Open Research Online

The Open University's repository of research publications
and other research outputs

Recycling the evidence: Different approaches to the reanalysis of elite life histories

Book Section

oro.open.ac.uk

Chapter 7

Recycling the evidence

Different approaches to the re-analysis of elite life histories

Joanna Bornat and Gail Wilson

Introduction

In this chapter we consider the re-analysis of one very specific body of data: the life histories of a select group of pioneers of geriatric medicine from the point of view of what they tell us about the changing attitudes to family and community of one group of professionals. The original data were collected in 1991 in the form of life history interviews by Professor Margot Jefferys and two co-researchers. Her purpose was to present the story, in their own words, of the men (predominantly) who founded the geriatric specialty in mid-twentieth century. As she explains, they were contesting:

> The predominant view, one shared by the public as well as the majority of the medical profession – most of whom would have been trained in the high prestige voluntary hospitals – ...that sickness in old age could not be cured or treated'.
>
> (Jefferys 2000: 76)

The interviewees were selected for their role and pre-eminence in this field, and the stories they tell are moral as well as professional accounts of career development (Bornat, 2004). Margot Jefferys elaborates: 'In telling their stories, many of our interviewees were recalling their own awakening as well as a life of professional campaigning against inequality and exclusion in health care provision' (Jefferys 2000: 77). Jefferys' aim was, therefore, somewhat distant from our own in re-analysing for references to family and community. Re-analysis, or secondary analysis as it is more commonly known, opens up possibilities for new theories, concepts, and data to be created from an original set of data. Our aim here is to outline Jeffery's study, discuss methodological issues arising from secondary analysis, and raise some ethical issues occasioned by returning to data, before identifying some new interpretations that specifically relate to family and community.

The Jefferys' data

Margot Jefferys chose a theoretical sample of the people whom she believed could tell her most about the development of geriatrics. As far as can be seen, she had a straightforward historical motivation to capture the experience of the 'pioneers' before they died. The oldest 'pioneer' was 92 in 1991, and 15 had been born before 1915. The theoretical model behind this approach appears to be that change results from the activities of key individuals. Though it seems unlikely that Margot Jefferys would have seen this theory as adequate for a full study, it is clearly embodied in the interviews and reflects the hierarchical nature of power in hospital medicine. The theoretical sample was mainly doctors (geriatricians, with a few psychogeriatricians and general practitioners), but the sample also included pioneering nurses, social workers, occupational therapists, civil servants, officials from voluntary organisations, and two ministers (Kenneth Robinson and Enoch Powell).

The interviews can be described as guided life histories. Interviewees were asked about family and early education in so far as it accounted for their going into medicine, but the main focus was their careers and their views on how geriatrics developed. During their careers geriatric medicine had moved from being a matter of rehabilitating bed-bound, chronically ill patients in former workhouses to visiting older people in their homes (to ensure they were being correctly admitted and that their relatives might be able to take them again after treatment), and finally to seeing relatives mainly in hospital with 'the community' now a recognised partner in care. These transitions were common to all interviewees' experiences, but they had taken place at different times. It appeared that all three stages could be found in Britain at any time up till the late 1970s. The interviewees describe their careers against the backdrop of changing organisational and recruitment practices before and after the establishment of the NHS. Many identify their own role in bringing about the relocation of beds and the movement of resources away from the old long-stay hospitals and towards models of care built on principles of rehabilitation and, increasingly, care in the community.

Secondary analysis

Writing as recently as 2000, Paul Thompson described attempts to identify methods for the secondary analysis of qualitative data as 'the silent space' (Thompson, 2000:3). Four years later, Thompson and Louise Corti pointed to the 'new culture of the secondary use of qualitative data' (Thompson *et al.* 341). The intervening period had seen a rapid growth of interest in secondary analysis, with new projects, new methods, and new data emerging into what is now an established arena for debate.[1] Definitions were called for

and Janet Heaton's definition has proved helpful, describing secondary analysis as 'a methodology for the study of non-naturalistic or artefactual data derived from previous studies, such as fieldnotes, observational records, and tapes and transcripts of interviews and focus groups' (Heaton 2004: 6).

There have, needless to say, been criticisms of the reuse of data. Principal amongst these have been those of Martin Hammersley and Natasha Mauthner and colleagues (Mauthner *et al.* 1998; Parry *et al.* 2004). Briefly, the points these authors make are that data are 'constructed', the product of a particular moment in time and of a particular set of interactions which 'involve an informal and intuitive element'. More than this, the 'cultural habitus' of a researcher, their ideas, and acquired research experience makes it impossible for another researcher to understand their original meaning and interpretation (Hammersley 1997: 138–9). Hammersley also suggests that even when two researchers are very close in their understanding 'there will also be relevant data missing'; in any secondary analysis it is likely that this will come to be increasingly significant' (ibid.: 139). Finally, he argues that to go back with a different purpose undermines the importance of context, something that is particularly important for ethnographic studies because 'The fieldworker interprets (fieldnotes) against the background of all that he or she tacitly knows about the setting as a result of first-hand experience, a background that may not be available to those without that experience' (ibid.). Of course these arguments could apply to most historical documents which are also products of time and place, as are oral history interviews. Without opportunities for reinterpretation, much of what we recognise as historical research would come to an end.

Mauthner and her colleagues (1998) identify similar and additional problems. On returning to their own data, each of the authors finds that these were created in specific researcher–researched interactions. They also raise the question of missing data, pointing out that the original researcher, in this case themselves in an earlier life stage, did not necessarily ask all the questions that might have been asked. They also argue that their original research exists in 'the boundaries within which the fieldwork was accomplished (Mauthner *et al.* 1998: 742). This boundedness renders their original data unreachable. In presenting their old data as beyond subsequent interpretation on the basis of their historically-embedded subjectivity, they criticise secondary analysis as 'naively realist' because it 'hoodwinks us into believing they are entities without concomitant relations' (ibid: 743).

Niamh Moore in a robust response, challenges this rather protectionist attitude to old data. As she points out, the original data still exist but to rework them is to open up new possibilities for advancing knowledge in a different context:

> Their account, with its attention to the context and reflexivity involved in the production of the so-called 'pre-existing' data, proceeds at times

as if they understand reusing data to be about some attempt to repeat or reconstruct the original research project, as if it is another interview project, rather than as a new project in its own right, this time an archival or documentary project. They fail to appreciate the necessity of attention to the context and reflexivity of the *current* project, which effectively makes new data out of old. Ironically it is their mistaking of the temporality of the context and reflexive production of the data which underlies their belief in the limitations of reusing data. Their construction of the issues in this debate consistently leaves the data behind in the past, in the original project that produced the data.

(Moore, 2006)

Creating new data from old offers intriguing possibilities which make practising secondary data analysis so attractive. In an earlier paper, one of us has already shown how a new reading of the Jefferys' data has led to new research questions and a new focus for that data. The pioneers of geriatric medicine were reliant on recruitment of doctors from South Asia to build up their departments. This was not a focus of the original set of interviews, but becomes obvious after a new reading of the data (Bornat, 2003). Though Jefferys and her interviewees were focusing on the roles and careers of a particular medical elite. The contribution of more junior doctors, many of whom were overseas-trained and (initially, at least) occupied a more lowly status, was only mentioned in passing:

... staffing geriatric departments hasn't always been easy, we have had to appoint quite a lot of doctors from the Indian sub-continent to be registrars and even senior registrars, so for quite a period the only applicants for consultant jobs were in fact not British citizens trained by British methods. They had been to respectable geriatric departments and learnt the trade but when they got appointed to x, y, z, they had Indian or Pakistani names or whatever else. And it tended to get known as the sort of, you know, dark-skinned specialty.

(John Agate, born 1919, British Library catalogue C512/8/01–02)

By addressing questions about ethnicity, new data emerged about the origins of the specialty and with it a different take on the role and influence of the pioneers. This is an area where the historical context has changed greatly over the last half-century. Awareness of discrimination, the uses and abuses of language, and the political and legal frameworks that support equal opportunities have developed in ways that impoverish interpretations of meaning that ignore the historical context (Bornat, 2005 and Evans *et al.* 2006 for discussions of changed language use and revisiting data).

However, the questions of 'missing data' and the contexts of their collection cannot be avoided. In our case, re-analysis of what was said about family

and community was relatively unproblematic. Neither was the main focus of the original interviews, so what the geriatricians had to say about them was either in response to one question (see below) or spontaneous mentions initiated as part of their general view of their role in geriatric medicine.

Missing data may arise simply because questions were not asked at the time of the original data set, but that begs the question of how this came to happen. Oral historians, and others who may use biographical material, often puzzle over the issue of 'silence' in the data. It is most commonly addressed in relation to assumptions about suppression, often with the implication that this follows from deliberate or unconscious self-censorship. Luisa Passerini began the debate amongst oral historians in her study of working–class remembering of the Fascist period in Italy. She heard people making only passing references to Fascism, or who apparently had selective recall, neglecting the detail of their daily lives, without a hint of what it was like to live surrounded by Fascist organisations and institutions (Passerini 1979). Subsequently, discussions about silence have tended to focus more on the insights of the interviewer or interpreter to make sense of what is heard or read (Moodie 2000; Roper 2003; Parr 2007). However, Passerini's conclusion was rather different. She argues that silences and omissions should more accurately be attributed to, 'incorrect formulations of problems' (Passerini 1979: 92). Secondary analysis offers the possibility of identifying what the missing questions might have been, or the limited nature of their formulation, and going further to ask new questions of the data, developing and extending the original focus of research.

In contrast to this important point made by Passerini, in the argument set out below, we are identifying a set of discourses on the concepts of family and community in geriatric medicine that were spontaneously produced by interviewees, even though the original data collectors did not ask for them. At this point in time we cannot know whether so few questions were asked because the interviewers shared a an understanding of the place of family and community in geriatric medicine which was taken for granted, or because the researchers were genuinely uninterested in that aspect of the development of the speciality.

Ethical issues

Long semi-structured, typewritten interviews need a great deal of work if they are to be reused in social research. However, digitalisation produces a new body of data that can be searched digitally, opening up a vast range of new possibilities and ethical problems. The first ethical issue is one of consent. The participants in the Jefferys' study had agreed to cooperate with a highly respected retired medical sociologist who had participated in most of the developments they described. They were willing to place their lifetime's achievement on record in the British Library Sound Archive for all to

access. The interviews were impeccably conducted. The researchers obtained oral and written consent, tapes were transcribed using a manual typewriter, and tapes and transcriptions were placed in the Sound Archive along with summaries of each interview. Informed consent had been given for a personal life history with emphasis on contributions to British geriatric medicine. At the time of interview additional data such as published papers, photos, and other documents were also collected if they were offered. Some participants, though we do not know whom or how many, also read through the transcripts of their interviews and corrected them before they went onto public display. Legally, therefore, there are no ethical issues involved in re-accessing and re-analysing these data.

However, the British Sociological Association's ethical guidelines state that:

> As far as possible participation in sociological research should be based on the freely given *informed* (our emphasis) consent of those studied. This implies a responsibility on the sociologist to explain in appropriate detail, and in terms meaningful to participants, what the research is about, who is undertaking and financing it, why it is being undertaken, and how it is to be disseminated and used.
>
> (British Sociological Association, 2002)

This leaves open the question of future uses, funded by different bodies, with different research agendas. The guidelines go on to say that:

> Sociologists should be careful, on the one hand, not to give unrealistic guarantees of confidentiality and, on the other, not to permit communication of research films or *records* (our emphasis) to audiences other than those to which the research participants have agreed.
>
> (ibid.)

Still more problematic,

> Where there is a likelihood that data may be shared with other researchers, the potential uses to which the data might be put must be discussed with research participants and their consent obtained for the future use of the material.
>
> (ibid.)

The original researchers were very clearly focused on one purpose and it seems likely that, when agreeing to be part of the British Library Sound Archive, the respondents understood that their words might be analysed by a range of researchers concerned with different aspects of medical history or medical sociology. Some respondents were aware of the tape recorder and even deliberately spoke off record, but there is no evidence that they were

thinking of others using their life stories for different purposes in the future. There is no record of discussion about the ways in which the values of future researchers, their areas of interest, the language used, and the inter-pretations thought viable would change over the coming decades. It was clear that informed consent did not, and could not, have included a full dis-cussion of potential uses for the data.

However, we have to note that there are fundamental limits to informed consent and the circumstances in which it can realistically be obtained. For example, it is almost certainly impossible to obtain when face-to-face inter-views cover highly personal or emotive subjects; neither the interviewer nor the respondent can be sure how an interview will develop in such circum-stances. It is good practice to make it clear that outcomes of such an interview cannot be predicted, and in some cases even to point out that the researcher has an overriding ethical duty to report illegal activities. The respondent should at least be warned and know to avoid certain subjects – but this is no guarantee that they will not be mentioned, or that other painful and identity threatening issues will not be raised. Consent may be freely given and even maintained after such an interview – especially if the experience was felt to be therapeutic (Bornat 2001) – but it will not have been 'informed' consent prior to the interview. Both participants and inter-viewers may know they are at risk, but they cannot be sure what the risk is and hence cannot be fully informed. In face-to-face or real-time interviews this problem can be partly overcome by allowing respondents to withdraw from a research project, but that may not be not possible in secondary analysis when participants have died or cannot be traced.

A second ethical issue is that the ethical guidelines for oral history or lit-erary biography are very much more permissive. Character assassination by a biographer may be deplored by reviewers, but as long as the analysis remains within the law it will not usually be deemed unethical. Oral histori-ans with a tradition of identification with their participants are unlikely to upset or denigrate their informants (Yow 2006). The Oral History Society's ethical guidelines are also firm on the issue of informed consent:

> Interviewing people serves very little purpose unless the interviews become available for use. It is unethical, and in many cases illegal, to use interviews without the *informed consent* of the interviewee, in which the nature of the use or uses is clear and explicit.
>
> (Ward, n.d.; Parry *et al.* 2004)

However, the guidelines go on to suggest possible avoidance procedures (mainly use of documentation, including copyright assigning, which can, at least, protect against future legal action).

The oral history traditionally places great stress on the nature of the interview, its enabling and empowering qualities, and its sensitivity and an

implied intimacy. Preparation for the interview not only involves familiaris-
ing oneself with the context of a person's life, their occupation, community,
generation, and the public chronology of their time, but it also means devel-
oping social and interpersonal skills, listening capabilities, and empathy
(Ritchie 2003). The result can often be a personal relationship that lasts
over some time, but most certainly the result is a sufficiently close relation-
ship that leads to changed perspectives on both sides of the microphone.

The responsibilities of the interviewer in such circumstances are great.
Attending to these, perhaps through the formality of the release form and
talking people through matters of ownership and rights to edit and change
what has been spoken, means that the relationship between the researcher
and the data is very different from that expected in social science. Some oral
historians argue the case for a continuing sense of partnership and shared
endeavour (Frisch 1990). Under such conditions and if, for the best ethical
reasons, oral historians sign up to the notion of 'shared authority', will this
make the interview a more personal and therefore private relationship, less
accessible to a secondary analyser?

For the reasons discussed above we would suggest that for all who reuse
qualitative data, the ethical issue is not informed consent but a duty of care
to the respondents, and possibly to their descendents. Consent, preferably
written, but in some cases as part of the recording, is essential. The purpose
of the research and its potential uses should always be explained. The key
points here are that there should be no deceit and that researchers should 'in
so far as is possible' ensure that the 'physical, social and psychological well-
being of research participants is not adversely affected by the research'
(British Sociological Association, 2002). This means that data which have
been freely given for one purpose should not knowingly be re-analysed in a
different context or in ways that would be likely upset or harm the original
respondents. The conclusions drawn from re-analysis should not cause
'physical, social or psychological' (British Sociological Association, 2002)
pain to the original respondents in the same way that real-time oral history
research would seek to avoid causing pain. And if there has been a lapse in
time, we must also ask how surviving relatives would feel. The upsurge in
family campaigns to clear the names of grandparents, and even great grand-
parents, who may have been wrongly convicted of crime or desertion
indicates a growing popular concern with family history and the ethical
issues that are involved (Kean 2004). It also raises questions about changing
constructions of what is meant by family, both over time and within the life
time of a family member.

Family and community

The Jefferys' interview transcripts were scanned and cleaned, and the result-
ing texts were put into a form suitable for computer-assisted qualitative data

analysis (CAQDAS) and analysed using the N6 version of QSR NUD*IST. Searches for topics relating to family and community were aided by the original researchers who asked two standard questions. The first was whether the family had maintained its caring abilities over the career of the respondent. The second asked for views on the NHS and Community Care Act 1990, which aimed to move care of older people from institutions into the 'community' (Means *et al.* 1998). In most cases the researchers succeeded in addressing these questions in some form or other, but these were elite interviews and the content varied depending on whether the participants took over the interview or allowed the interviewer to lead the discussion. However, once the typescripts were digitalised it became much easier to find a fuller range of references to family and community, and to analyse a wider range of comments than those attached to specific words or questions.

The use of CAQDAS raises the question of context of text segments. Digital searching or coding can lead to quotations from interviews that are divorced from their context and so distort the views expressed. The solution is to check on the context by displaying the word, sentence, or paragraph with its surrounding text and as much of the interview as is needed to clarify the meaning. Researcher judgement will still be necessary, but this is inherent in any qualitative analysis. Other researchers have pointed out the rewards of working with CAQDAS, suggesting that the process is enlightening and helpful to the development of more complex interpretations (Coffey *et al.* 1996). What is helpful and confirming is, as Thompson (2002) suggests, to make the process as transparent at possible. Digital searching and coding therefore enlarged our sample of views on family and community offered by the interviewees.

The distinction between family and community arises partly because of language change (see above). 'Community' was not a word much used in the earlier part of our period when it was largely covered by 'family' in so far as the concept arose, but it became increasingly popular in the 1980s with the policy of closing large long-stay mental hospitals. In the interviews it was associated with the results of the NHS and Community Care Act 1990 (even though this had not then fully come into force). Respondents were limited by class, culture, and historical context in their perceptions of family and community. They were uniformly middle class, and 48 out the 53 doctors were men, while most of their patients were women. In the case of the earliest pioneers, their patients were not simply working class, but severely disadvantaged members of the working class. They were old and they had been admitted to a building that was either the old workhouse or something very like it. The Poor Law, and with it the official designation of workhouse, ended in 1929. However, hospitals for the chronically ill were frequently part of the old Poor Law system, and popular folklore has only recently stopped seeing them as places where people were sent to die. Hence the lives of their patients were alien to the well-brought up doctors who

were suddenly faced with a layer of society they had not met before. This account from Dr Nagley, illustrates this sense of social distance:

> And the VD department [of the workhouse] was part of the dermato-logical section, of course. The other doctor was a lady, and she looked after the female VDs, and I looked after the male VDs. It may surprise you, but male VD is a lot more wholesome to deal with than female VDs. When Dr Peacock was on holiday I had to do the female VDs, and equally she did the males when I was away. And really, I was horrified, first of all, by the coarseness of the women, the young women there, and their lack of any sort of reticence about their problems down below. Oh dear, it put me off for a long time, having to do female VDs.
> (Lawrence Nagley, born 1911, British Library catalogue C512/58/01)[2]

Another, Samuel Vine, describes a formative incident in his first job as a registrar at Fulham hospital after an education at Cambridge and Guys Medical School, and war service in the Far East and consequent late demobilisastion:

> And she so she said, 'Now I've got these prescription forms for you to sign' and do you know, I was just about to do it and I said, 'Wait a minute, sister, I have never in my life signed a prescription for a patient whom I have not seen and I'm not going to start this afternoon. I will see all these patients before I sign these prescriptions'. And the sister nearly fainted at that point because this was the first time any doctor had insisted on seeing the patients. Well, I was shocked, amazed, appalled, saddened and very upset at what I saw that afternoon. I could not believe that, within the campus of one hospital, two separate stan-dards should exist for treatment based solely upon age, 65 for men and 60 for women.
> (Samuel Vine, born 1919, British Library catalogue C512/68/01–02)

Virtually no one who mentioned 'the family' felt that it had failed or was fail-ing. So, for example, the questions like the following never got agreement:

> You hear a lot of complaints that the voluntary and the statutory organisations have to make good because the family no longer helps support its dependent members, particularly the very old. Do you feel that there is something in that?

The respondents were very aware of popular discourse, but most stated that their experience of families did not bear it out. For example:

It was fashionable for people who knew nothing about it to say, 'of course, young people don't look after their elderly relatives and parents like they used to'. Well, of course people have been saying that since the time of the Romans ... If you're honest, it's incredible how marvellous people are. That was my view in the end. Of course, you came across the odd family who wouldn't be interested in mum or dad but when, when you did come across somebody like that it made such an impression on you, being so different from everybody else that you remembered that the more.

> (Ronald Dent, born 1906, British Library catalogue C512/63/01)

Another example is that of Eric Morton:

(I) Went into hundreds and hundreds of homes, and saw what everyone knows, or should know - incredibly squalid conditions in which they lived. Saw how wonderfully they coped. Saw how very few families neglect their old people, *despite what you read*.... I found in Nottingham that the rural districts and the real slums were the places where you found the kindest people. The middle-class housing estates were the worst. 'We've got to get rid of Granny. She's dirty.'

> (Eric Morton, born 1919, British Library catalogue
> C512/4/01–02, emphasis added)

A few took a scientific view and pointed out that the family had changed over time due to changed birth rates and survival rates or the migration of children. Many pointed out that families could be over stressed, but they all agreed that the majority of families were as caring as they had ever been:

I've heard of people who've required relatives to sign undertakings that they will take somebody back at the end of respite care, which is a very odd thing to do because it really approaches the whole situation in a very paranoid way, and I think I've never found that necessary. Whenever somebody's been admitted for respite and they have not been taken out, it's been because the carer has either died, which is hardly their fault, or become seriously ill. And, of course, many carers are pretty ancient and frail.

> (Brice Pitt, born 1931, British Library catalogue C512/42/01–02)

So we might ask 'What did the family mean to the pioneers of geriatric medicine?' In the first instance the family was central to their concept of geriatric medicine. They consistently saw their work as being about more than just a disease. Geriatricians saw the patient as part of a family and community. To some extent they shared this approach with general practitioners but they had the added status of being hospital-based. They saw themselves as problem

solving because they combined the diagnostic challenge of multiple patholo-
gies in older patients with an awareness of social needs; this set them apart
from other hospital-based medical specialties. The earliest pioneers who were
sent for one reason or another to old workhouses relied heavily on families
for their success. By working hard, examining patients who had not been
examined for years, if ever, and by converting the nursing staff to rehabilita-
tion, these pioneers were able to get their patients out of bed and make them
mobile. Despite, or because of, a lack of social workers and other support
staff outside nursing, they then called in the families of their long-stay patients
and suggested that they take their relatives home. Just as they did not question
how it came about that there were old, rundown institutions full of hundreds
of bed-bound elders, they did not question the existence of family for people
who had been in institutions for many years. This is a question that needs fur-
ther investigation since, if we are to believe their accounts of success, the
pioneers were undoubtedly able to find families and get them to take back
very large numbers of older patients.

> The staff, who had now been impressed with the desolation of treating
> the chronic sick, now were beginning to see and to look at patients
> from a new viewpoint: Shall we show this case to Dr Cosin to see what
> he can do about it? And this came our way and, of course, a lot of these
> patients continued to improve so that relatives who now came in with
> flowers and grapes twice a week were beginning to give the impression
> that 'Perhaps we can look after mother at home'.
>   (Lionel Cosin, born 1910, British Library catalogue C512/41/)

> We also saw the relatives, of course, how capable they were: whether
> the daughter was off work, whether she needed help. So that we devel-
> oped a much broader – coming back to the original subject – a much
> broader concept of care.
>   (Joseph Greenwood, born 1908, British Library catalogue
>   C512/31/01)

> I saw the relatives and I saw the home conditions, how they lived and
> how they managed. So I had a very good picture.
>   (Hugo Droller, born 1909, British Library catalogue C512/10/01)

Dr Droller was entirely normal in that he thought a short home visit could
tell him all he needed to know about a family. This was a very limited view
of family based on the old certainties that women would care and that the
real issue was whether there were women available and if the physical con-
ditions of their labour tolerable. The families were partners in care, but this
partnership was not recognised by the professionals in these interviews. The
goodwill of families and the labour of women were simply assumed. The

narrow view of family as having a duty to care was challenged by only one interviewee among those born before 1919:

> We used to think in those days that it was nearly ... would it be 1940s, I suppose, that if a patient seemed well enough, or border-line well enough to be discharged, you were really not doing anybody a service to discharge them, because there was very little in the way of unemployment pay and the family would have to support him or her without any pay, so that really it wasn't doing anybody a favour, so it was really kinder, so we thought, to keep a person who was ready to be well and could do some work in a hospital, in the hospital.
>
> (David Kay, born 1919, British Library catalogue C512/45/01)

However, once the old workhouses had been emptied, the aim of geriatric medicine was to keep patients moving through the hospital. This meant much more home visiting so that hospital doctors could be sure that admissions were appropriate – both medically appropriate and in terms of the possibility of discharge later. The interviewees who were most involved in home visiting saw this as one of the key aspects of their specialty. It also involved turf wars with other doctors including general practitioners in the community and consultants (mainly in medicine and psychiatry) in the hospital:

> Well, I spoke to all the GPs in the area and said 'Would you mind if I saw your patient when you referred?' And they all wrote back except one, and I convinced him. And then it enabled us to see the home, suitability of a home, whether it was a flat or a tower building or a cellar, or what the facilities were, so that it helped in the idea of discharge: could the patient go back to that home?
>
> (Joseph Greenwood, born 1908, British Library catalogue C512/31/01)

> Well I would guess... what were we doing? About five or six home visits a week each, throughout our time in Hull. And it wasn't for emergencies, it was for people that there was a genuine disagreement or diagnostic problem. And it was very good to see people at home and see their families and see the set-up there. I mean they are a lot of value to clinicians in seeing the real world outside the hospital.
>
> (Peter Horrocks, born 1938, British Library catalogue C512/48/01–02)

It appears from the interviews that the number of home visits fell as geriatric medicine became better established as a specialty and as new ideas of community care began to spread in the 1980s. Other doctors became able to identify potential geriatric patients and the specialty no longer feared

wholesale dumping of long-stay bedblockers. Visiting hours were extended and family and relatives began to be seen in the hospital itself rather than at home. The word 'community' became more common as the interviews moved to later stages in respondents' careers, but no one spoke of community as warmly as they did of family; the pioneers born before 1919 barely mentioned the word until they were asked about the 1990 NHS and Community Care Act. As seen from the quotations above, they focused on the family. Pitt, using the word community retrospectively, explains one aspect of the problem:

> The other thing that I well remember from Springfield, and it really still sticks in the mind, was that even my very good mentor had this attitude, which was that a good registrar did not admit an old person, and a bad registrar did. So the whole attitude of the hospital to its community as far as the elderly were concerned was that it was like a castle with a moat and a drawbridge and a portcullis, and a good registrar would keep the drawbridge down and the portcullis down and would fend off the elderly because those few who managed to get in were bound to stay, they were bound to be dumped by their families. There was a thoroughly paranoid view of the community as far as the elderly were concerned: there was a great anxiety that the place would be flooded with demented, old people.
>
> (Brice Pitt, born 1931, British Library catalogue C512/42/01)

The improvement in community services was a great help to geriatricians. It became easier to see families and community services as partners in the care of older people. The later pioneers mentioned good relations with social services as well as improvements in occupational therapy and community nursing. 'Community' was also a heading that allowed the needs of relatives and carers to be increasingly recognised, even though this was often in the context of greater exploitation. (See, for example, Finch *et al.* [1983] with their equation 'care in the community = care by the family = care by women'.) Evans and Sanford, among the younger pioneers, saw developments in the late 1980s and early 1990s as positive:

> And I think one of the ways things have improved recently is that we've gone very much more sensitive to the pressures put on families and, I mean in the 70s there was a policy in many districts, including the one I was working in then, that if a family was available, or, more specifically, if there was a daughter available – sons didn't count – if there was a daughter available then an old person was not eligible for home helps because it was assumed the daughter would do it. This was terribly misguided.
>
> (John Grimley Evans, born 1936, British Library catalogue C512/64/01–02)

> In the community itself there's been a lot of initiatives in terms of recog-
> nising the need for things like carer support groups to help the carers of
> the elderly. And that's been a main interest of mine, the needs of carers.
> (John Sanford, born 1948, British Library catalogue
> C512/14/01–02)

Once the interviewees began to discuss more recent developments, prob-
lems with attitudes to the word 'community' became clear. The closure of
long-stay geriatric wards and their replacement by private nursing homes
was not welcomed by these geriatricians. In medical terms they had two
fears: first, that patients in nursing homes would not be referred for spe-
cialist treatment; and second, that frail older people living in the
community would be sent directly to nursing homes without a specialist
assessment.

> What's worried us perhaps in the last four or five years is the return to
> the situation that when an older person becomes ill or disabled and the
> family can't cope, rather than seeking a medical or medical social opin-
> ion from the specialist who is interested, and who can help, and who
> will do so in a positive way, older citizens are now conveniently put into
> rest homes or nursing homes, and I find this very sad indeed.
> (Ivor Felstein, born 1933, British Library catalogue
> C512/33/01)

Or more bitterly:

> They talk so glibly about developing community resources as they close
> down this hospital and that hospital, and we see so much human misery
> as a result of the betrayal of those promises.
> (Alwyn Lishman, born 1931, British Library catalogue
> C512/39/01)

> Oh lord, yes. It is disastrous, in my opinion. The only reason for
> putting old people into nursing homes is to kill them off. . . . There is
> quite a good case to be made out for doing that, but doing it by decep-
> tion and deceit, which is what they are doing at the moment, I think is
> disgraceful.
> (Richard Benians, born 1906, British Library catalogue
> C512/55/01–02)

We conclude with the words of John Clifford Firth (qualified in 1941), which
link professional and medical change to changes in family, community, and
society:

…the actual care of the elderly people must bear some relation to the community circumstances at the time. In other words, whilst the attitude, the conditions for the community, change, so it must alter and change for the sick. So nothing's stationary in this life, change will occur. And I think this change goes on, the change at the moment trends to be towards community care, and I would have thought the possibilities of community care in principle fine, but it's a question of how much physical labour or people you can put in. I don't think you're going to be able to meet the demand, it's impossible.

(John Firth, born 1917, British Library catalogue C512/60/01–02)

Conclusion

There are ethical and practical problems in the reuse of qualitative data collected for different purposes by different researchers, who different value systems and different research questions. Some have gone so far as to argue that reuse is impossible and cannot produce valid data. However, we have argued that with an awareness of the ethical issues involved, and with attention to the context of the original research and the context of the actual data being re-analysed, qualitative interviews can became a valuable research resource.

The re-analysis of this body of life history data collected in 1991 has allowed us to look at family and community through the eyes of one group of professionals. As pioneers of geriatric medicine, both family and community were important concepts for the interviewees. The original interviews asked whether family care of the old had declined and about recent developments in community care. We were able to find many other spontaneous references to these key topics. As a result we have argued that to some extent interviewees' professional identity and ability to develop geriatrics as a medical specialty in its own right depended on their recognition of family and community. In the early days the word 'community' was not used, and the term 'family' covered the relatives of their hospital patients. There were very few community health and social services, and the earliest pioneers relied almost wholly on families to take back the inmates of the old workhouses to free beds so that the new geriatric medicine could be developed and practised. They also differentiated themselves from other hospital-based specialties by their willingness to consider the patient in terms of pathology and as a member of a family. They saw geriatric medicine as complex and problem-solving, and the problems were those of family carers and well as of patients themselves.

However, just as the historical context meant that community was not part of the early pioneering vocabulary, so these professionals took a very reductionist view of the family: it was assumed to be caring, and the work of women was rarely mentioned separately. As the specialty developed, home

visits were added to the distinctive identity of geriatric medicine. Again, an understanding of family and community were taken to be key features of geriatrics, and indeed were the aspects that attracted many pioneers into the specialty in the days when it was still deemed a dead-end career choice. As health and social services for older people in the community developed, geriatrics gained new partners and began to place more emphasis on the needs of family carers, including a recognition of the work of women. However, the data were originally collected in 1991 when policy aimed to shift from care by institutions to care by families, or 'the community' (Finch *et al.* 1983). Interestingly, several participants ruefully, and somewhat anxiously, reflected on their own situation now that they had become old. The interviewees were well aware that community care meant more patients in nursing homes and more strain on families. For some these were clearly backward steps that threatened the work they had done in improving care of older people. Others were slightly less critical but none could feel entirely positive about the term 'community'. This contrasted with their generally very positive view of families who were seen as doing their best in direct contradiction to the rhetoric of family failure that was so widely represented in the contemporary media.

Notes

1 See special issues of Forum Qualitative Research, 6(1) Art 31–January 2005 and Methodological Issues Online, vol, 2, no 1, 2007 for example.
2 We are grateful to Ros Edwards for this suggestion.
3 The Jefferys' interviews are identified by their individual British Library Sound Archive classification number.

References

Bornat, J. (2001) 'Reminiscence and oral history: parallel universes or shared endeavour?', *Ageing and Society*, 219–41.

Bornat, J. (2003) 'A second take: revisiting interviews with a different purpose', *Oral History,* 31(1): 47–53

Bornat, J. (2004) 'Chance as narrative theme or pragmatic function?: geriatricians recall their careers', European Social Science History Conference, Berlin, 24–27 March.

Bornat, J., (2005) 'Recyling the Evidence: Different Approaches to the Reanalysis of Gerontological Data', *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* [On-line Journal], 6(1), Art. 42. Available at: http://www.qualitative-research.net/fqs-texte/1–05/05–1-42-e.htm. [Accessed 27 April 2007]

British Sociological Association (2002) *Statement of Ethical Practice for the British Sociological Association.* Available at: http://www.britsoc.co.uk/equality/63.htm. [Accessed 27 April 2007]

Coffey, A., Holbrook, B. and Atkinson, P. (1996). 'Qualitative data analysis: Technologies and representation', *Sociological Research On-Line,* 1(1). Available at: http://www.socresonline.org.uk/1/1/4.html.

Evans, T. and Thane, P. (2006) 'Secondary analysis of Dennis Marsden *Mothers Alone*', *Methodological Innovations Online,* 1(2). Available at: http://sirius.soc.plymouth.ac.uk/~andyp/archive.php. [Accessed 27 April 2007]

Finch, J. and Groves, D. (eds) (1983), *A labour of love: women, work, and caring,* London and Boston: Routledge and Kegan Paul.

Hammersley, M. (1997) 'Qualitative data archiving: some reflections on its prospects and problems', *Sociology,* 31(1) 131–42.

Frisch, M. (1990) *A shared authority: essays on the craft and meaning of oral and public history,* Albany: State University of New York Press.

Heaton, J. (2004) *Reworking Qualitative Data,* London: Sage.

Jefferys, M. (2000) 'Recollections of the pioneers of the geriatric medicine specialty' in J. Bornat, R. Perks, P. Thompson and J. Walmsley (eds) *Oral History, health and welfare,* London: Routledge.

Kean, H. (2004) *London Stories: Personal lives, public histories: creating personal and public histories of working-class London,* London: Rivers Oram Press.

Mauthner, N. S., Parry, O. and Backett-Milburn, K. (1998) 'The data are out there, or are they? Implications for archiving and revisiting qualitative data', *Sociology,* 32 733–45.

Means, R., and Smith, R. (1998) *Community Care Policy and Practice,* Basingstoke: Macmillan. Second edition.

Moodie, J. (2000) 'Preparing the waste spaces for future prosperity? New Zealand's pioneering myth and gendered memories of place', *Oral History,* 28(2) 54–64.

Parr, A. (2007) 'Breaking the silence: traumatised war veterans and oral history', 35(2), 61–70.

Moore, N. (2006) 'The Contexts of Context: broadening perspectives in the (re-use) of qualitative data', *Methodological Innovations Online,* 1(2). Available at: http://erdt.plymouth.ac.uk/mionline/public_html/viewarticle.php?id17&layout=html. [Accessed 12 December 2007]

Moss, P. J. (1991) 'The Migration and Racialisation of Doctors from the Indian Subcontinent', unpublished PhD thesis, University of Warwick.

Parry, O. and Mauthner, N. S. (2004) 'Whose data are they anyway? Practical, legal and ethical issues in archiving qualitative data', *Sociology,* 38(1) 139–52.

Passerini, L. (1979) 'Work ideology under fascism' *History Workshop,* 8, 84–92.

Raghuram, P. and Kofman, E. (2002) 'The State, labour markets and immigration: the case of skilled emigrants in UK's medical labour market', *Environment and Planning,* 34(11) 2071–89.

Ritchie, D.A. (2003) *Doing Oral History: a practical guide,* New York: Oxford University Press. Second edition.

Roper, M. (2003) 'Analysing the analysed: transference and counter-transference in the oral history encounter', *Oral History,* 31(2) 20–32.

Thompson, P. (2000) 'Re-using Qualitative Research Data: a Personal Account', *Forum Qualitative Sozialforshcung/Forum:Qualitative Social Research* [Online Journal], *1*(3). Available at http://www.qualitative-research.net/fqs-texte/3–00/3–00thompson-e.htm [Accessed 26 April 2007]

Thompson, R. (2002) 'Reporting the Results of Computer-assisted Analysis of Qualitative Research Data', *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* [Online Journal], *3*(2). Available at: http://www.quali-tative-research.net/fqs-texte/2–02/2–02thompson-e.htm [Accessed 26 April 2007].

Yow, V. (2006) '"Do I like them too much"? Effects of the oral history interview on the interviewer and vice versa', in R. Perks and A. Thomson (eds) *The Oral History Reader,* London: Routledge. Second edition.

Ward, A. (n.d.) 'Is your oral history legal and ethical?', Available at: http://www.ohs. org.uk/ethics/index.php. [Accessed 27 April 2007]