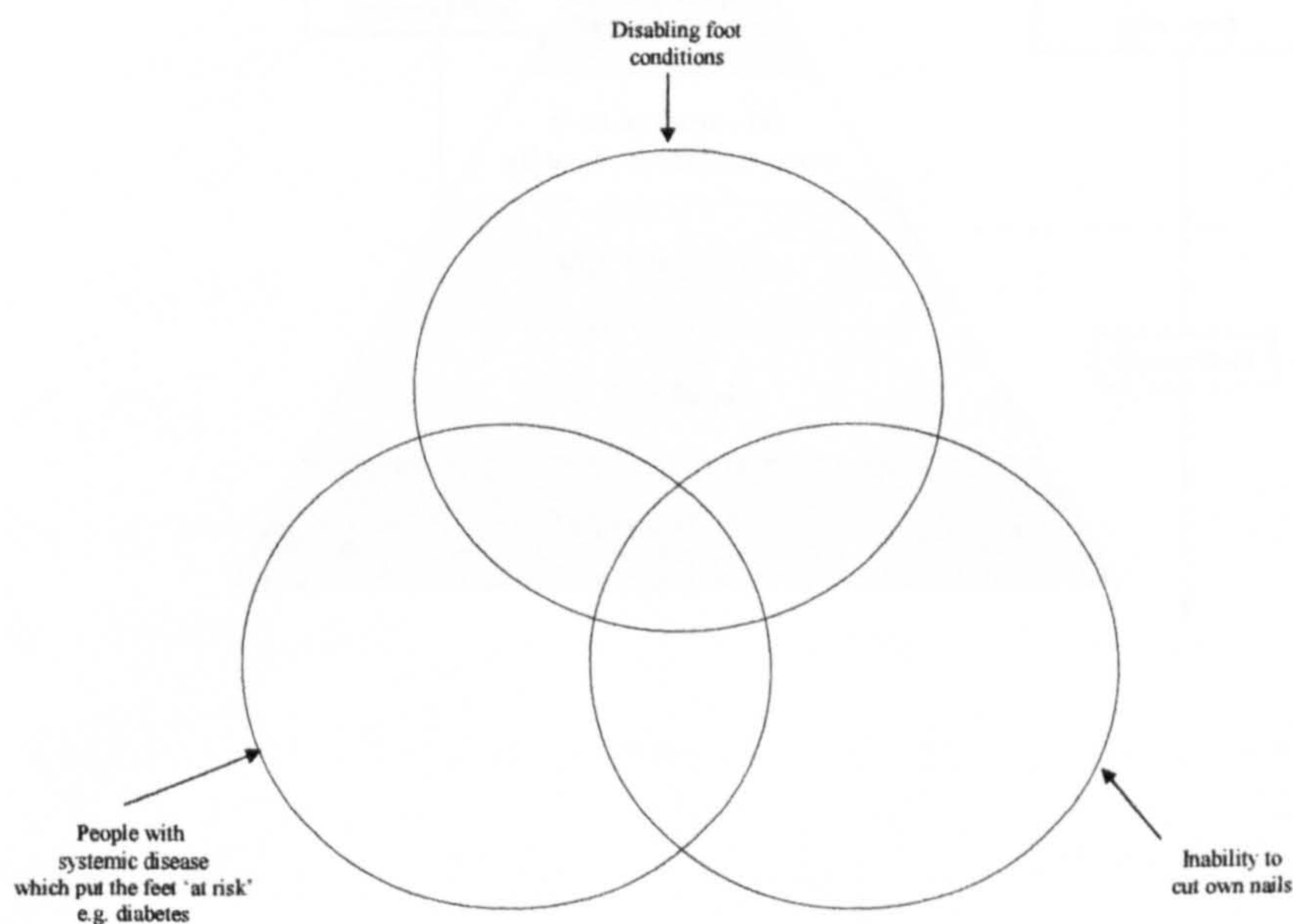
Clarke (1969), Kemp and Winkler (1983), and Cartwright and Henderson (1986), identified that demand for foot-care is high amongst older people and a small number of population studies have recognised that the 'need' for foot-care is also high. However, Macdonald and Capewell (2001) state that there has never been a precise definition of what constitutes 'need' for NHS podiatry services. 'Feet First' (1994) was the first official government publication that emphasised the requirement for NHS podiatry services to be reappraised on a new model of podiatry need (Figure 2.2 overleaf).

Unfortunately, little attention has been paid to the recommendations made in this document by Commissioners of Health Services (Health Authorities and later Primary Care Trusts). The 'Feet First' model of podiatry need is far less complicated than the concept of podiatry need suggested by Kemp and Winkler (1983) (Figure 2.3).

The 'Feet First' review (1994) was aimed at re-balancing skilled resources with need at no extra cost. In other words it encouraged the focussing of limited podiatry resources on specific areas of foot care practice. History may demonstrate that the 'Feet First' review (1994) drew attention to NHS podiatrists providing foot-care services that were not perceived by Commissioners of health services as meeting 'health' needs. Rather than changing the skill mix of professionals within NHS Podiatry Departments, many services were 're-profiled' which in specific terms meant

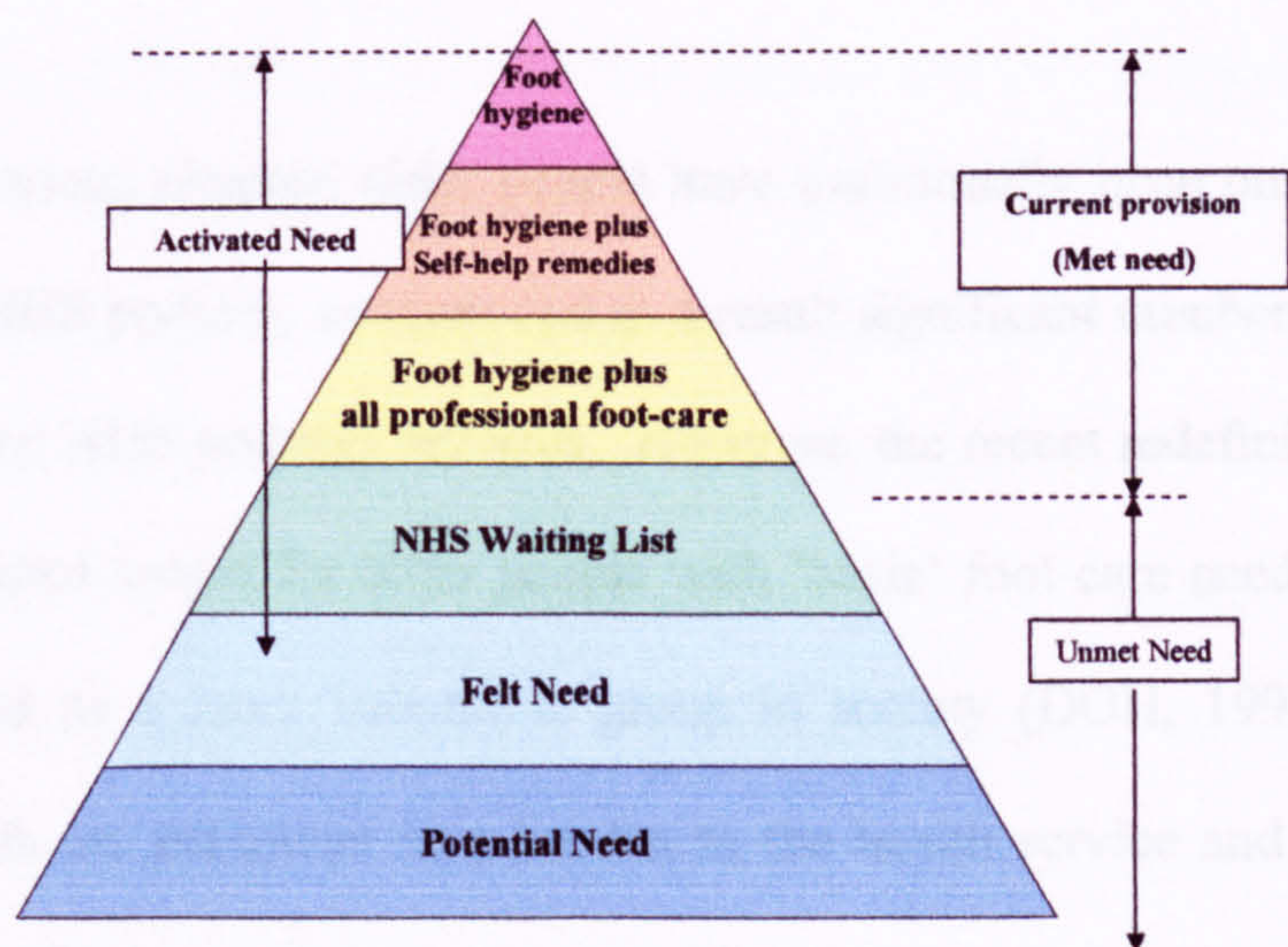
reducing their caseloads to focus on those people with greatest ‘clinical need’. This released funding to support other projects in local health communities, as discussed in the brief history of podiatry section, chapter two.

Figure 2.2: Podiatry Needs – ‘Feet First’ (NHSE, 1994)



Despite a large number of NHS Podiatry Services developing new access criteria based on medical and podiatry needs (Tippins, 1998; Lever and Shearer, 1999; Campbell and Bradley et al, 2000; Campbell and Patterson et al, 2002) there is still a lack of agreement between podiatrists about clinical assessments of need made in the various podiatry studies (Clarke, 1966; Kemp and Winkler, 1983; Cartwright and Henderson, 1986; Brodie and Rees et al, 1988; and Greenberg, 1994). Agreement on terminology seems to have focused on ‘podiatry’ and/or ‘medical’ needs yet there remains no consistency with definitions of podiatry need (Boden 1997).

Figure 2.3: Multiple concepts of podiatry needs (Kemp and Winkler, 1983)



A large group of the population have been documented to access NHS podiatry services based on an identified clinical need, and they are the age group selected for this research study. The following chapter provides a background context for this group of the population often referred to as ‘older people’.

Chapter Three

Concepts of ‘older people’

3.1 Introduction

As highlighted in the previous chapter, older people have traditionally been one of the ‘priority groups’ given access to NHS podiatry services and as a result significant numbers of older people have traditionally accessed NHS podiatry services. However, the recent redefinition of foot-care needs has severely restricted access for older people with ‘basic’ foot-care needs. Older people have also been portrayed as a more vulnerable group in society (DOH, 1998) and evidence suggests that older people are perceived as a burden to the health service and society (Tinker, 1984; Bytheway, 1995; Dalley, 1998; Maynard, 1999). As Johnson’s (2002) historical examination reveals, in Britain there never has been a ‘golden age’ for older people when they were respected and valued because of their age and this issue has influenced the selection of older people, specifically people 75 years and over, as the central group of people for this research.

This chapter seeks to identify and explore issues for older people relevant to this research. Much of the available research treats older people as a homogenous group of people. As this research seeks the viewpoint of the individual older person, it is recognised that some of the issues discussed may not be relevant to each individual, and they may not always respond in ways identified in this chapter. Each individual’s views of their experiences and expectations will be examined through the use of a medical and biopsychosocial framework, and from this comparison, differences will be documented. One of the key aims of this research is therefore to

discover and understand the individual nature of older people's needs and expectations of NHS podiatry services through an evaluation of these two different frameworks.

3.2 'Older People', who are they?

In terms of UK government statistical records anyone 50 years and over is classified as 'old' yet traditionally, 65 years is seen as the entry into 'old age'. Whitbourne (2001) states our chronological age is a number based on events in the universe that occur independently of events inside our bodies. Nonetheless, those people who are approaching 65 years of age confront very different issues and challenges to those who are 85 years and older. These issues and challenges for older people are often portrayed as relating to the quality of physical functioning and health, but they also involve different economic constraints and social opportunities, which makes the grouping of older people as a homogenous group problematic.

The term 'old' is often used in a derogatory manner particularly when describing 'older people'. One of the most derogatory 'medicalized' terms is 'geriatric', a noun used to describe a frail old person instead of its correct use as a branch of medical science concerned with old people and their illnesses (Norman, 1986). Whitbourne (2001) proposes that people who are 65-74 years are 'young-old', 75-84 years are 'old-old' and 85 years and older are "oldest-old", which the researcher considers to be equally derogatory terms because older people are individuals who have needs and demands like any other person.

Careful consideration has therefore been given to how to refer to people involved in this research. In order for people in this research to retain their individuality and not feel demeaned it is

proposed to refer to the individuals either by an anonymised forename, or if a generalised term is required, they will be referred to as a 'participant'.

A general distinction is drawn by Aldwin and Gilmer (1999 cited in Whitbourne 2001) between 'normal ageing' (primary ageing) that refers to age related changes that are universal, intrinsic and progressive and 'secondary ageing' a term used to refer to changes that are due to disease. The basis for the distinction is the need to differentiate between normal age related changes that occur throughout life and the diseases that eventually cause death by leading a vital life function to shut down. However, demonstrated here is the concept of linking old age with disease [medicalizing old age], when a large percentage of older people are able lead a 'normal' life. Rather than 'old age' being portrayed as deviant from leading a normal life, getting older involves being able to overcome threats to physical and psychological well-being presented by the ageing process. Whitbourne (2001) summaries this as:

“...it is important for practical as well as scientific reason to distinguish between normal ageing and disease. Practitioners who work with middle-aged and older adults must be able to recognize and treat a disease when it occurs rather than attribute it to the normal ageing process or simply getting older” (p.6)

Whitbourne (2001) suggests that rather than just taking a biological approach, the encompassing of psychological and social factors will enable a better understanding of successful ageing that involves the ability for the individual to become engaged with life in terms of both relationships and productive activity.

A person's age is therefore often used as an index of functioning, rather than taking it as an important social cue. As Whitbourne (2001) suggests, this one piece of information about a

person tends to generate a specific focus and is exemplified by the amount of attention given by the media to learning the age of a celebrity. This attention to a person's age has led to a careful consideration of the presentation of the findings and quotes in this research. It has been decided that when attributing specific quotes to a participant it will also include their age. This is not to sensationalise, but to highlight some of the misconceptions that 'normal' ageing brings and to celebrate what is possible, irrespective of your chronological age.

There is no denying that as we get older there can be a general reduction in an individual's ability to physically function compared with when we are younger. However, an individual's personal recognition of growing older occurs as a gradual process throughout adult life. This process has been described by Whitbourne and Collins (1998) as the 'multiple threshold model'. Whitbourne and Collins (1998) describe individuals passing through a threshold of feeling 'old' at different times through their adult life when different systems of the body are affected. 'Systems' constitute a concept relevant to the two central frameworks of this research (medical & biopsychosocial). It is the 'systems' contained within the human body, and outside of it, that will be identified and examined in detail in chapters five and seven.

3.3 Psychological aspects of Older People

Clearly, older people are more than just a group of people in society who experience increased medical problems. Older people are individuals, who have other relevant 'systems' that affect their lives and functioning. It is the biopsychosocial model, Engel (1977) claims that will capture these other systems by including psychological and social aspects of individuals. As this research seeks to compare the medical and biopsychosocial model approach to older people's foot-care needs, the exploration of wider psychological theories is therefore required. An

examination of some of pertinent psychological features of older people now follows, as these phenomena may make a relevant contribution to the development of an appropriate methodology for this research.

3.4 Theory of 'the self'

The importance of the concept of 'the self' was first highlighted in this research following the completion of two sets of pilot interviews with older people. How older people perceive themselves as individuals is an important factor in understanding and interpreting what exactly they are saying. Whitbourne (1996) suggests that older people approach their experiences of life from the vantage point provided by their personal identities and their ideas or concepts about 'the self'. This has become known as 'identity process' theory. The concept of 'self' in the identities of older people relates to physical appearance and functioning, cognitive abilities, personal traits, relationships with others and social roles. In other words individuals define themselves as looking a certain way, having certain abilities, behaving in accordance with certain dispositions, relating to others in certain ways and having a set of particular social roles that define them within their specific communities and contexts. Older people appear to use the identity process to minimize the perceived effect of potentially disabling health conditions through 'identity assimilation' and as Whitbourne (2001) suggests, the majority of older people are able to separate whatever discomfort and disability are associated with these conditions from their overall feelings about their abilities and their health.

The concept of 'the self' has been described by Markus and Herzog (1991) as multifaceted and a dynamic entity that incorporates an individual's experiences across time. It catalyses action and provides continuity and meaning to those experiences. This is the primary component of all

aspects of psychological experience, including emotion, well-being, motivation, control, efficacy and competence. Carstensen (1992) suggests older people who understand 'the self' usually have better outcomes in terms of healthcare, as this has the advantage of a more positive effect when individuals plan and engage in social activities successfully. Similarly, Markus and Herzog (1991) recognise that these features provide a view on how concepts of 'the self' provide resilience mechanisms for older people.

Understanding concepts of 'the self' not only brings organisation to an older person's life experiences and a sense of continuity and coherence across their diverse life experiences, it is also central to understanding the views of each participant in this research. A complex process of self regulation known as 'life review' which encompasses the reconstruction, explanation and evaluation of the past has been described by Butler (1963) and this can provide a rich source for the restoration of psychological balance in the face of life transitions. The development of 'the self' concept involves a selection of age-friendly environments (Lawton, 1982), the optimisation of certain skills and compensation for the loss of others (Baltes and Baltes, 1990), for the engagement in successful life review (Butler, 1963). 'Life review' became a key concept in developing the research methodology, and is of central importance in developing a method to 'hear the individual voices' of the participants in this research. This led to an exploration of 'life review' techniques as a method to gain trust and credibility with the participants, and to better understand what individuals are saying by situating the research in 'their world'. This concept is explored in greater detail in chapter nine. There is a note of caution. Individuals can view the events in their lives from the standpoint of relevance of those events to 'the self' and as Whitbourne (2001) suggests, events may not always be viewed from a realistic perspective, which has great importance in the design of the research methodology.

Bergeman and Wallace (1999) have referred to 'possible selves' which relate to what an individual thinks about himself/herself in the past, what the individual knows about themselves in the present and what the individual believes is possible for them in the future. This is supported by Paulus and Christie (1981) who had earlier suggested that older people can self evaluate through selective social comparisons. For example, as life changes, people find new aspects of comparison to help them reorganise their standards or values which led Bergeman and Wallace (1999) to propose:

“...the selection of an appropriate comparison group is an important mechanism that empowers an older person to manage the gains and losses of older age.”(p.211)

Markus and Hertzog (1991) agree that a positive sense of self can result in positive changes in health behaviours. Therefore, older people with a positive self-concept will be more motivated to follow up health-promoting behaviours and thereby improve their own health. Bergeman and Wallace (1999) support this view and advise that as everyone ages differently, a one size fits all intervention strategy will not work for all individuals. Rather than attempting to change individuals' specific behaviours, enhancing feelings of 'the self' through strategies aimed at life review or selecting an appropriate comparison group can be beneficial to older people. Alternatively, Rodkin and Timko (1992) suggest that a loss of self (or control) caused by situational changes related to ageing, such as retirement, elicit bodily preoccupation and symptom monitoring can facilitate an older person to adopt the 'sick role'. It is therefore important to recognise that an individual's response to healthcare interventions can be dependent on how they view their 'self'. A comparison of the operation of the medical and biopsychosocial models and their influence on 'the self' will be a key issue for exploration in this research which will support the development of an innovative approach.

3.4.1 Role theory

Closer examination of the concept of 'the self' gives acknowledgement to the number of different roles an older person can adopt, which are dependent on individual events throughout an individual's life. As a result, a brief examination of role theory, understanding older people's perspectives of their lives and the role they see themselves fulfilling is necessary. Gove (1994) suggests that individual identities are developed and sustained in role relationships (role theory). A meaningful existence over a life time therefore depends on the roles people adopt. Gove (1994) develops his theory by stating that as we start life, individuals first associate with 'role acquisition', then with 'role transition' as we grow older, and finally experience 'role loss' when a person retires for example. Gove (1994) suggests that as we age:

“...we develop a positive sense of self, an increasing satisfaction with social relations, a good affective state, low levels of alienation and a healthy and satisfying lifestyle.” (p.383)

This raises an intriguing question for the research: “As we get older will role loss influence an individual's actions towards their healthcare?” For instance do older individuals' no longer perceive it their role to hold any responsibility for meeting their own foot-care needs?

3.4.2 Coping strategies

Unfortunately, not all older people have such a positive outlook on life as Gove (1994) might suggest. Some older people develop coping strategies specifically in relation to their health problems. An additional aspect for this research to consider is coping strategies older people may use in identifying and managing their foot problems.

Michalos (1985) cites an example of a coping strategy; when individuals look at the situations of others who are more unfortunate than them and they comfort themselves with the thoughts that things could be worse. Luker (1982) also identifies the 'somebody worse off than me syndrome' as a way that some older people cope with growing older and suggest:

“...as long as older people believe that there is someone worse off than themselves they are then able to cope effectively with the restrictions that older age eventually imposes on daily life.” (p.57)

To demonstrate this, Luker (1982) uses a specific podiatry example from her study of Health Visitors. She compares two older individuals who both had 'identified medical reasons' for referral to a *podiatrist*. One individual had diabetes and the other had rheumatoid arthritis [medical disease labels]. The first individual had previous experience of podiatry whereas the second did not. This difference did not account sufficiently for the second individual's refusal to be referred. It was concluded that the second individual was someone who found comfort in the knowledge that there were people worse off than herself. This form of 'acquiescence' may be relevant to this research and acquiescence as an issue is explored later in this chapter and chapter nine. Luker's (1982) view is that despite the older individual's obvious need for podiatry the older person preferred to manage for the time being on her own and she seemed to take comfort from the fact that people worse off than herself would receive podiatry care. Luker (1982) continues this theme with a typical medical model approach (not taking into account the individual's views), stating that it was difficult to perceive of anyone worse off than this particular older person in terms of her physical disabilities [!].

Bury (1991), and Pound and Gompertz (1998) propose this form of 'coping', where the individual conceptualises others as worse off, as referring to the cognitive processes that individuals adopt to tolerate or put up with the effects of illness. Coping is therefore the sense of maintaining a feeling of personal worth, which is an important defence against the stress of any health problems. Pound and Gompertz (1998) advocate that people who live through their seventies, eighties and nineties may be equipped with considerable skills that enable them to deal with crises and successfully adapt to new situations whereas, Blaxter and Paterson, (1982) propose older people may have low expectations of health and may accept illness as an inevitability of their age. This suggests that age mediates the way in which chronic health problems are experienced and responded to. Being able to recognise participants' coping strategies and their relevant expectations is an important dimension in understanding how individuals construct their views. This will be considered in the development of the research methodology (chapter nine).

3.4.3 Trait theory

In recognising that older people may be employing various coping strategies leads to a brief examination of specific personality traits that may be presented by the participants in this research. It has been suggested by Costa and McCrae, (1984), Rodin and Salovey (1989), Booth-Kewley and Vickers (1994) and Jerram and Coleman (1999) that personality traits, along with other psychosocial variables may have a stronger link with health in older age, in terms of reporting physical symptoms, satisfaction with health, general well-being, and health behaviours.

The basic principle of trait theory is that personality is equivalent to a set of stable characteristic attributes. According to Kelly (1955) the ways that people characterise themselves and others are what make up their personality. Kelly (1955) argued that 'personal constructs' represent subjective interpretations of the world and these constructs are changeable. Descriptions such as 'generous' or 'outgoing' can be used to portray the personality of an individual and within trait theories of personality these adjectives will capture the essence of the individual's psychological profile.

The process of growing older may involve an increasing number of experiences in which the older person is unsuccessful at exerting any influence upon their world. It can be difficult for an older person to maintain their self-esteem, when at the same time they may be experiencing increasing losses and their individual goals being scaled down. This phenomenon can lead older people to expect less than younger people. The trait of 'loss of self' can lead older people to disengage from their social world, leaving them feeling disempowered and dependent. This is an important factor as the medical model will be identified as disempowering and the combination of the medical approach with an older person who already feels disempowered may add a different dimension to the development of a 'person-centred' approach to the delivery of podiatry services.

3.4.4 Disengagement theory

The loss of self can lead to disengagement from the social world. This was first described as 'disengagement theory' by Cummings and Henry (1961), and their theory proposed that during middle age and beyond, an individual can decide to disengage from social involvements. As this happens, society also withdraws support and interest from the

individual, which leads to older people progressively withdrawing from social interactions as they prepare for death. Victor (1987) suggested that disengagement in this sense implies a triple loss: of roles validated by society, of restricted social contacts and a reduced commitment to social customs. A critic of disengagement theory, Biggs (1993), presents older people in a more positive light by recommending that older people should be considered as “active creators of meaning and the authors of projects” (p.9) and that disengagement theory can be dismissed. Recognition of the phenomena of disengagement from society, or not, will be considered by the researcher, as this may influence the participants’ view of their world and their foot-care needs.

According to disengagement theory, to age ‘successfully’ or to have a positive approach to older age involves a mutual withdrawal of the individual from society. Cavan and Burgess, et al (1949) consider this theory to be harmful to the well-being of older individuals, forcing them out of productive social roles and they propose an alternative, ‘activity theory’. Atchley (1989) took activity theory and developed it into ‘continuity theory’. Atchley’s (1989) theory states that if older people are not allowed to maintain their desired level of involvement in society they will suffer a loss of well-being, and experience the negative effects of ageism. Whitbourne (2001) recognises the implications of continuity theory as either forced retirement or forced activity which leads to lower adjustment and self-esteem in older people. These theories have implications for the research and will need to be considered when engaging with the participants, because some older people may not feel they are able to play their full part in society.

3.5 Social resources

The biopsychosocial model also contains a social element, so a brief examination of relevant social issues for older people is required. Individuals have to be resilient to continue to lead a meaningful life as they get older. Resilience in older people usually involves mobilizing social resources at times of stress or when they feel they are unable to cope or achieve. Bergeman and Wallace (1999), note that when the effects of socio-economic status, initial health status, and health practices are quantitatively researched, social support health outcomes indicate that there is a consistent positive relationship between social support from family, friends and neighbours and physical health, and mortality. The maintenance of good physical and mental health is consequently linked to strong social support.

Carstensen (1993) suggests that older people tend to go to family members first for emotional and social support, and for crisis intervention because they are more likely than anyone else to help in times of need. According to Cirirelli (1989 cited in Whitman and Merluzzi, 1999), older siblings may experience a changed emotional closeness with one another often as a result of the normal shared losses associated with ageing, which in turn enhances their own self-esteem. Further, Whitman and Merluzzi, (1999) suggest that through adaptation, older people adjust their daily lives to fit the constraints they experience and learn to live at a certain level of health, income or discomfort in their situations. This research will however, need to be open to the alternative possibility that the older individual may not be able or wish to express their needs as a result of their adaptation to their current circumstances.

Lee (1985) proposes that formal support may become more important to older people because many do not want to receive support from family and friends unless they can provide support in

return. Acknowledging this issue leads to another question for the research which is, what is it that leads an older individual to seek assistance from professionals or the state, that in turn leads the individual to place reliance on the health professional?, (particularly if the older individual is unable to reciprocate when support is provided, and which may then lead them to feelings of dependency and loss of autonomy). Whitman and Merluzzi (1999) alternatively suggest that older individuals prefer to receive care from formal support networks that are not bound by having to reciprocate in return. This led Whitman and Merluzzi (1999) to believe that assessments of community involvement are relevant because measures of these interactions not only provide information concerning the potential for supportive interactions but also reflect the level of activity and integration of older people into the larger social community. This is clearly an indicator of when individuals in the community beginning to require interventions from professionals outside 'the family' and when dependence on outside agencies will be required. Does this mean that requests for podiatry intervention for older people are an early indicator of future needs for a wider range of input from other professionals?

Whitman and Merluzzi (1999) suggest that social resources serve a protective role by an enhancement of adaptive coping strategies however; the influence of social resources on an individual's health can be direct or indirect. Cohen (1988) takes a psychosocial approach to social resources and highlights four positive aspects that can assist in the reduction of the adverse effects of having to cope with stress by having:

- (i) friends and neighbours who can provide older people with information that can result in an increased ability to cope with stress;

- (ii) support networks that enhance older people's sense of identity or self-esteem. This can increase feelings of self-worth and control can influence appraisal and coping abilities;
- (iii) a social network that exerts pressure that can catalyse the adoption of normative coping behaviours and,
- (iv) supportive providers who can make tangible resources available or can provide aid that facilitates coping behaviours.

Therefore, in developing the research questions, consideration will be given to understanding the level at which each older individual's social resources have developed, because they may be relevant to the participants responses, particularly when examined within a biopsychosocial framework.

3.6 Health and illness

The image of older people, all in poor health, generates alarmist implications in relation to the future costs of providing healthcare for a growing older population. Yet, diseases related to age and physiological changes do not occur in the same way for all people, and as Dannefer and Sell (1988) suggest, neither do all individuals experience the same changes at a similar age. Therefore the fear of old age being a burden to the NHS is unfounded, in that it is the proximity of death rather than age that is associated with the greatest use of hospital services, or as the National Service Framework for Long-term Conditions (2005) suggests a small minority of people with long-term conditions (referred to as 'frequent fliers') who use health services the most. It is argued by McKeown (1976) and Fries (1980), that people are living longer not just because of medical advances, but because of improvements in the home and work environment,

better nutrition and health practices throughout life. Although health is obviously a dominant concern to older people, when asked about what really matters in their lives and invited to describe their wishes and hopes for the future, over three-quarters of older people refer to their health or the health of their spouse (Bearon, 1989). Many older people specifically mention concern about their capacity to look after themselves, maintaining independence and avoiding becoming a burden to others. Henwood (1990) suggests that the 'young elderly' (those aged 65-74) are likely to be highly independent and active and Sinclair and Parker et al (1990) found that the majority of older people regard their health as good or fairly good. It is recognised that more than a third of older people live alone, and more than half of those will be 85 years old or more, but as Sinclair and Parker et al (1990) suggest, the concept of all older people being dependent is socially constructed, since it is a matter of the way older people are treated rather than the way they actually are.

Unfortunately, these negative stereotypes of old age can lead to 'structured dependency'. This is justified by the mistaken belief that older people wish to disengage from life and can be exacerbated by the influence of healthcare professionals employed to deliver their care. The concept of ill health is therefore constructed by professionals to support the need for dependence on them. Earlier in the podiatry profession section it was suggested that podiatry enhanced patient independence, mobility and quality of life. This link between podiatry interventions and their assistance in maintaining older people's independence and quality of life will be explored with the participants to examine whether they make this connection, whether structured dependency exists in the podiatrist-older person relationship and if the application of the medical and biopsychosocial frameworks influences this relationship.

According to Nelson and Dannefer (1992), older people are more diverse than younger people in health, physiological functioning and in their extent of social interactions. Bergeman (1997) suggests that both genetics and environmental factors contribute to these differences. This theme is developed further by Peterson (1996) who argues that medical professionals view age as a static variable, like gender or ethnicity rather than a changing variable against which illness and interventions can be observed. Adler and Matthews (1994) make the point that older people who experience stressful life experiences often have more physical health problems but are also able to maintain higher levels of life satisfaction than young people. There are older individuals who manage to maintain high self-esteem, good physical health and a positive outlook on life, despite leading what may appear as stressful lives to others. Older people should not therefore be considered as a homogenous group; they all have different experiences as they get older and this will relate to their experiences of foot problems as well.

As individuals grow older, biological, cognitive, socio-emotional and behavioural changes occur, together with changes in the environment in which the individual lives (Whitman and Merluzzi, 1999). Little is known about how these changes, when viewed normatively as well as from an individual difference perspective, influence patterns of health and illness (Peterson, 1996). The examination of these aspects in this research, using comparisons between the medical and biopsychosocial models should add to this body of knowledge. This approach is supported by Ory and Abeles et al (1992), because a new emphasis is being placed on chronic illness and disability which requires an understanding of the complex interactions between social, psychological and biological factors that contribute towards 'good' health and well-being in later life.

3.7 Well-being

‘Well-being’ (or a sense of well-being) is mentioned here because it has been previously suggested (Chapter 2.1) that podiatry interventions have a positive effect on older individuals’ well-being. Well-being has also been identified as a component of successful ageing (Costa and McCrae, 1984; Griffin, 1988; and Diener, 1998). Studies of successful ageing often relate to subjective well-being or an individuals overall sense of happiness.

Diener (1998) attempted to describe the broad concept of well-being as three separate components, a positive affect, a negative affect and life satisfaction. Lykken and Tellegen (1996) share this view and suggest that genetics contribute to the tendency to experience both positive and negative affects. The hereditary view of well-being can be considered to be a medical model approach. However, it appears Diener’s (1998) concept of life satisfaction links to ‘self actualisation’, the pinnacle of Maslow’s (1943) hierarchy of need, a concept described later in chapter seven. Simple adaptation for example is one of the psychological theories that individuals may use to maintain their sense of well-being during objectively negative circumstances. Whitbourne, (2001) also proposes that well-being is affected by psychological and social factors (biopsychosocial approach) that in turn affect the provision of health services, support by family and others, and formal and informal public services.

Through the development of this research, well-being has been identified as being relevant to podiatry and older people and has been demonstrated to operate in both the medical and biopsychosocial models. A question for this research therefore is: “how is the interpretation of well-being affected by the application of the comparative models?” This section acts as an

introduction to the concept of well-being which will be developed later in the 'outcomes' section of the podiatry career described in chapter eight.

3.8 Epidemiology of older people and podiatry

There is a growing recognition that not only is the number of older people in the population increasing but also that people age differently (Peterson, 1996; Bergeman, 1997). The World Health Organisation (WHO) predicts that by the year 2020, the fastest growing sector of the world's population will be people aged over 65 years. This will increase globally by 82% to more than 690 million. Walker and Maltby (1997), state that women form the majority in the higher ranges of the 'age pyramid' for all Countries of Europe so that an increasingly 'feminized' population will be created as each member state ages.

Negative images of older people requiring increasing healthcare have been portrayed but it is important to remember that 49% of people aged over 65 years have no disability and 26% have only a slight disability. Interestingly, with relevance to podiatry, Bytheway and Keil (1989) suggest those with slight disability will:

“...have difficulty cutting their toenails and may have difficulty climbing up and down stairs” (p.75)

While those with only a slight disability represent about one in four of this section of the population, it does potentially place significant demand on current small NHS podiatry resources. What is not clear is where the foot-care needs of this increasingly aging population will fall in the podiatry spectrum of care previously described in chapter two. It is anticipated that significant

numbers of people will have ‘general’ foot-care needs (NHS provision) and ‘social’ foot-care needs for which provision is variable at best.

In England, (DOH 2001), approximately 59% of all new ‘episodes of care’ with podiatrists were with people over 65 years. The number of episodes of care with older people climbs steadily with each age grouping as can be seen below in Table 3.1. During the same year in east Gloucestershire (the area within which the research has taken place) nearly one in four people over 65 years of age have some access to the local podiatry service each year, well above the national average.

Table 3.1: Number of older people in population by age range attending for NHS podiatry (2001)

Age Range	No. of Older People
55 – 64 years	22 per 1000
65 – 74 years	49 per 1000
75 – 84 years	74 per 1000
85+ years	92 per 1000

Source: DOH, 2001 - National Statistics Office KT23 Return

With national disinvestments in NHS Podiatry Services in the 1990’s previously described (Tippins, 1998; Lever and Shearer 1999; Campbell and Bradley et al, 2000; Campbell and Patterson et al, 2002) and the introduction of more restrictive access criteria, NHS podiatry services have seen a steady decline in the numbers of older people accessing the service and receiving care. Interestingly, this coincides with the cessation of the collection of national statistics on the number of NHS podiatry treatments provided from the year 2000, which suggests a subtle change in health policy towards podiatry. This will be expanded upon in the next chapter.

Table 3.2: The National number of podiatry new episodes and treatments (2001)

Year	No. of New Episodes	No. of Treatments
1993/1994	1,006,000	8,005,000
1994/1995	975,000	8,270,000
1995/1996	951,000	8,328,000
1996/1997	975,000	8,352,000
1997/1998	936,000	8,329,000
1998/1999	896,000	8,082,000
1999/2000	860,000	7,895,000
2000/2001	826,000	Discontinued from 2000

Source: DOH, 2001 – National Statistics Office KT23 Return

3.9 Older people, podiatry and age discrimination

It has been previously identified in this chapter that ‘older people’ are often portrayed as a burden to health and social care services. Alongside this, Arber (1994) has highlighted the relative neglect of age from the sociological study of health and this can lead to an indirect form of age discrimination.

According to Arber and Ginn (1991), ‘ageism’, is the process of systematic stereotyping or discrimination of people because they are old and is not only a matter of attitudes held by individuals, but is reinforced and perpetuated by our culture and institutions. There are many possible causes of ageism, but Whitbourne’s (2001) view is that negative attitudes towards ageing are related to the fear of death and dying:

“...by their presence, the old remind younger people of the inevitability of their own mortality.” (p.13)

Arber and Ginn, (1991) rightly suggest that stereotyping older people profoundly affects the way they are perceived and consequently treated, both at societal level and as individuals in everyday

interactions. Henwood (1990) confirms that ageism permeates the provision of medical services in that older people are often victims of restricted assumptions about the quality of health that can be expected in old age (supported by healthcare professionals), which leads Arber and Ginn (1991) to conclude that this is why older people's particular health needs receive low priority in the NHS. There are numerous examples of older people being excluded from certain screening programmes and surgical procedures on the basis of their age. This is one reason why the National Service Framework (NSF) for Older People (2001), was initially welcomed by groups representing older people, although after closer scrutiny of the detail of the NSF the framework is still found to discriminate against older people. An example is the expansion of the breast screening service to include women up to seventy years old. Unfortunately, none of the women participating in this research will benefit from this extension because of their age. The disinvestment nationally in podiatry services has also disproportionately affected older people and led to a form of age discrimination. The recent introduction of 'medical need' criteria has tended to exclude people whose foot-care needs are of a social nature i.e. tasks that a normal person would carry out for themselves (Campbell and Bradley et al, 2000; Campbell and Patterson et al, 2002).

In chapter two, podiatry services were described as a free public service when they were first introduced by local authorities in the early 1960's. Access was provided to all people who were 65 years and older. As Boden (1997) suggests, these factors have led older people to believe they have an 'entitlement' to NHS podiatry services, when they had actually accessed NHS podiatry services on the basis of age rather than by 'entitlement'. The current move towards needs-based access to NHS podiatry services is therefore at best confusing, and often leads to great

dissatisfaction for those older people who believe they are entitled to NHS podiatry services, but are unable to gain access.

The introduction of the new 'medical need' criteria has led older people to become the single largest group of people who are being denied access to NHS podiatry services. As there are more women in this age group than men, it has already been suggested that there are also gender issues for older people within NHS podiatry provision.

3.10 Older people and gender issues

In the two previous chapters gender has been identified as a relevant element in the provision of NHS podiatry. Females form the largest proportion of people in older age groups, and two-thirds of people over 75 years attending NHS podiatry are female.

It is also recognised that gender has cultural and social factors relevant to this research; for example, the concept that individuals adopt specific roles in society dependent on being male or female. Older individuals, particularly women, are affected by additional biases beyond those caused by previously discussed issues of ageism. Systematic biases against women are thought to interact with older age to produce an increased risk of discriminatory attitudes in the provision of services to specific groups of older adults. Ferraro and Farmer (1996) described this as the 'multiple jeopardy' hypothesis.

The interconnection between gender and ageism is therefore important in the examination of health and well-being of older people. According to Ferraro and Farmer (1996), ageist attitudes, or multiple jeopardy do not appear to have deleterious effects upon feelings of happiness and

well-being. This statement needs challenging, and this research will need to take account of these two factors and ensure that any biases are recognised and identified. Issues of gender and ageism may therefore have different influences on older individuals when the comparison of the conceptual frameworks is undertaken. For example, ageist and gender issues can be linked with hierarchies of power and specifically the power of professions. Issues of power for older people are acknowledged in the next section and the implications of power are discussed with specific reference to the medical and biopsychosocial models in chapters five and seven.

3.11 Power

Faulkner (2001) identifies a role termed 'learned helplessness' in which older people become disempowered and dependent on healthcare professionals. This power relationship suggests that when people experience events out of their control, (which might be being unable to care for their own feet) they form an expectation that future events will also be uncontrollable.

Faulkner (2001) concludes that it is important for healthcare professionals to assess the extent to which older people want autonomy over their lives prior to prescribing their care. Power relationships, if they exist, will be examined through a comparison of the medical and biopsychosocial conceptual frameworks. Typically the medical model approach is perceived to 'reduce' older people to a position of disadvantage, and divests them of the authority and knowledge to control their own care, whereas the biopsychosocial model is perceived to provide a more holistic approach through inclusion of the participants' views in their care. A comparison of the perceptions of the two conceptual frameworks will form one of the central tasks of this research.

The idea of empowering people is very complex and it is important to recognise that it may prove difficult to return power to older people in a healthcare relationship, particularly within a medical model context. Hence the concept of 'empowerment' is another important theme in this research that will be discussed in chapters 9, 13 and 14. Issues of empowerment linked to older peoples' perceptions of their foot-care needs will be examined through the comparison of the medical and biopsychosocial framework in order to understand the differences each model identifies from the individuals own views and experiences.

The influence of professional power upon the 'professional-older person' relationship is therefore acknowledged. This issue affects the decisions that need to be taken on the appropriate research methods and methodology, in order to ascertain older people's views from *their* perspective i.e. not from a particular 'approach' embedded in these two models, and not the one they express following a consultation or advice with a healthcare professional.

An example of professional power in action is described by Owens and Batchelor (1996). In their study of district nursing they state that older people feel they have passed over their medical care to an 'expert' when receiving their care from the District Nurse. It is difficult to assess whether this is an example of 'learned helplessness' or whether the older person has been disempowered by the healthcare professional; as some older people in the study expressed a reluctance to take over the tasks that had previously been performed by the healthcare professional. Owens and Batchelor (1996) suggest that this might be because the older person did not want to take on the responsibility of care, since if they demonstrated they could cope independently they then feared the care would be withdrawn. Their study also demonstrated that

older people avoided a partnership with the healthcare professional on constructing a care plan, assuming unquestioningly that the healthcare professional knew what was best for them.

Ageist attitudes and stereotyping are key aspects of disempowering behaviour. To enable the adoption of a more empowering approach to care, Solomon (1983) suggests healthcare professionals need to be more aware of these discriminatory attitudes. Macdonald and Capewell's (2001), podiatry study demonstrated that older people felt a degree of resentment at what they felt was a lack of influence over podiatry services which they perceived to be essential to everyday life. This might suggest that given the appropriate circumstances, older people can express their own views without bias or influence from healthcare professionals, particularly when Macdonald and Capewell's (2001) study demonstrates the importance older people place on the provision of podiatry services.

It is therefore becoming more apparent, the degree to which the perspective of professionals as a whole differs from the perspectives of users and carers and the effect that this has on the way services are delivered and received. This has led to a suggestion that if healthcare professionals do not take account the views of users of services they will fall into the trap of providing unacceptable and inappropriate services (Dalley, 1998).

3.12 Older people's needs

As highlighted previously, in order to start to empower older people, and to understand their needs, it is necessary to listen to their views. Sappington and Kelley (1996) recommend using older people's knowledge to define what is best for them enables healthcare professionals to put the needs of older people first and permits older people to assume responsibility for their own

health and Allen and Hogg et al (1992) suggest that there has been little evidence to show what older people really think about the way in which services are delivered and the extent to which they think their needs are met. This research therefore seeks to add to this body of knowledge.

The healthcare assessment of older people's needs however, often focuses on tasks and practical operations with a specific focus on the physiological aspects of the individual. This approach generally excludes a holistic approach that would include relevant aspects of the older person's everyday life. The assessment of older people's foot-care needs will therefore be compared between these two differing approaches which are not without their difficulties, and as previously acknowledged, the task of eliciting a critical evaluation from older people can be problematic (Owens and Batchelor, 1996). This is reflected in the many different frameworks that have been developed to undertake needs assessment with differing groups (Stevens and Gabbay 1991). One example is Pickin and St Ledger's (1993) 'Life Cycle' model, that encourages healthcare professionals to think comprehensively about different population groups of different ages and is particularly suited to older people because of its simplicity. Stevens and Gillam (1998) argue that it does not distinguish need and demand or emphasise the medical model approach of meeting needs on the basis of 'capacity to benefit', a concept of medical need that will be examined in detail in chapter five.

Looking specifically at podiatry, only a small number of studies explore specific foot-care needs of populations (Clarke, 1966; Kemp and Winkler, 1983; Cartwright and Henderson, 1986; Brodie and Rees et al, 1988; Henwood, 1990; and Bowling and Farquhar et al, 1994). Kemp and Winkler's (1983) description of foot-care needs was presented in chapter two, figure 2.3, but what is missing from all these studies is an understanding of the benefits of addressing foot-care

needs as perceived by individual older people. Some aspects of self-care needs relate directly to an older person's mobility and dexterity (Henwood 1990), and the proportions unable to perform tasks such as toenail cutting or having a bath alone, are not unexpectedly much higher as a person ages. Klein (1979) notes another critical difference in the relationship between age and satisfaction: younger people are more likely to complain than older people. Klein (1979) also proposes that older people become more passive and less critical of healthcare as part of the ageing process

Klein's (1979) view supports the assertion that 'acquiescence' may be a behaviour that is demonstrated in discussions with older people, and he notes a generational effect in which people who grew up prior to the formation of the NHS have lower expectations than the next generation because they are more aware of the improvements brought about by the NHS and are less conscious of its shortcomings. The age group that was young in the 1930's and 1940's still compares present-day provision of healthcare with pre-war services (Gilleard and Higgs, 2000). This results in older age groups generally being satisfied with the NHS, whereas younger age groups tend to compare the NHS with other service industries and with other overseas healthcare systems. The expectations between the different age groups are diverse, which in turn affects individual perceptions of need. It is therefore recognised that the cohort of older people selected for this research will also be part of the homogenous population that has lived through a period of pre-NHS healthcare, and whose perceptions and expectations of NHS podiatry services may be shaped by these experiences.

3.13 Acquiescence and older people

In studies of needs assessment, acquiescence has been identified as a concern, particularly with older people, and is given further consideration in the development of the research methodology in chapter nine (9.11.1). Calsyn and Rodes (1992) found that either inflated estimates or biased estimates regarding a person's needs could occur if questions were asked in a particular way. They suggest that older people do not want to appear uninformed and therefore acquiesce. However, Calsyn and Rodes (1992) were able to identify samples of people who did and did not acquiesce, and they found that the two groups did not differ in their responses to specific aspects of needs assessment, self-health evaluation, prior use of services, current use of services and need for services. There were also no significant differences vis-à-vis other variables such as gender, income or marital status. Calsyn and Rodes (1992) concluded that while general acquiescence style did not appear to be a major problem in needs assessment, the response to questions that might be construed as measuring intellectual competence could lead to inflated estimates. An acknowledgement is therefore made in this research that older participants may acquiesce unless research questions are carefully constructed. 'Power' and 'knowledge' have therefore been identified as important and relevant factors that may lead to acquiescence by the participants'. Such issues will be discussed and addressed in the methodology chapter.

3.14 Social class and older people

The final issue to be examined in this section is: 'what relevance does assigning an older person to a particular social class have?' Arber and Ginn (1991) argue that social class can hamper analysis of structural inequalities in older people; in past research, older people have been categorised according to their chronological age rather than their physical capabilities, occupation, wealth, social class, ethnicity, gender or other characteristics. Arber and Ginn (1991)

conclude that after controlling for age, previous occupational class is a more important determinant of health among older people than current material resources. However, Johnson (2002) states:

“The social status of older people results from a process of negotiation in which social norms and individual attributes each play a role, yet it is recognised that current material resources significantly contribute to a sense of well-being”. (p123).

The matter of whether to classify older people is therefore problematic for the research. As this research intends to seek the views of individual older people it has been decided that grouping participants in this study by social class or any other classification is unnecessary because it could introduce an unnecessary bias or facilitate the loss of individuality of the views, which could lead to the formation of an artificial representation of the views of a homogenous group of older people.

3.15 Summary

The purpose of this chapter has been to describe the issues pertinent to older people as background context for this research. The research will be seeking to gain the views of individual older people about their foot-care needs and how these should be addressed from their perspective and the issues discussed in this chapter are felt to be the most relevant to the research.

Research with older people has generally considered them as a homogenous group of people, whereas it is proposed in this research to seek individual older peoples' views of their foot-care needs. This aspect and the other issues discussed in this chapter, underpin the development of the research methodology and methods used to seek this information from older people.

The next chapter, Health Policy 1987-2004, examines the final segment of the background context as this has been hugely influential on both NHS podiatry services and its delivery of service to older people. Links between health policy and its effect on podiatry services and older people will be drawn.

Chapter Four

Health Policy (1987-2004)

4.1 Introduction

Health policy is the third and final area of setting the background context to this research. Government policy through the 1990's and early twenty first century has had a profound influence on the shaping of the NHS, the development of the podiatry profession, its delivery and its status within the public sector. These significant policy changes and their implications are discussed in this section. The policy changes described will be linked with the development of the podiatry profession and the concepts of older people discussed in the previous two chapters.

4.2 The National Health Service (NHS)

The NHS has had repeated reforms and reorganisations since its inception in 1947. However, throughout NHS history, politicians from both sides of the political divide have stated and restated their commitment to a publicly funded NHS, and the core principle of the NHS which is to provide healthcare:

“...based on need and need alone, not on your ability to pay”
(Department of Health 1990, 1997, 2006)

In recent years this core principle has been silently qualified by the addition of the terms ‘clinical’ or ‘medical’ prior to the word ‘need’. The subtle introduction of this qualification of need has led to the development of individual, ‘local’ definitions of clinical/medical need made by healthcare professionals steeped in the tradition of the medical model. It can be argued that

the introduction of local access criteria to health services allows politicians to abdicate their responsibility for decisions made on the provision of services to 'local commissioners' of health services and healthcare professionals.

The result of this policy has contributed to the development of different types and levels of service being provided in different localities, a situation which has become known as 'the postcode lottery' of healthcare. One of the guiding principles of the NHS providing 'universal services' has been challenged and was first highlighted following the introduction of a policy initiative known as 'GP Fundholding' by the Conservative government during the early 1990's. This policy change placed a responsibility on local commissioners which led to the justification that the health needs of local communities would differ and therefore differing levels of health provision could be expected. However, it could also be suggested that this clinical qualification has led to a cynical rationing of healthcare based upon the requirements of healthcare professionals rather than targeting resources at areas of real need.

It is acknowledged that the NHS is a large and complex organisation. In attempting to describe the NHS as a concept, Johnson and Scholes (1999) have portrayed the National Health Service in terms of a 'cultural web'. Their cultural web represents the taken-for-granted aspects of the NHS and support a number of the perspectives already described in this research. The assumptions which Johnson and Scholes (1999) portray constitute a position that reflects the common public perception of the NHS:

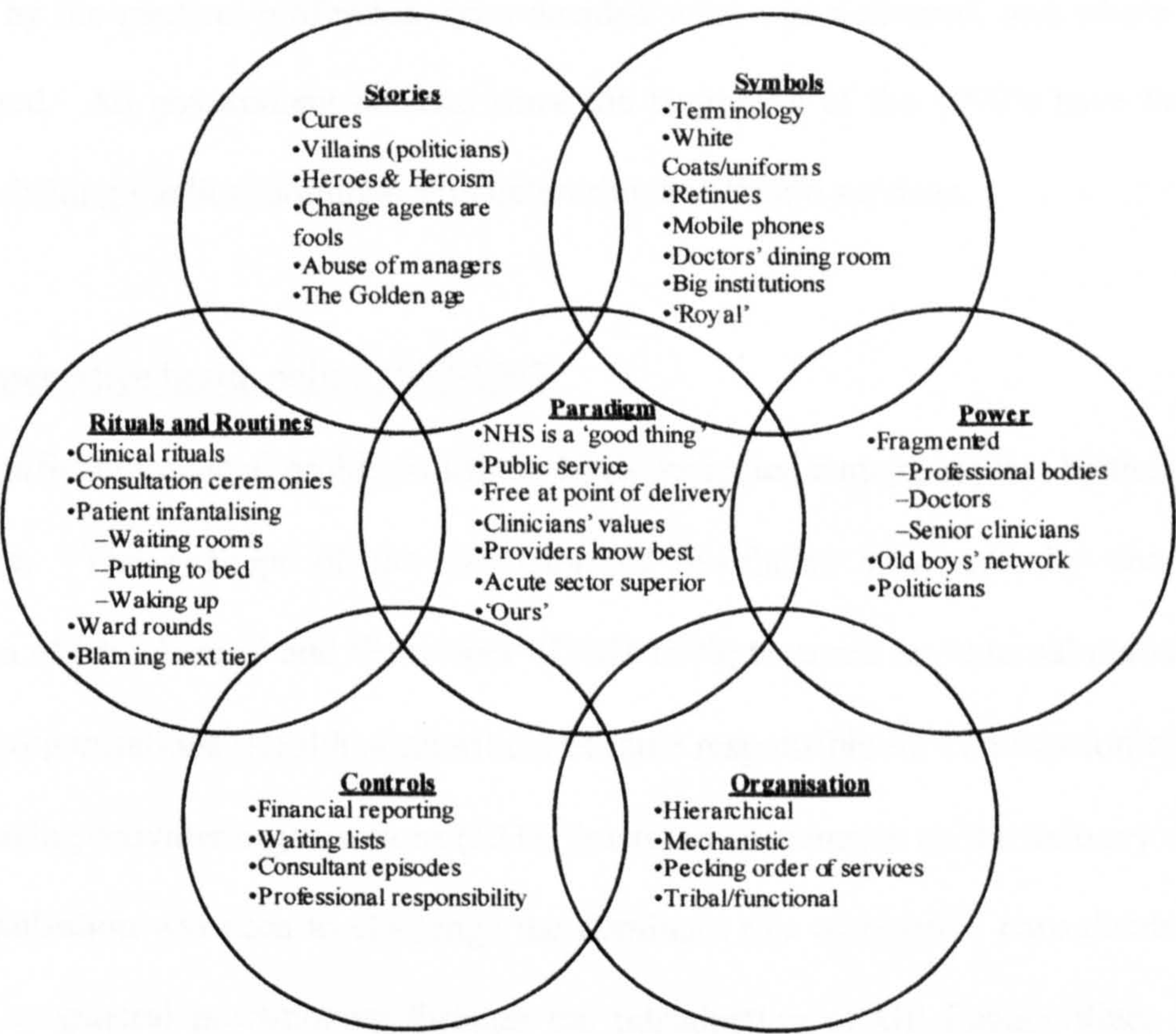
“...that the NHS is a 'good thing'; a public service which should be provided equally, free of charge. However, it is medical values that are central and, in general, those providing them who know best. This is an organisation about the provision of medical care for

those who are ill, subtly different from an organisation to serve the needs of those who are ill and quite different from serving the needs of those who are not ill...” (p.74)

...and,

“...the NHS is seen as ‘belonging’ to those who provide the services; and it is the acute sector within hospitals which is central to the service rather than, for example, care in the community.” (p.74)

Figure 4.1: The NHS Cultural Web (adapted from Johnson and Scholes, 1999)



As Johnson and Scholes (1999) suggest, for most of the NHS’s history healthcare professionals and patients took for granted that healthcare professionals ‘know best’ (p.76). This view supports the dominant and powerful role of healthcare professionals, especially doctors. The NHS cultural web also describes ‘rituals’ which ‘infantilise’ patients by putting them in their place. The patient is further disempowered by the elevation of healthcare professionals with

ritual consultation ceremonies and ward rounds. These rituals reinforce the health professional's power which in turn affects the 'professional-patient' relationship. The power relationship also places those healthcare professionals who 'cure' in greater esteem than those who 'care'.

Understanding the culture of the NHS begins to explain some of the intentions of new government policies for healthcare. The NHS was perceived as a public organisation that was dominated by the medical profession, who decided what was delivered, and where and when it was delivered. All government policies since the beginning of the 1990's have therefore been directed at shifting medical dominance in delivering healthcare services.

4.3 Conservative health policy 1987-1997

In 1987 significant financial problems for the NHS instigated a major review by the Conservative Government. The concept of the provision of healthcare was radically changed by the introduction of 'Purchasers' and 'Providers' (DOH 1990) to create an 'internal market'. The new purchasing organisations (Health Authorities) became responsible for commissioning local health services leaving provider organisations (NHS Trusts) to concentrate on the delivery of healthcare. This reorganisation was seen to challenge the dominant role of hospital consultants and shifting the power to general practitioners through the introduction of GP Fundholding, (Glennister, 1994) although this did not diminish the influence of the medical model on the NHS. This was a direct challenge to a specific group of doctors on their largely successful claim of exclusive expertise in decisions about the use of health service resources.

During the early 1990's an expanding gap appeared between what medical technologies made it possible to achieve and what was affordable. At the same time, the general public's perception

and expectations of what the NHS could provide had never been greater. As demands increased and finances were stretched, resources were taken from less glamorous and 'low-tech' services to fund the shortfall in 'high-tech' acute hospital services (Robinson and Le Grand, 1994).

Since the early 1990's pressures on NHS resources resulted in the rationing of some services' based upon explicit criteria and the identification of 'real' healthcare needs that could be measured and be shown to benefit the general population. This resulted in needs being assessed by the 'capacity to benefit' model (Steven and Rafferty, 1994), a medical model approach to rationing. This political approach to 'need' or 'capacity to benefit' will be examined in detail in chapter five (5.9).

It was during this period of financial austerity and government reviews that many NHS podiatry services were targeted and received no new investment to meet rising demands from their local populations. In fact, many podiatry services had funding withdrawn on the premise of redefining the classification of foot-care needs to those of 'medical/podiatry need'. The 'Feet First' Review (DOH 1994) attempted to describe a new model of podiatry needs (see figure 2.2, chapter two) and was published in order to highlight the perceived importance and value of the provision of podiatry services. 'Feet First' (DOH 1994) was the first attempt to provide a national template for the provision of NHS podiatry services but unfortunately, history may well show that this document had the opposite effect and drew attention to NHS Podiatry Services as an area for rationalisation because of the lack of clarity about foot-care needs and because the predominant care group accessing NHS podiatry was older people who were less likely to protest about a lack of services.

With the Conservative Government's restated principle (DOH 1990) of the NHS providing services based on need and need alone, the policy direction envisaged services moving from a 'service-led' to a 'needs-led' model. Crown (1991) states, that the Health and Community Care Act (1990) was one of the first instruments to instruct Healthcare Organisations (District Health Authorities and GP Fundholding Practices) to assess needs and pay more attention to the views of users of the services. Despite these legislative frameworks, access to services and assessment of needs has continued to be controlled by healthcare professionals (often described as 'gatekeepers'), with General Practitioners identified as the main and dominant 'gatekeeper' in healthcare (Allen and Hogg, 1992).

The original concept of a comprehensive NHS providing a full range of curative and preventative services which are free at the point of use was clearly being challenged from the early 1990's. During this period, Dalley (1998) suggests the NHS responded to the changing circumstances of community care policy by changing its definitions for access to healthcare in order to save money but also in response to central government pressure. Norman (1986) previously proposed this led to a power struggle between older people and those responsible for rationing and allocating resources. This potential hierarchy in the provision of healthcare led to a further disadvantaging of older people as Norman (1986) states:

“...the principle that priorities should be determined by assessment of risk to the individual is transformed by the idea that children as a group are more vulnerable than older people”. (p.10)

As a result, during this period older people's rights and power did not become closely linked with a realistic debate about needs or where resources should be allocated. Instead the debate focused

on what an individual could get, if they knew it was there and could ask for it. Unfortunately, this approach assumed older people are educated and sophisticated enough to request the service.

4.4 New Labour health policy 1997-2004

The New Labour government set out its reforming health policy (DOH 1997b) in the White Paper, 'The new NHS, Modern, Dependable'. This White Paper laid out a 10 year plan (2000-2010) to modernise the NHS through the abolition of the internal market and replace it with 'integrated care'.

"This new system of integrated care provision would be at home with easier and faster advice and information for people about health, illness and the NHS, so that they are better able to care for themselves and their families. In the community with swift advice and treatment in local surgeries or health centres, with family doctors and community nurses working alongside other health and social care staff to provide a wide range of services on the spot, and in hospital with prompt access to specialist services linked to local surgeries and health centres so that entry, treatment, and care are seamless and quick." (DOH, 1997a, p.3)

These proposals were supported with the promise of a significant rise in funding for the NHS, the funding primarily going to hospital services to increase capacity and reduce waiting times. The NHS Plan (2000a) was a detailed investment plan that criticised the NHS for still operating as it did when it was first created. The increased investment came with conditions for reform, with the NHS having to be redesigned around the patient. The NHS was described as a 1940's system operating in a twenty-first century world. It was suggested that there was a lack of national standards, with old fashioned demarcations between staff and barriers between services, and a lack of clear incentives and levers to improve performance with over-centralisation and disempowered patients.

“The purpose and vision of this NHS Plan is to give the people of Britain a health service fit for the 21st Century: a health service designed around the patient.” (DOH, p.1)

The NHS Plan stated that new Care Trusts would be formed to commission health and social care in a single organisation. This responsibility passed to Primary Care Trusts (PCTs) who were given the responsibility for identifying and purchasing services based on the needs of their local populations (DOH, 2000a).

This joining of health and social care commissioning was expected to:

“...help prevent patients – particularly old people – falling in the cracks between the two services or being left in hospital when they could be safely in their own home.” (DOH, 2000a) (p.5)

Arguments over the provision of health and social care are not new (Bernabei and Landi et al, 1999; Cowen, 1999), and in recognition of the apparent health and social divide in older people’s services, the government produced a National Service Framework (NSF) for Older People (2001b). Unlike previous NSFs (Cancer Plan, 2000b; Childrens’ NSF, 2004c) the political desire to improve standards of care for older people through the implementation of the Older People’s NSF came with no new funding. The Older Peoples’ NSF for the first time promoted ‘person-centred’ care with a focus on a personalised response, with older people treated with dignity and respect, and the rooting out of age discrimination.

The first standard is titled ‘Rooting out age discrimination’ and states:

“NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services” (DOH, 2001b) (p.16)

In chapter two it was acknowledged that access to NHS podiatry was until recently based on age (Boden, 1997). The emphasis for access being based on age and not individual needs and the recent change of podiatry access criteria to needs-led was in theory supported by this policy standard. However, there is one crucial element missing from the podiatry needs led approach and that is, who identifies the needs? The second standard from the Older People's NSF clarifies who this should be.

The second standard entitled 'person-centred care' states that NHS and social care services should:

“...treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrating commissioning arrangements and integrated provision of services, including community equipment and continence services”. (DOH, 2001b) (p.23)

In 2004 the NHS Improvement Plan (DOH, 2004a) set out the priorities for the NHS 2004-2008. The plan placed a greater focus back on 'patient-focused' care with specific initiatives including the choice of five different providers for acute healthcare and a target of no more than 18 weeks for an appointment with a hospital consultant. The Improvement Plan also introduced an increased role for the Independent Sector in providing NHS care.

Both of the above documents place a focus on putting individuals at the centre of care. However, it will be demonstrated later in chapter five that a 'patient-centred' approach has medical model connotations with the individual expected to adopt a 'patient-role' whereas a 'person-centred' approach begins to suggest a broader consideration of an individual's needs.

This section on government health policy covers up to 2004. It is recognised that this research will be undertaken as government health policy continues to evolve. Relevant health policy after 2004 will be identified and referenced in following chapters as appropriate.

4.5 The effect of health policy on local podiatry services

Local health policy has particular relevance to this research and local podiatry services: just over twelve months into this research project (unknown at the beginning of this research) a review of the local podiatry services in Gloucestershire was undertaken in 2000.

The basis of the review was to cut costs by restricting access through a redefinition of 'need' for podiatry. The redefinition of 'medical' and/or 'podiatry' need was developed by local healthcare professionals in order to focus the reduced resources on those people with greatest clinical need and to discharge those who no longer met the new criteria. Unlike the stated principle in standard one of the Older Peoples' NSF, the change in access criteria in Gloucestershire, to one based on medical/podiatry needs, was primarily to save money rather than prioritising scarce podiatry resources on those people in greatest need.

This example of rationing of healthcare resources was common during this period (Ainsworth 1999) as the focus on investment in acute hospital services grew and the so called 'Cinderella' services in the community had funding removed. This transfer in funding resulted in the local commissioning body (the Health Authority) shifting the responsibility for the delivery of some traditional aspects of healthcare provision to Social Care services through the redefinition of 'needs' from 'medical (*foot-care*) needs' to 'social (*foot-care*) needs' (see figure 2.1 - podiatry spectrum of care). This was in direct contradiction to government health policy which had placed

an emphasis on health service providers delivering 'patient-centred' services, because in this local example, no users of podiatry services were involved in the discussions on redefining 'need'. The redefinition of foot-care needs acted to raise the access criteria to NHS podiatry services, and focused on the area of what was previously termed 'basic foot-care'. This term was redefined as 'social' foot-care and was therefore no longer the NHS's responsibility. Unfortunately, this redefinition of foot-care needs has primarily affected older people and many thousands of older people are no longer able to access NHS podiatry services, services to which they previously felt entitled. This move has left many older people without supporting services to address their newly unmet 'social' foot-care needs, and so new groups and organisations such as social services, the private and voluntary sector, have formed to provide a level of basic foot-care for this group of people.

Dalley (1998) somewhat simplistically suggests that it is reasonably easy to define 'health' and 'social' care needs; the infirm and sick being the responsibility of healthcare and the frail and the aged the responsibility of local authorities. The introduction of the new needs framework for local podiatry services raises the issue of who is the appropriate provider of foot-care services for the newly defined 'social' foot-care needs, particularly from the perspective of older people? Linked to this, another of the main concerns for this research contained within the rationalisation debate, is the move of NHS podiatry services operating in an exclusively 'medical' model framework with medical foot-care needs, defined and developed by podiatrists as the only 'gateway' into NHS podiatry services. This has led to confusion and dissatisfaction with NHS podiatry services, both from the users of the service and the other healthcare professionals that previously referred people to the service.

While these questions are not central to the research question, they may prove to be an important concern to the participants who want to use the podiatry service. More importantly, and this is linked with the central research question; is how the medical model approach to the delivery of NHS podiatry services compares with the biopsychosocial model approach and which model better delivers a service to meet the participants perceived foot-care needs.

4.6 Health policy, podiatry and older people

Chapter three described increasing numbers of older people in the general population, most of whom, will be living in their own homes. This led Allen and Hogg (1992) to suggest that in the near future services offered to older people will have to change. While acknowledging that these changes were beginning to occur for the older population, Allen and Hogg (1992) further propose that the views of older people and their carers, their demands and their wishes have not always coincided and at times have remained in opposition to those of the 'gatekeepers' of healthcare. This has become one of the central concerns for government and policy makers, particularly around the period the new Labour government was elected, when demand for healthcare was outstripping supply, and funding had not kept pace with other European countries. The lack of funding was forcing the 'gatekeepers' of healthcare to increasingly focus those resources on providing healthcare for those people with the greatest medical needs (Needs which are defined by healthcare professionals – as such a medical model approach).

The medical model approach combined with the rationalisation of healthcare based on those with greatest medical need or 'capacity to benefit' (a concept described in chapter five) meant NHS service provision focussed on time limited 'episodes of care'. These episodes of care can be measured by having a clear beginning and end (outcome) that leads to discharge from healthcare

and this has become the typical acute care/hospital model. Unfortunately, as discussed in chapter three, for many older people their healthcare needs are chronic in nature and they need longer-term interventions such as maintenance and on-going support rather than short curative interventions. NHS podiatry provision has traditionally been based on the latter model, and has provided a maintenance service for older people by keeping their chronic foot problems in a pain free state in order to maintain mobility and comfort. This has led many older people to regard podiatry provision as regular 'treatments' for life. The model of podiatric care described here will be examined and developed in detail in chapter eight, where the concept of the 'podiatry career' will be presented as the process/pathway that older people pass through when they access and use NHS podiatry services and will also include the end point of care (the outcome) in the pathway.

With an increasing emphasis being placed on defining specific 'medical needs' for access to NHS services, another aspect of healthcare provision, that of preventative health services, either received lower priority or disappeared altogether. This is in direct contradiction to the health policy as described above and has led to commentators such as Allen and Hogg (1992) proposing that providing more preventative services for the population may actually have a greater value in keeping older people independent than by concentrating services on just a few. This is reflected in the implications arising from the strategy of rationalising podiatry services and the introduction of 'medical need' led services. As Campbell and Patterson et al (2002) have demonstrated, those older people whose foot-care needs are redefined as 'social need' find later that their medical foot-care needs will increase and this gives them access to NHS podiatry care again. For older people this means in practical terms that with increasing age, the prevalence of more serious foot problems ('medical need') will rise if the current policy direction continues.

This therefore not only leads to dissatisfaction for the older person with NHS podiatry services, but is also storing up an increased demand for future podiatry provision. Campbell and Patterson et al (2002) conclude from their findings that this must:

“...have implications for planning for service re-profiling, setting of future discharge criteria and foot health monitoring programmes.” (p.42)

The process of redefining podiatry services on the basis of ‘medical needs’ is therefore flawed and is one of the reasons for older peoples’ dissatisfaction with current NHS podiatry services. This dissatisfaction has led to the development of the research question which is to understand the foot-care needs of older people, by comparing two different models of care delivery, (the medical and biopsychosocial models), with the intention of understanding which model better meets individual’s needs in order to deliver a truly ‘person-centred’ podiatry service.

4.7 Conclusions

In chapter two a description of podiatry was provided through a brief history of the development the podiatry profession and of NHS podiatry provision. It has been suggested that the podiatry profession operates within a medical model framework in order to elevate its professional status through an alignment with the medical profession. In recent years the elevation of podiatry’s status has been consolidated by the focusing of scarce podiatry resources on ‘medical’ need access criteria that have been developed by podiatrists. Little attention has been paid to considering the views of users of podiatry services.

In chapter three, older people’s issues relevant to this research have been described. Older people have been portrayed as a group within society that are disadvantaged in terms of receiving

healthcare. Various hierarchies and issues of power have been identified that affect the delivery of NHS podiatry services to older people. A particular focus on older people has been the development of the concept of 'the self' and how older people are likely to construct their individual approaches to life and their foot-care needs. Also acknowledged are issues for attention in developing the research methodology with older people. These issues will therefore be recognized in the design of the research methodology in chapter nine. In order to secure older people's views of their podiatry needs and experiences of podiatry interventions, a unique research methodology will be described.

In chapter four, relevant health policies that have influenced services for older people and delivery of podiatry services have been described and examined. This highlighted the issue of health professionals as 'gatekeepers' to healthcare who influence who has access to healthcare and who provides these services. Challenges have as a result been posed to current health policy and the delivery of holistic foot-care services that straddle health and social care boundaries. All of these decisions are outside the older person's control, when the primary perception of the older person may be that their only requirement is the receiving of care.

As a consequence of this perceived disempowerment of older people, this research seeks to understand older peoples' foot-care needs and how these should be best addressed taking into account the individual's perspective. As the medical model approach has been identified as the model of current healthcare provision this model will form one of the central themes for the research. The biopsychosocial model has been selected as a comparison model because it will be demonstrated in chapter seven that the concept of the biopsychosocial model has been proposed to address many of the problems associated with the adoption of the medical model approach.

Therefore, Part Two undertakes an examination and comparison of the medical and biopsychosocial models. The comparison of these two models provides the central focus of this research, the aim being to understand which model best meets older people's perceived foot-care needs through the delivery of a 'person-centred' podiatry service. Discussion of the different issues in Part one has led to the formation of the research question:

"Would older people receive foot care services more relevant to their needs, if NHS Podiatry Services adopted a different approach?"

This now leads to Part Two which is an examination and discussion of the two conceptual frameworks, the medical and biopsychosocial models, which will be used to compare two differing approaches to the delivery of NHS podiatry services.

PART TWO: Contextual Frameworks

Chapter Five

The Medical Model

5.1 Introduction

Part One of this thesis set out the background context within which the research is set. Chapter two described the profession of podiatry in the NHS. It was suggested that podiatry services operate within a medical model framework and the main group of people they serve are older people. Chapter three described older people in homogenous terms but also identified specific issues for older peoples' research, relevant to this study. Older people and health services, but not the broader psychological and social aspects were all highlighted and discussed. The final chapter in Part One, chapter four, discussed health policy from the late 1980's through to 2004. This chapter focused on the implications of health policy for NHS podiatry services and its implications for the delivery of podiatry services for older people.

Part Two of this thesis describes and critically examines the two conceptual frameworks that form the central focus of this research, the medical model and biopsychosocial models, making comparisons of these two models in order to answer the research question:

“Would older people receive foot care services more relevant to their needs, if NHS Podiatry Services adopted a different approach?”

This chapter examines and critically appraises the conceptual framework known as the medical model, which is the central framework within which current NHS podiatry services are provided. The chapter will include descriptions of how the medical model permeates key aspects of

healthcare delivery. In more recent years a growing number of writers have described the shortcomings of the medical model and their criticisms are identified throughout the chapter. The medical model will be portrayed as 'mechanistic' in that any intervention to assist a health problem treats the body as a machine. The medical model is also presented as 'reductionist', a model that reduces health problems to the level of disease or illness but excludes the individual's feelings and views.

Much has been written about the medical model, too much to give a complete coverage in this chapter. The critique of the medical model in this chapter will therefore focus on those key elements considered to be relevant to podiatry and older people within the political setting described in Part one - background context.

Chapter five will begin by addressing the basic concepts of the medical model supported by a brief history of the development of the model. The next section explores criticisms of the medical model focussing on the key elements of the medical profession, medical knowledge, medical terminology, the medical consultation, medical needs and medical outcomes. Finally a description of podiatry and its operation within the medical model leads to chapter six which identifies and describes how the medical and social models of care have been considered within general systems theory, which led to the development of the biopsychosocial model (chapter seven).

5.2 Basic concepts of the medical model

The Medical Model [also referred to as the Biomedical Model] has been the dominant paradigm of medical science and healthcare provision in the twentieth and twenty first century (Porter, 1997). McClelland (1985) describes the medical model as ‘mechanistic’ in which:

“...the body is treated like a machine that is fixed by removing or replacing the ailing part or destroying the foreign body that is causing the problem” (p.452).

Illsley (1977) suggests a person’s body is viewed as a machine driven by the heart. The ‘sick person’ therefore becomes a faulty machine that can be repaired by a doctor [or body mechanic] who possesses the appropriate [medical] knowledge. Within a medical model framework individuals are therefore reduced to their component cells and tissues, a process known as ‘reductionism’. Moon and Gillespie, (1995) suggest the medical model focus on scientific answers to everyday health concerns has neglected other aspects of the person and has undoubtedly contributed to:

“...some neglect of social and spiritual aspects of people’s care”. (p.57)

Moon and Gillespie (1995) go further and propose healthcare professionals demonstrate ‘reductionism’ by narrowly focussing on the brain and this leads them to ignore the common experience of:

“...a ‘self’ that influences the brain, rather than of a brain that creates the self”. (p.58)

Recognition and acknowledgement of ‘the self’ by health professionals is an important element already identified in chapter three of this research because it assists with understanding the individual’s wider needs, wants, demands or desires. However, within the medical model

approach it will be demonstrated that the individual's views are not considered. It was because of the biopsychosocial models claim to include views of 'the self' that lead to its selection as the comparative model in this research.

It was Descartes (1590-1650) who first asserted that the mind could be separated from the body. This view has attracted much controversy and led to the development of alternative models of considering the mind and body. The scientific approach led Illsley (1977) to suggest that the medical model has two different components: firstly a 'disease' component in which illness results from pathological changes in the biochemical processes of the body and secondly an engineering component that views the body as a machine to be repaired by technical means. As Whitman and Merluzzi (1999) argue, the medical model with its disease focus has tended to view health as the absence of disease rather than as a state of good health that can be actively promoted. This specific focus has led biological and psychological symptoms to be treated in biological or medical terms only. As Weir (1991) contends, the mind is not considered in the aetiology, [the science of cause of disease], of organic illnesses and neither is its potential employed in achieving the optimum level of recovery. Therefore, concepts that do not fit this scientific model, or cannot be easily measured objectively, such as feelings, attitudes and experiences have disappeared or are given little acknowledgement in medical model dominated healthcare.

This 'reductionist' approach produces a tendency in the medical model approach to regard specific disease as adequately characterised in terms of the smallest component having causal implications. As a consequence of reductionism and mechanisation, healthcare focuses on scientific features that can be observed, measured and described (Welsby, 1999; Ahn and Tewari

et al, 2006). One of the key elements of the medical model is that pathology [the science of bodily diseases] can only be revealed by the laboratory test, this theme will be developed later in this chapter.

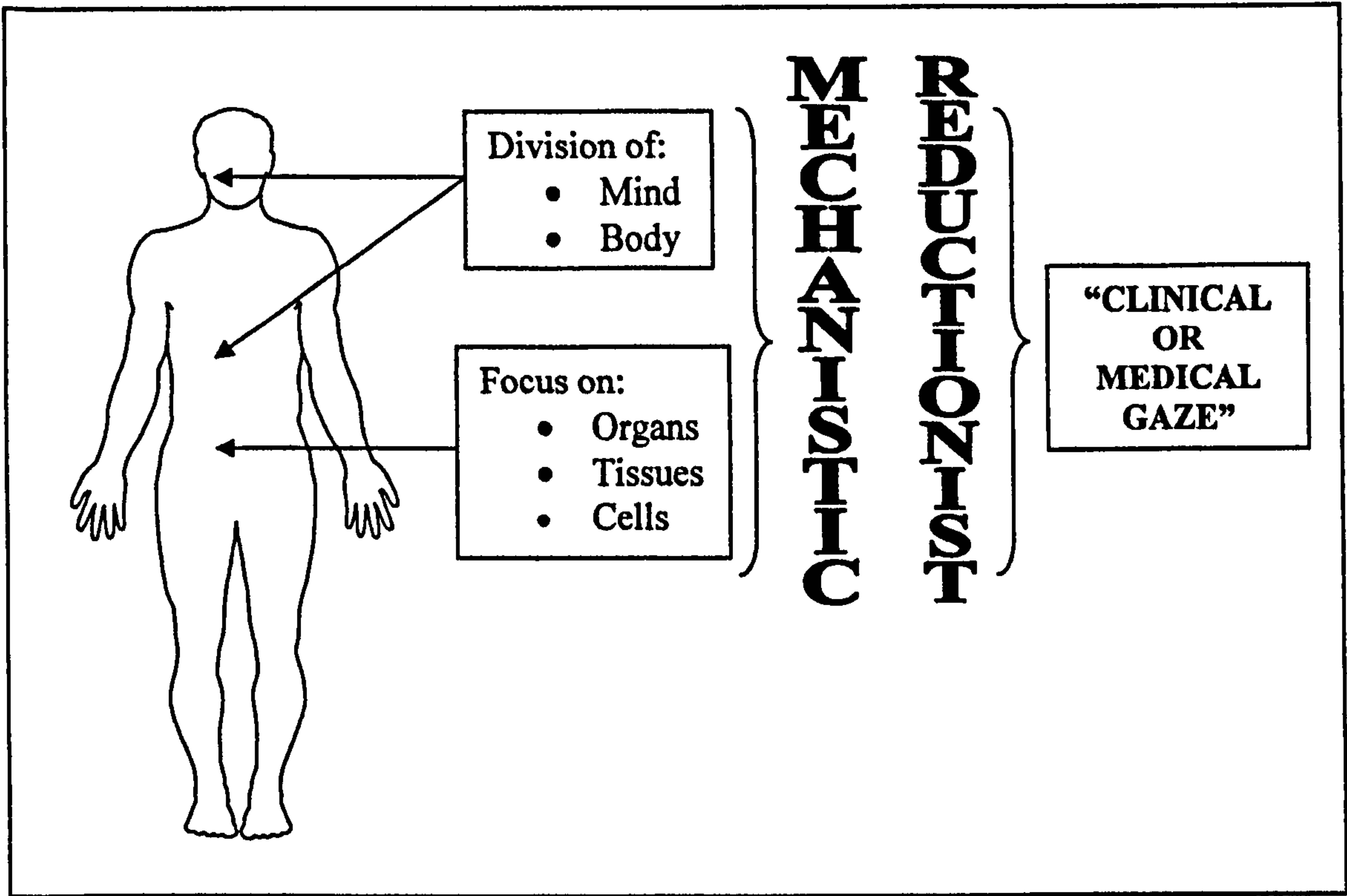
Annandale (1998) acknowledges that Foucault identifies the heart of the medical model with its 'natural/biological' approach, maintaining that,

“...what we know as diseases are themselves fabrications of powerful discourses of ‘truths’ about the body and its interaction with the social world.” (p.35)

Foucault (1989) traced the appearance during the late nineteenth century of the ‘clinical gaze’ or ‘medical gaze’ developing from the medical model approach to conceptualising the human body and this became the prerequisite for a new form of medical practice. Armstrong (1987) citing Foucault suggests that the resultant scientific medicine was not the product of a reasoned progression in understanding, but rather it represented the displacement of one ‘anatomical atlas’ by another. Other sociologists (Arney, 1982; Armstrong, 1983; and Nettleton, 1992) regard Foucault’s (1989) conceptualization of medicine to have generated new perspectives on professions, their knowledge and practice and the powerful position they hold. Nettleton (1992) cites dentistry, and through a description of the history of the dental profession she reconstitutes dental knowledge. Nettleton’s (1992) work focused on dental techniques that explore and work upon the mouth and the discourse that was developed through the construction of the mouth as an object which is structured by dental practices. Six main themes were drawn by Nettleton (1992) in which the disembodied dental ‘gaze’ has reconstituted the object of its focus, ‘spacialization’, or the locating of the mouth in its social context, the individual [patient] who has been shaped within the dental discourse, the dental profession’s disciplinary power, the concept of ‘exile

closure’ and ‘the plague’ with which dentistry is associated and finally, surveillance, a basic element of disciplinary power. These concepts will be shown to exist within the podiatry profession’s medical model approach which has developed into a ‘podiatric gaze’ (Borthwick, 1999a, identified in chapter 2, section 2.3 historical development of podiatry).

Figure 5.1: Basic conception of medical model



5.3 Brief history of the medical model

In order to understand how the medical model came to be such an influence on modern-day healthcare provision, it is necessary to trace the concept back through the historical development of the medical profession.

The medical model first developed in Western culture when the Church permitted dissection of the body five centuries ago. This led Descartes to describe the body as a separation of the

metaphysical and immortal element that later became known as 'Cartesian Theory' or 'Cartesian Dualism'. It was from the seventeenth century that medicine became scientific, as doctors and other scientists applied scientific methods to understanding treatment and prevention of disturbances that the public had first designated as disease or sickness (Engel, 1970). The basic principle of science during this early history was analytical (Galileo, Newton and Descartes) meaning that subjects to be investigated would be resolved into insolvable causal units from which it was assumed that 'the whole' could be understood. With the mind-body dualism firmly established within the Church, classical science readily accepted the notion of the body as a machine, and disease as a consequence of a breakdown in the machine. Repairing the machine became the remit of the medical professional and therefore the scientific approach to disease focussed on the analysis of biological process and ignored the psychological and social elements (Engel, 1977). According to Porter (1997) this has led Western society:

“...to evolve a culture preoccupied with the self, with the individual and their identity and this quest has come to be equated with (or reduced to) the individual body and the embodied personality, expressed through body language.” (p.7)

The Church's permission to study the human body included a tacit prohibition against corresponding scientific investigation of man's mind and behaviour. In the Church's view the mind and a person's behaviour had more to do with religion and the soul, and therefore remained within the religious domain. This compact may be considered largely responsible for the anatomical and structural base upon which scientific Western medicine is built.

The scientific approach to disease was further enhanced according to Diefenbach and Leventhal, (1996) with the discovery of vaccines in the late eighteenth century and gradually expanded over the next one hundred years to shape how doctors treat their patients today. Fox's (1986)

historical description of the medical model attempts to show that the medical model replaced a collective concept of health in the early twentieth century. As a result the focus on health policy moved from public health measures and the relief of poverty to the organisation of medical services. In his lengthy historical analysis Dubos (1960) criticises the medical model for its changing approaches to health and disease and provides evidence of the inability of the medical model to cope with present-day illness and disease.

Over the period of its history, the medical model approach has led the medical profession to develop specialities that concentrate on body parts, diseases, some life events and some age groups (Porter, 1997). As specialities developed, they involved the coming together of various elements i.e. a localised medical problem with a definable body of medical knowledge and techniques, and a pool of patients, patrons and donors. Porter (1997) suggests that specialities flourished when they involved a conspicuous body part or pain responsive to surgical treatment. This view is supported by Barbour (1995) who states:

“We go on to divide bodies into parts, each with its own specialist, every specialist with an advanced technology to rule out that part as the source of the disease.” (p.17)

While the history of the podiatry profession described in chapter two does not extend so far back in history, its development has followed a similar medically focused route not necessarily for the benefit of the individual. Interestingly, feet and foot problems have never become a medical speciality; they have been left to the domain of a profession allied to medicine [podiatry].

The medical model is therefore presented as a model that has developed by separating the mind and body and developing specialities to focus on the scientific aspects of organs and diseases.

While the medical model has developed a focus on scientific cure and medical 'care', it has led to concepts of health and disease, issues that will be developed later in this chapter.

5.4. Wider critique of the medical model

Different concepts of the medical model relevant to this research will be documented next (Dubos, 1960; McKeown, 1976; Illich, 1976; Navarro, 1976; Stacey, 1977; Illsley, 1977; Armstrong, 1987; Barney, 1994; Salole, 1994; Barbour, 1995; Diefenbach and Leventhal, 1996; Taylor, 1997; and Sarafino, 1998). These authors have critiqued the medical model through examination of how it came into existence and how it has influenced medical professionals and the provision of medical care.

Dubos's (1960) historical criticism of the medical model has already been identified and described in the previous section. McKeown (1976) criticises the medical model by demonstrating that the major contribution to improving the health of the population over the last 200 years was not just down to the medical profession but improved nutrition, purer water supplies, behavioural changes, limiting family size, and improved methods of sewerage i.e. public health issues. McKeown (1976), claims the decline in infectious diseases and the growth in the population were only due in part to medical progress and that social changes actually had a major impact on infectious diseases. He also suggests that the dominant role of medicine has led to a significant application of medical approaches to healthcare.

Illich (1976) dramatically portrays the medical model as a major threat to health. He introduces the concept of 'iatrogenesis', a term relating to disease or illness that is caused by the process of medical examination or treatment and this concept, when applied to clinical practice, is evidenced

by individuals suffering pain, sickness or even death as a result of medical care. He extended this definition so that it encompassed the wider implications of relying on medical solutions to what are primarily social and spiritual problems (cited in Moon and Gillespie, 1995, p.75). Illich's (1976) views are supported by Porter (1997) who also claims that the medical model has become a major threat to health. Porter (1997) in highlighting iatrogenesis notes that Illich has exposed many facets of modern medicine as positively counter-productive.

Armstrong (1987) contends that the central principle of the medical model is the reduction of illness to the lesion or organ. Armstrong (1987) also describes the concept of the 'dominance' of medicine which he states is maintained when illness is focused on the lesion inside the body, because only medical professionals can have access to 'the truth' or knowledge. In chapter two, it was demonstrated that the podiatry profession is different from medicine, because it commences with the treatment of corns and lesions visible on the skin and are therefore accessible to the individual. This conceptualisation is supported by Engel (1977) when he claims patients:

“...remain incapable of helping themselves” and there would always be a central role for the hidden lesion which only medicine is competent to identify.” (p.133)

This raises a question for podiatry: is the 'visibility' of the lesion to the individual disadvantageous to the profession in its attempt to use the medical model to enhance its professional status? It could partly explain why medicine has developed a higher status than podiatry in the public's perception as the 'lesions' they deal with are 'invisible'.

Navarro (1976) takes a macro-approach and suggests that countries whose economies are dominated and exploited by capitalism have health systems that reflect the needs of capital, and that arguments about the most appropriate healthcare model, or appropriate professional are misplaced. Navarro (1976) implies an important concern with the medical model approach is:

“...what is more important than the shape of the final product is the issue of who dominates the process”. (p.165)

Healthcare delivery is still determined by the medical profession within the medical model framework which has already been identified to exclude the views of the individual receiving the care. Navarro's (1976) broader analysis links economic, political and social information across time and across countries to expose the dynamics of social inequalities which he proposes can be tackled through class and community action. Navarro's analysis of medicine is however more concerned with the relationship between the needs of capital and the form that medicine takes in supporting it by making workers fit to work (or war) and curing the results of work-induced sickness.

The medical model has consequently had an important role to play within capitalism, as it was responsible for providing health services to keep the workers healthy and productive. It helps the workers to maintain, or to regain their health and this enabled them to play their productive roles in society effectively. This begins to suggest that the one of the priorities for the provision of health services is based on the need to keep people fit for productive work. If this concept is accepted, it leads us to consider the implications for those people who do not work, for example, older people who have retired from work. It may be suggested this is one reason why older people do not receive priority for healthcare provision and have at times been labelled a burden to

the state. Navarro's theory supports the concept of a 'hierarchy' within the medical model in the provision of healthcare for older people, a theme identified in chapter three.

This may begin to explain why podiatry does not have a high profile within the hierarchy of 'medical professions'. This assertion is supported later by comments made during one of the participant's interviews. The participant suggests (without prompting) that the foot, as a part of the body, only received significant attention when men were being medically screened to see if they were fit to fight during the two world wars [Participant: Arthur, 90]. This identification of the foot as an organ/lesion is unusual. It was interesting to note that under war conditions, a medical practitioner and not a podiatrist carried out the assessment and diagnosis, 'the medical attachment' thereby giving the process greater legitimacy.

Several key concepts have been discussed so far as central components of the medical model: the mind/body divide, a focus on the lesion, a dominant medical profession, and the manipulation of medicine to produce healthy workers for production. Stacey's (1977) view is that the medical model is an 'individualistic' approach that considers the causes of 'ill health' to be within the biological systems of the individual. Stacey (1977) also suggests that any attempts to provide a cure for the illness focus on making the individual fit for paid employment, a viewpoint already identified above. In Western society this individualistic approach to health therefore tends to dominate and is usually linked to ideas of functional fitness and curative approaches and is often supported by health policy (see chapter four).

Hart (1993) articulates additional issues with the medical model approach that provide central elements for this research and current podiatry provision. The 'organic' appearance of disease,

combined with a tendency to ignore, if not dismiss, the link between mind and body, and consequently between the significant concepts of physical and mental well-being are of major concern. There is a perception that 'disease' is an autonomous and potentially manageable entity which threatens personal health in temporary or intermittent ways, and equates disease to 'an intruder' that needs to be excluded (Hart 1993). This observation is in sharp contrast to the view of disease as an integral product of the person-environment relationship. Instead the medical model places a focus on 'cure' by medical treatment of the organic symptoms with the intention of making them disappear if at all possible. As Porter (1997) notes, this has made medicine share certain parallels with magic and religion as "all medical practitioners seek to perform their own style of conjuring trick". (p.6)

It has been acknowledged that the medical model operates on a division of mind and body, but a division also occurs when examining concepts of health, particularly when discussing the concepts of 'cure' and 'care'. This separation has been described by Dubos (1960) as the never ending oscillation between two different points of view in medicine. Another key difference between podiatry and medicine is identified here: podiatry provision for older people has tended to provide 'care' [long-term maintenance] rather than 'cure'. Moon and Gillespie, (1995) suggest these differing concepts concern the determination of the medical model to intervene directly in the process of disease, and provide a 'cure', compared to a necessity to achieve balance between the body, the mind and the environment often defined as 'care'. Recognition of this division leads Sarafino (1994) to argue for an integration of the mind and body, sometimes referred to as 'holistic' or 'whole person' approach, and challenge the 'mind-body divide' by suggesting they are thoroughly intertwined. Sheaff (1996) admits that only an incomplete medical model ignores the relations between mind and body, instead of admitting the possibility of physical production

of mental symptoms and mental production of physical signs. Sheaff attempts to bridge the 'mind-body divide', by arguing that mental activity is a special type of bodily process and suggests that mental illness is something that the patient suffers, which 'possesses' the patient, due to biological or social causes outside their control.

The medical model therefore focuses on disease and the body is treated as a machine with a faulty part. The medical intervention usually takes place in a 'medical environment' which is not normally the environment where the symptoms first appear. The focus on the site of the disease rather than the 'individual', leads any intervention [treatment] to be similarly focused on the disease with little involvement of the individual. This can leave the individual feeling isolated and not involved in their treatment. The medical environment therefore maintains medical professionals' domination of the 'professional-patient' encounter: one additional important element of the medical model influence that became 'a real life' example of the medical model in action during the ethical approval stage of this dissertation, this example is described together with its implications for the research in chapter nine.

The medical model has earlier been described as reductionist and this is exemplified by the medical model approach systematically ignoring the large influence that social interaction and the external physical environment exert on human health and needs. Pickin and St Ledger (1993) criticise the medical model of health for focussing on 'non-mental inter-corporeal matters', but according to Sheaff (1996) the medical model is not so weak and narrow as this. At its strongest, he suggests, it traces:

“...the microbiological causes of ill health outside the body into the environment, including the social environment and the causes of ill health in consumer goods and the workplaces”. (p.79)

The medical model’s scientific approach to healthcare requires health to be measured objectively. However, the measuring of mental illness [health] has historically been difficult. Measuring ‘health’ at any age is difficult and this is reflected in the numerous ‘assessment tools’ that have been developed, for example the sickness impact profile (Bergner and Bobbitt et al, 1976, 1981) and the Nottingham health profile (Hunt and McEwen et al, 1985). Despite this objective approach, Mossey and Shapiro (1982), Welin and Tibblin et al (1985), and Arber and Ginn (1991) suggest that subjective health measures should be just as important to consider, because individual reports of poor health have been found to be associated with premature death. Health needs identified by the individual are closely allied to feelings of ‘well-being’ and ‘quality of life’ (Blaxter, 1985). Subjective concepts such as ‘well-being’ and ‘quality of life’, are not normally considered within a medical model approach, but have already been put forward in chapter three as potentially important issues for older people who perceive they require podiatry interventions.

The medical model sets a framework for healthcare professionals to provide services in which they diagnose the disease, discover the causes and symptoms, and design an intervention that is aimed at eliminating or minimising the symptoms of the disease or cause of the disease. Rather than continue to add further detail to the concept of the medical model, this chapter will move towards providing a focused critique of specific issues with the medical model that relate to current NHS podiatry provision. Each of the following concepts will be examined and described in consecutive sections: the medical profession, medical knowledge, medical terminology, the medical consultation, medical needs and medical outcomes.

5.5 The medical profession

The 'medical profession' referred to in this research predominantly constitutes medical doctors. Other professions provide healthcare including nurses, allied health professionals and healthcare scientists. Podiatry was identified as an allied health profession in chapter two. Despite the increasing number of healthcare professions, the medical profession and the medical model remain the dominant influence in the delivery of healthcare. Yet, as Morrissey and Coakley (1999) contend, the medical model fails to define and understand nursing, psychological, emotional, or spiritual care, when in reality these forms of caring offer a wider approach to healthcare than the medical model. This leads Morrissey and Coakley (1999) to conclude that it is time to shift the focus of healthcare so that results can be measured in improving quality of care, respect, comfort and teamwork.

In Western culture, the attitudes and belief systems of medical students have been moulded by the medical model long before they embark on their professional education. According to Engel (1977), this reinforces the medical model approach without necessarily clarifying how its use for social adaptation contrasts with its uses for scientific research. Barbour (1995) describes how the medical profession has developed to the exclusion of other aspects of healthcare:

“...we have evolved a truly appalling practice of splitting our patients into minds and bodies, relegating the former to ‘shrinks’, the latter to ‘real’ doctors – a schizophrenia of care. The cleavage between medicine and psychiatry inevitably grants the medical doctors a licence to disregard what is ‘psychological’, because there is someone else ‘to do it’ if it really becomes necessary.” (p.17)

As a result, the medical profession places a focus on the body or organ, not the individual, a concept already referred to as the ‘medical gaze’ (Foucault, 1989), or an ‘individualistic approach’. The ‘individualistic approach’ reduces the individual from being a person [the self] to

a disease or impairment which has led the medical profession to place a greater emphasis on an accurate diagnosis of the disease and its underlying pathology. This process relies upon an objective concept of 'normality', with disability, disease and impairment considered as 'deviant physiology' that needs to be corrected. Treatment or interventions provided to individuals [patients] allow them to return back to 'normal' standards of life and behaviour. The labelling of the individual as a patient has also seen the introduction of the term 'sick role' in which individuals adopt certain roles (see chapter three), usually a disempowered role because of the perceived power of the medical professional over the disease. Recognising this powerful influence supports the approach suggested earlier, where reference is made to 'participants' in this research, recognising the powerful influence of the medical model when individuals are referred to [or labelled] as 'patients'.

The medical professional's 'expert' power over the 'patient' leads to an asymmetrical relationship between the doctor, and patient, where the patient submits to the medical profession's power. Porter (1997), in recognising the influence the medical profession has upon the provision of healthcare, suggests the power of the medical model has permeated Western culture and therefore it not only influences the approach of the medical profession, but how the medical profession is perceived by society as well.

Dingwall's (1976) critique of the medical profession's role suggests that they only use signs based on objective indices of biological structure or function to decide whether a disease is present or absent (scientific approach), whereas Hart (1993) contends that the medical profession's power is built on:

“...a combination of political organisation, ideological domination, and control over the infrastructure of public resources for health”. (p.129)

To reform the current medical model approach would require action to weaken the medical power base. One of the most important actions suggests Hart (1993), would be to dilute the power of medical ideas in our culture by exposing their limitations. Barbour (1995) observes the difficulties for those professionals trained in the current medical model to recognise the extent to which the individual is invariably bypassed by the medical process of reducing interventions to diagnosis and treatment. Barbour (1995) further suggests that because the diagnosis and treatment is specifically intrinsic to the goals of the medical model, most doctors feel secure about anatomic disease but uncomfortable about the ‘non-disease’ illness or functional syndromes and tend to treat them as though they were specific diseases. The dominance of the medical model has fostered reliance on external treatments, and Green and Shellenberger (1991) suggest both the individual and professional have come to view medicine as:

“...something done to the patient”. (p.413)

Another important element of the medical model approach is the medical consultation which appears as a one-way process: individuals get ‘done unto’ rather than being an active and equal participant. Podiatrists are similarly trained in medical model thinking, and it is felt that current podiatry practice also fails to take into consideration the human situation, with most podiatry interventions resulting in something being done to the patient, for example, the treatment of corns. This statement about podiatry interventions is supported by findings from the podiatrists’ focus group, conducted as part of this dissertation. As a bi-product of conducting this focus group, the researcher was able to identify his own ‘baggage’ (or biases) following his training in medical model thinking. These are documented in chapter nine.

5.6 Medical knowledge

One of the reasons for the powerful influence exerted by the medical model is the mystery it generates with its medical knowledge and its own form of professional language. However, Stainton Rogers (1991) challenges the view held by many health professionals that medical knowledge is superior, and therefore questions the legitimacy of its dominance. She outlines ways in which the dominance of the medical approach has often led to the discounting of lay knowledge, which at times is portrayed as a watered down version of medical knowledge, old wives' tales, or superstition. The emphasis on the superiority of medical knowledge derives from its objective and scientific basis, which has tended to reinforce the discounting of the views of the individual with the disease (because these are perceived by the medical profession as being subjective) and as a result interventions based on individuals' needs are rarely considered. This provides a challenge for this research as one of its primary aims is to understand individual older people's perspectives of how they identify their foot-care needs and what their experiences and feelings are about how their needs are met. This is something the medical model approach does not traditionally address and something the individual older person may not culturally expect. These challenges will be addressed more fully in chapter nine.

According to Moon and Gillespie (1995), the rapid growth of medical knowledge has led to the development of medical specialities. The focus on the disease has led to no one person being able to specialise in the whole body and thus a focus on different organs or disease has evolved. A medical model approach therefore tends to promote specialization of specific parts of the body or disease and reliance on treatment that can be costly and not always beneficial. Unfortunately, as Gordon and Fadiman (1984) recognize, this type of approach does not promote prevention, health improvement or an individual responsibility for health.

Interestingly, the medical profession has not seen the foot (or lower limb) as an appropriate area for developing a medical specialty or substantial scientific knowledge base. This suggests a hierarchy of medical specialties within specific parts of the body, with particular emphasis given to the head and the torso, with limbs (specifically lower limbs), being literally located at the lower end of this hierarchy. It could therefore be questioned why podiatrists have not grasped this opportunity to exploit and develop this area of expertise and professional dominance, when one of the podiatry profession's aims appears to be the attainment of a similar status to the medical profession?

Notwithstanding individual professional power, how can practitioners of the current scientific approaches to medical research (the randomised controlled trial), be sure that doctors are asking the right questions in order to provide the appropriate care, when those individuals receiving the care do not have their views considered? As Kitwood (1997) observes, there appears to be reluctance within the medical profession to engage in research that can empower people in care. Kitwood (1997) recognizes the importance of a 'person-approach' and stresses the importance of 'person-hood'. Engel (1977) describes a similar concept, but names it 'patient-hood', a reference that still has medical model association with use of the term 'patient'. Engel (1977) contends that by evaluating all the factors contributing to both illness and patient-hood, rather than giving precedence to biological factors alone, an alternative approach may explain why some individuals experience an 'illness' that others regard merely as problems of living, whether they are emotional reactions to life circumstances or somatic symptoms. The issue for the individual who experiences the problem lies in the 'not knowing' [not having the knowledge] why they feel or function badly, or what to do about it, coupled with the belief or knowledge that

the doctor did know and could provide relief. For the doctor, their focus is a commitment to their professional role as healer rather than sharing information and involving the person in their care.

In summary, the medical model approach has led to specific sets of expectations for both practitioner and individual, are reinforced by the culture, although these are not necessarily the same for the doctor as for the individual. Exploration of these expectations from the older person's perspective is one of the main objectives of this dissertation.

5.7 Medical terminology

Within the medical model framework, the development of medical knowledge has been accompanied by the creation of a specific language for medical professionals. The use of medical terminology assists medical professionals to maintain a mystery about their work; as it adds mystery to individuals' understanding of their condition and maintains the 'expert' power of the medical profession. Terms such as 'health', 'illness', 'disease', 'impairment', 'disability' are an attempt by the medical profession to place individuals into medical categories [labels] that do nothing but generate confusion for lay people.

As previously discussed, underlying the medical model approach is the implicit assumption that the illness described by an individual indicates a disordered part, or pathology, usually called the disease or disorder and identified as the cause or basis of the illness. However, it can be questioned whether the terms 'health', 'illness', and 'disease' have any relevance to older people when they seek care, whether it be medical or podiatry. An examination of these medically induced terms will assist in the identification of the medical model influence and operation, and its relevance to the provision of 'person-centred' podiatry services for older people. Examples of

the use of these terms in relation to the participants in the research will be considered, and in order to understand what is meant by these terms, an explanation of these three frequently used terms follows below.

5.7.1 Health

It is recognised that the medical model has introduced terms such as 'health', 'illness' and 'disease' in order to label specific conditions that affect the human body. However, it will be demonstrated that the term 'health' has different meanings for medical professionals and lay people.

Health has been defined by Luker (1982) as:

“...a dynamic state in the life cycle of an organism which implies continuous adaptation to stresses in the internal and external environment through optimum use of one's resources to achieve a maximum potential for daily living. Health relates to the way an individual deals with stresses of growth and development while functioning within the cultural pattern in which he was born and attempts to conform” (p.32)

Green and Shellenberger (1991) have stated that individuals perceive they are healthy when they are free of illness and disease or from a medical model perspective when physiological measures indicate no risk to health. However, these definitions are problematic as they fail to take into account notions of positive health, psychological health or deal with the complicated relationship between objective disease and an individual's subjective perceptions.

Culyer (1981 cited in Burgess, 1986), describes his medical model definition of health as simply: 'health as the absence of disease'. However, Culyer (1981) does acknowledge that other definitions exist: 'health as the absence of illness' (a sociological model), and 'health as an ideal' (the World Health Organisation model).

These two concepts of health are problematic for a medical model approach because for a sociological model to be acknowledged, it will be necessary to consider the implications of 'the self' or others. Within this approach, the 'absence of illness' definition may only be acknowledged after an illness has been recognised by a medical professional and therefore may not be relevant for comparative purposes, since it is dependent on individual or social circumstances. Consequently, it is essential to acknowledge that when considering issues of the 'the self' in models outside of the medical model, experiences and views of one individual's health will be different to another. This further supports the assertion that 'the self' is a significant concept (chapter three) to consider when examining issues of health outside of the medical model framework.

The World Health Organisation's (WHO) concept of health is also problematic when examined through a medical model framework. The WHO (1948) definition of health is presented as:

“...a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity” (p.100)

A 'primary healthcare strategy' was agreed by the World Health Organisation in 1978 with a goal of “Health for all by the year 2000”. The strategy focused on community

involvement in the spirit of self-reliance and self-determination to achieve essential health, a theme that now has greater prominence in health policy (DOH, 2005a, 2005b, 2005c, and 2005d). While the stated aim of the strategy in 1978 was to put greater emphasis on self-determination, it was not until the Long-term conditions National Service Framework (2005d) that self-care and empowerment became more explicit in specific areas of government health policy. Unfortunately, the WHO strategy gave priority to the role of health workers who continue to work within the medical model and medical definitions of health.

The WHO definition attempts to propose an idealised definition of health and has been criticised by Salole (1994) for being impracticably utopian and so broad as to perhaps be meaningless. However, the medical model's individualistic approach to preventative healthcare has been criticised for blaming the victim when environmental factors may have a greater effect on a person's health (see Townsend and Davidson's (1992) 'Black Report' Working Group, a seminal in-depth study that examined inequalities in health). While these different concepts are thought to exist, Stacey (1977) recognises that the medical model's individualistic, functional fitness and curative approaches remain the most influential in the NHS.

The need for a broader view of health is identified by Ham (1992) who acknowledges McKeown's (1976) concept of health, and provides an analysis of illness and disease in four basic areas. These are: human biology, the environment, life style and healthcare organisation. Ham (1992) concludes that human biology could include aspects of health such as ageing that are developed within the body as a result of the basic biology of a

human. Environmental aspects include matters over which the individual has little or no control, while lifestyle refers to decisions made by individuals that affect their health over which they also have no control and finally, healthcare organisations that examine the arrangements made for individuals' healthcare. While this model recognizes aspects of individuals' lives are outside of the traditional medical model framework, each element is still influenced by the medical model approach but none of the elements are within the control of individuals.

The medical model's individualistic approach to health tends to ignore the concept of preventing 'ill health'. Health prevention strategies are normally a shared concept that look at the broader causes of illness within the wider framework of the environmental, economic and social systems in which individuals live. These strategies attempt to prevent illness occurring by tackling the unhealthy aspects of these broader non-medicalised systems. Current podiatry practice, described in chapter two, demonstrates that little preventative work is carried out due to the current 'medical need' access criteria. This suggests current podiatry interventions for older people are targeted at treating conditions that 'maintain' older people's mobility and independence rather than considering the individuals' views or their wider social world. Stacey (1977) however portrays the existence of a 'welfare concept of health' that places great importance on 'relieving pain' and providing 'care'. This welfare concept of health can be related to podiatry provision, as one of its stated objectives is to relieve pain (Podiatrists' Focus Group) and potentially, although not actively, pursued for its service users to provide care. It is believed that foot problems are not considered to be 'ill health' by older people,

and the term 'welfare' would not be felt to be appropriate by podiatrists or service users, since this term is associated with means tested social care.

The link between podiatry and 'health' is therefore not obvious when taken to the level of an individual. While a podiatry intervention may be depicted as individualistic using Stacey's (1977) definition, they are rarely curative. The concept of 'health' is consequently problematic for podiatry, the latter, does not provide a 'medical' cure for disease or illness. Consequently, the podiatry profession's attempt to align itself with medicine is made more difficult as podiatrists cannot demonstrate that their interventions for older people are aimed at a cure. It is certainly not clear that a 'cure' is what older people want from podiatry interventions and as has been suggested by McAllister and Farquhar (1992) and Ham (1992) a broader approach to 'health' may be more appropriate. This is a further reason to question why podiatry follows the medical model approach when 'cure' is rarely achieved. An exploration of these concepts will be undertaken with the participants in this study, to see whether older people perceive their foot problem as a 'health' issue or whether they use other descriptions.

McAllister and Farquhar (1992) claim that individuals' beliefs about their health are complex and influenced by their culture, social background, experience of health and illness and exposure to health promotion. These broader concepts of health have been identified in definitions described above and lend support to the decision to select the biopsychosocial model as the comparison model for this research as this model accepts these broader definitions of health.

5.7.2 Disease

The central concept of the medical model of disease is the assumption that diseases have specific identifiable physical causes. However, freedom from illness and disease has been identified as the most common meaning attributed to the term 'good health' although the terms disease and illness are problematic for the medical model. For podiatry, the medical terms 'disease' and 'illness' have been identified as justification for access to the provision of NHS podiatry treatment, when it is possible that neither disease nor illness has any relevance to an older person's foot-care needs. As has been suggested, the concepts of health, disease and illness should be broader than the medical model view, since it is important that these terms are explored with participants in this research.

This position is supported by Antonovsky (1989) who suggests:

“...we must understand the causal factors in the 'disease' if we are to suggest appropriate 'therapy'. As we all know, all diseases have multiple causation.”
(p.248)

Engel (1977) suggests disease in its broadest sense is a term used to refer to a specific class of phenomena that individuals from all social groups have been exposed to. He goes further to propose that when individuals use terms such as disease they have in mind a harmful and undesirable condition, associated with impairment or discomfort, and if they have developed a disease, they have not normally gone out of their way to get it. However, the identification and naming of a 'disease' [diagnosis] is usually performed by a medical professional that results in the individual seeking a corrective intervention or 'cure'. The individual usually has preconceived expectations of the intervention that includes beliefs and explanations about the disease, as well as rules of conduct to

minimise treatment actions. These actions constitute socially adaptive behaviours for the medical professional to resolve for the individual, which can be problematic as the individual's expectations may have already been influenced by the medical model which leads individuals to only expect what a medical model provides. As Sheridan and Radmacher (1992) observe, the medical model approach conditions people to believe that the model is trouble-free.

Barbour (1995) states, if the problematic component of the body is a structure, it is called a 'disease' (medical model approach). If the disordered part is a functional disturbance of normal structures, it is simply viewed as a 'disorder'. However, when the functional disturbance is physical, the illness is known as a functional disorder. When the functional disturbance involves moods or emotions, thoughts, personality or behaviour, the illness is viewed as a psychological or mental disorder. These conditions are problematic when considered within a medical model framework because of its focus on organs. This research will therefore need to make a comparison of the participants' perceptions through the application of the medical and biopsychosocial models in order to take account of these wider issues.

Barbour (1995) additionally suggests that 'disease' no longer means 'dis-ease', lack of ease, or illness, it now solely refers to the disordered part to which the symptoms or disease are attributed. Taking the term disease and relating it to foot problems (foot disordered parts) is problematic, because the 'patient's disease' is not defined and cannot be fitted into a disease framework. In the medical model approach, sickness and disease have become synonymous because unless the medical professional can understand the

individual's problem in terms of disease, they cannot fully accept the situation as a medical condition. The failure to define foot disease or cures may be one reason why podiatry has been unsuccessful in securing a higher level of status within the medical profession's hierarchy.

There are three main issues with the objective view of disease. First, it is very difficult to develop universally valid norms of physical functioning because of the range of variability among individuals and this has been identified in chapter five, where age has been demonstrated to be a poor indicator of physical functioning and consequently what is "normal" for one will not be normal for another. Secondly, indices of disease may bear little relationship to an individual's subjective experience of pain, distress or debility. Thirdly, objectively defined disease may be so prevalent that most of the general population would have to be defined as diseased, an issue already identified in chapter three where older people are often portrayed as a homogenous group and a burden to the state.

The second and third points above make the medical model approach to disease, as a major criterion of ill health, highly problematic. As norms of bodily structure and functioning cannot be agreed, this must also apply to the classification of foot problems. The medical model framework may 'reduce' medical professionals to assume that older people's foot problems are part of the normal ageing process as the majority of older people's foot problems are not associated with a disease or illness. The strength and weakness of the medical profession has been that many individuals who consult them do not actually have a disease; they are, either sick, sad, lonely or they need comfort (Porter,

1997). He goes further to confirm that individuals can experience both physical and mental symptoms at the same time dispelling the mind-body divide previously identified in the brief history of medicine. This raises interesting questions for NHS podiatry services, as access criteria for these services have been developed by podiatrists based on medical concepts of disease or sickness. The implication of this is that NHS podiatry services operate within a medical model framework, which meets the needs and expectations of podiatrists, but not necessarily other healthcare professions or more importantly individuals who try to access NHS podiatry services.

Freidson (1970) proposes that disease may or may not have a basis in the biological model, but it always has a basis in the social model and he agrees that the medical model fails to acknowledge the multi-causal nature of diseases and illnesses. As Sheridan and Radmacher (1992) state, the medical model treats images and emotions as relating to the mind and therefore not capable of affecting the body. Sheridan and Radmacher (1992) also support Engel's (1980) view that only the biochemical factors of illness are considered within the narrow medical model framework, and social, psychological and behavioural dimensions are ignored. As Green and Shellenberger (1991) suggest:

“...the types of treatments that the medical model generates do not apply to lifestyle problems.” (p.415)

While it is suggested that medical approaches to disease and illness are problematic for podiatry, they are concepts used by podiatrists to justify access to NHS podiatry services and the delivery of their ‘medical’ podiatry treatment. This raises an interesting question

for podiatry provision. Are an individual's foot-care needs really associated with health, disease or illness?

The concepts of health and disease are therefore an area for exploration in this research, as they have relevance for how an individual perceives their foot-care needs and how a podiatrist translates and addresses these needs. A comparison will be drawn, examining the differences between the medical and biopsychosocial approaches to meeting these needs.

5.7.3 Illness

In the previous section it was suggested that the concept of disease focuses on the objective and is viewed in terms of a specific impaired state, whereas the concept of illness will be described in this section as focusing on the diffuse consequences of the disease process. Porter (1977) suggests illness is not just biological but social and concepts of the body and its sickness draw upon the powerful dichotomies of nature and culture. Chrisman (1977) considers lay theories of illness, and discovered lay people perceive illness being caused by four factors: ageing, blockage of blood vessels, poor diet and invasion of germs, not all of which fit the medical model approach. Interestingly, each factor's importance and dominance varies from one culture to another.

Illness and health are terms that are often used interchangeably, yet have been referred to by Sarafino (1994) as concepts at opposite ends of a continuum. At the illness end of the continuum Whitman and Merluzzi (1999), imply this is characterised by signs, symptoms and disabilities varying in severity and at the health end of the continuum there are

indicators that suggest a positive state of physical well-being. Whitman and Merluzzi's (1999) alternative concept of the medical approach to illness emphasises that although biological, psychological and social factors play a role in both health and illness, the specific types and pattern of factors that increase or maintain healthy states are different from those that produce illness.

Barbour (1995) states illness is personal to the individual and coined the term 'personal-illness'. Personal illness is an encompassing term that is used to view those illnesses caused predominantly by problems of the 'human condition' which Barbour (1995) cites as outmoded and unproductive behaviours, cognitive constructs, values, purpose and meaning, as well as emotions, relationships, occupation, sexuality, difficult childhood, poverty, racial prejudice, physical strains, the stress of modern day life, faulty nutrition, smoking, alcohol, drug abuse and many more that are not included in a traditional medical model approach. Barbour (1995) recommends every person with a personal illness should be considered a person in need and he suggests that health professionals would be far more productive if they did not ask individuals "what is wrong?" but, "who is this person; and what, is their need?"

The terms illness and disease are also used interchangeably, but according to Green and Shellenberger (1991) illness is more frequently used to refer to discomfort or disorders that are not caused by a virus or genetic defect (biologically identifiable defects). A distinguishing feature between illness and disease may therefore be that many physiological disorders are related to lifestyle and health behaviours and to stress. This poses another interesting question for podiatry provision, as many of the current podiatry

conditions identified for access to NHS podiatry services can be described as physiological disorders, but they are not illnesses or diseases. A distinction between illness and disease cannot therefore be made for podiatry, but for Green and Shellenberger (1991) the relationship between disease and illness is not isomorphic but highly complex and really depends on a combination of any social and psychological factors. Understanding these social and psychological factors in relation to podiatry will be examined through the comparison of the two conceptual frameworks.

Barbour (1995) proposes when illness is reduced to a specific entity with a specific therapy, the disease itself is the appropriate focus of medicine. However, as previously highlighted for many illnesses, the medical model's 'reduction' provides little more than a fragmentary if not misleading, view of the illness as a whole. As Barbour (1995) asserts, as many as one third of patients who seek medical care do not have any organic disease, but rather feel ill due to problems relating to their personal situation and a further third have organic disease, but their distress is primarily caused by psychosocial factors (a similar view to Porter (1997) cited on previous page). Stainton Rogers' (1991) approach to disease differs to Barbour's (1995) in that she states that disease is simply what doctors diagnose and the medical model treats, whereas illness is described as what people experience as bodily and psychological dis-ease.

Barbour (1995) and Diefenbach and Leventhal, (1996) advise the medical model's emphasis on the technical aspects of medicine has blurred the distinction between illness and disease. Barbour (1995) suggests that disease is pathology or a specific entity that is identified by predefined objective criteria, whereas an illness is a subjective phenomenon

and relates to the way a person feels. A disease is therefore characterised by a set of physical signs and symptoms whereas illness is the social definition of health. When health professionals agree that a person is sick, illness is a description that is used when the sickness is less clearly defined than a disease. According to Kety (1974 cited in Engel, 1977) the medical model suggests that a human illness does not become a specific disease all at once and is not equivalent to it, which leads Engel (1977) to suggest the medical model of illness is a process that moves from the recognition and treatment of symptoms to the characterisation of a specific disease in which the cause of the disease (aetiology) and symptoms of the disease (pathology) are known and treatment is rational and specific. An illness therefore may or may not include all disease specific signs and symptoms, (Kleinman 1980). However, it is not uncommon for people to feel ill and to complain about symptoms without any physical signs of disease. In these cases the medical model approach is unable to provide explanations that satisfy the health professional or the individual. This is because the medical model fails to acknowledge the individual's psychological processes in the evaluation of symptoms and in a wide variety of treatment situations. This approach also treats psychological factors in the same way that it treats physiological and clinical variables, as an attribute that is either absent or present, and ignores the processes that connect the trait to the behaviour of the individual.

The medical model framework of health, illness and disease can therefore be criticised for not including the individual's perspectives. It is increasingly recognised in health policy (DOH 2004a, 2005b, 2005c), that the individual's perceptions of their health are important factors in understanding and improving a person's overall health. The

definitions of health, disease and illness have been potentially identified as having little relevance to older people, their podiatry needs or foot problems because podiatry interventions are not associated with 'foot illnesses'. Commonly presented podiatry conditions are difficult to define in terms of disease or illness. This is clearly problematic for the podiatry profession as it tries to increase its professional status in line with the medical profession, because there is not a clear link with the 'cure' of disease or illness. One example where this may apply can be drawn from people with diabetes. The 'disease' of diabetes labels a person with problematic feet. The podiatrist is perceived as an expert who deals with a 'diabetic foot' but the 'podiatry gaze' does not necessarily take into consideration the psychosocial factors for the individual with diabetes when developing the appropriate intervention. An example of this approach to podiatry need was previously identified (Luker, 1992) earlier in chapter two.

All these challenges Barbour (1995) suggests can be resolved in a 'systems analysis'. A systems analysis gives consideration to the entire illness and as Barbour (1995) contends, a systems analysis demonstrates a continuity of related events, and how those known as 'disease' connect with those known as human. This then helps to demonstrate how the individual might be helped in the healing process. The concept of general systems theory may therefore be useful in understanding an individual's health needs. 'General Systems Theory' will be described in chapter six: it is based on systems analysis and is the unifying theory between the medical and biopsychosocial models. It also begins to explain the holistic nature of the biopsychosocial framework. With reference to understanding an individual's podiatry needs, the development of 'a system' is required. The concept of the 'podiatry career' will be described in chapter eight, and this concept

will illustrate the various stages and processes an individual passes through from identifying their foot-care needs to hopefully the resolution of those needs.

This critique of the medical model is thus directing this research towards greater consideration of the views of older people who are recipients of podiatry care and a comparison of the medical and biopsychosocial models: to explore which model would better deliver 'holistic', person-centred podiatry care.

5.8 The medical consultation

The medical consultation became of particular relevance when ethical approval for the research was sought. The ethics committee advised that information gathering from participants in the study should take place in a clinical facility. This had major implications for the research and will be discussed more fully in chapter nine.

One of the implications this raises is that the undertaking of the medical consultation can be artificial for the individual, as they are established primarily for the convenience of the healthcare professional and support the operation of the medical model approach. Most medical consultations, for example, take place outside of the social environment in which the individual's health problems may exist. The evaluation and analysis of these problems typically occur in a healthcare setting in which the professional assumes control over all aspects of the process of gathering information and in which the medical model subtly operates.

Ham (1992) suggests that confronting the medical model approach with health professionals challenges their traditional role. Yet, it remains the professional monopoly of health

professionals guarding and defining what is considered as 'legitimate medical knowledge': it maintains medicine as the dominant approach in dealing with illness. It is the conduction of the medical consultation that remains at the heart of the medical profession's resilience to any criticism or change from their approach to health problems. The power and influence of the medical model (identified in the medical profession section) enables the medical profession to continue to dominate modern healthcare and this preserves the doctors' control of healthcare delivery. As Barbour (1995) contends:

“...they have the knowledge, and the focus is therefore what the doctor knows and does, rather than what patients can do for themselves.” (p.152)

Although the medical consultation is recognised as an important component of the assessment process, it should only be considered the first step. It will be suggested in chapter nine that other methods of data collection such as interviewing family members, reviewing patient diaries or even observing patients at home or work would assist the professional to develop alternative concepts of the older person's requirements.

As described in the medical terminology section, the medical model legitimises the medical profession's power by giving a name and a treatment for every kind of illness. This approach pre-forms the 'patient' expectations of the medical consultation and inevitably this is what the individual receives and what the health professional wants to provide (Barbour, 1995). The use of medical terminology in medical consultations keeps the health professional in control over the entire duration of the consultation and illness. As Engel (1977) observes, even with the application of rational therapies, the behaviour of the medical professional and the relationship between the professional and individual powerfully influence the therapeutic outcome, for better

or for worse. However, from what has been described so far, there is a suggestion that all the above factors must have psychological effects on the individual that may directly modify the illness experience or indirectly affect any underlying biochemical processes which a traditional medical model would not recognize.

Engel (1977) proposes the medical professional's role should be that of an educator and psychotherapist. In these roles Engel (1977) suggests, they would know how to induce peace of mind in the individual and enhance their faith in the healing powers of the health professional but this requires psychological knowledge and skills, not merely a 'medical charisma'. Unfortunately the current medical model approach does not include these attributes, which has led Engel (1977) to state that the medical profession has developed a social order among healthcare professions and a hierarchy concerning what constitutes appropriate areas for medical concern and care, with the most obscure disorders at the top of the hierarchy. As James and Field (1996) suggest, nurses are not set apart in the same way as medical professionals, which means that the medical model continues to remain the dominant power in the hierarchy of healthcare practice. This is further evidence that hierarchies exist within healthcare professions, with medicine remaining the most dominant.

Despite their dominant role, medical professionals are not normally in the presence of the individual when a disease commences. Medical professionals have to wait for the individual to present themselves for a medical consultation which suggests the individual must have identified some need or have some knowledge that appropriate action is required to resolve the problem. In the medical consultation the medical model approach leads the medical professional to focus on the end point of the disease (a 'cure') and not its root cause. Therefore, for many medical

professionals the prevention of disease/illness is not of central concern and this has led to the development of another 'specialism' within the medical profession, public health. As Hart (1993) suggests:

“Like the efforts of witchdoctors, medicine is therefore primarily a pragmatic activity, orientated to answering the immediate needs of individual patients”. (p.11)

As previously suggested the primary aim of the medical consultation is an intervention, medically termed a treatment, and this begins with the individual's description of their symptoms. These are all reported as deviations from 'normal' health and provide clues required for the diagnosis and the application of the correct treatment. The individual who attends for the consultation (now labelled 'the patient') will have feelings and impressions of what is wrong with them, yet these remain less important than any organic signs that may be felt, observed or tested by the doctor. If necessary, samples of the individual's body such as urine or blood may be taken or more complicated mechanical tests may be requested, in order to find a medical label ('diagnosis') for the problem, the objective being the identification of organic causes beyond the individual's comprehension. Longino & Murphy (1995) acknowledge the use of the stethoscope, invented by René Laennec in 1816, allows the medical professional to examine individuals instead of just observing them. By localising the pathology with the stethoscope a medical professional is able to replace the individual's own account with their own medicalised, objective measure. The enormous investment in diagnostic and therapeutic technology in the NHS reflects the importance placed by the medical profession on clinical study and care of individuals that emphasize the already identified impersonal and mechanical nature of medical healthcare. The planning of systems of medical care and its financing is excessively influenced by the availability and promise of technology (Engel, 1977). The application and effectiveness of the technology

are often used as the criteria by which medical decisions are made as to what constitutes illness and who qualifies for medical care.

The place for the medical consultation or treatment is usually set apart from the environment in which the individual lives and carries out their normal activities of daily living. This potentially prevents the doctor from picking up any signs regarding the causes of the individual's illness. As well as this, the professional-individual relationship remains highly confidential and is surrounded by an impression of anonymity. The content of the consultation is usually restricted to the description and examination of organic symptoms and information is rarely requested about the individual's social identity, occupation, marital status, workplace, or income. Should the medical intervention become an issue of containment of the disease rather than treatment, then the freedom and quality of care of the 'whole person' is significantly reduced. This highlights the shortcomings of the medical model approach, restricting attention to the biological dimensions of any disease and treating the individual as a mindless object whose physical body can be treated like a machine ('mechanistic').

The medical consultation can lead to the perception of the medical professional as a 'body mechanic' who is insensitive to the spiritual welfare of the individual, oblivious to the injury that medical interventions may inflict on the individual and unaware of the wider environment in which the disease originates. This is in real contrast with the public perception of medicine being a scientific activity geared towards the discovery of the true causes of disease.

5.9 Medical needs

During the process of the medical consultation one of the duties of the medical professional is to assess the (medical) needs of the individual, acknowledging that this is a focused and narrow view of an individual's needs. 'Needs' are however, an important theme already identified in this research and therefore a discussion of 'medical needs' is required. Unfortunately, there are wide variations of the definition of 'need' (Maslow, 1943; Fitzgerald, 1977; Lederer, 1980; Clayton, 1983; Doyal and Gough, 1991; Stevens and Gabbay, 1991; Spicker, 1993; Nordenfelt, 1995; Sheaff, 1996; Chilton and Barnes, 1997). Within a medical model framework, 'need' is considered an 'objective' concept and tends to be operationalised around the notion of 'a capacity to benefit'. Culyer (1995) puts forward his pragmatic definition of need as, 'a need for healthcare is the minimum amount of resources required to exhaust a person's capacity to benefit' (p.728); his term being specifically aimed at guiding resource allocation in a centrally funded health service (Culyer, 1985; Dowie, 2003). Medical needs as a concept have therefore become confused between considering an individual's 'health needs' and 'needs for health services' (Powles 2006). The issue of objective and additionally subjective needs will be examined in the needs section in the biopsychosocial chapter. This section – 'medical needs', will examine the objective notion of need (as described above), and explore individuals' medical needs and at times their needs for the health service. It is also worthy of note that an aim of this research is to understand the foot-care needs from the older person's perspective and it is suggested here that it is unusual for a medical professional to identify a person's foot-care needs as part of a typical medical consultation.

When discussing 'need' it is necessary to distinguish 'need' from individual 'demand' and 'wants'. As discussed in chapter four, health policy during the 1990's has clarified the term

'health need' by putting the onus for deciding what is 'health need' to medical doctors and newly formed 'local purchasers' of healthcare (DOH, 1989). 'Need' as a concept therefore becomes difficult to define because needs identified by different health professionals and individual people are rarely similar. Conflict therefore arises over who decides which or whose 'needs' should be met. The introduction of the term 'clinical' to the definition of need has shifted the responsibility to the healthcare professions (by legitimising their knowledge) for deciding which needs are addressed by local providers of healthcare. Culyer (1983) identified that the main influence on defining need comes from within healthcare systems, and consequently, 'the values' that underpin 'need' are primarily driven by the medical professional with little or no consideration for the individual. Culyer (1983) states that the move from the concept of 'demands/wants' to that of 'need', raises potentially enormous problems because the concept of need appears to have been defined in as many ways as there are individuals who have examined them. Culyer's (1983) view is supported by Nordenfelt (1995) who suggests:

"The concept of need is at least as involved and loaded with ideology as the concept of health itself". (p.36)

Political policy towards 'health needs' have been put forward in various Health White Papers (DOH, 1990, 1997). The last Conservative Government policy on health and social services was documented in the NHS and Community Care Act 1990, which gave General Practitioners a central role in assessing the populations' needs. Both White Papers reinforced the government's commitment to Community Care and the encouragement of a range of services to enable older people to live as independently as possible in their own homes.

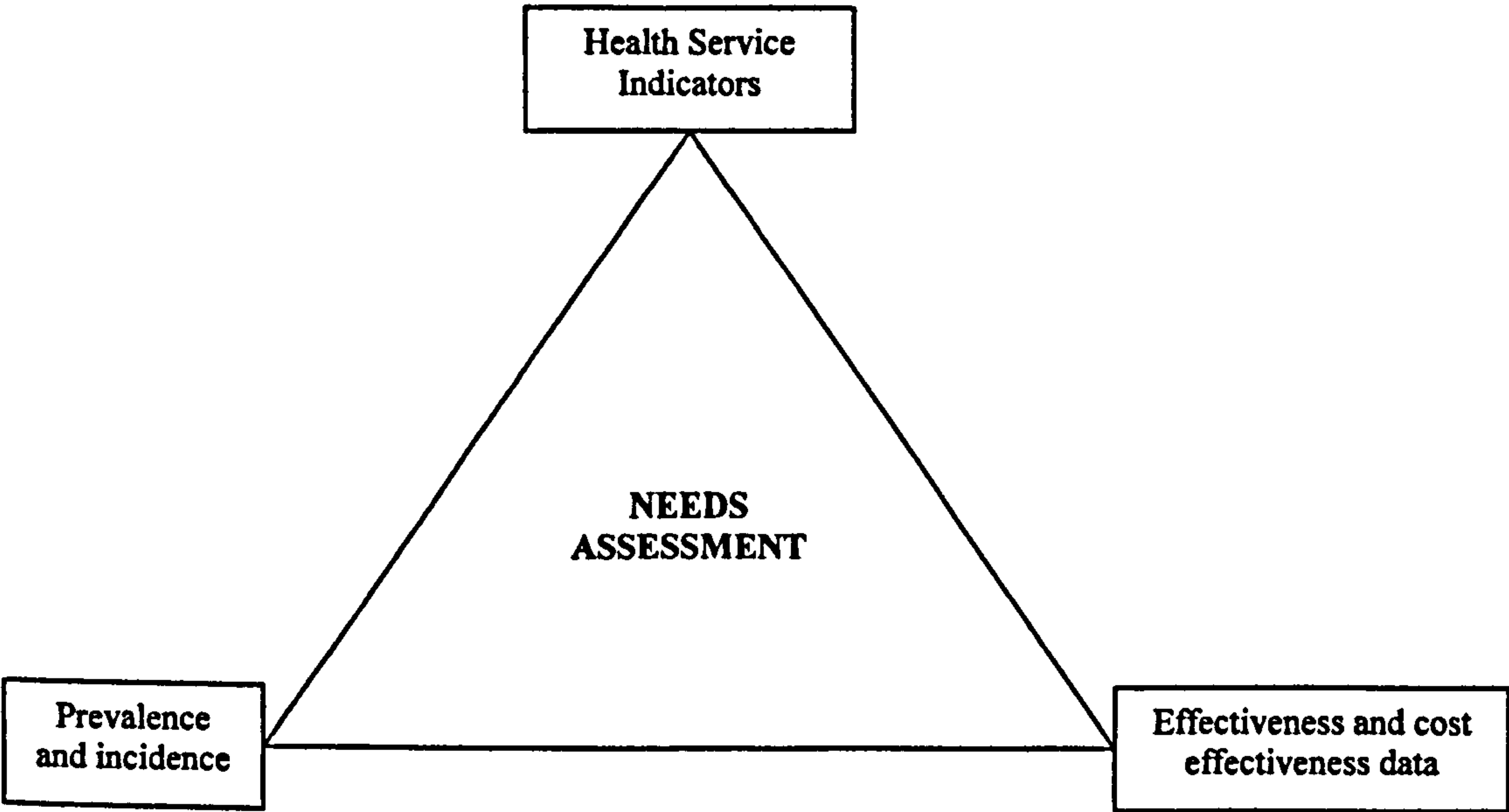
The Labour Government's White Paper on health services entitled "The New NHS. Modern. Dependable" (1997) represents a clear but subtle shift of political focus on 'medical' need, and not the demands or wants of the individual. This is supported by the recent emphasis on providing healthcare services based on a new term, 'clinical or medical need', a concept lay people ('patients') have difficulty contributing to because they are perceived by the medical profession to not have the relevant 'medical knowledge'. The refocusing of the definition of need, it can be argued, is more about targeting resources towards people most in need (often perceived by lay people as rationing) rather than a comprehensive service meeting all health needs. This subtle change to the term 'clinical need' is recognised as shifting difficult decision-making about the definition of medical needs away from politicians and firmly placing the responsibility with health professionals. However, the trade-off appears to be retention of the medical profession's dominant position.

During the early period of this research (2000), rationalisation of local podiatry services took place. A new definition of 'clinical need' was devised by health professionals for access to local NHS podiatry care. Those individuals who did not meet the new criteria, even those who perceived they had a need, were discharged from local NHS podiatry care. As previously discussed in chapter two, this local rationalisation took place during a period of rationalisation of podiatry services across England, (Tippins, 1998; Lever and Shearer, 1999; Campbell and Bradley et al, 2002; Campbell and Paterson et al, 2005). Harris (1997) suggests that difficulties that surround rationing on the basis of need are the different understandings of what constitutes 'justifiable need'. For most individuals the mere existence of ill-health is sufficient reason for intervention and that other factors should be irrelevant, although for podiatry, ill health has

already been identified to be of little consequence, and this therefore places foot-care and the profession in a vulnerable position in a healthcare system based on medical needs.

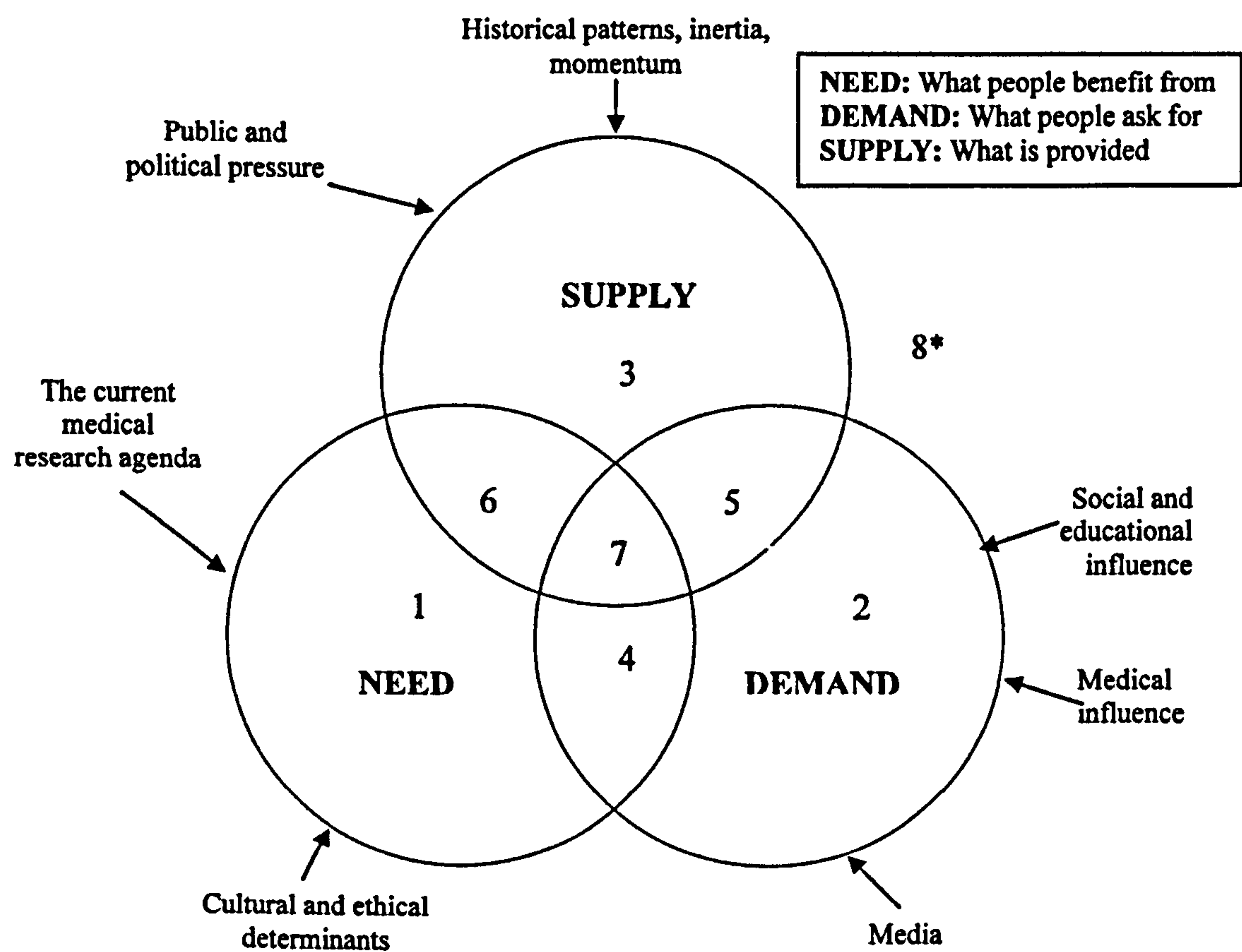
The classification of medical needs is therefore heavily influenced by the medical model approach. Medical needs assessment, it is argued by Stevens and Gillam (1998), is used to gather information required to bring about change beneficial to the health of populations. This is an interesting statement, as the medical model approach to ‘medical needs assessment’ appears to focus on populations rather than individuals. Therefore, while the medical model has been portrayed as ‘reductionist’ and ‘mechanistic’, focusing on the organ or disease rather than the individual, medical needs assessment takes a completely different approach by looking at large homogenous groups of people, ignoring the individual. Stevens and Gillam (1998) have described a medical approach to needs assessment as a three cornered triangle that considers the equal use of Health Service Indicators of existing services, the use of prevalence and incidence data and the use of effectiveness and cost effectiveness data (see figure 5.2 below).

Figure 5.2: Triangle of needs assessment (Stevens and Gillam, 1998)



An alternative medical model approach to needs assessment figure 5.3 has been identified by Stevens and Raftery (1994) in their model of needs assessment which includes need, demand and supply.

Figure 5.3: Model of needs assessment (Stevens and Raftery, 1994)



Stevens and Raftery's (1994) model of needs assessment is also problematic, as it is an example of disease or service provider focussed needs assessment. Sinclair and Parker (1990), suggest that a more useful method of identifying need for people who require help is to consider them over different time intervals. This proposal of examining individual's needs at different intervals is considered relevant, and will therefore be incorporated into the development of the 'podiatry career' in chapter eight.

Stevens and Raftery (1994) propose that 'needs', 'health gain' or 'capacity to benefit' should be more strictly interpreted, suggesting that the ability to benefit should be measured by concepts such as 'Quality Adjusted Life Years' (QUALY's). QUALY's and podiatry have been compared by Bryan and Parkin (1991) and Harvey and Frankel et al (1997) who found that health economic assessment demonstrates that the provision of podiatry is cost effective and surpasses other (medical) interventions. They conclude that careful consideration should be given in the purchasing process to ways of identifying those with severe foot morbidity and providing accessible services. These studies represent two examples of scientific/evidence based research that have not been exploited by the podiatry profession to increase its professional status or to secure additional funding from local commissioners of healthcare.

With Bryan and Parkin (1991) and Harvey and Frankel et al's (1997) evidence to suggest the provision of podiatry has 'economic benefit' and other studies which have demonstrated a growing need for podiatry provision, (Clarke, 1966; Kemp and Winkler, 1983; Cartwright and Henderson, 1986; Elton and Sanderson, 1986; Brodie and Rees et al, 1988; McGrotter and Clarke, 1988; Rees and Wilson, 1988; Greenberg, 1994; Benvenuti and Ferrucci et al, 1995; Salvage, 1998; Campbell and Bradley et al, 2000; Campbell and Patterson et al, 2002) why have

Health Authorities disinvested in local podiatry services in the last decade? The answer to this question is complex and probably requires another research study, but in part the conclusions that can be drawn from this section indicate that foot-care services for older people receive lower priority because the perception of podiatry need places them among the less 'glamorous' aspects of healthcare (Borthwick, 1999), and that they are not provided directly by the medical profession.

The medical assessment of needs does however recognise the limitations of funding (figure 5.3, Stevens and Raftery, 1994). This has led to the introduction of medical priorities and as Culyer (1995) suggests raises philosophical questions such as: should the principal criterion be the benefit that could potentially be obtained for each individual or the severity of their presenting condition ('a capacity to benefit')? These questions manifest in frustration for those individuals who find their perceived needs inadequately met by too medically orientated professions. These frustrations are generally interpreted by the medical profession as indicating 'unrealistic expectations' on the part of the individual rather than as Engel (1977) suggests, being recognised as reflecting a genuine discrepancy between illness actually experienced by the individual, and as it is conceptualised by the medical model.

'Medical needs' identified by healthcare professionals are therefore problematic in that they potentially ignore the perceived 'needs' of the individual. The identification of the individual's perceived needs (or demands/wants) are an objective for this research and the comparison between the two conceptual frameworks will identify if the individual's needs differ with each approach.

5.10 Medical outcomes

The medical model has been criticised for focusing on “Outcome” rather than “Process” (Morrissey, 1999). However, the measurement of modern-day healthcare has been guided by government policy that has focussed on ‘successful’ medical outcomes which include areas such as the number of completed consultant episodes of care, the number of discharges from hospital care, length of stay in hospital. These ‘outcomes’ are scientifically measurable and often interpreted as being a ‘cure’ to individual illness or disease. Therefore the term ‘cure’ and ‘successful medical outcome’ have become synonymous in contemporary healthcare provision, but these ‘successful’ outcomes are often not related to the individual’s perception of a successful outcome, which may be something completely different. Whitty (2001) suggests that:

“...over the past twenty years most western healthcare systems have focused on addressing patient and population outcomes rather than structure and process issues.” (p.265)

The concept of ‘outcome’ first arose in the 1960’s when Donabedian (1966) first described a quality framework for the delivery of healthcare based on the framework of “Structure”, “Process” and “Outcome”. This concept is taken to develop the components of the ‘pathway’, or journey which participants follow through the podiatry service, a pathway described as ‘the podiatry career’ in chapter eight. An ‘outcome’, according to McCallum’s (1993) definition is:

“...a natural or artificially designated point in the care of an individual or population suitable for assessing the effect of an intervention, or lack of intervention, on the natural history of a condition” (p.4)

McCallum’s (1993) definition recommends the overall purpose of examining the outcome of healthcare interventions is to produce a vision and practical framework within which the delivery, nature, and quality of care provided can be directed to improving the health of individuals and

societies. Medical conditions such as Alzheimer's disease, in which brain degeneration or loss of function occurs, goes beyond the focus of medicine as no cure can be offered or objective outcome can be specified except for subjective measures such as quality of life and well-being. Perhaps as Morrissey (1999) suggests, since there is no 'cure' for Alzheimer's this make the medical model redundant.

The focus on 'quantifiable measurement' of outcomes follows the medical model approach of scientific and objective measurements throughout the medical pathway. Unfortunately, within medicine, more subjective approaches to outcomes or outcomes identified by individuals receive little consideration. Haines and Blair (1999) suggest that while there remains a need to develop outcome measures, there is also a need to consider for whom these measures are important. Consideration should be given they contend, to the definition that an outcome results in the concept of an end point, in medical terms: the individual is discharged from care or given a 'cure'. In chapter three, it was put forward that 'outcomes' following many podiatry interventions with older people result in a series of further interventions in order to maintain the foot in a healthy or pain free condition or even managing a slow decline and this poses a persistent challenge for podiatry provided within a medical model framework. Podiatry outcomes therefore do not fit the traditional medical outcome; but are they appropriate outcomes from an individual older person's perspective? The issue of appropriate outcomes from an older person's perspective will be explored in this research through the comparison of the two models.

5.11 Podiatry and the medical model

From the detailed examination of podiatry and the medical model framework, it becomes difficult to understand why podiatry has embraced a medical model approach in its delivery of provision.

The reasons for this have perhaps more to do with the intention of enhancing professional status and maintaining the perceived advantages the medical model brings, rather than of meeting the foot-care needs of older people. The perception of podiatry provision through a medical model framework is treatment for foot problems that are merely annoying or discomforting and somewhat intrusive into social relations. However, as individuals grow older, they may experience an unexpected increase in their foot-care needs and develop alternative expectations as to how these foot problems will be resolved. This will raise new situations for older people with which they will have to come to terms and it is this aspect of meeting foot-care needs that will be examined through the 'podiatry career' pathway (chapter eight), and compared between both medical and biopsychosocial approaches.

5.12 Conclusions

Through its historical development the medical model approach to disease has been demonstrated to be the dominant model for the delivery of healthcare in the United Kingdom. It has dominated healthcare policy, and has contributed to a host of problems with healthcare delivery, according to the people using those services, by being reductionist and mechanistic. As Engel (1977) suggests, the medical model has become embedded in our culture, which has led to its limitations being easily overlooked. The medical model has acquired the status of dogma and requires that all disease, including mental illness, be conceptualised in terms of underlying physical causes. Within a medical model framework all behavioural phenomena are conceptualised in biochemical terms and whatever is not capable of being explained by the medical model approach does not exist. It has also been demonstrated that other professions have taken the medical model approach to develop their own autonomy and status within a hierarchy of healthcare professions.

Engel (1977) proposes that the medical model is the dominant model of disease today and it leaves no room within its framework for the social, psychological and behavioural dimensions of illness. The medical model approach, it has been demonstrated, bypasses the individual verbal account by placing greater reliance on technical procedures and laboratory measurements. This approach is not helpful to older people and in particular for older people who are not very articulate or have grown up being grateful for what they receive. The narrow focus of the medical model approach to health, disease and illness has disregarded the needs, demands, wants and feelings of individuals. Consideration is therefore only given to the individual's health problem, by the health professional, in relation to their medical requirements and those issues considered relevant to the diagnosis of their condition. Therefore, only medical issues are considered in the decision on how the condition is 'treated'. Psychological and social issues for instance are neglected from the decision-making process for the intervention. As the individual's perceptions are not considered, this results in the same intervention for specific conditions whereas if all circumstances were considered, interventions tailored to the individual's needs, demands and expectations could be made. The healthcare professional remains in control at all times throughout the intervention. NHS podiatry services have been portrayed to follow a medical model approach, despite the difficulty in linking podiatry interventions to medical concepts of cure. It is suggested that podiatry's link to the medical model has more to do with raising its status within the medical professions hierarchy than it has to do with improving the podiatry care provided to individuals. This suggests that an alternative approach to NHS podiatry provision is required if podiatrists are to deliver services that meet individuals' needs. According to current health policy this approach is centred on meeting an individual's expectations, needs, and demands and has been labelled a 'patient-centred' approach (DOH 2005b, 2005c). However, it is recognised that the terminology within this new approach is influenced by the medical model

with the continued use of the term ‘patient’. It will be proposed in chapter eight that only when there is a ‘person-centred’ approach will you really meet the needs of the individual.

This summary of podiatry and its relationship with the medical model concludes this chapter on the medical model. The dissertation now moves onto describe the unifying theory, general systems theory that underpins the development of the comparative model in this research, the biopsychosocial model.

Chapter Six

General Systems Theory

6.1 Introduction

This chapter describes general systems theory and how this theory developed from dissatisfaction with the medical model. It also describes how general systems theory underpinned the development and conceptualisation of the biopsychosocial model. The biopsychosocial model is the comparative model to the medical model in this research and will be examined in detail in chapter seven. The biopsychosocial model will be used to examine alternative approaches to the delivery of podiatry services, specifically, consideration of a 'person-centred' service, designed to meet older peoples' foot-care needs, expectations and requirements. General systems theory is therefore presented as the unifying theory between the two central frameworks in this research, the medical and biopsychosocial models.

Ludwig von Bertalanffy (1968) first described 'general systems theory'. General systems theory was developed as a unifying theory between the medical and social models of care, but more importantly the model was developed because of public dissatisfaction with the delivery of healthcare services. The development of general systems theory therefore began with the concepts of the medical and social models of health and this is described in the next section. The following sections describe the development of the concept of general systems theory and its links to the development of the biopsychosocial model.

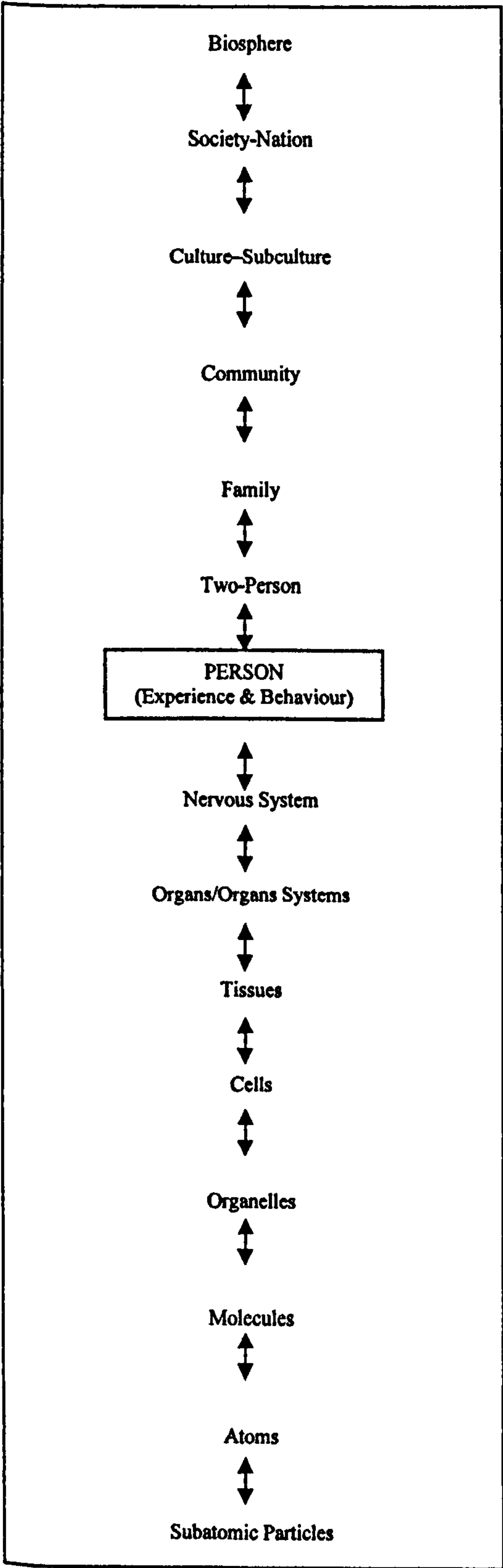
6.2 Medical and social models of health

Two models are identified as operating in the delivery of care services: the medical model and the social model of health. At times these models are viewed as diametrically opposed to each other. Yet in their operation the power of the medical model remains dominant throughout contemporary care provision, relegating the social model to the background, in effect establishing a hierarchy between the models. However, owing to the growing criticisms of the medical model approach, the social care model of provision is one such model that has been considered as an alternative model for care delivery.

Comparison of the medical and social models highlights the micro-level focus of the medical model and the macro-level focus of the social model. The table below, adapted from Moon and Gillespie (1995) (p.83) identifies these differences:

Table 6.1: Medical versus social models of health

Medical Model	Social Model
A state of health is a biological fact: <ul style="list-style-type: none">• It is immutable, real and independent	A state of health is socially constructed: <ul style="list-style-type: none">• It is varied, uncertain and diverse
Ill health is caused by biological calamities: <ul style="list-style-type: none">• ‘entrants’ to the body (e.g. viruses, germs);• ‘internal faults’ (e.g. genes);• trauma	Ill health is caused by social factors: <ul style="list-style-type: none">• Behind the biology lies society;• Root causes are social causes
Causes are identified by: - signs and symptoms; <ul style="list-style-type: none">• The process of ‘diagnosis’; Establishing deviation from medically established ‘normality’	Causes are identified through: <ul style="list-style-type: none">• Beliefs, which are varying, subjective, society and community based;• Interpretation, built up through custom and social constraint
Medical knowledge is exclusionary: <ul style="list-style-type: none">• It is the job of the expert or specialist;• Facts are accumulated and built upon;• Alternative perspectives are invalid and inferior	Knowledge is not exclusionary: <ul style="list-style-type: none">• It has a historical, cultural and social context;• It is shaped by involved people
Biomedicine is reductionist and disease orientated, concerned with pathology	The social model is holistic and concerned with context



6.3 The development of general systems theory

The differences and ‘distance’ between the medical and social models of health led to the development of a conceptual framework that attempted to reconcile the medical and social models of healthcare. It was Ludwig von Bertalanffy (1968) who first described ‘general systems theory’ as “complexes of elements in interaction” (p.37). This description had first applied to biology but systems theory was the first recognition that the functions of the body were made up of subsystems that interact to produce more complex systems that interact to produce the whole organism. Systems theory therefore, as Sheridan and Radmacher (1992) suggest, relates to systems that exist within systems for example, an organism is composed of tissues and tissues are composed of cells, and cells are composed of molecules, and molecules are composed of atoms.

Figure 6.1: Hierarchy of natural systems (Systems hierarchy – levels of organization)
(Engel,1980)

Systems theory therefore in essence, conceives of a hierarchical arrangement of 'systems' each comprised of related 'events' with common properties and functions. Bertalanffy (1968) cited in Green and Shellenberger (1991) recognised an important issue for this research by suggesting that:

“...in order to study living organisms they must be studied as they interact with their environment.” (p.202)

This view has subsequently been referred to as the 'ecological perspective', when considered within the 'systems theory' framework and is a further development of the hierarchy of natural systems described by Engel (1980), see figure 6.1 above.

Schwartz (1981) suggests that it is possible to organise various systems in nature in terms of their level of complexity. The organisation of these systems not only parallels evolutionary theory's explanation of the development of physical, biological, psychological and social systems, but also demonstrates how the various scientific disciplines have evolved developmentally to study the unique properties that emerge within each of these elements.

Bertalanffy's (1968) general systems theory therefore became a general science of 'wholeness', the first reference to a 'holistic' approach. However, general systems theory remains an obscure and semi-metaphysical concept, particularly to those who support an objective, medical model approach, despite the major aim of general systems theory to demonstrate a common tendency towards integration of the various sciences (natural and social). The integration of these sciences is centred in a general theory of systems which has the potential of aiming at an objective theory in subjective areas. General systems theory therefore not only attempted to bridge the gap

between medical and social models but to gain some credibility for non scientific approaches to understanding how humans interact within their social environments. As Schwartz (1982) suggests, general systems theory became concerned with the general principles that are thought to be applicable to all aspects of nature.

At this point it is important to acknowledge that general systems theory developed from a close analysis of findings independently discovered in diverse disciplines. These independent findings, considered together, led to the discovery of general principles that ultimately apply to and therefore unite diverse findings and disciplines. As Ludwig von Bertalanffy (1968) states:

“...general systems theory develops a unifying principle running ‘vertically’ through the universe of the individual sciences which in turn brings closer the objective of unifying the various sciences.” (p.37)

It is possible to organize these various systems in nature in terms of their level of complexity. This union not only parallels evolutionary theory’s explanation of the development of physical, biological, psychological and social systems, but also demonstrates how the various scientific disciplines (including medicine) have evolved developmentally for studying the unique properties that emerge at each level. Engel (1980) proposes that general systems theory can provide a conceptual framework within which both organised wholes and component parts can be considered.

General systems theory is a concept of systems that relate to each other within a hierarchy of systems. Miller and Miller (1992) define ‘a system’ as:

“...a set of inter-acting units with relationships among them in which the state of each unit is constrained by, conditioned by or dependent upon the state of other units” (p.11).

The units of a system within general systems theory are broken down into subsystems. Each subsystem has its own separate interacting components. This systems view is in distinct contrast to the medical model concept that the components of an item hardly depend on one another and that these components can be examined in isolation and then reintegrated in a combined way to understand 'the whole'. As a result, the whole systems approach is far greater than the sum of the individual systems.

Despite the description of general systems theory purporting to represent 'the whole', the theory still needs to be viewed with some caution, as the biological element can remain dominant in this theory over the social, thereby maintaining a 'hierarchy'. In spite of this, general systems theory does contain a hierarchy, but a hierarchy with a continuum that reveals any of the elements contained in the theory can at the appropriate time, be the dominant element in a higher system. Engel (1980) cites Weiss's (1959) view that general systems theory is best approached through common sense observation and that nature is ordered as a hierarchically arranged continuum, but is more complex. This is demonstrated by the vertical stacking representation to emphasize the hierarchy (figure 6.1, Hierarchy of natural systems).

Sheridan and Radmacher (1992) put forward that general systems theory should direct healthcare researchers to develop a global view of their research question or treatment. This global view should emphasize that interventions at one level of a system can often have unexpected effects at other levels, and at every level of analysis the occurrence under consideration by the researcher constitutes a system composed of sub systems, which in turn is part of a larger system. Antonovsky (1989) proposes that any failure to recognise a system as an entity and the

interactions and feedback between systems and sub systems will inevitably lead to an inappropriate diagnosis and intervention. If the health professional only considers the organ or disease (the medical model) and does not consider the individual as a whole or their broader systems of family, community, society and environment, they will not be able to provide actual 'holistic' healthcare.

As a result of the requirement to consider the 'holistic' nature of healthcare, general systems theory contributed to the development of the biopsychosocial model by affirming that nature is organized in terms of a hierarchy of units reflecting a continuum of complexity. Engel (1977) first described the biopsychosocial model as a framework that is explicitly derived from the 'scientific' model of systems theory. He suggests each area represents a system with its own distinct qualities, organization and methods that are appropriate to each system. In Engel's 'holistic' biopsychosocial model of health, the traditional medical model would operate in the region close to the more 'microscopic' end of the hierarchy, while the social model would occupy the upper, more 'macroscopic' region, with substantial overlap in between. Engel (1977) uses a nest of squares to emphasize the continuum (see figure 6.2: Continuum of natural systems). Engel (1980) portrays the two models as the person being at the highest level of the organismic hierarchy and at the same time at the lowest unit of the social hierarchy. In figure 6.2, Engel's continuum of natural systems has been adapted to represent this.

Green and Shellenberger (1991) are less convinced of the 'holistic' nature of Engel's biopsychosocial model and suggest:

“...general systems theory and the biopsychosocial approach are different ways of describing the same phenomena i.e. the interacting systems of the systems approach are

the biological, psychological, and social dimensions of the biopsychosocial approach”.
(p.22)

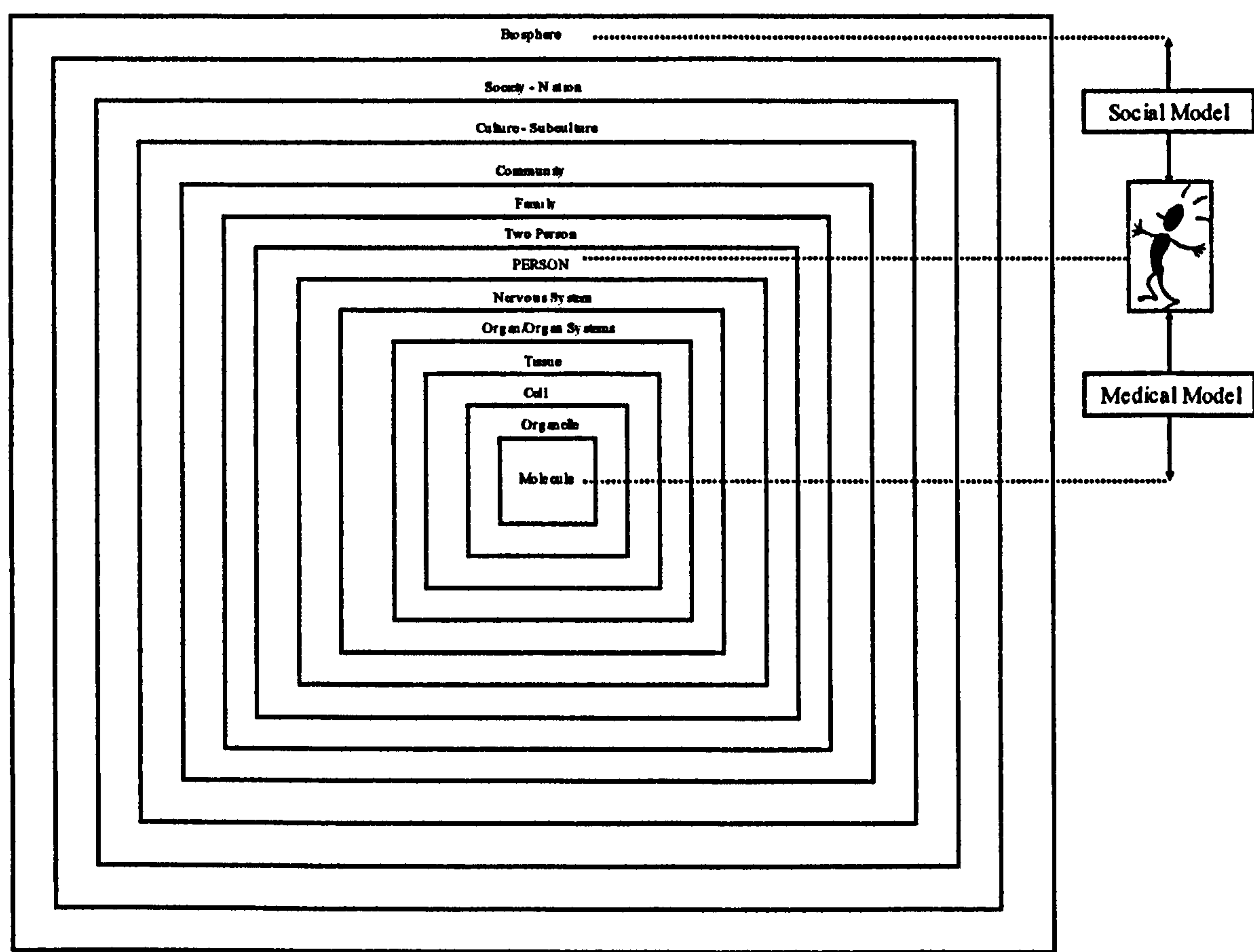
It is noted that the biological, psychological and social systems do not operate independently and should not be researched separately because they each interact. The medical model approach adopts the opposite of this, as the essence of the scientific approach has been to split wholes into parts and to study the parts in isolation, a view which is supported by Schwartz (1984):

“Science has historically overemphasized the analytic approach at the expense of the systemic approach”. (p.157)

Engel (1987) insists that the biopsychosocial model has developed further from general systems theory because of the need to consider the broader view. This broader view he suggests includes the need for improved communication skills, using all of the senses to elicit information from the individual, respecting the individual’s autonomy and cultural background and being empathetic and sensitive.

Unfortunately, not everyone is convinced of Engel’s claims. Armstrong (1987), for instance, suggests that Engel’s original and optimistic claims are “grossly medicocentric and sociologically naïve” (p.1215). Underpinning Engel’s model is systems theory that is borrowed from biology to provide a framework to integrate the biological, psychological and social elements. Therefore each apparently different discipline is seen to operate at one level of a more general hierarchy of inter-related levels. Antonovsky’s (1989) critique also suggests that the model is explicitly derived from the scientific model of systems theory, whereas, Day (1985) remains unconvinced with the view that the biopsychosocial approach is ‘holistic’ as it focuses on the study of biological elements while only giving scant regard to social issues.

Figure 6.2: Continuum of natural systems (Engel, 1980)



Engel (1980) defends the model by suggesting that nothing exists in isolation, and that neither the cell nor the person can be fully characterised as a dynamic system without characterising the larger system (the environment) that surrounds it.

6.4 Conclusions

It has been demonstrated that General systems theory was developed as an attempt to bridge the gap between the medical and social models. The concept of general systems theory has been used by Engel (1977, 1980), Ogden (1997), and Goodman and Levy, (2000) to demonstrate the dynamic interplay of the components within the biopsychosocial model that provide a broad conceptual framework rather than a unifying theory.

General systems theory has led to the development of Engel's biopsychosocial model, but both models have been criticised for not being scientifically proven, particularly by those supporters of the scientific medical model approach. The concept of general systems theory and the subsequent development of the biopsychosocial model are portrayed as complex paradigms that make either model difficult to implement, adopt or interpret in the way the models are meant to be applied. Accusations of the application of a hierarchy will be difficult to suppress. However, supporters of the theory, Green and Shellenberger (1991) state:

“...the complexity of the biopsychosocial approach correctly reflects the complexity of human nature”. (p.23)

When considered alongside Green and Shellenberger's (1991) criticisms it is recognised that the concept of Bertalanffy's (1968) general systems theory and the development of Engel's (1970) biopsychosocial approach is complex. As a framework for research or as a new way of considering the world it is still valid but it is also recognised that the concept can be developed further.

Therefore, having discussed general systems theory and its role in the development of the biopsychosocial model it can be put forward that the biopsychosocial model as a concept is still emerging and is being adapted and developed to meet differing research needs. Despite the potential difficulties identified with the biopsychosocial model, it has been selected as the comparative model for this research because of its claim to provide a 'holistic' framework for understanding the 'holistic' nature of older people's podiatry needs. The next chapter therefore examines the biopsychosocial model in which comparisons will be made with the previously discussed medical model approach (chapter five) and the various elements contained within it.

Chapter Seven

The Biopsychosocial Model

7.1 Introduction

The second conceptual framework selected for this research is the biopsychosocial model. It will be used as the comparative conceptual framework with the medical model, to explore older people's perspectives of NHS podiatry provision and to examine which model better addresses older people's foot-care needs for their perspective. As a result, this chapter will explore and critically examine the different perspective(s) the biopsychosocial model potentially brings to the provision of healthcare.

Having previously discussed the medical model and its application to health services and older people in chapter five it has been demonstrated that this approach to healthcare provision does not always meet older people's perceptions of their healthcare needs. It has also been demonstrated that the strength of the medical model lies in its foundation in the biological sciences and the large technological resources supporting it. Medicine has a history of achievements in quantitatively (scientifically) explaining mechanisms of disease and devising new treatments.

Dissatisfaction with the medical model approach was described in chapter five. This stems from the inference that as 'disease' is defined in terms of physical boundaries, any psychosocial aspects of healthcare will be outside the responsibility and authority of healthcare professionals. This position is derived from the medical model considering the mind and body as separate. The

biopsychosocial model considers both the mind and the body through the development of concepts such as the 'identity model' and as Green and Shellenberger (1991) imply, they exist through manifestations of a common substance that are distinctly different. The benefit of the 'identity model' is that it accepts mental processes even though it does not necessarily escape reductionism when the common material is thought to be brain cells. When behavioural and psychosocial symptoms are presented to a healthcare professional, the medical model directs them to a scientific and rational approach. This presents the first challenge in comparing the medical and biopsychosocial models. The power and influence of the medical model may guide this researcher to adopt scientific methods of research and the risk is that the research is drawn back into medical model concepts.

Hewa (1994) describes the biopsychosocial model as the approach to replace the medical model in the future, and as Armstrong (1987) suggests, if medicine continues treating the psychosocial at arm's length, it risks losing its historical domination in healthcare provision. The growth in complementary/alternative medicine offers evidence of this and as alternative therapies grow increasingly popular with the general population, they have begun to question the traditional medical model approach.

A future challenge to the medical model is that if it does not provide a satisfactory framework for the delivery of healthcare from the perspective of the individual receiving that care, individuals will seek care from alternative providers, thereby dismissing the medical model's dominance. The dissatisfaction with the medical model approach is also leading to the development of other models of provision such as the psychological and social models which were discussed in the general systems theory section.

The biopsychosocial model has therefore been proposed as an ‘alternative model’ for the delivery of healthcare services. Its claim of providing a ‘holistic’ framework that considers the views of the individual is the primary basis for the selection of the biopsychosocial model as the comparative model for this research. One of the many challenges for the biopsychosocial model is that it is perceived to be flawed by those steeped in the scientific medical model. As Schwartz (1982) states:

“...the ultimate challenge facing medicine is the empirical testing of the biopsychosocial model”. (p.1040)

The examination of the biopsychosocial model will begin with a brief history of its development.

7.2 Brief history of biopsychosocial model

American Psychiatrist, George Engel (1977), first described the model by applying systems theory to the medical model with a view to abolishing the dichotomy between the medical and social models of healthcare. Engel’s (1977) theory of the biopsychosocial model was born out of his view that:

“...the dominant model of disease today is biomedical, and it leaves no room within its framework for the social, psychological and behavioural dimensions of illness. A biopsychosocial model is proposed that provides a blueprint for research, a framework for teaching and a design for action in the real world of healthcare.” (p.135)

The cornerstone of Engel’s model is general systems theory described in chapter six, which was borrowed from biology to provide the framework. The framework aims to integrate biological, psychological and social elements, with each apparently separate discipline operating at one level of a more general hierarchy of inter-related levels (Armstrong, 1987).

Engel's background in psychiatry led him to advise that psychiatry could not operate effectively through a medical model approach. This is because psychiatry is a branch of medicine which focuses on the mind and as previously described in chapter five, traditional medical model approaches had separated the mind from the body. Szasz (1961 cited in Engel, 1997) confirms that the medical model views 'mental illness as a myth' since it does not conform to the accepted concept of disease.

"...the medical model suggests that sufficient deviation from 'normal' represents 'disease', that disease is due to known or unknown natural causes, and the elimination of these causes will result in cure or improvement in individual patients" (p.129).

Engel (1977) recognised that psychiatry could not clarify its status within the mainstream of medicine and this lent support to the psychiatry profession being based on a new discipline called 'behavioural medicine' because its focus was on the mind and not disease of the body or illness. It might therefore be suggested that Engel's support for the biopsychosocial model was an attempt to raise psychiatry's status within the medical profession's hierarchy. Engel (1977) attempts to deflect this suggestion by stating that the problem with the current medical model, was not just for psychiatry but a problem for medicine as a whole.

Engel's (1977) argument should be viewed with some scepticism as psychiatry chose to retain the term 'medicine' in its new discipline and therefore the suggested move away from the medical model can be questioned. This move lost psychiatry its historic, if tenuous, relationship with medicine by endorsing mental illness as categories of 'problems with living'. There is a similarity here between podiatry and psychiatry, in that both perceive they have a low status within the medical profession's hierarchy. Armstrong (1987) supports this position by proposing

that the development of the biopsychosocial model actually came about because it was intended to promote the elevated status of psychiatrists', who were then (and still are) torn between pursuing a biological reductionist model of mental illness, and a more psychosocial approach.

Engel (1977) criticised the medical model in other ways by proposing that medical professionals lack interest and understanding, and are preoccupied with procedures that lead doctors to be insensitive to the personal problems of patients and their families. Engel (1977) noted the growing dissatisfaction of healthcare users, commenting on the growing uneasiness among the general public that health needs are not being met.

Unfortunately, Engel (1977, 1980) failed to include and describe the role of the individual person in his model. It was Sarafino (1998) who first introduced the concept of the individual being included in the biopsychosocial model (see figure 7.1). Sarafino (1998) suggests the individual brings a different and broader representation of how concepts such as health and illness are constructed and further suggests this perspective will necessitate the understanding of the involvement of the interplay of biological, psychological and social aspects of an individual's life. According to Sarafino (1998) the biopsychosocial model came about because of the specific failure of the medical model to appropriately address issues of the individual's health, disease or illness.

Interestingly, the biopsychosocial model has now been in existence for nearly thirty years, but it has yet to seriously challenge the dominant medical model approach to healthcare. Throughout the last thirty years there are examples of use of the biopsychosocial model (Engel, 1980; Schwartz, 1982; Cordes, 1985; Ferguson and Ferguson et al, 1992; Hewa, 1994; Nicassio and

Smith, 1995; Rock and Goldstein, 1996; Carswell, 1997; Coyle, 1998; Goodman and Levy, 2000; Pilgrim, 2002; Keefe and Smith, 2002) but it can be suggested that these were also cases of professions using the biopsychosocial model to enhance their status. It also appears that the biopsychosocial model, when used in healthcare setting, still places greater importance on the biological elements than the psychological or social aspects, which means that a hierarchy still exists within the biopsychosocial model. This has a key relevance to this research as it must ensure that each element of the biopsychosocial approach receives appropriate priority at the appropriate time.

7.3 Development of the biopsychosocial model

The development of the biopsychosocial model was therefore based on the notion that biological, psychological and social models all combine to influence health, disease and illness. Engel (1980) suggests that by applying the biopsychosocial model, the onset, course and treatment of 'physical' illness is best understood by involving each of the biological, psychological and social models. In order to understand these individual elements, a brief description is offered below:

7.3.1 Biological model

The biological model (also known as the medical model) has previously been described in detail in chapter five. The biological model essentially conceives the body as being made up of complex physical systems which are then reduced to the level of organs, tissues and cells including the diseases and illnesses that affect these elements. The biological model also includes aspects of an individual's physiological functioning, for example, whether the body contains structural defects, responds effectively in protecting itself, (fighting infection) and whether it overreacts in protective function (allergic responses). Biological

factors also include genetics, environmental factors that affect physiological functioning, and behaviours that affect biological functions i.e., smoking, diet and exercise.

7.3.2 Psychological model

The psychological model is derived in part from psychosomatic medicine, behavioural medicine and health psychology traditions. As Whitman and Merluzzi (1999) suggest, this model recognizes that people's knowledge, beliefs and attitudes about their health and illnesses can influence whether they engage in health promoting behaviours, contract a disease, comply with a treatment regime or recover from an illness. Taylor (1995) contends this model also has a vital relationship between people's emotional status and the state of their health and recognises people who are in a poorer emotional health have more physical problems and generally need greater medical care.

Characteristics that distinguish the psychological model from the medical model include a greater emphasis on health, prevention of illness and the critical role that individuals play in maintaining their own health. Within this model, the emphasis on the individual is different in that the individual is expected to be partially responsible for their illness and recovery rather than being a passive recipient of medical care which raises 'locus of control' issues. Identification of the importance of 'the self' in chapter three has relevance to the psychological model. Psychological factors also include such factors as personality, stress management, life goals, perceptions, feelings and health and sickness behaviours although as Whitman and Merluzzi (1999) allude to, people can learn their health behaviours and attitudes from significant others, such as parents, teachers and mass media.

7.3.3 Social model

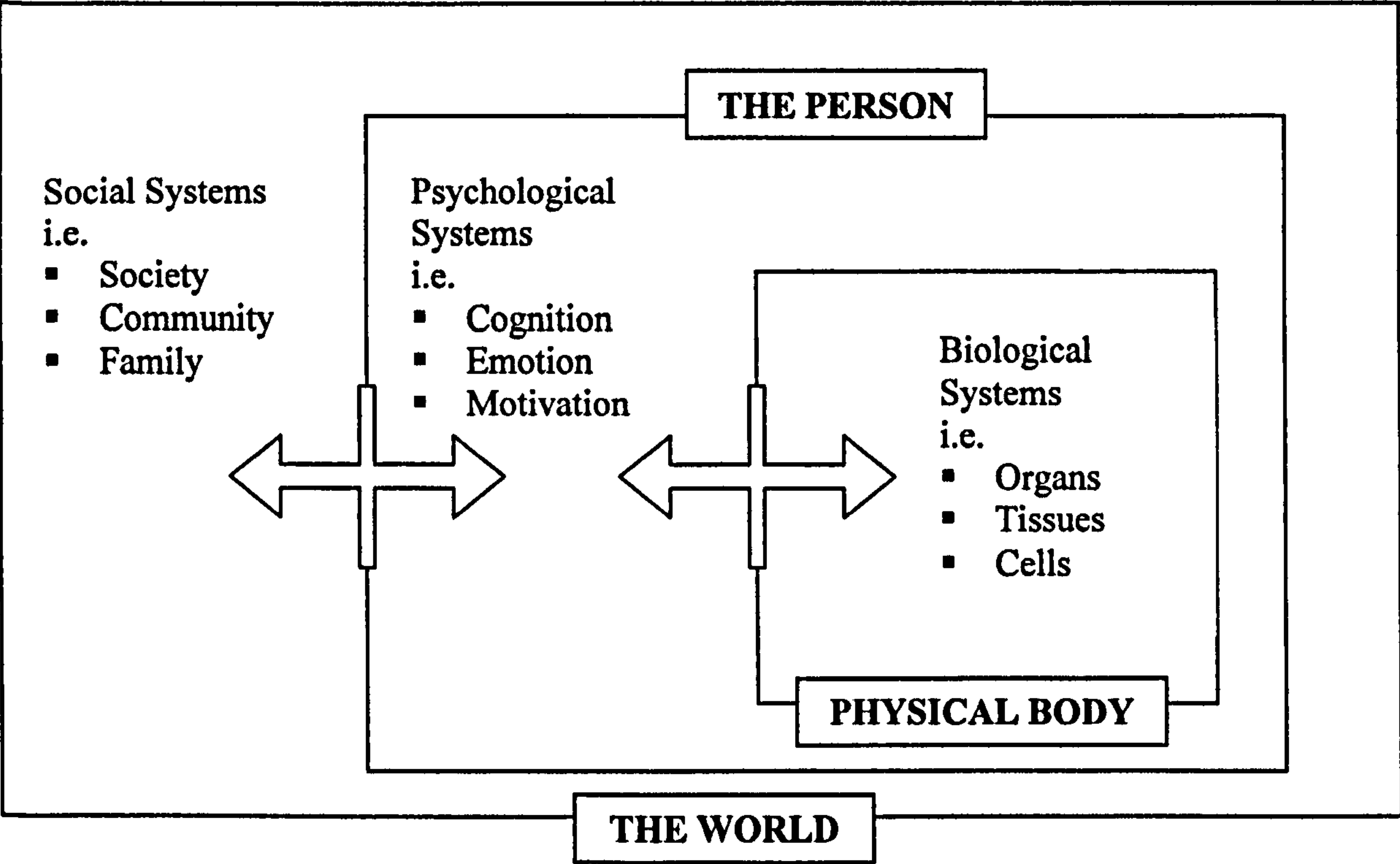
This model has also previously been described in some detail in chapter six, 'general systems theory'. Basically, the social model places importance on how social and physical surroundings can affect a person's physical status. This model comprises a diverse range of factors that include neighbourhoods, sanitation, housing conditions, employment setting and peer groups. The social model also recognises and includes the impact government policies can have on a person's health. Social aspects may include social systems such as the family and work, and social values, customs and social support.

Engel, (1977), and Taylor, (1995) prefer to use the description 'social' in the biopsychosocial model, whereas others (Whitman and Merluzzi, 1999) use 'environmental' i.e. the biopsychoenvironmental model. The term environmental instead of social has been incorporated because of the recognition of the critical role of non-social and social factors in health and illness. This is one example of how different versions of the biopsychosocial model could therefore be generated, based upon how the three factors (biological, psychological and social) exert their influence.

What is important for this research is to note suggestions that each of the elements play a distinctive and independent role in determining a person's health and that these elements operate independently and interactively as part of a complex system (Green and Shellenberger, 1991; Whitman and Merluzzi, 1999; Whitbourne, 2001). As previously described, different interpretations exist regarding the construction of the biopsychosocial model and which concepts or elements really make an effective 'holistic' framework for examining the individual's perspective of the provision of their healthcare.

Figure 7.1 below demonstrates Sarafino’s (1994) view of how the biological, psychological and social systems interact within the biopsychosocial framework.

Figure 7.1: The interplay of systems in the biopsychosocial model (Sarafino, 1994)



7.4 Systems and the biopsychosocial model

Engel (1977) assumes that by considering all three elements (biological, psychological and social), a more ‘holistic’ approach to a person’s healthcare will result. Although the biopsychosocial model contains biological, psychological and social elements there is still a risk they may be applied independently or that one element will receive greater priority or remain dominant when it is not appropriate. As the ‘holistic’ nature of the biopsychosocial model is central to this research it will be explored in greater detail in a separate section in this chapter.

The value to individuals of each model is far greater by examining the model as a whole rather than its individual elements (Engel, 1977). This approach is supported by Schwartz (1982) who states:

“...single category, single cause, single effect models of health and illness (medical model) are being replaced by multi-category, multi-cause, multi-effect models (biopsychosocial models) and that this reflects a major paradigm shift in science in general”. (p.1040)

Engel (1980) contends the scientific approach to medicine has contributed to a widespread public feeling that modern day healthcare provision is impersonal, whereas one of the beneficial claims of the biopsychosocial model to address this is its ‘holistic’ approach. As Engel (1980) asserts, healthcare professionals still place scientific approaches at the forefront of their engagement with the individual in their everyday work:

“...for the physician, science and the scientific method have (more) to do with the understanding and treatment of disease, not with the patient and patient care”. (p.538)

Higgs (1996) supports Engel’s view and acknowledges that the scientific approach and objectivity that established modern medicine’s reputation and power in the nineteenth century has removed the experience of the patient. Sarafino’s (1998) position that the biopsychosocial framework offers the individual an opportunity to contribute to their healthcare through a ‘holistic’ approach will be evaluated in this research. The purported ‘holistic’ nature of the biopsychosocial model that puts the individual’s needs and demands at the centre is one of the justifications for the selection of this model as a comparison with the medical model.

7.5 The biopsychosocial model and health, disease and illness

In chapter five, an examination of health, disease and illness within a medical model framework was presented and therefore it is necessary to compare this approach with a biopsychosocial model analysis. The concept of the biopsychosocial model is of elements interplaying. This consequently requires health, disease and illness to be considered as interplaying concepts rather than as separate entities. The biopsychosocial model can also represent complex variables and reflect the interactive nature of these variables. Engel's biopsychosocial model presents health, disease and illness as the result of a complex interplay of many psychosocial factors (Ogden, 1997). These are further operationalised within other disciplinary paradigms such as behavioural medicine and behavioural health. Green & Shellenberger (1991) suggest that the advantage of the biopsychosocial model over the medical model of disease and illness is:

“...that it emphasizes the multi-causal nature of the diseases and illnesses.” (p.416)

A note of caution to adopt with the biopsychosocial model approach is that it is potentially limited by the historic medical model approach of the healthcare professional in assessing whether the individual seeking help is actually sick or well. If a true biopsychosocial approach is applied it has to be assumed that the healthcare professional will look beyond the cause of the disease or illness. If the individual is assessed as sick, it will be necessary to consider in what ways they are sick and then to develop a realistic intervention with the individual that treats the illness and restores and maintains health.

There are other difficulties with the biopsychosocial approach, as the boundaries between health and disease, and well and sick, are still far from clear and it is doubted whether they ever will be

clear, for they are diffused by cultural, social and psychological considerations. To quote Engel (1977):

“...by evaluating all the factors contributing to both illness and patient-hood, rather than giving primacy to biological factors alone, a biopsychosocial model would make it possible to explain why some individuals experience as ‘illness’ conditions which others regard merely as ‘problems of living’ be they emotional reactions to life circumstances or somatic conditions.” (p.133)

Within a biopsychosocial approach it is likely that a hierarchy of numerous and complex causes will be recognized, and these will be explored with older people in this research. Nicassio and Smith, (1995) and Whitman and Merluzzi, (1999) describe that using the biopsychosocial approach an individual’s behaviour is identified as often playing a key role in their disease and illness. In this context, behaviour has a broad definition including perceptions, beliefs and overt actions. A link can be made here again to chapter three where the concept of ‘the self’ was identified as an important element in understanding an individual older person’s views. However, it will be important to remember that while the biopsychosocial model may give the impression of being ‘holistic’, as long as the ‘medical terms’ disease, health and illness are still used, it should be remembered that the proposed holistic approach may merely disguise a dominant medical model approach, which will be similar for the concept of ‘need’.

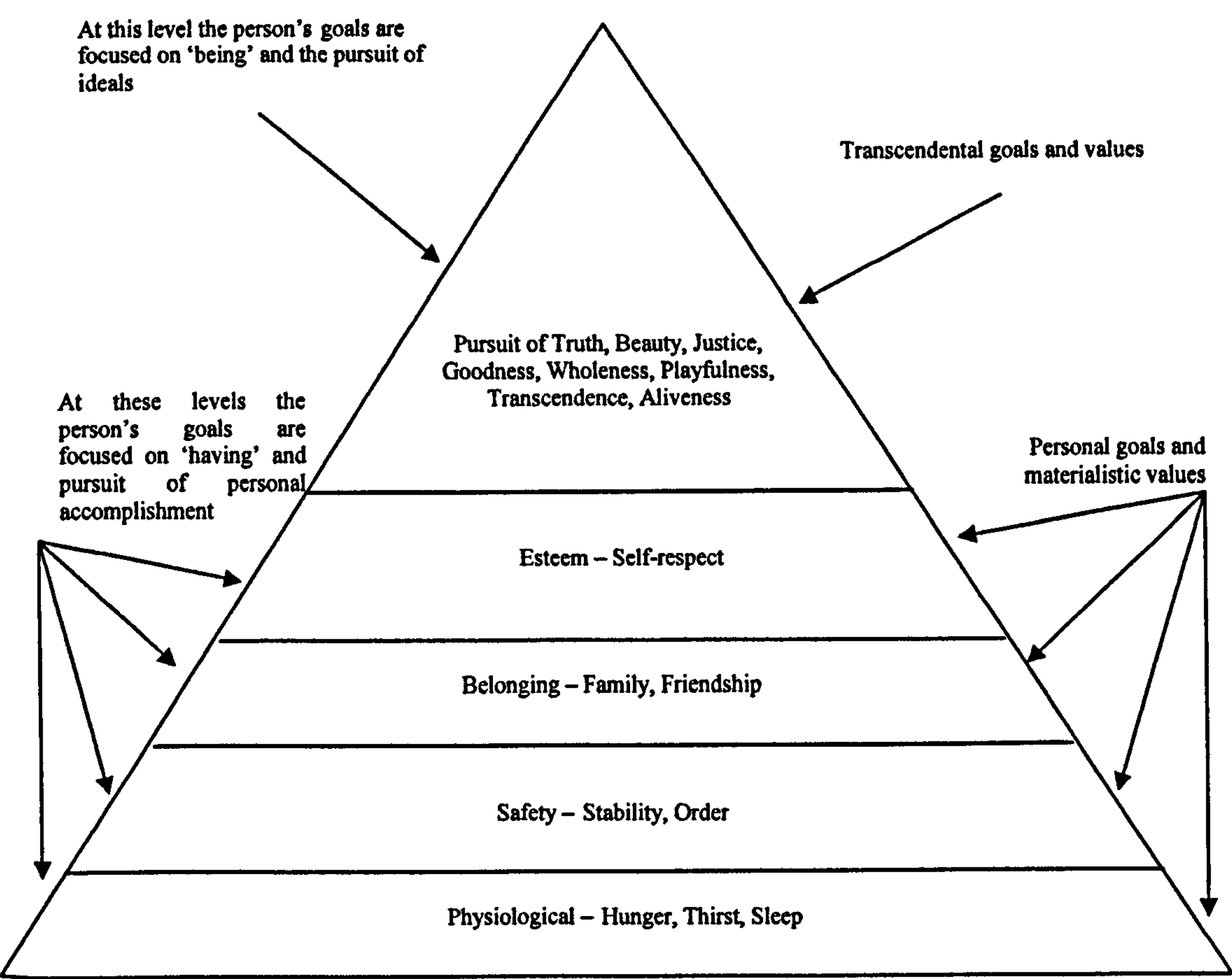
7.6 The concept of ‘need’ within a biopsychosocial framework

As described in chapter’s two to five, the concept of ‘need’ has a wide variety of definitions and more often relates to a medical framework of need. Unfortunately, the concept of a biopsychosocial model of need does not exist. However, as the biopsychosocial model encompasses psychological and social elements, an examination of need from these perspectives is required. Although each definition of need was intended to improve health service delivery,

ambiguity of the term has increased to such an extent that as Culyer (1998) suggests it may be a delusion to suppose that there might ever be a consensus about the meaning of needs.

The psychological approach to needs can be demonstrated by Maslow's (1943) seminal 'hierarchy of need'.

Figure 7.2: Maslow's hierarchy of needs (1943)



Maslow (1943) suggests a limited set of six basic human needs, universal to all human beings. Maslow's (1943) hierarchy starts with the satisfaction of basic physiological needs, moving up the hierarchy (pyramid) to the needs of safety, then the need of belongingness and love, the need of esteem, and finally the need of self actualisation (Figure 7.2 above). Maslow (1943) puts forward that these basic needs appear in individuals as physiological and psychological drives.

At the base of his pyramid are physiological needs, these being the most basic and primary. When these needs are met, Maslow (1943) proposes that individuals then move up the hierarchy/pyramid towards self-actualisation, although it is questionable if any individual ever achieves complete 'self-actualisation'. Maslow's (1943) hierarchy of need is similar in some respects to the biopsychosocial model with biological elements as the focus, whilst psychological and social needs, which are considered after basic physiological needs, are met. Nordenfelt (1995) adds to this theory by stating the fulfilment of basic needs is necessary for the survival of the individual or for the health of the individual. This raises a number of questions for this research. Do older people when identifying their foot-care needs follow Maslow's (1943) proposed hierarchy? Does a biopsychosocial approach, when operating within a holistic framework, ensure equality between each of the three elements, and will this challenge the assertion that physiological needs have to be met first?

To conclude this section, Bradshaw's (1972) social model of need will be described. Bradshaw's (1972) taxonomy of need consists of four elements of need:

First are normative needs, identified by the expert or professional for any given situation. Second are perceived or felt needs, which reflect the individual's own assessment of their requirement for healthcare and third are expressed needs, which are felt needs converted into action by the individual seeking assistance.

The concept of assessing normative need, despite being identified by healthcare professionals, is criticised for lacking objectivity and reliability because the judgements made by professionals are neither objective nor value free. Normative needs also neglect psychosocial and quality of life

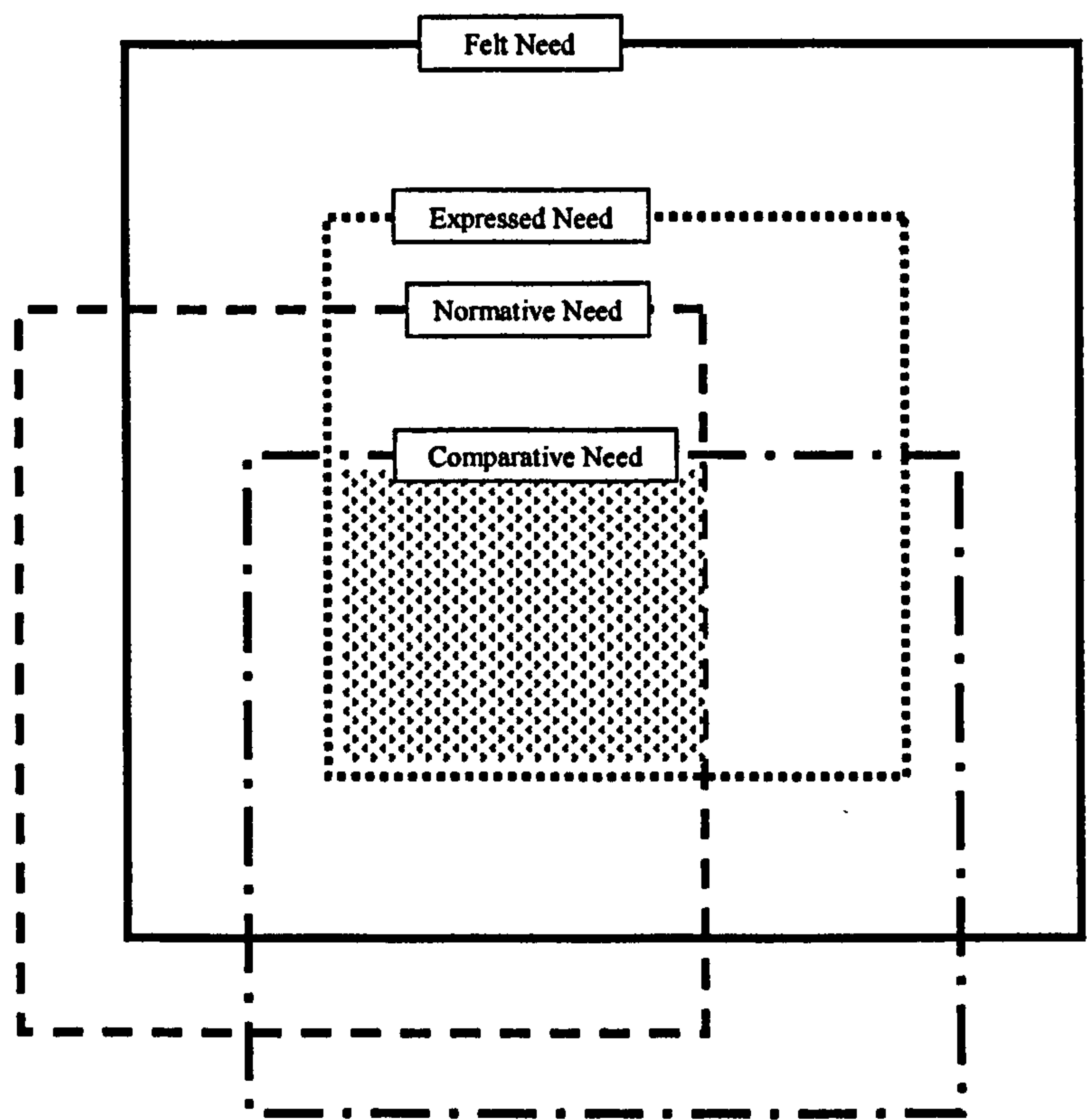
concepts. Models of health such as the concept cited by the World Health Organisation (1978) adopt a wider perspective than that of normative need and incorporates the concepts of functional, psychological and social well-being.

Bradshaw (1972) terms individuals' wants as 'felt' need. Within a medical model framework felt need is considered an inadequate measure of real need because it is generated from an individual's perceptions. However, Bradshaw (1972) also suggests that an individual may not highlight these needs as they may represent a loss of independence for the individual.

Expressed need is the third type of need identified by Bradshaw (1972) and this need is often related to 'demand'. As presented in the podiatry chapter, 'demand' for podiatry services outstrip NHS supply and is commonly represented by waiting lists. Expressed need is also related to the concept of unmet need, which in podiatry terms has been acknowledged by Clark, (1963); Kemp and Winkler, (1983); Cartwright and Henderson, (1986); Brodie and Rees et al, (1988); especially for basic or 'core' podiatry provision (Merriman, 1993; Farndon and Vernon et al, 2006).

Comparative need is the fourth concept of need recognized by Bradshaw (1972). This concept is related to objective measures of need of both individuals and populations. If individuals with similar needs are not receiving a service, they are then considered to be in need. When need is established using this concept, comparisons between the provision of services in different areas are often used by the NHS to standardise provision. However, as is the case with podiatry provision, these comparisons of foot-care need between areas portray a false perspective of need as no NHS podiatry service fully meets the foot-care needs of its population.

Figure 7.3: Bradshaw's (1972) concept of social need



In figure 7.3 (above), the four concepts of need within Bradshaw's (1972) model are presented. The shaded area in the diagram represents the area of the framework where all four definitions of need overlap and using this concept, if individuals fall within this area their needs are likely to be met by both a medical or biopsychosocial approach to need.

7.7 Critique of the biopsychosocial model

The biopsychosocial model has been presented so far as rational, cogent and offering a promise of a far greater understanding of health and illness. All of which in theory should ensure that healthcare is delivered to better meet the individual's needs.

So why has modern healthcare been slow to incorporate the biopsychosocial model into routine practice? Antonovsky (1989) suggests that one of the reasons may be that the exponential increase in medical knowledge makes it difficult for medical practitioners to keep up with the literature and this explains why they are reluctant to revise the conceptual models on which their practice is based. Armstrong (1987) states that, on the contrary, doctors strengthen the use of the medical model approach by ensuring that 'the patient' is successfully managed, when they often portray 'the patient' as an awkward and unpredictable factor in the smooth operation of clinical work.

Engel's (1980) specific criticism of the medical model was its dependence upon a scientific approach which excludes the human aspects of the individual. This has been supported by current political ideology discussed in chapter four, (health policy section), in which current health policy places the healthcare professional or more specifically doctors at the centre of decision making on deciding where and how healthcare resources are used (DOH 1990, 1997). Engel's (1980) criticism of the medical model led Armstrong (1987) and Antonovsky (1989) to question whether the biopsychosocial model was the revolutionary new model Engel (1977) had claimed. Armstrong (1987) suggested that Engel appeared to remain rooted in a medical model framework and that he failed to recognise that social aspects could be anything other than:

“...a bit player on the stage of medicine”. (p.1215)

Antonovsky (1989) comments:

“...the medical model is alive and well and there are few signs of it being questioned by the mainstream of medicine” (p.243)

Regrettably, even with current healthcare models becoming increasingly multidisciplinary, the approach employed by healthcare professionals is still based on a scientific or statistical analysis used on simple single-cause models. According to Hewa (1994) in order for healthcare professionals to understand an individual's needs or even to practise preventative medicine, the modern healthcare professional must be required to have a better understanding of the social, cultural and environmental conditions upon which an individual's health depends. Unfortunately, the biopsychosocial model lacks creditability because of its non-scientific background, which means healthcare professionals do not take the biopsychosocial approach seriously. Hence Schwartz (1982) recommends that the biopsychosocial model will need to maintain a scientific approach and be empirically tested. Arnetz (1996), goes further and argues that to ultimately prove that psychosocial environments impact on health, large-scale population-based, intervention studies must be designed, using both intervention and reference groups. This means that Schwartz and others will still require scientific and medical model types of research to be carried out before they will embrace the less tangible, but nonetheless important 'holistic' or person-centred aspects of healthcare.

Antonovsky (1989) finds that there is no evidence that the biopsychosocial model has actually been integrated into any healthcare institutions in western society and where the biopsychosocial model appears to have been adopted a 'holistic' biopsychosocial approach appears not to have

been employed. Antonovsky (1989) asserts that supposedly biopsychosocial approaches have tended to put the emphasis on communication skills and the psychology of the individual, whereas the broader concepts of the family, community, social class, and culture (social aspects), are not included, again inferring hierarchical approaches underpin this model.

Further criticism of the biopsychosocial model is put forward by Antonovsky (1989) when he suggests that the biopsychosocial model has not only failed to replace the medical model in the western medical world, but it has had no more than a minor impact. This view is supported by Armstrong (1987) who proposes:

“...the supporters of the psychosocial perspective at no point challenge the dominance of the medical practitioner or undermine or threaten the supremacy of the reductionist doctrine of the lesion contained in the medical model”. (p.1214)

Engel's (1977) biopsychosocial model, claims Armstrong (1987) portrays social sciences as subservient to medicine because Engel maintained a medical bias because he could not see that “the lesion or biological abnormality was anything but the very truth of illness” (p.1215). Armstrong (1987) develops this theme further by proposing that Engel appears unaware of the sociological work of the professions, which has charted the consequent rise in the dominance of the medical model and the increase in status of the medical professional. Much of this results from political manoeuvring and monopoly practices that place the medical profession in their dominant position (described in chapter five). In effect, far from a ‘new biopsychosocial model’ being created from general systems theory based on an integrated hierarchy, the biopsychosocial model appears to adopt traditional biological, reductionist medicine whilst at the same time according only secondary consideration to the psychological and social elements of the framework.

Saole (1994) and Moon and Gillespie (1995) observe that the medical and biopsychosocial models have been presented as incompatible. In chapter five, it was demonstrated that the medical model did not provide the basis for understanding the determinants of disease that deliver appropriate treatments and patterns of healthcare acceptable to the general public. Whereas the biopsychosocial model has been proposed to work by taking into account the individual, their psychological elements, the social context in which they live and the complementary systems devised by society to deal with the disruptive effects of health problems. This is not to suggest that different healthcare professions are not actively embracing the biopsychosocial model as an alternative to providing services through a medical model approach to healthcare. However, in examining some of the professions adopting a biopsychosocial approach, it is difficult not to be sceptical of their intentions as some appear to be using the biopsychosocial model to enhance their professional status or to make their particular 'specialty' more exclusive and unobtainable rather than with any view to improving patient care (McCelland, 1984; Cordes, 1985; Ferguson and Ferguson, 1992; Hewa, 1994; Salole, 1994; Rock and Goldstein, 1996).

Therefore, it is acknowledged that the biopsychosocial model's application can be heavily influenced by the medical model. The historical function of the medical model influences the health professional to establish whether the person seeking help is 'sick' or 'well' and if sick, why and in what ways sick, and then to develop a 'medical' programme to treat the illness and restore health. Whereas, according to Green & Shellenberger (1991) the benefit of adopting a biopsychosocial approach, should be to ensure that any intervention by a healthcare professional includes all relevant psychological and social factors as well as biological factors. Similar to the 'treatments' generated by the medical model for infectious diseases, biopsychosocial 'treatments'

(or interventions) will need to demonstrate a beneficial difference to the individual if they are to be accepted by healthcare professionals. This raises another issue for the research. If a biopsychosocial approach is applied to meet an individual's care needs, but is not scientifically demonstrable: how can healthcare professions be encouraged to adopt a biopsychosocial approach?

Another significant difference of a biopsychosocial approach relates to the intervention with the individual. A biopsychosocial approach implies that each intervention should interact with each other, as well as with the individual and their environment. Assessing individuals using a biopsychosocial approach should make it possible to tailor interventions to the individual more effectively as consideration of diseases will not be in isolation and therefore, as Schwartz (1982) suggests, the health professional will be able to:

“...make recommendations that may apply to two or more problems simultaneously and finally look for treatment interactions across modalities that could have additive and possibly synergistic effects.” (p.1047)

In Engel's (1980) biopsychosocial model any medical diagnosis should always consider the interaction of biological, psychological and social elements in order to assess an individual's health and to make recommendations for an intervention that is decided upon through a biopsychosocial focus. As Schwartz (1982) assumes, the more information that is collected, and the better the information is organised, the better the diagnosis will be. The intervention options, as a result of the biopsychosocial assessment, could be quite different to the intervention options provided through a medical model assessment. A challenge for the research is that the biopsychosocial model has been adopted by some healthcare specialties which place greater emphasis on the biological element of the model and lesser emphasis or importance on the other

two elements. An aim of this research will be to ensure that the influence of the biological element is acknowledged and to carefully analyse the differences that may occur if priority is given to alternative elements in the model. It may prove that from an individual's perspective, the psychological and/or social elements carry greater priority in meeting their needs. It may also prove that using terms such as diagnosis and treatment may be irrelevant to a biopsychosocial intervention, as these are considered to be medical model responses. This may lead to the conclusion that different interventions for older people would be decided upon following the comparison of the two models. Therefore, different options for how these will be implemented will require a new model of working for podiatry provision.

When an individual decides that their health needs require help from a healthcare professional Moon and Gillespie (1995) recognize that there should be a range of alternative approaches available to them. This is an important issue for Freidson (1970) who acknowledges that an individual's perceptions of illness and disease are influenced by their 'medical' knowledge, and this consequently shapes their expectations (health beliefs) about a resolution to their problem. Taussig (1980 cited in Stainton Rogers, 1991) claims that the medical model's scientific approach reproduces political ideology in the guise of a science of 'real things', a process termed 'reification'. Reification takes a complex and formless mixture of observed events, experiences, accounts and ideas and conceptually turns them into something that is then given a medical term, when what is happening is the construction and then promotion of a particular version of reality. Stainton Rogers (1991) highlights this as an insidious and subversive method of constraining individuals to see the world within a medical model framework. Therefore, the researcher has to be conscious that some individuals who seek healthcare may already be influenced by a medical

approach and their expectations may be restricted because this is the only approach they have known, which may be particularly relevant to older people, as discussed in chapter five.

The biopsychosocial model does not depend on scientific tests in order to arrive at the 'diagnosis' and in theory it should enable the healthcare professional to practise preventative interventions by recognising illness before these abnormalities appear (Hewa, 1994). Alternatively, the medical model approach applies a diagnostic label only after measurable abnormalities have appeared. This concept led Engel (1987) to accept that his biopsychosocial model no longer existed within general systems theory but should be considered within an even broader sphere. As a result, he envisaged a new type of health professional who develops and uses their communication skills as well as new treatment skills. These will be required to elicit information from across a wide range of situations and at the same time to be empathetic and sensitive to the individual.

Any adoption of this new biopsychosocial approach will demand other changes such as limiting the use of medical terminology in the consultation. Terminology, it has been acknowledged in this chapter and chapter five, will hinder the development of a genuine 'holistic' approach to older people. One of the ways of facilitating this is to allow the individual with the 'need' to play an equal and active part in their care. Through a broader biopsychosocial framework the issues of terminology and labelling should become redundant as the model views the causes of illness as external to the individual, irrespective of how their personal view has been formed. Accordingly, Gold (1977) argues that when applying a holistic approach to health and illness, it is necessary to develop systematic explanations of their relationship to external social factors.

A further consideration in this broader biopsychosocial framework is the previous reference to the hierarchical nature of the model. The term biopsychosocial contains a component of the medical model. This has led to criticism of the model operating in a hierarchical manner with the 'bio/medical' aspect of the model being the dominant influence in the hierarchy. However, Salole (1994) sees the incompatibility between the medical and biopsychosocial models as more superficial than fundamental. This raises further questions for the comparative research as to whether the biopsychosocial model is truly an alternative for healthcare and questions the use of the term 'holistic'. What does the term 'holistic' mean to the older people in this study? The research will therefore compare the term 'holistic' between the medical and biopsychosocial models and examine which one older people use to address their foot-care needs. It will also assess whether older people's foot-care needs will be more appropriately addressed by a new 'holistic' perspective towards podiatry care.

7.8 Holism and the biopsychosocial model

The biopsychosocial model is therefore portrayed as a 'holistic model', for it encompasses all aspects of an individual's world. But can the biopsychosocial model really claim to be holistic? The first challenge to this claim has already been demonstrated, as the biopsychosocial model has been shown to operate in a hierarchical manner, with the scientific method or medical aspect being the dominant element.

Therefore, what is meant by the term holistic? 'Holism' is taken from the greek word 'holos', meaning complete, whole, or entire. The early Greek model of health and illness was considered to be holistic as a result of a combination of biological, psychological and environmental factors (Hewa, 1994). The Oxford Modern English Dictionary (Swannell, 1995), philosophically

describes holism as 'the theory that certain wholes are to be regarded as greater than the sum of their parts' and medically as 'the treating of the whole person including mental and social factors rather than just the symptoms of disease' (p.506).

Unfortunately, 'holistic' has also been used to refer, not to wholeness and a comprehensive interpersonal understanding, but to a proliferation of 'alternative' diagnostic and therapeutic techniques, many of which provide no further understanding of the origin of an individual's care needs than do other medical techniques. When adopting the term 'holistic', this research will adopt the comprehensive concept but, in the context of this research a holistic approach should consequently be an integrated and individualised approach to each person, who is considered unique in all aspects of human life (mental, emotional, behavioural, social and spiritual as well as physical). However, it has already been acknowledged that the public are turning towards alternative therapies for their health related problems because current medical interventions have not met their needs or expectations. The consumers of healthcare are feeling that their health needs are not being met, and if individuals want a more psychosocial approach, they might turn to alternative practitioners who provide a more sympathetic, psychosocial perspective (Armstrong, 1987). If medicine continues treating psychosocial elements at arm's length, it risks its historical dominance in healthcare provision, and Armstrong recommends that the solution is therefore 'biopsychosocial medicine', which at once both encompasses and neutralises any threat to its supremacy, although the addition of the term medicine to the model still suggests a threat of medical influence.

Implicit in the application of the biopsychosocial model is a team approach to 'diagnosis' and 'treatment'. This is necessary in order to ensure that appropriate biological, psychological and

social data are collected, integrated and interpreted comprehensively. This is problematic, as Schwartz (1982) notes: no one discipline, by definition, can represent all of the information collected and multi-professional approaches have already been demonstrated to be complex and operate within professional hierarchies. Weir (1991) provides an example of the difficulties this will create, by suggesting that if medicine is to embrace a holistic understanding and acceptance of health and illness, a deeper understanding of psychology will be required which will constitute a challenge for medical professionals with their historical division of the mind and body. However if it is accepted that to understand human beings you must embrace a broad spectrum approach by including the physiological, psychological, emotional and spiritual aspects then this also becomes problematic with Maslow's (1943) hierarchy of need because his concepts of self-actualisation and self realisation are difficult to achieve when individuals may only expect to have their basic needs addressed.

The term 'holism', described as a concept embraced by the biopsychosocial model is therefore a complex one. Adopting a genuine 'holistic' approach will direct the researcher to ask different kinds of questions from those dictated by the medical model approach. Therefore, as Green (1978) suggests instead of understanding just the medical model aspects of sick individuals as if these attributes explain the condition, it is necessary to seek out all the illness-producing elements and record their effects as provided by the individual. In order for this research to critically examine older people's foot-care needs through a biopsychosocial model approach, consideration will have to be given to whether the framework is holistic in nature or whether a new 'holistic, person-centred model' is required. The claim that the biopsychosocial model is *naturally* holistic raises an additional question – can a biopsychosocial approach provide genuine holistic care and

does person-centred care mean the same thing to an individual older person or are they viewed as completely different entities?

7.9 Biopsychosocial model and outcomes of care

The scientific medical model of need and 'capacity to benefit' brought with it a concept of a measurable outcome (chapter five). The application of a biopsychosocial framework may mean a different concept of outcome must be considered. From the discussion of the biopsychosocial framework so far in this chapter, a biopsychosocial approach requires that the individual must be allowed to identify their desired outcomes of care. However, it is probable that one of these outcomes will be an improvement in the individual's quality of life. This has not prevented some authors (Bowling 1997, Coyle 1998) from suggesting in health and social care research that issues such as quality of life are increasingly being incorporated into the broader assessment of outcomes. Improved quality of life is clearly more difficult to measure scientifically because each individual's view is a subjective view which has led to difficulty in gaining acceptance from medical healthcare. Bowling (1997) proposes any intervention or care, needs to be evaluated in terms of whether they are more likely to lead to an outcome of a life worth living, whereas Coyle (1998) considers more specific advice in relation to older people such as: age-related changes in pain tolerance, variations in psychogenic pain significant increases in depression and the multiple losses of important relationships that are a potentially part of the normal ageing process but nonetheless relevant to participants' in this research. This suggests that each of the biopsychosocial elements, the social, psychological and biological, need to be considered in relation to individuals' perceived health status and quality of life as a consequence of their status. This will ensure that the individual, and/or their carer, are involved in deciding the intervention they require which consequently should mean they are satisfied with the input and outcome of the

healthcare professional's intervention. In the medical model approach 'wants' are dismissed as an irrelevant concept within need assessment or medical outcome; in fact 'wants' of the individual are perceived as negative, yet are recognised in both Maslow's and Bradshaw's models of need. Therefore the link between needs and wants in the development of biopsychosocial outcomes will be different to the medical model approach.

7.10 Older people and the biopsychosocial model

In chapter three, Longino and Murphy (1995) were quoted as stating that as never before an ageing population is one where healthcare will have to confront chronic illness and disability. Many older people have chronic illnesses which have an effect on individuals' emotional, social, vocational and sexual functioning. Depressions, disrupted marital and family relationships and reduced ability to work are common among older people who are chronically ill. If these two issues are considered together, it poses serious problems for a healthcare system based on a dominant medical model.

Seldin (1981) believes that the economic, social and cultural structure of society influences health profoundly, but he does not necessarily support a biopsychosocial approach to older people's healthcare. Instead, Seldin (1981) suggests each person should be considered as an individual and not as a 'patient'. He concedes that medicine has little influence in controlling or altering older peoples' health. Alternatively, Antonovsky (1989) who supports a biopsychosocial approach, highlights that the individual has knowledge, wisdom and responsibility, as well as the healthcare professional, and hence rights and power that can be shared with or withheld from the healthcare professional as the individual chooses, whereas the medical model leaves the clinician in full control of the clinical situation. Armstrong (1987) however, considers yet another concept

and states individuals are now socialized into acceptance of the legitimacy of the concentration of power with medical professionals. These three diverse approaches to older people's views require the research to examine the roles older individuals play within the medical and biopsychosocial models and whether this role remains the same or is different.

In this chapter it has been suggested that a hierarchy may exist when the biopsychosocial model is applied with the dominant 'bio' element (or medical model) operated by healthcare professionals. If the medical element is dominant then other factors such as health promotion, risk factor control, aetiology, accessibility, diagnosis, therapy and outcome (whether death, recovery or chronicity) may be ignored (Engel, 1977). These factors may have relevance for the participants' in this research. A challenge has also been placed on the biopsychosocial model's claim to operate across other factors and to be genuinely 'holistic'. It appears there is no agreement about how the biopsychosocial model operates, despite what other commentators might advocate (Engel, 1977, 1980; Jeffery, 1986; Hewa, 1994; Bowling, 1997; and Sarafino, 1998). The implications for this research are raised awareness of the various hierarchies operating within the biopsychosocial, and the adoption of various strategies to ensure they are not allowed to dominate or influence a holistic approach. The researcher will need to take a conscious, holistic approach when applying the biopsychosocial model to what is said by the participants in order to capture what the individuals are really meaning, rather than medical model interpretations by the researcher.

If progression towards a holistic understanding of human responses is to occur, the researcher will be required to concentrate on the biopsychosocial framework, systems theory and interdisciplinary working (Jeffery, 1986). This is supported by Whitbourne (2001) who has used

a biopsychosocial approach to describe the complex interactions of biological, psychological and social processes that take place in the formation of an individual's identity. An individual's identity is a composite of self-representations in the biological, psychological and social domains and the interaction of these domains is interpreted in terms of the individual's view of 'their self'. The construction of 'the self' therefore remains important for this research, as this proved to be the case during the development of the semi-structured interviews with older people (see chapters three and nine). The construction of 'the self' and the interaction of the three elements of the biopsychosocial approach are acknowledged here as relevant when working holistically with older people.

One method for ensuring an appropriate and consistent approach to capturing all elements of older people's views is to adopt a life-span perspective. A life-span perspective approach (Pickin and St Ledger, 1993; Whitman and Merluzzi, 1999) views characteristics of an individual with respect to their prior development, current level and likely development in the future. The life-span perspective also adds an important dimension to the biopsychosocial perspective in our effort to understand how people deal with the issues of health and illness (Sarafino, 1998). The life-span perspective suggests that in older age biological systems decline, but with our psychological systems, we become better able to understand the implications of our illness when sick. Changes can also occur in social relationships that can be related to health and illness. Therefore, the biopsychosocial approach accepts that the individuals' needs can change over time. Therefore, it is recognised that throughout individual's lives, the role of different biopsychosocial systems change in relation to an individual's health and illness. Individuals pass through a series of transitions in which they are particularly sensitive or vulnerable to a complex

interaction of biological, psychological and social forces characteristic of their period in life (Erikson, 1963).

The relevance of this comparative research with older people is supported by Higgs (1996) who suggests that the increasing number of older people in future may act as a catalyst for change. The general public, albeit mainly younger adults, is demanding this change but healthcare professionals and this research needs to be aware of the multiple positions older people may take in resolving or maintaining their healthcare.

7.11 Conclusions

The critique of the biopsychosocial model portrays the medical model as ignoring the individual's interpretation of their problem and reducing the condition to that of an organ or disease. During the medical consultation there is also a failure to analyse the meaning of the individual's report in psychological, social and cultural as well as in anatomical, physiological or biochemical terms. A biopsychosocial model approach would make it possible to explain why some individuals experience as illness, conditions that others regard merely as problems of living.

How illnesses and other health problems are conceptualised within a medical and biopsychosocial approach have been discussed in chapters five and seven and it has been demonstrated that all health problems are reported as individual, complex experiences. A biopsychosocial model has been proposed as a framework to understand the needs of the individual and to provide a 'holistic' framework for action in the real world of healthcare.

Healthcare provided within a medical model framework is under threat because its epistemological foundations are being challenged. Yet, the discussion of the medical and biopsychosocial models in this dissertation has displayed that the biopsychosocial model can be demonstrated to operate in a framework similar to the medical model with the 'bio' element remaining dominant. Engel's (1977) biopsychosocial model is firmly linked to the medical model with its central and dominant biological focus, but as this chapter has demonstrated the promise of a 'holistic' biopsychosocial approach is still problematic. Only when individuals feel that their needs and expectations have been met by this approach to their healthcare can the claim be made that the biopsychosocial model framework provides a truly 'holistic' approach.

The medical model's focus on scientific evidence supported by health policy for the provision of any healthcare is now being discounted by the general public, since healthcare provision does not always meet their needs. As described in this chapter, there is increasing evidence of the role of 'the self' and other psychological and social factors in disease and illness and this is supported by Kuhn (1970) who suggested that every scientific model will become exhausted after time as the existing theories and methods no longer provide satisfactory solutions to emerging problems. However, Hewa (1994) confidently states, the medical model will be replaced in the near future by the biopsychosocial model. Unfortunately, contemporary healthcare continues to be provided within the traditional medical model approach even though the scientific approach to medicine does not meet the needs of the people accessing health services. Part two of this thesis has therefore identified the limitations of the medical model and the development of alternative theoretical approaches such as the biopsychosocial framework to the study of health and health care provision.

The biopsychosocial model has been promoted by other healthcare professions to be the model to change individual's dissatisfaction with the medical model. Unfortunately, the proposal of the adoption of the biopsychosocial model to aid psychiatry has just demonstrated how healthcare professions can manipulate models for their own benefit rather than those of the individual in need. The proposal that the biopsychosocial model would lead to the downfall of the medical model has led to some discrediting of the model, specifically when it has been demonstrated that psychiatry has attempted to use the biopsychosocial framework to raise its professional status. The biopsychosocial approach might be used in those circumstances in which it really is the only way for the medical model to shift its perspective, but no single aspect of biopsychosocial model supports its approval as the 'new model' that will change healthcare professionals approach to delivering a new holistic form of healthcare.

It has been argued that the biopsychosocial model involves the individual, who also possesses knowledge, wisdom and responsibility and hence rights and power, which if the individual chooses or is articulate enough, could be shared or withheld from the health professional. This conception of the individual's views of their needs and requirements standing at the centre of healthcare delivery is one that will be tested through the comparison of the medical and biopsychosocial approach to delivery of podiatry services. If a healthcare system is conceptually based on a biopsychosocial framework in its fullest and most radical sense, it will inevitably involve a partnership with the individual, their carers, family, health professionals and scientists (Antonovsky, 1989). Such partnerships would mean an end to the power of doctors to autonomously control the healthcare system. It is therefore acknowledged that the biopsychosocial approach may leave the health professional feeling more vulnerable because the medical model gives the healthcare professional complete control of the clinical situation.

Recent Government policy indicates that the role of the individual in their healthcare is becoming a higher priority. In the latest White Paper (DOH, 2003), 'patient-centred' care is given prominence but exactly how 'patient-centred' care will be introduced is open to question especially as the terminology, 'patient', has already been linked to a medical model approach. If healthcare professionals continue to view individuals as 'patients' there is little chance of the policy embracing individuals own views and feelings.

The primary aim of this research then, is to compare the conceptual frameworks of the medical and biopsychosocial models and apply them to the delivery of podiatry services for older people. Each model has been critically examined to demonstrate how they operate so that an understanding of how each framework might appropriately meet the needs and expectations of older people. The biopsychosocial model has been portrayed as 'holistic', able to include all aspects of healthcare from the perspective of the individual but, in some circumstances it continues to operate with the medical element remaining dominant. In terms of this research, it can be concluded that if podiatrists continue to operate within a medical model framework there will be little opportunity to develop appropriate interventions to meet older people's foot health needs. The challenge for this research is therefore to compare the two models to test the theory that the biopsychosocial model can deliver podiatry care to meet the needs and demands of older people in a truly 'person-centred' approach.

Part three of this thesis will now move on to examining the appropriate methods and methodology for exploring and identifying the participants' views and feelings relating to their foot-care needs. The participants' views will then be examined from within a medical and

biopsychosocial model perspectives to enable comparisons to be made between the two frameworks to observe which model is best adapted to meet the individuals foot-care needs and to develop a 'person-centred' podiatry service.

PART THREE: Methodological Issues

Chapter Eight

The concept of the ‘podiatry career’

8.1 Introduction

During the discussion of the medical and biopsychosocial frameworks in chapters five and seven, reference has been made to the ‘journey’ or ‘process’ an older person passes through, from identification of their foot problem, to an end point that is a successful conclusion to the problem from the individual’s perspective. The older person’s ‘podiatry journey’ will be described and developed in this chapter, through a description of a ‘medical podiatry career’ to a consideration of the wider elements of a biopsychosocial journey, that leads to the concluding section where the concept of the ‘biopsychosocial podiatry career’ is developed. The concept of either ‘podiatry careers’ have not been described in these terms elsewhere. However, the ‘podiatry career’ is an important reference point for the development of the research methodology in the following chapter nine.

Within the medical model framework various descriptions have been used to explain and study the process of an illness or disease, but none of these consider the views of the individual. The next section therefore illustrates the ‘medical’ process of illness or disease which has become known as the illness or disease trajectory.

8.2 Illness/Disease Trajectories

Illness or disease trajectories have been developed within the medical model framework to describe the process which individuals travel through in the course of their disease, and the appropriate interventions that should take place and when. Strauss (1980), and Milliken and Northcott (1996), describe their trajectories by identifying the processes and eventual

outcomes linked to specific illness or diseases. Milliken and Northcott (1996) suggest that trajectories can be applied to specific illness/disease and only occasionally may there be slight variation in these trajectories, thereby acknowledging there is little variation for the individual. This they support by stating “each specific chronic illness tends to have a general pattern.” (p.203)

The medical model approach to the illness/disease trajectory therefore gives little consideration to the individual and how they may manage the illness/disease during its course. It also gives no acknowledgement to how individuals may prevent medical problems or adjust to any changes in the disease course in order to control their symptoms for themselves. In the illness/disease trajectory, little concern is given to whether an individual can follow prescribed ‘treatments’, whether the illness causes them to become socially isolated, or whether the individual can normalise the interactions caused by the disease. As Strauss (1984) concludes, medical illness trajectories do not include:

“...a confronting of attendant psychological, marital, and familial problems” (p.16)

Unfortunately, some illness trajectories tend to follow a downward direction overall from diagnosis to eventual death, particularly chronic illness trajectories (Strauss, 1984). This suggestion that some illness trajectories do not lead to successful medical outcomes mirrors the current podiatry provision, where older people are referred for podiatry treatment which they then usually receive at routine intervals for the rest of their lives. In many instances, NHS podiatry for older people is provided to enable the management of a steady decline in an individual’s foot health and mobility until they die. However, most individuals want to, and can, learn how to handle their symptoms, “without deep involvement of their identities” (Strauss, 1984, p.53).

This is in contradiction with the discussion in chapter three where having an appreciation of 'the self' of older individuals was identified as an important factor in understanding the individual's world. Strauss (1984) further states that while some 'minor' illness are not fatal, many chronic illnesses in older people are slow to start and clearly can be ambiguous with the symptoms only getting worse with advancing age. Strauss's (1984) approach evidently follows the medical approach as he suggests that it is not until symptoms are diagnosed as an illness or disease by a medical professional, that the older person is accepted as being ill.

Adamson (1997) describes a more personal and positive view of illness trajectories. From her personal experience she suggests she behaved like a patient because of the uncertain diagnosis of her disease and its unpredictable course. She became a lay clinician and attempted self diagnosis and treatment and she often experimented with a wide range of medically unorthodox therapies. There is anecdotal evidence to suggest that older people who experience problems with their feet often try to find solutions to resolve their foot problems long before they approach a health professional. They try this long before they acknowledge they have a problem and seek help from elsewhere.

In developing the illness trajectory, Milliken and Northcott (1996) suggest a three stage approach. They suggest that an individual experiencing an illness will be familiar with the symptoms and decide they were ill (stage 1). Following this they consult their medical professional (stage 2) who diagnoses the illness and prescribes appropriate treatment (stage 3) that leads to the disappearance of the symptoms. Interestingly, in their study Milliken and Northcott (1996) found that people do not proceed along the anticipated trajectory in either an easy or consistent manner.

This suggests Milliken and Northcott (1996) do not acknowledge they have followed a medical model approach and have not taken into account all the confounding factors relating to an individual's condition. Milliken and Northcott (1996) propose when an individual's condition does not fit into the three stages it undermines the self-efficacy and self esteem of the individual which in turn invalidates 'the self'. However, this does not prevent individuals from visiting their medical professional when the symptoms on their own are not sufficient to initiate seeking professional help (Zola, 1973). This suggests that the reasons for individuals initiating a consultation with a health professional will not always follow an illness trajectory. A relevant aspect of this research will therefore be to explore with individual older people what initiated their visit to the podiatrist.

NHS Podiatry provision for older people has been shown to provide maintenance interventions for chronic foot conditions (Merriman, 1993). Chronic illness has common stages but each trajectory will be different for each individual because of their own variety of symptoms, their distinct social environment and style of coping. It is suggested (Strauss, 1984), that some illnesses which might be considered as annoying, discomforting or intrusive into social interactions, may not have any observable effect on self conceptions and their impact on the individual is more difficult to predict. This may explain why some individuals develop their own routines for controlling their symptoms, 'without [a] deep involvement of their identities' (Strauss, 1984, p.53). This statement appears to reflect a similar approach that older people take with their foot problems. However, as people grow older they may encounter an increase in their symptoms which may be unanticipated but, as Strauss (1984) suggests this leads individuals to develop changed trajectory projections and, "they then may have to come to new and deeper terms with their illness." (p.73)

In an apparent contradiction to the previous assertion that individuals do not involve their 'self' in their own health condition, Strauss (1984) is left to conclude that:

“...until health personnel are genuinely responsible for the social and psychological aspects of giving care there will be limited improvement in those aspects of care” (p.185).

8.3 Care Pathways

Care pathways have evolved from the concept of illness/disease trajectories and the development of the 'care plan' approach which has been described as a continuous loop (DOH 1989b, 1990). The care plan approach commences with a clinical assessment of the individual and this is followed by the formulation of the care plan that is then implemented by the care professional(s). Following the implementation of the care plan, an evaluation to assess the impact of the process is undertaken by the professional. It is claimed that care pathways provide inbuilt techniques of evaluation called 'variance analysis' that consider anyone who varies from the expected 'norm'. The care pathway approach therefore demonstrates a medical model approach to care by only examining individuals who deviate from the "norm".

There are numerous synonyms for care pathways which include: integrated care pathways, clinical pathways, multi-disciplinary pathways of care, pathways of care, care maps and collaborative care pathways. A contemporary feature of healthcare policy has seen the development of the term 'care pathway' (DOH 2000b, 2001b, 2001c, 2002b, 2004a, 2004b, 2004c, 2005a, 2005b, 2005c, 2005d, 2005e, 2007a and 2007b). Care pathways are presented as simple algorithms, in the form of a flow diagram of when decisions need to be made and when care is provided for specific illnesses or diseases and laid out in a logical sequence. However, care pathways are now proposed within healthcare policy as an alternative means to

deliver 'holistic' healthcare (DOH 2000b, 2001b, 2001c, 2004a, 2004b, 2004c, 2005a, 2005c, 2005d, 2005e, 2007a and 2007b).

The care pathway concept has been subsequently developed into integrated care pathways (ICP's). The ICP is proposed to consider individual aspects of the disease or illness and identifies who and what is an appropriate intervention at any particular time in the pathway. It is proposed that the integrated care pathway will ensure patients receive the highest possible standards of care and the activity of different clinicians involved in healthcare will be coordinated, so that the care provided is effective, efficient and convenient for the patient, leading Middleton and Roberts (2000) to suggest: "ICP's will reduce practice variation, optimise resource use and improve patient treatment" (p.38).

The National Pathways Association's (1998) definition of an integrated pathway, in Middleton and Roberts (2000) is:

"An integrated care pathway determines locally agreed, multi-disciplinary practice, based on guidelines and evidence where available, for a specific patient/client group. It forms all or part of the clinical record, documents the care given and facilitates the evaluation of outcomes for continuous quality improvement" (p.4)

Middleton and Roberts (2000) claim that integrated care pathways are patient focussed:

"... [integrated care pathways] place the patient at the centre of the care cycle. They encourage both professionals and organisations to view 'the patient's journey' from a different perspective..." (p.6)

A potential flaw in the theory of integrated care pathways is that they are designed by, and for clinicians, based on the medical model of illness and disease, which generally means it ignores the views and feelings of the individual.

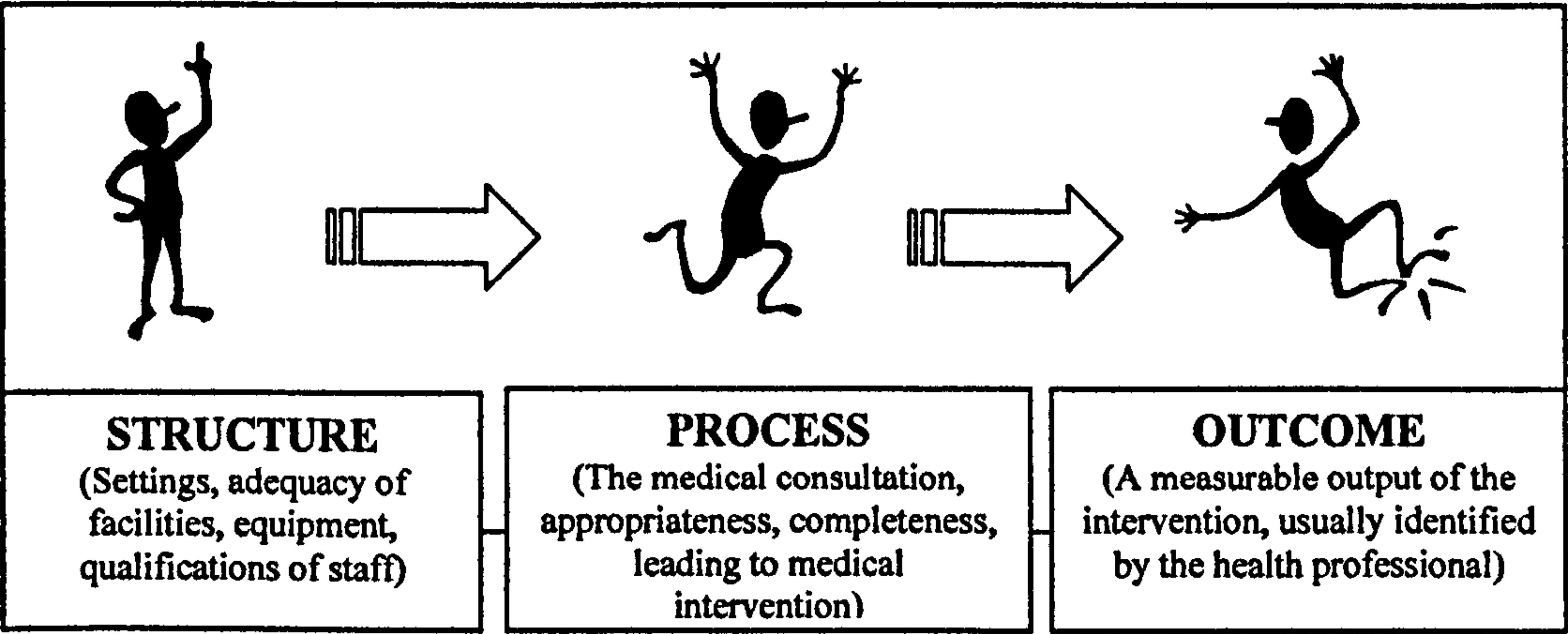
8.4 The concept of the 'patient career'

The current provision of NHS podiatry, the 'illness/disease trajectory' and 'integrated care pathway' models have been described as following a medical model framework. The concept of the 'patient career' has been described as a 'heuristic device' (McKinlay, 1971). The patient career places events in a natural sequence that corresponds to various stages which the individual may pass through when sick. McKinlay's patient career strategy commences with the distribution of health and illness in society, proceeds through the process of referral, use of services, 'patient-hood' and the sick role to variously organized medical interventions that end with either rehabilitation or death. These issues when related to podiatry are identified in the 'medical' podiatry career (section 8.5, figure 8.2).

Taking the above issues into account, it has been decided to use Goffman's (1972) concept of an individual's journey through healthcare, which he coined the 'moral career', from his studies of mental health services. This concept will be used to describe and develop a podiatry career. The reason for selecting Goffman's concept of the 'career' is because he was concerned with the moral aspects of career that is the regular sequence of changes that a career entails in the individual's self and in Goffman's framework of imagery for judging oneself others (p.528). Therefore Goffman's (1972) career describes wider issues than the narrower focus of the illness trajectory or integrated care pathways. In order to construct a framework for the development of the new 'podiatry career', an approach from Donabedian (1966) will be adopted and adapted. The reason for this is that the local podiatry service, like many health services, have used Donabedian's model to examine the processes, and measure the 'quality', of the service they provide. It is recognised that this initial model has medical model components, but it is used purely as a starting point for developing a wider 'holistic' approach when the biopsychosocial model is applied to the podiatry career. Luker (1982)

describes Donabedian as a pioneer in medical care evaluation and described his framework by dividing it into three separate areas for evaluation: structure, process and outcome (see figure 8.1, Donabedian’s (1966) structure, process, and outcome framework).

Figure 8.1: Donabedian’s (1966) structure, process and outcome framework



Donabedian (1966) described the ‘structure’ element of his framework by including the care settings within which assessments take place but he also includes the processes that support and direct the provision of healthcare. This section of the framework assumes that with the correct settings, personnel and processes in place, “good medical care will follow” (p.170). In the ‘process’ section of Donabedian’s (1966) framework, he describes an examination of the processes of care. Consideration is given to appropriateness, completeness and any superfluous information obtained through the medical consultation together with the ‘treatment’ that is provided after the diagnosis. The third section of Donabedian’s (1966) framework is the concept of outcome. This, Donabedian (1966) suggests as a dimension of quality is rarely questioned. However, consideration should be given to the limitations of outcomes as measures of quality of care. From the themes generated so far in this research, consideration should be given as to who the outcome is relevant for, especially if a person-centred approach is adopted.

From the description of Donabedian's (1966) framework above it can be demonstrated to be influenced by the medical model, because Donabedian's primary preoccupation is to consider measuring outcomes. He reasons that outcomes tend to be fairly concrete and as such, seemingly amenable to more precise measurement. Donabedian's (1966) framework therefore focuses on outcomes because he contends that outcomes "reflect both the power of medical science to achieve certain results under any given set of conditions, and the degree to which 'scientific medicine' is currently conceived" (p.168). While it is acknowledged that Donabedian's model follows a quantitative/scientific approach it has already been demonstrated in previous chapters that there are other frameworks that can be considered for healthcare provision which are delivered to an individual's satisfaction. The difficulty therefore with Donabedian's description is that most of the outcomes contained in his framework have scientific measures developed to determine them, but with few outcomes generated by the individual's receiving the care.

8.5 Developing the patient career into the 'medical podiatry career'

Donabedian's (1966) framework will form the basis for the description of the journey an individual takes when they contact NHS podiatry services. Current NHS podiatry services have previously been demonstrated to follow a medical model approach (chapter two). The current NHS 'podiatry career' can therefore be described in the following terms:

Structure: the current 'structure' section of the 'podiatry career', within a medical framework, therefore consists of registered health professionals working within NHS premises using 'medical need' criteria for access to NHS podiatry provision.

Process: the ‘process’ section of the podiatry career consists of a medical consultation at which assessment and diagnosis take place and a treatment plan is devised (Tippins 1998, Lever and Shearer 1999) . For older people this treatment plan is more commonly of a maintenance type intervention, with little involvement of the individual.

Outcome: outcome measures are now the primary focus for the delivery of contemporary medical health services (Wilkin and Hallam, 1992; McCallum, 1993; Jenkinson, 1994; Long, 1994; Booth and Clardy, 1998; Britton and Thorogood, 1998; Whitty, 2001). As previously suggested integrated care pathways improve outcomes (Hoffman, 1997), although it is not stated whether the improvement is a medical one or for the individual. The ‘outcome’ section of a podiatry intervention is frequently a maintenance intervention and is normally performed to reduce pain, increase mobility and improve wellbeing (Kemp and Winkler, 1983; Merriman, 1993; NHS Executive, 1994).

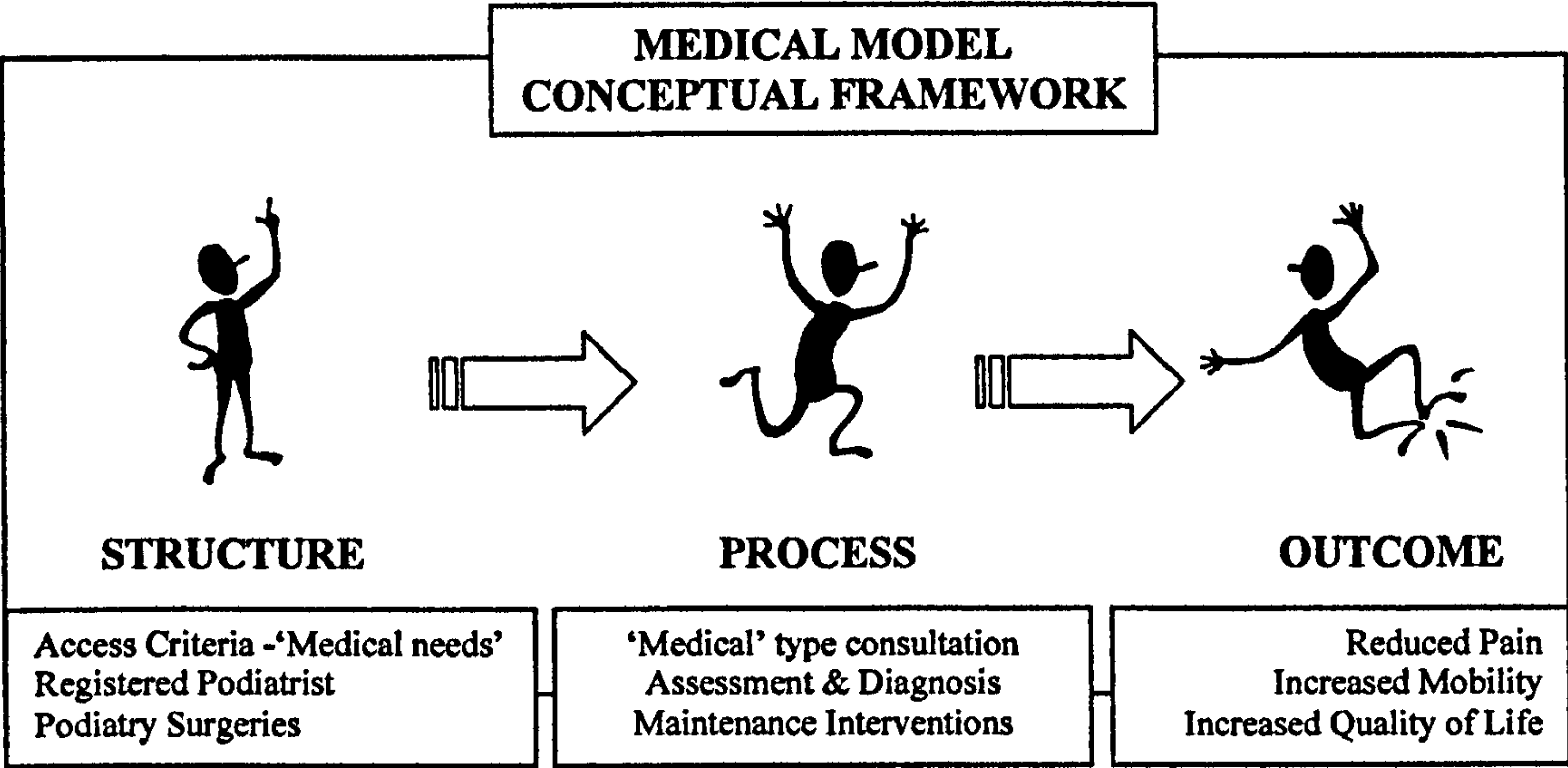
Within this approach, no timeframe is placed on the ‘podiatry career’ whereas, medical care pathways normally identify periods of time, as they are perceived to be a tool that will not only enable delivery of quality care, but will also increase the efficiency of the process (DOH 2001b, 2005d). In the concept of clinical pathways, as well as a time-line, there are also three key components: the categories of care or interventions, intermediate and long term outcome measures and a variance record (Hill M, 1994, 1998), previously described in 8.3 as ‘variance analysis’. Little attention appears to be given to the influence of the structure and process components, since Donabedian’s framework places greater emphasis on the outcome of the intervention. However, it will be shown later that both of these issues are significant in attempting to understand and develop the appropriate approach to meet individuals’ needs.

Medical model approaches to healthcare generally have clear beginnings and endings that regularly lead to discharge, whereas NHS podiatry interventions can be provided for the individual's lifetime. It is, according to Gaffney (1993), the especially glamorous 'acute-type' interventions whose outcomes are more easily identified and measured and therefore a quick before and after comparison can be made, which in turn is more attractive to commissioning bodies and politicians. The long timeframe or lack of measurable outcomes in the medical 'podiatry career' has long been considered by podiatrists to be disadvantageous and as a profession, podiatry has endeavoured to make the 'podiatry career' a series of short interventions with a review built in to reassess the older persons' need for podiatry (Kemp and Winkler 1983, Tippins 1998, Lever and Shearer 1999, Campbell and Bradley 2000).

Donabedian (1966) acknowledges the medical influence on his framework by suggesting that health professionals should not be interested in the results achieved by medical interventions, but in whether 'good' medical care has been provided. Donabedian (1966) suggests that any evaluation of medical care should be measured in medical terms, through complete and appropriate information obtained, by physical examination and diagnostic tests, a technical competence of the health professional in the performance of diagnostic and therapeutic procedures, and lastly an acceptability of care provided to the individual.

While it is not suggested that a hierarchy exists within Donabedian's list, current health policy suggests there should be a greater focus on the acceptability of care to the individual (DOH 2004b, 2005b). Donabedian acknowledges in his final point that the approach should consider the individual's views, and this is central to the research question which is to evaluate 'podiatry career' frameworks that deliver person-centred NHS podiatry services.

Figure 8.2: The medical podiatry career



8.6 From medical podiatry career to biopsychosocial podiatry career?

The biopsychosocial framework has been presented in chapter seven as being a potential conceptual framework within which all aspects of the individual’s ‘world’ are considered, in order to deliver health services based on the needs and expectations of the individual. However, the biopsychosocial model is similar in some respects to integrated care pathways (Middleton and Roberts, 2000), as both concepts claim to be patient focused and able to deliver ‘patient-centred’ or ‘holistic’ care.

In the previous section it has been demonstrated that care pathways and patient careers may purport to offer a patient-centred approach. However, closer scrutiny exposes that in these paradigms the health profession is still in control and the true involvement of the individual is questionable. It was Engel’s (1980) contention that the biopsychosocial model provides a conceptual framework that enables health professionals to rationally consider elements that are excluded from a scientific approach. The biopsychosocial model it is claimed motivates the health professional to accept psychological and social elements of individual’s

circumstances, elements often neglected even by those who intuitively recognize their importance. As Engel suggests:

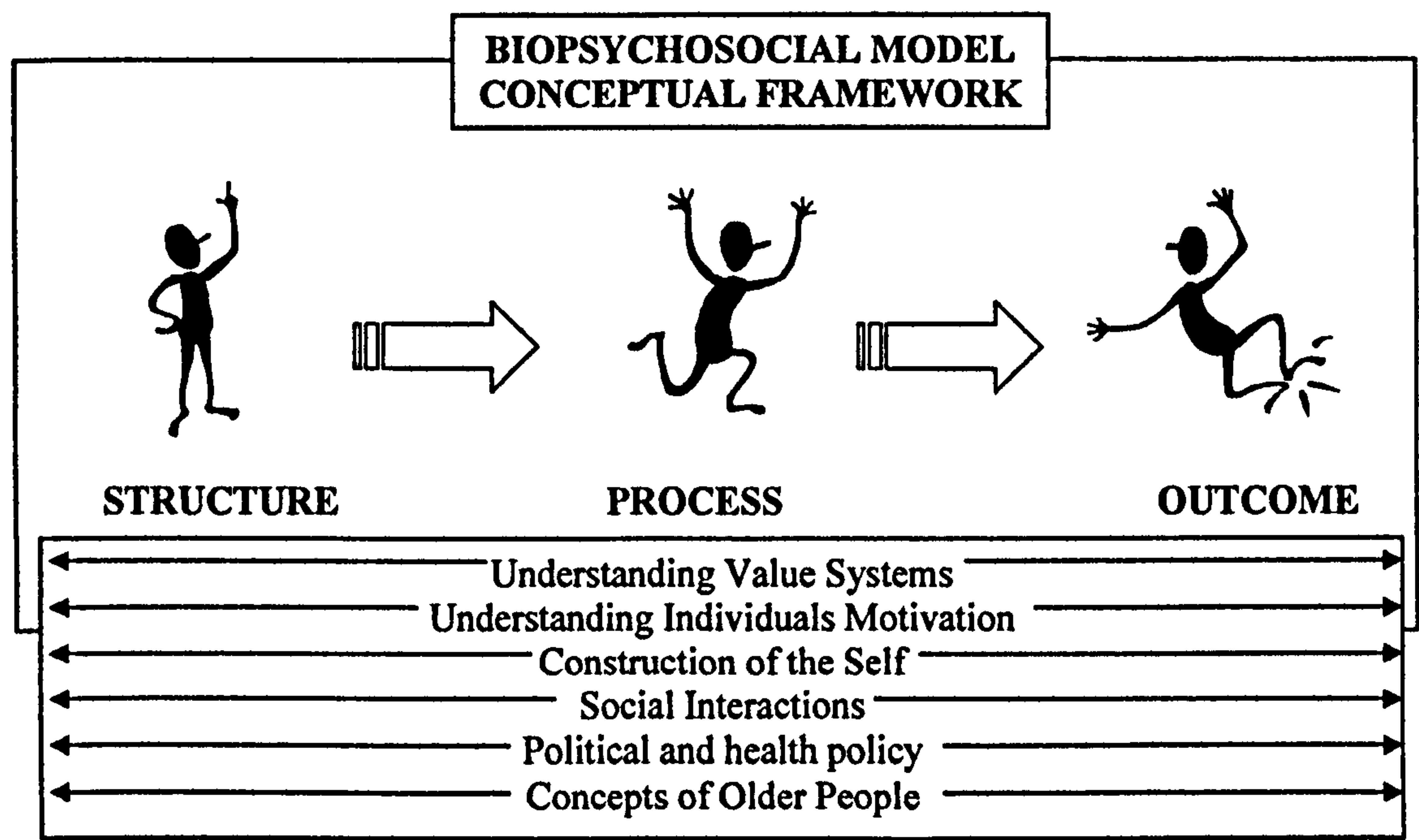
“...the biopsychosocial model serves to counteract the frequently wasteful reductionist pursuit of what often prove to be trivial rather than crucial determinants of illness.”
(p.543)

An important feature of the biopsychosocial approach to the podiatry career is that it is not ‘reduced’ into identifiable elements under structure, process and outcome. As the biopsychosocial approach contains a system’s hierarchy, this allows consideration of all information in terms of systems levels, and the possible relevance and usefulness of the information from each level from the individual’s perspective. Appreciating the ‘connectedness’ of the hierarchy, as Engel (1980) suggests, allows each system including components of systems higher in the hierarchy to be thought about at the same time. This approach recognizes that to involve an individual appropriately, higher system elements need to be considered with the same rigour and critical scrutiny as applied to systems lower in the hierarchy.

The systems identified in the biopsychosocial paradigm from preceding chapters include a notion of understanding the individual’s self, their value systems, their social relationships, and the impact on their psychological and social well-being because within most patient careers personal adjustments are made by individuals, which are in respect to self-identity, social relationships, attitudes toward the sick role and interpersonal perception (Swanson, 1970). Within the higher systems, issues such as political and health policy and the impact on the individual’s social world will be examined. These are all issues that the traditional medical framework does not include, and most significantly does not include an examination of these elements from the individual’s perspective.

At this stage of the research it is therefore proposed that the biopsychosocial approach to the podiatry career may include the elements highlighted in figure 8.3 below.

Figure 8.3: The biopsychosocial podiatry career



8.7 Conclusions

The biopsychosocial model has been selected for this research because it is felt that the current model for delivery of podiatry care for older people does not provide an appropriate framework for older people to influence their intervention. It is assumed by the author, using professional knowledge and the information contained in the previous chapters, that ‘foot problems’ are seen by older people more as ‘problems of living’ than as medical problems. This is an additional element of a potential new model of service delivery that will be examined during the research. During the process of this research project, reflection by the researcher has led him to question himself and his thinking, because his quasi-medical background and training predominantly directs him into scientific methods and thinking which may have been incorporated into the development of the biopsychosocial pathway

above. These potential biases will be discussed and developed further in the next chapter. However, the development of the biopsychosocial model has so far led the researcher to question: should the older person be considered a “patient”?, Are podiatry interventions “treatment”?, Are the requirements for podiatry intervention perceived as “problems” by older people?, Should foot problems be classed as “health, disease or illness” issues?, Are older peoples’ requirements of podiatry for care instead of “healthcare”?, and is the podiatry career, when presented from a biopsychosocial perspective, a truly person-centred or holistic approach from the perspective of the individual receiving the care?

In wider terms, for the development of a potentially new model of NHS podiatry delivery there is a requirement to examine the proposed biopsychosocial podiatry career and to examine the process of ‘care’ itself.

In the next chapter, the methods and methodology used to examine the medical and biopsychosocial podiatry careers from the perspective of older people will be explored and defined.

Chapter Nine

Research Methodology

9.1 Introduction

Parts One and Two of this thesis set out the background context and conceptual framework. In Part Three, chapter eight developed and described the concept of the ‘podiatry career’. This chapter seeks to describe the research methodology and methods used to determine and construct an understanding of older people’s views of their foot-care needs as they pass through the ‘podiatry career’ within the conceptual frameworks of the medical and biopsychosocial models.

These concepts have led to the development of the primary research question which is:

“Would older people receive foot-care services more relevant to their needs, if NHS Podiatry Services adopted a different approach?”

It was demonstrated in Part Two, chapter five that current NHS podiatry services operate within a medical model framework. In chapter seven the biopsychosocial framework was presented as an alternative approach to healthcare that involves the individual in developing resolutions to their medical problems. This is achieved through a systems theory approach of the biopsychosocial model which provides a conceptual framework within which organised wholes and component parts can be studied. The biopsychosocial framework therefore provides a useful comparative model to the current medical model approach to the provision of podiatry services. It is proposed that this research will undertake a comparison of the medical and biopsychosocial frameworks in order to test the primary research question.

The medical and biopsychosocial model approaches have been taken to examine older peoples' views and experiences of their needs at specific points within the 'podiatry career'. Four key areas of the podiatry career were originally identified for exploration these were subsequently refined to two key areas. The decision for this will be explained in greater detail in section 9.7.4. Consideration of the primary research question, the medical and biopsychosocial model critiques and the podiatry career has generated the following secondary objectives that support the primary research question for exploration in this research:

- What interactions take place between podiatrist and participant before, during and after podiatry interventions?
- What do participants who request podiatry services perceive their social, health or other related needs to be?
- How do participants identify their foot-care needs, and how do they feel podiatrists' address these needs?
- How are the participants podiatry needs met in order to provide successful outcomes?
- What do participants consider to be successful outcomes in relation to their podiatry interventions?
- What are appropriate models for delivering NHS podiatry services from the participants' perspective?
- What, as yet unknown aspects of the 'podiatry career' does a biopsychosocial model approach reveal?

9.2 Conceptual frameworks

In chapter seven it was suggested that Engel's biopsychosocial model (1977, 1980) would encourage a broader view of the complex concepts that occur within an older person's 'podiatry career'. The biopsychosocial model has been proposed because it poses a challenge to, and questions, the domination of the medical model and therefore its influences on the provision and development of podiatry services.

The biopsychosocial model proposes that medical interventions should always consider biological, psychological and social elements in order to assess a person's health and to make recommendations for treatment. The medical model has been revealed as neglecting the individual and 'reducing' them to the level of disease. The offer made by the biopsychosocial model is that the more information that is collected, and the better the information is organised, the better the diagnosis and intervention for the individual. A secondary difference between the two models is that the biopsychosocial model predicts that interventions will interrelate with each other as well as with the individual and their environment. Theoretically, by applying a biopsychosocial approach to individuals, it should be possible to customize interventions to the individual more effectively, and not just consider diseases in isolation, but also in interaction. One of the advantages of this approach is that it enables the healthcare professional to make recommendations that may apply to two or more problems simultaneously, and to look for interactions across different interventions that would have far greater and synergistic effects when meeting the needs of the individual.

The biopsychosocial approach therefore proposes that the individual too has knowledge, wisdom and responsibility, and hence rights and power, which can be shared with or withheld from the healthcare professional as the individual chooses (Antonovsky 1989). The adoption of the biopsychosocial approach offers healthcare organisations a partnership with the individual. Such a partnership would enable an equitable share of power within the healthcare system. In terms of this research it could potentially provide podiatry services with different approaches to appropriately meet the needs of the individual.

9.3 Research Design

In order to explore these broader complex concepts a careful selection of research methods and methodology had to take place. This was undertaken by considering a broad examination of the following two questions: “what methodologies and methods are appropriate for this research?” and secondly “how are the chosen methodologies and methods justified?” The next four sections provide some of the answers to these two questions.

In examining the research design, Crotty (1998) identifies four basic elements, crucial for successful research. These four elements will be taken and examined in developing and justifying the research methodology adopted. The first element considers the appropriate ‘methods’ used to gather and analyse the data that is collected. The second, ‘methodology’ is described as the strategy or plan of action informing the choice and use of particular methods and then connecting the methods to the desired outcomes of the research. The third element considered is the ‘theoretical perspective’ or philosophical stance that informs the methodology and provides the context for the process, and grounding of its logic and criteria. Finally the fourth element ‘epistemology’, is the theory of knowledge embedded in the theoretical perspective and thereby in the methodology. These four elements are now discussed and developed in detail commencing with epistemology.

9.4 Epistemology

The provision of medical services have traditionally been based on scientific or positivist models of cause and effect (Speller and Learmonth, 1997), with the ‘gold standard’ of medical research previously being identified as the randomized control trial. However, in conducting systematic research, alternative approaches such as qualitative research can provide equally valid results into

the effectiveness of healthcare interventions (Naidoo and Orme, 1997; Sheldon and Sowden, 1998). As this research seeks to compare the medical and biopsychosocial frameworks of podiatry provision for older people the selected epistemology is constructivism. One of the most powerful reasons for this decision has been the demonstration of the influence of the medical model (see chapter five) with its objective, scientific stance whereas, “constructivism describes the individual human participant engaging with objects in the world and making sense of them” (Crotty 1998, p.79), which implies constructivism is an appropriate approach to meeting the primary research aim.

The application of the medical model has supported the development of the scientific approach to healthcare research. The promotion of the randomized control trial has been accepted as failing to consider the views of the individual involved in the research. Unfortunately, qualitative research approaches to healthcare are shunned by medical researchers because of issues with validity and reliability, whereas other concepts such as confirmability, dependability, credibility, and transferability may be just as relevant to this research and the individuals taking part in it (Guba and Lincoln, 1989). A divide between the objective/positivist approach (quantitative research) and constructive/subjectivist approach (qualitative research) needs to be acknowledged. Therefore, in formulating the epistemology of this research it is necessary to provide a philosophical grounding for deciding what kinds of knowledge are possible and how it can ensure that they are both adequate and legitimate (Crotty, 1998). While the epistemological foundations of qualitative research differ from those of quantitative research, this does not mean that qualitative research lacks rigour, as suggested by positivists and supporters of a medical model approach. Some of the best examples of participatory research adopt no less a systematic

approach to the creation of evidence than the best randomised control trial (Truman and Raine, 2001).

The decision to adopt a constructivist approach is supported by constructivism's rejection of the positivist/objectivist epistemology in accepting there is no objective truth to be discovered. Constructivism suggests truth and meaning are only observable when the researcher engages with the reality of the research participant's world.

A constructivist approach suggests:

“...all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context” (Crotty, 1998, p.42)

A qualitative methodology has therefore been selected for this research because it provides a framework within which individuals can respond in ways that represent accurately and thoroughly their views. As Kvale (1996) proposes, it can be harder to dismiss the actual words of participants as they can convey the individual's powerful emotions. However, as indicated earlier in this chapter, qualitative research is still regarded by those who work in a scientific, quantitative paradigm (the medical profession) as secondary research because of the issues of reliability and validity in qualitative research (Bowling, 1997b). This leaves the credibility of qualitative methodologies in health services research lagging behind the 'gold standard' of randomized controlled trials. Yet, in qualitative research it is the same elements of transparency, depth of account enabling replication, the validity of research tools used, the appropriateness of methods of analysis and presentation of the data collected that are applicable to all research. Additional factors specific to qualitative research that are also dismissed by quantitative research

are felt to be just as important and will be clearly identified during the research process such as: the researcher's self-conscious reflection on the research process or the extent to which findings are considered to be relevant to other contexts or populations on the basis of their reliability.

In chapter three it was stated that little qualitative research has been undertaken with individual older people who live independently, specifically in relation to their foot care needs (Clarke 1966, Kemp and Winkler 1983, Campbell and Bradley et al 2000, Campbell and Patterson et al 2002). This could be because research with older people is not valued equally as productive and reproductive contributions to society (Biggs, 1993). Studies of older people have generally been either, quantitative and not involving direct contact with the older person, or qualitative using tools to measure well-being or the ability to carry out particular tasks. Studies of older people have also been found to concentrate on homogenous groups of older people, those who either live in old people's homes or sheltered accommodation. This has given rise to specific groups of older people being studied rather than the general population of older people.

While the influence of the medical model on directing researchers towards quantitative research methodologies is acknowledged, recent government policy initiatives identified in chapter four, have encouraged the involvement of users of services in the planning and delivery of health and social care services (DOH 2001c, 2005b, 2005c). Initially, health policy has proposed the ideology of 'patients coming first', 'patient-centred care' and individuals being 'consulted about their perceived needs' (Ende and Kazis, 1989; Gerteis and Edgman-Levitan et al, 1993; Deber, 1994; Elwyn and Edwards et al, 2000; Mead and Bower, 2000; Wensing, 2000; Larivaara and Kittu, 2001; Stewart, 2001; Lewin and Stea et al, 2002; Moore and Farndon, 2003). This began to change the way policy makers and professionals saw their tasks (Gilleard and Higgs, 1998).

However, the concept of 'person-centred care' is now being recommended (Zola, 1973; Coulter, 2001, 2002). This subtle change from 'patient' to 'person' centred care proposes radical change to the way in which healthcare professionals engage with individuals. Unfortunately, all too often the views of users of health services are still missing from evaluations of health service provision (Bowling, 1997b). As previously suggested this could be because the current research culture within health services only places value on quantitative research and it is on this evidence that decisions are based for clinically effective healthcare interventions and for the investment of health service funding by commissioning authorities.

It is suggested by Anil Kumar (1998) that with quantitative research there is 'a truth' to be discovered. However, this statement does not recognise that in many studies of individuals there is more than one truth involved. Instead, the medically dominated health service has tended to accept top-down initiatives aimed at providing information to keep those in power in their powerful positions (Pollitt, 1988; Booth and Clardy et al, 1998; Perkins and Repper, 1998). Unfortunately, the secondary nature of qualitative methods are increasingly being accepted as complementing quantitative research as a method of exploring process issues related to understanding how interventions work and how they can be refined, rather than as a primary research methodology (Britton and Thorogood, 1998). However, Rogers and Popay (1997) have argued that:

“...qualitative research is needed to explore the social distribution of the context and processes with which health related actions are shaped. More importantly, there is a role for qualitative research in illuminating further the link between human agency and structural context of people's lives.” (p.31)

9.5 Theoretical perspective

In this section a description of the philosophical position that supports the choice of methodology is presented, with an explanation of how it provides the context for the research process and grounds its logic and criteria. In this research a number of assumptions are made about the chosen methodology and this will be explored with a description of the theoretical perspective of this research. The assumptions made are largely to do with the world that the methodology envisages as the different ways of viewing the world dictate that different research methods for researching the participants' world will be required.

For this research the selected theoretical perspective is interpretivism. Schwandt (1994) suggests interpretivism was created “in reaction to the effort to develop a natural science of the social.” (p.125) Interpretivism can therefore be described as a theoretical perspective that looks for culturally derived and historically situated interpretations of the social life-world (Crotty 1998) (p.67). Interpretivism has been linked with the work of Max Weber (1864-1920) who considered that the human sciences are concerned with ‘understanding’ [*Verstehen*], whereas Weber contrasts the interpretative approach needed in the human and social sciences with an ‘explaining’ approach [*Erklären*] which focuses on causes found in natural sciences. This raises again the issue of quantitative verses qualitative research and which methods should be used in human and social sciences, the same dilemma that has been highlighted between the approaches of the medical and biopsychosocial models. Other commentators such as Wilhelm Dilthey (1833-1911) explore the challenges of the two approaches and he contends that human reality and social reality are different types and researching them will require different methods.

Other philosophers, Windelband (1848-1915) and Rickett (1863-1936) disagreed with the concept “that there is a real distinction between the two concepts except that posited by the mind” (Crotty 1998). This distinction with the mind is similar to the mind-body divide described in the medical model (chapter five). An implication of this is that in considering the natural and social sciences there are different purposes to the research. In the case of the social sciences we are concerned with the individual’s perspective or an individualising method rather than the natural sciences more generalising method. Here, Crotty (1998) makes a distinction between the two sciences and suggests that the natural sciences seek to establish general laws whereas the social sciences seek individual phenomena in order to find their unique development.

As this research seeks to understand and interpret older people’s experiences of views within the ‘podiatry career’ it is considered that interpretivism is an appropriate theoretical approach to adopt even though the medical models scientific research approach has been presented as objective and ‘gold standard’ research. However, this positivist approach cannot be sustained when health service policy is focusing more on the individual involvement and a personal approach to health service research which now requires an understanding and interpretation of social constructions and human interpretations.

In adopting a constructivist and interpretative perspective this leads the research to consider three approaches, namely, symbolic interaction, phenomenology and hermeneutics. Symbolic interaction introduces a research methodology known as grounded theory. This approach works through a series of carefully planned steps leading to the development of theoretical ideas. Throughout the process this theoretical approach seeks themes and ideas appearing from the texts. This is an inductive process firmly embedded in an analysis of the individual texts. A

phenomenological approach allows the researcher to revisit the immediate experience of the phenomena which can lead to new possibilities for additional meanings to emerge or for a confirmation or enhancement of previous understandings (Crotty, 1996). This presumes there are things to revisit in our experience or in other words objects to which our understandings relate. A central theme of phenomenology is the notion of 'intentionality' which Husserl (1931 cited in Crotty, 1998) describes as "a concept which at the threshold of phenomenology is quite indispensable as a starting point and basis". (p.45) 'Intentionally' is an essential relationship between the conscious participants and their objects or in other words the relationship between the individual and their world and neither can be considered without the other. The use of phenomenology requires the researcher to engage with the phenomena in the individual's world and to make direct and immediate sense of them. The use of phenomenology therefore requires the researcher to consider their position and previous influences and to put their usual understandings of the world to one side while considering the data from a fresh and unbiased position. The researcher's position and influences are described in section 9.4.2, later in this chapter.

A phenomenological approach therefore suggests that the researcher "sets aside all previous habits of thought, see through and break down the mental barriers which these habits have set along the horizons of our thinking" (Husserl, 1931 cited in Crotty, 1998, p.43) and to "call into question our whole culture, our manner of seeing the world and being in the world in the way we have learned it growing up" (Wolff, 1984) (p.192). In this research the phenomenological approach has objectivity but, it is in the sense of objects of experience rather than being content with a description of the participant's experiences. Secondly, it will provide a critique of what we would usually take for granted. The phenomenological method in this research will be

focused on collecting and analysing the data in a way that does not prejudice its subjective nature. To ensure this occurs will require the use of unstructured or semi-structured interviews with open-ended questions. It will also be important to ensure that the themes identified in the data do actually exist in the data and are not manifestations of the researcher's previous history and influences. This leads to a more detailed discussion of the methodology to be adopted in this research.

9.6 Research methodology

Crotty (1998) describes research methodology as:

“...the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes.”
(p.3)

The methodology is therefore the research design that informs the choice and use of particular methods and links them to the stated aims of the research. What is required therefore is not just a description of the methodology, but an account of the rationale for the choice of methods to be employed. Describing the research methodology encourages consideration of the political, theoretical and philosophical implications of making particular choices of method (Seale, 1998).

In chapter three, theories of ageing were discussed and identified as relevant to this research and therefore to the methodology. These theories are namely, theory of self, role theory, coping theory, trait theory and disengagement theory. Understanding the individual 'self' was identified as an important aspect of understanding older people (Chapter 3.4). When researchers have knowledge of an individual's 'self' they can begin to situate themselves in the individual's

'world'. If the various theories associated with 'the self', namely role, coping, trait and disengagement theories are in operation they will become more apparent in the research process.

In chapter three, disengagement theory, identified by Cummings and Henry (1961 cited in Biggs, 1993) proposed that older people progressively withdraw from social interaction as a preparation for death. Disengagement in this sense implies a triple loss of roles: those validated by society, restricted social contacts and reduced commitment to social traditions (Victor, 1987; Biggs, 1993). A medical model approach is more likely to suggest that disengagement is brought about by illness than any other cause (Palmore, 1968, 1981 cited in Turner, 1995). Alternative theories of disengagement theory suggest that it is also associated with the functionalist analysis of social systems (Parsons 1960, 1962 cited in Turner, 1995) which may be more obvious with the application of the biopsychosocial framework as this is constructed within a systems framework (see chapter seven). In intergenerational terms, this may arise as a wish to use experience to assist those "who are still developing", thereby indirectly influencing the working or family world (Deickmann, 1985, cited in Biggs, 1993, p.32). Identification of this factor led the researcher to identify this as 'a role' for older people who wished to participate in the research. However, it is important to recognize that in considering older people as active originators of meaning and the writers of projects, disengagement theory would be rejected.

There is an assumption that older people who have a high engagement in social networks have a high morale and positive life satisfaction. This has led to the value judgment that activity in old age is 'a good thing'. As Estes (1979) and Biggs (1993) observe "activity is proposed as essential to successful ageing" (p.9). It therefore follows that 'activity' is problematic because as Biggs (1993) states, "it says little about who defines and ultimately controls it". (p.10)

9.6.1 Grounded Theory

Initially, a grounded theory approach (Glaser and Strauss, 1967) was chosen for this systematic, exploratory study evaluating the research participants' views of podiatry interventions. The value of this methodology lies in its ability not only to generate theory but also to ground that theory in the data. Both the theory and data analysis involves interpretation, but with grounded theory it is interpretation based upon a systematic inquiry. Grounded theory derives from systematically gathered data that is analysed throughout the research process. This requires the development of a systematic understanding which is clearly recognisable to the participants in the research setting, with the analysis conducted as much as possible in the participant's own terms, but in a greater systematic and necessarily more explicit form than found in the typed transcripts. According to Chenitz & Swanson (1986) and Milliken & Northcott (1996) the external validity of grounded theory methodology depends not on a representative sample but on internal variety. In this method, data collection, analysis and eventual theory are all in close relationship to each another but, more importantly the research does not commence with a preconceived theory.

This research therefore begins with the area of study and allows the theory to emerge from the texts. When identifying themes in the texts it will be necessary to show what is meant by these themes, how these themes emerged, how they were identified and what was done with them when they did arise. Theory drawn from the texts is more likely to resemble 'reality' than theory derived by putting together a series of concepts based on experience or solely through speculation on how the researcher thinks it should work. In order to achieve reality from the data, the discussion chapter (chapter ten) will use the

participants' words, ideas and modes of expression wherever possible, but seek to extend these. This method will allow an understanding of the older persons' experiences and how they change over time, by enabling them to express their experiences as it happens. Therefore the theory is grounded because it is drawn from the data and it is likely to provide insight, enhance understanding and provide a meaningful guide to developing conclusions.

9.6.2 Interpretative phenomenology

Initially a grounded theory methodology was used to develop and articulate the semi-structured questions, but the analysis of the participants' transcripts uses an interpretative phenomenological framework. This is because an interpretative phenomenological analysis proposes to uncover the meanings and perceptions of the individuals in the texts produced from the interviews. Interpretative phenomenology and grounded theory share many features. Each approach aims to create a cognitive plan that characterizes an individual's or a group's view of the world. Both operate by systematically working through the texts in order to identify themes and categories, these are progressively integrated until higher order elements are recognized which capture the essence or nature of the phenomenon. In other words, grounded theory and interpretative phenomenological analysis begin with individual texts that are then integrated to obtain a composite view which tells us more about the phenomenon than an individual text would be able to.

The reason for the change to an interpretative phenomenological analytic (IPA) approach is that grounded theory was developed to study basic social processes, while IPA was

created to gain insights into individual participant's psychological worlds. While grounded theory has been used to provide organized depictions of participants' experiences, it can be suggested that it is a methodology aimed at primarily addressing sociological research (Benner 1994). This is because grounded theory attempts to identify and explain contextualised social processes which account for the phenomena, whereas interpretative phenomenological analysis is focused on understanding the quality and texture of individual experiences (Willig, 2001). Interpretative phenomenological analysis is less controversial than grounded theory; in fact, the creator of this approach, Jonathan Smith (1997:189 cited in Willig, 2001), suggests it is "an attempt to unravel the meanings contained in ...accounts through a process of interpretative engagement with the texts and transcripts." (p.53)

Interpretative phenomenology is:

"...a relative new and developing approach that leaves more room for creativity and freedom to explore on the part of the researcher who uses it." (Willig, 2001) (p.69)

Interpretative phenomenological analysis (IPA) is a version of phenomenological method that "accepts the impossibility of gaining absolute access to the participant's life world" (Willig, 2001). Using this analytic approach, the participant's story is the phenomena with which the researcher will engage. It is this approach that justifies the researcher's stated intention to carry out semi-structured interviews and to use a non-directive form of questioning with the participants. Although interpretative phenomenology aims to explore the participant's experiences from their own perspective, it also recognizes that this type of exploration will implicate the researcher's own observations of their world as

well as the nature of the interaction between the participant and researcher. A phenomenological analysis identifies different approaches to human understanding (Willig, 2001 p.50). It therefore does not make sense to conceive of the 'world' and the 'self' as separate issues. Instead there is only the experience of the world based on a relational unit of 'self' and 'world' (O'Connor and Hallam 2000). Phenomenology is the study of the world as it is experienced by human beings within specific contexts and at particular times rather than in abstract statements about the nature of the world. Therefore, phenomena that appear in the consciousness of the participants in relation to their foot-care needs will be relevant to this research as; they will be 'real' to the participants as they will come from their 'lived world'. This means that 'the self' and 'the world' become inseparable components of meaning (Moustakas, 1994). Therefore, the important 'reality' in the research is what participants perceive it to be (Kvale 1996b), since this research aims to gain an understanding of how the world appears to the participants. As a result, this type of phenomenological analysis, produced by the researcher, will always be the researcher's 'interpretation' of the participant's views.

While interpretative phenomenological analysis aims to gain an understanding of how the participants view and experience their world, it is also acknowledged that it is impossible to obtain direct access to the participants' world. Researchers who use IPA have to immerse themselves in the participants' texts in a way that supports an 'insider perspective' (Willig, 2000). IPA starts from the assumption that the participants' texts will inform the researcher about some of the participants' private thoughts and feelings, which will be linked to the participants' experiences. However, it has already been noted that this researchers understanding of the participants' thoughts could be influenced by his

way of thinking. This should not be perceived as a bias that could affect the outcome of the research; instead it can be considered as a necessary requirement for making sense of the participants' experiences.

As an interpretative phenomenological approach is primarily concerned with the participants' subjective experience of the world rather than the scientific/objective nature of the world, it assumes that the participants will experience the same objective condition but in many different ways. This is because a participant's experience is reconciled by their own thoughts, beliefs, expectations, and judgements, which leads them to attribute meanings to events in their lives which then shape their experiences of those events. An interpretative phenomenological analysis makes no claims that participants' texts are true or false unlike the positivist approach. This does not mean that participants' accounts are 'idiosyncratic or free floating' (Willig, 2001). Instead the interpretative phenomenological approach puts forward that the participants' experiences are contained within social interactions and processes that are shared between the participants.

Interpretative phenomenological analysis recognises that any information gained from an analysis of the texts is only an interpretation. While the aim of IPA is to understand the participant's world, the researcher accepts that any understanding can only be obtained through an engagement with, and an interpretation of the participant's own words. This suggests that IPA recognises the researcher's views; however, it is not always clear how this insight is incorporated into the research process. Understanding the researcher's own conceptions, when undertaking an analysis of the participants' texts is therefore important to the research. Willig (2001) suggests that when using an interpretative

phenomenological analysis, the research does not claim direct access to participants' experiences and meanings. Rather, the terminology used in the presentation of the findings (chapter ten) will be as a sense of discovery rather than construction, with themes emerging and categories identified, as in grounded theory methodology.

A phenomenological approach consequently allows the researcher to enter the 'life world' of the participant. As a result it is important that any questions posed to the participants remain open-ended and non-directive, with their only purpose being to provide the participant with the opportunity to express their personal experiences of the phenomena contained within the research framework. An interpretative phenomenological approach works with texts created from the participants' by taking an 'idiographic approach' in which insights into the texts are produced as a result of detailed and exhaustive analysis and integrated only later in the research (Willig, 2001). Interpretative phenomenological analysis makes no claims to provide a definitive answer (or 'truth') to the participants' texts; it does however, provide a joint construction between participant and researcher of the participant's account following the researcher's analysis and interpretation of the texts (Osborn and Smith, 1998).

As this study requires the researcher to move beyond sharing an experience with the participants, it will be necessary to understand their experiences well enough to explain them, so the researcher will need to be aware of the circumstances that give rise to these experiences in the first place. These circumstances may lie well beyond the moment and location of the experience itself and may be found in past events, histories 'or the social and material structures within which we live our lives' (Willig 1999, p.65). The

reminiscence method selected for the first interview can now be justified as this technique will provide the life history from which the researcher can begin to understand the participant and their world. A further detailed discussion of the research methods used now follows.

9.7 Research Methods

Research of this type is uncommon, which allows the researcher to present a unique combination of research methods. There have been few studies that describe the methodological issues this research entails and none specifically with older people and podiatry services. Research methodologies for older people in the qualitative paradigm have tended to concentrate on using two specific methods, reminiscence and life histories. Other important issues that need to be considered with older people, highlighted in chapter three, include the location of the interviews and the participants' ability to be interviewed i.e. their mental health status. According to Tinker (1984), older people differ in three major ways from young people in terms of their health. This includes the number and type of diseases they experience, usually a number of chronic, long-term conditions. Older people experience very few fatal diseases, as these individuals have normally died at an earlier age and thirdly, special features relating to an older person's background, their lack of status, poverty, and disability. Tinker (1984) notes that older people themselves seem to fear illness and loneliness more than any other condition; however older people often declare their health as 'good' (p.59).

In developing appropriate methods for this research it is important to explore the various aspects of research design and for the researcher to 'position' himself with regard to the entire research process. Other specific issues that are specifically relevant to the research methods include the

selection/exclusion criteria, drop-out rates, acquiescence, power relationships, interview methods, and data interpretation procedures. These important additional aspects of the research are described in sections 9.10, 9.11 and 9.12, later in this chapter.

9.7.1 The methods

For this research older people, specifically individuals 75 years old and over will be selected and individually interviewed. There is no proposed upper age limit for inclusion in the study. People 75 years and over are considered to be a ‘vulnerable group’ by the NHS and academics (Thompson and Itzin, 1990; Chapman and Johnson, 1995; Bowling, 1997; Bytheway and Keil, 1989; Barnard, 2000; DOH, 2001b; Carlisle, 2005b), when they are involved in research projects and this is one of the probable reasons for the scarcity of research with this specific age group. This vulnerability raises ethical issues that are detailed in section 9.9, ethical issues in this chapter.

Traditionally, older people as patients and clients of health and welfare services have been perceived as passive and grateful for the services they receive (Breemhar and Visser et al, 1990; Gilleard and Higgs, 1998). As a recognised vulnerable group it will be necessary to carry out this research with sensitivity. Arksey and Knight (1999) suggest that some research topics that may on the surface appear mundane will manifest sensitive aspects as the research progresses. This is in part because the concept of sensitivity is socially constructed, and what matters in the research situation is what the participant finds sensitive (Fielding, 1990; Arksey and Knight, 1999).

As one of the primary purposes of the research is discovery, at this stage it is not known which variables are important in the individual's podiatry career, what their properties are or how these vary dimensionally. Therefore the sampling technique used must be appropriate, as this will be guided by the developing theory.

In this study it is intended to interview older people at key stages already identified in the 'podiatry career' in chapter eight. Each individual will be interviewed twice. During the piloting phase it was considered that four interviews were required. However, throughout the piloting stage it was found that the third and fourth interviews were repetitive of the second interview and the participants were reluctant to participate anymore because they felt they 'had nothing further to add'.

"I think I've said more in the last five minutes or so than I ever thought I would... whatever can I tell you?" (Jessie, 83)

A decision was then made that the first interview would be undertaken before any treatment or podiatry intervention took place. This initial interview was seen as crucial to a successful set of interviews with older people and was initiated following a request from an older person for an intervention from the NHS podiatry service. The aims of the first interview were to develop a relationship of trust between the researcher and participant and to get to know more about the person and what was important to them in their world, using a combination of reminiscence and life history techniques. At this interview, development of a wider perspective of the older person's views of their health and foot health problems and possible linkages would be examined.

The second interview was conducted in the period of the podiatry career after the initial intervention but before the second intervention with the podiatrist. At this interview it was intended to seek the views of the participants about the intervention they experienced, to explore the individuals' feelings about whether it met their perceived foot-care needs, and what they felt would be required to meet their foot-care needs if these were not met and finally, the individuals' views on the benefits or not (outcomes) from the intervention. Each older person may require additional interventions but these are irrelevant, as the research was seeking the feelings and views of the person on the chronic nature of their condition and not the number of treatments they might have received, although comments from the participants themselves might reflect their feelings or views on the number and frequency of interventions they may wish to receive in the future.

A more detailed description of the research methods now follows. It was felt important to not just talk about the carrying out of interviews but to identify in detail what kind of interviews will be carried out and what interviewing techniques will be employed and in what setting they will be conducted as this was crucial in gaining ethical approval.

9.7.2 Participation

It was recognised that the process of sharing of knowledge and experience between researcher and participant is a means to an end and not an end in itself. It has been suggested that the greater the participation of individual's the better the research, although it can be suggested that this is not true of all participatory research. Truman and Raine, (2001) suggest this raises two issues for participants in any research. Firstly, any research on health usually means the participant has health problems. This may lead to barriers

and constraints on the process of the research and it is therefore important to stress the context in relation to the researcher finding the means and methods to enable shared relationships to take place within the research setting. This will be explored in the next section, research techniques. Secondly, the recognition of the nature of participation in terms of the partnerships developed between participant and researcher. Cornwall (1996) suggests the model of participation is more complex than a simple linear model. Cornwall's (1996) model (see table 9.1 below) describes different forms of participant involvement and suggests methods in which the participant and researcher relationship influences the types of knowledge that are constructed.

Table 9.1: Participation, involvement and research
Adapted from Cornwall (1996), (p.96)

Form of participation	Nature of Participant involvement	Researcher, Participant relationship
Co-option	Token; representatives are chosen, but no real action	On
Compliance	Tasks are assigned, with incentives; researchers decide agenda and direct the process	For
Consultation	Participants' opinions asked, researcher analyse and decide on course of action	For/with
Co-operation	Participants work together with researcher to determine priorities; responsibility remains with researcher for directing the process	With
Co-learning	Participants and researcher share their knowledge to create new understanding and work together to form action plans with researcher facilitation	With/by
Collective action	Participants set their own agenda and mobilize to carry it out, in the absence of outside researchers or facilitators	By

Cornwall's (1996) model demonstrates how most research involves some level of participation, but that the levels of participation may vary in different contexts. The model also provides recognition that participation is a process that may evolve within and throughout the research (Truman and Raine, 2001). For this research the forms of participation required are: consultation, co-operation and co-learning.

9.7.3 Research Techniques

The main focus of this research and its primary aim is to understand the views and experiences of older people who have foot-care needs. As a result the primary research data was obtained by using a semi-structured interview process to determine the different concepts contained within the older persons' 'podiatry career' and by involving unstructured interviewing techniques if new and unexplored areas of the research were expressed by the participants'. This approach is supported by Robson (1993) who suggests that to find out what people think, feel and believe the researcher should consider interviews, questionnaires and attitude scales. Kvale (1996b) defines this form of qualitative research interviews as an:

“...attempt to understand the world from the subjects' point of view, to unfold the meaning of people's experiences, to uncover their lived world prior to scientific explanations”. (p.15)

Larivaara and Kiuttu et al (2001) identify the differences between the 'doctor-centred' interview and the 'patient-centred' interview. The essence of the patient-centred interview is that the professional tries to enter the world of the 'patient' to get a holistic picture by including information from all levels of the biopsychosocial model, also acknowledging that at times the biopsychosocial model has been operated as a hierarchy with the biological or scientific element of the biopsychosocial model taking priority. In Larivaara and Kiuttu et al's (2001), patient-centred model the healthcare professional has to support the patient's autonomy by giving them personal authority and responsibly to take a central role in managing their health and illness, although the use of the term 'patient' implies the medical model hierarchy is still operating in the relationship.

There is growing agreement on most of the key elements of the patient-centred encounter (Larivaara and Kiuttu et al, 2001). These include, assessing the full spectrum of the individual's concerns and fully understanding the individual's problem(s). This is followed by the healthcare professional providing a diagnosis with appropriate information to develop a treatment plan (in conjunction with the individual) and at the same time educating and motivating them.

9.7.4 Piloting

Exploratory interviews were considered to be the most appropriate method to address this qualitative research and these would be applied across the podiatry career. The method chosen to assist the development of the researcher-participant relationship was to try reminiscence techniques with the use of a reminiscence book. The first reminiscence book was made up from a collection of photographs of footwear from the last two centuries. The purpose of the reminiscence book was that it gave reassurance to the participant, as they would be reminded of things in their past. This would assist in developing the participant-researcher relationship and secondly would aid the understanding of the participant's life history.

The first of a series of piloted interviews were arranged. The initial interviews were undertaken with a small number of older people [3] who had already accessed the podiatry service, with the objective of testing a series of questions and the reminiscence technique. The questions in these interviews were partly derived from what was considered to be components of the biopsychosocial podiatry career identified in chapter

eight and from themes identified by a focus group conducted with NHS podiatrists prior to the commencement of the research.

Initially it had been decided that interviews would be conducted at four key points within the podiatry career. The reasoning behind this was that the first interview would be treated as an opportunity to get to know the older person and to gain their trust, the second interview would explore the views and expectations prior to the podiatrist's intervention, the third interview would explore the views of the older person after the intervention and whether their expectations and needs were met. The fourth interview would be three months after the first intervention to see if the older person's views had changed over a further period of time.

Despite careful wording, the first series of interviews resulted in the elicitation of short answers. Following reflection on the content of the transcripts it was noted that a medical model approach had been adopted, and the participants were responding to the researcher as if they were in a traditional doctor-patient relationship. It was therefore decided that a semi-structured interview technique was needed as the more formal, structured interview technique employed directed the participant to either provide yes or no answers, with no elaboration of their views, or the participant appeared to be attempting to give a response they thought the researcher wanted. This type of response known as acquiescence will be explored later in section 9.11.1. Reflection on the reminiscence book also showed that it had worked reasonably well with women, but men on the whole seemed uninterested. This highlighted an early indication that fashion and image are a key element, particularly in older women's views of their own foot-care.

A second series of interviews were then undertaken at the four intervals identified from the podiatry career. Following analysis of the resulting interviews and reflections on the process it was decided to reduce the number of interviews with some minor development to the question areas. The reason for reducing the number of interviews was twofold. Firstly, there appeared to be a certain amount of repetition in the second and fourth interviews and secondly, the older people were quite prepared to be interviewed once however, they demonstrated an unwillingness to participate in more than two interviews. Most, older people stated that they felt that they had nothing additional to offer and that they could not see the point [!] It was therefore decided to reduce to two interviews and that these would take place between receipt of a referral to the podiatry department and the first intervention by the podiatrist and a second interview taking place after the first intervention but before a second.

Following the piloting, the question areas were expanded further and developed into specific issues and areas contained within the systems of the biopsychosocial model. It was also decided that a new approach to the reminiscence technique would be adopted to gain the participants' trust, to understand a little of their life history and to put them at their ease during the interview. Another reminiscence book was developed which contained general photographs of people, places and scenes from the early twentieth century, times in the 'life-span' when the older people participating in the research would have been in their childhood, adolescence and young adulthood.

9.7.5 The first interview

The first interview with the older person has previously been identified to be crucial for a successful sequence of interviews through the podiatry career. With such an emphasis being placed on the importance of the first interview it is felt necessary that the objectives of this interview need to be clearly stated.

The objectives of the first interview included:

- putting the participant at their ease with the researcher and research process;
- for the participant to understand the purpose of the research;
- developing a friendly and trusting relationship with the participant;
- finding out about the participant's background, life history and person circumstances;
- understanding some of the participant's expectations of the research;
- understanding the context of the participant's 'problem' and,
- enabling the participant to have a 'role' in the research.

The first interview therefore commenced with a simple reminiscence techniques. For this reason it is felt appropriate to provide a brief account of reminiscence methods in order to justify its selection as the most appropriate strategy for introducing the participant to the research topic and eliciting a brief personal biography of the participant.

9.7.6 The reminiscence method

Central to understanding an individual's thoughts, feelings and behaviours in later life, it is necessary for the researcher to know something about their past experiences (Coleman, 1986). Older individuals will differ in their reactions to the experiences they encounter in old age according to their own personal history. This has led to the seeking of appropriate details about the participant's life history that may be relevant to the research topic.

Life review is a research process which is psychoanalytically based, and focuses primarily on the individual. It involves a more structured format and can have a therapeutic intent. For these reasons a formal life review as a method was discounted for this research. However, a modified form of life review was selected which developed the reminiscence method that was used. Modified life review can be a form of story-telling that requires an unstructured telling of the individual's life story which seeks to uncover and explore personal and common meanings situated in the pattern of the individual's life. A modified life review can also focus on the individual within a historical, socio-economic, psychological, physical, political and spiritual context which allows a holistic or biopsychosocial approach to be applied. This technique eliminates the formality of structure and allows the individual to tell their story within a conversational format, a one-to-one relationship of trust and reciprocity. The researcher is allowed to comment or share thoughts and this type of life review is considered appropriate for meeting the aim of the research question.

Other research methods were considered including word cueing, projection and reflection, patient career diaries and items to stimulate discussion such as old photographs. Cohen and Taylor (1998) suggest that much of the relevant research that has relied on the word cueing method is inappropriate for the study of reminiscence. Word cueing is inappropriate for this research as words suggested by the researcher may influence and bias the responses from the participant. In chapter three, other methods suggested for research with older people included reminiscence and life review. Reminiscence is normally a non-threatening form of research method and is felt to be an appropriate approach for this sensitive research. In a group format, reminiscence enables individuals

to become involved in intra-personal reminiscence without necessarily contributing to the group. It is often enjoyable and “not suggestive of a therapeutic intervention” (Fielden, 1990, pp.23). Reminiscence and reminiscence techniques have been used for addressing many later life ills, from alleviating depression (Magee, 1988; Bluck and Levine, 1998) to encouraging the development of integrity (Havighurst and Glaser, 1982; Bluck and Levine, 1998).

Coleman (1986) suggests that:

“...the character of reminiscence research can be analytic, informative, self, or society focussed and can be related to the individual’s life circumstances.” (p.14)

The benefits of reminiscence techniques are that they facilitate an eliciting of memories of past events which may assist in the participants’ responses. Reminiscence can also aid the research along the lines the older person may wish to take it, not along lines the researcher thinks it should go and can also support the development of questions for later interviews. Coleman (1986) suggests that when older people commence reminiscence, this is a happy instance of behaviour serving both personal ends and social goals and that:

“...the older person’s knowledge of a bygone era provides them with an opportunity to enhance their self esteem by contributing in a meaningful way to their society” (p.13)

Adopting a reminiscence technique will assist the participants to gain a role in the research (they would be helping the younger generation) and assist in the achievement of one of the research objectives.

“I’ve told you all I can think to tell you anyway and as I say if it’s helped you in anyway I’m quite pleased if it’ll have helped somebody else.” (Gwendoline, 78)

Wong and Watt (1991) and Webster (1999) suggest there are three different types of reminiscence: simple reminiscence, informative reminiscence and life review. Simple reminiscence depends on recollection of the past and provides a source of strength and esteem in the present. Informative reminiscence is where recollection is used as a method to pass on knowledge and life review is where an analysis of memories of one's life is used to integrate a proper image of oneself in the face of death. While these different types of reminiscence techniques are acknowledged, reminiscence techniques in this research will be used primarily to make the participant feel at ease with the research process, to gain a brief life history and enable the participants to respond in greater depth to interview questions. However, Fielden (1990) identifies one of the key values of reminiscing is that most people enjoy it. Gubrium and Wallace (1990) and Biggs (1993) report that older people, rather than simply regurgitating reminiscence as a continuation of 'consciousness-past', can be more concerned to provide a response they think the researcher wants, or in other words to acquiesce. It is also quite possible to obtain different life stories depending on the cues given by the researcher (Wong and Watt 1991). According to Cohen and Taylor (1998) there is no method of studying reminiscence that is entirely satisfactory because when reminiscence is undertaken it is bound to lose spontaneity and privacy: "naturally occurring reminiscence is almost by definition impenetrable" (p.608). Despite these issues it is important to highlight that this research is just using reminiscence as a method to put the participant at their ease and in order to enable them to talk freely about their thoughts, experiences and feelings.

Some of the materials considered as reminiscence techniques for this research included:

- A 'recall' package produced by Help the Aged. The material is divided into three parts, reflecting the life span of an 80 year old person. The first part covers childhood, school days and the First World War. The second part covers youth and living through the Thirties. The third part covers the Second World War and living today.
- A book called "A Century of Shoes, 100 Icons of Style" (Pattison and Crawthorne, 1998) that contains many pictures of footwear through the last Century or more precisely the era between 1910 and 1940 when most of the participants' would be wearing fashion footwear plus other books (Baynes and Baynes, 1979; Swann, 1982).
- A patient career diary. This diary has been produced by the University of Leicester. Patients are asked to complete it personally. It covers the period from referral to intervention but unfortunately is quantitative in its layout and interpretation. However, it might be possible to modify the format to the needs of this research (Baker and Preston et al, 1998).
- An individual collection of old pictures and photographs were collated by the researcher and this was the technique used in the final research.

9.7.7 The second interview

The second interview took place after the participant had seen the podiatrist for the first time. The interview consisted of semi-structured questions covering both the medical and biopsychosocial approaches to healthcare. The objectives for the interview included:

- Investigating the experiences and feelings of the participant with regard to their contact with the Podiatry Service,
- Exploring the participants' experiences and feelings of any outcomes, prior and following the podiatry intervention in their physical activity or any other issues,
- Exploring the participants' experiences and feelings of the outcomes in their general mental state prior and following the intervention,
- Investigating and recording the views of the participant on the types of advice and help they would offer younger people,
- Exploring the types of changes that occur in the participant following their experience of the intervention and
- Developing new theories about podiatry intervention(s) and using these to develop new models for future provision to meet participants' needs and to influence health policy.

During the second interview, the researcher had an outline of topics or issues to be covered that were identified from the participant's first interview. The researcher was free to vary the wording or order of the questions to some extent, depending on the responses from the participants. The major advantage of this approach meant that the process and the data were more systematic and comprehensive than in the informal conversational style first interview. Like the first conversational interview, the second interview required the researcher to be relatively skilled and experienced in the research topic, as he needed to know when to probe for more in-depth responses or guide the conversation to make sure that all the topics on the outline are covered. Foddy (1993) suggests it is important that the responsibility for controlling the question-answer process of the research should be exercised by the researcher. This requires the researcher to formulate questions that have standardised meanings for all participants but not to prescribe or influence the ways in which the questions can be answered. A possible drawback to this approach was that sticking to the outlined topics could prevent other important topics from being raised by the participant. It was also appreciated that while this format is more systematic than the conversational interview, it may still be difficult to compare or analyse data because different participants were responding to somewhat different questions.

The chosen method for this research allows for the acceptance of the subjectivist point of view of how human beings 'experience' their world rather than how physical events impact on each other. This has required methods that are based on prolonged immersion in the social interaction in question, and the use of non-directive, open questions that participants answer in their own words rather than in terms of pre-set responses. The

implications of this mean that the length of interviews cannot be predicted therefore it is also important for the researcher to recognise when participants no longer wished to participate, either through loss of interest or tiredness.

9.8 Additional research methodology issues

9.8.1 Power relationships

Any participation in research raises a range of issues with power relationships between participant and researcher and how each is able to influence the way in which the research evidence is created and used. Participants in the research may be 'on different wavelengths' from the researcher and this may limit the potential for meaningful involvement by the participant (Martin, 1994). This was addressed by developing the participant-researcher relationship through the use of the reminiscence technique during the first interview. Walmsley (1993) and Martin (1994) propose that any relationship between participants and researcher always suggest a hierarchy. Participants often see healthcare professionals as experts and therefore this limits the potential for equal relationships in the research process.

9.8.2 The researcher's position

It was identified in the research methodology section (9.6) that it was important for the researcher to acknowledge their position and potential influences on the research. It can be suggested that the researcher's background apportions power that could lead to an unequal relationship with the participants and is potentially the single strongest influence

in conducting this research. It is therefore important for the researcher to provide a brief biography and to acknowledge any issues that might influence the research process.

The researcher and author of this thesis is a registered podiatrist (Health Professions Council, Registration number: CH06622) who qualified in 1976 and has worked solely in the National Health Service since this time. The researcher has received professional training (medical model based) and more than thirty years of experience of working in the NHS within a traditional medical model framework. In 1983 the researcher became the head of service for the NHS podiatry service covering East Gloucestershire and remained in this post to October 2002. From this date the researcher was appointed head of podiatry services for Gloucestershire following a reorganization of health services in the county. Between 1995 and 1998 the author undertook a Masters Degree in Applied Social Sciences. The dissertation was a study of NHS and Private podiatrists' views and experiences of human needs in relation to podiatry needs. This study has assisted in informing this research and also facilitated the researcher's interest in the provision of podiatry services from the perspective of the service user.

9.8.3 Specific power issues

Power relationships always arise in intergenerational research. The following, specific power issues were identified for this research: the researcher's position as manager of the staff providing the service, and manager of the service being provided to the participants and finally, the researcher's training and working experience within a quantitative and medical model environment.

The power relationship with podiatry staff has the potential to affect the types and quality of interventions provided to the participants being interviewed. In an effort to allay the podiatrists' fears and the potential influence this would have on an intervention, the podiatrists' were involved in the research from the outset. At a general staff meeting all of the podiatry staff, were informed about the research and its objectives prior to the conducting of a focus group meeting with them. Potential benefits of the research for the podiatrists and participants were discussed during the focus group. All podiatry staff were invited to discuss the types of responses that were likely from the participants'. This action helped to tackle several issues, namely the power relationship, the development of appropriate question areas (which would also be useful for triangulation purposes later in the analysis) and the bias towards 'different' interventions should the podiatrist find one of 'their patients' in the study.

The data that resulted from the transcribed focus group with podiatrists' provided themes and views that were used to develop the interview questions. The process of involvement did appear to reduce any anxiety that the podiatrists may have had, although the NHS Ethics Committee did raise specific concerns with the researcher's normal 'working dress' (formal suit and tie) which introduce a power relationship between researcher and participant. The environment that the interviews were undertaken could have an effect on the participants and therefore, an appropriate environment was necessary for participants to be able to speak freely and for them to feel unthreatened. It was also recognised that older people are reluctant to express negative aspects of their care or even to complain about a health service they require and that a strategy was required if this situation arose

In order to address these issues, the researcher ‘dressed down’ for the interviews, although it was important to appear casual and smart, an issue raised by Basil (84), one of the participants. All participants were informed of the researcher’s status and given opportunities to withdraw from the research at any time. Participants were also reassured that opting out of the research would not affect their future treatment in any way. The option to opt out, at anytime was highlighted in an introductory letter, information booklet and consent form. (Appendices: 1, 2 and 3).

The issue of position power could be further compounded by the participants knowing they were being interviewed by the manager of the service they are receiving. In developing a ‘trust’ between the researcher and participant there may be occasions when participants wish to make comments of a complaint type nature. If these arose during an interview the participant would be informed of the appropriate method to make a more formal complaint should this be necessary, recognising that this was outside of the research process. The issue of power relationships and the perceived ‘vulnerability’ of interviewing individual older people raised several ethical issues.

9.9 Ethical approval (Medical model influence)

There was a requirement for the research to be scrutinized and approved by the Local NHS Medical Research Committee prior to commencement, which proved to be a particular challenge. The process of gaining ethical approval became a classic example of the medical model in action.

The first test was in presenting a research proposal that appeared to challenge the operation of the medical model. This combined with the suggestion of a qualitative research project did not fit

easily into a local NHS ethics committee model that was designed to operate and assess traditional quantitative approaches to medical research. The consequences for submission to the ethics committee meant that methodological and research questions had to be clearly stated and in a format so that the health professionals on the committee were able to judge and assess the research design within their medical model framework. The local medical ethics committee states that one of its principal aims is to protect participants [*patients*] from potential harm by the researcher. However, this arrangement effectively prevented the participants from having any input into the research design process, as the researcher was unable to have any contact with participants until the research was approved. If reference is made to Cornwall's model (1996) (table 9.1) with regard to the design of the research, it could be suggested that participation was through "coercion" rather than "co-option" (Truman and Raine, 2001). However, after ethical approval had been gained, participants were invited to "co-operate" with the research study.

The ethics process begins with the completion of a detailed application form, made up of thirty seven questions in seven sections (appendix 4). The medical model format of the ethics committee application form was evidenced by the assumption that the research was quantitative and followed a randomised control trial format. The first question asked for the title of the research to be completed in no more than six words. A working title of 'older peoples' perspectives of NHS podiatry' was coined for the ethics application although as can be seen this was not the final title of this research. Other sections of the application form were difficult to complete in order to depict the true representation of the objectives of the research.

When the completed application form was submitted to the local NHS ethics committee it was a requirement that the researcher attend a committee meeting to present the application. The

majority of members on the committee were doctors and many others had medical backgrounds or training. The first submission was rejected, with a few suggestions and minor amendments. The most difficult of these was the suggestion that the proposed interviews were undertaken in the clinical area, just prior to the first intervention. The researcher had suggested a neutral and non-threatening venue for the first interview, the participant's own home. This would also allow the participant to have their spouse, relative or friend with them during the interview. The reasons for the ethical committee's decision, it could be suggested, has more to do with 'medical control/medical dominance' a strong theme identified in the medical model section (chapter five). The ethics committee decision introduced a 'power relationship' that was not acceptable to the academic ethics committee. It should also be added that the application to the ethics committee was made during the time that Dr Harold Shipman was being investigated for multiple murders of older people, predominantly, older women. A second submission with the suggestion that participants should be given the choice of where the interview took place was eventually accepted by the committee. After all the interviews were completed all the participants did actually choose to be interviewed in their own homes.

In completing the submission to the ethics committee the following specific issues were also identified (Robson 1994) and addressed:

Confidentiality: preservation of the participants' identity was important. Each participant was reassured and consulted about a preferred 'alias' name for use in the transcription. As participants did share very personal information it was important to honestly assess how much confidentiality the researcher could promise. Personal details such as current medical condition may have had an influence on participant's responses. Therefore it may be necessary to cite these

in the findings which could be a breach of confidentiality however, as will be seen it was possible to maintain participants anonymity throughout the research.

Informed consent: a requirement of the NHS and academic ethics committees was that the research required the participant to sign a consent form agreeing to participate, after being informed of the research process including the potential risks and benefits. The principle of informed consent is respect for people and acknowledgement of individual autonomy. As Kimmel and Moody (1990), cited in Birren (1992) state, “individuals are not allowed to be participants in treatments or experimentation without their free and informed consent.” (p.490) The legal definition of informed consent requires that an individual makes the decision to participate voluntarily and that they are mentally capable. This definition suggests that some individuals may be particularly vulnerable to pressure for participation and unfortunately, due to ageist biases, older people can be viewed as incompetent simply because of a momentary confusion or an insignificant gap in short-term memory.

Risk assessment: it was important to consider all potential risks and include them in the informed consent process. Even though ‘just talking’ may appear harmless, older people may experience psychological stress or fear their actual treatment may be affected in the future. It has also been identified that a high proportion of older people experience depression (chapter three) and that the interview process may involve older people in relating experiences that relate to their depressive state or just reminding and remembering occurrences that were not pleasant to them.

Promises and reciprocity: it was identified that it was important for participants to get something in return for sharing their time and insights. Informing the participant of their role in

the research and how they, their children, their grandchildren or their community may benefit from the study was something that the participant might be interested in. It was particularly important that promises of feedback or copies of reports were followed through.

Interviewer/participant mental health: interviewing experiences can be intense interpersonal experiences. Just as participants may experience psychological stress from disclosing more than intended or being reminded of painful experiences, it is suggested that researchers may be overwhelmed by the sensitive nature of what is seen or heard, especially in home or field-based interviews (Denzin, 1989, 1992; Denzin and Lincoln, 1994; Robson, 1994; Rubin and Rubin, 1995; Sewell, 2000). During the interview stage the researcher was surprised by the intimate and sensitive nature of the material relayed by some of the participants. Careful consideration was given to disengagement from the participant, especially after disclosure of sensitive material. Debriefing for the researcher after a sensitive interview was considered, although during the interview stages this aspect of the research was not necessary.

9.10 Recruitment of participants

It was clear that in order to gain the views of participants, the research methodology needed to fit around participants' needs and constraints. It was identified in section 9.7.1 that individuals 75 years old and over would be recruited to the research. Ethical committee approval was based on the perceived need to protect the participants and retain 'control' by invoking a medical model approach by suggesting participants were interviewed in the clinical environment. Eventually, potential participants were invited to take part on their own terms. This resulted in the participant taking part in a one-to-one interview with them deciding the time and venue and whether or not they had a spouse, friend or carer accompanying them.

9.10.1 Sampling method

Older people were selected using a purposive sample (Robson, 1993; Bowling, 1997; Willig, 2001) from new referrals received by the podiatry service. Purposive sampling is the usual method for data collection with interpretative phenomenological analysis (Benner, 1994; Willig, 2001). This means that the participants are a homogenous group to the extent that they all share experience of a specific set of circumstances. This involved dividing the population into a number of groups or strata because the podiatry service receives referrals of all age groups. In applying grounded theory researchers do not initially know which persons or places to visit to find examples of how concepts vary, they tend to sample by sensible logic or convenience. Each situation that is examined has the potential to present different features of phenomenon or phenomena, if not the inability to sample to the point of saturation will become a limitation of the study. Therefore, the selection of participants' that reflected 'the mix' of current podiatry caseload was fundamental and a key issue for this research.

9.10.2 Inclusion criteria

For this research the chosen strata were people aged 75 years old or over, with no age limit for inclusion. There was purposive sampling within the strata. The inclusion/exclusion criteria were proportional to reflect the numbers of males/females referred by General Practitioners, healthcare professionals and the participants themselves (self-referral). At present in this age group there is a 2 to 1 representation of females to males. All participants lived independently in the community. While the sample was a stratified purposive sample, it was recognised that the sample would also be 'self selecting' in that the participants would select whether to take part in the research or not.

Therefore participants in the sample were more likely to be articulate, well educated, more active, and feel they have something to say.

While it can be stated that the sample was biased, the intention of the research was to develop ideas and theories regarding podiatry interventions and not to provide statements and conclusions that would encompass every podiatry intervention.

9.10.3 Exclusion criteria

Older people who choose not to participate were excluded as were older people living in residential, nursing or hospital accommodation, older people who were unable to give informed consent and older people with senile dementia, severe mental illness or someone with a terminal illness.

One major consideration when involving older people in research is taking care in ensuring that the person is in a fit mental state to be interviewed. According to the USA Duke Adaptational Longitudinal Study (Busse, 1985; Fielden, 1990) very few older people escape the experience of depression, with an incidence of 21.5% at any one time. Life events such as bereavement, social change, physical ill health, are often frequent and associated with the onset of depression in older people (Murphy, 1982; Fielden, 1990). It has been suggested by Coleman (1986) that depression can be considered to be a 'normal' characteristic in older people. Therefore it is recognized that older people are a vulnerable group at risk of depressive illness and low morale, and therefore the research design is aimed at being sensitive during the interview phases.

9.10.4 Drop-out rates

Following identification of the inclusion/exclusion criteria it was anticipated there would be a level of drop-out from the study. A requirement of ethical approval was that participants must be able to retain the right to withdraw from the study at any time. For instance, some participants may not have wished to take part in the second interview if they were unhappy with the intervention from the podiatrist and may not wish to talk about unpleasant or unsuccessful interventions.

As all participants in the study were older people, there could have been an increased chance of them not feeling well enough or 'up to' a second interview. There may have been occasions when the participants were no longer in a fit physical/mental state to continue with the interviews or the participant no longer lived 'independently'. This aspect of the research was difficult to predict. However, it was intended to have thirty completed sets of interviews covering the two interventions in the 'podiatry career', sixty interviews in total. It was anticipated that up to forty participants would need to be recruited in order to achieve the required amount of completed interviews across the 'podiatry career'.

9.11 Methodological issues specific to older people

It is acknowledged that older people are generally more, not less diverse than younger populations (Birren, 1992). Most of the experimentally designed projects have tended to focus on older people as objects of research with few older people being drawn into the process or being invited to reflect on their own feelings and experiences as part of the research. There is therefore the opportunity that the researcher could impose his own interpretations on later life

issues in ways that interpretative phenomenological analysis would identify as an abuse of power, rather than let the older person define their own experience. Biggs (1993) suggests that it is quite possible to obtain different life stories depending on the questions provided by the researcher and this emphasises the importance of a grounded theory technique to develop the questions.

Biggs (1993) contends that because older people are often deeply embedded in their local community this can help the researcher understand why things are organised as they are, which supports the requirement to interview the participant in their own environment. Other problems that exist in researching older people by interviewing are that questions need to be carefully formulated and expressed. Nussbaum and Thompson et al (1989) and Biggs (1993) comment that the simplification of speech, a strategy often used by younger people to enhance communication, may contribute to misunderstanding if not handled with sensitivity. It can make the researcher seem unfriendly. Slowed memory transmission and production of speech is often incorrectly perceived as an indication of less animation, intelligence and extroversion, all of which are positively valued by Western cultures when present.

9.11.1 Acquiescence

Calsyn and Rodes (1992) have suggested that acquiescence can be an issue when interviewing older people and therefore pose specific methodological issues. Post survey research, Schuman and Presser (1981) and Calsyn and Rodes (1992) and psychological research, Bentler and Jackson et al (1971 cited in Calsyn and Rodes, 1992) do indicate that acquiescence is more prevalent in certain segments of the population. Jordan and Marcus et al (1980 cited in Calsyn and Rodes, 1992) found higher levels of acquiescence response bias in phone interviews than in person interviews. It was noted that across all

samples acquiescers and non-acquiescers did not differ on several other need assessment variables i.e. self health evaluation, prior use of services, current use of services and need for services.

Failure to control for an acquiescence response in this research could result in the participants taking the researcher's ideas and theories and relating them throughout the interview process. As one of the prime research objectives is an exploration of older peoples' views, experiences, feelings and ideas, acquiescence is a recognised issue, the affects of which must be minimised. Using individual, personal interviews helped to reduce the incidence of acquiescence. Cross checking of answers and asking similar questions on the same subject also assisted the limitation of acquiescence.

There is a requirement to avoid patronizing older people by using language such as 'dearie'. The researcher recognises that some individual differences may affect the results because of the diversity with the older people's population. Therefore, the asking of intrusive questions that may be stressful or cause distress to the participant will be treated with extreme sensitivity.

Debriefing procedures for explaining the research to the participant are especially important in older persons' research. If any ageist stereotypes are expressed in the research, participants will be debriefed so that they do not leave the research with any greater age bias than at the beginning.

9.12 Data interpretation procedures

The analysis of this research needs to give consideration to individual differences, group variances and contextual differences, but as not all older people are similar, no generalisations are made from the findings.

This research did not start with a theory to be tested, it began with an issue and this research attempts to allow, from a participants' perspective, what is relevant in the podiatry career to emerge from the analysis of the participants' text. Grounded theory has been described as the process of discovering theory from data that has been systematically collected and analysed. Generating a theory from texts means that most hypotheses and concepts not only come from the texts, but are systematically worked out in relation to the data during the course of the research (Glaser and Strauss, 1967). This research therefore generates theory that is inductively derived from the study of the phenomena it represents.

With the grounded theory method, the collection, coding and analysis of data, proceeded systematically and simultaneously. Emergent codes and categories were amalgamated with the conceptual framework to produce an analytic framework that guided the writing-up of the findings. If the initial data analysis revealed unexpected categories, subsequent interviews would include questions to test emerging themes.

A phenomenological approach was chosen for analysis purposes because it explores the dynamics of interaction rather than attempting to provide cause and effect explanations. Phenomenology places an emphasis upon the internal workings of the human mind and the way that people classify and make sense of the world around them. As Schwartz and Wiggins (1985)

contend, Engel's humanistic approach and his biopsychosocial model must incorporate the phenomenological conception of the 'life world' if it is to capture the breath of the patients' dilemma. The 'life world' according to Schwartz and Wiggins (1985) is the realm of everyday social interaction and practical projects (p.333). Through this phenomenological approach it is proposed that using people's experiences of the podiatry service and by relating these to the tensions between the biopsychosocial model and the medical model, will allow theories and ideas to be developed and explored in the inter-relationships that take place in the podiatry career.

Initially it was decided to use QSR NUD*IST 4 software to analyse and code the interview texts. QSR NUD*IST 4 software is designed to aid researchers in handling non-numerical and unstructured data in qualitative analysis, by supporting processes of coding data in an index system, searching text or searching patterns of coding and theorizing about the data (QSR NUD*IST, 1997). Following further investigation it was decided that the interviews would more appropriately be analysed by using QSR NUD*IST Vivo (NVivo) software. This was because NVivo provides a range of tools for handling rich data records and information about them for browsing and enriching text, coding it visually or at categories, annotating and gaining accessed data records accurately and swiftly (Richards, 2000). NVivo is a software package specifically designed for assisting in the analysis of diverse interviews that do not contain common or repeated themes.

9.13 Conclusions

The research methodology for this study has been carefully planned and will be just as carefully undertaken. It is anticipated that the success of the first interview will be crucial to understanding the 'patient career'. At the first interview reminiscence methods will be used to put the

participants at their ease and to help them focus on the interview questions. The wording of the questions and their sequencing needs to be carefully constructed and piloted prior to the actual interviews. Additional piloting of the reminiscence material needs to take place. However, some positive outcomes of reminiscence research have been that reminiscence interventions were found to be effective in bringing about changes in psychological wellbeing and life satisfaction (Fielden, 1990, p.29). This provides a potential problem, as wellbeing is one of the topics under review during 'the patient career'. Therefore, if wellbeing is seen to improve during the research, this may not be as a result of the podiatry intervention, it may be a result of the reminiscence. The clarification of both personal and common meanings with the participants through the telling of the life story helped to contextualise the concepts of wellbeing and health within the participants' world because they were not solely the products of individual achievement. As Heliker (1997) suggests, wellbeing and health are relational and contextual.

The process and outcome of the NHS ethics committee required the first interview to be carried out on NHS premises, which confirmed the medical models influence operating in the NHS. Other examples of the medical model operation will undoubtedly be identified during this research. For the interviews a semi-structured interview format will be used. Some of the topic areas will be developed from the responses given at the first interview and others will be developed based upon current knowledge of the interactions that are carried at various intervals in the 'podiatry career'.

Although this particular research topic has shown the need for a new and complex research methodology, it was felt that this qualitative study is still the appropriate method for investigating older peoples' views of their experience of podiatry interventions. It is recommended that

microscopic coding of ten good interviews or observations can provide the skeleton of a theoretical structure (Strauss and Corbin, 1990, p.281). The conducting of thirty interviews should therefore be appropriate and in some case may provide a saturation of data.

By using grounded theory techniques requires the researcher not to control variables, but to try to discover them. It also requires the researcher not only to look for representativeness or distribution of populations, but to look at how concepts vary dimensionally along their properties. However, because the research uses a purposive sample it is recognised that this may be detrimental as it may prevent this researcher from discovering the variations I am seeking.

Biggs (1993) suggests that a partial empathy may arise between researcher and older person and this can be used to develop what has been called 'enlightened self-interest' on the part of the older person. Should this occur, researchers should check out any insight gained with the actual experience of the older person to make sure any conclusions are not simply the product of a younger person's thoughts. Therefore crosschecking and checking back with participants will be an important aspect of this study.

"I want to pay you a compliment but I don't quite know how to pay it. I think it's been a very good interview and serious and pleasant and thank you." (Ellie, 85)

Using triangulation with published research by experts in ageing and the information gained from the focus group interview with podiatrists will also play an important role in this research.

Analysis of the interviews using an interpretative phenomenological approach has been demonstrated to be appropriate. In fact the interview process in phenomenology has been described as an invitation to conversation (Weber, 1986 cited in Heliker, 1997).

While the researcher is proposing to generalize from this study, if similar conditions exist in another area then perhaps much of what is learned from this study may help an understanding of the interactions, the views and experiences of the participant's podiatry career from a medical and biopsychosocial perspective. The enclosed methodology should then enable appropriate and relevant information to be discovered in response to the research aim:

“Would older people receive foot care services more relevant to their needs, if NHS Podiatry Services adopted a different approach?”

The next part of this dissertation covers the findings, following the conducting of the interviews with the participants' and subsequent coding using the NVivo software tool. Part Four of the dissertation contains three chapters. The following chapter presents an evaluation of the findings of the participants' themselves in order identify general themes about their 'lived worlds'. Chapters eleven and twelve move on to examine and evaluate the findings from the texts using a medical model and a biopsychosocial approach.

PART FOUR: Reflections from Older People

Chapter Ten

What it means to be an ‘older person’

10.1 Introduction

The primary research question highlights older people as the primary research subjects in this study.

“Would older people receive foot care services more relevant to their needs, if NHS Podiatry Services adopted a different approach?”

The purpose of this chapter is to portray the cohort of participant’s, who were participants in this study, in terms of their lives as ‘older people’. The following chapter (eleven) presents findings from an interpretative phenomenological examination of the podiatry career within a ‘medical model’ framework, and chapter twelve considers the responses with the biopsychosocial framework, thereby enabling comparisons between the two approaches.

The presentation of the research findings, follow an interpretative phenomenological analysis and subsequent coding of the interviews using NVivo v.1.3 computer software. This has created a large amount of data, which presents a dilemma for the researcher in how to portray the many issues, themes and stories the participants relayed. Each participant has their own perspective on the research topic and therefore to represent all of the participants’ points of view is not possible. Representation of each participant’s view has therefore challenged the researcher’s own thinking and working, as I have moved from a traditional medical model approach into a more holistic, biopsychosocial paradigm. In an attempt to resolve the

challenge of representation, the following three chapters include comments from all 36 participants. Individual participant profiles or 'pen portraits' of all of the participants' are contained in appendix 5.

The researcher's previous quantitative research background has provided a temptation towards grouping or clustering responses and presenting the data in the form of 'x' number of participants stated 'y'. This has caused a tension for the researcher between my scientific background and presenting a representation of wide ranging data from all of the participants, similar to the 'crisis of representation' described by Dickens and Fontana (1994) and the 'boundary oscillations' quoted by Evans (2000). The 'research process' has been a journey similar to that described by Weinstein-Shr, (1990), where many of the texts are unfolding stories about the individual journeys of older peoples lives. These findings are therefore presented in the form of building a picture from individual issues that have multiple links into other elements of older peoples lives, like a three dimensional picture. This picture develops the journey of the podiatry career leading to the building of a larger, three-dimensional picture.

The participants did not consciously identify 'medical' aspects of the podiatry career before they had contact with the podiatrist. The medical aspects of the podiatry career are therefore, identified through the interpretative phenomenological analysis and highlighted by the researcher. The wider psychological and social aspects of the biopsychosocial model were however explicitly highlighted by the participants and subsequently interpreted by the researcher. It is not clear whether this phenomenon actually occurs or whether it is because the researcher is now familiar with the biopsychosocial approach and now consciously observes the wider world of

individuals. A discussion of this phenomenon is included in the final concluding chapter (fourteen).

10.2 The participants

The participants selected for this study were 75 years or more in age. The intention of this chapter is to give the reader an understanding of the participants as individual human beings and as a generational group. Being part of the oldest generation brings specific problems and issues for individuals and means different things to different people. This section includes the participants' view of 'their world' and 'their view' of podiatry services from both a medical and biopsychosocial perspective.

The handling of large amounts of data at times has almost appeared unmanageable, and at times became repetitive and even boring, a concern identified by other researchers (Richardson, 1994; Evans, 1997, 2000). However, it is important to acknowledge that the participants have life-long experiences, and are telling 'their story' from 'their perspective'. The participants in this research study have a total of 3012 years of 'lived experience', which brings with it a wealth of knowledge and experiences from older people. Readers of the interview transcripts have commented how they can hear their mother, father, grandmother or grandfather in the quoted texts. This therefore suggests a specific representation and reality of this particular generation in the interview transcriptions.

Without fail, almost all participants stated at the beginning of the interviews, off tape, that they felt they did not have much they could contribute and what they had to contribute was of little consequence. This presented an unforeseen challenge prior to

conducting the interviews in getting participants to discuss their foot problems. This suggests that the participants do not normally consider their feet and foot problem(s) to be central aspects of their daily lives. This phenomenon may be one reason why research with individuals in this generational group is limited, as highlighted in chapter three. More reassuringly, following the interviews, nearly all participants without prompting commented that they had not realised how much information they were able to provide.

When a theme first appears in a quote, annotation will be in “***bold italics***”.

Perhaps not surprisingly ‘***being older***’ was one of the commonest and strongest themes identified during the interpretative phenomenological analysis and the participants were clearly conscious of the effects on them (‘the self’) of ‘being older’. Within the theme of ‘being older’ issues of acquiescence, stoicism, being alright for age, denial, awareness of own mortality, personal networks, independence, caring, entitlements, wellbeing and physical inabilities were all recognized and will be highlighted throughout the presentation of the findings where they are relevant.

Participants frequently cited their age as either having a direct effect on them (‘the self’), and how they viewed, or approached things. Some older people described ‘old age’ in terms of an illness:

“Oh yes I'm suffering with old age you know generally speaking yes...”
(Violet, 92)

A division in the participants appeared when some described physical disability and pain linked to their age, whereas other participants compared themselves to people of their own age to demonstrate their continued '*independence*' and '*active lifestyle*'.

"I just enjoy walking and now I can't walk but that's not the fault of my feet as they say. That's old age." (Tom, 87)

"...I mean when you get old you do get aches and pains, I mean I get arthritis, I get it in my shoulders, well, so I don't do things that I know are going to aggravate it." (Eileen, 80)

"Well anybody says if you're over 70 you're old and past it or something. I never admitted it. I don't really admit it now because as long as I'm active that's the thing, I do see deterioration in the..., in people I do know of my own age. I do realise that they're going." (Basil, 84)

From Basil's (84) statement above and in both of the following statements, participants express a sense of '*mortality*'. Clearly, where participants considered where they are in their 'life cycle' (Pickin and St Ledger 1993) this influenced their lives, views and opinions. This acceptance of mortality by the participants has relevance to meeting older peoples' foot-care needs and expectations when delivering podiatry services.

"Well I think really probably for my age and comparing with other people, I don't know many people of my age I mean the older you get the less you know you got because they all start dying off." (Elsie, 80)

"...that it doesn't hurt [*foot problem*]...but I mean it wouldn't stop me, well I hope it never stops me walking because by then that's it. The reaper will have to come along. That's it!" (Gwendoline, 78)

Central to this research is a comparison of two conceptual models, the medical and biopsychosocial. It is interesting that participants in this study often described themselves in terms of a divide of the mind and body, as described in chapter five, the medical model. While some participants were clearly less able to continue to

undertake '*physical tasks*', they consistently placed importance on keeping their '*minds active*' which leads to a recurring theme of concern to the participants, which was the '*loss of their mental abilities*'.

"I read, and I like to do crosswords and all that sort of odds and ends. If there's a puzzle in a book I go, oh I must do this...but it's better than having Alzheimer's isn't it?" (Lizzie, 82)

Most of the participants recognised that their '*independence*' was being threatened but indicated that they wished to maintain their independence as long as possible, dismissing the frequent portrayal of older people being dependent on others for help. This demonstrated a '*determination*' or '*stoicism*' in their attitude.

"Oh yes, I don't want to rely on..., I don't want to be taken out in a chair or anything you know or that sort of thing. I want to do things myself and be independent. It's a stubborn streak with old people I think." (Violet, 92)

When discussing waiting times for podiatry, participants considered that their '*age*' and '*medical condition*', should influence the '*priority of access*' to services. The participants were more insistent on these priorities for access when they discussed the foot-care needs of their partners or the people they cared for.

"Well because my wife is diabetic and therefore is automatically expected to be under care with her age, she's 88." (Arthur, 90)

"I don't know how long I'd been going, they [*doctor*] just said that you know, when you get to a certain age, I don't know whether it was 70 or whatever, we had a note saying that you know, to go to the podiatrist if we needed to go." (Anne, 78)

A frequent experience for the participants was how their age affected other peoples' responses to them, including previous contact with medical services. These experiences were rarely positive:

“Well when you’re young and enthusiastic it’s different...you’ll probably hope that if you’re lucky or unlucky you’ll be old one day and you’ll find that you’re treated differently...it’s shattering. I mean because the thatch is a bit thin on top doesn’t mean to say there’s nothing in the attic underneath but you’re treated as though there is.” (Molly, 81)

“...when you’re old, people are apt to think perhaps you don’t know what you’re talking about or you’re a bit dim or you shouldn’t be having a say...even the family have been inclined to be a bit like that you know... ‘well you shouldn’t be worrying about this’, and different things... and you do get different people treat...will say, well even the doctors, not my doctor, but I have had a..., you know, where it’s ‘oh well it’s your age’, and they don’t want to know because, well it’s your age.” (Gwendoline, 79)

Some participants chose to follow their own view on medical advice given. Others used their age as a reason to divest themselves of any responsibility for their foot condition, in a ‘*handing over*’ of their foot-care. The ‘handing over’ of foot-care back to the podiatrist was indicative of a general theme that older people felt ‘vulnerable’ in its widest sense.

“Well I had a very good doctor once, who did advise me to stop smoking and I said alright, if you think so then I will, I’ll give up drinking too. He said [*participant’s name*] I’d never advise a man of your age to give up all his vices at once...so I stuck to them all!” (Tom, 87)

“If I’m asked to do anything I say oh no I’m getting rather too old to take responsibility for anything.” (Maggie, 84)

The participants indicated how their age influenced their ‘*feelings*’ and their ‘*interaction with others*’.

“Well I mean, you get tired with old age anyway don’t you I would think. Oh I do get irritable I must admit [*husband also talking*]...” (Iris, 80)

Participants also linked their age to ‘*general concerns*’ and ‘*worries*’ that affected them.

“...I'm scared stiff with these kids, if they can see a man, an elderly man, walking like that they might take advantage.” (Frank, 86)

Examination of the participants' texts highlighted that their 'social activities' were clearly affected and restricted. A participants' age was cited as, the commonest cause of '*infirmary*' and a '*diminishing circle of contacts*'.

“...But, apart from that, when one of them retired or when one of them was seventy or something, we used to have a lot of social events didn't we. We were invited to everything weren't we, everything? So, we had a good social life up 'til a few years ago...but, as I say they're all gone now.” (Helen, 80)

“...it's very sad, that's one of... the rotten things about getting old you know, when you lose your friends and family. (Violet, 92)

Any discussion on social activities and relationships often made participants' discuss their own age and '*own mortality*' a theme that required sensitive questioning from the researcher.

“...he was going to funerals for two years constantly, weren't you [*Albert*]? ...though [*person's name*] was just about your age when he died. Oh no, he was eighty when he died, but as I say, they're all in that age group and they've all gone.” (Helen, 80)

It was identified at the beginning of this chapter that participants' initially expressed they did not feel they had much to say. However, when a participant began to discuss their foot-care needs and described its effect on their lives, they consciously acknowledged a resolution to their foot-care needs had increased in '*priority and value*'. Leder (1990) identifies that an individual is often unconsciousness of their body until some part of it becomes dysfunctional, when he describes the conscious acknowledgement of a faulty body part. This conscious acknowledgement is especially relevant when considering the views of the participant on the benefit(s) of a podiatry intervention. Participants' suggested one of the benefits or successful

outcome of a podiatry intervention was an improvement in their sense of '*well-being*', which it can now be stated, will not be acknowledged, until a person is conscious of their foot problem.

"...not only does it cramp your style [*painful feet*], but it affects you in one way. You just don't feel like doing anything, but when it has been attended to by a podiatrist your whole life changes and your mind, you're more alert and you don't think about your feet, whereas if you've got anything wrong with you're feet and you're going around like this, ooooooooooh, and this is the problem. The thing is it's in the mind, ...if you've got nothing wrong with your feet you can really go to town and do all the things you want to do. Then you have to have sticks you see, and when you have sticks you're going aaaaaahh [*groan type noise*] you start to look and feel your age...and can't be bothered." (Sylvia, 76)

10.3 Conclusions

The views of the group of participants' in this study were many, wide and varied. It is difficult to draw a straightforward conclusion to the group as a whole and perhaps this is because the research is seeking the views of a significant number of individuals.

A conclusion drawn is that foot-care needs are not at the forefront of the participants' minds. However, when the individual foot-care need begins to affect the individual's daily living activities the priority and value of a podiatry intervention increases noticeably. While recognition of specific 'medical' foot-care needs occurs through the application of the medical model framework, the issue of participants' expectations, priorities, and values only occur following the application of a biopsychosocial approach. The following chapters, eleven and twelve, examine the texts of the participants with in a medical and biopsychosocial framework to support the above conclusion.

This concludes the general findings describing an overview of the participants' or older people in this study. In the next two chapters, the focus is on the detailed findings from a medical and biopsychosocial approach to the podiatry career.

Chapter Eleven

Medical Model Findings

11.1 Introduction

This chapter examines the findings from an interpretative phenomenological analysis of the participants' texts, across the structure, process and outcome sections of the podiatry career, taken from interviews before, and after the initial podiatry intervention. In chapter five, the medical model approach demonstrated a focus on objective and scientific signs and symptoms that reduced the individual to an illness or disease. The medical model approach was described as, both 'mechanistic' and 'reductionist'. A comparison of the findings from this chapter will be made with the findings of the biopsychosocial approach to the podiatry career described in chapter thirteen. Chapter fourteen will draw conclusions from a comparison of the two approaches.

11.2 Medical findings - 'structure'

Following the presentation of the podiatry profession in chapter two and the demonstration of the professions operation within a medical model framework in chapter five, it was claimed that 'access' to podiatry services and the 'identification of foot-care needs' were the two main themes anticipated to be contained within the 'structure' section of the medical podiatry career.

Medical model approaches to the podiatry career did indeed begin with a significant number of the participants identifying their '*access*', to podiatry services to be via their General Practitioner (GP) despite the podiatry service operating a self-referral policy. A frequent perception was that

the General Practitioner was the gatekeeper to podiatry, and other healthcare services. However, this did not mean that participants were adopting the ‘sick role’. Most participants questioned the relevance of medical issues when linked to ‘their’ expectations of the podiatry service.

“Well, it’s very difficult I think for a patient to interpret to a doctor the level of concern that *[a person]*, has for his own condition and if the doctor doesn’t see it your way then you just become part of the normality of the process and you move along very slowly on the escalator” (Arthur, 90)

Some participants considered they were ‘*eligible*’ to access NHS podiatry services by citing their medical condition or age as relevant criteria. In most circumstances, the participants felt that either their age or medical condition should be the principal factor to gain access to NHS Podiatry Services. Other participants questioned their eligibility to the NHS Podiatry Service, feeling that there was a certain amount of ‘serendipity’ to access a theme picked up later in this chapter.

Participants frequently describe visiting their GP for a condition other than their foot problem, but it is during this consultation a referral to the podiatry service is initiated. This would suggest that the identification of ‘*foot-care needs*’ are by a medical professional and not necessarily generated by the participant. The association with a medical practitioner also adds legitimacy to the referral. Participants’ demonstrated a reluctance to acknowledge that they had a foot-care need. The reasons will be expanded upon in a later section. There also appears to be a sense of serendipity in the visit to the GP, with foot-care needs being identified subsequent to some other ‘medical’ reason. This introduces the concept of a ‘*hierarchy*’ in the acknowledging of foot-care needs by participants, and that it is the medical professional, not the participant, who is responsible for identification of foot-care needs. However, this ‘medicalization’ of the

diagnosis of foot-care needs presents differently when examined from a biopsychosocial perspective.

“Well I didn’t, it was the doctor, Dr *[named]* who told me it was arthritis and she said I’ll get you an appointment for the foot clinic because I think they might be able to help you.” (Eileen, 80)

“I thought I’ll call in the surgery and ask them what the procedure is for the podiatrist because I know no-one who’s been.” (Jessie, 83)

Some participants perceived access as a simple process via a health professional. The theme that podiatry is perceived as something ‘*simple*’ is developed in the ‘process’ section of this chapter. The GP in their role as ‘*gatekeeper*’ are perceived by the participants to be able to influence what intervention is provided, and the length of time the participant waits for the intervention. The GP is perceived to have ‘power’, and is therefore placed higher in the professional hierarchy than the podiatrist at this stage of the podiatry career.

“I’d been seen by my doctor and he arranged for the appointment. I don’t know whether if I’d have gone down to see the podiatrist down there..., whether I would have had a quicker appointment or not. I think the doctor, my doctor, got me the quicker appointment.” (Cyril, 83)

On numerous occasions participants cited GPs as attributing participants’ health problems to their ‘*age*’. In this study the theme of ‘age’ is similar to the theme of ‘hierarchy’ in that it is a continuous theme across the podiatry career from both a medical and biopsychosocial approach.

“...I’ve heard a lot of people say, well they went to the doctors with such and such, and the doctor said ‘oh well it’s your age’, and they’re not into any symptoms because you’ve reached the age where it doesn’t matter.” (Gwendoline, 78)

Gwendoline uses projection rather than her personal experience above, but the GPs dismissal of an individual’s needs reflect the application of the medical model approach where those

individuals who do not have a recognised disease or illness, are dismissed with the ‘diagnosis’ of ‘its your age’.

When examining foot-care needs from a medical model perspective, it is evident that psychological and social elements are contained within the participants’ statements. These become more understandable when examining the participants’ perception of their foot-care needs, because most of the participants do not perceive them to be ‘*health*’ needs or specifically ‘*medical*’ needs. Acknowledgment of these broader elements reflects that once the researcher had accepted and worked with the concept of the biopsychosocial model, the restrictive nature of the medical model approach became more obvious.

Most participants recognised when they had a foot-care need, even if it did not rate high on their priorities or values but, they utilised the perceived ‘power’ of the GP to legitimise a referral to podiatry. When participants acknowledged a foot-care need they nearly always tried to ‘*resolve the problem*’ themselves before seeking medical attention. This demonstrated in some participants a reluctance to visit their GP. Whether, this was because they felt their foot problem was not important enough to bother the GP, or whether it was because of their distrust of the medical profession, or for some other reason will be explored later in this chapter.

Understanding the participants’ expectations was part of the primary research question. One of the common ‘*expectations*’ of the participants’ was that their GP would resolve their foot-care need if the podiatrist could not.

“Well, I mean, if I was really crippled with it for any reason I would have gone back to the doctors, but when I say really crippled, I mean, I was for about a week or ten days as I told you till I could get it better.” (Elsie, 80)

When questioning participants about the role of the different professions in meeting their foot-care needs, support was given to the concept of a hierarchy of health professions. Participants’ place the GP at the pinnacle of a hierarchy, with the doctor’s view frequently taking precedence over what the podiatrist may have said about their foot-care needs. However, foot-care needs along with other needs of older people are also felt by the participants to be included in a hierarchy.

“Well it may be, but it’s perhaps the knees and eyes and ears and things of that kind are not more important but more pressing in the conditions of people..., are more prevalent in the malaise of the elder population.” (Arthur, 90)

The ‘*influence of doctors*’ over ‘their patients’ cannot be underestimated. Participants when they visit their doctor appear to be in ‘patient role’ and happy to take the advice of their doctor and as Marjorie recounts some, maybe inappropriate, personal comments.

“One doctor said to me years ago he says..., he says you’ve, when I said about dancing, he said yes you look as though you’ve got the legs for it.” (Marjorie, 79)

Following Marjorie’s visit to her doctor, she describes below her reluctance to attend for the intervention, because she feels that her foot-care needs are minimal. This introduces the theme of ‘*acquiescence*’. This form of acquiescence is a theme that appears before and after the podiatry intervention. Acquiescence, it was suggested in chapter three may be linked to this generational stage in the life course. Closer examination of the participants’ texts did not always mean they had an actual foot-care need, some participants felt obliged to attend, following their doctors instructions. This supports the view that the doctors’ power influenced the participants. There

were however, a few participants (Frank, 86), who described their reluctance to visit their GP. This suggests that in a few cases participants' access to podiatry was down to '*serendipity*'.

"I never go to the doctor until uh, I'm really bad. In fact, I look at my medical book first to check it out myself..." (Frank, 86)

Participants questioned the link between podiatry and medicine, as most appeared to consider their foot-care need as separate to their medical conditions. This is in direct contradiction to the podiatrists' perspective, whose focus is on medicalizing foot conditions as part of meeting eligibility criteria for NHS podiatry.

"Far as I'm concerned feet are feet and that's it. I am sufficiently aware that with a diabetic your feet are likely to deteriorate with nerve end shorting back, and you lose feeling in your feet and subsequently you can finish up with amputations." (Basil, 84)

Only six participants talked about specific medical conditions [*diabetes*] and their effects on the feet. Other participants spoke about their relatives or other members of the family with medical conditions and their effects on the feet. The participants clearly articulated a hierarchy between their medical condition and their foot problem.

"I'm almost sure she [*grandmother*] had a least one removed [*a foot*] and that was donkey years ago and she was diabetic as well and I think her, one went gangrene so perhaps that's why she had it off..." (Elsie, 80)

This perceived lack of a link, by the participants, between medicine and podiatry, lead to questions about their perceptions of podiatry a theme titled, '*conception of podiatry*'. In the participants' view, podiatry was perceived as subsidiary to the medical profession in the hierarchy of healthcare professions.

“...Oh god, if you can’t learn something about a foot in three years time my goodness me, I would think you’d be bursting with it.” (Jimmy, 78)

This was possibly because very few participants expressed the view that their foot problem was affecting their wider health condition or that they were aware of the direct effects it may have on other parts of the body.

“I find that if my feet are not paining, and they’re not rubbing, and there’s nothing wrong with them, I can walk straight along, and really you know hit the light fantastic. Whereas if you’ve got something wrong with one foot and not the other you’re like this [*sharp/deep intake of breath again*], or you’re this way you know, if it’s on this foot you go this side and it knocks your hip out.” (Jimmy, 78)

Therefore, while some participants acknowledged the potential link between medical conditions and their feet, most separated the medical condition from their foot condition, particularly if the medical condition did not appear to directly affect their daily activities. Participants who did recognise that their current medical condition could affect their feet felt that the podiatrist had a role in referring back to the medical professional when their condition changed, which supports the view of a hierarchy in the participants view between the podiatrist and doctor.

Another ‘expectation’ of the participants’ was that the podiatrist therefore provided ‘*maintenance*’ or a ‘*watching brief*’ rather than a medical diagnosis described in the medical intervention, chapter five. It appears that the podiatrist medicalizes the participants’ foot-care needs and the responsibility for the task passes to the podiatrist.

“...Oh, just regularity. Regularity and watchfulness over a dry condition, which the person who’s treating me would notify me, or the vascular people. I mean I’ve had this experience in the past that the watchfulness of the podiatrist gives rise to advice to other sections for attention and certainly I could take that in my wife’s case of watchful all the time for diabetics and the condition that alerts them to other things.” (Arthur, 90)

Moving from the participants' expectations to their specific foot-care needs moves the research back to medical model issues and a specific focus on the foot. From the interviews undertaken, participants' 'medical needs' focus on specific parts of the foot and are separated into the following groupings: Toenails, skin problems including hard skin and corns, toe and foot deformities such as bunions and, hammer toes. These are foot conditions labelled 'medical needs' by podiatrists.

The most commonly identified foot-care needs were problems with toenails, and the inability to cut them. Frequently, these two common problems were the reason participants contacted the podiatry service. There was an expectation by the participants that the podiatrist would undertake the task they could no longer perform. The reasons participants gave for this ranged from physical conditions, such as toenails being too thick, or other medical problems associated with getting older such as failing eyesight, arthritis, or being unable to get down. Some participants cited other medical problems they perceived as more serious and beyond their skill. Here we see a switch from the participants wishing to 'self-care' for themselves to being dependent on the podiatrist.

A significant proportion of the participants experienced problems with undertaking toenail cutting expressing numerous reasons for being unable to undertake what the participants perceived as a relatively short and '*simple task*'. Most participants' requests were for practical help, either because they perceived they did not have the appropriate tools, physical inability or just not wanting to cut their nails themselves.

"Well not big problems no, they're not big problems, well I just wanted me nails done"
(Pamela, 85)

“Well simply the trimming of the nails to an appropriate length...” (Arthur, 90)

“Yes, it’s a sort of straightforward job isn’t it really so I mean I haven’t got me toe off or anything I mean...” (Mary, 83)

“I mean it’s a simple and short procedure and I’m sure quite a lot of elderly people wouldn’t mind paying a fee to have it done” (Kenneth, 75)

“This is a very simple thing [*foot problem*] compared with that [*medical condition*] ...very minor” (Jessie, 83)

Other participants connected their medical condition to their inability to cut their own toenails. Citing a medical condition gave participants ‘permission’ to prevent them from carrying out this task because it introduced the theme of ‘*risk*’. This suggests that participants’ expectations are therefore that the podiatry service will meet their foot-care needs by providing a ‘task’ for something they used to undertake themselves but through a ‘medicalized’ risk are no longer able to perform.

11.3 Medical findings - ‘process’

The medical process section of the podiatry career was presented as encompassing clinically effective interventions, assessment and diagnosis (see medical model diagram, p.184). In a medical model framework, a number of participants have already indicated that they see this as the role of the GP. Some participants described their experience of the medical profession as also operating within different hierarchies and as already suggested they clearly place foot problems at a lower level within this hierarchy.

“It’s not that interesting [*feet*], you’ve got to have something really interesting before they’ll [*doctors*] sit up and take notice sort of thing.” (Rita, 75)

Initially it appeared as though the participants' early expectation was that they would seek advice to continue to undertake a task, whereas after the intervention phase the participants' expectation clearly changed to the podiatrists' solely undertaking the task. A medical assessment or making a diagnosis was not part of participants' expectations mainly because they had often already made a decision on what the foot-care need was.

“...’cause I knew that the big toe, the nail was growing inside the skin and I was wondering if they might say that you've got to have the nail out.” (Frank, 86)

“...well if you go to a podiatrist you would expect them to cut your nails, don't you?” (Iris, 80)

At the intervention, participants therefore expect a '*task*' to be undertaken. If the participant perceives the intervention and task linked with 'medical' elements, it gives the intervention greater credence. In some cases, participants expected the task to lead to pain if the actual foot-care need was painful. Participants then showed great surprise, if not relief, when the task was undertaken painlessly. An experience of a painless intervention raises the level of the '*skill*' of the task performed by the podiatrist in the view of the participant. This level of skill was not one of the participants' earlier expectations.

“So I was surprised when she did look at my nails and just well one was ingrown, but she managed to cut it to prevent it getting worse and it didn't hurt at all.” (Frank, 86)

Participants' perceived the task required as something easy and simple to undertake. Jimmy (below) introduces the theme of '*time*' into the process phase which indicates an expectation that podiatry interventions are not only easy and simple, but they can be undertaken '*quickly*' as well.

“...but this is what happens in podiatry, just go for one session, ten minutes and it's magic, it was for me anyway.” (Jimmy, 78)

Participants appeared to be reluctant to admit to having a foot-care need. Frequently, a significant period of time appeared to have passed before the participant sought help for their foot-care need, therefore by the time the participant sees the podiatrist, the necessity for intervention has increased in '*importance*' for the participants.

“...I’d suffered it two or three weeks, tried everything, couldn’t get any satisfaction so I thought well I’ll have to go to the foot clinic...” (Gwendoline, 78)

“Oh, it’s become a priority now.” (Norman, 86)

When the doctor has made the decision to refer to a podiatrist, this authenticates the '*priority*' of foot-care need for the participant. If the foot-care need is linked to a medical condition this increases the priority further.

“...and all I want to do is to see the Podiatrist... to find out if that is an in-growing toenail, whether I’d have to have to have it cut or stop it going septic or I don’t want to get blood poisoning or anything like that.” (Cyril, 83)

As participants perceive the task required as something that is quick and simple to perform, when it has increased in importance, their expectation is that it should be undertaken immediately. This raised expectation by the participants creates the potential for discontent with the podiatry service. The level of priority appears to rise for participants when they leave their foot-care need to advance to a stage where the condition is either very painful or the condition of their feet causes embarrassment.

Along with the already identified theme of image, participants appear to reflect a '*personal*' nature to their foot-care needs. Specific analysis of their expectations identifies that asking other people such as relatives or carers to provide the task of 'simple' foot-care, made participants

respond that their foot-care was a very ‘personal’ matter for them, and not something they would ask others to do. This theme is expanded in the next chapter when a biopsychosocial approach is applied to the personal nature of individual’s foot-care needs.

“No, it is rather embarrassing to ask somebody to do. Your feet are a personal thing aren't they? *[laugh]*.” (Kenneth, 75)

Following the ‘medicalization’ of their foot-care needs, participants’ were concerned that their foot problem would affect their current medical condition.

“...I can’t help my varicose veins because of my condition, and what is this thing on my ankle I had these two huge lumps on both ankles, now that’s part of my feet isn’t it?” (Ellie, 85)

At the intervention phase, participants linked the task to medical issues and in particular pain, although pain of course also has psychological and social dimensions. There was an expectation that the podiatrist would make the foot pain free with their skill in applying padding and dressings.

“My toes get terribly sore, they feel as though they’re stiff as though all the ligaments and everything in my feet are stiffish, and the pain at times is terrific... I have had corns, and my toes are all bandaged up now.” (Molly, 81)

Identified within the medical model chapter, high technological diagnostic equipment raises the profile and ‘expertise’ of the profession. The participants perceived an increased level of expertise in the podiatrist when they used technical equipment. Unfortunately, in the wider NHS, podiatry is perceived as a low technology service. However, when equipment is involved, the podiatry intervention moves up the hierarchy in the participant’s view.

“She used an amplifier with a microphone on it you know so she could count the pulses in your feet to see how they work...” (Agatha, 81)

As an addition to this, participants also appear to gain in ‘*confidence*’ with the podiatrist and intervention if equipment is involved, even if this makes no difference to the outcome of that intervention.

“I feel a bit more confident with the other one. She's got more gadgets and things.” (Molly, 81)

“...very thorough checked everything, the general condition of the feet, asked all the questions and used her little scanner to make sure that I got a sort of pulse in the foot.” (Kenneth, 75)

“I think X-rays do show up a lot, I think you feel satisfied that you’ve looked inside, well somebody’s looked inside to see what is going on.” (Valerie, 83)

In Kenneth’s statement above we can see elements of the ‘medical consultation’ described in chapter five, taking place. The asking of questions and use of equipment enables the podiatrist to elicit relevant medical information to make a diagnosis. Valerie (above) has clearly been influenced by the medical model concept, as she perceives the problem is within the individual, and only the medical professional is able to identify it.

A number of participants discussed their experiences of having cancer, whereas others discussed the wide range of surgical operations they had undergone. Some of the details of the experiences were frank and intimate and it would be inappropriate to discuss these here. However, this type of discussion is typical of the type of ‘*relationship*’ the researcher and podiatrists have with participants, in that once the participants feel confident enough in the professionalism of the researcher/podiatrist they will divulge these details through the medical assessment, although participants’ do not always make the link with why this is required.

It is therefore questionable why participants provide this information so freely. What relevance do participants see in providing this information to the researcher and podiatrist, especially when podiatry is at a lower level in the hierarchy, compared with medical interventions?

The key to this phenomenon is the participant-podiatrist relationship which will be expanded upon later in this chapter. The participants probably accept that podiatrists are interested in medical issues following the medical consultation. This suggests that when podiatry operates within the medical model framework, participants accept podiatry is contained in a medical hierarchy but podiatry is secondary.

Some participants discussed surgical operations undertaken on their feet. This was probably because the participant perceived it as relevant and having a connection to the podiatry task to be undertaken. Participants perceived having an operation as quite a different concept to a podiatry task. However, there are comparable themes between a surgical operation and a podiatry intervention; one of these is '*image*'. Agatha's comments below give an early indication of the image element that is evident in both medical and biopsychosocial frameworks.

“Yes I've had this knee done and that was the scar you see, beautiful, beautiful.” (Agatha, 81)

Other participants made the link between specific surgical operations and the after effects it may have on their feet and mobility. Exploration of the concepts of health and illness in a medical and biopsychosocial framework (chapters five and seven) were considered relevant to this study following comments made at the podiatrists' focus group. The podiatrists' clearly identify their role as one of a 'healthcare' provider, however, participants found this a concept difficult to relate

too. When questioned about their health in a medical model sense, they demonstrated a different perspective to the podiatrist's view.

“Well it's difficult for a lay person to distinguish between the two. I mean, I would call my tummy trouble a health problem because I've got to keep having medication for it all the time but, I mean, I didn't have it years ago and it's something that has developed, it doesn't seem to make me be in poor health...” (Elsie, 80)

While participants did not make a direct link between their foot-care needs and health and illness, they did make links to psychological aspects. Discussion of these concepts also appears in the 'structure' and 'process' sections of the biopsychosocial findings.

Some participants attempted to give an answer to the question without really understanding the concept, or being able to make any links. In some cases, (Helen), makes comments attempting to link health and foot-care needs.

“...no, 'cause, I'm quite healthy really I don't have any problems at all really.” (Anne, 78)

“...because it definitely affects your health if your feet play you up like that.” (Helen, 80)

When participants' were asked how their foot-care needs '*affected them*', they tried to link their foot problems to their health but as previously presented they actually linked their foot-care needs to other issues such as their age.

“...well, it's an ancilliary part of general health [*foot problem*], it could be more increasing as you get older of course...” (Jimmy, 78)

“...well a health problem? ... no it isn't like that, no, I was born with it you see and it's just got a bit of a nuisance as I've got older.” (Elsie, 80)

Image was a general theme identified earlier in relation to medical interventions. The theme of image appears again in the medical context in relation to the '*appearance*' of the professional. For older people it appears that the way professionals dress is also an important factor for them. Interestingly, participants expected podiatrists to appear and act like doctors and nurses, but when the podiatrist was female, they frequently referred to her as 'nurse'.

"I always expect medical people to look the part. If they turn up in their shirt sleeves, man or woman or doctor, they're not so sure, I know it's not the modern way of looking at it, oh you can dress casually. As far as I'm concerned medical people and the nurses such as she they ought to look the part... as far as that one is concerned you get the feeling that she knows what she's doing. I imagine she always puts on surgical gloves." (Basil, 84)

This may be a generational phenomenon, but for some participants, once they had confidence that the podiatrist was a 'medical professional' denoted by their uniform, and the undertaking competently of a task, they were more likely to take notice of advice and to act upon it.

"...wouldn't say it's going to be practical I wouldn't say it's going to be possible, but I shall jolly well try to do it because she [*podiatrist*] said so." (Basil, 84)

The hierarchy between medicine and podiatry becomes more apparent during the process section, with podiatry always coming second to medical matters. Examples of the hierarchy in the participants' comments were identified when they were asked about when the foot-care need arose. This specific issue, is also closely connected with, 'image' and 'concept of podiatry'.

"You only think anything about them if you do something to 'em [*laughs*] like you know, break your toe or something." (Norman, 86)

"Well, to be quite truthful in my life the podiatrist doesn't play any part" (Robert, 87)

"There's nothing that's really sort of life threatening [*related to feet*]" (Maggie, 84)

While Maggie above does not perceive her foot-care need within a medical model framework to be life threatening, within a biopsychosocial framework, foot-care needs can be perceived as *'life-style'* threatening, a theme that will be developed in the next chapter.

Participants' concept of podiatry is clearly very different to the podiatrists. This concept initially presented itself with the expected role the podiatrist would perform.

"I mean for anyone with bad feet that service is very good because I think people think the main thing is just cut nails and do corns..." (Agatha, 81)

Cyril below attempts to define the difference between podiatry and medicine.

"... you find majority of people say if they got anything wrong with them up from the knees upward it's the doctor but nobody bothers to say go to see a doctor for having your feet" (Cyril, 83)

Even though the participants do generally hold doctors in high esteem, this may be a generational phenomenon. When asked directly, some participants were prepared to defend the medical profession despite evidence to the contrary (at the time of the interviews there were some high profile medical cases in the news, i.e., Dr Harold Shipman, Bristol children's heart operations).

"Why do doctors have to be regarded as infallible, they're not infallible they're humans. They've been educated, usually well educated in their science but they can't be expected to be infallible, no-one's infallible, they're humans" (Tom, 87)

For balance, other participants were prepared to criticize the medical profession in general terms, particularly during the process stage. Participants gave examples of personal experiences with the medical profession that were not always positive and related to the 'medical consultation' described in chapter five. Participants' were however, all united in offering an indication of how

medical model framework because the outcome of podiatry interventions usually result in long-term interventions based on maintenance and this is what participants state they require. The participants have indicated that they regard the meeting of their foot-care needs as requiring podiatry services to provide maintenance and long-term care. Therefore, the podiatry profession will have difficulties when attempting to measure its outcomes. Participants' perception of successful podiatry outcomes are as follows:

“.....as long as you keep it at bay, I am a great believer in going back every so many months and even if it only it takes say ten minutes.” (Sylvia, 76)

“No, except gratitude at getting into the system and now on some three months regularity because this is the problem with the lack of circulation there's lack of growth in the normal sense. It is therefore slower and three months might be the right period and so I'm simply glad to be on the treadmill as it were.” (Arthur, 90)

“... and keeping an eye on them so that I don't get an ulcer.” (Maggie, 84)

Participants' therefore identified successful outcomes of the podiatry intervention as the '*maintenance*' of the feet in a '*pain free*' state and '*prevention*' of further '*medical problems*' with the feet. As anticipated in chapter two, other successful podiatry outcomes included '*reducing pain*' that in turn improved participants' '*mobility*'.

“Well I think this we're going down there and see that young lady and it has been a success. I'm able to walk now without pain.” (Cyril, 83)

“Fine, I was chuffed oh yes I walked around I said 'oh that's better' you know. I said at least I can put the heel down and I couldn't do it before I was tiptoeing on that one foot.” (Ivy, 82)

Pain, was identified by the podiatrists' focus group as a potential foot-care need for participants. Generally participants initially tended to medicalize their pain rather than consider it as a foot-care need and linked it to the taking of medication and requiring medical management. This

probably explains why a significant number of the participants' had experienced foot pain for sometime before seeking help and when they did, they contacted their medical practitioner. Participants occasionally perceived the pain in their feet to be self inflicted and they could make the situation worse if they intervened.

“...well I'd make it worse and make it extremely painful yeah that's for sure, anything to do with your feet, anything wrong with your feet is painful and I've had this on the best of medical advice too...” (Jimmy, 78)

If the participant had attended the first podiatry intervention with pain and it was relieved, there then followed an anticipation that treatment would need to continue at regular intervals to maintain the feet in a pain-free state. However, because the participants' perceive the likely recurrence of their pain, they were reluctant to seek 'discharge' from the podiatry service. The ability of podiatrists to relieve pain is therefore an important medical outcome. Acknowledgement is given that the relief of pain brings other subjective benefits, not necessarily acknowledged in a medical model framework. Maggie (below) identifies subjective benefits such as feeling better.

“...it was uncomfortable, and they felt a great deal better since my first treatment and I'm looking forward to my second to keep it going.” (Maggie, 84)

As in the process section, some participants cited their age as if this were a criterion for continual interventions. At the medical outcome stage of the podiatry career, there is an expectation, and even requirement, from the participants that ongoing treatment will be necessary. However, there were a few participants (Rita), at the outcome stage of the medical podiatry career, who wished to retain some control over their interventions.

“But I personally think I ought to go on a three monthly list which would be more sensible now I'm getting older.” (Basil, 84)

“....and I object to people in the Health Service making appointments for me deciding when I should go and see them but if I want to go see them off my own back ‘oh no you can't come and see us you've got to wait’”. (Rita, 75)

Following the intervention, the resultant pain-free feet often appeared to give participants more confidence in the professional, but this still did not remove the participants' impression that it was a routine, simple and quick task to undertake.

“...she gave me confidence to feel that, you know that she would do more so I was pleased that these two big toes don't hurt anymore...” (Agatha, 81)

This confidence in the podiatrist, by the participant, encouraged the expectation of podiatry interventions as a regular and long-term occurrence in order to maintain the feet in a pain-free state. To give balance to this outcome section, not all participants expressed interventions that had been successful. This most frequently occurred when expectations were unmet:

“I didn't come away with plasters on the soles of my feet or patches on the side where I've been cut or anything.” (Basil, 84)

“...and one or two of them have had this sometime ago, have had disastrous experiences when people have dug far too deep and make things bleed.” (Maggie, 84)

Clearly an expectation was for a task to be performed and when the podiatrist did not provide what the participant considered an appropriate treatment or dressing, the participants considered the intervention had an '*unsuccessful outcome*'. If the podiatrist requested the participants to undertake a task for themselves, but the participants considered their initial foot-care need was an inability to undertake tasks, this would inevitably lead to an unsuccessful outcome from the participants point of view.

they wanted to be '*personally treated*' and this raises an important issue for the participants, the '*participant-practitioner relationship*'.

“There’s one thing about the medical profession that I can’t quite understand, you can go to them and you can say to them... is it a possibility that so and so happens, well he’s fixed his ideas but they can’t move... ” (James, 79)

“I think this is in every department of care. I mean we’re used to this about doctors who don’t have a good bedside manner or something of that kind and I think a lot of problems are created in the health service by this lack of understanding or lack of bonhomie between the patient and the consultant whoever he is or she is.” (Arthur, 90)

11.4 Medical findings - ‘outcomes’

The third stage of the podiatry career relates to ‘outcome’ which normally arises as a result of the process section of the podiatry career. This requires participants to comment on their contact with podiatry and the intervention they received. The findings in this section solely relate to information provided by the participants at the second interview.

It is important to highlight here that there is the potential for the participants to acquiesce when commenting on the service they received. Many may not have wished to appear to be critical of the NHS or podiatry service during the interview. This could be due to either, fear that future interventions may be affected or respect for the podiatrist who provided the intervention. A good example of this was presented by Maggie (below):

“Yes, that’s right but oh no I’m, I’m very satisfied you know with my doctor and generally the NHS. I mean I think they’re very good indeed.” (Maggie, 84)

Outcomes in medical terms have traditionally been measured in episodes of care or numbers of discharges (see chapter five). It was suggested that podiatry services (chapter two) do not fit the

“Well she did but it’s nothing like, you can see it, it’s like a piece of plaster with something stuck over the top. She put that on but it, it comes off at night in bed. I can just about get it on in the daytime. She gave me some more to do it myself but I can’t do it.” (Molly, 81)

Some participants did not always accept the view of the podiatrist or feel that the task had been fully completed by the podiatrist:

“...she did dig it out because she said she dug it out but it looks as if she didn’t like get to the root of it.” (Lillian, 77)

Participants’ expectation of a podiatry intervention was not for a medical model ‘*cure*’ for their foot-care need. Some participants’ acknowledged their foot-care needs were a result of previous medical mistakes, yet they apportion no blame to the medical practitioners, they appeared quite accepting of the chronic nature of their foot-care need, but also expected the podiatrist to maintain their foot in a pain free state for the rest of their lives. Only a minority of participants perceived the podiatry intervention as a preventative measure.

“I know several people that have had it, but mine is a bit of what they call a cock up, not successful at all, now that’s a handicap for me yeah. Now I can’t use the scissors to cut my toenails that’s it now that’s one thing I can’t do, I can’t do my own feet because of this hand as well...” (Violet, 92)

11.5 Conclusions

The medical model approach has been presented as having a reductionist and mechanistic effect on the provision of healthcare. It is therefore not surprising that an interpretative phenomenological analysis of the podiatry career within a medical model framework has provided a picture focussed on medical issues and the foot.

When participants had acknowledged their foot-care needs they considered that either their General Practitioner or their age would give them access to NHS podiatry services. However, when participants' expressed their foot-care needs as requiring the task of toenail cutting to be undertaken, podiatrists either medicalized this task or identified other needs that could also be medicalized.

The majority of participants initially perceived their foot-care need as minor. Frequently, the foot-care need identified was for toenail cutting, either because of an inability to cut them themselves or because cutting of the toenails was linked with a medical risk. Participants felt that these needs were not necessarily a medical need but acknowledged it gave them eligibility to access NHS podiatry services. A significant number of participants also felt that their age was criterion enough to give them eligibility to NHS podiatry services.

The participant's age is a hugely influential factor on the medical podiatry career. A person's age affects their approach to podiatry services and this suggests that generational factors may play a part in the developing understanding of the participants' perceptions of the podiatry career. Where a person is situated in their 'life course' has an effect across the whole podiatry career, even when considered across medical and biopsychosocial paradigms.

In chapter two it was demonstrated that large numbers of people access podiatry services and the incidence of access increases with a person's age. Significantly, not all participants had specific foot-care needs, some participants feeling that their age should be an eligibility criterion for access to NHS podiatry services. While participants recognised that some medical conditions had a potential impact on their foot condition, they placed their medical condition higher in a

hierarchy of needs than their foot-care need. In the participants' consciousness, their foot-care need requires a task to be performed by the podiatrist but it increases in priority with the passage of time.

In the process section of the podiatry career the participants described their requirement for an intervention in terms of medical checks on their feet. This was probably because of the influence of the medical approach adopted by the podiatrist with the emphasis on a medical consultation. However, participants place the podiatry consultation in terms of a hierarchy below that of a medical consultation. They perceive foot-care needs as something simple that is quick and easy to resolve. This led participants to expect the undertaking of a task during this section of the podiatry career but no anticipation of assessment and diagnostic tests as with medical interventions. Participants expected the task to be performed to relieve the problem(s) they were experiencing. Prior to the intervention, participants expected to be able to undertake the required tasks themselves in the future. However, after the podiatrist has undertaken the task, the participant quickly changed their expectation to one of regular and continued intervention from the podiatrist. This change represents a medicalization of the podiatry career under the direct supervision of the podiatrist. If participants are then able to link their foot-care need with a 'medical' condition, this adds further emphasis to the requirement for continued input from the NHS podiatry service. Podiatrists are perhaps unwittingly creating a long-term dependence on podiatry services. There is however, a point early in the podiatry career where the participants' still wish to retain control and influence over the resolution of their foot-care needs. This line is crossed when the participant-podiatrist relationship is formed, and the foot-care needs are medicalized, this then initiates the participants hand over of their foot-care.

The tasks that were expected by the participants focussed on specific aspects of foot-care such as toenail cutting and hard skin and corn removal. Participants' requirement for this was primarily because they felt they were unable to cut their toenails because of either a physical disability or the risk from an associated medical condition. Tasks that participants previously were able to undertake for themselves are perceived as short, simple, and easy tasks, and therefore they are put at the lower end of a hierarchy of skills. If the task undertaken by the podiatrist involves diagnostic equipment, the participants interpreted the podiatrist to have attained a higher-level in the skills hierarchy.

The timing and time interval within the podiatry career, was identified by the participants as being relevant in both the medical and biopsychosocial approaches. At the structure stage of the medical podiatry career, there is no time imperative to get the foot-care need resolved. However, participants tend to leave the requirement for an intervention to the stage when the foot-care need is more urgent, usually because of pain or perceived impending immobility. Linked to this, because the participant perceives the foot-care need as requiring a quick and simple task, their expectation is that the intervention should happen quickly and they should not have to wait.

Primarily, older participants consider a successful outcome to be the provision of long-term maintenance of their foot problem in a pain free state and for the intervention of podiatrists to continue at frequent and regular intervals. This, of course, is exactly the opposite of the medical model of intervention cited in chapter five, that seeks to discharge 'patients' from care by providing a 'cure'. It is clear that the concept of outcome from the medical podiatry career does not match the participants' perception of a successful outcome. The provision of a task was enhanced if participants received additional padding or dressings on their feet. If they perceived

these interventions as assisting their mobility, they also perceived the dressings as a 'short-term fix'. This then supported the participant's view that interventions should be frequent in response to recurring need.

The specific medical model issues of health and illness as discussed in chapter five appear to have no relevance to the majority of participants. However, recognition is given to the participants who were at times reluctant to criticise any 'medical' intervention and appeared to acquiesce on this issue. Whether this was because the participant feared repercussions from the professional or that they felt it would affect their requirement for on-going care was not clear. The participant-podiatrist relationship is clearly important to older people. In taking a medical model approach participants clearly expect the podiatrist to dress in a particular way, and that each professional will perform a particular role within a professional hierarchy. An inequitable 'power' relationship between the participant-podiatrist exists in the medical podiatry career, similar to the doctor-patient relationship described in the medical consultation in chapter five. Participants do not perceive podiatrists as medical professionals. This point is supported by participants not always being convinced that the podiatrist had all the answers and they often clarified or checked information provided with other medical or healthcare professionals. Participants perceived podiatrists somewhere in the middle of a hierarchy between medical doctors and alternative practitioners.

A number of the themes identified in the findings of the medical model approach to the podiatry career are themes that are further developed in the biopsychosocial approach. The next chapter therefore presents these and additional findings in the interpretative phenomenological analysis of the biopsychosocial approach to the podiatry career.

Chapter Twelve

Biopsychosocial Model Findings

12.1 Introduction

This chapter presents the findings taken from an interpretative phenomenological analysis of the participants' transcripts, except this time the analysis is made within a biopsychosocial framework. This approach allows interpretation of both psychological and social aspects of the podiatry career as well as the biological aspects contained in the medical podiatry career.

From the presentation of the podiatry career in chapter eight, the participants' expectations were not identified as being a significant element of either the proposed medical or biopsychosocial podiatry career. However, the primary research question included the concept of participants' perceptions of their requirements to meet their foot-care needs. Identifying an individual's expectations has been found to be a central consideration in understanding and addressing participants' foot-care needs, and becomes more important to the individual in the biopsychosocial approach.

12.2 Biopsychosocial findings - 'structure'

While individuals' expectations were considered in the medical model approach, these mainly related to the expectations of the participant and podiatrist following the intervention. The participants' '*expectations*' prior to any contact with podiatry were identified as an important element within the biopsychosocial model as they help to give an understanding an individual's '*value systems*'. Following an interpretative phenomenological analysis of the texts in a

biopsychosocial framework, it has been found that the participants' expectations are discussed by the participants' throughout all aspects of the podiatry career.

A general theme throughout the podiatry career is participants' anticipate a sense of increased '*well-being*' and generally '*feeling better*'. Both of the following quotes identify psychological and social dimensions to the podiatry intervention.

“Well, looking forward to it because I, it might ease my foot and I'll be better for it.” (Cyril, 83)

“...that's all really it's just that they're uncomfortable and I know they don't feel right, they want some attention that's all.” (Anne, 78)

An expectation of maintenance for the feet was identified in the medical model approach. However, using a biopsychosocial approach, identifies this expectation is linked with ensuring the feet remain in a pain-free state, which the participants perceive will maintain their sense of well-being and feeling better. This view was held by male and female participants.

“Well, just keep an eye on them really, since the toes have gone so arthritic you know I'm worried about them and just recently I've noticed that I've had to get them and I'm hoping that she [*podiatrist*] will give me something to relieve the pressure of the shoes or whatever I'm wearing” (Agatha, 81)

Agatha indicates above that her foot-care needs cause her to '*worry*' but, a biopsychosocial approach enables an identification of a general '*concern*'. The comments below are linked to where Gwendoline acknowledges the hierarchies within healthcare in relation to maintaining life, and urgency with relation to coping with pain, but also this to her own situation, specifically her age.

“It’s a thing that builds up in you. You get scared when you’re old, you get scared, so you panic at the least thing. Now not me, because to me, I’ve said to him, ‘well what are you worried about you’ll either die with cancer or you’ll die with a heart attack’. Now if its cancer that’ll do away with you quick and if it’s a heart attack you just won’t wake up, so what’s the odds? Why worry about it and why worry about each little pain unless it’s urgent?” (Gwendoline, 78)

A biopsychosocial approach therefore begins to help with an understanding of the psychological aspects of individual’s foot-care needs, and insight is gained into an understanding of how this affects participants *‘feelings’*. This perception by the participants’ contributes towards their sense of *‘well-being’* which in turn affects their *‘quality of life’*. Sylvia and James below give an insight into their feelings and what they consider will happen if their foot-care needs are unmet, and states:

“...it [*foot-care needs*], affects your mind as well as your body and how it functions you start to look and feel your age and can’t be bothered.” (Sylvia, 76)

“I think they [*foot-care needs*] affect your mind, I think that’s why I say it’s the primary thing, they cause you more worry, more bother, more than anything else.” (James, 79)

Examination from a biopsychosocial approach demonstrates that participants were concerned or even worried by their foot problem and the future unknown podiatry intervention. This was linked with the participants *‘consciousness of their age’* and effected the participants’ expectation of the *‘priority’* of the podiatry intervention. It appears that participants do not always perceive a resolution to their foot-care need to be vital in its initial early stages. However, as time progresses the resolution of the foot-care need seems to grow in urgency. This phenomenon appears to be due to either, an increase in pain (medical model), the perceived need for a task to be undertaken, or worry. This then has a cyclical effect for the participants’ as time passes the *‘anxiety’*, or worry increase.

“Well, probably be able to walk a lot better. If I don’t I shall say ‘oh well they’re old what else can you expect.’ They can’t do miracles with people my age. (Basil, 84)

“...but then we all are on borrowed time when we get to this age, but they did tell me the tablets I’m on will probably reduce my life by about 6 months.” (Lizzie, 82)

When participants considered their foot-care needs, they nearly always related these to their inability to undertake a *‘task’*, this was identified in the medical model approach. From a biopsychosocial approach participants link the undertaking of the task to *‘image’* and their own *‘personal prioritization’*. Images of feet are often negatively perceived (see chapter two) and this was similar with participants in this study. The *‘value’* participants place on their foot-care need was in the first instance low, mainly because their perception was for a simple task to be performed. However, as has been demonstrated the value of the podiatry intervention to the participant increases with the passing of time. The participants often described a period of time where they continued to attempt to undertake the task, often unsuccessfully, at which point the urgency rapidly rises and the expectation is that the simple task can be undertaken promptly by the podiatry service. *‘Time’* is an intertwining theme throughout the biopsychosocial model and participants not only expect the podiatry intervention to occur quickly they also expect the intervention to take only a short time. This is interesting and is thought to be related to the participants perception of the task being something that they used to be able to undertake, and therefore must be *‘quick and simple’* for a professional to undertake.

The element of time in the biopsychosocial approach is more complicated than it first appears. The medical model approach identified some participants appear to acquiesce when in *‘patient role’*. The biopsychosocial approach widens this view as participants appear to acquiesce when explaining their foot problem and putting it down to their age.

“Well I think they, I think they get worse as you get older really, I really do and of course you get a bit heavier.” (Elsie, 80)

When participants identify their foot-care needs, these clearly have wider effects on the individual. In current podiatry provision participants are normally asked about specific signs and symptoms relating to the feet (the medical assessment process). Using a biopsychosocial approach, wider ‘psychological’ and ‘social’ effects such as the effects on how an individual of their foot-care need that may go unrecognised by the medical model approach are identified.

By taking a psychological view of the theme time, some participants demonstrate a sense of ‘*stoicism*’, despite discomfort or the foot-care need impinging on their activities of daily living. Participants put up with their foot-care need for some time before seeking assistance, despite the clear effect it has on them.

“...you never sort of lose it, you think all the time you’re sitting you can feel them, they’re uncomfortable you know really, but it doesn’t affect me any other way, just mentally I think.” (Anne, 78)

These psychological aspects of foot-care needs are further expanded by Arthur, who describes how once the pain or discomfort is removed, the urgency and value of foot-care disappears completely from the consciousness.

“Well I guess, if one is unconscious of a limb then you’re in good state aren’t you if you’ve got a good appetite you’re in good health it’s rather like that I mean I think it’s all unconscious health really so generally speaking once the niggling pain is removed one is back on track...” (Arthur, 80)

This unconscious aspect of the podiatry career is similar to concepts described by Leder (1990), and developed later in chapter thirteen. This concept is when ailments of the body only take on importance if they have an effect on an individual's normal activities of daily living.

“Well I think, generally speaking you don't realise you've got feet until they begin to tell you they're there... you can't forget you use your hands, they're there, and you use them, and you don't think twice about them. I never think about my feet until I've got an appointment or haven't got it and as soon as you put your feet to the ground they are going to hurt and that tells you can't move without them hurting.” (Violet, 92)

The effects on social elements of participants' lives are also identified as wide and varied. Reduced mobility was cited as a direct result of participants' foot-care needs. Participants' expectations of podiatry were therefore an improvement in their '*mobility*'. Not surprisingly, reduced mobility affected participants' normal daily lives.

“Well, the only thing is I'd like to get out and walk a bit and get his, because he's so unsteady on his feet.” (Helen, 80)

“Well, it just stopped me from doing what, or as quickly as I normally do things. Luckily I've got a little car so I can pootle about in that but otherwise I don't honestly know what I would have done to start with because it really was painful.” (Eileen, 80)

The wider effects of improved mobility on daily living included meeting friends and relatives, but also other aspects of daily living within the participants own home that could effect independence were also identified.

“Yes, it's affected me not being able to sort of go out for well I've got one friend who she likes walking and we perhaps go out and have a bit of lunch. We used to have a walk around but I don't do it now...” (Eileen, 80)

“...and you can't really go out much, it keeps you sitting around in the house because, well for one thing you can't get your shoes on very well and the more walking I've done with the heel probably hasn't improved it...” (Valerie, 83)

12.3 Biopsychosocial findings – ‘process’

In the structure section of the podiatry career only three participants expressed a requirement for just advice to enable them to continue with their own foot-care and therefore remain independent. Examining the participants’ responses within a medical perspective identified a common theme of a requirement of the podiatrist to perform a task and, this was often described by participants’ when their foot-care needs had reached a stage where they felt that the task was beyond their capabilities. Mary below demonstrates that while participants have an expectation of a task to be undertaken, most participants felt they knew what was required.

“I said it was time you went and got some professional opinion, I don't mind doing her feet but I don't want to ruin something where it could be put right” (James, 79)

During the process section, the way that participants perceived the podiatrist considered and dealt with the foot-care need appears to have a big impact on the participants’ perception of the care they receive. This begins to suggest the *‘participant-professional’* relationship is of central importance. The participant-practitioner relationship now begins to appear throughout the podiatry career, within the biopsychosocial framework. Jimmy and Sylvia (husband and wife) have their own positive but differing individual perceptions on this issue, and link it to a consideration of ‘the mind’:

“Well that’s right, well I certainly didn’t feel a thing and everything was super, she took all the pain away that was the main thing.” (Jimmy, 78)

“You see we both think differently, because this is an expert who’s looking after my feet and no, and also it affects this part of me [*points to her head*] and she’s done it I won’t have any trouble and she does a good job and that’s why I like her.” (Sylvia, 76)

The above statement from Sylvia begins to suggest wider psychological affects from a podiatry intervention. How a foot-care need *‘affects’* a participant is an important theme picked up here

as Sylvia (above) is indicating it is more than physical pain that the podiatrist is addressing. Frank (below) also suggests that his foot-care need has a connection with his brain which is interesting because throughout the biopsychosocial examination of the podiatry career, participants appear to connect the effect of the body on their mind. This is in direct opposition to the medical model separation of the mind and body (see chapter five).

“....well, I'm not saying that my problem that I've got with my feet, that's going it's to get worse, I think it's partly through the brain controlling the feet and it's not co-ordinating. That it's going to get worse, it won't get any better, there's no cure for that.” (Frank, 86)

When the relationship between podiatrist and participant is established, and the task or intervention identified, the participants begin to discuss podiatry interventions in terms of ‘*care*’.

“Well as I say I wasn't expecting anything other than that to be done really. I mean what care I got, that was done, and that was what I expected.” (Iris, 80)

“I think if somebody's nice and chatting away to you and you got a very painful thing, they seem to ease all of the pain.” (Cyril, 83)

In chapters five and seven, care was described in terms of ‘healthcare’ and ‘social care’. Care in its broadest sense was a theme identified throughout the biopsychosocial narrative from the participants. Participants perceived care in a number of ways. During the pilot phase of the interview questions development, during a discussion about health and social care, one of the participants stated:

“I don't think about what type of care is provided, when I need care, I just need care!” (Josephine, 75)

The term ‘care’ meant different things to different participants’, and they had no perception of the concept of a division between healthcare and social care described in chapter four. This was

similar with the concepts of health and illness which from a biopsychosocial approach had no meaning for the participants. Participants did express views that led the researcher to believe that their foot-care needs were related not only to their physical health but also to their wider psychological and social needs. For an example, participants expressed '*frustration*' and '*annoyance*' rather than feeling unwell or unhealthy when experiencing a foot-care need.

“Well I don't see it as my health is actually affected it's just that I can't get out and about. It's just that I can't walk.” (Sybil, 83)

“Well it doesn't make me feel ill no. It just makes me frustrated yes ...and maybe annoyed. Well, not even annoyed I suppose, but it doesn't make me ill no... I suppose if it did get worse, if it did and it starts rubbing and all that I suppose it would. I would get frustrated so being frustrated and if I couldn't get out then it would definitely because I feel I'd deteriorate.” (Gwendoline, 78)

Gwendoline describes her frustration with her foot-care need and this suggests the development of the '*personal*' nature of participants' foot-care needs. Tom's comment below presents a slightly different angle on the personal nature of the podiatry intervention as he introduces the concept of a personal image as well as the undertaking of a practical task. This personal image of feet appearing '*respectable*' could perhaps be assumed to be more of a feminine trait.

“Simply cut my toenails and make them respectable” (Tom, 87)

Therefore, once established the participant-podiatrist relationship becomes an essential aspect of the participant feeling 'cared' for. This caring relationship becomes important when considering successful outcomes later in this chapter. The participants' tended to devalue the task performed by the podiatrist, but value the resulting pain-free state and as a consequence being able to undertake daily living activities again.

“...two years ago I was running this house, spring cleaning every year all through the house washing ceilings, god knows what doing the gardening-and now look at me, it's shattering... At the moment, well the silly part about is that part of me feels quite healthy except for the parts that hurt [*indicates feet*].” (Molly, 81)

“...it used to stop me walking, that's for sure, and that's fairly important, yes it did, it got painful and so I was reluctant, in fact there's many a time I would have liked to stay in bed... It makes all the difference to your brain, your body actions, everything...” (Jimmy, 78)

A biopsychosocial examination of participants' responses of the effects of their foot-care problem on 'the self', has already suggested effects to their normal daily tasks. A focus was therefore placed on examining how participants attempt to make adaptations to their lifestyle and activities as a result of their foot-care needs. At times, the effects on participants' social activities were linked into a hierarchy, which led, in the participants' perception to a requirement for '*regular interventions*'. As well as using their individual age as a reason for the foot-care need the participants also cited their '*personal inheritance*' [*in terms of their genes*] and general '*luck*'.

“You see they [*older people*] need someone for shopping and there's so many things that of course I've been so fortunate to be healthy, I mean there's, it's not me, its my good fortune.” (Violet, 92)

When participants' perceive they require a task undertaking to return them to their normal daily activities and a successful participant-podiatrist relationship is in place, the participants begin to '*hand over*' their foot-care. It was apparent that whilst the participants did not always make the link between maintaining mobility, independence and health, it did have an effect in making participants think they could hand over their foot-care. This in turn gave Maggie in particular a reason not to take responsibility for her own health and foot-care.

“If I'm asked to do anything I say 'oh no I'm getting rather too old to take responsibility for anything.'” (Maggie, 84)

A further dimension of the biopsychosocial approach has highlighted the theme of *'personal image'*. This theme varies from podiatrists being able to undertake the task of nail cutting to making toenails look more acceptable and presentable (feet were portrayed as not very pleasant in chapter two), and it applied to both males and females. The presence of these factors enabled some participants to excuse themselves from undertaking personal foot-care tasks. The theme of 'handing over' foot-care becomes a recurrent theme throughout the podiatry career after the initial intervention. In certain situations it was difficult to disentangle the individual meaning of 'handing over'. Some participants may have had an actual physical inability to undertake foot-care tasks, whereas to others, using the broader psychological view cited their age, medical condition or personal distaste to undertake their own foot-care. On the other hand some participants were not sure what was required and were happy for the podiatrist to take control.

“...I’m sure I’ve got the most horrible big toenails I think anybody could ever have, horrible feet, horrible feet” (Marjorie, 79)

“Well the thing is you see I don’t know what I want on my feet. I’m hoping that they’re going to do what is needed.” (Violet, 92)

Therefore, before the participants have any contact with the podiatry service, they spoke of their expectations of tasks to be undertaken, but not for long-term interventions. Following the podiatry intervention the participants’ expectations change. An examination of the process section demonstrates that participants indicated that they were happy to ‘hand over’ the task element of their foot-care to the podiatrist, and for this to become a permanent responsibility for the podiatrist. However, it is important to recognise it is the podiatrist that legitimises the ‘hand over’. This is facilitated by the podiatrist ‘medicalizing’ the foot-care need by linking it with a medical complication, or a demonstrable competence or ability to undertake a task without pain.

“...well no I wouldn't you see because I'm not allowed to cut anything or do anything in case of infection you see. So, I'm not allowed to do any. I mean I wouldn't feel like risking it after being warned you see and that was I was warned not to do any gardening that involved digging or in case a fork dropped on my foot or anything.” (Maggie, 84)

Sometimes the participants' 'handing over' of tasks was quite explicit:

“I told her I wasn't going to do it anymore [*husband for wife*] in case I damaged you and that was that and I'm diabetic and you know you don't like anybody playing with diabetics feet...” (James, 79)

Therefore, it appears participants' 'expectations' of foot-care needs start with an expectation of assistance to continue to self-care, then very quickly in the transition between the structure and process phase, participants' expectations change to a complete handing over of care.

In chapter four, understanding 'the self' was presented as an important factor in understanding the individual. It has been identified that the participants have already presented personal issues in the form of personal image and this was as a direct effect of their foot problems, while others identified how their foot problem affected how they may be perceived by other people, thereby, suggesting a social effect. Frank's comments below demonstrate a participant linking their foot-care need with an effect on his walking that in turn affects his '*self-image*', making him feel he looks old.

“It might do in my expressions, it could do. I suppose it would because you screw your face up somehow. If something's hurting you then, you're inclined to sort of screw up a bit.” (Gwendoline, 78)

“...well, no it's the only problem I've got is my feet really. When I'm walking they don't know where their going. I don't know why, but when I walk I walk as if I'm drunk, I can't keep a straight line. I suppose if I saw someone they'd say well you'll have to use a stick but I don't want to do that, I will think I'm old.” (Frank, 86)

Further examination of the process section within the social paradigm of the biopsychosocial framework, sees participants' identify aspects of foot-care currently not provided by NHS podiatry services (Anne below). How, podiatry services address these needs when restrictive NHS access criteria prevent this form of intervention will form a challenging dimension in the next chapter.

“...well as I say I just want me nails sorting out and you know a bit of massaging and things, that's all really” (Anne, 78)

Interwoven with the theme of image are the themes of '*pain*' and '*time*'. When pain, is examined from a psychological perspective, it was also found to be connected to long-term maintenance.

“I wouldn't say that was anguishing or permanent but was constantly reappearing and alerting me to the fact that time had elapsed since the last treatment and therefore discomfort was increasing as the time went on.” (Arthur, 90)

Reference, was made by the participants to tasks undertaken by the podiatrist that provided only short-term relief. This left the participant wanting more frequent interventions at shorter intervals, mainly because the participants were unable to undertake the task themselves. In some cases this left participants feeling the task had not been completely satisfactorily.

“...I said I thought it was an in-growing toenail and she [*podiatrist*] said something to the effect 'oh you'd get much more pain than you've had if it had been.'” (Jessie, 83)

“I don't think so, they only done me toenails that was all.” (Kate, 78)

Another important finding from the examination of the process section from a psychological and social aspect was that all the participants have a complex, personal support system that helps to them remain independent.

“...the only thing people help me to do, my next door neighbour does my washing for me and then my elder daughter does my feet.” (Kate, 78)

“No, I mean they're neighbours, they're good to me. They do a lot for me and I feel I can't ask them to do any more.” (Dulcie, 88)

This presents an interesting dichotomy in the participants' responses. Previously, the participants' identified that they considered their foot-care need to be a personal issue. It has also been identified that each participant has a complex network of social support from family, relatives and friends. It is perhaps surprising that the participants do not wish this personal aspect of their care to be undertaken by someone who is close to them. There are three possible reasons behind this. First, the participants have identified that their foot-care need requires the task to be undertaken by a competent person. Secondly, the task is too personal to ask a close relative or friend to undertake or finally it might be suggested that the participants' do not wish to be dependent on close family and friends as the requirement for a 'simple' foot-care need to be addressed is perceived to be an early indicator of the participant losing their independence.

The biopsychosocial approach has highlighted the 'personal' nature of the each individual participant's foot-care needs which have included themes such as image, pain and time. Participants' indicated that 'time' as a theme was important for them. Time in a medical model framework can be aligned with the influence of recent high profile government policy on reducing waiting lists (DOH, 1989a; 1992; 1997b; 2002b; 2004b; 2006). However, from a biopsychosocial perspective participants views on waiting, takes different forms. Both Lizzie and Valerie below express concern regarding the length of time they are waiting and not knowing what the problem is.

“...I think waiting when you're like I am, waiting is awful.” (Lizzie, 82)

“But when you’re waiting and you’ve seen nobody that was very, I was horrified I thought surely I could’ve been seen, wondering what it was for two months.” (Valerie, 83)

Although it has been portrayed that participants perceive toenail cutting as a simple and easy task, following the initial intervention, they realise they require these tasks to be undertaken on a regular basis. Participants have a clear view on the frequency of interventions and are also clear when too much time has passed between the interventions. Following the passage of time, the foot-care need becomes a greater priority in the participants’ consciousness. From a biopsychosocial perspective because the perceived task is quick, simple and easy to perform, participants find it difficult to understand why podiatry services have long waiting times between interventions. ‘*Time*’ and ‘*long waits*’ for podiatry interventions, are identified throughout the process and outcome section of the podiatry career, as an important issue for most of the participants. Time between podiatry interventions and the participant’s age are clearly linked in the consciousness of the individuals taking part in the study.

“Yes, and I mean I’m not being funny but when you get to my age tomorrow isn’t any good its today that counts. You’ve got to live today, you can’t think of tomorrow because you’ve lived three score years and ten you’re on a bonus that you can’t sort of say well I am going to do this in six months because you don’t know you don’t plan for six months you live your life as you go. So to wait two months is a long time out of your lifetime.” (Gwendoline, 78)

“The sooner the better because I don’t think any, there’s been any foot, any attention to the nail situation since before Christmas so I’m nearly, it’ll be six months growth and I can imagine the podiatrist sighing when he or she sees it.” (Arthur, 90)

There are recurrent themes throughout the interviews of age, time and health/illness and one of these, particularly linked to being older, was ‘*limited time*’. When discussing health and illness

this obviously raised issues of '*mortality*' and, the effects that medication or poor health had on a participant's life. These issues clearly needed handling with sensitivity when they arose.

"We're all on borrowed time when we get to this age but they did tell me the tablets I'm on will probably reduce my life by about six months." (Lizzie, 82)

"Well I think really probably for my age and comparing with other people, I don't know many people of my age I mean the older you get the less you got because they all start dying off." (Elsie, 80)

The theme of limited time also connects with the previously identified themes in the expectations section, of anxiety and worry. The psychological element of anxiety and worry, are not only linked with pain but also with the fear of getting older. For some participant's (Gwendoline) this brings out the personal sense of 'stoicism'.

"It's a thing that builds up in you. You get scared when you're old, you get scared, so you panic at the least thing... why worry about it and why worry about each little pain unless it's urgent." (Gwendoline, 78)

12.4 Biopsychosocial findings - 'outcome'

The biopsychosocial examination of the structure and process sections of the podiatry career has identified many themes that cross over and are interlinked. Given the biopsychosocial model's holistic nature, it has proved problematic to differentiate and tease out specific medical and biopsychosocial elements of the podiatry career. A problematic element of attempting to understand the participants' views was that many perceived they had little to offer in the way of useful information. This supports the suggestion that foot-care needs are not at the fore-front of the participants' minds.

"I don't think there is. I've probably chatted far too much about unimportant things." (Marjorie, 79)

Despite these difficulties it has been possible to construct a three dimensional conceptual model of the podiatry career which becomes apparent with further investigation within the biopsychosocial paradigm.

The 'medical model career' has been presented as having a clear beginning and end. While podiatry appears hidden from most participants' consciousness, for most of the time, when their foot problems become acutely painful, or it has effects on their psychological or social worlds, then the importance and value, they place on getting appropriate podiatry interventions rises as described in Maslow's (1943), and Bradshaw's (1972) models of needs presented in chapter seven. Very few participants, once they had attended and received treatment from the podiatrist, felt that podiatry interventions had a beginning and end. Robert was the only participant who took a medical model approach and felt that his interaction with the podiatry service was time limited at both first and second interview.

"Oh no, no I mean provided the toe heals up and I can wear a pair of shoes comfortably without it being kind of sore because it's too tight" (Robert, 87, 1st interview)

"....well I know that in the end um this thing will clear up and that will be success." (Robert, 87, 2nd interview)

Robert was very articulate about his expectations for his foot-care needs and was insistent that he would remain independent of the podiatry service. It would be interesting to go back to see if Robert's expectation was achieved in the longer-term.

The podiatrists' in their focus group anticipated that the podiatry intervention would improve participants' mobility. When participants were asked about wider effects on their world, a common response was an increase in their social activity. However, this was often tempered by

the participants citing their age as a reason for some improvements not being as successful as they might like, even if quite unrealistic. Although as Mary (below) suggests, an improvement in her mobility will be limited because of her age.

“Well I have been going into town an extra couple of times you know” (Ivy, 82)

“...I don't walk well anymore which is a nuisance but that's old age I guess unfortunately.” (Mary, 83)

From a biopsychosocial perspective a strong link exists between age and image and a successful podiatry outcome. Podiatry interventions therefore have an important part to play in preventing older people from thinking they have to comply to type.

“I suppose if I saw someone they'd say well you'll have to use a stick but I don't want to do that, I will think I'm old.” (Frank, 86)

Within the concept of ‘outcome’ in the podiatry career, a successful outcome for most participants was the confidence and knowledge that they would be able to have regular and on-going interventions.

“Oh sure on the little toes once they've been cut they last a couple of months and then you think you'd better go and see the podiatrist you know and get yourself booked up again.” (Violet, 92)

“...they've done a good job as long as they keep it up, as long as they keep your nails right I'll be happy.” (Albert, 82)

Linked to the longer term interventions comes the perception that a small and short intervention at regular intervals will suffice in order to ‘maintain’ the feet in a ‘*comfortable condition*’.

“...you're standing on your feet for about an hour while you shop and that's normally somewhat painful depending on how recently my feet have been done.” (Ellie, 85)

Therefore, a *'successful outcome'* for most of the participants after the initial intervention is for *'long-term maintenance'* and that this should be at regular intervals, because it is perceived by the participants as a quick and simple task that does not take up much time. Arthur (below) was accepting of the intervention provided, seeing the podiatrist as the expert person to undertake the appropriate task. He appeared not to expect to participate in his own foot-care. Agatha also had low expectations from the initial visit but left feeling pleased because the podiatrist appeared pleased with her foot condition. This is another example of the importance of the podiatrist-participant leading to a successful outcome in the podiatry career.

“well, good prior advice as to the date to attend, arrival on time so that I'm not late for the appointment and then acceptance of the treatment that follows according to the condition that I've brought to them. (Arthur, 90)

“Oh no, I mean the first time I didn't think they'd be able to do a lot. I didn't know what to expect the first time but what they did I was quite pleased about and I was pleased that she was pleased with my feet *[laugh]*.” (Agatha, 81)

The theme of relief of 'pain' was identified in the medical model approach. The biopsychosocial approach identifies that the participants appear surprised at the instantaneous results of the podiatry intervention, an outcome that goes consistently unrecognised by the podiatry profession. An important biopsychosocial outcome therefore is the *'instant relief of pain'* for 'the self' (the individual).

“I'm talking now not, not for social reasons or anything like that but for treatment or anything like that, because the transformation was so fantastic, I mean you can't go to a doctor and he gives a pill and instantaneously you feel marvellous.” (Jimmy, 78)

'Pain' in one form or another was a constant variable for all participants. Although pain appeared to almost be a way of life for many older people, there was a certain amount of reticence to

discuss it as an issue. This suggests the participants expect and accept pain to be part of being older.

“...yes I've got a rheumaticy shoulder I say I'm as fit as a fiddle but I've got a few aches and pains its no good talking about them it's best put behind you and try and forget it.” (Violet, 92)

The maintenance of pain-free feet was perceived by the participants to be a longer-term ‘successful outcome’ prior to the podiatry intervention. This was linked by the participants to maintaining their mobility and independence although this was tempered by adding caveats regarding their age that restricted some of their expectations. While improved or maintained mobility is difficult to measure, following the initial intervention participants expressed a feeling that the podiatry intervention had aided their mobility and that they considered this a successful outcome.

“Well probably be able to walk a lot better. If I don't I shall say ‘oh well they're old what else can you expect?’ They can't do miracles with people my age. (Basil, 84 - 1st interview)

“...to keep me able to keep on my feet as much as I am now still.” (Elsie, 80 – 1st interview)

“...he seems to walk a bit quicker.” (Rita, 75 – 2nd interview)

“...but I can walk to where I need to walk to I mean just recently I walked back from [road named] you know (Robert, 87 – 2nd interview)

The subject of ‘*independence*’ was not a concept that participants consciously linked with their foot-care need. When talking about their independence, participants tended to talk in terms of their relation to specific medical conditions rather than their foot problems, thereby supporting the conjecture that a hierarchy exists between medical and foot-care needs. However, the effect

on an individual's independence from a biopsychosocial perspective is more subtle and will be highlighted later in this chapter.

"I'm hoping it never comes, I think the affecting my independence will probably be a stroke, something like that because it is, it's always very high indeed. In fact, I've been on pills for 30 years and I'm on the absolute maximum so I mean. But I don't anticipate I just think if well if it happens it happens, and that's the only thing that will make me go into a nursing home." (Maggie, 84)

From the texts the participant-podiatrist relationship is a key issue identified in delivering successful outcomes. A biopsychosocial approach however, identifies additional elements to this relationship. A common theme across both approaches is the concept of a task being undertaken by the podiatrist. A biopsychosocial approach identifies that the participant considers that if the task is undertaken in a competent manner it leads to a pleasurable feeling or experience for the participants.

"Comfortable in the feet, if you're comfortable on your feet you do feel better. It's like coming home and getting out of your outdoor shoes and putting your slippers on". (Kenneth, 75)

"...just to make them more comfortable, to cut them and that. I mean I knew I didn't want a lot of, I mean I did have a corn underneath me big toe, this one and she dug that out and everything so that was, as I say it was just a relief, it was good." (Anne, 78)

Arthur (below) demonstrates insight into the repercussions of the effect of a breakdown in the participant-medical professional relationship and his view that even within a medical model framework the 'patient' does often know more than the medical professional. While Arthur talks within a medical model framework, the concept of the individual knowing as much, if not more about their condition than the medical profession is a concept that is accepted within a biopsychosocial paradigm.

“Well I can't, I can't overemphasise personally the necessity for in-training for people to realise that their tone of voice their sense of concentration, their sense of self giving to understanding the patient's condition and I've learned this from this long experience... I remember on one occasion, having a doctor come there talking about the care of people in relation to the needs of children. I'll never forget him saying 'all of you ought to be listening to the mother she knows more than you do about the condition of her child'. Which, I thought a rather humbling experience for a medical man to say that she knows more than the man she's talking to... ” (Arthur, 90)

A supplementary addition to this interaction is the facet of '*consistency*' of podiatrist throughout the podiatry career. Anne had recently come to Gloucestershire from another area and had experienced podiatry previously. Her comment below therefore refers to her previous experiences:

“I was just going to say we didn't see the same one [*podiatrist*] every time you know, different ones and uh, yeah it wasn't so good...” (Anne, 78)

The above themes of participant-podiatrist relationship, performing of a task to maintain the feet in a pain-free and healthy state, with consistency to promote independence are all intertwined to produce for the participants what can be described as improving their '*quality of life*' and developing a greater sense of '*well-being*'.

“...yeah, well I, I'm far happier now, I much rather go to the podiatrist than I'd go to the doctor [*with painful feet*].” (Jimmy, 78)

Jimmy's comment raises issues of participants expecting the outcome of the intervention to be to improve well-being and to provide a '*feel good factor*'. As NHS podiatry services are currently focussed on 'medical' foot-care needs this means that NHS podiatry services are potentially missing an important aspect of a 'successful outcome' of foot-care interventions for older people. Issues of improving well-being, maintaining independence and the feel good factor are difficult

to define, but appear to include unexpected benefits to the participants' general health and well-being, such as being able to sleep undisturbed.

“...and it's much, much, she said it'll hurt probably for a day or two which it did. Wasn't painful, painful but at least it wasn't keeping me awake at night.” (Lizzie, 82)

“But I was glad to put my feet up a bit you know during that time when it was so sore. But since it's healed up and particularly since I've had the treatment I mean I just carry on as usual.” (Elsie, 80)

Being able to '*carry on as usual*' is therefore an important outcome for the participant which enables the retention of a '*sense of normality*' for the individual participant. This almost taken for granted aspect of the podiatry intervention for both podiatrist and participant would not have been identified without applying a biopsychosocial approach.

Some participants' expectations of the podiatry intervention related to aspects of care considered as '*other foot-care needs*' currently defined by the NHS as '*social care*'. Therefore, some interventions that were expected and would have led to a greater sense of well-being, independence and improved quality of life are not currently provided by NHS podiatry services. These 'successful outcomes' for participants are not considered as outcomes at all within the current medical model provision of podiatry services in east Gloucestershire. It can therefore be questioned if a 'patient-centred' NHS podiatry service would really meet the needs of older people with foot-care needs. If podiatry services are to meet the foot-care needs of older people then they need to take a 'person-centred' approach, outside of the restrictive and hierarchical medical model. It is questionable whether a biopsychosocial approach would meet older peoples' foot-care needs if the biopsychosocial approach operated within a hierarchy with the 'bio' element taking primacy. Therefore, if older peoples' foot-care needs are to be addressed from the

individuals perspective (person-centred care) then it must be questioned whether the provision of these services are appropriate within the current National Health Service.

12.5 Conclusions

By undertaking an interpretative phenomenological analysis of the biopsychosocial approach to the podiatry career it has proven difficult to identify the three distinct sections as the themes are inter-related across each section. Using this approach, participants did not perceive their requirement of the podiatry service in terms of a beginning and end as described by Donabedian's (1966) structure, process and outcome model. At the beginning of the podiatry career a psychological perspective identifies most participants are unconscious of their foot-care needs until they increase in importance by threatening the mobility and independence of the participant. This unconsciousness, of parts of the body until they become problematic was identified in chapters five and seven and are similar to those described by Leder (1990).

Following a biopsychosocial approach that the participants' expectations of the podiatry service are found to be influenced by what the participants know about podiatry services and more importantly what they believe should be undertaken to improve their foot-care need. An individual's expectations are not normally considered by the medical model approach, and are absent in the medical podiatry career. A significant change in participants' expectations occurs between identification of their foot-care needs and the intervention from the podiatrist when considered in a biopsychosocial framework. Before accessing the service and seeing the podiatrist, most of the participants expressed the wish to continue carrying out the foot-care activities themselves. However, following the podiatry intervention participants appear to wish to hand over their care to the podiatrist. This is based on a number of influences, namely a

medicalizing of the podiatry intervention by the podiatrist, the individual linking their foot-care need to a more complex and possibly risky medical condition, the foot-care need being of a personal nature, and also the podiatrist portrayed as an appropriate person with the appropriate skills to undertake the task required.

The participant-podiatrist relationship was identified as an important issue in the medical model approach. While participants may have begun their podiatry career with an expectation that the intervention would be short-term, following the first intervention, participants changed to an expectation of on-going maintenance for their foot-care need. As long as participants felt they could have on-going treatment they considered the podiatry intervention as a successful outcome. However, the successful outcome is perceived as 'care' and not a medical model 'cure'. Participants' find it difficult to understand why these interventions cannot be made on demand. From a biopsychosocial perspective participants articulated that they expected a task to be undertaken following the podiatry intervention. This action does not normally occur in the medical consultation where the participant consults the doctor because they are perceived as the expert. In most cases participants' felt they knew exactly what was required and what they wanted to resolve their foot-care need. Only when participants expect an intervention that is aimed at removing pain from the foot-care need is the podiatrist perceived as an 'expert'. This leads to an increase in the participants' view of the podiatrists' professionalism. This increase in expertise in the minds of the participants is thought to contribute to the participant wishing to hand over the care of their feet to the podiatrist. If the podiatrist has been particularly helpful and sociable, this just aids the handing over of care and encourages the participant to attend regularly as the consultation also becomes an additional pleasurable social activity. This aspect of the podiatry career is an important factor for consideration in future podiatry service delivery.

From the biopsychosocial approach, pain in the feet was identified as causing older people concern, anxiety and worry. It is normally pain or inability to undertake a task that raises the consciousness of the individual to get their foot-care need resolved. While participants link their foot-care problems with wider effects on the brain as well as their mobility and independence, this only occurs sometime after the foot-care need is acknowledged. It is assumed that following exploration of the effects of the foot-care need with the participants that they began to realise the wider impact podiatry interventions could have on their well-being and quality of life. These phenomena were not necessarily immediately obvious to the participants.

The wider issue of 'care' was identified within the biopsychosocial approach. Participants saw the podiatry intervention as a caring act. However, they did not link the podiatry intervention with healthcare, although the relationship of participant-podiatrist supports the participants' perception that they are receiving care. The participants perceived this type of care to have a direct impact on their social activities and this was just as important to them as was meeting a medical or psychological need.

From the interpretative phenomenological analysis some of the social aspects of the podiatry intervention have identified strong themes of image. From a medical model perspective images of how the participants' feet appear following the intervention were identified. The biopsychosocial framework provided a more holistic view of how the participants thought they are perceived as older people by others in society. While a number of the participants cited their age as a reason for a number of their needs, none of the participants wished to be considered old.

A number of participants were however concerned that their foot problem was making them appear to act in preconceived ways of acting old.

Interwoven with the theme of 'image' was the previously identified theme of 'pain'. Participants' who had experienced pain from their foot-care need, expected the pain to return following a period of time and therefore the image of appearing old would return. This view supported the requirement from the participants for regular maintenance interventions in order to prevent a return of their foot-care need. This issue is also linked to themes of 'age' and 'time'. Participants linked their current age (perceived place in the life course), with the need for prompt interventions. Time was a real issue for the participants but not in the same sense of the medical model waiting times and waiting lists. The participants perceived they had limited time left and that lengthy waits for what they perceived as a straightforward, simple task were not acceptable. Each participant anticipated that the podiatry intervention would also occur frequently. This was particularly evident where the participant had not sought assistance from the podiatry service for some considerable time after identifying their foot-care need and at a period when their foot-care need had become a priority due to pain or immobility. One of the potential successful outcomes identified at the podiatrist focus group was improved mobility, it was a theme also identified by the participants. They described being able to walk better and quicker and as a consequence the participants' personal view of their body image improved.

A biopsychosocial approach suggests successful outcomes are more likely to occur if there is a strong and equal participant-practitioner relationship. Linked to this, if the podiatrist presents as a caring, sociable professional then successful outcomes of interventions are more predictable.

With these factors in place it is probably not surprising that participants want a continuous and long-term relationship with the podiatrist.

Another new theme from the biopsychosocial approach was the 'personal' nature of providing care for the participants' feet. While most participants found the image of their feet unpleasant, most expressed a preference that any simple, straightforward task to the feet be undertaken by a professional rather than the participant themselves, a relative or carer. When examined from a biopsychosocial approach the personal nature of a participant's foot-care needs and expected intervention appear far more complex and sensitive. Concepts, such as a sense of well-being and feeling better were expectations that participants identified would only occur if the 'task' had been undertaken by a podiatrist. Meeting the participants' expectations enabled participants to be able to continue to carry out their social activities which in turn facilitated a general feeling of 'well-being' and improvement or maintenance of the participants' 'quality of life'. The improvement in quality of life issues ranged from being able to sleep through the night to being able to continue to undertake normal daily activities and not appearing 'old' and vulnerable.

An unexpected outcome of the podiatry intervention participants considered very successful, was the instantaneous result of pain-free feet following podiatry intervention, something that does not result from a medical consultation. This instantaneous improvement resulting from the podiatry intervention provides an immediate enhancement in the participants' sense of well-being which in turn is perceived as an improvement in their quality of life. The biopsychosocial approach has identified an aspect of podiatry that places it above the medical profession in a hierarchy of professions and an area that should be exploited by the profession in any future new models of podiatry provision for older people.

Working within the NHS, an organisation that continues to give the medical model approach primacy above any other will continue to support the hierarchies described in this chapter. Continuing with medical model approach will continue to put a clear divide between health and social care. The findings from an interpretative phenomenological analysis, of the biopsychosocial approach to the podiatry career, demonstrated that older people require a different type of approach from the medical model in order to meet their foot-care needs.

The next chapter will discuss the findings from this chapter and chapter eleven in order to draw conclusions in chapter fourteen.

PART FIVE: Evaluation of the Models

Chapter Thirteen

Discussion of the Findings

13.1 Introduction

This chapter will discuss the findings of the application of the medical and biopsychosocial frameworks on the podiatry career in order to answer the primary research question:

“Would older people receive foot care services more relevant to their needs, if NHS Podiatry Services adopted a different approach?”

In chapters ten, eleven and twelve the findings from the interviews with older people who participated in this study were presented. In chapter five, the medical model was described as reducing people to the level of organic disease, and not taking into account the views of individuals. Chapter seven examined the biopsychosocial model developed by Engel (1977) which was presented as a model that had the potential to be more inclusive of an individual's views and was portrayed as a 'holistic' approach. The purpose of this chapter is therefore to compare and analyse the two models using the information provided in Part Two-conceptual frameworks and the new information presented in Part Four – Reflections from older people. This information will be used to suggest and develop a new model for the delivery of a person-centred NHS podiatry service.

It is acknowledged that the interpretative phenomenological analysis of the findings is based on participant responses and this is not a traditional medical model research method. It is also recognised that the participants in this study come from a specific generation that were born and have lived prior to the formation of the National Health Service in 1947. Therefore, any conclusions that are drawn will relate to this specific generation and that broader conclusions

across a wider population cannot be made. However, an interpretative phenomenological analysis can be undertaken of the medical and biopsychosocial frameworks using alternative generations of people approaching healthcare services and similar conclusions may be made. Unfortunately, undertaking qualitative research of people's views of healthcare have often been conceptually or methodologically flawed (Cleary, 1999). They have on the whole tended to focus on the health professional's view rather than on issues that are important to individuals. The studies are frequently too broad to provide evidence to change practice or they lack the scientific rigour to be acceptable to the medical profession. A predicament therefore presents itself because if 'patient' or even 'person-centred' quality improvements are to occur in healthcare then the medical model approach will require more rigorous research. This research has focused on seeking the detailed views of participants' experiences by facilitating them to talk about processes and events that occurred during the course of the podiatry career, a method conceived by Cleary and Edgman-Levitan, (1997).

During the period of this research the context of the delivery of podiatry in east Gloucestershire changed. Podiatry Services across Gloucestershire were rationalized following a requirement of the commissioning organisation to reduce funding for podiatry services. This occurred at a time when other Health Authorities across the UK were introducing new access criteria based on 'medical need' as described in chapter two. Participants were interviewed after the new access criteria were implemented. The new access criteria attempted to define participants' needs as either 'medical', 'podiatry' or 'social' and only those individuals with medical and/or podiatry needs were given access to NHS podiatry in Gloucestershire.

The participants' journey through the podiatry career was divided into structure, process and outcome sections as described in chapter eight. The analysis and development of future podiatry provision therefore follows this structure and framework. At times it proved difficult to distinguish between the medical model and biopsychosocial model in the participants' texts. Where analysis is able to clearly distinguish between the two models the conclusions will be presented separately. However, it is considered important to present a description of the participants first.

13.2 The participants

All the participants initially demonstrated a challenging stoicism to their individual foot-care needs which meant they tended not to approach anyone for help. The perception of older people being dependent on health services, in particular podiatry services, was not demonstrated by the participants in this study in the early stages of identifying their foot-care needs. The participants clearly wished to maintain their individual independence. It is questionable whether this generation alone holds this view and value when relating it to their foot-care needs. [Pen portraits of the participants can be found as appendix five].

As part of the normal ageing process older people find it more difficult to undertake tasks because of changes to their physical body. When this begins to occur, it appears from this study that older people begin to adapt their lifestyles and use their social networks of relatives, friends and carers to maintain their independence. Complex social networks were evident in the cohort of participants studied, which they used to undertake a wide range of tasks that assisted the maintenance of their independence. In this study the participants perceived their foot-care needs would be met by the undertaking of specific tasks. These tasks were considered 'personal' tasks and participants were very selective about the people who

were allowed to undertake them. A related and important factor for healthcare professionals to consider is when this specific generation talk about their children or relatives as carers, these carers could also, within a medical model framework, be considered as physically and biologically old. This was highlighted when one participant was describing her son as her main carer. The son was in his early seventies which almost qualified him for participation in this research. A significant number of participants described a caring relationship they had with their grandchildren. It can therefore be suggested that new caring relationships are beginning to emerge as life expectancy is extending and the number of older people is increasing.

From both a medical and biopsychosocial model perspective, foot-care tasks were not considered by participants to directly relate to their health. Participants perceive the undertaking of the foot-care tasks as too personal for their close relatives, and in the 'structure' phase of the podiatry career preference was given to the requirement for a 'professional' to undertake their foot-care tasks. This was consolidated after the initial consultation with the podiatrist when a form of medicalization of tasks took place in the participants' consciousness. It appeared that the incidence of a foot-care need for the participant was both a reminder of their position in life-course, and a threat to their independence. With the current political agenda for older peoples health services (DOH 2007a, 2007b) focusing on the early identification of failing health, NHS podiatrists could play an important role in early identification of an older person's failing independence. In chapter two it was also identified that one of the few foot related nationally recorded statistics was 'the ability to cut your own toenails' (OPCS, 1994). This highlighted a high prevalence of older people requiring help with the cutting of their toenails. This was supported by the

participants and was the single most frequent foot-care need identified. This specific issue will be discussed in podiatry career sections of this chapter.

13.3 General Themes

Examination of the texts using a medical and biopsychosocial approach has identified that participants' expectations and views do not fit neatly into either model. Describing the 'podiatry career' has proved challenging to Donabedian's (1966) structure, process and outcome model. This has therefore led the research to question the medical model focus on specific illnesses or disease as a framework for the delivery of podiatry services to meet older peoples' foot-care needs. There are also challenges to the proposed holistic nature of the biopsychosocial model which can be demonstrated to operate as separate constituent parts, with the 'biological/medical' element often taking precedence. From an interpretative phenomenological analysis of the participants' texts it is clear that neither of the models exactly fit the participants' expectations, needs or demands. The following general themes however, have been identified as consistent throughout the podiatry career and contained in both models.

13.3.1 Time

The issue of time was inexorably linked to all of the issues the participants raised. If NHS podiatry services are to deliver person-centred services, it is important to recognise that while participants may have demonstrated stoicism towards their early foot-care needs, together with attempts to self-care, once they had decided that they could no longer provide for themselves, their requirement for an early intervention from the podiatry service increased dramatically. Participants were also conscious of their own limited life left and therefore the concept of waiting a long time for an

intervention was not acceptable to them. An opportunity was also identified early in the podiatry career, before the participant had made contact with the podiatrist where they still expected assistance from the podiatrist to self-care. Therefore, current long waiting times for NHS podiatry treatment are unacceptable to the participants and secondly podiatrists are missing an opportunity to support older people meet their own foot-care needs.

13.3.2 Image

Another theme identified in the medical and biopsychosocial podiatry career is the concept of image. Within the medical model approach this related to the 'podiatric gaze' of making the feet and toenails look 'acceptable'. In the biopsychosocial approach participants expressed concern that if their foot-care needs were not addressed then they would appear 'old', which left them feeling more 'vulnerable' in wider society. The biopsychosocial perspective therefore facilitated the identification of additional needs and 'successful' outcomes that a traditional podiatric, medical model approach would not have done.

13.3.3 Hierarchies

Donabedian's (1966) structure, process, outcome model was used to describe the podiatry career. This model described a method for ensuring the deliver of quality 'medical' care. Examination of the podiatry career using medical and biopsychosocial models has established that Donabedian's model itself operates within the medical model paradigm, together with its hierarchical overtures.

Hierarchies have been identified from the biopsychosocial approach, with the biological/ medical element taking priority over the other two. Hierarchies also exist in the provision of healthcare for this specific age group of the participants. The participant-professional relationship in the medical model approach has revealed a hierarchical relationship which affects the delivery of NHS podiatry services and does not necessarily meet the needs of the individual. If podiatry services are to deliver foot-care services more appropriate to the participants' needs, then these hierarchies have to be acknowledged and tackled so that more equal partnerships between participant and professional can be established.

13.4 Podiatry career – 'structure'

The medical 'structure' section of Donabedian's (1966) model described in chapter eight focuses on the identification of 'needs' relevant to allow access for a service. A medical model framework allows for a focus on perceived medical/health issues and this, it can be argued, was used by podiatrists to maintain their professional status. Examination within a biopsychosocial framework has shown participants' expectations and perceptions of their foot-care needs are created a long time before they decide to seek assistance. This may be a generational response, although Coulter (2002) proposes that people do not generally consult a health professional immediately they identify a need. It could be argued that as the researcher has become more confident in the use of the broader biopsychosocial elements of investigation, a previously unknown section of the podiatry career has appeared. Using a biopsychosocial approach across the podiatry career allows identification of participants' needs and expectations prior to the 'structure' phase of the podiatry career. These issues have been described by Coulter (2000) as key elements of ensuring participant involvement in their care. The new phase which precedes the 'structure' phase includes identifying the

participants' value systems and leads to the development of their expectations of the podiatry service. This is an important new phase as it sets the scene for the development of the following three sections in Donabedian's model (1966).

It is during the new phase, the 'individuality' phase of the podiatry career, that the participant recognises they have a foot-care need which they wish to resolve themselves. This opportunity for the podiatrist to act as advisor and facilitator to the person with the foot-care need is missed. It was only after the participant-podiatrist relationship had been established, that the meeting of the person's foot-care need transferred to a requirement for a task to be undertaken by the podiatrist. A 'medicalization' of the foot-care need takes place at the podiatry intervention through the medical assessment approach that is adopted, although it is worth noting that at no time, in either a medical or biopsychosocial framework, do participants relate their foot-care need to issues of medicine or health. It is only after the 'process' stage of the podiatry career that participants are conscious of the impact of resolution of their foot-care need on their well-being and independence. As participants identify their primary foot-care need by the inability to undertake a task, the issue of whether this is a medical or even a podiatry need does not enter their consciousness.

Most people try to help themselves initially, often consulting family and friends and this was the case described in the texts by some of the participants. Initial questioning by the researcher did tend to focus on medicalised questions that generated a medicalised response from the participant. Despite attempts to minimise this effect, closed questions were unavoidable which generated responses that were short, to the point and provided little information. This type of interaction, which routinely occurs in the 'medical' consultation, tends to promote passivity and dependence for the participant, which in turn saps self-

confidence and undermines participants' ability to cope. If a biopsychosocial approach is to be adopted, it is essential that podiatrists acknowledge the participants input as this is essential to understanding and defining the participants foot-care need, and then are able to identify possible solutions to the need that gain real commitment from the participant, enabling them to play their full part in achieving a realistic outcome. It is clear that this cannot be achieved by using a medical model approach to the participant-podiatrist relationship. However, caution should be applied to adopting a biopsychosocial approach that purports to provide a 'holistic' approach to the participant-professional relationship because it is relatively easy to adopt a hierarchical approach to the biopsychosocial framework and manipulate the biological to be dominant. As Coulter (2000) suggests, if health professionals are to be genuine in their attempts to centre quality health improvement efforts on the needs and demands of patients they must acknowledge and understand how things are perceived through their and their relative's and carer's perceptions.

From an examination of the 'structure' section of the podiatry career using the medical model framework, it is clear that the model focuses on specific foot problems, the most frequently cited being toenail problems. Despite participants frequently having other medical foot-care needs, the participants' requirement is for an intervention regarding their toenails, which appears to have primacy in the identification of their foot-care needs. Within a biopsychosocial framework the foot-care need is identified by the participant's recognition of their inability to undertake a task they used to be able to do, and they link this need to the provision of a podiatry service. This has clear implications for current access to the podiatry service which nowadays is related to medical and or podiatry criteria and via referral from a healthcare professional.

There are a variety of factors influencing the participants' decision to seek professional help. This includes their ability to assess the foot-care need and its severity along with the participants' perception of the effectiveness of 'interventions'. Using a biopsychosocial approach allows recognition of the participant's perceptions of the effect of their foot-care need on their own state of well-being, including psychological feelings of confidence and self-efficacy. These perceptions are undoubtedly affected by age, gender, education, cultural norms, social networks and attitude towards healthcare professionals.

If the podiatrist acts in a way that undermines the participant's coping skills the podiatry service can expect to see the participants requiring their services with increasing frequency. However, if podiatrists appear to assist participants to help themselves from the initial intervention they may find that participants are better able to cope with their own foot-care needs. With a biopsychosocial approach this issue was specifically highlighted after the participant-podiatrist intervention (in second interviews). This affords an opportunity to podiatry services, as the participants are more receptive to being involved in their care before the first podiatry intervention. Recognition of this opportunity is supported by Vickery and Lynch (1995), Crow and Gage (et al) (1999), and Coulter (2002) who suggest that educational interventions, rather than medical assessment interventions, enhance an individual's sense of self-efficacy which can reduce the demand for a healthcare intervention.

In chapter five it was suggested that one of the reasons the medical model has survived is because it maintains a form of hierarchy within healthcare professions. This will be problematic for the podiatry profession as it strives to align its status with the medical profession. Despite the podiatry profession's attempted alignment with medicine, the participants do not perceive their foot-care needs as a medical requirement. The only link in

the participants' consciousness with medicine is when they access the podiatry service via their General Practitioner, which in some cases is as a consequence of a visit to the GP for another perceived health related problem. Following the participant's referral to the podiatrist, the participants tended to see the input of the podiatry service as performing a simple task, certainly not as the podiatrist acting as an autonomous practitioner who would undertake a medical consultation of assessment, diagnosis and treatment. In fact most participants initially felt they knew exactly what was required to resolve their foot-care need and did not see the requirement for any assessment or medical history taking. This situation demonstrates a tension between delivering a service that participants perceive they require and a profession trying to develop or maintain its 'medical' status in a hierarchy of professions.

Further detailed examination from a medical model perspective reveals that the participants' perception is they require a task to be undertaken that they can no longer perform for themselves. This is perceived as a 'simple task' that does not require a specialist skill as it is something they previously performed themselves. Only when the task is linked to a medical condition does the task to be undertaken gain any integrity. It will be demonstrated later in this chapter that it is only after the podiatry intervention that the participants perceived the podiatrist as having more 'expertise' than them in performing the task.

The general theme of time is relevant at the 'structure' phase of the podiatry career because the participants recognise the requirement for a simple task to be undertaken but they feel it can be undertaken quickly, both in terms of performing the actual task and waiting for the podiatry service to provide the task. From the wider biopsychosocial perspective it is noted from the participants' texts that they make a conscious recognition of no longer being able to

address their own foot-care needs, and this becomes a constant reminder of both their age and impending dependence on others, which in turn raises anxiety and worry. This is the point at which the priority of the task becomes of increasing importance and value to the participant. This in effect sets up a vicious circle in which the participants have anxieties and worries about a simple task that needs to be performed. As they used to perform this task themselves, they perceive it can be performed quickly and because NHS podiatry services have traditionally had long waiting times for toenail cutting (because of medical/podiatry needs access criteria) this leads to greater anxiety, worry and dissatisfaction for the participants. These perceptions, when linked with an increased consciousness of impending dependence on others, reduced mobility and possible pain increases further the participants' anxiety and value placed on the task to be performed. Once the task is performed to the satisfaction of the participant, the issue becomes 'hidden' again, a concept described by Leder (1990). However, the issue is hidden from the consciousness of the participant only until after a certain time period has passed, when the requirement for the task occurs again.

From the texts relating to the structure phase, an important factor highlighted by the participants, is they do still appear to want to remain independent and wish to be able to undertake the care necessary to address their foot-care need. However, as soon as the podiatrist performs the required task the participants view of independence changes to one of dependence. This is a clear example of the 'medicalisation' of a normal life process, as described by Johnson and Newburn et al, (2002), Double 2002, Ebrahim (2002), and Hart and Wellings, (2002). This issue will be explored further in the next section, podiatry career - 'process'.

13.5 Podiatry career – ‘process’

This stage of the podiatry career moves the participants into direct contact with the podiatrist. According to Donabedian's model (1966) this section of the career encompasses the clinical assessment and diagnosis at the medial consultation in order to identify access to NHS services. Analysis from the medical model perspective of the texts places importance on the development of the 'participant-podiatrist' relationship. From the participants' perspective, they see their relationship with the podiatrist differently to their General Practitioner. As described earlier, participants do not perceive the podiatrist or the intervention they perform in any medical or health context. Only when participants have attended a podiatry consultation and experienced the 'medical' equipment within the podiatry surgery, do the participants begin to associate any skill requirement with the task to be performed. No links are made by the participants between the relationship of their foot-care need and any future health or illness issues at the beginning of the participant-podiatrist relationship. When viewed in the medical model framework, the first contact between the podiatrist and participant is identified as crucial to developing the 'professional' relationship and therefore status which the podiatry profession seeks. It is during this first contact that the expectations of the participant change from wishing to be in control of their foot problems to a formal 'handing over' of their foot-care needs to the podiatrist. This occurs for a number of reasons. Initially, the podiatrist will undertake an assessment and diagnosis of the participant's individual foot-care needs. This process goes unnoticed by participants unless 'medical' equipment is used or if the foot problem is linked with a medical disease such as diabetes. The performing of the task following the consultation then becomes 'medicalised' in the participant's consciousness. From here the term 'intervention' rather than 'treatment' will be used because it is recognised that the participant's needs in the first instance were based on the requirement for a task to be undertaken (a task that needed professional attention) rather

than the term 'treatment' with its medical connotations to alleviate specific diseases or illnesses.

As suggested earlier, an examination of the process section of the podiatry career, within a biopsychosocial framework highlights a change in the participants' views. The participants change their perception of the task to be undertaken as they observe the podiatrist's proficiency. At this stage, the participant-podiatrist relationship begins to develop, with the participants adopting a different perspective where the podiatrist is perceived to provide a service that requires some skill. More importantly, the participant actively appears to want to hand over their foot-care need to the podiatrist at the same time as appearing willingly to become dependent on the podiatrist. An opportunity for NHS podiatry services arises here, to support the participants in maintaining their own foot-care rather than entering into a dependent relationship, where the podiatry service is expected to deliver frequent, routine maintenance interventions for foot-care needs. This also raises a question for current health policy and the concept of patient-centred care. "Is the passing of responsibility back to the participants what this policy requires?" or more importantly, "Should NHS podiatry services provide what the participant demands?"

Development of the participant-podiatrist relationship in most instances appeared to be positive from the participants' perspective. This assisted in the development of confidence in the practitioner which in turn reinforced the participants' views that their foot-care needs should be provided for by the podiatrist. Empathy and reassurance appear to be particularly important elements of the participant-podiatrist relationship, although as Hadler (1996) implies, when these elements are viewed within a medical model framework they are perceived as irrelevant. Traditionally, doctors and indeed podiatrists have been unwilling to

inform their patients when traditional 'medical' interventions can do little to help their condition which in turn almost encourages the development of a dependent relationship where the individual frequently comes back to the professional. This form of relationship inevitably leads to frustration for the professional and dissatisfaction for the participant (Cherkin and Dyko, 1996).

From within a medical model framework, the participant-podiatrist relationship commences with two sets of different but equally cogent health beliefs. The podiatrist is required to convey their professionally developed health beliefs to the participant, and for the participant to entertain and accept these. The stated intention is to assist the participant to make an informed choice about the diagnosis and available interventions, about the benefit and any risk, and to take part in a 'therapeutic alliance', but as already demonstrated the participant usually has no choice because the intervention is 'medicalized'. Although this alliance should be reciprocal, the most important determinants should be those that are made by the participant (Marinker, 1977). This poses an interesting challenge for the podiatrist in that many participants had already identified their foot-care need prior to any discussion with the podiatrist, and as previously identified, the participant and podiatrist come to the initial consultation with completely different views of the foot-care need. It is only during the initial intervention that the participant appears to be influenced by the medical model assessment of their foot-care needs. The podiatrist proactively engages in a medical model assessment of foot-care provision whereas the participants' views are far more basic. It is possibly the 'professional caring' act and 'skill' demonstrated by the podiatrist when undertaking the foot-care task that helps cement a successful participant-podiatrist relationship when on the face of it each party initially appear to be addressing different needs.

The medical model framework establishes a 'paternalistic' approach to foot-care needs and a number of participants in this study did appear to prefer the paternalistic consulting style of the podiatrist. It has been suggested by Savage and Armstrong (1990), that this is particularly prevalent in older people. Examination of the same elements within a biopsychosocial framework introduces the concept of 'care'. The development of the relationship between the podiatrist and participant, where the podiatrist is perceived to be providing 'care', gives the participants confidence in the practitioner, although confidence was also enhanced by the 'medical appearance' of the podiatrist. For this generation it appears particularly important that podiatrists and other healthcare professionals 'looked the part'. Once confidence in the podiatrist was established it appears as though participants were more receptive to advice about how the podiatrist addresses their foot-care needs. However, the receptiveness to advice is limited to the 'process' section of the medical podiatry career due to the 'medicalisation' of the task. The participants appear to become more dependent on the podiatrist as they take control of the foot-care needs. Is this phenomenon an example of older people being more passive than younger people, or does it suggest that the preference for active involvement in healthcare is increasing over time, thereby suggesting more of a cultural change? It is therefore not clear whether this is an age or group effect, although age has been found to be a related factor in a number of studies, (Blanchard and Labrecque et al, 1988; Ende and Kazis et al, 1998; Anall and Rosen, 1997; Krupat and Rosenkranzz et al, 2000; Caress, 1997; Stiggelbout and Kiebert, 1997; Strul and Lo et al, 1984; and Deber, 1994). This specific issue may not have been recognised without a comparison of the medical and biopsychosocial models.

The process section of the podiatry career when examined from a biopsychosocial perspective gives a broader view of the themes identified from the medical model analysis. While

participants may not initially perceive their foot-care needs as related to medical issues, participants did identify the wider psychological effects the foot-care need had for them and how this affected their feelings. This begins to challenge the Cartesian mind-body divide described in the medical model, chapter five. The concept of a mind-body divide was a real everyday issue identified by the participants, but not in the sense of two separate entities but as two inter-linking and often connected phenomena. Many of the participants were beginning to be aware that a number of their physical capabilities were becoming limited because of the normal ageing process. This example of the failing physical body can be compared to the participants' eagerness to express that they still retained their mental capabilities. Perhaps as a reaction to demonstrate to the researcher that they still retained a sense of decision-making that enabled their independence? A significant number of the participants demonstrated their mental capabilities by completing puzzles, reading books, keeping in touch with relatives around the world by writing letters and emails, a demonstration of the participants' wide ranging, and active social networks. It appeared as if the participants were demonstrating to the professionals and themselves that they were still able to think for themselves; while not always being able to undertake normal everyday tasks they still believed and had a desire to demonstrate their independence.

It might be suggested that as older people become less independent, because of an inability to undertake some normal tasks of daily living, their focus turns to keeping the mind active. Of great concern to all the participants was the thought of losing their mental abilities (maybe even more so than their physical abilities), which in turn they linked with their personal dignity and a requirement for personal care. Participants considered that the addressing of their foot-care needs was maintaining personal dignity, and therefore a requirement for personal care from the podiatrist. A biopsychosocial perspective allows an appreciation of the

importance of the 'personal' nature of the foot-care need to each participant. This phenomenon is linked closely to the participant-podiatrist relationship, and because participants consider it so 'personal', this may be the reason why some participants took time before seeking help for their foot-care need. However, once the participant-podiatrist relationship is established the participants appear to feel more able to discuss the personal effects their foot-care needs bring, leading to the development of the perceived 'caring' role of the podiatrist. The development of a successful participant-podiatrist relationship in turn leads to the greater likelihood of a successful outcome for the participant. This concept is picked up in the outcome section where it will be analysed in greater detail.

It has already been acknowledged that the performance of the task is closely linked to the participants' many concepts of time. Despite retirement perhaps being viewed by some people as a time of leisure, many participants were acutely aware that their time was limited. Therefore, the thought of delay in getting what was considered a relatively simple task undertaken was difficult for the participants to comprehend. Other participants were concerned to know what their foot problem was, and the 'not knowing' caused participants' anxiety, worry and concern. Another legitimate concern with time, was that of time intervals between visits to the podiatrist

While many of the participants did indicate a willingness to play some involvement in their care, a biopsychosocial examination of the participant responses demonstrates that some participants legitimately choose to undertake a more passive role. This informed and impartial choice, to be involved or not involved is an important element for the participants in the participant-podiatrist relationship. A criticism of the tendency of some professionals to assume that autonomy is mandatory is identified by Schneider (1998), who believes

participants must be allowed to make decisions personally, whenever feasible. Unfortunately, there are other professionals working within the medical model who assume sick people do not want to participate in decisions about their care. This therefore returns us to the notion of paternalism in healthcare and therefore the denial of autonomy for participants. Dowie (2002) suggests that participants should be involved in their care where significant choices are available. However, biopsychosocial findings in this research suggest that role preferences of participants are important and should be explored after the offer of full information and involvement, whenever choices can be made. This form of paternalism is harmful to health, suggests Coulter (2002), because it promotes passivity, takes away confidence and undermines participants' ability to cope. Paternalistic relationships create and reinforce dependence on health professionals. This in turn can lead to the breakdown of an effective participant-podiatrist relationship. Podiatrists feel their time and skills are being taken up with trivial tasks that do not need their input and this is specifically relevant to podiatrists who feel their skills are not being appropriately used when requested to 'cut toenails', remembering these are the primary foot-care needs identified by the participants. This inevitably leads to participants feeling disappointed and disillusioned when podiatry services do not live up to their expectations or when 'treatment' is not as effective as they believed. In order to resolve this dichotomy, participants should be encouraged to be equal partners in the 'process' of their own foot-care.

An important issue to acknowledge here is that while the age group in this study may be perceived to have lost some of their physical capabilities, an individual's age on its own should not be used as an indicator of whether an individual is able to make decisions about their care, or whether they want to be involved in their care. Findings from the research demonstrated that a significant number of participants in this research did want to remain

independent and were keen to be provided with information to enable them to be involved in their own care, but only at the early stages of the podiatry career prior to the participant-podiatrist relationship being established. Unfortunately, many podiatrists as well as other healthcare professionals will feel that they do not have the time to carry out the additional tasks of informing, educating and developing a partnership. Yet, from biopsychosocial analysis of the participants' texts there is a clear opportunity at the first intervention to develop this partnership, as participants demonstrated a willingness to retain some control of their own foot-care. At the initial intervention podiatrists undertake the assessment in a 'medicalised' consultation and therefore miss these obscured messages from the participant. Following the podiatry assessment and diagnosis, the podiatrist proceeds to provide an intervention to meet the participant's need, and the opportunity to 'empower' the participant by the development of an equitable partnership between podiatrist and participant is lost. Despite podiatrists concern that empowered participants will require more time, it is believed that the demand for podiatry and podiatrists' time will be reduced if this approach is employed. What is required is a new type of podiatrist who will help participants to interpret and use the information made available. As the general public becomes more knowledgeable about issues related to their own care, podiatrists and other healthcare professionals will find they will need to develop new educating skills rather than a focus on physical skills. Undoubtedly some podiatrists will perceive this suggestion as threatening because it will challenge their striving for professional authority and professional autonomy. They may also fear that their position is being reduced to that of facilitator rather than decision maker or expert, thereby devaluing their professional expertise and professional status. Nearly all of the participants' accessed podiatry via their GP whom they saw as the 'gate-keeper' to podiatry services. If the proposed change in the podiatrist's role is to occur then general practitioners should be targeted with information that facilitates empowerment of the

participant seeking podiatry care. The general practitioner needs to discuss realistic expectations with the individual in relation to their remaining independence by seeking advice, information and support from the podiatrist rather than reliance on the podiatrist to take over and provide a task.

Despite some of the perhaps more obvious concepts and themes which have been identified, some participants identified concepts and themes that were more difficult to explain. Nonetheless, these themes were real in the consciousness of the participants, despite the lack of scientific evidence required by medical model analysis. Such examples included the perception by the participants that if they felt they had developed an equal relationship with the podiatrist, this then aided the provision of the 'intervention' in a pain free manner. Therefore, the social character of the participant-podiatrist relationship has an important impact on the delivery of successful outcomes for the participant.

From a biopsychosocial perspective, image was identified as one of the most significant and previously unrecognised concepts in the podiatry career. This concept first became evident as a possible issue in chapter two, with many people expressing a dislike with the appearance of their feet. This concept was supported by the participants' texts as they appeared to cite this as a reason for handing over their foot-care, although on occasions, this handing over was legitimised by the podiatrist linking the foot-care need to a medical condition. Far wider implications of image for the participants relate to ensuring they do not appear to look to others as old and vulnerable, with a number of participants expressing how the podiatry intervention had made them feel able to walk more upright rather than the 'stooped' image the media often portray older people.

In the biopsychosocial framework, participants' described psychological elements of frustration and annoyance related to their foot-care need. This was particularly in their inability to perform a task, and the impact this had on them performing normal activities of daily living. Further development of this theme introduces the concept of self-image and the image of their feet, another 'personal' element of the podiatry career. Many participants were concerned that the podiatrist should make their feet look 'respectable', a concept that would not be recognised in a medical model approach. This aspect of respectability clearly links into the participants' personal wish to maintain their sense of 'self', through retaining their dignity, and an appearance that enables coping with normal daily activities. The podiatrist therefore has an important role to play in maintaining the participant's sense of well-being. In support of this sense of improving a person's well-being, a number of participants expectations were that podiatry provision should be of a non-medical nature and that bathing and massage of the feet would logically be included. It can be argued that this type of intervention should be provided by developing the participants' social networks into supporting their basic foot-care needs. Following discussion of this concept with the participants, this will prove difficult because the participants either felt this would put an undue pressure on their support network, which might put it at risk, or they felt their foot-care need was too personal for other non-professional people to address. As a result it can be suggested that because participants do not like the image of their feet, they are too embarrassed to ask a person close to them to perform foot-care tasks. Unfortunately, once the podiatrist has undertaken the task, this action makes it even more difficult to encourage the individual to use their social network to perform foot-care tasks. As a consequence there are major implications for identifying and developing appropriate people to perform the full range of health and social foot-care issues, particularly those 'social' tasks identified at one end of the podiatry spectrum of foot-care needs in chapter two.

Despite the policy debate between health and social care and the divide that is apparent between the two organisations, the participants did not perceive either health or social care as relevant to the meeting of their foot-care needs. In fact, participants in the main made no differentiation between health and social care in relation to their foot-care needs, most participants not perceiving their foot-care needs to be health related. This brings into question the debate in the podiatry profession between the meeting of health and social foot-care needs as highlighted in chapter two and questions as to whether the National Health Service is necessarily the appropriate organisation to provide services for older people's foot-care needs? This question will be discussed in the following conclusions chapter.

13.6 Podiatry career - 'outcomes'

A medical model approach to the 'outcome' section of the podiatry career focuses on the minutiae of what participants were able to identify as successful and unsuccessful outcomes. Traditional 'medical' outcomes have been described as 'discharge' from the medical intervention (chapter five) and from the development of the podiatry career (chapter eight) anticipated outcomes included reduced pain, increased mobility and increased quality of life. An interpretative phenomenological analysis of the medical model approach to the podiatry career has shown that when participants have accessed and received a podiatry intervention, their expectation of a successful outcome changes from seeking information and advice to support their independence, to a position of requiring a personal task to be undertaken at regular intervals, changing their expectation of podiatry to a dependent, long-term maintenance role.

The difference with the medical model framework is that individual older people are classified as a 'patient' as soon as they have accessed NHS podiatry services and undergone

an assessment and intervention in the process section of the podiatry career. It has been recognised that a change in the participants' expectations takes place early in the podiatry career and this is related to the medicalizing of the medical podiatry career and the converting of the individual's role into a 'patient' role. It appears that the participants collude or acquiesce because of the processes, influences and power relationships that the medical model develops. The expected outcomes of increased mobility and quality of life are subjective by nature, but also become medicalized through the medical podiatry career as these are measures that are acknowledged by the professional, but not by the participants. Significantly, scientific or any other measurement of improved mobility and quality of life remain absent from most NHS podiatry services.

The opportunity to develop the participant-podiatrist relationship is missed by the medicalization of the podiatry career, as in a general sense people who are well informed about potential interventions and their outcome, including benefits, risks and side-effects, are more likely to participate in their own care which leads to better outcomes for both participant and professional (Mullen, 1997). Kaplan and Greenfield et al, (1989) suggest educational interventions appear to improve communication by increasing the participants' participation in consultations which in turn have led to improvements in scientific functional and physiological measures. A small number of participants in this study indicated that they may not follow up further interventions if they did not have some influence over when they occurred. This suggests a delicate balance in the participant-podiatrist relationship, and podiatrists will need to be able identify these opportunities for self-care when they arise. These participants had a strong sense of self but were not prepared to challenge the medicalization of the consultation/intervention.

Through a biopsychosocial approach additional successful outcomes such as an increased sense of well-being and independence have been recognised. Participants' also described broader themes of personal image that portrays them as stereotypical older people, which raises specific issues of how other individuals interacted with them. There have been many examples cited by the participants of healthcare professionals stating that age was the reason for their needs. This appears to the participants as a dismissing of their personal foot-care needs which they do not consider helpful when they are also keen to maintain and present their independence by demonstrating they still want to play an active role within their social networks. During the early phase of the biopsychosocial podiatry career this sense of maintaining independence was clearly affected by the perception of their foot-care need, but once the foot-care need was resolved, the value of the podiatry intervention became 'hidden' again to the participants.

'Time' has been a continuous theme throughout the podiatry career, both within a medical and biopsychosocial framework. Time in the outcome section of the medical podiatry career relates mainly to the regularity of future interventions. Following the medicalized intervention, the importance of ensuring foot-care needs are addressed promptly is emphasized by the podiatrist and this influence ensures participants consider an early intervention as important. Participants are also more aware that the condition could recur, or affect their medical condition following the 'medicalized' podiatry intervention and it therefore becomes important to the participants that the podiatry service should be available to them when they require it. This was clearly a source of dissatisfaction for the participants with the podiatry service, and their views of unsuccessful outcomes were often related to delays in follow-up interventions.

When the participant had received the intervention from the podiatrist and their foot-care need resolved, the standing of the podiatrist in the participants view was raised. Within a medical framework, participants wished to be treated with confidence, competence and skill. A biopsychosocial approach additionally confirmed that if the intervention was carried out to the satisfaction of the participant then the podiatrist was also perceived as caring and led to the identification of the participant's desire for a 'personal service' from podiatry services. A number of participants identified podiatrists applying a 'medical' focus (or 'podiatric gaze') to their foot-care need, which left the participant feeling uninvolved in their care. The participants perceived this as the podiatrist being uncaring. This concept of 'caring' is difficult to identify within the medical model, but from a biopsychosocial perspective, as participants progress through the podiatry career, they appear to place increasing personal value on the podiatry intervention and expect the podiatrist to be caring in the provision of podiatry care. The medical model framework presents this caring phenomenon similarly to the provision of nursing services, the nature of which Davies (2003) describes as creating dependence, not independence, once participants have accessed a service. A true biopsychosocial approach should therefore allow the participant to feel they are appropriately cared for, and at the same time, still empowered to be involved in the provision of their own care to ensure the maintenance of their independence.

A participant's age or position within the life course has earlier been cited as a significant and consistent theme throughout the podiatry career. While participants stated they did not want to be considered by their age, there were occasions when participants referred to their age as a reason for the lack of a 'medicalized' cure or improvement in their foot-care need. The participants reason that their age directly impacts on the amount of improvement they can expect in their condition, although examples were also cited of medical practitioners using

this as a reason which probably influenced the participants to acquiesce about their expectations of an intervention. This diminished expectation, as a result of the medical podiatry career, is used by the participants to hand over their foot-care to the 'professional expert'. In order to support participants' expectations of continuing foot-care interventions, they collude with the podiatrist to link traditional medical conditions to their foot problem, in order to support indefinitely the continuance of interventions, stating that they have a need for continued 'foot-caring' in order to maintain their mobility and independence.

Further interpretative phenomenological examination of a biopsychosocial approach has acknowledged that participants link their foot-care need to personal image. Participants considered their foot-care need contributes to their appearance of being old and vulnerable. Therefore, an additional successful outcome for the participants was that when their foot-care need was resolved they perceived they were able to walk and stand in a way that made them appear not 'old' and therefore, less vulnerable. Significantly, shortly after participants had received a podiatry intervention, the visibility of the foot-care need disappeared (Leder, 1990), and along with this so did the value of priority and urgency of access to NHS podiatry services. When the foot-care need began to reoccur, the value and urgency placed on resolution increased rapidly. The psychological and social implications of a podiatry intervention, which include increased social activities, because of the greater confidence and mobility, and the general feel good factor (well-being), was not always linked by the participants to the direct result of the podiatry intervention.

A biopsychosocial approach has therefore allowed identification of additional psychological and social aspects of the podiatry career. For the participants, they consider the continuation of regular maintenance interventions to be the main successful outcome. Participants readily

acknowledge the instant impact the podiatry intervention had on their general sense of well-being. This perception further builds on the importance of the participant-podiatrist relationship and cements the participants' view that the podiatrist is skilful, competent and caring. In a biopsychosocial approach, participants state a keenness for consistency of podiatrist, once the participant-podiatrist relationship is established. As this relationship is built upon tasks that require skill and competence, rather than assessment and diagnosis, it is easier to begin to understand why podiatrists are placed lower in the hierarchy of 'medical' professions. Medical practitioners were perceived by the participants as the expert with knowledge and authority, who identifies the task to be undertaken and makes the decision to pass it on to the podiatrist.

13.7 Implications for the medical model podiatry career

It has been shown in this study that podiatry is using the medical model approach in a number of ways. It was suggested in chapter two that the podiatry profession associates with the medical model in order to enhance and develop professional status and this has been identified in the findings (chapters ten, eleven and twelve), and discussed in this chapter. The adoption of a medical model gives the podiatry profession permission to restrict access on the basis of relevant medical conditions. Individual foot-care needs are 'medicalised' through a 'podiatric gaze' by podiatrists, which leads participants to perceive podiatrists as the only people who can resolve their foot-care need, a situation identified by Armstrong (1987) that arises when health professions focus on a lesion, as only they have access to 'the truth'.

Examination of the medical model has demonstrated the focus on the body or organ rather than the individual. This was described as the 'medical gaze', which has lead to the identification of the 'podiatric gaze'. The medical model approach places emphasis on an

accurate diagnosis of the disease and its underlying pathology (Barbour, 1995) and throughout the podiatry career the first podiatry intervention has been demonstrated to follow this medical approach. Following podiatric assessment, podiatrists diagnose the foot problem and offer interventions aimed at maintaining or resolving them. This process relies upon a strong conception of 'normality', with disability, disease and impairment seen as a physiological problem that needs correcting. The medical podiatry intervention provided to participants therefore attempts to allow individuals to conform back to 'normal' daily activities and behaviour.

It has been demonstrated that at the first medical podiatry intervention the podiatrist appears to 'take over' the responsibility for the foot-care needs and the signs prior to the intervention, where the participant indicates a need and a desire to continue with self-care is ignored. Stainton Rogers (1991) challenges the superiority of medical knowledge when she outlines the ways in which the dominance of the medical model approach has often led to the discounting of an individual's knowledge. This phenomenon, and the introduction of medical access criteria for NHS podiatry, has led to the lack of promotion of health prevention (Gordon and Fadiman, 1984) and the individual's involvement in their own health and care.

The use of medical terminology by the podiatry profession is perceived as adding to its expert power. Yet, terms such as health, illness, disease, impairment and disability have little meaning for participants in this research. This begins to suggest that the medical model is an inappropriate approach for podiatry services to meet participants' foot-care needs and expectations. Ham (1992) identified the limitations of the medical model and its terminology and this is supported by the findings in this research as most of the participants' responses related to personal needs such as retaining a sense of independence, mobility and well-being.

Stacey (1977) stated that the individualistic approach of the medical model considered the causes of ill health to be within biological systems of the individual and attempted to give a cure for the illness in order to make the individual fit for work. The term 'cure' was not considered by the participants: they felt their needs required regular interventions for life, and of course the objective of the intervention is not for the participants to return to work but to maintain or assist an active, independent lifestyle. Townsend and Davidson, (1992), and Stacey (1977) recognised that different concepts exist but confirm that the individualistic, functional fitness and curative approaches remain dominant in the NHS. There is therefore, a danger that the individualistic, medical model approach will be interpreted as the method to address the 'patient-centred' policy drive expected by current health policy. The participants in this research have demonstrated that in order to deliver patient-centred care there is a requirement to understand each individual participants needs and to provide a tailored personal intervention to meet these needs.

In a medical model approach, if an individual's medical need is identified as a functional disturbance of normal structures, it is called a 'disorder' but if the disordered part is a structure it is called a 'disease', (Barbour, 1995). Participants in this study did identify their foot-care need as a disorder but they made no link with a disease or even a health problem. This again suggests that the medical approach to podiatry interventions is inappropriate to meet the participants' needs. It was identified in chapter five that when the functional disturbance involves moods or emotions, thoughts, personality or behaviour, the illness is viewed as a psychological or mental disorder. Undoubtedly, psychological issues were raised by the participants, but none of them could be described as having a psychological or mental disorder and this brings into question the concept of the mind-body divide. Viewing foot-care needs using a medical model framework, the distinction with disease is confounded because

the individual's foot-care needs cannot be defined, and cannot be fitted into a disease framework. Participants' perceptions of their foot-care needs do not fit into the medical model, because they tend to perceive their needs as the inability to undertake a simple task. The medical model has therefore conditioned people to believe that there is a single type of influence to all diseases which identifies a strength and weakness of medicine, in that many individuals do not actually have a disease: they are sick, sad, solitary, or they need comfort (Porter, 1997). In the case of podiatry this has presented itself as participants simply seeking personal care. This aspect of meeting the participants' foot-care needs therefore will not be addressed by a continuation of the medical model approach.

The medical model sees images and emotions as belonging to the mind and not affecting the body (Sheridan and Radmacher, 1992), because the medical model framework only considers the biological processes of illness. The other elements (social, psychological, behavioural, cultural and environmental) fall outside of the medical model's narrow framework and are therefore ignored (Engel, 1980). The biopsychosocial approach recognises these additional themes in the participants' texts such as the previous identified concepts of image and emotions. Participants were only aware of these themes at specific times of the podiatry career, but they are nonetheless worthy of consideration in order to understand how to meet the participants' foot-care needs and to the developing of the all-important participant-podiatrist relationship.

Health and illness were described in chapter five as concepts at the ends of a continuum. Health being described as a positive state of physical well-being (Culyer, 1981; Luker, 1982; Green and Shellenberger; Sarafino, 1994), whereas illness is not just biological but social and concepts of the body draw upon the powerful dichotomies of nature and culture (Chrisman,

1977; Barber, 1995; Porter, 1997; Whitman and Merluzzi 1999). Participants in this study did not acknowledge the link with concepts of health and illness in relation to their foot-care needs, but the resolution of their needs did lead to an improved sense of physical well-being. The maintenance of the participants' sense of well-being was an important outcome of the podiatry intervention which leads to a challenge for the medical approach described above. Green and Shellenberger (1991) suggested a distinction between illness and disease to highlight the fact that many physiological disorders are related to lifestyle and health behaviours. One of the behaviours demonstrated in this study was the 'handing over' of care to the professional, although this behaviour was only identified when using a biopsychosocial approach.

The podiatry intervention takes place in a clinical environment which is outside the social context in which the participants' foot-care needs exist and supports the concept of the podiatrist being perceived as the 'expert' with the knowledge and skills. The focus of the intervention therefore becomes what the podiatrist knows and does, rather than what participants can undertake for themselves, a view described by Barbour (1995, p.152). Using a medical model approach the terminology and interventions keep the podiatrist in control throughout the majority of the podiatry career. Even with the provision of rational interventions, the behaviour of the podiatrist in the participant-podiatrist relationship powerfully influenced the 'outcome'. This type of behaviour led Engel (1977) to suggest a change of role for the professionals to that of educator and psychotherapist, in order to change the power associations that exist in the medical model participant-podiatrist relationship.

The medical model has been criticised for focussing on the 'outcome' rather than 'process' section of 'patient careers' (Morrissey, 1999; Whitty, 2001). For participants in this study

each had individual expectations and needs that could not be identified using just the medical model approach.

13.8 Implications for the biopsychosocial model podiatry career

The biopsychosocial model has been described as the 'holistic' model designed to meet patients' biological, psychological and social needs (Engel, 1977). However, as demonstrated above, current NHS podiatry provision adopts a dominant medical model approach. By using a biopsychosocial model approach the research was able to identify that both participants and podiatrists have evolved different sets of expectations, with the podiatrists' expectations being reinforced by their medical model approach.

The participants initially perceived their foot-care needs required the podiatrist to perform a procedure or task. However, following examination through a biopsychosocial framework it can be suggested this was because the participant was 'medicalized' into dependence. A biopsychosocial model approach illustrates that podiatrists are insensitive to the personal problems of the participants and their families and in this respect they miss the opportunity for engagement with the participants' social network which could help to support and meet the participants' needs.

Engel (1980) stated that the scientific approach to medicine has contributed to widespread public feeling that scientific medicine is impersonal and, as Higgs (1996) suggests, removes the experience of the 'patient'. The biopsychosocial approach to the podiatry career did appreciate aspects that were important to the participants and which are not acknowledged by the current podiatry medical model. The biopsychosocial model appears to offer a framework that is more holistic and inclusive.

There is however, still the risk that the biopsychosocial model will be used with the biological element as the priority within this model. This led Antonosky (1989) to suggest that “the medical model is alive and well and there are few signs of it being questioned by the mainstream of medicine”. (p.243) A biopsychosocial model approach should be able to look beyond the medical concepts of disease and illness and a theme often identified by a biopsychosocial approach is that an individual’s behaviour plays a key role in disease and illness (Nicassio and Smith, 1995; Whitman and Merluzzi, 1999). However, while claiming to be a more holistic approach, it should be recognized that the influence of the medical model can still remain dominant in the biopsychosocial model as long as concepts such as disease, health and illness are still used. The literature review demonstrates no feasible explanation why the medical model is still so dominant, yet the biopsychosocial model, despite its holistic claims, appears to have remained a short lived framework that is little discussed today.

This research has recognised the lifespan approach as a useful dimension of the biopsychosocial model in its effort to understand participants’ needs and expectations and as Sarafino (1998) suggests, how people deal with the broader issues of health and illness. According to the biopsychosocial model, changes in physical functioning have psychological and social implications. In older age, biological systems decline, but with our psychological systems, we become better able to understand the implications of our illness when sick. Changes in social relationships can also be related to health and illness. Therefore, it is important to recognise that participants’ requirements of health professionals change over time and as circumstances change. Engel’s (1977, 1980) biopsychosocial approach makes no allowance for this. Therefore in order for the biopsychosocial model to ensure participants’

needs and expectations are met in future provision, continual dialogue and assessment needs to take place, and interventions amended accordingly in consultation with the participant.

The biopsychosocial model proposes the medical diagnosis should always consider the interaction of biological, psychological and social factors in order to assess a person's health and to make recommendations for interventions. An assumption is therefore made that the more information collected and the better the information organised, the better will be the diagnosis. Unfortunately, this means that as long as the biopsychosocial model contains a biological element or medical focus as the first consideration or priority, it is difficult to see how the biopsychosocial framework can truly claim to be holistic or put the participants' needs and expectations at its centre. A decade after Engel (1977, 1987) proposed the biopsychosocial model, he stated that the biopsychosocial model was no longer within systems theory and required consideration within a broader sphere. Was this his attempt to diminish the influence of the biological aspects? Can a model that operates within a hierarchy still claim to be 'holistic' when it has been shown that the biopsychosocial model has in the past worked in collusion with the medical model? The biological element often takes priority when the model should equally take into account the person, the social context in which they live, and the complementary systems devised by society to deal with the disruptive effects of the health condition.

Implicit in the biopsychosocial model framework is a team approach to diagnosis and treatment. This is necessary in order to ensure that appropriate biological, psychological and social data are collected, integrated and interpreted comprehensively. Even the terminology used to describe the biopsychosocial model suggests a priority in the medical/biological elements of the biopsychosocial framework preceding the others. The relevance for instance

of diagnosis suggests a medical model approach is taking place yet it was noted from the participants in this study that they did not anticipate the need for a diagnosis. The participants felt they already knew what their problem was and what their expectations of the podiatrist were. This identifies a tension therefore between the needs and expectations of the participant and the need and expectation of the podiatrist to maintain a medical status. It appears as though the contribution of wider psychological and social factors undermines the medical model's mind-body dualism and threatens the health professionals' status in the participant-professional relationship.

This therefore advocates that a new type of 'health' professional is required in order to develop and use new communication skills, and to use all these skills to elicit information from the individual, at the same time being empathetic and sensitive. For podiatry this will require a change of focus from delivering a 'skilled' task to the development of an equal partnership between participant and podiatrist in order to facilitate the meeting of the participants' needs and expectations.

Higgs (1996) observes that the increasing numbers of older people may act as a catalyst for change in the medical model approach, but the requirement to be aware of the multiple, individual personalities of these people will be the transforming medium. A truly holistic biopsychosocial model needs to acknowledge that the individual also has knowledge, wisdom and responsibility, and hence rights and power, which if the individual chooses can be shared or withheld from the podiatrist. It was clear from this study that participants need the opportunity to articulate their needs and expectations appropriately and it can be suggested that the traditional medical consultation in a medical facility may not be the most appropriate environment for this to happen. These suggestions can leave the professional feeling more

vulnerable as the medical model approach puts the podiatrist in complete control of the clinical consultation.

In order for the NHS podiatry service to begin to deliver a service that meets the needs of the participants there has to be a radical change from the paternalistic approach to one of involvement of participants in their care. If a new system of healthcare/podiatry provision is to be conceptually based on a biopsychosocial framework in its fullest and most radical sense it will inevitably require a partnership with the individual, their carers, family and health professionals. Such a partnership across the whole of healthcare provision would mean an end to the dominance of the medical model and the power of doctors who autonomously control healthcare provision in the United Kingdom.

The issues identified from the findings and discussion in chapters eleven, twelve and thirteen will now be drawn together and presented in the concluding chapter fourteen.

Chapter Fourteen

Conclusions

14.1 Introduction

The aim of this research was to evaluate the medical and biopsychosocial frameworks in order to identify which approach might be better able to meet older peoples' perceived foot-care needs. This led to the development of the primary research question as:

“Would older people receive foot-care services more relevant to their needs, if NHS podiatry services adopted a different approach?”

The research has highlighted a complex set of needs and expectations from the participants' texts which neither framework completely addresses although the biopsychosocial approach is able to distinguish much of the complexity of human nature. The biopsychosocial approach is a concept or a way of thinking that can be further developed, and will be, in this concluding chapter. The biopsychosocial model demonstrates that nothing exists in isolation and suggests that neither the cell nor the person can be fully characterised as a dynamic system without characterising the larger system (or environment) that surrounds it. In this chapter, theories about how the biopsychosocial framework can be adapted and developed to provide a more holistic or person-centred podiatry service to meet older peoples' foot-care needs will be described.

In the next section of this chapter general conclusions arising from the research that relate to older people are discussed. The views of people over 75 years old in terms of their health and social care, have not received a great deal of attention. It is considered that older people deserve equal consideration to other groups of people in society and this research attempts to

add to the limited body of knowledge relating to their health needs, in particular their foot-care needs, and the delivery of appropriate NHS podiatry services to meet them.

Following the critical evaluation of the medical and biopsychosocial models, conclusions will now be drawn in this chapter on the issues raised. This predominately relates to the medical model's hierarchical influence on service delivery. Similar hierarchies are contained within the biopsychosocial model framework which is often dominated by the biological element. This section concludes that if a truly holistic, person-centred podiatry service is to be delivered, then each of the elements of the biopsychosocial model need to be considered equally or appropriately at each stage of the podiatry career. This requires recognition that at different stages of the podiatry career any one of the components may be relevant and therefore more dominant.

This leads to a description of an alternative, enhanced model of podiatry delivery which is built on the current biopsychosocial model. In this section the contribution to knowledge is the description of an enhanced biopsychosocial model, with individual elements being more relevant and dominant at appropriate stages of the podiatry career. New and additional components are suggested as being relevant to the new model e.g. environmental, behavioural and cultural.

The closing paragraphs describe the implications for health policy. If patient-centred care is to become a reality, or perhaps more appropriately named 'person-centred' care, then new and innovative ways of hearing and listening to older peoples' voices will need to be employed. One clear message in this research was that older people requested individual, and personal care. In order to deliver this, there will need to be greater cross working between health,

social and independent sectors, with the potential for the development of new roles and professions. It is recognised that this will require a commitment from commissioners of care to safe-guard appropriate funding for these services, and for providers of care to re-structure the 'structure' and 'process' sections of the current podiatry career in order to address the foot-care needs identified by older people.

Older people will form an increasing proportion of the population in the next decade including, a significant number who will still be carrying out paid work and will be gaining in influence through the power of the 'grey vote'. Therefore it will be important to hear their voices, as their opinions and views will be an important influence in the development of health, social and independent services in the future according to health and social care policy (DOH, 2004a, 2006). This research has demonstrated that far from being a burden to the state, many older people will become carers for a wide range of dependents, from parents to grandchildren or even great grandchildren. With increasing life expectancy, caring relationships will undoubtedly change and this has been highlighted in this research, and will have policy implications for the future provision of podiatry and related services.

Older people clearly consider their requirement for foot-care to be a personal need. With increasing infirmity, comes a diminishing circle of contacts, which affects the participants' social activities and relationships. Issues of personal care are initially transferred to close family relatives but participants' continue to demonstrate a degree of stoicism for those issues on which they place a personal value despite a raised consciousness of their own age and mortality. Once their consciousness is raised, participants are able to relate their foot-care need to the effect it has on their lives, and at this point addressing their foot-care need becomes of greater value and importance to the participant in maintaining their quality of life

and well-being. This raises an important issue for the future delivery of personal care for older people, as the responsibility for this will either fall to family members across generations or to care services in the public, independent or private sectors. This will require the development and support of new community caring roles for care providers in the near future.

Despite deteriorating physical abilities, the research identified that many older people still kept their minds active and as a result were still able to know how and what their needs are and how to express them. It is therefore important that health professionals recognise, that, just because an individual has reached a certain phase in the life course, their views and needs should not be ignored, misunderstood or treated any differently. There is a danger that by the application of the medical model an individual's real foot-care needs are ignored because the professional just focuses on the medical aspects of the condition.

Participants came to the podiatry service with a specific set of expectations and needs that they could not resolve themselves. Initially, they expected support and advice on how to self-care but following consultation with the podiatrist the responsibility for their personal care passed to the professional. A division between health and social care has been described in the literature, but the participants make no distinction between health and social care in describing their foot-care needs. The health and social care divide, linked with the greater dependence on care within the family, exerts an important impact on current health policy which itself is putting greater emphasis on self-care. This has implications for current health and social care policy and the delivery of care and will be discussed in greater detail in the recommendations on health policy.

At the point of referral to the podiatry service, participants often viewed their foot-care needs as simple and something that is provided by the NHS. While participants have to meet current 'medical need' criteria to access NHS podiatry, many perceive their needs to be of a personal caring nature. A challenge will undoubtedly be placed to one of the founding principles of the NHS, free care available at the point of access, as professions continue to base access to their services on 'clinical need'. This will leave those services that are not classified in this way to require funding for its provision to be through other sources.

Participants tended to identify simple tasks that need to be undertaken in order to maintain their well-being and quality of life, whereas podiatrists were initially identifying medical conditions that participants were unaware of. Therefore continuing to use a medical model focus to foot-care needs means that podiatrists will not fully appreciate the participants' own expectations and needs. This suggests that using a medical model approach restricts the delivery of podiatry services to meet the needs and expectations of the participants.

The medicalization of foot-care needs is being used overtly to restrict access to NHS podiatry services, with 'medical' needs taking priority over other needs which may be of higher priority or greater value to older people in this research. It has been established that older people talk in terms of personal care needs, whereas podiatrists focus on medical foot-care needs. At the first meeting between the podiatrist and participant, the participants are made aware and acknowledge relevant medical conditions which support their need for a podiatry intervention. This suggests collusion between participant and podiatrist in order to manipulate the medical model to justify access to NHS podiatry and also highlights one of the subtleties of power exchanges in the participant-podiatrist relationship. The dominance of the medical model influences what services are provided and following the participant-podiatrist

collusion, influences the participant's perspective of the outcome of any intervention. A form of acquiescence takes place as a number of participants linked the cause of their foot problem to their age. However when the podiatrist offers a medical reason to the participants for their foot-care need, the collusion between the two parties appears to substantiate the need for a podiatry intervention. This supports the concept of the medical model and its hierarchical position placing greater importance on 'medical' needs as the gateway to gaining access to NHS podiatry services. The application of the biopsychosocial model does not necessarily provide the answer, as the medical element of the model can also be applied in a hierarchical sense with medical elements taking priority. This leads to the following conclusions about the use of both models in the next section.

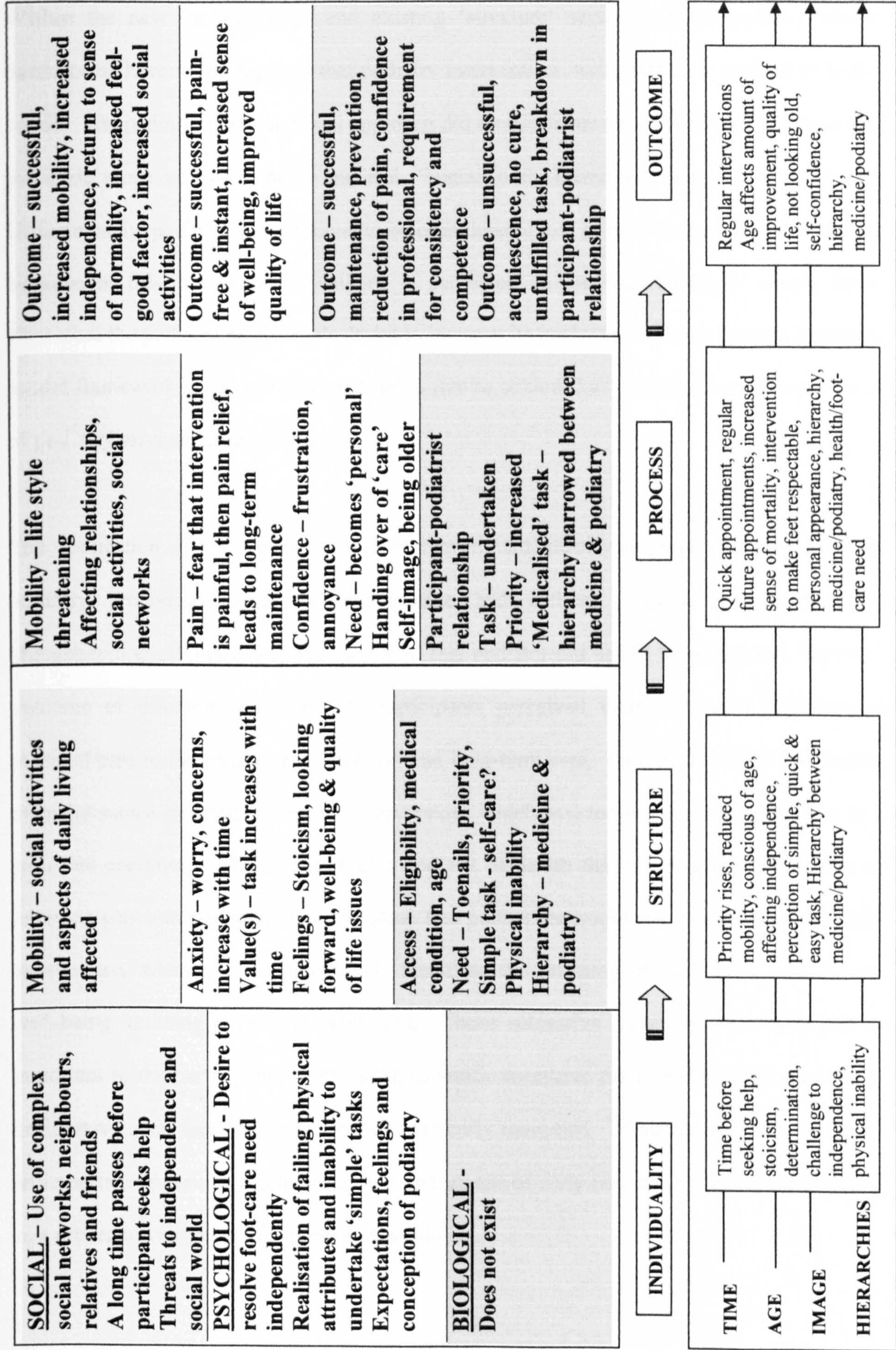
It is considered important to restate that it has proven very difficult to identify clear themes and perceptions that fit neatly into either the medical or biopsychosocial model or any individual section of the podiatry career. It can be suggested that this is because I have become so indoctrinated with the biopsychosocial model approach that restricting myself to the narrow focus of the medical model makes it difficult for me place all the issues uncovered into the 'reductionist' medical model. There have been many cross-cutting themes identified e.g. age, time, image, that increase and decrease in priority between sections in the podiatry career and between the medical and biopsychosocial models and this should perhaps not be surprising as each participant is a unique individual, with their own personal needs and expectations. The biopsychosocial model approach therefore provides a more realistic reflection of the older peoples' human nature approach to their foot-care needs.

This research has focussed on whether the medical or biopsychosocial model framework would deliver appropriate foot-care services in order to meet participants' needs and

expectations. Using the structure, process and outcome model to describe the podiatry career has demonstrated that this model has its basis and development within a medical model framework. This raises questions regarding the appropriateness of the model in describing the podiatry career, although this is the first time the podiatry career has been described in these terms. One issue identified by an examination of the podiatry career with the two models, was that participants' expectations were not included in the model and could not appropriately be placed in any of the current sections of the medical podiatry career. Therefore an additional section prior to the 'structure' section, the 'individuality' section, has been revealed and should be considered before any intervention is made. The new section 'individuality' section is included in figure 14.1 overleaf. Inclusion of this new section in the podiatry career will aid the facilitation of a true person-centred approach and is therefore a contribution to knowledge.

The medical model was identified as mechanistic and reductionist in chapter five. The focus on organs and diseases has been shown to be applied by podiatrists in the delivery of NHS podiatry services. This research has demonstrated that the participants and podiatrists are working to differing sets of priorities in the current delivery of NHS podiatry services which will not assist the delivery of a person-centred podiatry service. Podiatrists appear interested in delivering a medically focussed service, whereas the participants' expectations focus on the undertaking of a simple task. It is not until the 'process' section of the podiatry career, when participant and podiatrist first meet, that participants begin to be influenced by the medical model approach. Participants collude with podiatrists in order to gain access to podiatry services by accepting their medical needs and individuals gaining in confidence with the podiatrist, particularly when 'medical' equipment or terminology was used. This facilitated the handing over of the responsibility of personal care from the participant to the podiatrist.

Figure 14.1: The new podiatry career



Within the new 'individuality' and existing 'structure' sections of the podiatry career, participants have no perceptions that podiatry interventions will meet their medical or health needs. The podiatry medical model approach did clearly focus on specific foot problems (the podiatric gaze) which, within a medical, 'human body hierarchy', remain a low priority. Unfortunately, podiatry will continue to be considered a low priority in the medical hierarchy because of this, and because podiatry is perceived as the undertaking of simple tasks. Therefore the podiatry profession's desire to increase its professional status through a medical model framework is an aspiration that will never be achieved as long as the current provision of podiatry services remains the same.

The application of the medical model framework did identify important issues which the podiatry profession needs to acknowledge and address. From the interpretative phenomenological analysis it was identified that podiatry did not fit the traditional 'medical' outcome of discharge and cure, as participants perceived their successful outcomes as personal care in the form of maintenance, and long-term care. Participants identified themes of maintenance in terms of regular interventions which assisted in maintaining the feet in a pain-free condition. The existence of a concept of health that places great importance on relieving pain and providing care are issues that podiatrists would cite as the purpose of their intervention, whereas most participants identified the retaining of their independence and well-being as being equally as important. These subjective measures are clearly just as important to the participants as objective scientific measures particularly as reports of poor health have been found to be associated with early mortality. Therefore podiatry is missing an important opportunity to highlight the importance of early podiatry interventions as acting as a preventative measure for premature mortality.

The only 'medical' outcomes identified by participants were reducing pain, which lead to improving mobility, the second outcome being questionable as a medical outcome because it is difficult to measure objectively. Within the biopsychosocial framework some participants did identify the impact and affect their foot-care needs had on their independence. Another important outcome or quality measure for participants was the notion of instant relief created by the intervention of the podiatrist. This reinforced the importance to the participant of regular podiatry. These important issues are included in the development of a new model of podiatry services delivery discussed later in this chapter.

General systems theory was presented in chapter six as the unifying theory that acted as the link between the medical model and the development of the biopsychosocial model. It was identified that general systems theory consisted of a hierarchy of elements that individually interacted but with the suggestion that the biological/medical element could be dominant in a hierarchy within the biopsychosocial model. This finding has important implications for the application of the biopsychosocial model in delivering any new form of service to meet the participants' needs.

At the commencement of this research it was anticipated that the biopsychosocial model would provide a more appropriate model to deliver podiatry services to meet older people's foot-care needs. While current 'medical' issues have been identified by podiatrists to validate access to podiatry services, examination of the podiatry career using a biopsychosocial framework has identified psychological and social perspectives that are equally as important to the participants. While the biopsychosocial model has been cited as 'holistic', it has also been demonstrated to contain a hierarchical element in which the 'medical/biological' element takes priority. There is therefore evidence to suggest that the biopsychosocial model is not

truly 'holistic' and there is a risk that the biopsychosocial model will be employed in a hierarchical manner, which can make its application little different to a medical model approach.

The research demonstrates that the participants' needs, change in a cyclical form during the 'process' and 'outcome' phases of the podiatry career. It appears that in order to change the repetitive cycle of ongoing interventions, due to the handing over of care, changes need to occur during the 'structure' phase of the podiatry career. It is at the first intervention that participants' expectations appear to change, and it is at this stage that there is an opportunity for podiatrists to adopt a person-centred or holistic approach.

The biopsychosocial approach in this research did allow identification of participants' expectations such as, senses of improved well-being and feeling better following a podiatry intervention. If podiatrists were to employ a biopsychosocial approach these expectations would be appropriately acknowledged and addressed in partnership with the individual and this would lead to a greater likelihood of participant satisfaction as they would perceive their needs and expectations had been met. This would automatically lead to an improvement in the participants' feeling of a sense of well-being, which in turn would lead to an improvement in their quality of life.

Participants' feelings were identified as an important issue from applying the psychological element of the biopsychosocial model. These feelings led the participants to explain their expectation of an improved quality of life following the podiatry intervention. Participants related this to being able to carry on as normal and retaining a sense of normality in their remaining years. Another outcome identified by application of the psychological and social

elements of the biopsychosocial model was personal image. This was felt by the participants to be affected following the podiatry intervention. The benefits participants identified ranged from a greater sense of security in being able to 'walk taller', to being able to have a 'smile on your face' because your feet do not hurt anymore. These issues all have a big impact on the participant's quality of life. These are all important outcome measures included in the development of a new model and used to evaluate the successful delivery of foot-care services. These outcomes are difficult to measure using traditional scientific measures and therefore the new model needs to consider alternative methods of demonstrating and evaluating that participants' needs and expectations are met.

While participants' podiatry outcomes are complex and difficult to measure, there should be recognition that this generation of participants are very conscious of their age. The nature of their foot problem becomes of increasing priority with the passing of time. Time is a theme that was identified throughout the podiatry career and within each element of the medical and biopsychosocial models. This is of particular relevance when linked to the participants' perception of their foot problem as just requiring a simple task. The non-completion of this task led to an increasing sense of anxiety for participants, particularly when they had to wait for what they considered a long time for a podiatry appointment.

In summary, the biopsychosocial model has helped to identify the differences within the delivery of podiatry in relation to health and social care. Other professions also struggle with trying to define what is delivered in the name of 'medical' care. What is required is a narrowing of the differences between these health and social care roles. Therefore, this suggests that any new holistic model of delivery should consider participants' immediate needs and ensure they are addressed in an appropriate timeframe. This may not be by a

podiatrist; it could be provided through self-care with support. Other needs which may be medical could be met through interventions delivered by a relevant professional.

It has been recognised in the participants' texts that the application of either model does not completely address their expectations, their needs or demands. The participants in this study have demonstrated that their foot-care needs are individual, and require personal and tailored interventions to meet those needs. This suggests older people are seeking a 'personal service' but is this service the same as a 'person-centred' service? Medical model terms such as health, illness and disease are clearly not within the participant's consciousness and therefore do not relate to their expectations and foot-care needs and this would be a similar case if the biopsychosocial model operated with a hierarchy of its individual elements.

Participants saw their relationship with the podiatrist to be quite different to that with their medical practitioner. The podiatrist was perceived to play a far more caring role, a person who can offer instant relief from pain, someone who can perform a task, through to someone who can help an older person to return to 'normal' daily activities that maintains their independence and therefore their quality of life.

The biopsychosocial model potentially offered a broader perspective, but did not offer a solution as to how these expectations and needs could be met. The research identified that participants placed as much value in psychological and social elements of the model, depending on their personal circumstances and their position in the podiatry career. Equally at times the medical, psychological and social elements of the model could not be related to the participants' needs or expectations in terms of environmental and cultural issues. This is because the participants' expectations and needs are not definable in these individual

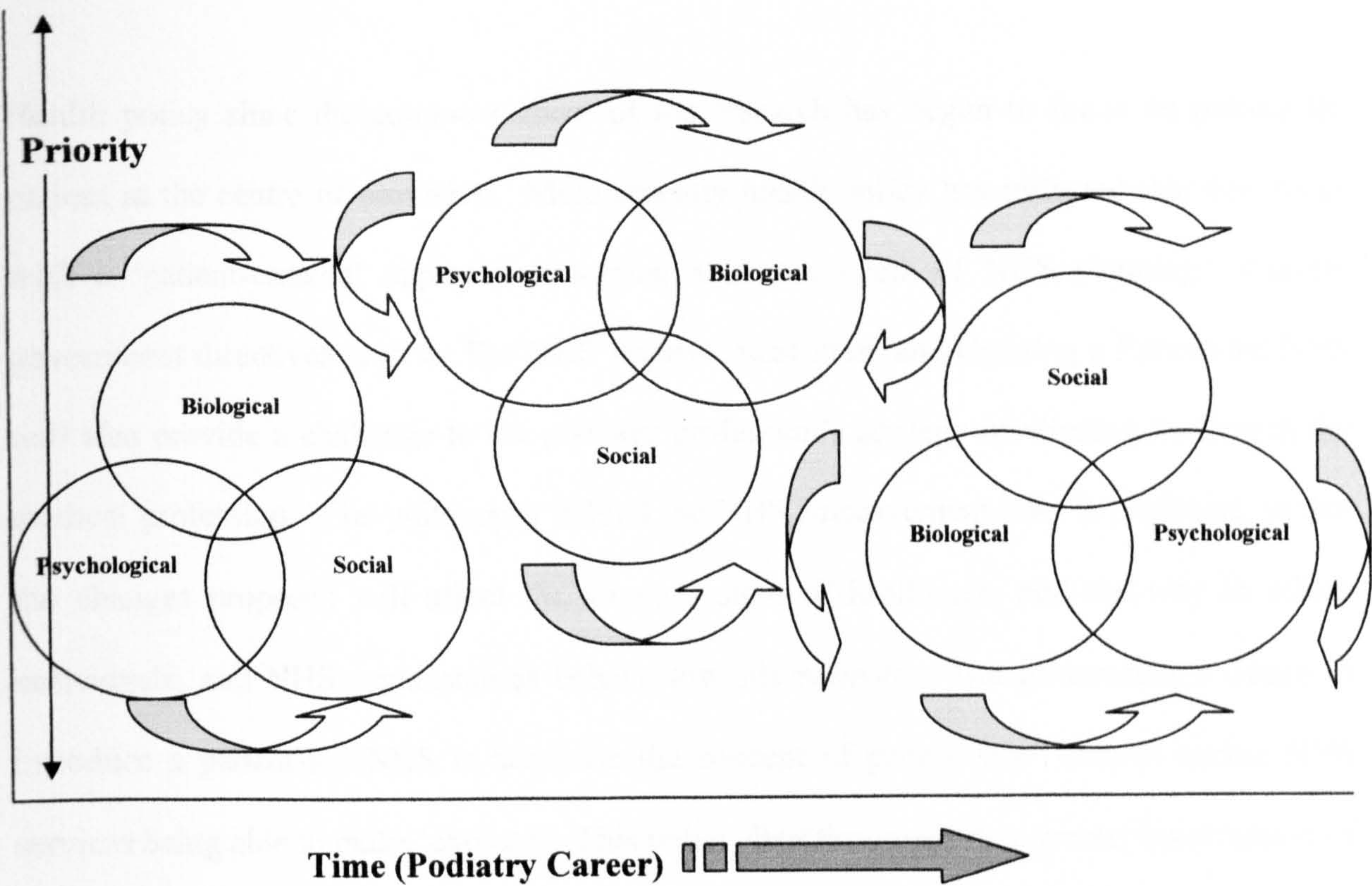
elements. It is therefore important to recognise that it is not helpful to consider a person-centred or holistic approach by applying a rigid medical or biopsychosocial model because this forces you to consider participants' needs in neat 'segments' or 'hierarchies' (biological, psychological and social elements) when in reality each participant has differing expectations, needs, values and requirements.

The new model can be described starting with the biopsychosocial model as the basis (see figure 14.2 overleaf). However, the new model is not self contained with each element just interacting with the other. The new model views the three elements (biological, psychological, social and others) moving along the podiatry career according to a time line, the participants' changing needs, demands and expectations being considered within the different elements of the biopsychosocial model. An important difference is that any element may have greater dominance at different times in the career, dependent on the participants' expectations, demands or needs, recognising that additional new elements may also be relevant and that these elements operate independently and interactively as part of a complex system.

The new model therefore suggests the need for a new approach to the delivery of podiatry services but as demonstrated, the original biopsychosocial model is not the complete model needed to meet participants' podiatry needs and expectations.

The new model also suggests the introduction of new roles to meet participants' needs and expectations and also raises questions as to whether the health service is the appropriate organisation in which to deliver these new types of services to meet individuals' personal needs.

Figure 14.2: The new ‘person-centred’ podiatry career



At the early stages of the podiatry career a number of participants expected the podiatry service to assist them to self-care. A way in which podiatry service delivery could change would be with the introduction of educational interventions in order to assist participants to become more involved in their own self-care for their foot-care needs that are defined as ‘social’ (identified in podiatry spectrum of care, chapter two, figure 2.1). During the new ‘individuality’ stage of the podiatry career, participants spoke of their expectation of maintenance or the podiatrist having a ‘watching brief’ over their foot-care needs. This led in some cases to the belief that with this support the participant could still self-care for themselves. Participants who wished to self-care their foot problems changed their views during the ‘process’ stage of the podiatry career, when they developed a relationship with the practitioner, at which time a transfer of care took place. This suggests that different

applications of the new model should take place, at different stages within the podiatry career according to the participants' expectations, needs and demands.

Health policy since the commencement of the research has begun to focus on putting the patient at the centre of provision. More recently health policy has reflected this new focus with a 'patient-centred' approach becoming a central plank of NHS planning. Current government directives such as The NHS Improvement Plan, and Creating a Patient-led NHS will also provide a challenge to the podiatry profession's strategy of aligning itself with the medical profession. The philosophy behind the NHS Improvement Plan is profound, in that the changes proposed will affect the whole system of healthcare, and the way in which individuals, and NHS organisations behave towards patients. The government's desire to introduce a patient-led NHS is based on the concept of people who wish to access NHS services being able to make 'choices'. This policy direction suggests a greater involvement of the 'patient' in the planning and provision of services to meet their health expectations, demands and needs, although the use of the terminology 'patient' more than suggests a form of medical model influence is still in operation. A more recent development of shifting power from the medical profession (and medical model provision) is appearing through this 'choice' agenda. This introduces a choice of service provider, although at this stage it can be argued that the medical profession still has a major influence on patient choice, and this research has demonstrated the challenges to genuine involvement of older people in the care that they receive.

Collusion during the participant-podiatrist consultation can influence the role that each individual plays. Evidence of acquiescence in the participants, in this research, has been established. Therefore, it will require an innovative application of the new model to ensure

older peoples' voices are truly heard and listened to, and that services to meet their needs, expectations and demands are put in place.

One of the challenges for the podiatry service will therefore be to discontinue the use of the medical model approach. In the National Health Service, the only research methods that have any creditability are scientifically measured, randomised control trials. New methods of evaluating improved well-being, quality of life and mobility within the new model will therefore need to be developed.

Continued use of the medical model has allowed NHS podiatry services to collude with commissioners of health services to redefine clinical need in terms of foot-care needs which has led to restricted access to podiatry services, but also allowed commissioners to stay within expenditure limits. This highlights another tension with any model of service delivery in a National Health Service that is limited by the amount of money the public is prepared to pay for it, balanced against increasing expectations, demands and needs of a population that is getting older.

Participants did not recognise a division in care between health and social care needs. In order for podiatry services to deliver 'person-centred' services, there will be a requirement for health, social and independent care providers to work more closely together. The current divide between health and social care presents an area of difficulty for future NHS podiatry services which are focussed just on healthcare, especially now there is a requirement through government policy to encourage and facilitate joint working across health, social and independent care organisations.

Using a biopsychosocial approach confirmed that participants have their own perceptions of the effect their foot-care need has on their own state of health and psychological feelings of confidence and self-efficacy. They also recognised the effect on social aspects of their lives. These perceptions are undoubtedly affected by age, gender, education, cultural norms, social networks and attitudes towards the podiatry profession. Therefore, if podiatry services are to meet each individual's perceived foot-care needs, service provision will need to be delivered in different ways and through new organisations. Greater investment in podiatry or associated services is required in order to deliver these new services, which the increasing number of older people deserve and demand. This investment issue, to meet older people's foot-care needs has been recognised in a recent Audit Commission Report (2006), calling for an increase in funding for NHS podiatry services.

The theme of participant-podiatrist relationship appeared to be very important to participants and had a large influence over whether the outcome of the intervention was successful or not. The impact of the foot problem on the participants' lives was also a recurrent theme which introduced the new theme of 'personal care'. Participants developed a sense of the personal nature of the podiatry intervention and linked this to their need for 'care'. Much of what the participants were identifying as their foot-care needs is currently classified as 'social' foot-care needs (see spectrum of podiatry care, chapter two). Participants however, tended to indicate their foot-care needs as being more personal and basic in nature, whereas it was the podiatrist who 'assessed and diagnosed' individuals who required more specialist podiatric interventions that were classified as 'clinical need' and are at the opposite end of the spectrum of podiatry care.

Participants were very conscious of their personal image, more specifically with expectations of making their feet look more respectable. This contributed to the participants feeling that the skill of the podiatrist was greater than their own, in dealing with their foot problem. This led to the handing over of their foot-care to the podiatrist at the process stage in the podiatry career. This potentially makes the current government policy focus on developing more self-care challenging. The current, different policies for funding health and social needs continue to promote the division between these two types of care delivery. A greater policy focus on redefining 'personal' care and its delivery could potentially help to bridge this gap.

The participants in the study demonstrated a particular stoicism which made them reluctant to approach health services in the first instance for what they perceived as a minor problem, but one that was having a clear effect on their quality of life. In order for NHS podiatry services to begin to deliver a service that meets their expectations, demands, and needs, there has to be a radical change away from the paternalistic medical model approach to one of involvement of participants in their care. This change is supported by the recent 'Long-term Conditions' policy (Department of Health, 2005a, 2005d, 2005e, 2005f), which comments on enhancing patients' role in self management of chronic diseases that reduces dependence on health professionals and produces very beneficial results. Given appropriate training and support when necessary, patients with long-term conditions can look after themselves most effectively and their quality of life can be improved. Increasing life expectancy and increasing numbers of older people in the population will lead to the requirement for new caring relationships which may include those formed between participants and their younger relatives.

With respect to the future, a fresh approach is required if podiatry services are to meet the needs and expectations of older people. This dissertation presents a new framework for

engaging with older people that facilitates a better understanding of individual older peoples' needs and expectations thereby leading to 'person centred' podiatry care.

Although a biopsychosocial approach may be a more useful framework to deliver 'person centred' podiatry care, caution needs to be applied. Elements contained within the framework can be used in a hierarchical manner that maintains the medical model dominance. The biopsychosocial framework is useful, but only if the biological, psychological or social elements are prioritized in practise, and in considering an individuals 'lived world' at different points along the podiatry career.

New caring roles transgressing the boundaries of health and social care and the profession will be necessary to deliver 'person-centred' podiatry services. This will require both co-operation with carers/relatives but, perhaps more importantly, the development of new roles and/or new professions to deliver foot-care services. As a result, current training of podiatry students will be required to change to include older peoples' expectations (and demands) for foot-care provision to meet their individual needs. Involvement of the individual in provision of their care must be central to this new framework of care. Early signs of this new form of foot-care provision are emerging in the 'Sheffield' project (Farndon, 2007) and in new podiatry care pathways in Gloucestershire. To support such developments, government policy since 2004 to date has focused more closely on 'patient empowerment' and 'patient-centred' services. Delivering the amount of personal care required will demand government policy pay greater attention to supporting the new multi-fold caring relationships that will inevitably develop. The findings and conclusions of this thesis therefore contribute towards this new model of 'person-centred' podiatry services to meet the needs and expectations of older peoples' foot-care in the twenty-first century.

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APPENDIX 1 – Introductory Letter

Chiropody & Podiatry Services, St Paul's Medical Centre
121 Swindon Road, Cheltenham, Gloucestershire
GL50 4DP

Tel: Cheltenham (01242) 707860
Fax: Cheltenham (01242) 707857
e-mail: chris.boden@egnhst.org.uk

30th November 2001

{Participants Name}
{Participants Address}

Dear {Participants Name}

Re: RESEARCH STUDY – “Patients’ perspectives of NHS foot-care interventions”

We have recently received a request for you to receive NHS foot-care treatment for your current foot problem. We have processed your request and you will shortly be sent an appointment card with an appointment to attend the clinic of your choice for treatment.

My purpose in writing to you is that I am carrying out research exploring patients’ views of their experiences of their foot problems, how this affects their lives and their experiences of the interactions with NHS foot-care services.

I am currently seeking to recruit patients who would be prepared to volunteer to be participants in the above research study and would be grateful if you would consider being a participant. The research would involve you in two discussions over the next couple of months at a time, date and location convenient to you. It would be quite acceptable for you to have someone with you during the discussions. Before deciding to take part in this research you may wish to discuss this with your spouse, carer, relative or friend.

Cont’d.....

I have enclosed a leaflet that gives more detailed information about the research. Participation in this research is entirely voluntary and if you choose not to take part this will not affect in anyway the foot-care treatment you receive. If you do take part in the research you will not be named and you will always retain the right to withdraw from the research at anytime. However, your views will add to the development of theories that will be used to develop and shape the future provision of NHS foot-care services.

I will contact you again in the next few days to ask if you are willing to take part and to answer any questions you may have about the research study.

Thank you in anticipation of your help.

Yours sincerely

Chris Boden (Mr)
Researcher (& Head of Service)

Encs

Appendix 2 – Participants Information Booklet

Useful contacts:

East Gloucestershire



NHS Trust

Researcher:

Mr Chris Boden
Chiropody & Podiatry Services
St Paul’s Medical Centre
121 Swindon Road
Cheltenham GL50 4DP
Tel: Cheltenham (01242) 707858 or 07778 627985

Research Supervisor:

Mr Harry Cowen
Principal Lecturer
Cheltenham & Gloucester College of Higher Education
“Ireton”, The Park
Cheltenham GL51 9PP
Tel: Cheltenham (01242) 543243

Ethics Committee:

Gloucestershire Local Research Ethics Committee
C/o Gloucestershire Health Authority
Victoria Warehouse
The Docks, Gloucester GL1 7UU
Tel: Gloucester (01452) 318864

12th March 2001
6th revision

**INFORMATION
LEAFLET**

TAKING PART IN RESEARCH

**“Older patients’
perspectives of NHS foot-
care interventions”**

GENERAL INFORMATION

You are being invited to take part in a research project. The enclosed information is intended to help you decide whether or not to take part. Please take time to read the following information carefully and discuss it with your spouse, carer, friends, relatives or your General Practitioner if you wish.

Please ask about anything you do not understand or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for taking time to read this leaflet.

SPECIFIC POINTS TO CONSIDER

You may or may not receive any direct benefit from taking part in this research. However, information obtained during the

course of the research may help us to understand better your condition or illness. It may also help us in selecting appropriate treatment(s) and interventions for future patients' benefit.

It is entirely your decision whether to take part or not. If you do decide to take part, you will be asked to sign a consent form. You will be free to withdraw from the research at any time and without giving a reason. This will not affect the standard of future foot-care you will receive in any way. Your clinician will not be upset if you decide not to take part.

All the information collected about you during the course of the research will be kept strictly confidential. You will remain anonymous in any data produced and you will be asked to choose an alias name for use in the transcription of any interview data. Any published report of the research will not identify you. All audio-tapes will

be kept in a secure location and will either be destroyed or returned to you when the research is completed.

Depending upon the type of the study, your GP will normally be informed that you are taking part. If this is a problem for you, you should discuss it with the researcher.

Consumers for Ethics in Research (CERES) publish a leaflet entitled 'Medical Research and You'. This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 13655, London N16 0BW.

SOME COMMON QUESTIONS

What is the purpose of the study?

There are two main purposes to the study.

1. It is intended to better understand the process(es) that a patient experiences, from when they first identify they have a foot problem, hopefully, through to a successful treatment outcome that meets the needs identified by the patient.
2. The researcher is undertaking a research degree (PhD) with the Cheltenham and Gloucester College of Higher Education and this study is the central component of the dissertation necessary for successful completion of the research degree.

Why have I been chosen?

You have been chosen because we have received a form completed with your details requesting NHS foot-care treatment. The research is concentrating on patients who are 75 years old or above. Your 'referral' form

has been selected at random from other referrals we have received from people in your age group. The research will involve up to 30 other participants.

Who is organising the study?

The study is being organised by the researcher in-conjunction with Cheltenham & Gloucester College of Higher Education and East Gloucestershire NHS Trust. For each patient the study will involve 2 interviews over a period of approximately 3 months.

What will happen to me if I take part?

The researcher would like to interview you twice over the next three months. The interview will take place at a location, time and date convenient to you. Each interview should last no longer than one hour and will be audio-tape recorded.

The researcher will ask you questions about your foot condition and how it affects you. The first interview will take place before your first treatment. The second interview will take place very soon after your first treatment.

The following flowchart overleaf indicates what will happen at each interview:

The first interview will take place at a time, date and location of your choice, as soon as possible after your application has been received (within 2 weeks).

At the first interview the research will be explained, as will any further questions you may have. Specific questions will include why you felt you required help with your foot-care and how your current foot problem is affecting you.

Other questions will include what type of foot problem you have, why you approached the foot-care service, how your foot problem has affected you, what you might have done to help your own foot problem.

The second interview will also take place at a time, date and location of your choice, but as soon as possible after your first treatment has taken place. Questions will be similar to previous questions but more related to how you feel following the foot-care treatment and what effect it has had on you.

Other questions will seek how your foot problem has been since your treatment. Questions will include how your foot problem has affected your lifestyle and whether the foot-care treatment has made any difference.

Are there any disadvantages in taking part in the study?

There are no known disadvantages of taking part in this study. However, if you want to stop taking part in the study you can do so at any time by telephoning the researcher on 07778 627985 at any time. This will not affect any future foot-care treatments given to you by the department.

What are the possible benefits of taking part?

It is hoped that your involvement in this research will help clinicians to better understand the benefits of their provision to you and to better target future resources to the requirements of their patients. Whilst you might not initially directly benefit from the research you may be involved in influencing the way in which NHS foot-care services are provided in the future.

You will be told if important new information about this research becomes available which might affect your willingness to continue taking part. If at any time the researcher considers it in your best interest, he will stop the interview(s). The researcher will explain the reasons and arrange for your foot-care treatment to continue unaffected.

What happens when the study stops?

When the two interviews have taken place your foot-care treatment will continue as prescribed by the clinician providing your treatment.

What if something goes wrong?

In the highly unlikely event of anything going wrong during the interview stages you have the option to withdraw from the

research or to stop the interviews. If you have any problems or concerns regarding the interview process you should take these up with the researcher as soon as possible so that this can be rectified. If you do not feel the researcher can resolve your problem you should contact the researcher's supervisor whose name is detailed at the end of this information sheet.

Your normal statutory rights to complain about any treatment provided are unaffected. If you have cause to complain you should put your complaint in writing to Mr Philip Southam, Administrative Services Manager, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham.

Confidentiality – who will know I am taking part in the study?

All of the information that is collected about you during the course of the research will be

anonymous and kept strictly confidential. Any information about you that is placed in the report will be anonymised so that you cannot be identified from it.

Your General Practitioner will be notified of your participation in the study unless you object. Your agreement will be sought about this at the start of the study.

What will happen to the results of the study?

The information gained from the interviews will be used to develop theories and recommendations in the presentation of a PhD thesis. Articles and reports may also be taken from the information obtained and published in professional journals. Any information you might have provided will not be attributable to you and your anonymity will be maintained. Copies of

the thesis or any reports and articles can be obtained from the study researcher.

Ethical Approval

The Gloucestershire Local Research Ethics Committee and Cheltenham & Gloucester College of Higher Education have approved this study.

and finally..., if you agree to take part.....,

Thank you very much!

Chris Boden

(Researcher)

Appendix 3 – Consent Form

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Chiropody & Podiatry Services, St Paul's Medical Centre
121 Swindon Road, Cheltenham, Glos GL50 4DP
Tel: Cheltenham (01242) 707858

CONSENT FORM

Title: "Older patients' perspectives of NHS foot-care interventions"

Researcher: Mr Chris Boden

Independent Person: Mr Harry Cowen (Research Supervisor)
Cheltenham & Gloucester College of Higher Education
Ireton, The Park Campus, Cheltenham

Please initial/tick box

1. I confirm that I have read and understand the information sheet dated 12/03/01 related to the above study. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time from the research without my foot-care or legal rights being affected. ☐
3. I agree to allow the interview(s) to be audio-taped and understand that anything I say will remain confidential and that my identity will remain anonymous. At the end of the research I understand that the audio-tapes will either be returned to me or destroyed. ☐
4. I agree to take part in the above research. ☐

Name of patient

Date

Signature

Name of person taking consent
(if different from researcher)

Date

Signature

Researcher

Date

Signature

1 for patient, 1 for researcher, 1 to be kept with clinical notes

Chair:
Mrs P A Bennett

Chief Executive:
Mr P Lilley MSc CPFA

Appendix 4 – Ethics Committee Application Form

**SOUTH WEST LOCAL RESEARCH
ETHICS COMMITTEE APPLICATION FORM**

<i>For Ethics Committee use only</i>	Number:	Date received:	
	Outcome:	Applicant informed:	

INSTRUCTIONS: Please complete in typescript. Please select Yes/No options as appropriate. A version of this form is also available on disc in Word for Windows from the Ethics Committee Secretary.

It is essential that this form is completed fully and the relevant enclosures are received if the study is to receive proper scrutiny by the Ethics Committee. Please refer to the accompanying Guidance Notes when completing the form. Please complete the checklist before sending the form.

CHECKLIST

Please indicate if the following have been enclosed by selecting *Yes/No/Not applicable* options below. For details of the numbers of copies of the form and relevant enclosures required, please contact the relevant LREC secretary. (See Appendix 4 in the Guidance Notes for details.)

	Yes	No	Not applicable
<u>14</u> copies of application form (double-sided if possible)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>14</u> copy/ies of protocol	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>14</u> patient consent form(s)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>14</u> patient information sheet(s)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>14</u> GP/consultant information sheet(s)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>1</u> copy/ies of lead applicant's CV on 2 sides A4 (Do not submit if already submitted in last 12 months.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Questionnaire* <input type="checkbox"/> Finalised <input type="checkbox"/> Not yet finalised	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Copy of manufacturers data sheet for all drugs (one copy only)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Copy of investigators brochure (one copy only)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Copies of manufacturers indemnity (2 copies only)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Copy of CTX/CTL/DDX (one copy only)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Annexe A**	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Annexe B***	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Annexe C†	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

* Please indicate if not yet finalised. Include interview schedule if used.

** If the study involves the use of a new medicinal product or medical device, or the use of an existing product outside the terms of its product licence.

*** If the study includes the use of ionising or non-ionising radiation, radioactive substances or X Rays.

† For research in general practice.

Please indicate below to which LREC this application is to be submitted:

Gloucestershire - March 2000

1. Short title of project (in not more than 6 words)
"Patients' perspectives of NHS podiatry interventions"

Full title
"'You'll never walk alone' - older peoples' perspectives of NHS podiatry interventions"

Summary of practical benefits/improvements in patient care which are envisaged
Identify patient expectations; identify why patients approach podiatry services; what percieved and expressed footcare needs are so services can be focussed to appropriate utilisation of service. Identify appropriate and measureable outcomes. Identify medical/social podiatry needs/outcomes.

2. Applicant (All correspondence will be sent to this address unless indicated otherwise.)

Surname: BodenForename: ChristopherTitle: Mr

Present appointment of applicant: Head of Chiropody & Podiatry Services

Qualifications: MSc Applied Social Sciences
BSc (Hons) Community Studies
DMS (Diploma Management Studies)
SRCh

Address: East Gloucestershire NHS Trust
Podiatry Service, St Paul's Medical Centre
Swindon Road, Cheltenham
GL50 4DP

3. Other workers and departments/institutions involved

Cheltenham & Gloucester College of Higher Education,
The Graduate School,
Faculty of Education & Social Sciences.

4. Signature of relevant bodies

I undertake to carry out the work in accordance with the principles of the Declaration of Helsinki (copy available from the LREC secretary) and its amendments.

Signature of applicant Date

Signature of Head of Department/Supervisor/Principal in General Practice
with overall responsibility
for the project..... Date

NAME AND TITLE IN CAPITALS

I am fully aware of the details of this project and happy for it to continue as outlined here.

Signature(s) of relevant Clinical Director(s) where study is being conducted/Medical Director(s) signing on behalf of Trust(s) involved (where appropriate).

..... Date

NAME AND TITLE IN CAPITALS

This section must be completed. A copy of the protocol should be enclosed with the application form, but it is not sufficient to complete questions by referring to the protocol.

5. Aims and objectives of project (i.e., what is the intention of the project?)

To explore the medical, social and other processes taking place in a podiatry intervention.

To examine the "patients' experiences" of podiatry interventions (including their perception of their needs and expected outcome).

To examine the processes patients's use in identifying needs and outcome.

To provide a theoretical critique of 'medical' and other models used in podiatry.

To examine the differences between health, social and other needs and to explore this in relation to current policy on health and social care.

Study endpoints: To better understand why patients use podiatry services.

Identification of models of patients' footcare needs. Gain an understanding of "patients' career" through podiatry intervention; thereby ensuring patient received appropriate intervention. Identification of realistic outcome(s).

6. Scientific background of study

Current provision of podiatry services is based upon the 'medical model'. This has been further highlighted by recent governmental changes to NHS provision. A previous study (Boden 1998 unpublished) suggests that podiatrists provide services to satisfy both health and social needs. This causes difficulties for podiatry services as NHS resources are targetted towards 'high-tech' health needs and outcomes. The exclusion of the patient experience from the identification of podiatry needs and outcomes are apparent. Sappington and Kelley (1996) suggest that using a person's knowledge to define what they feel is best for them enables professionals to put patient needs first and permits patients to assume responsibility for their own health. A grounded theory approach (Glaser and Strauss 1967) will be used in this sytematic, exploratory study evaluating podiatry interventions. The study will look at the patients experience of 'illness' as it unfolds over time. The context of the course of illness as a career or trajectory (Diederiks & Bal 1997) will be used to identify significant points on the trajectory. Patient experiences will be related to the conceptual framework of the biopsychosocial model (Engel 1977), which takes more of a 'holistic' approach to the provision of appropriate 'health' care.

7. Brief outline of project (i.e., what do you intend to do?)

To interview patients (over 75 years old) at four key stages in their 'career' with the podiatry service, using semi-structured interviews in patients own home. Obtain written informed consent beforehand. It is intended to gain twelve complete sets of interviews. This will probably require more than twelve people to be interviewed. Each interview will last 45-60 minutes. The key stages are (i) just after referral, (ii) just after first treatment, (iii) three months after first treatment and (iv) six months after first treatment. Each interview to be transcribed and analysed using NUD*IST computer software. All data will be anonymised and using Glaser and Strauss's (1967) "Grounded Theory" approach ideas and theories will be developed. Information gained will be used to develop a "podiatry patient career" which will inform professionals of appropriate interventions. Models such as the medical and biopsychosocial models will be used to understand the processes taking place with the career. Reference will also be made to current policies affecting podiatry services in relation to the defining of health and social care provision.

8. Study design (e.g. cohort, case control)

A Phenomenological study using a Grounded Theory Approach.

9. i) How was the size of the study determined?

Twelve complete interviews or until data saturation is reached.

ii) Was there formal statistical input into the overall study design?

☐ Yes

☒ No

If Yes, please give name of adviser:

iii) What method of analysis will be used?

NUD*IST qualitative software. A phenomenological approach to data analysis.

10. Does the study fall into any of the following categories?

Pilot

☐ Yes

☒ No

Multi-centre study

☐ Yes

☒ No

Student project

☒ Yes

☐ No

If this is a multi-centre study, please complete the details below, otherwise go to Question 11.

i) Which centres are involved?

ii) Which ethics committees have been approached, and what is the outcome to date?

iii) Who will have overall responsibility for the study?

iv) Who has control of the data generated?

11. Where will the study take place and in what setting?

The study (interviews) will take place in patient's own homes.

12. Is any payment being made, or actively being sought by the investigator or department/unit in respect of this study (include research grants)?

☐ Yes ☒ No

If Yes, complete the section below; if No, go to Question 13.

i) Is the payment:

a) A block grant

☐ Yes ☐ No

If Yes, give details, including amount and source of funding

£

Name of funding body: _____

b) Based on the number of subjects recruited

☐ Yes ☐ No

If payment is based on number of subjects recruited (per capita/payment), state total sum payable for each subject completing the study.

£

State number of subjects agreed.

Will patients have their travel costs paid?

☐ Yes ☐ No

If multi-centre study, state total number of subjects to be recruited.

ii) Is the payment made in order to:

If Yes state sum

a) Pay a salary(ies)

☐ Yes ☐ No

£

b) Fund equipment

☐ Yes ☐ No

£

c) To support further departmental research

☐ Yes ☐ No

£

d) Other (state)

☐ Yes ☐ No

£

iii) Who will have control of the funds? eg Charitable Trust etc.

iv) Does the investigator(s) have any direct personal involvement (eg financial, share-holding etc.) in the sponsoring organisation? (If Yes, give details.)

☐ Yes ☐ No

v) Will all the costs incurred by the institution be covered by the grant?

☐ Yes ☐ No

13. If the project is to be carried out in a Trust has the R&D lead in the Trust been notified of the project?

☒ Yes ☐ No ☐ NA

If no/NA give reasons:

Adrian Bamford has been notified.

14. Schedule

Proposed starting date: May 2000

Proposed duration: 18 months (12/01)

15. How will the patients or subjects in the study be selected, approached and recruited; what inclusion and exclusion criteria will be used? STATE IF THEY ARE THE SUBJECT OF THERAPEUTIC OR NON-THERAPEUTIC RESEARCH

Non Therapeutic Research. Selection will be from a stratified random sample, focussed on males and females referred to the podiatry department by GPs, health care professionals or self referral. All subjects will be 75 years old or over. People who are unable to give informed consent will be excluded. Others excluded will be people with senile dementia, severe mental illness or someone with a terminal illness. People selected will be from a representative referral. They will receive a letter and information pack. This will be followed with a telephone call to make an appointment.

16. How many subjects will be recruited and of what age group?

It is anticipated that 15 - 20 subjects will be recruited in order to obtain 12 completed sets of interviews or data saturation. All subjects will be 75 years old or over.

17. How will the control group (if used) be selected, approached and recruited; what inclusion and exclusion criteria will be used? Type *NA* if no controls.

Not Applicable

18. How many controls will be recruited and of what age group?

Not Applicable

19. Are the subjects or controls included in this study involved in any other research investigation at the present time?

☐ Yes ☐ No ☒ Not known

If Yes, please give details.

20. Will healthy volunteers be used?

☒ Yes ☐ No

If Yes, complete details below. If No, go to Question 21.

- i) What is their relationship to the investigator? They will be patients of the service the researcher manages.

- ii) Will they receive any payment, and if so, what is the source of that funding? ☐ Yes ☒ No

If Yes, give details of payment per subject.

Applicants should undertake to explain to volunteers that the researcher will contact their GP to ask about any drug therapy and that they must inform the researcher if they consult another doctor during the study, and that this doctor will be informed of this study.

21. Is written consent to be obtained?

☒ Yes ☐ No

If Yes, please attach a copy of the consent form to be used.
(Guidance on consent is given in Appendices 1 and 3 in the Guidance Notes.)

If no written consent is to be obtained is it because one of the following methods of research is employed?

Postal questionnaire	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Interview	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If Other, please justify.

22. Does the study include subjects for whom English is not a first language?

☒ Yes ☐ No ☐ NA

If Yes give details of arrangement made; if No please justify.
All patients need to be fluent in english.

23. Are the subjects or controls in one of the following vulnerable groups?

Children under 16	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
People with learning difficulties	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Other vulnerable groups e.g. mental illness, dementia	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

If Yes, please complete the details below, otherwise go to Question 23.

i) What special arrangements have been made to deal with the issues of consent and assent, e.g. is parental or guardian agreement to be obtained, and if so in what form?

ii) In what way, if any, can the proposed study be expected to benefit the individual patient/subject on whom it is performed?

24. Will the patient/subject be given a written information sheet or letter?
(For suggested format see Appendix 2 in Guidance Notes.)

☒ Yes ☐ No

If Yes, please attach copy to this application form.
If No, please justify.

25. Does the study involve the use of a new medicinal product or medical device, or the use of an existing product outside the terms of its product licence?

☐ Yes

☒ No

If Yes, please complete Annexe A in the Guidance Notes, otherwise go to Question 26.

26. Will any ionising or non-ionising radiation, or radioactive substances or X-Rays be administered to a patient or volunteer?

☐ Yes

☒ No

Please ensure information in Q14 includes exclusion criteria with regard to ionising radiation if appropriate.

If Yes, please complete Annexe B in the Guidance Notes, otherwise go to Question 27.

27. What investigations and/or interventions will subjects and/or controls have over and above routine care?
(Please complete the table below by selecting YES/NO options as appropriate. If YES, please give details.)

Investigation

Self completion questionnaires	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Interviews/interview administered questionnaires	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Interview administered questionnaires	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Video/audio tape recording	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Physical examination	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Internal physical examination	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Venepuncture*	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Arterial puncture*	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Biopsy material*	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Other tissue/body sample*	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Imaging investigations (<u>not radiation</u>)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Other investigations not part of normal care	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Additional outpatients attendances	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Longer inpatient stays	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Local anaesthetic	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
General anaesthesia	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Other	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Details:

* If yes, will samples be retained beyond the end of the study for testing for other factors beyond that in this proposal?

☐ Yes

☐ No

If yes, will samples be anonymised?

☐ Yes

☐ No

If no, please justify

If additional investigations or tests are involved with revenue consequences for the NHS the relevant head(s) of department(s) *must* be contacted.

Signature of Head of Department..... Date

NAME IN CAPITALS..... Position.....

28. Are there any ethical problems or considerations that the investigators consider to be important or difficult with the proposed study?

☒ Yes ☐ No

If Yes, please give details:

Ensuring subjects are able to give informed consent. Reassuring patients of anonymity and confidentiality. Ensuring subjects understand that they can withdraw at any time. Ensuring subjects do not become distressed or anxious about interview process.

- 28a. Is it possible that the trial medication will not be available at the end of the trial?

☐ Yes ☐ No ☒ N/A

- 28b. If yes, is this made clear in the patient information sheet?

☒ Yes ☐ No

If No, give reasons

-
29. Are there any potential hazards to subjects or patients?

☐ Yes ☒ No

If Yes, please give details, and give the likelihood and details of precautions taken to meet them, and arrangements to deal with adverse events and overdoses, including reporting to the relevant authorities.

-
30. Is this study likely to cause discomfort or distress to subjects/patients?

☒ Yes ☐ No

If Yes, estimate the degree and likelihood of discomfort or distress entailed.

A small amount of distress or anxiety may be experienced by the subject. If the interviewer detects any distress the interview will be stopped or if the subject requests it the interview will cease.

31. Will information be given to the patient's General Practitioner (*especially* if a drug is to be given or an invasive procedure is undertaken)?

☒ Yes ☐ No

If *Yes*, please enclose an information sheet for the GP.
If *No*, please justify.

If the study is on hospital patients, has the consent of all consultants whose patients are involved in this research been obtained?

☐ Yes ☐ No

If the study is in general practice, has the consent of all the partners been obtained?

☐ Yes ☐ No

Where available, please enclose an information sheet for consultants or GPs.

Product liability and consumer protection legislation make the supplier and producer (manufacturer) or any person changing the nature of a substance, e.g. by dilution, strictly liable for any harm resulting from a consumer's (subject or patient) use of a product.

32. i) If you are not a member of staff of an NHS Trust or Health Authority what arrangements have been made to provide indemnification and/or compensation in the event of a claim by, or on behalf of, a subject for negligent harm?

Not Applicable

- ii) What arrangements been made to provide indemnification and/or compensation in the event of a claim by, or on behalf of, a subject for non-negligent harm?

Not Applicable

If applicable, the arrangements involving a drug supplied by a company should conform to the most recent ABPI guidelines on patient indemnity or individual Trust documents.

- iii) Will a medical student be involved directly in the project?

☐ Yes ☒ No

33. Has a manufacturer provided any equipment or medical devices?
(Please indicate NA if not applicable.)

☐ Yes ☐ No ☒ NA

If Yes, what arrangements have been made with the manufacturer to provide indemnity?

34. i) Has the relevant Data Protection Officer been notified of the study? ☒ Yes ☐ No

Give name of Data Protection Officer: Miss Margaret Drury

- iii) If No, give reasons

35. Will the patient's medical records be examined?

☐ Yes ☒ No

If Yes, will information relevant to this study only be extracted

☐ Yes ☒ No

If extra information is extracted, please justify.

What, if any, additional steps have been taken to safeguard confidentiality of personal records?

36. Will the study include the use of any of the following?

Audio/video tape recording

☒ Yes ☐ No

Observation of patients

☐ Yes ☒ No

If Yes to either,

a) How are confidentiality and anonymity to be ensured?

All data will be anonymised. Each patient will be assigned a number or alias (chosen by patient). Data will be shared with supervisors and examiners in anonymised form. Any interview or field notes will also be anonymised. Interview tapes will be anonymised before transcription.

b) What arrangements have been made to obtain consent?

Patients will be invited to participate in an interview by letter, followed up by a telephone call. A consent form will be supplied to patient together with explanatory notes and information sheets. Patients will be contacted to arrange a convenient date and time for interview.

c) What will happen to the tapes at the end of the study?

The tapes will be securely kept in a locked cupboard until the end of the PhD process. Any labels or data kept with the tapes will be strictly anonymised. All tapes will be destroyed at the end of the study. Transcriptions will be identified by study number/alias only.

37. Will medical records be examined by research worker(s) outside the employment of the NHS?

☐ Yes ☒ No

If Yes, it is the responsibility of the principal investigator to ensure that research workers understand that they must:

- i) *undertake never to divulge information about patients or research subjects, recorded or otherwise, to anyone without the authority of the Consultant/GP under whose care the patient is;*
 - ii) *also understand that the names, addresses and places of work of patients or research subjects are confidential and must not be divulged.*
-

Please ensure that you complete the check list on the front cover of the application form and enclose all relevant enclosures.

Appendix 5 – Pen Portraits of Participants

PARTICIPANT PEN PORTRAITS

AGATHA (81) (JAMES (75) husband)

Agatha is married to James and they live in a semi-detached private house in a village on the outskirts of a town. Both Agatha and James were very talkative people (there was no requirement for the Reminiscence book) and at times had to be brought back to purpose of interview. Agatha was a retired health professional. She herself had suffered from multiple health problems including cancer of the breast. James suffered from bouts of depression, was diabetic and a heavy smoker. Agatha talked very easily and freely and included some very intimate details of her operations (possibly because interviewer was fellow health professional?). The first interview took two and a half hours. Both Agatha and James appeared to enjoy having someone to talk to. Agatha expressed apprehension at the beginning of second interview however, after a few minutes she began to speak freely. There was distinct difference between Agatha and James's view of the podiatry intervention. Agatha talked about "pampering" whilst James saw it as a task and "just wanted the job done". Agatha and James are a close knit team working together to get through the day. James was pleased to receive advice and to be able to help his wife, whereas Agatha would not help her husband with his feet because she saw it as a medical problem i.e. his diabetes.

ALBERT (82) (HELEN (80) Wife)

Albert lives in a flat in sheltered accommodation for older people with a warden. Albert has recently suffered from a severe stroke that has affected his speech and ability to undertake most of the tasks of daily living. Albert is married and supported by his wife, Helen. She is Albert's main carer and during the interviews often spoke for him. Albert's mobility is limited but he can walk with sticks with support from Helen. Albert had a poor upbringing coming from a working class background.

ANNE (78)

Anne is a widow who had recently moved to a town in Gloucestershire from a large industrial town in North East England. Anne had moved to Gloucestershire to be nearer her son following the death of her husband. Anne has three sons who all live large distances apart. Anne lived in a flat in an older persons secure, sheltered accommodation. Unbeknown to the interviewer Anne has received NHS podiatry in her previous location. Anne appeared to be in good health although she had been diagnosed with cancer eleven years ago and had a slight hearing impairment. Anne felt that she was unable to undertake the tasks that he feet now required and clearly felt she could no longer care for her own feet. This led Anne to felt that she required the NHS podiatry service to perform a task and that she did not see this as health care, although she did ask her general practitioner to refer her to the service.

ARTHUR (90)

Arthur is a retire vicar and lives with his wife in private sheltered accommodation with a warden. Arthur appeared quite fit and articulate. The first time I visited him he was emailing his relatives in Canada. Arthur's main medical problems are with the circulation in his legs and he has a history of problems with his legs. This has led Arthur to experience problems with mobility and walking. Arthur also has failing eyesight. Arthur's wife is quite infirm and does not get about the house at all. Arthur had contacted the podiatry service direct as he had recently moved to Gloucestershire from the North and had previous experience of NHS podiatry there. Arthur had formally contacted the researcher by letter expressing a wish to take part in the research.

BASIL (84)

Basil is a widower who lives in a large town in a private detached house on his own, although daughter occasionally visits to give support. Not a wealthy man according to Basil, during his working life he was a builder/surveyor. Basil retired at 70. Now has multifactoral health problems including diabetes and a blood disorder. Basil demonstrated his independence throughout the interviews. In the first interview he continued to prepare and make his dinner at the same time as talking to me. Basil felt he “had to survive” using his own words and this was his way of proving it. Basil appeared to be very regimented (said from his army days). Basil was keen to talk to someone and it was quite obvious that he was lonely. Basil was very pragmatic about his life and death and talked about this “off tape”. Basil clearly missed his wife. The second interview was much shorter as Basil stated he did not feel too well. Basil again continued to prepare vegetables during the interview and demonstrated his illness by using his “puffer” in front of me. Basil stated “off tape” that his breathing would finish him off – he was conscious of death being near. Basil stated that he thought he might live for another fifteen years (until he was 99). Also “off tape” Basil spoke of older people in an interesting way. He spoke of “older peoples Thursdays”. This day was pension and shopping and on Thursdays older people did proper shopping and not window shopping.

CYRIL (83)

Cyril is a widower living in a semi-detached council on a “run-down” estate in a large town. Cyril lives alone but has a small group of friends in his own age group. Cyril contacted the researcher with regard to his participation in the research, following a conversation with a near neighbour who had also taken part in the research. Cyril is an articulate person who started the first interview by stating that he did not wish to talk about politics, religion or race. At the end of the second interview Cyril asked for the tape to be switched off and then proceeded to speak of issues using racially abusive language. This was of no relevance to the research or researcher and therefore the researcher made a polite departure.

DULCIE (88)

Dulcie is a widow of twenty years from a “well to do” background. Dulcie lived in her own town house in a major town. Dulcie was smart in appearance and took great pride in her appearance and the appearance of her house. She is fiercely independent. Dulcie stated that she could not get to the podiatry clinic for treatment and this eventually led to her only taking part in the first interview. Despite stating that she would not be attending for treatment Dulcie moved about her house very well and had attended the hospital recently for a serious medical condition. Dulcie was preoccupied by money. Dulcie’s independence came through when she stated that she would not ask anyone to help with her foot-care. She also described the frustrations experienced by her condition and that she lived “day to day”.

EILEEN (80)

Eileen is a widow with one daughter. She lives in her own private bungalow in an affluent suburb of a large town in Gloucestershire. Eileen had been running a very successful local business with her husband. Since the death of her husband she has become very active in the local community in various voluntary capacities. Eileen is still fiercely independent. She had a knee joint replacement several years ago and uses private health insurance for most of her health needs. In the past this has included a private podiatrist. At the time of visiting Eileen she had recently had an accident that had resulted in a broken arm. This had temporarily incapacitated Eileen and her GP had requested a podiatry visit to help with foot-care. From discussion in the interview it became apparent that Eileen’s daughter was seriously ill and need major surgery. At end of first interview and “off tape” Eileen stated “Feet, they’re

nothing compared to your insides" (Eileen's daughter has Crohn's Disease and she wanted to give her intestine to her daughter). She later commented that "'you can do without your feet, you can't do without your insides". The second interview was cancelled due to a dislocated shoulder and admittance to hospital.

ELLIE (85) (TOM (88) husband)

Ellie was the participant selected for the study. However, when I went to the house for the first interview it became apparent that both Ellie and her husband Tom had been referred to the podiatry service. The interviews therefore included comments from both participants. Ellie was so keen to be a participant that she came to the department to state that she wished to take part. Ellie and her husband expressed that they thought the opportunity to contribute to the study was a good idea. Ellie and Tom accepted that they would have to wait the normal period for an appointment and that their participation would not affect the departments normal processes. Ellie was an American by birth who had travelled extensively. Ellie was married to Tom who had been a District Commissioner in Africa. Both Ellie and Tom were well educated. They lived in a ground floor flat in a large town. Tom was physically frailer and was a chain smoker. Ellie wanted to take part because she had not been asked for her opinion before on anything. Ellie portrayed her foot problem as insignificant. "Off tape" she told me how painful her foot had been at the end of her holiday and that she had to get private treatment immediately she returned from holiday. It had clearly affected her holiday. "On tape" she was not so definite that her foot problem had been such a problem and again kind of brushed it off as a small insignificant problem. After second interview made comments "off tape" about being lucky enough to grow older but she currently "felt it was a curse" because she could not physically do the things she used to like to do. She made numerous references to body image and with reference to footwear that she did not want to look "a granny".

ELSIE (80)

Elsie is twice widowed, her last husband died seven years ago. Elsie had recently moved into her own semi-detached bungalow in large town in Gloucestershire from a very large town in Wales where she had lived for fifty seven years. Elsie was born in London where she was brought up. Elsie has a son who has recently retired and he lives in America. Elsie is socially active, very articulate and quite remarkable in that she drives her own motor home and travels around the UK meeting friends and relatives. She also takes part in activities for single people who go camping and has made lots of friends through these activities. Elsie has previous experience of accessing podiatry services in Wales where she had to wait twelve months for an appointment for an assessment and then waited a further twelve months for treatment. This obviously influenced Elsie's comments.

FRANK (86)

Frank lives with his wife in a private semi-detached house in a village on the outskirts of a large town. Frank had been referred to the podiatry service more than twelve months ago when he requested another referral. According to Frank his foot problem was not acute at the time of the initial referral and he had managed to assist his own foot problem and therefore was not concerned about not hearing from the podiatry service, although upon requesting the service felt he would take up the appointment this time. Frank described his wife as "disabled" and that he was her carer. During the first interview Frank's wife arrived home following a visit to the hairdresser. Frank's wife appeared far from "disabled" and it appeared that both Frank and his wife actually led quite independent lives. It appeared that Frank's wife was already receiving treatment from the podiatry service and had done so for

many years. At the second interview Frank's wife attempted to dominate the conversation and appeared to want to be the centre of attention. This had occurred at the first interview but not much notice was taken of this other than a comment from her in the kitchen to her husband, "is he still here?" During the second interview the impression that Frank rather looked forward to the interview as a distraction. Interestingly, both interviews were organised by Frank whilst his wife was out. Frank's wife appeared to be quite a domineering and selfish lady who wanted Frank's attention all of the time. Looking back the interviews were a definitely an inconvenience for Frank's wife.

GWENDOLINE (78)

Gwendoline is married and lives in a semi-detached house in a town with her husband. Gwendoline has two children and several grandchildren. Gwendoline now feels "redundant" (I asked did she mean retired, she reiterated, redundant). Gwendoline was born outside of Gloucestershire and had worked in silk mills for most of her life. Gwendoline had always had jobs that involved standing on her feet and would see herself as "working class". However, Gwendoline was proud of her children who she felt had done very well and were now "middle class". Gwendoline's main priority in life was to keep active by going out each day. On both occasions I visited her husband was out, Gwendoline put this down to the fact that "she talked too much". Gwendoline felt that keeping active was important in maintaining her current status and remaining "young" and healthy. Gwendoline had acted as a carer for her grandchildren until her daughter's recent divorce. "Off tape" Gwendoline made the following interesting comments – "oh I was expecting an older man" and "I don't see foot-care as a health problem – to fix it, or correct bone deformity you'd go to surgeon at hospital, its like the optician they sort your eyes out but if there's something wrong you go to the eye surgeon at the hospital".

IRIS (80) (GEORGE (80) husband)

Iris was married to George and they lived in a semi-detached council house in a cotswold village. Both Iris and George were very active despite Iris awaiting a replacement knee due to osteoarthritis. Iris and George were very articulate, organised and independent. They worked together effectively as a team. They still holiday each year abroad. Iris and George had two children, a son (53) and an adopted daughter (51) who they visited frequently. Iris was relatively healthy other than having osteoarthritis, a hearing impairment and being slightly overweight. Both Iris and George regularly participate in voluntary work.

IVY (82)

Ivy is divorced and lives in a small, secure tenement flat on the third floor of a block of council flats in a complex of buildings purpose built for older people. At first Ivy was reluctant to take part and took some persuading before she consented. Ivy was an active person in the local community. She is carer for an old gentleman next door (although he is younger than Ivy) and organises trips and cooks cakes for the local pensioners club. Ivy was one of a family of eleven and would be placed in the lower social classes. Unfortunately, Ivy was sent an appointment to attend a clinic across the town when there was a clinic much closer to Ivy's home. Ivy had a daughter who came around when halfway through first interview. Daughter came on social visit and not in a carer role. At the time scheduled for Ivy's second interview the interviewer attended by Ivy had to go to look after her grandchildren as there was an emergency in the family. A second attempt was made to undertake the second interview which took place but as soon as it finished Ivy needed to go and check on her elderly neighbour.

JESSIE (83)

Jessie is a widow who lives alone in own bungalow in cotswold market town. Jessie openly stated that she was a loner. She and her husband (when he was alive) kept themselves much to themselves. Jessie expressed that this would lead to difficulty in actually getting to the podiatry clinic ("we'll have to see!"). Jessie had severe osteoarthritis in her hands and feet and described difficulty in carrying out such "simple tasks". Jessie has multifactorial health problems that she did not relate to her foot problems. Jessie realised that the severe bunions she had were hereditary.

JIMMY (78) (SYLVIA (76) Wife)

Jimmy lived with his wife in a newly built close knit series of older peoples private dwellings. Jimmy was a retired RAF pilot. He was married to Sylvia. Jimmy was comparatively well off compared with main other participants in this study. Jimmy and Sylvia had a family that was spread across the world. Both Jimmy and Sylvia were generally in good health and both very active. At this particular stage in their lives they felt that they had no requirement for additional support networks. During the interviews it became apparent that both Jimmy and Sylvia were both very articulate although at times they had quite different views on things.

JOYCE (77)

Joyce is a widow who cares for her disabled son, Michael (52). Michael has a visual impairment and epilepsy. Joyce lives in a ground floor council maisonette. Joyce would be classed as lower working class. Joyce has a very limited number of friends, neighbours and relatives and her social networks are virtually non-existent. Joyce acts as main carer for her son. Joyce had a limited education and is unable to articulate very well. Joyce has no great expectations of life and was referred to the Podiatry Service by her General Practitioner although she does not know why. She did not feel she had anything wrong with her feet and that her main problem was varicose veins.

KATE (78)

A widow who lives on her own in a council bungalow on the outskirts of a Cotswold market town. Kate has a complex support network of relatives and neighbours who provide different levels of support or caring. Kate's husband died 14 months prior to first interview. She is profoundly deaf and short of breath. Kate has lived in the town for most of her life. She rarely goes out other than to shop in the town and then this is done with support from one of the many relatives. Kate has two sisters, two daughters (son died at nine months), six grandchildren and three great grandchildren.

KENNETH (75)

Kenneth is a widower who lived in a cotswold village in a semi-detached council house. Kenneth is a carer for his son Tim, who has cerebral palsy and epilepsy. Kenneth had been active in the local community undertaking voluntary work with local youngsters. Kenneth was a very hospitable and easy going gentleman. His main interests were looking after his son, amateur electronics and supporting his son's amateur radio interests.

LILLIAN (77)

Lillian is a widower, her husband died six years ago. Lillian has two daughters and grandchildren. Lillian has an extended family network that supports her and has a daughter and granddaughter that live next door. Lillian lives in a council house in a large town. Lillian is forgetful and has early signs of dementia and short-term memory loss. She also has

multifactoral health problems. This includes a serious heart problem and chronic obstructive pulmonary disease. When discussing her foot problem Lillian's focus was on one thickened toenail. This she described as painful. Interestingly Lillian had other foot problems including corns and callouses which she made no mention of. Lillian has asked her granddaughter (beautician) to look after her toenail because "she had the right equipment". During the interview with Lillian it was difficult to go into any great depth with the questioning because of Lillian's mental state.

LIZZIE (82)

Lizzie lives on her own (with her cat) with support from carers and neighbour in her own terraced house in a large town. Lizzie lives down stairs (her frailty and limited mobility prevent her from getting up stairs) with her bed in the front room. Lizzie has multiple health problems (heart, breathing difficulties, diverticulitis, osteoarthritis in spine and neck) and as a result was very disabled, being restricted to a chair in her front room. Despite her frailty and disability Lizzie remained fiercely independent. Lizzie was a lady who had experienced a strict upbringing during her childhood that she said had affected her approach to life and health services. During the two interviews it was apparent that Lizzie became tired quiet quickly during our conversations and the interview techniques had to be adapted accordingly. Lizzie had one adopted daughter who had provided her with grandchildren and great grandchildren.

MAGGIE (84)

Maggie is a widow who lives in a third floor flat in a large market town. Maggie's flat is secure, it has a buzzer and call system and is in a complex of private flats for older people. Maggie came across as a very intelligent and articulate lady who made the interviewer feel welcome from the first meeting. Maggie was politically aware and not afraid to voice her views in writing to Tony Blair (Prime Minister) and senior Church men. Maggie described herself as a self confessed socialist and she was also a Quaker. During the war Maggie was a conscientious objector and campaigned at Greenham Common during the 1970's. She had been on many CND marches and marches with the TUC (Maggie cited an example of a march from Swansea to London in four days). Maggie went to a boarding school when she was young (as did her son). Maggie's husband was a teacher and they moved to Gloucestershire because he had breathing difficulties and the air was thought to be good. After seven years in Gloucestershire Maggie's husband died. Further tragedy followed when her only son died 5 years ago. Maggie has two grandchildren who she proudly stated were the first in the family not to go to public school.

MARJORIE (79)

Marjorie lives alone in her own semi-detached bungalow in a cotswold market town. Marjorie is divorced following thirty seven years of marriage. Her ex-husband has recently died and Marjorie is beginning to get her life back together and build up her self-esteem. Marjorie has recently started to socialise again and has started dancing. Marjorie was adamant that the current foot problem she was experiencing would not stop her from dancing and socialising. Marjorie has no children, some close relatives and generally feels alone. Marjorie was very apprehensive when first contacted but following a telephone conversation became very keen to take part. At the first interview Marjorie was very talkative. It was clear from Marjorie's responses that she was unusual in wanting one off treatment and advice and to be able to continue with own foot-care.

MARY (83) (CHARLES 85 Husband)

Mary lives with her husband in a detached bungalow in a village on the outskirts of a large town and have been married for sixty one years. Mary used to be a teacher and had no children. Mary had previous experience of private podiatry provided at her home. This made Mary reluctant to visit an NHS podiatry establishment. Mary and Charles have a comprehensive support network that consisted of numerous people calling on them. During the times that I was there people from health, social services and voluntary sector called bringing food, meals and differing type of care to the home. The private podiatrist visited a number of people in close proximity to Mary and Charles. When this no longer became a financially viable option for the podiatrist the visits ceased. Mary's GP then referred her to the NHS podiatry service. Mary and Charles are comfortably off and give the impression that they would prefer to continue receiving private podiatry if it means they can be seen at home. Both Mary and Charles are articulate and have strong personalities and it was they who contacted the researcher, wanting to take part because "nobody has ever asked their opinion before".

MOLLY (81)

Molly is a widow with two daughters and several grandchildren. She lives alone in a semi-detached house in a large town. Molly is very unsteady on her feet due to severe rheumatoid arthritis and never goes out alone. Molly has fallen out with one of her daughters because of her new husband. Molly has received podiatry treatment privately previously and commented that she had not used the NHS podiatry service previously because of perceived waiting time. Molly is remarkably cheerful despite her disability and retains a very keen sense of humour. Molly's daughter contacted me because Molly was worried that I had not contacted her (she thought it might affect her appointment). (*I had not considered this as I thought people might be glad if I did not contact them!*). At the second interview Molly was not feeling too well, although she stated she felt better at the end of the interview because she had someone to talk to. During the interview Molly indicated that she was lonely. "Off tape" Molly commented on her new son-in-law and said she often said to him "I've got a bigger computer than you, it just takes longer to get things out". This was reference to being older and Molly attempting to assert that her mind was still active. Also "off tape" Molly commented about being lucky enough to grow older but that she currently felt it was "a curse" because she could not physically do the things she used to like to do. Molly also made frequent references to image and footwear and despite her deformed feet due to the arthritis Molly was determined not to look like "a granny".

NORMAN (86) (RITA (75)– wife & chief carer)

Norman lives with his wife (and dog) in a small Cotswold village in a group of semi-detached older peoples bungalows. Norman has multiple health problems (asthma, heart, deaf) and his wife is the chief carer (a determined and forthright character). Norman is reserved, quiet and very laid back (wife would suggest lazy). Neither have any social activities although Norman still drives a car. Norman spends most of his spare time doing crosswords, puzzles and watching TV. Rita, although his chief carer will not cut Normans toenails which is what he sees as his only foot problem. They say they lead busy lives (?) as Wednesday is the only day I can visit them. They (she) do something on every other day e.g. shopping, washing, cleaning. Issues were raised regarding access to service(s), expectations of service for life (including home visits). Rita raised interesting concept of only attending for appointments that she requests. Norman and Rita appear to work as a cohesive unit in a planned and organised way.

PAMELA (85)

A widowed lady who lives alone, in a council flat (1st Floor) with security doors, in a large town. Pamela is verging on the edge of dementia. Pamela had forgotten I was coming and looked like she was about to go out when I called. She had her hat and coat on and said she was off to the hairdressers when I arrived (even though she did not have an appointment at hairdresser). The house was untidy although she did get some support from Home care Services. Pamela did know that she had a podiatry appointment although she did not remember when it was. I was not convinced she would attend the appointment. Conversation with Pamela was difficult as she kept wandering off the subject. The interviews were short with short answers although some answers had relevance much of the conversation was incoherent. When I returned to undertake the second interview, I discovered that Pamela had failed to attend with no notification to the podiatry clinic. Pamela stated that the clinic was too far away. This made the undertaking of the second interview irrelevant.

ROBERT (87)

Robert is a widower living in a semi-detached private house on the outskirts of a large town. Robert is well educated having been to Oxford University and then a career in the army. Robert is therefore very articulate and organised. This was demonstrated by the fact that he had made a list of issues that he wished to discuss and speak about before the interview. Robert was beginning to feel he was losing his independence and he had recently had to give up driving. It transpired that Robert's wife had previously used NHS podiatry but that in the past they had both preferred to attend a private podiatrist.

SYBIL (83)

Sybil is a widow living in a council flat in a market town. Sybil has osteoarthritis and other medical problems. Sybil showed signs of early dementia. She lived with her dog who was her companion and clearly very important to her. Sybil has a carer/helper called Tina who came in to help with the shopping and washing. Despite this help Sybil remained fiercely independent. Sybil do not really appreciate much about the need to have her feet looked at. She even stated that she was not sure if she would turn up for the appointment despite being referred to the podiatry service. Sybil stated that if she was sent appointment she would attend. Sybil clearly did not feel she was old and felt that admission of foot problems were an indication of getting older. She also felt that there was always someone else worse off than herself. Sybil felt you were old when you lost your mind or could not cope anymore. Sybil did repeat herself on numerous occasions throughout the interview and sometimes contradicted herself. Sybil had little social interaction and did not go to out to meet people in groups or other activities. Sybil stated that most people she knew of her age had already died. Sybil talked "off tape" about already having arranged her funeral and she was concerned that she did not want anyone to worry about it.

VALERIE (83)

Valerie lives alone in a semi-detached council house on the outskirts of a large town. The house came with Valerie's previous employment. Valerie is divorced with one daughter. The daughter is in attendance at both interviews and acts as Valerie's carer. Valerie's daughter is not included in the research because she does not meet the age criteria for the research. Valerie is a cheerful lady who appears to be quite outgoing. However, she is very nervous of interview, in particular having to speak for a tape recorder. Valerie's main foot problem is pain in the heel. Up until now Valerie has undertaken her own foot-care with her

daughter attending to toenail cutting. Valerie was concerned that she wanted to remain independent of the podiatry service and that she saw the intervention as temporary. During the interview it became apparent that Valerie was primarily a solitary person and fiercely independent. She appeared to have had numerous "crises" that had led to contact with the podiatry service via her GP. Prior to the interview Valerie had made a list of the things she wanted to say.

VIOLET (92)

Violet is a widow living in a new private ground floor flat in the centre of a large town. Violet has a son who lives nearby Violet talks about her son as if he is a little boy. He is in fact retired and visits occasionally to ensure that things are alright with his mother. Violet seemed a little forgetful at the first meeting. She was also apprehensive of meeting strangers. Once conversation was struck up with Violet she appeared to enjoy conversation although at times she became forgetful. During the first interview it became apparent that Violet was lonely and frightened of the "alien" world that surrounded her (this is probably due to moving to a new home in a new town. It became apparent that Violet did not stray far from her flat or familiar surroundings. The move was initiated so that she could be nearer to her son. At the second interview Violet appeared much more relaxed and able to converse more easily.