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A Phenomenology of Fall Prevention: Lived-Identity and Careful Practice in Community Outreach Care

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A thesis submitted in partial fulfillment of the requirements for the degree in Doctor of Philosophy

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Abstract

The increasing number of injurious falls amongst older people living in the community is continuously portrayed as a major public health problem facing the Canadian health care system. As additional resources are allocated for community-based fall prevention programs, health service providers are increasingly expected to understand and enact fall prevention in effective and meaningful ways. The aim of this two-phase interpretive phenomenological study was to enhance understandings of the taken-for-granted meanings that characterize everyday practices of community-based fall prevention in order to foster more sensitive, tactful, and meaningful approaches to fall prevention with older people.

In the first phase of this study, I engaged nine older people living independently in the community in individual phenomenological interviews to explore the meaning of the experience of anticipating falling. In the second phase of this study I engaged six health professionals working on a community outreach team in phenomenological interviews exploring the meaning of the experience of enacting fall prevention with older people in the community.

The findings of this two-phase study overall gave rise to four key insights that may inform the refinement of fall risk assessment and fall prevention practice for physiotherapists and other service providers. First, a phenomenological ethics of caring was central to enacting fall prevention for service providers in the community. Second, lived-identity was central to the experience of anticipating falling for older people. Third, meaningful risk-taking was essential to older peoples' quality of life and enactment of their lived-identity. Finally, the meaning of anticipating falling was learned experientially

through older peoples' experience of falling or witnessing others experience falls. Understanding these key insights, service providers might seek to adopt a *transformative learning approach* to fall prevention that focuses on affirming an *appreciative* understanding of lived-identity, meaningful risk, and meaningful caution in older peoples' lives. Erich Fromm's distinction between *having* and *being* orientations to lived-identity may be used to provide insight into the enactment of such a transformative approach to fall prevention.

Keywords: Fall risk, fall prevention, community outreach, community-based health care, phenomenology, hermeneutics, physiotherapy, physical therapy, inter-professional care

Co-Authorship Statement

This dissertation was written under the close guidance and supervision of Dr. Denise Connelly and Dr. Carol McWilliam, who will be co-authors on publications arising out of chapters four, five, and six. Their critical feedback and continued mentorship was integral to fostering the interpretive sensitivity of the empirical phenomenological studies that compose this two-phase dissertation study, and this work would not have been possible without their experience, patience, and tireless effort.

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Without the love and support of my life-long partner, Olivia, I could never have made it this far. Not only by making my priorities abundantly clear, but by stimulating my intellect in ways I am constantly discovering, she made this work possible.

Finally, this dissertation is dedicated to my parents: The reason I am here, the reason I appreciate life so much, and the reason I need to give myself back to the world in everything I do. Thank you. You are the reason this was possible.

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Chapter One: Introduction

> Two young fish are swimming down a river and happen to meet an older, wiser fish along the way. The older fish nods toward the younger ones, saying "Morning, boys. How's the water?" The two young fish swim on down the river, and eventually one of them looks over at the other, confused, and asks "What the hell is water?" (Adapted from Wallace, 2005)

The daily experience of health care *practice* for people who work as health service providers unfolds in the broader context of unique lives that are meaningful wholes, of which health care practice is only one part; an important part, but still only one part. Health service providers are people who go home at the end of a shift to face all of the burdens that confront any other person living-in-the-world. We are influenced by popular television, politics, and fashion just like everyone else. We buy houses and cars, make friends, and get married just like everyone else. In other words, we participate in and contribute to the normal, natural human order-of-things that characterizes every day existence and experience. This order-of-things is everywhere imbued with readymade, *pre-reflective* meanings that help us to make sense of the "life-world", or the world as we live it (Schutz & Luckmann, 1973; van Manen, 1990). In this sense, *pre-reflective* refers to the meanings that come from texts we have adopted to understand our life-world, in the form of thoughts, conversations, beliefs, etc., without critically reflecting upon them. We hold pre-reflective meanings for *most* common constituents of daily experience. For health service providers this includes things like "sickness", "wellness", and "aging". No matter how critically reflective we are, *at least some* elements of the lifeworld have to be taken for granted – we simply do not have time to be reflective about *everything*.

The collection of these infinite pre-reflective meanings that constitute the structures of our daily experience in the life-world has been aptly referred to as the "natural attitude" (Husserl, 1970; Schutz & Luckmann, 1973), reflecting the position that it appears to be an unintentional but automatically occurring orientation to the things of the world – unless, of course, we do something about it. But why would we feel obliged to do something about this natural attitude, as though it was a problem in its current form? The answer to that question comes in the explanation of the preceding opening story about the two young fish.

> The point of the fish story is merely that the most obvious, important realities are often the ones that are hardest to see and talk about. Stated as an English sentence, of course, this is just a banal platitude, but the fact is that in the day to day trenches of adult existence, banal platitudes can have a life or death importance. (Wallace, 2005)

This seems to be especially true in the field of health care for older people, where un-critical, un-reflective meanings can lead to the reinforcement of oppressive stereotypes and diminutive treatment of some of the most "vulnerable" people in the population. Taking the natural attitude to work, so to speak, can prevent health service providers from interactively, inter-subjectively co-creating their meanings of "sickness", "wellness", and "the elderly" in collaboration with the older people with whom they work. In effect, it prevents them from establishing new realities in which "vulnerable", "sick", and "frail" are not associated with the meaning of "the elderly". Intentionally orienting ones consciousness to interpretively understanding how older people *understand themselves* will permit establishing a new *unnatural* attitude that "edifies the

personal insight (Rorty, 1979), contributing to one's thoughtfulness and one's ability to act toward others, children, or adults, with tact or tactfulness" (van Manen, 1990, p. 7). As phenomenology shows us, these new insights are only possible after "bracketing" the natural attitude, re-cognizing our taken for granted meanings of what we do and the world in which we live. This dissertation entails an attempt to focus on an element of health care for older people by doing just that – bringing what we think we know about fall risk and fall prevention to our critical awareness, and exploring how we might edify our insight in a more interpretive, understanding approach to fall prevention with older people.

Background and Significance

> [I]n the public imagination, bodies that fall down also fall out of the social domain. They are assumed to belong to people who lack the physical control to "hold on" and thus become "fallers" out of balance with their environments. While falls are attributed to the older faller, as if their proclivity to falling was already a certainty, it is the fall that defines the faller. And this happens because a fall is an entry point into professional worlds of care, risk and prevention programs, hospital and community centers, and insurance and medical planning. Thus, the process of falling out of one world and into another is not simply physical; it is also embedded in the discursive practices and authoritative vocabularies that define the relationship between falls and fallers. (Katz, 2011, p. 194)

The issue of accidental falls among older people has become increasingly visible in the public and political spotlights throughout the past several years, as attention to this

paradigm-case for aging studies has been amplified through growing government and media scrutiny. The 2009 Canadian Senate Report on Aging maintained a strong focus on the delivery of fall prevention services as an essential component of a comprehensive and integrated national health care system in order to support the health and quality of life of older Canadians (Special Senate Committee on Aging, 2009). The development and support of fall prevention-specific initiatives through the Canadian Public Health Association (CPHA, 2008), Canadian Patient Safety Institute (CPSI, 2011), Veterans Affairs Canada (VAC, 2011), Ontario Injury Prevention Resource Center (OIPRC, 2008), and many other public and not for profit organizations reflects the proliferating concern for the economic, social, and personal costs associated with falls among older people. In the news media, the increasing rates of falls among older people and narrative news stories of fall-related injury experiences have become a pervasive "cautionary tale for the boomer generation" (Teotonio, 2011), inciting further dialogue and attention to fall risk and fall prevention as the population continues to age.

Data collected by the Canadian Institute for Health Information regarding injuries secondary to trauma in Ontario between 2009 and 2010 suggested that accidental falls were the second leading cause of trauma-related hospitalization behind motor vehicle collisions (Poon, Sidhom, & Fortin, 2011). Fall-related injuries were the leading cause of in-hospital deaths during that period, and the mean and median age of hospitalized fallers was 62 and 68 years, respectively. The World Health Organization's (2007) report on falls worldwide suggested that 28-35% of older people over the age of 65 experience a fall each year. Furthermore, the burden of these injuries on the public health care system is likely far greater than that currently estimated by policy makers (Scott et al, 2011).

The Public Health Agency of Canada's (2005) report on falls in Canada suggests that the rate of falls for older people between the ages of 65-69 is 35 per 1000, however this rate increases to 76 per 1000 for older people over the age of 80. As the average age of the Canadian population increases, it may be assumed that the absolute number of falls among older people will continue to rise simply as a function of the larger absolute number of older people. The mounting concern associated with the rising profile of the "baby boom" generation and perpetually increasing acute health care costs has led to record amounts of resources being shifted toward fall prevention initiatives across the continuum of health care (Edwards, 2011). The approach taken by the majority of these fall prevention initiatives mirrors the evidence from which they are derived (Fixsen, Scott, Blase, Naoom, & Wagar, 2011), taking a positivist, biomedical stance in the assessment of fall risk factors and provision of specific interventions to mitigate those risks (Ballinger & Payne, 2002). Such biomedical orientations to fall risk and prevention take a distinctly instrumentalist approach to fall prevention interventions, seeking to achieve the outcome of preventing falls without critically reflecting on the rationale, unintended consequences, and broader implications of fall prevention programs in the lives of older people.

Best Practices for Fall Prevention

The Canadian Falls Prevention Curriculum (CFPC) is an information package and online course based upon the extensive and comprehensive integration of behavior change theory with peer-reviewed research literature on best practices for the assessment of fall risk and prevention of falls (Scott et al, 2007). The online course is offered to health service providers, public health officials, and health care managers who are

seeking to advance their knowledge and understanding of fall risk assessment and fall prevention strategies; it was developed to be relevant specifically for a Canadian audience. The course emphasizes a multi-factorial, multi-dimensional approach to the assessment of risk and prevention of falls, including recommendations to attend to biological/intrinsic, behavioral, social/economic, and environmental risk factors. These recommendations are based on best practice guidelines of the Public Health Agency of Canada, American Geriatric Society, British Geriatric Society, National Institute for Clinical Excellence, American Medical Directors Association, as well as systematic literature reviews from the Cochrane Collaboration (Scott et al, 2007).

The Canadian Falls Prevention Curriculum advocates for an approach to fall prevention that focuses explicitly on changing the behavior of older people to incorporate caution and active prevention (Scott, Gallagher, Higginson, Metcalfe, & Rajabali, 2011). Six categories of interventions are suggested that are all situated within an understanding of social psychological behavior change theory. The intervention categories are: 1) fall risk education, 2) provision of necessary safety equipment, 3) modification of the environment to promote safety, 4) engagement in exercise and preventive activity, 5) modification of clothing and footwear, and 6) management of health and chronic conditions.

Health service providers, particularly those working in home and community care or outreach services, are expected to be able to address as many of these risk factors and interventions as possible with their older clients (Campbell & Robertson, 2006). Indeed, a number of initiatives throughout North America in the past ten years have sought to broaden service providers' understanding of the multi-dimensional nature of fall risk and

the importance of linking specific interventions to specific risk factors (Brown, Gottschalk, van Ness, Fortinsky, & Tinetti, 2005; Fortinsky et al, 2008). Alternatively, efforts to improve health services for fall prevention have focused on encouraging service providers to collaborate in interprofessional teams, providing opportunities for a person's fall risk to be assessed and fall prevention interventions devised from a number of different professional perspectives (Baxter & Markle-Reid, 2009). Presumably, such interprofessional efforts maximize the likelihood that the variety of multi-dimensional risk factors will be adequately addressed.

Efforts to improve health services for fall prevention reflect the somewhat obvious observation that fall prevention is considered to fall under the purview of the public health care system (Scott et al, 2007), and despite the emphasis on sickness and healing in the education and practice of many health professional groups, health service providers are expected to be experts at assessing fall risk and preventing falls. An underlying assumption of this expectation is that because health service providers are experts at dealing with the *consequences* of falling, they will also be experts at dealing with the *prevention* of falling. Considering the emphasis on behavior change in best practices for fall prevention, and the virtual absence of behavior change theory in the education of physiotherapists (APTA, 2003; CPA, 2009), the assumed expertise of this professional group is problematic. As previously described, the number of falls in international populations of older people continues to rise despite perpetually increasing resources devoted to fall prevention, again drawing attention to the problematic nature of current approaches to fall risk assessment and fall prevention in contemporary health care practice. These "red flags" for fall prevention practice, signs that point out the need to

step back from identifying more fall risk factors, more prevention interventions, and more knowledge translation initiatives, invite us to critically reflect upon the fall prevention enterprise and its place within our contemporary health systems. Specifically, these red flags give us the opportunity to ask the question, "Are we approaching community-based fall prevention in the right ways, taking the meaningful lives of older people into account?", and perhaps more controversially, "Should we be approaching community-based fall prevention within the health system at all?" At the very least, it is important to explore in detail current approaches to fall risk assessment and fall prevention practice and hermeneutically address their value and worth in the lives of older people, providing further insight into the role and delivery of fall prevention services in the social, political, and economic context of contemporary public health care.

Statement of Purpose

While fall prevention initiatives are delivered on various scales, including population-based media campaigns and in-depth one-to-one encounters between older people and health service providers, the focus of this dissertation is on the approach of unique people who are health care providers interacting with unique people who are older clients. As the rhetoric of health care reform emphasizes health promotion and disease and injury prevention, health service providers are being expected to know and do more about preventing falls among older people. The aim of this dissertation research was to explore the meaningful lived-experiences of older people and health care providers in order to critically reflect upon fall prevention services and help us imagine how health service providers might be able to approach fall prevention with greater skill, artfulness and tact; in ways that affirm the dignity and worth of older people who may be identified

as “at risk”. By exploring the meaning of the experience of anticipating falling among older people living independently in the community, I aimed to interpret the hermeneutic essence of the experience which health service providers encounter with their clients as they interact with them in enacting fall prevention activities. By then turning to explore the experience of health service providers who travel into the community, into the homes of older people in order to assess fall risk and help to prevent falls, I aimed to interpret the hermeneutic essence of the experience of enacting fall prevention with older people in the community. This two-phase study is situated within the context of health care and fall prevention practice in the study’s regional setting. The intentions of this dissertation were to explore the taken-for-granted meanings that constitute the experience of enacting fall prevention in community outreach care, fostering insight from an inter-professional context to inform the approach of physiotherapists seeking to enact fall prevention in more tactful, ethical ways.

Overview of Chapters

This dissertation follows the integrated article format as accepted by the School of Graduate and Postdoctoral Studies at the University of Western Ontario. Chapter two presents the findings of a literature review including studies related to the experience of anticipating falling amongst older people as well as studies including physiotherapists’ and other service providers’ experience of providing fall prevention services. Chapter three presents the methodology and methods that constitute the two empirical studies for this dissertation. Chapter four presents the findings of an interpretive phenomenological study exploring the meaning of the experience of anticipating falling amongst older people living in the community. Chapter five presents the findings of an interpretive

phenomenological study exploring the meaning of the experience of enacting fall prevention services amongst health professional members of a community outreach team. Chapter six presents the key insights arising from the two phases of this dissertation study, outlining implications for how physiotherapists and other service providers might enact fall prevention with older people in the community in more tactful, sensitive ways.

References

American Physical Therapy Association. (2003). Guide to Physical Therapist Practice. Available at: http://guidetoptpractice.apta.org/content/current

Ballinger C. (2002) The construction of the risk of falling among and by older people. *Ageing & Society*, 22, 305-324.

Baxter, P. & Markle-Reid, M. (2009). An interprofessional team approach to fall prevention for older home care clients 'at risk' of falling: Health care providers share their experiences. *International Journal of Integrated Care*, *9*: 1-12.

Brown, C., Gottschalk, N., van Ness, P., Fortinsky, R., & Tinetti, M. (2005). Changes in physical therapy providers' use of fall prevention strategies following a multicomponent behavioral change intervention. *Physical Therapy, 85*(5): 394-402.

Campbell, J., & Robertson, M. (2006). Implementation of multifactorial interventions for fall and fracture prevention. *Age & Ageing*, *35*: 60-68.

Canada, Parliament, Senate. Special Senate Committee on Aging. (2009). Canada's aging population: Seizing the opportunity. Retrieved from http://www.parl.gc.ca/Content/SEN/Committee/402/agei/rep/AgingFinalReport-e.pdf

Canadian Patient Safety Institute. (n.d.). Reducing falls and injury from falls. Retrieved from http://www.saferhealthcarenow.ca/EN/Interventions/Falls/Pages/default.aspx

Canadian Physiotherapy Association. (2009). The Essential Competency Profile for Physiotherapists in Canada. Available at:

http://www.physiotherapy.ca/PublicUploads/224032Essential%20Competency%20Profile%202009.pdf

Canadian Public Health Association. (2007). Canadian Public Health Association 2007 resolutions. Retrieved from http://www.cpha.ca/uploads/resolutions/2007_e.pdf

Edwards, N. (2011). Preventing falls among seniors: The way forward. *Journal of Safety Research, 42*: 537-541.

Fixsen, D., Scott, V., Blasé, K., Naoom, S., & Wagar, L. (2011). When evidence is not enough: The challenges of implementing fall prevention strategies. *Journal of Safety Research, 42*: 419-422.

Fortinsky, R., Baker, D., Gottschalk, M., King, M., Trella, P. & Tinetti, M. (2008). Extent of implementation of evidence-based fall prevention practices for older patients in home health care. *Journal of the American Geriatric Society, 56*: 737-743.

Husserl, E. (1970). *Logical investigations*. New York: Humanities Press.

Katz, S. (2011). Hold on! Falling, embodiment and the materiality of old age. In M. Casper & P. Currah (Eds.) *Bodies of Knowledge: Interdisciplinary Studies* (pp. 187-206). Minneapolis: University of Minnesota Press.

Ontario Injury Prevention Resource Center. (2008, February 03). *About the Canadian Falls Prevention Curriculum*. Retrieved from http://www.oninjuryresources.ca/cfpc/about_the_canadian_falls_preve.html

Poon, V., Sidhom, M. & Fortin, C. (2011).Ontario trauma registry 2011 report: Major injury in Ontario, 2009-2010 data. *The Canadian Institute for Health Information*. Retrieved from http://secure.cihi.ca/cihiweb/products/OTR_CDS_2009_2010_Annual_Report.pdf

Rorty, R. (1979). *Philosophy and the mirror of nature*. Princeton: Princeton University Press.

Schutz, A. & Luckmann, T. (1973). *The structures of the life-world*. Evanston: Northwestern University Press.

Scott, V. Lockart, S., Gallagher, E., Smith, D., Asselin, G., Belton, K. et al (2007). *Canadian falls prevention curriculum (CFPC)*. Vancouver: BC Injury Research & Prevention Unit.

Scott, V., Gallagher, E., Higginson, A., Metcalfe, S., Rajabali, F. (2011). Evaluation of an evidence-based education program for health professionals: The Canadian Falls Prevention Curriculum. *Journal of Safety Research, 42*; 501-507.

Teotonio, I. (2011, November 18). After the fall. *The Toronto Star*. Retrieved from http://www.thestar.com/living/article/1089529--after-the-fall

Tinetti, M., Baker, D., King, M., Gottschalk, M., Murphy, T., Acampora, D. et al. (2008). Effect of dissemination of evidence in reducing injuries from falls. *New England Journal of Medicine, 359*: 252-261.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. London: Althouse Press.

Veteran Affairs Canada. (2011, October 01). *Health promotion – falls prevention initiative*. Retrieved from http://www.veterans.gc.ca/eng/health/fallprev

Wallace, D.F. (2005). This is Water: Transcript of a Commencement Address. Available at: http://moreintelligentlife.com/story/david-foster-wallace-in-his-own-words

Chapter Two: Literature Review

Phenomenological inquiry is considered to have a significant "nontheoretical thrust" (van Manen, 1996, p. 43), a function of the focus on the pre-theoretic lived experience that characterizes meaning in our everyday lives. As such, it may be appropriate for certain approaches to phenomenology to bypass the literature review phase of an empirical study, as it may be seen to merely cloud the lens through which the researcher sees and interprets pre-reflective, pre-theoretic lived-experience. While issues associated with the phenomenological notion of "bracketing" will be addressed in the following chapter, a fundamental assumption of this phenomenology is that the complete bracketing, complete setting-aside of my theoretical and pre-existing knowledge of fall risk and fall prevention is impossible (Merleau-Ponty, 1962). Instead of falsely claiming to be able to do so, I will explore and embrace my existing presuppositions and theoretical assumptions as they relate to fall risk and fall prevention, such that I am able to better understand how they influence my research objectives and interpretations (van Manen, 1990). Having been trained as a physiotherapist and studied as a doctoral student in health sciences, I have been continuously exposed to peer-reviewed research literature addressing topics related to experiences of fall risk and fall prevention: a thorough review of this literature will help to facilitate my reflexivity and reflection on how my approach is influenced by this body of empirical and theoretical research (Finlay, 2002).

In the context of efforts to explore lived-experience related to fall risk and fall prevention on both sides of the client-provider relationship, it is important to explore existing research literature addressing both perspectives. This dissertation chapter presents a review of two distinct bodies of literature within the context of fall risk and fall

prevention, re-presenting the experiences of both older people and health service providers. Specifically, the first body of literature is that which addresses the subjective experiences of older people in relation to the primary experience in question for the first phase of this dissertation study, that of *anticipating falling*.

In this sense, "anticipation" refers to thoughts and emotions that characterize the experience of expecting an event to occur in the future (Poli, 2010). The experience of *anticipating* falling is important to study in relation to living with fall risk and the potential for falling, in part because the concept of risk is inherently temporal; fall risk refers to the potential for a fall to occur at some unknown point in the future. Older people may thus make decisions regarding whether and how to engage in further risk-taking or cautious actions with respect to falling in relation to their experience of *anticipating* this future event. In this way, the experience of anticipating falling may be what mediates the experience of living with fall risk and decisions to engage in fall prevention activity. Whether and how anticipating falling is experienced by older people may help practitioners to better understand the ways in which living with fall risk are meaningful for older people, informing their efforts to more sensitively engage older people in fall prevention initiatives.

In relation to falls, there are a number of "constructs" that are included in this literature review for their contributions to understanding work that has been done related to the experience of anticipating falling. These constructs include 1) experiences of living with risk of falling, 2) experiences of living through accidental falls and their consequences, and 3) experiences of engaging in or being encouraged to engage in fall

prevention activities. Each of these categories of experience has the potential to provide insight into the experience of anticipating falling.

For the first search, five databases were reviewed: CINAHL©, Medline©, PsycINFO©, Sociology Abstracts ©, and Scopus ©. Both qualitative and quantitative studies were included for consideration in this review. Only articles published in English were included. No date limitations were set. Search terms were split into three general construct categories, within which searches for individual terms were combined using the "OR" function prior to being combined with the other two construct categories using the "AND" function. Subject headings were searched using pre-determined search terms to determine if any were applicable, and the database search strategy included all subject headings and keywords as applicable. The first construct category, titled "search A", included the following search terms: accidental falls, fall prevention, fall risk, and falls. The second construct category, titled "search B" included the following search terms: aged, elderly, older adults, older persons, geriatric, and gerontology. The final category, titled "search C" was most complex, focusing on the experience of living with fall risk, and included the following terms: experience, meaning, opinion, view, attitude, knowledge, and perspective. Irrelevant studies were initially screened out by title, and then by abstract for less obvious cases. The full text was retrieved and read for each included study. A secondary review of references was also conducted to identify studies that were not captured within this search strategy. The findings from the literature review include 25 published papers that addressed the topic of focus.

The second body of literature reviewed addressed the subjective experiences of physiotherapists approaching fall risk and fall prevention services with older people.

Studies were included in the review if physiotherapists were included amongst participants in the study, even if additional service provider groups were also included as participants. This review emphasized initiatives that are delivered in the community as opposed to institutional settings in order to reflect the experience of physiotherapists working with older people who are living independently in the community, or transitioning back to such independent living. The primary focus in this aspect of the review was on the orientation and experiences of physiotherapists providing fall prevention services for older people living in the community or preparing to return to living in the community.

The second review included the same five databases: CINAHL©, Medline©, PsycINFO©, Sociology Abstracts ©, and Scopus ©. Both qualitative and quantitative studies were included. Only articles published in English were included. No date limitations were set. As in the first search, terms were split into three general construct categories, within which searches for individual terms were combined using the "OR" function prior to being combined with the other two construct categories using the "AND" function. Subject headings were searched using pre-determined search terms to determine if any were applicable, and the database search strategy included all subject headings and keywords as applicable. This search included the findings from "search A" and "search B" previously described, combining these searches using the "AND" function with two additional categories. The first additional category, titled "search D" included the following terms: physical therapy, physiotherapy, physical therapist, and physiotherapist. The final search category, titled "search E" included the following terms: practice, approach, experience, meaning, opinion, view, knowledge, attitude, and

perspective. Irrelevant studies were initially screened out by title, and then by abstract for less obvious cases. The findings from the literature review included only two studies that addressed the topic of focus. Authors of the two included studies for this aspect of the literature were contacted and asked about any additional studies in this area, and one additional study which is currently undergoing peer review for publication was found. As such, this one additional study was not available for inclusion in this review. The full text was retrieved and read for each included study. A secondary review of references was also conducted to identify studies that were not captured within this search strategy.

Review of Literature on Older Peoples' Experiences of Falling, Fall Risk and Fall Prevention

The primary aim of this first review was to explore literature that has addressed subjective experiences associated with the central experience in question, that of anticipating falling. Excluded from the review were studies which did not focus on an exploration or description of subjective experience, such as those focusing solely on older peoples' knowledge and attitudes of fall risk factors or fall prevention behaviour. No quantitative studies were found that addressed subjective experiences related to anticipating falling, and thus only qualitative studies were summarized. Furthermore, only studies addressing the subjective experiences of older people living independently in the community were included, and thus studies focused on hospital patients or long term care residents were also excluded. Finally, studies which included an evaluation of intervention components or educational material were also excluded. Participants in the studies included in this review resided in Australia or European or North American

countries unless otherwise stated. A total of 23 qualitative studies and two systematic literature reviews met the inclusion criteria and are summarized below.

Two systematic literature reviews were found addressing older peoples' subjective experiences of living with fall risk and their views on fall prevention initiatives (McInnes, Sears, & Tutton, 2011; McMahon, Talley, & Wyman, 2011). McInnes, Sears, and Tutton (2011) conducted a meta-ethnography of older peoples' views regarding fall risk and fall prevention, including 11 qualitative studies of varying methodologies in their final analysis. These authors found six key themes re-presenting older peoples' views: beyond personal control, rationalizing, salience, life change and identity, taking control, and self-management. The six themes reflect the experiential process of living through a fall and the personal and subjective experiences of accepting and managing a new understanding of the self as "at risk" for falling.

McMahon, Talley, and Wyman (2011) conducted an integrated systematic literature review, including 19 qualitative and quantitative studies addressing older peoples' perspectives on fall risk and fall prevention programs. These authors found three themes related to fall risk and four themes related to fall prevention programs. With respect to fall risk, they found the following themes: fearing vulnerability, maintaining autonomy and independence, and interpreting risk. With respect to fall prevention programs, they found the following themes: influence of participant and program characteristics, need for personal relevance and preference, maintaining autonomy and independence, and increased support for and access to programs. The presentation of themes by McMahon, Talley, and Wyman (2011) was separated into fall risk and fall

prevention programs as separate categories, and did not emphasize the connection between these two concepts.

The presentation of findings from the literature review I conducted for this dissertation reflect the temporal process of experiencing fall risk, experiencing a fall, experiencing fall consequences, and then experiencing engagement and encouragement to engage in fall prevention programming. This collection of experiences is seen to reflect aspects of the overall experience in question, that of anticipating falling, and thus the findings are presented in the context of their contribution to understanding the experience of anticipating falling. While it may seem overly simplistic to present the findings in such a linear order, I recognize that these experiences do not occur in such a linear fashion; fall risk is a complex concept, and the influences on the experience of anticipating falling could not be said to unfold in a straightforward, linear, or predictable way. The purpose is not to draw definitive conclusions regarding the temporal nature of the experience in question, but is merely to clearly re-present sensitivity to and awareness of the work that has been done in this area.

Exploring the Experience of Living with Fall Risk

The approach taken in the following studies was to explore the views of older people regarding their everyday experiences of living with fall risk. The studies did not specifically address the experience of falling or motivation to engage in fall prevention. While many participants included in the following studies had experienced a fall in the past, these studies focused on the experience of *being at risk for falling* within a given social context.

Ballinger (2002) conducted a qualitative ethnographic study with older people using the services of a day hospital in England, exploring their views and conceptualization of fall risk in contrast to those of service providers. Findings from this study emphasized that older people were concerned with risks to personal and social identity as opposed specifically to risk of falling. Advice or intervention by service providers at the day hospital to encourage caution and prevent falls sometimes led to instances of social embarrassment and damage to social identity. As older people sought to protect their social identities in order to preserve quality of life, instances of infantilizing by service providers in order to prevent falls actually undermined older peoples' quality of life. However, older people also conveyed that experiencing a fall would significantly damage their personal and social identity. Thus, fall risk was constructed by older people in terms of potential threats to identity.

Horton (2007) conducted a grounded theory study specifically exploring the influence of gender on older peoples' perceptions of fall risk and the implications of those perceptions for their future behavior. Two primary categories emerged: gendered meanings of risk and gendered responsibility. In terms of gendered meanings of risk, men considered themselves to be rational and calculating, making them capable of controlling their own risk with precision. Women did not express such perceived control over their risk of falling, attributing their risk both to internal and external factors. However, women felt older people ought to be responsible enough to take caution and prevent falls in part to prevent inconveniencing potential caregivers; men did not express such concern. In summarizing the findings of the study, Horton (2007) suggested that fall risk was understood by older people in the context of their gendered identities.

Hallrup, Albertsson, Tops, Dahlberg, and Grahn (2009) conducted a phenomenological study of the experience of older women living with fall risk in the context of a lifeworld approach. Findings from this study suggest that the "life space" which older women could occupy had been reduced as a result of fractures and a changing body, leading to the necessity of taking caution in any continued daily activities. As a consequence, the participants in this study felt they only ambiguously understood their self-control and dependency on others, and sought further understanding of the implications of their fall risk for their health and their lives.

Phenomenology of the Experience of Falling

The following two studies took a unique approach to exploring older peoples' experiences of falling, using phenomenological methodologies to explore in detail the actual experience of a fall event in older peoples' lives. The focus in these studies is not on the long term consequences in the lives of participants, but the immediate consequences, experience, and decision-making of older people who live through a fall.

Porter (1999) conducted a descriptive phenomenology with nine frail older women who had fallen multiple times, exploring the immediate actions and perceived consequences of the fall directly after the fall occurred. Participants discussed the inevitability of needing to "get up from here", reflecting the very first most common-sense task: standing up after the fall. Participants described strategies and problem-solving to help find safe ways to get up, most having not been taught to do so by health service providers. Immediately upon getting up, participants evaluated the extent of their injuries and resisted seeking help if possible. Understanding the importance of their relationships and not wanting to be a burden on others, they informed potential caregivers

of the fall and their current status. Participants sought to minimize the experience and wanted to prepare themselves with strategies to get up should another fall occur.

Mahler and Sarmivaki (2010) conducted an interpretive phenomenology with six older people who had each had multiple previous falls while living independently, exploring the meaning of falling in participants' lives. Participants discussed the falling episodes with specific emphasis on getting up after the fall, feeling that while they were on the ground they felt shame and shyness because their bodies must be failing if an event like a fall could happen to them. Participants understood that they were prone to falling, and chose to limit their activities in the community not necessarily to prevent physical injuries, but to prevent the feelings of embarrassment associated with falling in public. Finally, participants sought coping strategies to move on with meaningful lives, including using humor to laugh at the irony of their life situations. As such, the meaning of falling for participants was one of re-creating life meaning as they lived through their newly limited daily activities.

The Consequences of Falling

Studies that explored the meaning of falling in the lives of older people specifically in terms of the consequences of falling could be separated into two specific categories: those emphasizing independence or autonomy and those emphasizing fear of falling. All three of these constructs (independence, autonomy, and fear of falling) were present in each of the studies summarized in this section, however, characteristics of each were emphasized differently by participants and/or authors in each study. Findings from studies in this section highlight the *interaction* between older peoples' professed need to

remain independent and autonomous and their fear of falling, out of which future actions related to taking further caution or taking further risks emerged.

Studies focusing on independence and autonomy versus limiting activities. Roe et al (2008) conducted a generic qualitative study from a post-positivist lens of older people having recently experienced a fall, in order to understand the circumstances of the fall and the perceived consequences of the fall in the older peoples' lives. Findings from this study suggest that most falls occurred while participants were alone in their own homes. While interview questions focused primarily on specific behavioral consequences of falling as opposed to subjective experiences, emotions, and views of older participants, the authors suggest that the meaning of the falling episode was in the need for participants to adopt more cautious living strategies and rely more on both informal and formal support networks for their daily activities. Implications for community-based falls prevention programming were drawn by the study authors, including tailoring interventions to be specific to the older person's beliefs and needs with respect to independence in daily life.

Kong, Lee, Mackenzie, and Lee (2002) interviewed twenty Chinese older people who had recently experienced a fall using a generic post-positivist qualitative approach, exploring their views regarding the perceived psychological and social consequences of falling. Three primary themes emerged from this analysis: powerlessness, fear, and seeking care. The first theme reflects the perceived lack of control over the occurrence of falls, and includes a unique finding among studies exploring older peoples' experiences of falling: a lack of emotion with respect to the fall. The authors of this study reported that participants stated they had no emotions regarding the fall itself, which they

interpreted as potentially being a result of Chinese cultural expectations regarding maintaining the privacy of negative emotions. Only half of the study participants reported fear as a reflection of their perceived consequences of falling, which was also interpreted by the authors to be derived from Chinese cultural expectations. Participants in this study received a great deal of family support after experiencing the fall, and highly valued this support. The authors of this study emphasized the strength of cultural values in orienting older people to the experience of falling, suggesting that health service providers ought to be culturally sensitive to the older people with whom they work to prevent falls.

Ward-Griffin et al (2004) explored the everyday experiences of older people using a phenomenological methodology, focusing on their views of safety, fear of falling, independence, and quality of life. These authors interpreted their findings in the context of two competing fundamental forces in life: exercising precaution and striving for independence. Participants expressed a lived-tension between these two forces, seeking to maintain their independence in order to achieve quality of life despite their recognition of the need for safety in order to prevent falls that would interfere with their independence. This process meant acknowledging the risk that is present in many daily activities, and exercising a cautious strategy to permit the continued performance of the activity as opposed to eliminating it from their lives.

Host, Hendrikson, and Borup (2011) conducted a generic qualitative study from a post-positivist perspective with fourteen older people who had recently experienced a fall. These authors found that older people associated the experience of a fall with shame and embarrassment, leading to fear that another fall might occur. An additional consequence of experiencing the fall was the detrimental effects on health and function

that ensued, interfering with participants' abilities to live their lives as they pleased. As such, older people had to establish their own unique coping strategies or else to limit their activities and prevent falls based on knowledge of previous experiences. Through support from informal caregivers as well as health service providers, participants found new motivation and new ways to engage in meaningful life activities.

Stewart and McVittie (2011) conducted an interpretive phenomenological analysis study with eight older people who were unable to leave their home without assistance and who had experienced a fall within the past six months. Findings from this study focused on the aftermath of falling, and participants largely discussed consequences in terms of multiple types of loss. Falling meant losing independence in daily activities and losing confidence in remaining balanced and functional to prevent a fall from occurring in the future. The profound changes in daily activities and psychological outlook associated with fear of falling meant these older people experienced a loss of social identity, and their interactions with formal and informal caregivers reflected their sense of loss of identity. Despite these feelings of loss and lack of control of future fall events, participants still conveyed a strong sense of agency over their life and activities, reflecting the final theme of managing a changed self. As such, participants forged new identities that permitted them to maintain control over their lives.

Studies focusing on fear of falling. Huang (2005) conducted a grounded theory study of Chinese older peoples' experiences of coping with fear of falling as a consequence of a fall. In this study, participants discussed specific manifestations of fear of falling in terms of physical symptoms and emotional reactions that arise in specific circumstances. Participants believed that falling was a normal aspect of aging, and that

these reactions were to be expected and managed. Participants thus adopted an attitude of risk prevention and limited activities accordingly, modifying their environment and behavior. Participants did not discuss this as an emotional or difficult process, but simply adjusted their lifestyle to incorporate safety as a necessary aspect of aging. While participants regretted ceasing certain activities they considered to be important, they prioritized safety over personal satisfaction.

Lee, Mackenzie, and James (2008) conducted a phenomenological study exploring the meaning of fear of falling amongst nine older people living in the community. While phenomenological inquiry does not typically address linear cause-effect relationships, the authors of this study deduced that older people living in the community typically do not develop a fear of falling until having experienced a fall themselves. The authors suggest that while participants' activities changed over time to provide less physical strain to their aging bodies, the reasons for the limited activities might not be solely attributable to a fear of falling. Participants described an orientation primarily toward being independent as opposed to preventing falls, and took actions to prolong their independent daily activities. Participants primarily attributed the occurrence of falls to their own behavior, believing that it was their own carelessness that caused them to fall. Thus, in order to maintain independence they sought to take more caution in daily activities and cope with their continued fear of falling.

Tischler and Hobson (2005) conducted a generic qualitative study from a post-positivist perspective with seven older participants residing in the community, focusing on describing their fear of falling and what activities were feared by older people in this context. Participants explained that falls themselves as well as consequences were

specifically feared, describing the lack of control and physical injury associated with the fall event as emotionally bound and associated with the experience of pain. The consequences of the fall were described primarily in terms of social loss and burden, as participants explained that they did not want to lose their capacity to be independent and need to rely on the support of others in their daily activities.

The Experience of Decisions to Engage in Fall Prevention

Studies addressing the experience of older people who are faced with a decision regarding whether or not to participate in fall prevention activities, including structured exercise programs, home modification, taking caution in daily life, and use of gait aids, also have provided insight into older peoples' experiences of anticipating falling. Many of the following studies have explored older peoples' beliefs that falls may not be preventable, and therefore that participation in fall prevention initiatives may not be warranted. Many older participants in these studies did not admit that they were themselves at risk of falling. Such experiences and beliefs might enter into decisions about whether to engage in fall prevention initiatives or not. Overall, the findings of these studies illuminate the need for older people to continue to exert control and autonomy over their lives, and to make decisions based on positive messaging as opposed to the prevention of an adverse event such as a fall.

Studies focusing on decisions to engage in exercise for fall prevention. Evron, Schulz-Larsen, and Fristrup (2009) conducted a generic qualitative study from a post-positivist perspective with ten older people who chose to participate in a hospital-based falls prevention program and ten who chose not to participate in the program. The thematic analysis of the interviews focused on the identification of barriers to

participating in the fall prevention program. Participants identified a number of factors related to the program, including the required dedication of more personal time than participants cared to give, communication issues regarding setting up the appointments and transit, and administrative details (e.g. paperwork) that acted as barriers to participating. In terms of barriers related to the participants themselves, the authors identified attitudes to fall prevention as a potential deterrent to participating in the program. Specifically, those participants who refused to participate in the fall prevention initiative believed that falls were not preventable, and thus fall prevention programs would be a waste of time.

Yardley, Donovon-Hall, Francis, and Todd (2006) conducted a generic qualitative study from a post-positivist perspective using both focus group and individual interview techniques with a sample of 66 older people living in the community. Their study focused on older peoples' views regarding fall prevention in general. Findings suggest that older people believed fall prevention consists primarily of limiting activities and small modifications to daily life such as the use of gait aids and taking caution. Most older participants in this study did not see fall prevention advice as personally relevant, because they did not believe themselves to be personally at risk for falling despite their awareness of a number of fall risk factors. Furthermore, participants felt that fall prevention advice was rejected because it was seen as a threat to their autonomy and identity, which were more important for quality of life than attending to advice regarding the prevention of falls.

Calhoun et al (2011) conducted a generic qualitative study from a post-positivist perspective with 20 older people who had agreed to participate in a fall prevention

program and 19 older people who declined to participate. Interviews focused on aging, values, falls, and fall prevention. Findings from this study suggest that both groups of older people expressed similar experiences of loss associated with aging, as they lost social connections and had to cease performing activities that were previously associated with their quality of life. Furthermore, they expressed similar values, such as the need for independence, and had similar emotional responses to falling, including anger, fear, and embarrassment. The primary distinction between the two groups with respect to choosing to join the program was with respect to beliefs regarding whether fall prevention initiatives could be of help to them specifically. Older people who chose not to participate in the program felt either that they had not deteriorated in their physical functioning enough to require prevention programming, or that falls were not preventable and thus there was no point in attending. Thus, some older people neglected to accept themselves as "fallers" as they aged, preventing them from participating in fall prevention programs.

In their generic post-positivist qualitative study, de Groot and Fagerstrom (2011) interviewed 10 older participants who had previously participated in a hospital-based exercise program designed to prevent falls. Findings from this study suggested that older people were motivated to exercise by the positive results of exercise, including maintaining independence and current health status, and improving balance and the ability to walk. Barriers to participating included lack of motivation, previous unpleasant experiences with exercise, and a lack of understanding of the benefits of exercise. For participants in this study, exercising with others of comparable physical functioning was

also important, as poorer physical functioning was often accompanied by feelings of inferiority when exercising in the presence of more functional older people.

Horne, Speed, Skelton, and Todd (2009) conducted an ethnographic study with Caucasian and South Asian older people living in a British community to explore their understanding of exercise for fall prevention. The authors reported finding similarities between the two cultural groups in the study. Participants from both groups understood the benefits of exercise for preventing falls. However, understanding the benefits did not translate into motivation to engage in exercise. Many participants did not believe they were personally at risk for falling, claiming that because they were a younger age group (aged 60-70 years), they did not have to consider issues of fall risk. In addition, both cultural groups felt that falling was a natural consequence of aging and therefore may not be preventable.

Studies focusing on home-based interventions for fall prevention. Porter, Mustada, and Lindbloom (2010) conducted a descriptive phenomenological study of 40 older female home care recipients who had experienced falls at home, exploring their experience of having intentions to prevent falls. After reporting findings that re-present participants' experience of living with fall risk at home, the authors report findings re-presenting participants' intentions to initiate activities to help prevent falls. These authors found that the majority of participants' intentions to prevent falls were specifically targeted at the situation in which the fall occurred. Participants' did not have intentions to integrate caution into daily life on a broader scale, but intended to engage in the particular activity in which they fell with more caution and awareness. Participants felt that falls were generally not preventable events. Some felt that they would simply have to take

extra caution or avoid the situations in which they had previously experienced a fall, while others did not express any intentions to change behavior or take caution in order to prevent future falls.

Aminzadeh and Edwards (1998) conducted a generic post-positivist qualitative study involving focus groups with 30 older people living independently in the community, focusing on participants' views regarding the use of assistive devices to prevent falls. Participants in this study described the meaning of falling in terms of its consequences, focusing on the impact it had in limiting their activities and raising awareness of the inevitability of death. Participants agreed that gait aids, specifically canes and walkers, had become symbols of aging in contemporary culture, but disagreed about the cultural perceptions of aging. Participants of Italian descent felt that it was shameful to have to use gait aids because it represented the inability to contribute to family and society, whereas participants of British descent did not feel as negative about their use. Social referents were important influences on older participants' decisions regarding use of gait aids to prevent falls.

Horton and Arber (2004) conducted a grounded theory study involving interviews with older people and their informal caregivers, primarily their adult children, regarding efforts to prevent falls. Findings from this study suggested that gender roles impact the nature of the interaction between family members regarding fall risk and fall prevention. Adult children sought to provide protection for their parents regarding their risk of falling, and the type of protection they provided depended upon the gender dyad. Male children of female parents used coercive strategies; male children of male parents used respectful strategies; female children of parents of either gender used engagement and

negotiation strategies. Study findings suggest that specific gender and contextual relations were at play in the everyday enactment of fall prevention amongst study participants.

Kilian, Salmoni, Ward-Griffin, and Kloseck (2008) conducted a focused ethnography regarding the perceptions of falling and fall risk by older people in the contexts of family relationships with adult children. Findings highlighted the different perceptions of falling and fall risk held by older people and their children. Older people did not perceive themselves to be specifically at risk of falling despite their awareness of the presence of certain fall risk factors, as they felt their common sense could remove risky behaviors in their daily lives. However, adult children participants felt their parents were at risk of falling, and each had expressed a covert agenda for action in order to prevent their older adult parents from experiencing a fall. Findings from this study illuminate the complexity of factors influencing perceptions of risk within a family context, and provide insight into family relations and differing beliefs among family members with respect to the perceived risk of falling in later life.

Clemson, Cusick, and Fozzard (1999) conducted a generic qualitative study from a post-positivist perspective with nine older women who had not followed through with occupational therapists' recommendations regarding home modifications to prevent falls, exploring their experiences of living at home with increased risk of falling. Participants reported understanding the risks within their home environments based on previous experiences with falling or almost falling, and believed they could make decisions on their own regarding which specific aspects of their home needed to be changed for their own personal prevention of falls. These women were confident in their ability to avoid a

fall within their own homes, and felt the need to enact their self-reliance in making their own decisions. Researchers interpreted "exerting control" to be the core concept of living at home with increased risk of falling, as participants felt the need to maintain control over their lives and their homes.

Summary

This literature review included the literature relevant to the experiences of living with fall risk, experiencing a fall, the consequences of a fall, and decisions to engage in fall prevention. Common themes among the different studies included the following: 1) beliefs about self-risk for falling; 2) beliefs about the preventability of falls; 3) emotional consequences of falling (fear of falling); 4) mobility consequences of falling (activity/participation limitations); 5) need for independence and autonomy; and 6) taking caution. Older people in the studies summarized herein did not express unanimous views on any of the issues reported, instead revealing differences and similarities both across and within cultural groups. While the insights uncovered by research to date may help health service providers to better understand the experiences of living with fall risk, experiencing a fall, and making decisions to engage in fall prevention, research has not yet specifically addressed the experience of *anticipating falling*. Further research specifically exploring anticipating falling in the context of aging will provide unique insight into the everyday meanings that characterize older peoples' understanding and experience of the intersection between fall risk and fall prevention in daily life.

Review of the Literature on Physiotherapists' Experience of Providing Fall Risk Assessment and Fall Prevention Services

The primary aim of the second review was to explore existing literature that addressed the subjective experience of physiotherapists and other health professionals providing fall risk assessment and fall prevention services in an interprofessional context. Only two studies, both qualitative, could be found, and both of these drew upon an interprofessional group of service providers as participants. While my dissertation research focused on community-based fall prevention services, due to the very small body of literature addressing this topic one study based in a hospital environment was also included. The findings of this review highlight the paucity of research conducted on this topic. I contacted the authors of the two studies included in this review, and identified one additional study which was currently undergoing review for publication and was thus not available for inclusion in this review.

Physiotherapists' Subjective Experiences of Providing Fall Prevention Services: An Interprofessional Perspective

The two studies that have addressed the experiences of physiotherapists providing fall risk assessment and fall prevention services explored the views of interprofessional groups, and as such, the subjective views and experiences of physiotherapists were not separated from those of other professional disciplines. As health services for fall prevention are considered to be best approached by an interprofessional group (Baxter & Markle-Reid, 2009), these studies explored the experiences of providing fall prevention services across professional disciplines.

Mackenzie (2009) conducted a study using grounded theory methods of health service providers in Australia, the United Kingdom, and Canada regarding their perceptions about effective practice in falls prevention. Participants included nurses,

occupational therapists, physiotherapists, rehabilitation assistants, paramedics, and a geriatrician, all of whom provided services in the community as part of their practice. While no overall theory of effective fall prevention practice was reported in the study, three main themes emerged. Despite the lack of consistency between the knowledge claims made and the reported methodology, the study findings may provide insight into community-based fall prevention. The primary themes were: 1) client experiences of fall prevention, 2) professional skills and clinical reasoning in fall prevention, 3) service issues in fall prevention. In relation to the first theme, service provider participants sought to ensure their approach to fall prevention was as client-centered as possible, recognizing the emotional nature of fear of falling and clients needs to remain feeling safe in their own homes. Service providers stated that they provided suggestions and interventions within the context of the client's resources and readiness for change. In relation to the second theme, service provider participants explained how they had to establish excellent rapport and apply creative problem solving in order to help clients deal with personal barriers to changing behavior in order to prevent falls. This meant at times sacrificing more effective interventions for interventions that could more easily be adopted by a specific client. In relation to the final theme, participants felt that limited time and other resources were a significant barrier to providing evidence-informed fall prevention services. Participants also suggested that while service providers from different professional disciplines were expected to identify the same risk factors, it was expected that their approaches to addressing those risk factors would be quite different. The findings from this study highlight the complex integration of professional, client, and system concerns in the provision of community-based fall prevention services.

Ballinger and Payne (2000) conducted a qualitative study from a discourse analytic perspective involving interviews with both service providers (occupational and physical therapists) and patients in an acute care ward treating older people who had experienced a fall-related fracture. Ten occupational therapists and ten physical therapists were asked how they understood the notion of "fall risk". Findings suggest that both occupational and physical therapist participants drew on their professional discourses in understanding fall risk, emphasizing their professional skills and knowledge and their responsibility to protect patients whom they see as vulnerable. Occupational and physical therapists considered falls to be predictable and controllable events, and felt that they were the experts who could coach patients into engaging in appropriate behaviors to prevent falls. The authors suggest that service provider participants approached fall prevention in an authoritative way that was focused on minimizing the vulnerability of their older patients.

Summary

The research reviewed in this section addressing physiotherapists' and other service providers' subjective experiences of providing fall prevention suggests that the experience may be very different in hospital versus community care settings. Furthermore, community-based service providers may need to be creative in the ways in which they provide fall prevention in their older clients' homes, understanding that older people will make the final decisions regarding whether or not to adopt suggestions made by service providers. Nonetheless, health service providers may emphasize and rely upon their professional expertise when enacting fall prevention with older clients. Further research exploring the lived-experience of engaging older people in fall prevention in the

community amongst inter-professional service providers may contribute to understanding the lived meaning of providing such services, garnering insight into how physiotherapists might approach fall prevention in ways that are meaningful to both older people and physiotherapists themselves.

Future Directions

The literature summarized in this review suggests that while thoughtful and critical approaches to inquiry are being applied to this growing area of gerontological health services, there is still much being taken-for-granted in traditional approaches to understanding fall risk, falling, and fall prevention. The literature exploring older peoples' views and experiences related to living with fall risk and engaging in fall prevention rarely questions the importance and value of holding the prevention of falls as the prioritized concern of inquiry, and thus of older people themselves. In some cases, critical approaches have sought to uncover the ways in which older people understand fall risk without taking the importance of falling for granted, thus focusing on questioning the most fundamental assumptions of fall prevention as a valued element of health care (Ballinger, 2002; Ballinger & Payne, 2000; Horton, 2004). These more critical studies approached fall risk as understood within older peoples' broader life contexts in order to avoid the narrow focus on informing/improving fall prevention programs that characterizes most post-positivist, biomedical, and instrumentalist studies in this area (Calhoun et al, 2011; Evron, Schulz-Larsen, & Fristrup, 2009; Roe et al, 2008; Tischler & Hobson, 2005; Yardley et al, 2006). Such a critical focus on understanding the meaning of falling in the context of broader lives that are meaningful wholes seems crucial to placing fall risk and fall prevention in context, helping service providers to

address these issues in ways that resonate with the actual lived-experiences of older people. As such, the aim of this two-phase dissertation study was to explore the meaningful lived-experiences of both service providers and older people without taking the importance or value of fall prevention for granted.

The specific focus of the second body of literature reviewed in this chapter, on research that included physiotherapists as participants, has yielded only two published studies. As the goals of this dissertation include edifying the practice of physiotherapists in relation to fall risk assessment and fall prevention, it is important to highlight the paucity of attention given to this area of health care by the physiotherapy profession. Despite the presumed expertise of this professional group (Ballinger & Payne, 2000), very little work has been done exploring physiotherapists' experiences, views, and perceptions related to fall risk and fall prevention. As such, in this dissertation I sought to encourage physiotherapists to better understand the meanings that are taken-for-granted in fall prevention programming in the increasingly inter-professional context of community-based health care.

Considering the personal, social, and economic costs associated with the occurrence of falls and fall risk among older people, the need for sensitive, holistic approaches to fall prevention practice that consider the meaningful lives of older people seems apparent. In order to co-construct sensitive approaches to fall prevention that encourage the mutual establishment of new meanings regarding living with fall risk, it is important for health service providers to understand the experiences of older people living with fall risk in the community; the experiences of older people *anticipating falling*. As such, research specifically exploring the meaning of the experience of

anticipating falling will help service providers to better understand how they can address the meaningful experiences of the older people with whom they work. Efforts to improve service provider practice must also consider their own subjective experiences of their normal, everyday practice within the context of increasing emphasis on interprofessional health care. Exploring service providers' experiences will help to understand what is important to them in their approach to providing care, and how this can be built upon to address the meaningful experiences of older people when providing fall prevention services that seem necessarily focused on changing behaviour. In this sense, behaviour is not a risk factor to be dealt with, but the means by which people live meaningful lives. The purpose of this dissertation is to attend to the meaningful experiences of both older people and service providers in the context of interprofessional health care practice, with the aim of uncovering insights that inform practical strategies for enhancing the sensitivity, skill, and artfulness of physiotherapists' practices of fall risk assessment and fall prevention with older people living in the community.

References

Aminzadeh, F., & Edwards, N. (1998). Exploring seniors' views on the use of assistive devices in fall prevention. *Public Health Nursing, 15*(4), 297-304.

Ballinger C. (2002). The construction of the risk of falling among and by older people. *Ageing & Society*, 22, 305-324.

Ballinger, C. & Payne, S. (2000). Falling from grace or into expert hands? Alternative accounts about falling in older people. *British Journal of Occupational Therapy, 63*(12): 573-579.

Calhoun, R., Meischke, H., Hammerback, K., Bohl, A., Poe, P., Williams, B., et al. (2011). Older adults' perceptions of clinical fall prevention programs: A qualitative study. *Journal of Aging Research, 2011*, 86-91.

Clemson, L., Cusick, A., & Fozzard, C. (1999). Managing risk and exerting control: Determining follow through with falls prevention. *Disability and Rehabilitation, 21*(12), 531-541.

de Groot, G. C., & Fagerstrom, L. (2011). Older adults' motivating factors and barriers to exercise to prevent falls. *Scandinavian Journal of Occupational Therapy, 18*(2), 153-160.

Evron, L, Schultz-Larson, K., & Fristrup, T. (2009) Barriers to participation in a hospital-based falls assessment clinic programme: An interview study with older people. *Scandinavian Journal of Public Health*, 37, 728-735.

Hallrup, L., Albertsson, D., Tops A., Dahlberg, K., & Grahn, B. (2009) Elderly women's experience of living with fall risk in a fragile body: A reflective lifeworld approach. *Health and Social Care in the Community, 17*(4), 379-387.

Horton, K. (2007). Gender and the risk of falling: A sociological approach. *Journal of Advanced Nursing, 57*(1), 69-76.

Horton, K., & Arber, S. (2004). Gender and the negotiation between older people and their carers in the prevention of falls. *Ageing & Society, 24*(1), 75-94.

Høst, D., Hendriksen, C., & Borup, I. (2011). Older people's perception of and coping with falling, and their motivation for fall-prevention programmes. *Scandinavian Journal of Public Health, 39*(7), 742-748.

Horne, M., Speed, S., Skelton, D., and Todd, C. (2009). What do community-dwelling Caucasian and South Asian 60-70 year olds think about exercise for fall prevention. *Age & Ageing, 38*(1); 68-73.

Huang, T. T. (2005). Managing fear of falling: Taiwanese elders' perspective. *International Journal of Nursing Studies, 42*(7), 743-750.

Kilian, C., Salmoni, A., Ward-Griffin, C., & Kloseck, M. (2008). Perceiving falls within a family context: A focused ethnographic approach. *Canadian Journal on Aging, 27*(4), 331-345.

Kong, K. S., Lee, F. K., Mackenzie, A. E., & Lee, D. T. (2002). Psychosocial consequences of falling: The perspective of older hong kong chinese who had experienced recent falls. *Journal of Advanced Nursing, 37*(3), 234-242.

Lee, F., Mackenzie, L., & James, C. (2008). Perceptions of older people living in the community about their fear of falling. *Disability and Rehabilitation: An International, Multidisciplinary Journal, 30*(23), 1803-1811.

MacKenzie, L. (2009). Perceptions of health professionals about effective practice in falls prevention. *Disability and Rehabilitation, 31*(24), 2005-2012.

Mahler, M., & Sarvimäki, A. (2010). Indispensable chairs and comforting cushions—Falls and the meaning of falls in six older persons lives. *Journal of Aging Studies, 24*(2), 88-95.

Mcinnes, E., Seers, K., & Tutton, L. (2011). Older people's views in relation to risk of falling and need for intervention: A meta-ethnography. *Journal of Advanced Nursing, 67*(12), 2525-2536.

McMahon, S., Talley, K., & Wyman, J. (2011). Older peoples' perspectives on fall risk and fall prevention programs: A literature review. *International Journal of Older People Nursing, 6*(4); 289-298.

Merleau-Ponty, M. (1962). *The Phenomenology of Perception*. Routledge: New York.

Poli, R. (2010). The many aspects of anticipation. *Foresight, 12*: 7-17.

Porter, E. J. (1999). 'Getting up from here': Frail older women's experiences after falling. *Rehabilitation Nursing : The Official Journal of the Association of Rehabilitation Nurses, 24*(5), 201-6, 211.

Porter, E. J., Matsuda, S., & Linbloom, G. (2010). Intentions of older homebound women to reduce their risk of falling again. *Journal of Nursing Scholarship, 42*(1); 101-109.

Roe, B., Howell, F., Riniotis, K., Beech, R., Crome, P., & Ong, B. N. (2008). Older people's experience of falls: Understanding, interpretation and autonomy. *Journal of Advanced Nursing, 63*(6), 586-596.

Stewart, J., & McVittie, C. (2011). Living with falls: House-bound older people's experiences of health and community care. *European Journal of Ageing, 8*(4), 271-279.

Tischler, L. & Hobson, S. (2005). Fear of falling: A qualitative study among community-dwelling older adults. *Physical & Occupational Therapy in Geriatrics, 23*(4); 37-53.

Ward-Griffin, C., Hobson, S., Melles, P., Kloseck, M., Vandervoort, A., & Crilly, R. (2004). Falls and fear of falling among community-dwelling seniors: The dynamic tension between exercising precaution and striving for independence. *Canadian Journal on Aging = La Revue Canadienne Du Vieillissement, 23*(4), 307-318.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. The Althouse Press: London.

van Manen, M. (1996). Phenomenological pedagogy and the question of meaning. In D. Vandenberg (Ed.), *Phenomenology and Educational Discourse*, pp. 39-64. Heinnmen Further Education: Durban.

Yardley, L., Donovan-Hall, M., Francis, K., & Todd, C. (2006). Attitudes and beliefs that predict older people's intention to undertake strength and balance training. *The Journals of Gerontology: Series B: Psychological Sciences and Social Sciences, 62B*(2), P119-P125.

Chapter Three: Methodology

The aim of this dissertation research was to co-construct a meaningful and sensitive understanding of how fall prevention services might be enacted with older people in the community in appreciative, empathetic, and mutually valued ways. In order to achieve this understanding, I engaged in phenomenological inquiry of the meaning of the experiences of both older people and service providers in relation to fall risk and fall prevention. Specifically, in integrated manuscript one I explored the meaning of the experience of anticipating falling amongst older people living in the community. In integrated manuscript two I explored the meaning of the experience of enacting fall prevention with older people amongst health service providers working within a geriatric-specific community outreach team. In the discussion chapter I brought the findings of these two studies together to establish and reflect upon implications of the dissertation research overall. The aim of this chapter is to explore the methodology and methods that constituted this two-phase dissertation study.

Context of the Dissertation Research

This dissertation research was inspired by my inclination to believe that all people have equal worth and value because of their "facticity" (Merleau-Ponty, 1962), because of the very fact that they live-in-the-world. Along with this normative inclination toward a concept of equality comes an immense appreciation for the lived-experiences of all people living-in-the-world. This appreciation pervades my scholarly work, at times appearing as critical reflection on social practices, but primarily in positioning me hermeneutically to embrace the empowerment of others to continually and freely constitute meaning in their lives. As such, the research undertaken herein fits within a

humanist approach to social inquiry that "demands comprehending [older people] as people, not treating them as strangers whose predicaments are foreign to those of others" (Edmonson & von Kondratowitz, p. 1, 2009). The same demands are relevant for health service providers, who are sometimes "blamed" for alienating the older people with whom they work (Ballinger, 2002).

The research was undertaken from a perspective that explicitly values the experiences of both older people and service providers in understanding community-based fall prevention, and with the intention of seeking to better understand the meaning each person makes out of these experiences. This contingent understanding of lived-experience in a particular time and place enabled the co-construction of implications from this two-phase study, providing recommendations in a hermeneutic context in which I recognize they may or may not apply to those in other times and places. In adopting the methodological orientation taken in this dissertation I sought coherence between its humanist inspiration, epistemological position, and the methods used in the research process. The following discussion outlines how such coherence was achieved.

Paradigmatic Position

While I am aware of the danger inherent in "naming" my paradigmatic position because of the multiple interpretations that will inevitably arise, I would describe my view as "anti-foundational ironism", premised on the work of Richard Rorty (1979; 1982; 1989). As applied to my approach to research, "anti-foundational" refers to the impossibility of ultimate foundations for human knowledge, re-cognizing that inquiry does not get us closer to something called Ultimate (or Foundational) Truth (Rorty, 1982). With an ironist approach I re-cognize that I am not inching progressively closer to

essential or timeless knowledge and truth, but nonetheless understand the knowledge I use every day to reflect the meaningful truth of experience (Rorty, 1996). As such, "truth" takes on a new meaning – as opposed to imagining truth as "out there" in the world waiting to be found or discovered, I understand it as made by human action and interaction every time knowledge is put to use in our practical being-in-the-world (Rorty, 1996). The truth that is sought in my dissertation research is the truth of everyday experience. It is not inspired by a hope for something timeless, but by a new and nonetheless "true" appreciation of something we tend to take for granted.

The paradigmatic position that I have adopted constitutes a post-modern sentiment toward epistemology, wherein I "face up to the contingency of [our] own most central beliefs and desires" (Rorty,1989, xv). From my paradigmatic position I re-cognize that despite the impossibility of ultimate foundations on which we can base our moral and factual convictions, we nonetheless act in the world as though we *do have and know* the foundations for all such convictions. Through language we interpret the meaning of our experience, and it is these unique interpretations that compose our convictions. As such, there is *irony* in our efforts to understand the world and the way we think we should act within it, as it is only ever linguistic interpretations that constitute such convictions in meaningful ways (Rorty; 1979; 1996).

I believe that we always come to our inquiries with an existing language that we use to make sense of the world, and this language always forms our starting point as we engage in social research. We cannot escape our existing presuppositions, or the existing interpretations through which we already understand the world, and as such "we shall never be able to avoid the 'hermeneutic circle'" (Rorty, 1979, p. 319). In this way,

language can be seen to fundamentally *constitute* the reality we experience every day, because without language that reality would be meaningless and incoherent (Kinsella, 2006; Rorty, 1998). We live in a complex web of interpretations in language, and it these interpretations that provide our lives with meaning.

Reflecting on the importance and value of reflexively outlining my epistemological assumptions and their role in my dissertation research, I re-cognize how the type of knowledge I seek influences the questions I choose to ask, the methods I choose to answer them, and the interpretations I am inclined to make of my research "findings" (Finlay, 2003; Davies et al, 2004). Drawing on Rorty's version of hermeneutics as characterizing every passing moment of experience, I have put myself in an *interpretive relationship* to each element of the research process. In re-cognition of my epistemological position, that all knowledge and belief is in the most fundamental way interpretive or hermeneutic, I emphasize and foreground the interpretive acts that compose my dissertation. It is this hermeneutic interpretive orientation, embracing our sheer contingency (Sartre, 1960), that characterizes the irony of my humanistic approach to this dissertation research. Orienting myself interpretively to each aspect of my dissertation research has meant re-cognizing and emphasizing that interpretation "goes all the way through" the dissertation; it is not a methodological tool being applied, but an ironist's truth about the nature of inquiry.

Epistemological Rigour

Re-cognizing the irony inherent in discussing rigour in social inquiry because of the sheer contingency of the beliefs and assumptions that inform such discussions, I suggest that evidence of a strong interpretive stance in relation to the procedures of my

dissertation research contained herein portray the overall coherence of my methodological approach (Caelli, 2001; Denzin & Lincoln, 2005; Holloway & Todres, 2003). Rigour in qualitative research may best be understood as located in the strength of the consistency and coherence between the philosophical underpinnings and the procedures that constitute the study (Holloway & Todres, 2003). I created the procedures for this dissertation research in order to achieve consistency and coherence as the primary indicators of rigour, deriving the methods applied from the methodological orientation of Max van Manen in ways that resonate with my paradigmatic position.

"Consistency" is defined as a "goodness of fit" between the most fundamental assumptions of an approach to inquiry and the questions, methods, and implications that constitute the study and its findings (Holloway & Todres, 2003, p. 347). When such "goodness of fit" is achieved by a study it can be said to be "coherent" and sufficiently rigourous (Holloway & Todres, 2003). Embracing the goal of achieving consistency and coherence from an ironist, interpretivist position means understanding the constitution of research methods out of the epistemological and methodological commitments that motivate the study (Schwandt, 1998). While the ironist position I adopt in my dissertation re-cognizes that any evaluative criteria for truth and rigour are simply derived from consensus among individuals within a community of scholars (Rorty, 1982), there must nonetheless be a coherent means of justification for those methods in order to foster collaboration and practicality (Rolfe, 2006). In the spirit of interpretive inquiry as a constructive and creative activity, I have applied an approach that locates the rigour of my dissertation research in the coherent and integral relationship between my interpretive, ironist understanding of knowledge and the procedures enacted in the

research process. I have further adopted two additional strategies to convey rigour to my audience: transparency and systematicity (Meyrick, 2006).

Transparency has been described as "the disclosure of all relevant research processes" (Meyrick, 2006, p. 803), providing readers with the opportunity to judge for themselves whether the procedures were sufficiently rigorous. In addition, ensuring transparency throughout the research process gives the researcher the opportunity to be reflexive about his or her own conception of rigour and how it may or may not be evident within the various decisions made while carrying out the study procedures. As such, integrating transparency into my doctoral research has promoted judicious reflexivity regarding my methodological and procedural decisions (Finlay, 2002). In conducting the data collection and analysis for this research I systematically returned to questioning what findings were emerging from the study through my interpretations. By engaging in the continual (systematic) questioning of emerging findings and how they ought to inform future interviews and study procedures, I integrated *systematicity* as a marker of rigour in this study (Meyrick, 2006).

These signposts for rigour, including consistency, coherence, transparency, and systematicity, are to be understood as elements of rigour *at the level of epistemology*. These "criteria" reflect a conceptualization of rigour applied to the dissertation as a whole, indicating how the two-phase study that composes the dissertation may be viewed as a continuous and coherent study. From an interpretive perspective, the most important indication of rigour is not "what" is being done, but "how" it is being done. By exploring the philosophical underpinnings of my methodological approach in as much depth as possible throughout the conduct of the research, I have sought to adopt the interpretive

language of the philosophical writing from which my research is derived. By engaging in this process of philosophical exploration I have made every effort to integrate the interpretive language and beliefs of my philosophical and epistemological position, and thus this depth of understanding, throughout each aspect of my dissertation.

Integrated Manuscripts

Two empirical phenomenological studies, as presented in manuscripts one and two, were approached from the same methodological perspective (van Manen, 1990). These studies explored the meaningful experiences of older people living in the community (study one) and health service providers who work on a community outreach team (study two). The following discussion provides an outline of the methodological orientation and the methods applied in these studies. Where there were differences between the methods employed in the two studies, for example in the different strategies of recruitment required for such different groups of participants, those differences are addressed under the relevant sub-headings. Other than instances in which differences are directly addressed, the methodology and methods employed were the same for both phenomenological studies.

Methodological overview: Hermeneutic phenomenology. As stated at the outset of this chapter, the overall aim of this dissertation research was to construct a meaningful and sensitive understanding of how fall prevention services might be enacted with older people in the community in appreciative, empathetic, and mutually valued ways. Such a goal resonates strongly with Max van Manen's phenomenology of practice (1990; 2002; 2007), which explicitly seeks to edify the orientation and approach of practitioners engaging in professional activities that are focused on *care*. These

practitioners include educators, who are the focus of much of van Manen's work, but also those working in health science, medicine, and psychology (van Manen, 1997). For van Manen (1997), these practitioners "are the people who are able to enrich our perceptiveness and who contribute to our reflective understandings of the possible meaning and significance of everyday experiences" (p. 350). Van Manen's approach to phenomenological human science recognizes that phenomenology is not about "solving problems", but has practical import in its capacity to inform the most fundamental and tacit assumptions we integrate into our approach to caring practice. Thus while no timeless or ultimate truth is sought as a product of inquiry, the findings can constitute implications for the very ways in which we approach the practice of fall risk assessment and fall prevention with our older clients.

Van Manen's approach to the phenomenology of practice is explicitly hermeneutic (van Manen, 1990; 1996), and resonates strongly with Rorty's ironist approach to inquiry. Van Manen integrates post-modern insights into his phenomenological methodology, considering knowledge to be a function of the pervasive linguistic interpretation of our lived-experiences (Levering & van Manen, 2002; van Manen, 1990). As such, my previously described paradigmatic and epistemological position resonates strongly with van Manen's claim that "lived experience is soaked through with language" (1990, p. 38). To explore the meaning of lived-experience in a holistic and sensitive manner, I attended to both "gnostic" (cognitive) and "pathic" (non-cognitive or emotional) ways of experiencing our being-in-the-world throughout the two studies of my dissertation (van Manen, 1990; 1999). Re-cognizing the value and importance of non-cognitive ways of knowing is also an important point of resonance

with the post-modern sentiment toward epistemology outlined in my paradigmatic position.

In keeping with van Manen's (1990) application of Merleau-Ponty's emphasis on the gestalt nature of meaning in lived-experience, my phenomenological research integrated an explicit effort to explore the life-world as a lived-through meaningful whole (Merleau-Ponty, 1962; Primozic, 2001; Small, 2001). Hence, the "themes" or "essences" co-constructed in my phenomenological research are to be understood in the broader context of everyday life from which the meaning of these themes is derived. Furthermore, the paradoxical and ironic nature of re-presenting essences of a holistic lived-experience suggests that the themes are to be understood as the contingent re-presentation of the meaning of an experience within the inherent communicative limitations of language. This re-cognition does not detract from their gestalt meaning and significance in the life-world, but simply places the thematic findings of my phenomenological inquiry in the context of my paradigmatic orientation toward social inquiry.

While engaging in this phenomenological inquiry I have oriented my interpretations toward the normal, common-sense meaning structures that characterize everyday social experience (Schutz, 1943; Schutz & Luckmann, 1973; McWilliam, 2010). This has meant exploring and re-presenting the meaning of lived-experience as a function of the "natural attitude", or the everyday life-world "which the wide-awake and normal adult simply takes for granted in the attitude of common sense" (Schutz & Luckmann, 1973, p. 3). In this dissertation research, this has meant exploring the taken-for-granted meanings in everyday practices of community outreach fall risk assessment and fall prevention. In so doing, I have applied the methodological tool of "bracketing" as

Merleau-Ponty did: as a reflexive awareness of the meanings we take for granted that "slackens the intentional threads which attach us to the world and thus brings them to our notice; it alone is consciousness of the world because it reveals that world as strange and paradoxical" (1962, p. xv). As opposed to a naive attempt to *limit* the influence of my taken-for-granted meanings of fall risk and fall prevention on my interpretations (Schutz & Luckmann, 1973), this approach to bracketing helped me to be *more aware* of how taken-for-granted meanings may be influencing my interpretations.

My application of the phenomenological "reduction", traditionally seen in conjunction with the notion of bracketing as the primary methodological tool of phenomenological inquiry (Depraz, 1999; Seeburger, 1975; Taminiaux, 2004), reflected the methodological approach espoused by van Manen (1990). Instead of a traditional application of the phenomenological reduction (Depraz, 1999; Flynn, 2006; Husserl, 1970), I used phenomenological *writing* as the primary means of intuiting, interpreting, describing, and disclosing essences (van Manen, 1990; 2002). By writing and re-writing my interpretations of participants' lived-experience I arrived at a contingent but nonetheless meaningful gestalt hermeneutic understanding. As such, the writing and re-writing of the phenomenological findings of my dissertation studies are analogous to the notion of phenomenological reduction, constituting the primary method by which I put my emerging interpretations into re-presentations of the lived-experience in question.

Sampling and recruitment. I sought to recruit a purposeful sample for each phenomenological study composing this dissertation in order to best achieve the aims of the dissertation overall (Coyne, 1997; Patton, 1990). While the term "purposeful sampling" has been described as encompassing a variety of more specific sampling

strategies (Patton, 1990; Sandelowski, 1995), it may be more appropriate to simply describe the sampling strategy applied in a particular qualitative study and the reasons particular participants were recruited (Coyne, 1997). Thus, as opposed to naming specific sub-strategies of purposeful sampling applied in these studies, I will describe my approach and rationale for the sampling strategy applied in each of the two phenomenological studies composing this dissertation.

In purposefully sampling participants for the phenomenological study on the experience of anticipating falling, I sought to include older people who were living independently in the community and maintained their engagement in physical and social activities. By focusing on those who continued to maintain social relationships and physical mobility through recreation activities, I sought to explore the experience of anticipating falling amongst older people in their larger life contexts, endeavoring to uncover the meaning and value in their continued function and mobility. My recruitment goal was not to include only those older people who achieve the highest levels of physical fitness and social connectedness, but to explore a diversity of experiences of older people who seek out and value activity and connectedness. My purposeful sampling strategy helped me to recruit a diversity of older people in terms of chronological age as well as functional mobility, each of them engaging in efforts to maintain their fitness and relationships through exercise and recreation classes. These diverse characteristics provided the opportunity to critically consider what essential themes might characterize the meaning of the experience of anticipating falling across a diverse group of older people (van Manen, 1990).

I did not make initial contact with potential participants for recruitment purposes due to commitments to the ethics of recruiting older people to research, particularly to ensuring "non-exploitation" of older people (Harris & Dyson, 2001). Instead, I developed a relationship with a recreation therapist at a local community center who was an advocate for health and social research with older people. This gatekeeper was responsible for providing exercise and recreation classes for older people living within a local "naturally occurring retirement community" (Masotti, Fick, Johnson-Masotti, & McLeod, 2006), where older people participated in the classes on a voluntary basis. I provided her with information handouts which were formatted and designed to be easily understandable for potential participants, and discussed the study and its aims with her (letter of information and consent available in Appendix A). This recreation therapist mirrored my excitement and passion for the study, and agreed to provide information to the older persons who participated in her exercise and recreation classes. She also provided potential participants with my name and a telephone number at which I could be reached, and encouraged them to contact me for more information and to participate in the study. My efforts in recruiting additional participants were stopped when I interpreted the meaningful resonance of narratives and descriptions of the experience of anticipating falling amongst older participants.

For my second phenomenological study I sought to purposefully sample health service providers who worked primarily with older people on a geriatric community outreach team. I recruited an inter-professional sample of health care providers to achieve variation amongst participants' professional disciplines, including physiotherapy, occupational therapy, nursing, and social work. There were two specific reasons for

seeking such diversity among professional disciplines. The first reason is that the increasing emphasis on inter-professionalism in contemporary health care, and particularly within fall prevention care (Baxter & Markle-Reid, 2009; Scott et al, 2007), suggests that the meaning of the experience of enacting fall prevention in community care may be best understood in an inter-professional context. The second reason is that while the primary aim of this two-phase dissertation study was to provide guidance and reflection specifically for physiotherapists enacting fall prevention in community care, such guidance and reflection may be more aptly derived from studying the experiences of a diversity of professional disciplines as opposed to focusing solely on physiotherapy. Such diversity of professional perspectives may encourage a more holistic understanding of community-based fall prevention.

Furthermore, I focused my purposeful sample for this phenomenological study on a single community outreach team. By focusing on a single team I sought to achieve a greater depth of understanding of the meaning of the experience of enacting fall prevention. As participants collaborated on case review discussions and joint visits in the context of their inter-professional outreach team, they engaged one another in shared experiences of facilitating the social construction of the meaning of fall prevention. By recruiting from within a single community outreach team I was able to explore the meaning of these shared experiences in enacting fall prevention, co-constructing in greater depth the meaning of the experience of enacting fall prevention in community outreach care.

Upon receiving ethics approval from the participating organizations involved in this study, I was invited to provide a brief overview about the study and sample

recruitment at a staff meeting attended by the geriatric outreach team members. I then provided my name and email address and encouraged interested participants to contact me (letter of information and consent available in Appendix B). I stopped recruiting potential participants when participant narratives and interpretations of the experience of providing fall prevention in the community strongly resonated with previous participants' accounts.

Through exploring the meaning of the experience of service providers who enacted fall prevention with older people living in the community, I hoped to gain insight into their understandings and assumptions regarding the older people with whom they worked. These older people with whom they worked could very well have meaningful experiences that resonated with the findings of my first phenomenological study, providing a unique opportunity to explore the relationships, tensions, and resonance between experiences and meanings for both groups of people participating in encounters involving fall prevention. This was not done with the intent to "generalize" the findings of either phenomenological study, but simply to cultivate shared insight about how we can approach fall prevention in more meaningful ways.

Data collection. Data in phenomenological inquiry are comprised of the exploratory co-construction of shared knowledge by the researcher and participant (van Manen, 1990; Vandermause & Fleming, 2011). As such, my interview guide for the semi-structured in-depth interviews addressed both phenomenological and hermeneutic purposes through the conversational interview method, seeking to gather lived-experience material (stories, anecdotes, recollections of experiences, etc.) and engage participants in mutual reflection (van Manen, 1990). In this way, the participants conveyed the concrete

and lived-through nature of the experience through specific narratives and stories, while also engaging in the active, interpretive co-construction of the essence of the experience in question (van Manen, 1990). Thus the participants explicitly acted as collaborators in constructing the emerging interpretation of their experiences, providing reflective insight about the meaning of the narratives and stories they had conveyed (Interview guide for study one is available in Appendix C; interview guide for study two is available in Appendix D).

In both phenomenological studies, my initial interview with each participant maintained a specifically phenomenological focus, seeking to elicit detailed concrete stories about particular lived-experiences. I engaged in follow up interviews with two particularly insightful participants in each study for specifically hermeneutic purposes, eliciting their help in the interpretation and co-construction of the meaning of the experience in question. In the context of reflexivity, nevertheless, given the impossibility of achieving a *purely* phenomenological or *purely* hermeneutic interview, each interview in this study contained elements of both phenomenological and hermeneutic purposes.

The interviews took an organic and emergent form as they conversationally unfolded, moving between concrete phenomenological storytelling and interpretive hermeneutic co-constructing as new ideas emerged. In study one, my interview questions focused on specific stories involving falling or almost falling, as well as stories about efforts to prevent falling. In study two, my interview questions focused on specific stories involving the provision of fall prevention services. As stories emerged, I would encourage further detail and then ask participants to reflect and interpret the experiences along with me. I also asked about their social relationships and broader context, in order

to construct a holistic gestalt within which the meaning of the experience in question could be situated. As the meaning of the experience that is the focus of inquiry is always situated within a holistic context, exploring and understanding this context was a crucial aspect of interpreting the meaning of experience. As I developed the art of listening (van Manen, 1990), I focused on interpreting instances of cognitive (gnostic) and non-cognitive (pathic) aspects of participants' stories, learning to phrase my emergent questions and probes in terms of how participants *felt* as opposed to what they *thought* during a particular experience. My focus during the interviews was on the common-sense meanings of everyday experiences specific to each study.

To encourage rich and detailed descriptions of lived-experiences in these interviews, I used specific strategies such as incomplete sentences and returning the participant to his or her story with simple requests such as "tell me more about that experience" (Vandermause & Fleming, 2011). As I gained experience in engaging participants in interview conversations, I became better at asking questions and participating in conversation in ways that fostered greater detail and deeper hermeneutic reflection. I also came to understand particular phrases that denoted obvious shifts in the purpose of the interview, such as when participants would say "I've never thought about that before", which indicates hermeneutic reflection on a particular experience. I stopped engaging participants in interviews when the emerging interpretation had been refined and resonated with participants' understanding of their own experiences.

Data analysis. I engaged in analyzing the interview data concurrently with data collection, and the emerging interpretations and findings from the analysis informed any new questions or changes to existing questions in the interview guide. Re-writing and

adding to the interview guide as new interpretations emerged was a crucial aspect of constructing rigour in my phenomenological studies (Vandermause & Fleming, 2011), contributing to the refinement of the interpretation of the experience in question.

Immediately after each interview I listened to the recording of the interview and wrote reflective memos regarding my presuppositions and emerging interpretations. The audio file of the interviews were then sent to a professional transcriptionist and transcribed verbatim. The transcribed interviews were initially analyzed on printed paper copies of the transcripts, using van Manen's (1990) wholistic/sententious approach, selective/highlighting approach, and the detailed/line by line approach. After analyzing the printed transcripts, I created "mind maps" exploring how the key emerging themes appeared to be related in the meaning of the experience of anticipating falling (Buzan & Buzan, 2002). As key themes emerged, I analyzed the transcripts in NVIVO qualitative data analysis software, focusing on the relationships between important themes. Important emerging themes from the reflexive memos, printed paper transcripts, computer based analysis, and mind maps were then brought together in the act of phenomenological writing, which was the primary method of analysis for my phenomenological studies (van Manen, 1990).

Van Manen (1990) warns against presuming that the notion of "theme", which is central to phenomenological analysis, is an unambiguous and straightforward concept. In keeping with van Manen, while the themes uncovered in my dissertation studies re-presented simplifications of an interpretation of meaning, I did not construct themes as generalizations, but rather as shared "structures of experience" (van Manen, 1990, p. 79). Re-cognizing that there is always something more, something ineffable in the meaning of

our lived-experiences that cannot be "captured" in the language of a theme, themes are simply constructed as ways to talk about the meaning of a particular experience. Ironically, as the meaning of a theme is a function of the web of language that surrounds it, the themes uncovered in this research can never be expected to fully grasp the lived-through meaning of the experience itself. Thus, my interpretive analysis re-presented only my best interpretive effort to re-present the lived-through meaning of the experience in question in thematic form.

I used van Manen's (1990) three distinct approaches to analyzing lived-experience descriptions in constructing thematic aspects of the meaning of the experience in question. In applying the wholistic or sententious approach I read the text as a whole and tried to imagine a phrase or statement that could convey the meaning of the entire text. In applying the selective or highlighting approach I read through the text with a careful eye to interpret certain phrases or stories that I believed were particularly revealing of the meaning of the experience. I then identified these specific phrases and stories as playing a more prominent role in the analyses. In the detailed or line-by-line approach, I looked closely at every sentence or cluster of sentences and imagined what it might tell us about the meaning of the experience in question.

In my reflexive memos, I kept track of how I naturally found myself jumping between these three different modes of analyzing data as the data called for different modes of analysis. At times, when dense and detailed stories were being told, I used the line-by-line approach. At others, when participants were following a tangential stream of consciousness, I used the highlighting approach. In forming the overall interpretation of the meaning of the experience in question, I took a wholistic approach. As such, it was

the interplay between each of these modes of analysis that inevitably led to the emergent themes refined through further reading of transcripts, composing of mind maps, and engaging in phenomenological writing.

After the initial reading and analyzing of the printed transcripts, I created mind maps to facilitate the process of free imaginative variation. Free imaginative variation involves considering the themes that emerge, imagining their relationships with other themes, and critically reflecting on whether they are essential to the meaning of the experience in question or merely incidental (Depraz, 1999; van Manen, 1990). Creating a mind map involves portraying the emerging themes in visuo-spatial relation to one another, imagining which themes could be considered as conceptually or experientially connected to the others (Burgess-Allan & Owen-Smith, 2010; Buzan & Buzan, 2002; Northcott, 1996). Engaging in this process helped me to be critically reflective about my assumptions regarding the relationships between and the importance of particular themes, encouraging me to structure and re-structure my thoughts and interpretations in preparation for phenomenological writing (sample mind map for study one is available in Appendix E; sample mind map for study two is available in Appendix F).

Having created the mind maps and engaged in continual critical hermeneutic reflection regarding my emerging interpretations, I went back to the transcribed interviews to read through and analyze again prior to engaging in phenomenological writing. This provided an additional opportunity to question my emerging interpretations and re-view the stories and experiences provided by participants. By re-visiting the narratives of my participants, I felt able to begin phenomenological writing with *their* language fresh in my mind.

For study one, I returned to the transcripts through the computer-based qualitative data analysis software NVIVO, and highlighted new or previously unnoticed stories, phrases, and interpretations. While I found benefit from returning to the transcripts to re-read through the participants' stories, I also found that the NVIVO data analysis software was more of a burden than a help to my efforts. As my preference for printed paper transcripts, multi-coloured pens, and highlighters became clear, I chose not to use NVIVO for this phase of data analysis in my second study.

In both studies, following this preceding analysis strategy, I then began to engage in phenomenological writing and re-writing, seeking to re-present my interpretations in the language of themes that re-construct and re-describe the meaningful experiences of participants. I structured my writing around anecdotes taken verbatim from participant transcripts, presenting the phenomenological data and describing my interpretations alongside participants' stories and reflections. Anecdotes are considered to be a key methodological device, as they help to concretize the themes being discussed in the actual lived-experience of participants. In addition, anecdotes invite us to consider how the experience presented in the anecdote is one the we have had or could have had, bringing us to find resonance with the text and boosting its evocative value (van Manen, 1990). Throughout my phenomenological writing I sought "to make some aspect of our lived world, of our lived experience, reflectively understandable and intelligible" (van Manen, 1990, p. 125), inviting the reader to place the text in the context of his or her own imagination and encouraging the reader to seek further resonance with his or her own lived-experience.

Ethics. The two phenomenological studies were approved by the Health Sciences Research Ethics Board (HSREB) at the University of Western Ontario (ethical approval from for study one is available in Appendix G; ethics approval form for study two is available in Appendix H). In addition, the second phenomenological study required ethics approval from Lawson Health Research Institute and the Clinical Resource Impact Committee at Parkwood Hospital, as it involved health service providers as participants.

Each participant in both phenomenological studies was provided with a full letter of information, and was offered time to read through the letter of information prior to beginning the study. I then summarized the letter of information for each participant, emphasizing that the interview would be audio recorded. I ensured that each participant understood that the interview would be recorded and that their identity would not be connected to the data, either on the audio recorded files and tapes (identified by coded numbers) or in any presentation of the findings (i.e. in my dissertation, in publications, or in conference presentations). Each participant then signed informed consent for the initial interview, as well as a separate informed consent to be contacted in the future for a second interview. I ensured that each participant understood that this separate consent was only to *be contacted* for a second interview, and that they could choose to decline a second interview at that time. All participants consented to the initial interview, as well as to be contacted for a second interview. An additional signed consent was obtained for those who agreed to participate in the second interview.

Ethical considerations related to phenomenological human science were also addressed throughout this investigation (van Manen, 1990). First, I re-cognized the effects the research may have on study participants as well as people for whom the study

findings may be relevant. While studies of this nature have the potential to foster excitement and reflection that can change participants' orientation to the study issue in positive ways, it can also lead to further anxiety regarding the experience in question. Particularly in my interviews with older people living independently in the community, I felt I had to be sensitive to the possibility that discussing fall risk and fall prevention could lead to anxiety or fear related to falling. After each interview with older participants, I provided them with a brief summary of activities related to fall prevention, emphasizing the activities they were already doing that would help to prevent falls. I also suggested that they could contact the gatekeeper recreation therapist if they wanted to participate further in fall prevention activities.

For the second phenomenological study, I suggested that each participant contact me if they had additional questions or issues that arose related to the conversations we had during the interviews. I also committed to presenting the findings of my dissertation back to them after its completion in order to enable participants to understand and consider the resonance between the findings from the two phenomenological studies. The importance of this additional commitment became increasingly obvious as the interviews with service providers progressed, as they continued to express increasing interest in the study and its outcomes.

Van Manen (1990) also outlined the ethical implications that engaging in phenomenological research may have for the researcher, as learning to enact and actually completing this kind of inquiry "often has a transformative effect on the researcher himself or herself" (p. 163). This certainly was the case in my experience of engaging in

my dissertation research, and I will discuss these issues now as I turn to my statement of self.

Reflexivity and Statement of Self

Van Manen (1990) warns that not all students of qualitative research and phenomenology will find themselves successful in the application of this approach, as a particular draw to the interpretive meanings of the everyday life-world, a motivating interest in the philosophical question of being, and the ability to write artistically and interpretively are essential to excellent hermeneutic phenomenology. As a person who has been interested in the reflection and knowledge that philosophy makes possible since my introduction to critical thinking in elementary school, my fascination with human-being-in-the-world and the dumbfounding meaning of everyday life are what have driven me to continue my independent reading and exploration of ever-diverse philosophical perspectives. However, in a reflexive context, I have struggled greatly with learning how to write in an artistic and interpretive way.

My introduction to the health research enterprise began during my undergraduate education in kinesiology, while working in a post-positivist research lab exploring the effects of conditions of the central nervous system (e.g. Parkinson's Disease) on the biomechanical control of balance and gait. My time in this lab solidified the language available to me to discuss and interpret research, but also motivated me to look outside of this research community of laboratory experimental work to see what other kinds of research questions and methodologies could be relevant and important to improving health. Through undergraduate courses in sociology and philosophy I knew that there were very different ways to conceptualize knowledge than the foundations on which

laboratory research rested, and I sought to explore various conceptions of knowledge in my graduate training. While exploring new approaches to conducting research, including my introduction to qualitative inquiry in my first year of graduate school, I maintained the epistemological assumption that had been with me throughout my whole life: I could find the one right way to approach health and social research.

My first year of graduate education was a crucial time in my personal and academic development, as I was introduced to qualitative research and the variety of approaches that can be taken in conducting social and health research. I met a group of students who were equally interested in the foundation of our approaches to research, and was able to debate and discuss, pit and pursue (Davies et al, 2004; DeForge & Shaw, 2012) our beliefs and their implications in our work. Additionally, I was looking ahead to begin my professional training as a physiotherapist during my second year of graduate school, and hoped to have as many of my assumptions regarding the conduct of research laid out clearly and reflexively before beginning my professional training. Throughout this time of profound intellectual development, I maintained the assumption that I could find the one right way, the best way to approach my doctoral research. As I discovered the philosophy of pragmatism, in only the most introductory sense, I believed I had found that way.

I have wanted to "be" a physiotherapist since my own experience with orthopedic injuries early in high school, and was immensely excited to begin my professional socialization and training as I progressed into my second year of graduate school. Pragmatism's focus on practical implications in the lives of people seemed a neat and tidy fit with my practical professional interests. Armed with an understanding of the

health system and health research, I felt I could achieve a better, clearer, more thorough understanding of the practice of physiotherapy than any of my peers. I worked very hard to master the material and live up to my own expectations, as well as those placed upon me by my friends and family.

Nevertheless, the most important lesson that I learned through critical reflection on my professional training was the opposite of what I expected – I learned just how little we actually know and understand about human life. In one profound experience which has remained salient for me throughout the past few years, a retired economics professor, a client with whom I was working on clinical placement, gave me some invaluable advice. He told me that doing a PhD has one of two effects on people – it either makes them think they know everything, or makes them realize they know nothing. He said I should reflect on which of those results I wanted for myself.

The experience with that retired professor is just one of many that encouraged me to question the most fundamental assumptions I had about what can be known about my self, the world, and my professional practice. I began to realize that the most fundamental assumptions and tacit beliefs I had about reality had to be further examined, which brought me to a new and deeper level of reflexivity. I realized that my upbringing in a Catholic family must have had a more profound impact on my most fundamental ways of thinking about the world than I had previously realized, as the language and socialization that comes with "believing in God" is clearly associated with the assumption that there is one right way, one right Truth, an ultimate Foundation on which all of life rests. While I had parted ways with religious belief much earlier in my life, the tacit assumptions that underpinned those beliefs stayed with me. As I continued to read pragmatist philosophy, I

became intrigued by many other philosophical traditions, including critical social theory, existentialism, phenomenology and post-structuralism. I soon realized that my assumption that a single best way for the conduct of research must exist was unexamined, and that much philosophical writing had been devoted to debunking that very position. As I began to become interested in the work of Richard Rorty, I lost my interest in the title of pragmatism, and I came to understand that philosophical labels only serve to create contrived and artificial boundaries among groups of scholars. I hope for emancipation, as does critical theory, I reject ultimate foundations for knowledge, as does the neo-pragmatism of Richard Rorty, and I appreciate the poles of human life, the anguish and joy discussed by the existentialists.

These experiences continue to inform my unique approach to the practice of physiotherapy and a unique approach to the practice of health and social research that are continuously coming into my awareness. My ongoing reflexivity has been crucial in guiding my development as a practitioner and researcher, and I am always uncovering assumptions about various aspects of my orientation to work and life in general. My focus on home care as a physiotherapist is a reflection of my philosophical beliefs, as clients requiring home care seem best served by a practitioner who seeks to understand the unique meanings and experiences of risk, health, and wellness that resonate most with their lives and lifestyles. This determination to co-create meanings of injury prevention, disease management, and rehabilitation with the people I serve was an active resistance to the paternalistic mentality fostered during much of my clinical education experience. My capacity for the artistic and interpretive writing of hermeneutic phenomenology has also developed in profound ways as I have learned to move away from the definitive and

scientistic writing of approaches that assume a singular foundation to research and knowledge is possible.

Methodologically, phenomenology often includes a focus on the lived-body and embodied meanings in exploring lived-experience (Katz, 2011; Merleau-Ponty, 1962; van Manen, 1990). In my dissertation study I moved away from a focus on the body and behaviour toward a focus on the social, inter-subjective meanings that characterize the natural attitude as understood by Alfred Schutz (Schutz & Luckmann, 1973). The emphasis on social interaction and the social nature of meaning in my work reflects my understanding of the instrumentalist bias toward the physical body in the physiotherapy profession. Physiotherapists work with people, but treat bodies. In my experience of being mentored during my clinical education, I too often witnessed senior physiotherapists entirely neglecting the social meanings and social implications of particular conditions or injuries, focusing instead on a particular body segment in order to restore physical functioning. In my dissertation work I wanted to push beyond the physical, mechanical, view of the body and emphasize the social constructions that characterize the meaning of the experience of living with fall risk. In so doing I sought to encourage physiotherapists to reflect upon the person with whom they are working when enacting fall prevention instead of so narrowly focusing on the body and behaviour as biomedical risk factors. While re-interpreting and re-describing the body in relation to physiotherapy is crucial in further inquiry, I felt that the social phenomenological orientation taken in my dissertation was equally important to broadening the perspective of the physiotherapy profession.

As I have embraced anti-foundational, phenomenological, existential, and humanist philosophical positions, my views regarding the substantive subject matter of my dissertation has grown and evolved. I have come to question the very practice of fall prevention, considering the potential that the application of behavior change theories to reduce the risk of falling was not a humanist approach to health services. What right do we have to exert such power and influence over the behavior of others? This dissertation research reflects this personal and professional journey, my evolution from a positivist bio-medically oriented practitioner to a humanist anti-foundational one. The dynamic outcomes of my ongoing reflexivity are contained in a hermeneutically incomplete interpretation within the pages of this doctoral thesis – it is a shame to have to "cut off" the integration of my reflexivity into the interpretation and writing of the research by laying it down on the page. But, I am living in an academic professional world, and have to do the best I can within the limits of the accepted practices of my community of scholars. Recognizing the irony of claims to truth, I present this dissertation as one such claim amongst many in the effort to improve health and health care.

References

Ballinger C. (2002). The construction of the risk of falling among and by older people. *Ageing & Society*, 22, 305-324.

Baxter, P. & Markle-Reid, M. (2009). An interprofessional team approach to fall prevention for older home care clients 'at risk' of falling: Health care providers share their experiences. *International Journal of Integrated Care, 9*: 1-12.

Burgess-Allen, J. & Owen-Smith, V. (2010) Using mind mapping techniques for rapid qualitative data analysis in public participation processes. *Health Expectations*, 13, 406-415.

Buzan T. & Buzan, D. (2002) *The mind map book*. London: BBC Books.

Caelli, K. (2001). Engaging with phenomenology. Is it more challenging than it needs to be? *Qualitative Health Research, 11*: 273-281.

Coyne, I. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing, 26*; 623-630.

Davies, B., Browne, D., Gannon, S., Honan, E., Laws, C., Mueller-Rockstroh, B., Peterson, E. (2004). The ambivalent practices of reflexivity. *Qualitative Inquiry, 10*: 360-389.

DeForge, R.T. & Shaw, J.A. (2012). Back- and fore-grounding ontology: Exploring the linkages between critical realism, pragmatism, and methodologies in health & rehabilitation sciences. *Nursing Inquiry, 19*: 83 – 95.

Denzin, N. & Lincoln, Y. (2005). The discipline and practice of qualitative research. In N. Denzin & Y. Lincoln (Eds) *The Sage handbook of qualitative research*. New York: Sage. (pp. 1 – 33).

Depraz, N. (1999). The phenomenological reduction as praxis. *Journal of Consciousness Studies, 6*: 95-110.

Edmondson, R. & von Kondratowitz, H-J. (2009). *Valuing older people: A humanist approach to ageing*. Bristol: The Policy Press.

Finlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research, 2*: 209-230.

Flynn, T. (2006). *Existentialism: A brief insight*. New York: Sterling.

Harris, R. & Dyson, E. (2001). Recruitment of frail older people to research: Lessons learnt through experience. *Journal of Advanced Nursing, 36*: 643-651.

Heidegger, M. (1962). *Being and time*. Malden: Blackwell.

Husserl, E. (1970). *Logical investigations*. New York: Humanities Press.

Holloway, I. & Todres, L. (2003). The status of method: Flexibility, consistency, and coherence. *Qualitative Research, 3*: 345 – 347.

Hoy, D.C. (1993). Heidegger and the hermeneutic turn. In C. Guignon (Ed.) *The Cambridge companion to Heidegger.* Cambridge: Cambridge University Press. (pp. 170-194).

Kinsella, A. (2006). Hermeneutics and critical hermeneutics: Exploring possibilities within the art of interpretation. *Forum: Qualitative Social Research, 7*: 1-16.

Levering, B. & van Manen, M. (2002). Phenomenological anthropology in the Netherlands and Flanders. In T. Tymieniecka (Eds.) *Phenomenology worldwide*. Dordrecht: Kluwer Press (pp. 274-286).

Masotti, P., Fick, R., Johnson-Masotti, A., & MacLeod, S. (2006). Healthy naturally occurring retirement communities: A low-cost alternative to promoting healthy aging. *American Journal of Public Health, 96*: 1164-1170.

McWilliam, C.L. (2010). The theoretical basis of phenomenology. In I. Bourgeault, R. Dingwall, & R. de Vries (Eds.) *Sage handbook of qualitative methods in health research*. London: Sage (pp. 229 – 248).

Merleau-Ponty, M. (1962). *The phenomenology of perception*. New York: Routledge.

Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology; 11*: 799-808.

Northcott, N. (1996) Cognitive mapping: An approach to qualitative data analysis. *Nursing Times Research*, 1, 456.

Patton, M. (1990). *Qualitative Evaluation and Research Methods, 2nd Edition*. Sage: California.

Primozic, D.T. (2001). *On Merleau-Ponty.* Belmont: Wadsworth.

Rolfe, G. (2006). Judgments without rules: Towards a postmodern ironist concept of research validity. *Nursing Inquiry, 13*(1): 7-15.

Rorty, R. (1979). *Philosophy and the mirror of nature*. Princeton: Princeton University Press.

Rorty, R. (1982). *The consequences of pragmatism*. Minneapolis: The University of Minnesota Press.

Rorty, R. (1989). *Contingency, irony, solidarity*. Cambridge: Cambridge University Press.

Rorty, R. (1993). Putnam and the relativist menace. *The Journal of Philosophy, 90*: 443 – 461.

Rorty, R. (1996). The challenge of relativism. In J. Niznik & J. Sanders (Eds.), *Debating the State of Philosophy: Habermas, Rorty, and Kolakowski*, pp. 31-66. Prager: Westport.

Rorty, R. (1998). *Truth and Progress: Philosophical Papers Volume 3*. Cambridge University Press: Cambridge.

Sandelowski, M. (1995). Focus on qualitative methods: Sample size in qualitative research. *Research in Nursing and Health, 18*: 179-183.

Sartre, J-P. (1960). *The transcendence of the ego*. New York: Hill & Wang

Schutz, A. (1943). The problem of rationality in the social world. *Economica, 10*: 130-149.

Schutz, A. & Luckmann, T. (1973). *The structures of the life-world*. Evanston: Northwestern University Press.

Schwandt, T. (1998). Constructivist, interpretive approaches to human inquiry. In N.K. Denzin & Y. S. Lincoln (Eds.) *The Landscapes of Qualitative Research: Theories and Issues*, pp. 221-259. Thousand Oaks, CA: Sage.

Scott, V. Lockart, S., Gallagher, E., Smith, D., Asselin, G., Belton, K. et al (2007). *Canadian falls prevention curriculum (CFPC)*. Vancouver: BC Injury Research & Prevention Unit.

Seeburger, F. (1975). Heidegger and the phenomenological reduction. *Philosophy and Phenomenological Research, 36*(2): 212-221.

Small, R. (2001). *A hundred years of phenomenology: Perspectives on a philosophical tradition*. Burlington: Ashgate.

Taminiaux, J. (2004). *The Metamorphoses of the Phenomenological Reduction*. Marquette University Press: Milwaukee.

Vandermause, R. & Fleming, S. (2011). Philosophical Hermeneutic Interviewing. *International Journal of Qualitative Methods, 10*: 367-377.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. London: Althouse Press.

van Manen, M. (1996). Phenomenological pedagogy and the question of meaning. In D. Vandenberg (Ed.) *Phenomenology and educational discourse*. Durban: Heinemann Higher and Further Education (pp. 39-64).

van Manen, M. (1997). From meaning to method. *Qualitative Health Research, 7*: 345 – 369.

van Manen, M. (2002). *Writing in the dark: Phenomenological studies in interpretive inquiry*. London: Althouse Press.

van Manen, M. (2006). Writing qualitatively, or on the demands of writing. *Qualitative Health Research, 16*: 713 – 724.

van Manen, M. (2007). Phenomenology of practice. *Phenomenology & Practice, 1*: 11 – 30.

Chapter Four: The Meaning of the Experience of Anticipating Falling

Injurious falling by older people continues to be constructed as one of the most important public health concerns facing contemporary Western health systems, as researchers and policy makers cite the many economic, social, and personal burdens that are associated with "fall-related injuries" (Fletcher & Hirdes, 2004; Scheffer et al 2008; Scott, 2005; Stevens et al 2006). Public health care organizations are continually engaging in efforts to prevent falls (Edwards, 2011), with the primary challenge of reducing public and private expenditures related to the consequences of falling. As such, health service providers are increasingly expected to understand fall risk and fall prevention and to be able to implement fall prevention programs that help older people to prevent falls in their daily lives (Brown, Gottschalk, van Ness, Fortinsky, & Tinetti, 2005; Fortinsky et al, 2008).

Ballinger and Payne (2000) suggested that health service providers tend to approach fall prevention from a particular professional perspective, focusing on the professional expertise they have to provide as opposed to the meaningful experiences of the older people with whom they work. However, attending to the meaningful experiences of older people in the context of fall prevention services may focus the attention of health care providers on more authentically and sensitively addressing older peoples' subjective concerns and quality of life. Such emphasis on older peoples' meaningful experiences fosters an approach that leads us to advocate for a specifically humanistic orientation to providing health and social services to older people, recognizing the value and worth of each person involved in fall risk assessment or fall prevention initiatives. In a humanistic approach we consider the meaningful lived-

experiences of older people to be the most important focus of inquiry (Edmondson & von Kondratowitz, 2009), and contribute to understanding the meaning and significance of older persons' actions and decisions, whether tacit or explicit, in engaging in "risky" or "preventive" behavior. The purpose of this study was to address the lived-experiences of older people, specifically by answering the research question: What is the meaning of the experience of anticipating falling for older people living independently in the community?

Several qualitative studies have explored older people's perspectives of living with fall risk and decision-making to engage in fall prevention initiatives. Ballinger (2002) used an ethnographic approach to gain insight into the social construction of risk by older people using the services of a day hospital in the United Kingdom. Contrary to the typical biomedical notion of risk, she found that older people considered their entire social situation and context in their understanding of fall risk. Older people embedded the experience of fall risk in the context of broader personal and social risks, such that study participants at times prioritized their portrayal of independence even if this put them at risk of falling.

The perspectives of older people regarding fall risk and fall prevention were also explored in a study by Yardley et al (2006). These authors conducted focus groups of European older people to better understand their views regarding advice about falls. Older participants considered a much broader perspective in self-reflection about risk and felt that admitting the self-relevance of fall prevention information might constitute a threat to their autonomy and identity. Building upon a broadened perspective of risk-taking, Horton (2006) investigated the understanding of fall risk by older people

specifically in relation to their identities. This author found that older peoples' gender, fundamental to identity, influenced their decisions and perceived level of control in risk-taking behavior. Older men believed themselves to exercise rational decision-making processes and control over risky behaviour, and women discussed their perception of risk in terms of external factors and pressures.

More recently, Hallrup et al (2009) conducted a phenomenological study of frail older women's experiences of living with fall risk. These authors found that study participants experienced a changing body and focused on recognizing their social value to others despite their perceived need to take caution in their activities on a daily basis. The broadened perspective of "risk-taking" supported by these studies suggests that older people appear not to think about their behavior specifically with respect to fall risk, but with respect to their self and social experience in general.

Together, these findings suggest that for older people, social interactions and self-perceptions associated with aging intersect with the experience of fall risk. This research also suggests that social context enters into the *experiences* of individuals in achieving the lived-meaning of falling and fall risk, as lived-experiences of understanding and living with fall risk depend upon social interactions with peers, family, and professionals. As such, unique insights may be gained by further exploring the lived-experiences of older people with respect to anticipating falling while paying particular attention to how social context and interactions are integrated into their narratives about anticipating falling. In the interpretive phenomenological inquiry presented in this paper I focused on the meaning of the lived experience of anticipating falling within the social context of aging.

Methodology

I approached the exploration of lived-experience in this study from an anti-foundationalist epistemological position inspired by the work of Richard Rorty, embracing an explicitly hermeneutic perspective on social inquiry (1979; 1982; 1989). The methodology was guided primarily by the work of Max van Manen, and integrated insights from Alfred Schutz (1943; 1953) and Maurice Merleau-Ponty (1962). Specifically, Schutz's emphasis on the social nature of meaning in our common-sense way of living in the world focused my interpretation and analysis of concrete stories of everyday lived-experience. In order to reflexively interpret the meaning of the (social) lived-experience of anticipating falling, I explicitly applied a hermeneutic orientation to the conduct of the interviews and interpretations of the transcripts (van Manen, 1990). In his hermeneutic approach to phenomenological research van Manen (1990) suggested that a researcher must pay attention to more than the objective, rational knowledge which is typically sought during scientific research. Instead, I also attended to the pathic knowledge, that is, the "lived dimension: our 'moods' or ways of being in the world" (van Manen, 1999, p. 3), described by study participants in order to interpret the meaning of the experience in question. As such, I sought to achieve a holistic gestalt that re-presents both the cognitive and non-cognitive meaning of the experience in question (Merleau-Ponty, 1962). From a hermeneutic perspective the essence of the lived-experience can be re-presented in phenomenological writing, but can never be considered absolute or complete (Rorty, 1979; van Manen, 1990). As such, my goal in this phenomenological inquiry was to describe as best as possible the evocative accounts of

participants' experience of anticipating falling, in order to inspire a more sensitive, empathetic approach to professional practice (van Manen, 1990).

Methods

Ethical Considerations

The context of this phenomenological inquiry was a naturally occurring retirement community within a medium-sized Canadian city. This study was approved by the Research Ethics Board of The University of Western Ontario. I ensured that all participants provided prior informed consent for audio-recorded interviews and use of anonymous data for analysis, interpretation, and dissemination. As such, pseudonyms have been used in reporting the findings. Due to the potential for the topics of fall risk and fall prevention to raise anxiety amongst older people living in the community, I provided each participant with information regarding fall prevention activities after each interview, emphasizing the activities in which they were currently involved that would help to prevent falls.

Participant Recruitment

The purposeful sample recruited for this study included nine older people over the age of 65 living independently in the community (Coyne, 1997; Patton, 1990). I purposefully recruited participants through a local senior's community centre who maintained their engagement in physical and social activities. In so doing, I sought to explore the meaning of anticipating falling in the context of efforts to maintain physical mobility and social relationships and functioning. While all participants were involved in recreational activity maintaining physical and social participation, I sought a diversity of ages (65 to 94 years) and both genders (7 women, 2 men) in order to explore the meaning

of the experience across these diverse participants. I sought to achieve such diversity in participant characteristics to encourage my interpretation of shared meaning by seeking commonalities amongst the narrative experiences of *diverse* participants (van Manen, 1990).

All participants had completed high school education. All participants lived independently in the community, and were capable of independently performing basic and instrumental activities of daily living. One participant, an 84 year old man, was living with Charcot-Marie Tooth Disease, a neuro-degenerative condition that affected his mobility, but maintained his functional independence with the use of assistive devices (a single point cane and a standard walker). A total of three participants used either a single point cane or walker for independent community mobility. Four of the nine participants had experienced at least one injurious fall within the past five years, and all had experienced a non-injurious fall within the past three years. The lived-experiences of these falls and their consequences were explored in each interview. For additional participant information see Appendix I.

Data Collection

I engaged in in-depth individual interviews ranging in length from 50 – 90 minutes with each participant between August 2009 and April 2011. The initial "phenomenological" interview (van Manen, 1990) was comprised of open-ended questions eliciting stories and descriptions of concrete lived experiences re-presenting older peoples' experiences of anticipating falling, in which I sought their thoughts and feelings about falling; the potential impact of falling; and what the risk of falling meant to them. While the focus of these initial interviews was not on forming an interpretation

of the lived-experience, I integrated probes and questions to explore emerging interpretations into each interview, when appropriate. At the end of each interview I asked participants about their social context, including their social network (friends and family support), social and physical activities, living environment, work life/retirement, and general health. All interviews were audio recorded and transcribed verbatim.

In accordance with phenomenological methods, I completed follow-up "hermeneutic" interviews (van Manen, 1990) with two participants after all initial interviews had been completed. I requested this second interview with two particularly insightful participants, constructing an opportunity to reflect in conversation with the participants on the findings of past interviews, and creating a deeper understanding in order to achieve further interpretive insight (van Manen, 1990). Hermeneutic reflection in conversation with participants helps to provide a *reflective understanding* of the experiences described during initial interviews, which were focused on eliciting daily lived-experiences without explicitly encouraging any critical reflection (van Manen, 1990). The goal of the second interview was to determine whether select themes that had emerged throughout the interviews resonated with select participants and whether any new phenomenologically meaningful themes would emerge through further discussion. Van Manen (1990) suggests that the descriptions of the lived-experience ought to be recognizable by participants as an experience they have had or could have had. As these two participants conveyed that the interpretation resonated with their own lived-experience and no new themes emerged, I did not engage in any further interviews.

Data Analysis

I analyzed the phenomenological data using the wholistic/sententious approach, the selective/highlighting approach, and the detailed/line by line approach as discussed by Van Manen (1990) in conjunction with mind mapping methodology (Burgess-Allan & Owen-Smith, 2010; Buzan & Buzan, 2002; Northcott, 1996). Specifically, immediately after each interview was conducted, I listened to the entire interview and made reflective notes on details of the conversation and any immediate interpretations. I wrote reflexive memos to explicitly identify which assumptions may be influencing my interpretations of the data, recognizing my inherently practical orientation as a physiotherapist (van Manen, 1990). After the data were transcribed, each interview was loaded into qualitative data analysis software (NVIVO 7) for data management. I engaged in the initial interview analysis with printed paper copy transcripts, and secondary analysis using the computer data management system. I initially coded participants' descriptions of experiences, behaviours, decisions, thoughts, and feelings on printed transcripts as a simple, common-sense interpretation of what was being said. As common interpretations were co-constructed within and between transcripts, I established themes to characterize phenomena that appeared to be a part of the everyday lived-experience of anticipating falling. These themes were held in question and compared to one another, using the method of free imaginative variation (van Manen 1990), to determine whether they were to be considered phenomenological themes unto themselves. I then coded these themes in NVIVO for ease of comparison between interviews.

I engaged in a third level of analysis using the "mind mapping" method. That is, I created a "mind map" or "cognitive map" for each interview individually, providing a visuo-spatial depiction of the inter-relationships between the themes present in the

interview (Buzan & Buzan, 2002; Northcott, 1996). This process fostered a more thorough analysis of the relationships between themes composing the phenomena in question, providing a method of analysis that may more closely match the natural non-linear thought patterns of humans (Buzan & Buzan, 2002). This additional phase of analysis provided further opportunity to explore whether emerging themes ought to be considered incidental or essential aspects of the lived-experience in question (van Manen, 1990). The mind mapping analysis technique did not replace any of the language-oriented analyses suggested by van Manen (1990; 2002; 2006), but simply complemented the free imaginative variation process.

To synthesize themes into hermeneutic interpretations of the lived-experience of anticipating falling, I brought recurring themes from the written analysis and the mind maps together in a written phenomenological description (van Manen, 2006). While the interpretation of the meaning of the experience in question may never be considered satisfactorily complete, I created the final interpretation of this study in the writing of the findings (van Manen, 1990). The findings, interpretations, and discussion of the interviews were written and re-written in order to explore my interpretations of an aesthetic and practical hermeneutic understanding of the lived-experience of anticipating falling (van Manen, 2002). Each step of this comprehensive analysis strategy was completed with peer review by experienced phenomenological researchers, who suggested refinements promoting coherence and cogency.

Rigour

I pursed consistency and coherence between the philosophical underpinnings of the selected research methodology and the interpretive knowledge claims arising from

this research as the primary indicators of rigor (Caelli, 2001; Holloway & Todres, 2003). My paradigmatic position, inspired by Richard Rorty's anti-foundational philosophy, suggests that hermeneutics ought to be a fundamental assumption for all social inquiry, as all experience and knowledge is based upon interpretation (Rorty, 1979; 1982). As such, I chose to apply Van Manen's (1990) approach to phenomenological human science for its resonance with my interpretive paradigmatic position. I drew upon van Manen's discussions of pathic ways of knowing (1999), phenomenological writing (2006), and the phenomenology of practice (2007) to guide my interpretations and presentation of the findings. In so doing, I have made every effort to integrate the interpretive language into the data collection, data analysis, and implications derived from this study. By seeking to re-present the findings as a meaningful gestalt (Merleau-Ponty, 1962) of the experience of anticipating falling within the social context in which the inquiry was situated, I have sought to emphasize the interactive and social co-constitution of lived-meaning for the experience in question (Schutz & Luckmann, 1973). To promote the attainment of these attributes of rigor (consistency and coherence), I applied two general principles: *Transparency*, or the reflexive disclosure of all decisions made within the study, and *systematicity*, involving the regular and reflective returning to the data and my interpretations to better understand the emerging findings (Meyrick, 2006).

Findings: The Meaning of Anticipating Falling

For older participants residing in the community, the experience of anticipating falling meant confronting their *lived-identity* in the context of aging. The essence of confronting lived-identity was composed of three major themes. The first major theme was *the centrality of lived-identity* to the experience of anticipating falling, understanding

lived-identity as the *performance of meaningful activities* (sub-theme one) and the *inter-subjective portrayal of self-image* (sub-theme two). Participants sought to *continually strive for health and independence* (sub-theme three) in order to enable themselves to continually enact lived-identity. The second major theme was *experiential learning of the meaning of anticipating falling*, as participants learned how falling may disrupt lived-identity through their own personal experiences or by witnessing the experiences of others. The final major theme was *preserving lived-identity through caution*, which was constituted by two additional sub-themes. The first sub-theme was *fear of falling*, describing how participants understood their fear of falling in relation to their lived-identity. The final sub-theme was *modifying meaningful activities*, as participants altered activities in order to take caution in their lives while continuing to perform activities that were central to their lived-identity.

Major Theme One: The Centrality of Lived-Identity to the Meaning of Anticipating Falling

For older people in this study, the experience of anticipating falling meant confronting their *lived-identity*. Lived-identity was conveyed as central to their life-world, and as such confronting lived-identity through anticipating falling encouraged participants to discern ways to *continually strive for health and independence* that enabled them to continually enact their identities. Lived-identity was enacted by participants through *performing meaningful activities* and *inter-subjectively portraying self-image*. The following sub-sections illuminate the interpretation of performing meaningful activities and inter-subjectively portraying self-image in terms of their constitution of lived-identity, and then recounts the means by which participants

described striving for health and independence in order to enable their enactment of these two elements of lived-identity.

Sub-theme One: Performing meaningful activities. When asked about their experience of anticipating falling, participants talked about their lived-identity, conveying an urge to maintain the lived experience of self throughout and despite advancing age and any accompanying anticipation of falling. Lived-identity was understood by participants in part through the continued performance of activities that provide their lives with meaning. One participant described what it meant to enact her lived-identity by constantly keeping herself busy and active despite her advancing age:

> Wendy: Even this morning working out there, I can't do anything slow, I sweat fiercely doing it. Why don't I slow down, I'm 80 years old? All I can explain is, it's my nature. I don't know how else to, and I think once in a while, even if I sit down for a few minutes, I'll sit down and [get] right back up again [and] I'm doing where I left off. How do you explain that?

This participant conveyed pride in her identity, or nature, as someone who is always doing things, thereby reinforcing her re-presentation of identity in terms of the way in which she enacted it, the way in which she performed her *self*. Her discussion recounted being someone who is active; active with physical activity, with errands, and with social involvement, emphasizing the important contribution of performing meaningful activities to the constitution of her lived-identity. Through her emphatic discussion of meaningful activities, she portrayed lived-identity as central to her life-world in the context of aging.

Confronted with questions of anticipating falling, another participant also emphasized the importance of being able to perform her identity through activities considered to be defining features of her self:

> Shirley: I don't want to hinder my ability to walk and drive and live the way I do because I think I'd be devastated.

As participants discussed their selves in relation to the meaning of anticipating falling, they illuminated the importance of self-affirming experiences and thus enacting lived-identity through performing meaningful activities that would be undermined by the perceived consequences of falling or fear of falling. As such, the continued performance of meaningful activities, contributing to the constitution of lived-identity, was confronted by participants in the experience of anticipating falling as they felt their performance of meaningful activities (and thus lived-identity) was disrupted in the experience of living with fall risk or the consequences of falling.

Sub-theme Two: Inter-subjectively portraying self-image. The meaning of anticipating falling was also understood by participants in terms of defining *self* by the experience of portraying ones' self-image to those around them, and how this inter-subjective experience was felt and perceived in the context of anticipating falling. The ability to inter-subjectively portray self-image as desired was essential for older participants' enactment of lived-identity, and participants confronted their ability to portray self-image in their experience of anticipating falling. In discussing how she had decided not to use a cane while out shopping in the community, another participant stated:

> Rachel: You have to learn. I have to learn to accept everybody to know that I need help [with walking]... And when [my daughter and I] go places I know how slow I am. So sometimes [she'll] take me by the arm, and given the extra security I know I can go faster. And here [in the retirement community], I'm better and faster than a lot of people so that's a bit deceiving, because I begin to feel I'm okay, I can go, I can go quicker. And so there are two worlds that's you're living. The slow one, and everybody knows you're slow, and here, some people think you are fast.

This participant storied the meaning of anticipating falling by relating her experience of self as social, presenting her lived-identity as someone who wants to protect the way she is perceived by others despite her awareness of her potential for falling. For her, being able to perform the things she needed and wanted to do was important, but she tacitly recognized that alongside the need for the experience of enacting one's self is the need to have others recognize her as a person who can do so. Her understanding of the perceptions of others seemed to underpin her construction of what she felt she could and could not do in relation to those around her, reflecting a profound and recognized dependence on her social environment. She did not seem upset by this, but embraced it as a part of her life, further conveying the centrality of lived-identity to participants' life-world in the context of aging.

Yet another participant portrayed how her self-image in relation to anticipating falling was co- constructed by those around her:

> Paula: Well [my daughter] gets mad at me because I won't use a cane, but I feel so self- conscious with a cane [that] I just use it when I go shopping.

Participants often discussed how important it was to them to present their identity as capable, independent, and youthful. Their feelings of being different from others around them reflected their experience of the meaning of anticipating falling by their rejection of aids for walking to convey their feeling of pride in the way they are perceived to be *able*. This finding further suggests that participants confronted their continued abilities to enact lived-identity, here through their continued portrayal of self-image, in the experience of anticipating falling.

Participants constructed images of their identities that emphasized different elements of a *dynamic* or *performative* concept of self in the context of aging. A rudimentary image of the experience of lived-identity in anticipating falling seemed to raise a spectrum of accounts of identity, with one end emphasizing actions and behaviours that reinforce a sense of self, and the other end emphasizing the images and constructions of self that are reflected back toward someone by others in their surroundings. As lived-identity was central to the life-world in the context of aging, the lived-experience of anticipating falling was understood by participants through a confrontation of their lived-identities, as they sought to establish ways to continually enact lived-identity along with and despite the experience of living with fall risk.

Sub-theme Three: Continually striving for health and independence. Participants felt that they were enabled to continue enacting their identities when they maintained their health and independence, as these were understood as essential to performing the activities participants found meaningful and inter-subjectively portraying their self-image as desired. As such, participants constructed the continual achievement of health and independence as the means by which they could ensure their capabilities to

continually enact their lived-identity. One participant discussed the centrality and importance of maintaining health and independence, reflecting her desire to maintain the ability to enact her lived-identity:

> Maurine: I want to be healthy. I have an 87 year old aunt who I say [is] failing. She shouldn't be at home, I took her for a physical yesterday and her memory is nearly gone. We're not saying she has Alzheimer's, we're not saying she's got dementia, but she falls. She fell in the doctor's office and those things just make me think more cautiously. I want to live healthy, I don't care if I don't live a long time but I don't want to live depending on somebody.

For this participant, the experience of being healthy and independent was essential for her ability to continue enacting her lived-identity. Without the ability to be independent, and thus perform her identity and enact those aspects of self that provide her life with meaning, this participant conveyed that she would feel her life might be devoid of meaningful quality. In this way, participants described continually striving for health and independence as a means of actualizing lived-identity in daily life; as a means of overcoming their confrontation of lived-identity. With lived-identity as the focal point of the life-world, participants strove to achieve health and independence in order to continually enact their lived-identity.

Major Theme Two: Experiential Learning of the Meaning of Anticipating Falling

Study participants portrayed the meaning of anticipating falling as situated within their experiential learning about falling, either personally or indirectly through the experiences of others in their social lives. Participants pathically integrated the derived self-referential meaning of these experiences into their present experience of anticipating

falling, conveying their experiential learning in reference to lived-identity. By so doing, these study participants created a personal understanding of the meaning of falling with respect to both the ability to perform meaningful activities and to uphold their sense of dignity and worth through the continuous projection of self-image. In discussing her own experience of a fall, one participant stated:

> Shirley: And then, of course, I had to accept the fact that I couldn't get my shoes on, I couldn't go places, and then I had to start support hose. It was a nuisance! So I think from that time on, I've been more careful and more aware of the fact that [a fall] could happen, and so suddenly.

This participant reflected on the most immediate limitations in her ability to engage in meaningful activities after experiencing a fall, discussing generally how it was difficult to get out into the community. She continued her thought by stating that she had become more careful and aware, reflecting the integration of the meaning of the consequences of falling into her experience of anticipating falling. In order to support and enable her continued experience of lived-identity, she had internalized the experience of the consequences of falling through the construction of self-referential meaning regarding how her activities are limited after experiencing a fall. She connected this lesson learned experientially with being more careful and aware.

Another participant discussed the experience of falling in front of others:

> Doug: Well, in front of other people, other seniors, falling is loss of dignity, in my experience anyway.

This participant, a man with a neuro-degenerative disease that affected his mobility, discussed falling in reference to its impact on his ability to portray his self-

image. As a sub-theme of lived-identity, participants' continual striving for health and independence included seeking to portray themselves in certain ways that were socially constituted to reflect their lived-identities. For this man, the lived experience of falling meant not being able to enact his lived- identity through the portrayal of self-image in a satisfactory way, creating a loss of dignity and a detriment to his efforts in achieving quality of life. This participant's experience re-presents the impact of experientially learning the consequences of falling, not only in terms of performing meaningful activities, but also in terms of the ability to inter-subjectively portray oneself as one desires.

Participants also drew on their observations of the experiences of others in constructing understanding of the meaning of anticipating falling. One participant explained how it was not just her own experience of falling, but the experiences of family and neighbours that impacted her understanding of the consequences of falling:

> Nancy: Oh, I guess it's all kind of a muddled picture and all these other factors kind of going on at the same time. And, well, maybe from my experience at [work in a hospital], you know, and another experience I remember, not of me falling but just the neighbour and another neighbour had a big dog, a nice friendly dog, but the dog was too friendly, and I can remember my mother saying "That dog is going to knock over [the neighbour]"…. This was when I was in high school and that happened and she broke her hip or something and she did not recover. So that was, [pause], gosh, break a hip and you die?

Through personal experiences of falling and observing the experiences of others, participants integrated the *meaning of experiencing a fall* into their experience of *anticipating falling*.

Major Theme Three: Preserving Lived-Identity through Caution

Participants expressed an implicit understanding of the consequences of falling in terms of its impact on their lived-identity, discussing a fall for its potentially devastating impact on their ability to live their lives as desired. The meaning of the experience of anticipating falling was constructed pathically in the context of a tension between understanding the potentially severe consequences of falling and yet continually striving to engage in activities that provided meaning for their lives.

Participants who had salient fall-related experiences (either personally or socially) discussed the importance of continuing to perform meaningful activities regardless of perceived risk or vulnerability with respect to falls. Participants who *had not* had salient fall-related experiences did not construct vulnerability, anxiety, or fear as meaningful aspects of their experiences of anticipating falling, and thus described lived experiences of anticipating falling that did not reflect *anticipation* in its traditional definitional sense. Conveying an effort to continually enable themselves to construct their lived-identities, participants who did recognize their vulnerability to falling and/or the potentially devastating consequences of falling described the adoption of implicit lived-caution in daily activities.

Sub-theme One: Fear of falling. Participants who described having salient personal experiences of falling varied in terms of whether and how they expressed being fearful of falling. While certain participants denied any fear of falling, others described

their efforts to continue engaging in meaningful activity despite their fear that a fall might occur. One participant who denied a fear of falling, despite being cautious with mobility, stated:

> Maurine: It's not a fear, I just wouldn't want to [fall]. My concern is that I would be, my living would be curtailed, my lifestyle, but, you know, I don't have a fear. I don't think I worry about [falling]. You know what, I don't worry about anything really, you know.

This participant suggests that while she understands the meaning of the consequences of a fall in terms of limiting her ability to engage in meaningful activities, she does not experience any fear in her lived experience of anticipating falling. Despite her understanding that she might be vulnerable to experiencing another fall in the future, she denies the experience of fear that might otherwise arise from this understanding. This reflects the non-rational nature of anticipating falling, in that a gnostic knowing of the self-risk of falling does not necessarily translate into the pathic knowing or feeling of fear related to that risk. Rather, the tacit and implicit negotiation of gnostic or rational knowledge of fall risk with pathic or emotional experience seems to be embedded within a continual process of achieving oneself while aging, that is, a process of enacting lived-identity.

Another participant described the omnipresence of her fear of falling, which she attributed to multiple salient experiences with falls leading to fractures. She elaborated that even though she is fearful, she will not allow this to prevent her from engaging in those activities that she finds meaningful in her life, similarly revealing the negotiation between gnostic and pathic modes of constructing the self.

> Paula: No nothing will stop me. I take a chance to do anything. [Fear of falling] doesn't bother me. This morning I got up and I thought I could hardly walk. But I still got up and went and swam for an hour.... I won't let anything come between me [and my activities]. If I have to do something, I will do it.

The meaning of her experience of anticipating falling focuses on her capacity to continue enacting her identity in the face of her profound fear of falling, as she presents herself as a brave, independent, and capable woman who can accomplish the tasks she believes she ought to do. Her fear seems to provide her with an opportunity to express her identity, to perform her self-image of self-determination toward those around her, despite her lived-fear and fall risk.

Other participants denied any self-understanding of vulnerability to falling, in which case no fear or anxiety with respect to falling was discussed.

> Nell: I never think about [falling]… It never occurred to me that I would fall and break my neck or something… I think that I kept walking and I think that my muscular system is in better shape than most of the older people here [at the retirement community] certainly, because I notice they have an awful time walking or doing, moving around, and I think it's a shame.

Without any salient experiential learning to draw from in understanding the self as vulnerable to experiencing a fall, this participant had never considered the notion that susceptibility to falling is something that might be considered as she ages. Instead, she achieved her lived-identity in aging without consideration of vulnerability, anxiety, or fear regarding anticipating falling.

Sub-theme 2: Modifying meaningful activities. Participants who understood themselves as vulnerable to experiencing a fall discussed minor modifications to engaging in meaningful activities in order to continue performing these activities and their lived-identities. These participants portrayed their adoption of generalized cautious habits in daily life, or lived-caution, as a way-of-being that was compatible with their lived-identities and would enable their continued participation in self-affirming activities. Other participants who did not seem to understand themselves as vulnerable to falling, but who have had salient experiential learning regarding falling and its consequences, also discussed lived-caution in daily activities:

> Robert**:** Well, like, [the chance of falling is] there anyway in my mind and I see [falls] happening many times [at retirement homes]. So I don't have to make a conscious effort at all. … I think safety has always been a factor I've considered…. I just try to be sensible and, you know, make sure that I am doing things that are safe and things like that as much as possible. I mean, if things happen beyond my control, then I'll deal with that at the time and I will try and keep the right frame of mind and handle things as they happen.

Integrating safe habits through cautious actions was discussed by participants as the primary way to enable the continued experience of lived-identity. Participants did not discuss this explicitly as a strategy to prevent falls, even though it has this potential. Participants discussed caution in terms of what it *enabled them to do* in their daily lives, as opposed to *what it prevented* from occurring (i.e. a fall).

Discussion

The ways in which the immediate, common-sense meanings of aging and fall risk are understood by health service providers who work with older people on a daily basis not only affect how unique persons are treated in one-to-one interactions, but also contributes to the social construction of the context of aging that is reified by professional, cultural and political discourses (Lynott and Lynott, 1996; Biggs, 2001). In an effort to break from these salient and often implicit, un-reflective, and presupposed meanings, this research project focused attention on the meaning of the lived-experiences of older people with respect to anticipating falling. Although the findings of hermeneutic phenomenology are not "generalizable" in the conventional post-positivist sense of this term, several implications for health and social service providers working with older people might be interpreted from the study presented herein (Piercey, 2004; Kinsella, 2006; van Manen, 1990).

Lived-Identity and Anticipating Falling

Confronting lived-identity in the context of aging composed the central theme in this phenomenological study, suggesting that identity and how it is lived-through in everyday life is essential to understanding the meaning of the lived-experience of anticipating falling. Specifically, older participants discussed two conceptually distinct aspects of lived-identity emerging as essential elements. The first element of identity, the *performance of meaningful activities*, re-presented the inner experience of self which acts and reacts toward the world. The second element of identity, the *inter-subjective portrayal of self-image*, re-presented participants understanding of the self in relation to significant others in social contexts, or their self-understanding derived from how others act toward them. It is important to emphasize that these two elements of identity are only

conceptually or *analytically* distinct, and that they cohere in a gestalt "whole" in the actual lived-experience of identity. Participants sought to continually enact this gestalt experience of lived-identity as a central element of their life-world.

The anti-foundational work of Richard Rorty suggested that no consistent and essential "self" is possible in the conventionally understood sense, that humans have no "glassy essence" that characterizes the continuity of identity across the life span (Rorty, 1979). However after breaking down the logical or rational possibility of a continued sense of identity, Rorty (1989) re-cognized that people nonetheless have the *lived-experience of identity*. In this way, ironically, identity is true for us because we experience it as being true in a continuous way. Phenomenology considers the truth of immediate experience, or the primary truth of perception to be the fundamental character of our knowing- and being-in-the-world (Merleau-Ponty, 1962; van Manen, 1990), and as such experiencing identity in meaningful ways makes our identity true for us in meaningful ways. Very simply, identity gives us the capacity to understand our place in the world, "to know 'who's who' (and hence 'what's what')" (Jenkins, 2008, p. 5). Understood in this way, identity provides a fundamental sign-post to orienting ourselves to being-in-the-world.

Analyses of identity found in much contemporary theory and philosophy have been derived from the pioneering work of George Herbert Mead, whose distinction between personal and social types of identity have pervaded sociological explorations of identity (Aho, 1998; Jenkins, 2008). Mead (1934) provided the conceptual or analytic distinction between the "I" and the "Me" aspects of identity, roughly corresponding to the two aspects of identity found in this phenomenological study. The "I" aspect refers to the

inner monologue, the inner experience of the continuity of self, resonating with the *performance of meaningful activities* element of lived-identity found in this study. The "Me" aspect refers to the way people understand and see themselves through the imagined eyes of others, resonating with the *inter-subjective portrayal of self-image* element of lived-identity found in this study. While these are perhaps rough comparisons, they are intended to have analytic benefit as opposed to ontological or transcendental similarity.

Importantly, it is in the relationship between these two strictly *analytic* categories (the "I" and the "Me") that self emerges (Jenkins, 2008), co-constituting the essence of lived-identity as a gestalt experience. As the participants in this study revealed, it is through the convergence of both their meaningful actions and their inter-subjectively constructed self-image that an understanding of their lived-identity is established. Furthermore, these participants portrayed this construction as *dynamic*, that is, as a continual process of enacting the self in the context of aging. Thus, it may be more apt to interpret lived-identity in terms of this continual process of constructing one's identity: as *identification*, denoting a process, as opposed to *identity*, denoting a static state (Jenkins, 2008). Such an interpretation of the notion of identity coheres with a phenomenological concept of experience, in that we are always changing and thus always becoming as we interact with our environmental context in meaningful ways (Heidegger, 1962; van Manen, 1990). Overall, this continual process both shaped and was shaped by the experience of anticipating falling for the older people who participated in this study.

Issues of identity have been raised previously as primary concerns for older people in the context of fall risk and prevention (Yardley et al, 2006; Hallrup et al, 2009;

Hanson et al, 2009). A recent meta-ethnography (2011) of nine qualitative studies exploring older peoples' experiences and perspectives of living with fall risk found life change and identity to be a central theme across studies (McInnes, Sears, & Tutton, 2011). In the context of aging, the risk of experiencing a fall has been found to be an important signifier of unwelcome changes to a person's sense of self (Ballinger & Payne, 2000), reflecting the potential labeling of a person as a "faller" and indicating their lack of control over how they are identified (labeled) by family, peers, and professionals alike (Hanson et al, 2009; Katz, 2011). Often this new label is bound up with meanings of loss of independence and autonomy, amounting to the perceived loss of personal agency amongst older people in contributing to the determination of the way they are understood by others (Hanson et al, 2009; Jolanki, 2009). The finding of my phenomenological study that older people enact and enable lived-identity as a central element of their life-world, as both the performance of meaningful activities and the inter-subjective portrayal of self-image, suggests added emphasis and attention to their continued *identification* is warranted in fall prevention programs.

Taking care to approach fall prevention activities with tact and sensitivity, exploring how older people perpetually make meaning through lived-identity, will encourage service providers to avoid displaying their tacit or explicit labeling of older people as "being at risk" in front of others. This awareness of how service providers' actions affect older peoples' abilities to inter-subjectively portray self-image can avoid negatively affecting how older people are able to influence the ways in which they are perceived by others. Laybourne, Biggs, and Martin (2008) point out that most fall prevention intervention trials do not account for effects of participation in fall prevention

activities on participants' quality of life. Further attention to lived-identity, as an ongoing process of identification, during the provision of fall prevention activities can ensure that service providers are taking the quality of life of their older clients into account while encouraging mobility and safety in preventing falls.

An example of how service providers may integrate a meaningful understanding of lived-identity into their fall prevention initiatives with older people may be found through the theoretical work of Erich Fromm (1976). Fromm studied under one of the founders of existentialist philosophy, Karl Jaspers, and developed a notion of identity that departs from Mead's version by attending to the processes of constructing identification from a critical perspective (Fromm, 1976). Fromm's (1976) discussion of "having" and "being" modes of existence also provide an analytic as opposed to ontological distinction, stimulating further hermeneutic exploration of the critical implications of the study findings. In the having mode, one's "relationship to the world is one of possessing and owning, one in which I want to make everybody and everything, including myself, my property" (p. 21). Conversely, the being mode is to be understood as "aliveness and authentic relatedness to the world" (p. 21), in which continually becoming oneself and appreciating the relationship to the world is what provides life with meaning. While this distinction is not to suggest that people live their lives continually engaged in a single "mode" ("having" versus "being") exclusively, it provides further hermeneutic guidance as to how service providers may orient themselves to the perpetual identification of their older clients while engaged in fall prevention.

Objectifying and commodifying fall risk, mobility and fall prevention, as in the "having mode", inevitably contributes to older people's difficulties in maintaining their

lived-identities, stripping away the possibility of living up to their own self-expectations of aging. When older people are encouraged to view issues of risk, mobility, and prevention as things that may or may not be *owned and possessed*, they are unable to understand them in terms of *authentic relatedness to the world*, and thereby neglect to see how fall risk *does not necessarily* lead to decline in lived-identity and quality of life. By contrast, interventions which appreciate and promote lived-identity by enabling the older person's self-construction through activity and inter-subjective relationships with others have the potential to preserve and reinforce lived-identity and, in turn, quality of life. This insight suggests the importance of engaging older people in developing their own ways of preventing falls, with due consideration of their prioritized activities and relationships; for example, by employing relational health promotion strategies (McWilliam et al., 1997; McWilliam, 2009). It also suggests that programs addressing falls prevention need to emphasize the client-centered minimization rather than avoidance of risk, as some risk may be essential to older person's holistic health and well being, and thus quality of life.

Experiential Learning and Anticipating Falling

As is illuminated by the findings of this study, the meaning of the experience of anticipating falling is derived from self and social (vicarious) experiences of falling. It was through a process of making meaning out of these experiences that the study participants arrived at diverse experiences of fear of falling and modifying meaningful activities accordingly.

Qualitative studies by Tischler and Hobson (2005) and Lee et al (2008) suggest that older people develop fear of falling primarily through directly experiencing a fall.

The embodied experience of the fall itself and the consequences of fall-related injuries are integrated into the lived-knowledge of older people, leading to an implicit understanding that falls should be avoided. Some older people have reported feeling that they are not in control of preventing falls, but that falling is a natural symptom of aging (Lee et al, 2008; Evron et al, 2009). Older persons who have not experienced a fall themselves, but have seen others live through a fall and its consequences have also reported this perspective (Evron et al, 2009). Clearly, waiting for, or anticipating, an event that may dramatically alter one's life might elicit emotions of anxiety and fear. In my phenomenological study, older people who perceived themselves to be vulnerable to falling reported the internalization of a tacit awareness of the consequences of falling into their daily lived experience. While this did not necessarily lead to a fear of falling, it did lead to a heightened caution in daily activities; importantly, this *did not mean* a *limitation* in daily activities, but rather a modification of them.

Previous research has explored the tension between older peoples' maintenance of self-affirming activities and protection of themselves from falling (Ward-Griffin et al, 2004; Lee et al, 2008; Hallrup et al, 2009). Regardless of whether participants in this dissertation study recognized or felt their own vulnerability to falling, they all described the importance of maintaining their lived-identities through the performance of meaningful activities. Where fear existed, participants modified rather than eliminated activities that were important to them. Study participants' descriptions of efforts to address this tension did not reflect a rational process, but a *pathic* and emotional process. These findings suggest that rational biomedical simplifications are not appropriately applied in negotiating understandings of fall risk and prevention strategies. As such, it

seems essential that health service providers pay special attention to the potentially counter-intuitive emotions and perspectives related to older persons' personal experiences of anticipating falling.

Further Implications for Fall Prevention Intervention

In keeping with van Manen (1990), the implications of these insights into the relevance of lived-identity to older people at risk of falling raise important questions regarding how health service providers might *tactfully* approach fall prevention with older clients. A primary issue is the question of whether to define the fundamental goal of health care as being to protect the client from provider-determined risks, or to foster lived-identity as perceived by the client. These two goals may conflict with one another, which raises important issues regarding the assumptions, beliefs, and moral imperatives that underpin methods of health care delivery for older people.

With respect to services that maintain fall prevention as a priority, Ballinger (2002) found that service providers may actually instigate social risks to clients' identities by protecting them from falling. By treating them as frail and dependent, service providers stigmatize older people in front of their peers, potentially undermining their self-identity (Hanson, Salmoni, & Doyle, 2009). Group programs focusing on fall prevention, such as the geriatric day hospital studied by Ballinger (2002), risk compounding this effect due to the inherently social nature of such services.

Fall prevention initiatives taking place in the home raise different issues with respect to the tension between fall risk and lived-identity. MacKenzie (2009) studied the perceptions of health professionals providing fall prevention education to older people in their homes, finding that health professionals felt they would only tolerate a certain level

of risk-taking on the part of their clients. When health professional participants in this study perceived their older clients had crossed a subjectively defined threshold of risk-taking behaviour they felt compelled to provide more poignant and targeted recommendations regarding limiting risky behaviour.

Familiarity with the consequences of falling creates an understanding of how devastating falling can be to older persons' lived-identity, which may enter into the perspectives of both providers and older people themselves. Salkeld et al (2000) found that many older people would sacrifice much of their hypothetical life expectancy in order to avoid a fall and fracture that would lead to living in a long term care facility. Thus, service providers and clients may both intuitively have goals to minimize risk of falling and maximize capacity to enact lived-identity. However, the way in which these goals are prioritized may differ (sometimes drastically) between clients and providers. Such differences suggest the importance of open exploration of this issue in fall prevention intervention. Consciously and *conscientiously* addressing older people's *being mode* of existence (Fromm, 1976) may enable health service providers to act and react appropriately in relation with their clients' needs, desires, and expectations when providing fall prevention education and intervention.

Previous research has developed and tested health promotion interventions that align with Fromm's *being mode* of existence (McWilliam et al., 1997; 1999), with outcomes of improved independence, perceived ability to manage one's own health, and decreased need for information (McWilliam et al, 1999). Interventions such as this can foster critical reflection on issues like fall risk, encouraging older people to embrace lived-caution while seeking a critical understanding of how they continuously construct

lived-identity. By empowering older people to make these decisions through critical reflection, service providers can encourage a *being mode* of existence that fosters acceptance of the need for caution in daily life without sacrificing the meaningful activities from which lived-identity, hence quality of life is derived.

Biggs' (2001) encourages us to question assumptions of the "third way" to age that he identified in British social policy, which emphasizes discourses of "positive aging" that incite youthfulness, autonomy, and independence as the desirable cultural model of the next generation of older persons. Biggs' critique of the "third way" reflects Fromm's resistance to capitalist-derived modes of existence (i.e. the *having mode*), which lead older people to glorify youthful and often contradictory accounts of aging (Biggs, 2001). Twigg (2006) argued that focusing on the aging body "ironically, help[s] to disrupt the narrative of frailty and decline that is commonly presented as rooted in the body, showing how bodily experiences in ageing are both more diverse and more rooted in social and cultural constructions than this account would allow." (p. 53). Thus, health promotion and fall prevention strategies that focus on encouraging older people to deconstruct their socially constituted assumptions of successful aging may facilitate the achievement of approaches to fall prevention that more emphatically affirm lived-identity and foster quality of life.

Conclusion

This paper presents original phenomenological research that explored older persons' experiences of anticipating falling. This work raises the importance of lived-identity to this experience, and hence, to health and social services and care aimed at risk reduction and fall prevention. Health service providers concerned about falling in later

life confront the challenge of recognizing how they may impact upon the health and quality of life of older clients, for whom lived-identity is a continuous priority. By fostering open critical reflection about the meaning of falling, fall risk and fall prevention with older people, integrating their knowledge of the consequences of falling with the thoughts, beliefs, goals, needs and priorities of older people, health service providers may succeed in working *with* older people to achieve fall risk education and health promotion. Thereby service providers foster new understandings that lead away from the commodification of the aging body and toward a more authentic relatedness to the world. In this way, service providers can help clients to manage the tension between the inevitability of aging and older peoples' continued process of enacting lived-identity.

References

Aho, J. (1998) *The things of the world: A social phenomenology*. Praeger: Westport.

Ballinger C. (2002). The construction of the risk of falling among and by older people. *Ageing & Society*, 22, 305-324.

Ballinger C. & Payne S. (2000). The construction of the risk of falling among and by older people. *Ageing & Society*, 22, 305-324.

Biggs, S. (2001) Toward critical narrativity: Stories of aging in contemporary social policy. *Journal of Aging Studies*, 15, 303-316.

Brown, C., Gottschalk, N., van Ness, P., Fortinsky, R., & Tinetti, M. (2005). Changes in Physical Therapy Providers' Use of Fall Prevention Strategies Following a Multicomponent Behavioral Change Intervention. Physical Therapy, 85(5): 394-402.

Burgess-Allen, J. & Owen-Smith, V. (2010) Using mind mapping techniques for rapid qualitative data analysis in public participation processes. *Health Expectations,* 13, 406-415.

Buzan T., & Buzan, D. (2002) *The mind map book*. London: BBC Books.

Caelli, K. (2001). Engaging with phenomenology. Is it more challenging than it needs to be? *Qualitative Health Research, 11*: 273-281.

Coyne, I. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing, 26*; 623-630.

Drew, N. (2008) The primacy of intersubjectivity. *Advances in Nursing Science,* 31(1), 74-80.

Edmonson, R., & von Kondratowitz, H-J. (2009). *Valuing older people: A humanist approach to ageing*. Bristol: Policy Press.

Edwards, N. (2011). Preventing Falls Among Seniors: The Way Forward. *Journal of Safety Research, 42*: 537-541.

Evron, L, Schultz-Larson, K., & Fristrup, T. (2009) Barriers to participation in a hospital-based falls assessment clinic programme: An interview study with older people. *Scandinavian Journal of Public Health*, 37, 728-735.

Fletcher P. & Hirdes J. (2004) Restriction in activity associated with fear of falling among community based seniors using home care services. *Age and Aging*, 33, 273-279.

Fortinsky, R., Baker, D., Gottschalk, M., King, M., Trella, P. & Tinetti, M. (2008). Extent of Implementation of Evidence-Based Fall Prevention Practices for Older Patients in Home Health Care. *Journal of the American Geriatric Society, 56*: 737-743.

Fromm, E. (1976) *To have or to be?* London: Continuum.

Hallrup, L., Albertsson, D., Tops A., Dahlberg, K., & Grahn, B. (2009) Elderly women's experience of living with fall risk in a fragile body: A reflective lifeworld approach. *Health and Social Care in the Community, 17*(4), 379-387.

Hanson, H., Salmoni, A., & Doyle, P. (2009) Broadening our understanding: Approaching falls as a stigmatizing concept for older adults. *Disability and Health Journal*, 2, 36-44.

Heidegger, M. (1962). *Being and time*. Malden: Blackwell.

Holloway, I., & Todres, L. (2003) The status of method: Flexibility, consistency and coherence. *Qualitative Research*, 3(3), 345-357.

Horton, K. (2006) Gender and the risk of falling: A sociological approach. *Journal of Advanced Nursing*, 57(1), 59-76.

Jenkins, R. (2008) *Social identity: 3rd edition*. New York: Routledge.

Jolanki, O. (2009). Agency in talk about old age and health. *Journal of Aging Studies, 23*; 215-226.

Katz, S. (2011). Hold on! Falling, embodiment and the materiality of old age. In M. Casper & P. Currah (Eds.) *Bodies of Knowledge: Interdisciplinary Studies* (pp. 187-206). Minneapolis: University of Minnesota Press.

Kinsella, A. (2006). Hermeneutics and critical hermeneutics: Exploring possibilities within the art of interpretation. *Forum: Qualitative Social Research; 7*: 1-16.

Laybourne A., Biggs, S., & Martin, F. (2008) Falls exercise and reduced falls rate: Always in the patients' interest? *Age and Ageing*, 37(1), 10-13.

Lee, F., MacKenzie, L., & James, C. (2008) Perceptions of older people living in the community about their fear of falling. *Disability & Rehabilitation*, 30(23), 1803-1811.

Lynott, R., & Lynott, P. (1996) Tracing the course of theoretical development in the sociology of aging. *The Gerontologist*, 36(6), 749-760.

Mackenzie, L. (2009) Perceptions of health professionals about effective practice in fall prevention. *Disability & Rehabilitation*, 31(24), 2005-2012.

Mcinnes, E., Seers, K., & Tutton, L. (2011). Older people's views in relation to risk of falling and need for intervention: A meta-ethnography. *Journal of Advanced Nursing, 67*(12), 2525-2536.

McWilliam, C., Stewart, M., Brown, J., McNair, S., Desai, K., Patterson, L., Del Maestro, N., & Pittman, J. (1997) Creating empowering meaning: An interactive process of promoting health with chronically ill older Canadians. *Health Promotion International*, 12(2), 111-123.

McWilliam, C., Stewart, M., Brown, J., McNair, S., Desai, K., Coderre, J., & Galajda, P. (1999) Home based health promotion for chronically ill older persons: Results of a randomized controlled trial of a critical reflection approach. *Health Promotion International*, 14(1), 27-32.

McWilliam, C. (2009) Patients, persons, or partners? Involving those with chronic disease in their care. *Chronic Illness*, 5(4), 277-292.

McWilliam, C. (2010) The theoretical basis of phenomenology. In I. Bourgeault, R. Dingwall, & R. de Vries (Eds.), *SAGE Handbook of Qualitative Methods in Health Research* (pp. 229 – 248). London: SAGE

Mead, GH. (1934/1962) *Mind, self, and society: From the standpoint of a social behaviourist*. Chicago: The University of Chicago Press.

Merleau-Ponty, M. (1962). *The phenomenology of perception*. New York: Routledge.

Meyrick, J. (2006) What is good qualitative research? A first step towards a comprehensive approach to judging rigor/quality. *Journal of Health Psychology*, 11(5), 799-808.

Northcott, N. (1996) Cognitive mapping: An approach to qualitative data analysis. *Nursing Times Research*, 1, 456.

Patton, M. (1990). *Qualitative Evaluation and Research Methods, 2nd Edition*. Sage: California.

Piercey, R. (2004). Ricoeur's account of tradition and the Gadamer-Habermas debate. Human Studies, 27; 259-280.

Rorty, R. (1979). *Philosophy and the mirror of nature*. Princeton: Princeton University Press.

Rorty, R. (1982). *The consequences of pragmatism*. Minneapolis: The University of Minnesota Press.

Rorty, R. (1989). *Contingency, irony, solidarity*. Cambridge: Cambridge University Press.

Rowe J. (2011) Fall prevention: Core characteristics and practical interventions. *Home Health Care Management & Practice*, 23(1), 20-26.

Salkeld, G., Cameron, I.D., Cummings, R.G., Easter, S., Kurrie, S.E., & Quine, S. (2000) Quality of life related to fear of falling and hip fracture in older women: A time trade off study. *British Medical Journal*, 320, 341–346.

Scheffer A., Schuurmans M., Van Dijk N., van der Hooft T., & de Rooij S. (2008) Fear of falling: measurement strategy, prevalence, risk factors, and consequences among older adults. *Age and Aging*, 37, 19-24.

Schutz, A. & Luckmann, T. (1973) *The structure of the life-world: Volume 1*. Northwestern University Press: Evanston.

Schutz A. (1953) Common-sense and scientific interpretation of human action. Philosophy *and Phenomenological Research*, 14(1), 1-38.

Scott, V. (2005) Report on Seniors' Falls in Canada. Ottawa: Public Health Agency of Canada.

Stevens J., Corso P., Finkelstein E., Miller T. (2006) The costs of fatal and nonfatal falls among older adults. *Injury Prevention,* 12, 290–295.

Stevens J., Baldwin G., Ballesteros M., Noonan R., & Sleet D. (2010) An older adult falls research agenda from a public health perspective. *Clinics in Geriatric Medicine*, 26(4), 767-779.

Tischler, L., & Hobson, S. (2005) Fear of falling: A qualitative study among community dwelling older adults. *Physical & Occupational Therapy in Geriatrics*, 23(4), 37-53.

Twigg, J. (2006) *The body in health and social care*. New York: Palgrave McMillan.

van Manen, M. (1990) *Researching lived experience: Human science for an action sensitive pedagogy*. The Althouse Press: London.

van Manen, M. (1999) The pathic nature of inquiry in nursing. In I. Madjar & J. Walton (eds) *Nursing and the experience of illness: Phenomenology in practice*. 17-35. London: Routledge.

van Manen, M. (2002). *Writing in the dark: Phenomenological studies in interpretive inquiry*. London: Althouse Press.

van Manen, M. (2006). Writing qualitatively, or on the demands of writing. *Qualitative Health Research; 16*: 713 – 724.

van Manen, M. (2007) Phenomenology of practice. *Phenomenology & Practice*, 1(1), 11-30.

Ward-Griffin, C., Hobson, S., Melles, P., & Kloseck, M. (2004) Falls and fear of falling among community dwelling seniors: The dynamic tension between exercising caution and striving for independence. *Canadian Journal on Aging*, 23(4), 307-318.

Yardley, L., Donovan-Hall, M., Francis, K., & Todd, C. (2006) Older people's views of advice about falls prevention: A qualitative study. *Health Education Research*, 21(4)508-517.

Chapter Five: The Meaning of the Experience of Enacting Fall Prevention in the Community

As injurious falls amongst older people continue to be portrayed as an important public health concern in Western nations, health service providers are increasingly expected to understand and enact effective fall risk assessment and fall prevention services (Brown, Gottschalk, van Ness, Fortinsky, & Tinetti, 2005; Fortinsky et al, 2008). While health professionals, including physiotherapists, are trained largely in the context of rehabilitation and reactive care (APTA, 2003; CPA, 2009), they are nonetheless also expected to have expertise in the prevention of falls amongst older people (Campbell & Robertson, 2006). Increasing attention and effort have been devoted to knowledge translation initiatives seeking to improve the knowledge and skills of health service providers who may work with older people to prevent falls (Fortinsky et al, 2008; Scott, Gallagher, Higginson, Metcalfe, & Rajabali, 2011), with lesser attention devoted to understanding the meaningful experiences of service providers who co-construct such services with their older clients. However, attending to such meaningful experiences and views of the professionals providing fall prevention services may contribute to understanding how to enact more sensitive and empathetic approaches to fall prevention that emphasize the health and quality of life of older people.

The experiences and views of physiotherapists, amongst other service providers who work with older people for fall prevention, have been explored in only two qualitative studies in the literature – one in a hospital setting and the other in the community. Ballinger and Payne (2000) used a discourse analytic approach to focus on inpatient hospital-based physiotherapists' and occupational therapists' perspectives on

falls and falling. These authors found that therapists focused on the professional knowledge and expertise they could provide to their clients, emphasizing that falls were predictable and controllable and ought to be prevented by clients. By providing clients with their professional knowledge, therapists felt that they could help clients to prevent falls while in hospital. As such, therapists relied on the language of risk and prevention to position themselves as experts who enabled older people to prevent falls by providing them with the appropriate education (Ballinger & Payne, 2000).

The second qualitative study, a grounded theory (Mackenzie, 2009), explored the perceptions of community-based health service providers from multiple professional disciplines enacting fall risk assessment and fall prevention with older people. While no overall theory of the process of engaging older people in fall prevention was presented, the findings suggested that service providers had difficulty integrating research evidence into their fall prevention practice. Specifically, the life situations of their older clients and the limited resources in contemporary home care were seen to impede their efforts at providing best possible fall prevention education and care. Nonetheless, service providers emphasized their professional skills and knowledge in conveying their ability to negotiate the real-life challenges of the home care context, relying on their skills to provide the education necessary to enable older peoples' fall prevention in daily life.

The findings from these two studies by Ballinger and Payne (2000) and Mackenzie (2009) suggest that the experience of providing fall prevention services may consist of providing education and behaviour change strategies to older clients in ways that emphasize service providers' own professional skills and knowledge. Furthermore, service providers' abilities to enact fall prevention by drawing upon their professional

skills and knowledge may be impeded by the real-life challenges of the home care context (Mackenzie, 2009). While these findings suggest that service providers' experience of providing fall prevention resonates with an expertise-based model of health care (Ballinger & Payne, 2000), the *meaning* of the experience of providing fall prevention for service providers' themselves has yet to be studied. As such this study explicitly explored the meaning of the experience of enacting fall prevention with older people in the community. In the interpretive phenomenological study presented in this paper I focused on the experience of enacting fall prevention in the social context of a geriatric-specific community outreach team.

Such insight into the meaningful experiences of geriatric-specific health care professionals working in the community may help to understand how to encourage their co-construction of fall prevention services in ways that are meaningful and sensitive to both older clients and service providers themselves. By attending to the meaningful experience of health service providers we can better understand their orientation toward providing fall prevention services, helping to construct research findings that contribute to edifying their approach to engaging older people in fall prevention in more tactful, meaningful ways (van Manen, 1990; 2002). The purpose of this study was to explore the lived-experience of service providers by answering the research question: What is the meaning of the experience of enacting fall prevention for health service providers working on a geriatric-specific community outreach team?

Methodology

The epistemological orientation from which I approached this inquiry was inspired by the anti-foundationalist philosophical position of Richard Rorty (1979). Such

an epistemology explicitly embraces a hermeneutic perspective, claiming that all acts of inquiry are fundamentally interpretive in nature (1979; 1982; 1989). The methodology in this study for exploring the meaning of lived-experience was primarily informed by the phenomenological human science of Max van Manen, and integrated phenomenological insights from Alfred Schutz (1943; 1953) and Maurice Merleau-Ponty (1962). Specifically, in this study I applied a hermeneutic phenomenological methodology that emphasized the importance of both the gnostic (cognitive) and pathic (non-cognitive) elements of lived-experience (van Manen, 1990; 1999). I focused on concrete lived-experiences in order to understand the thoughts and feelings that constitute the meaning of the experience, and then engaged participants in hermeneutic reflection when co-constructing an interpretation of the experience (van Manen, 1990). I emphasized the importance of social interaction to constructing the meanings that characterize our everyday lived-experience, providing methodological insight regarding the focus on concrete experiences of *interactions* regarding fall prevention (Schutz, 1953). While focusing on concrete stories of interactive encounters regarding fall prevention, I sought to hermeneutically co-construct a *gestalt* understanding of the meaningful experience as suggested by Merleau-Ponty (1962). I sought to re-present the meaning of the experience of enacting fall prevention through evocative phenomenological writing while re-cognizing that such a written account can never be considered "final" or "complete" (Rorty, 1979; van Manen, 1990; 2007). The goal of the study then was to interpret and describe the meaning of the experience of enacting fall prevention, in order to inspire the edification of approaches to fall prevention in more empathetic and meaningful ways.

Methods

Ethical Considerations

Approval for this study was obtained from the Research Ethics Board of The University of Western Ontario as well as the research ethics board at the health care and health research institutions with which the outreach team is affiliated. I chose to focus on service providers working in geriatric-specific community outreach representing physiotherapy, occupational therapy, nursing, and social work to develop a purposeful sample for this study (Coyne, 1997; Patton, 1990), as these health professionals provide care to older people within the older persons' own home and community life-context. As such, these practitioners may have unique experiential insight into fall prevention in the home and social life contexts of the older people with whom they work. Study procedures and intended use of audio recorded participant data were described to each potential participant before obtaining written informed consent for the use of their anonymous data for analysis, interpretation, and dissemination. Participants were informed that pseudonyms would be used when referring to participants in the findings of this inquiry.

Study Context

The context of the inquiry was a geriatric-specific community outreach team affiliated with a large rehabilitation hospital in Ontario. These health care practitioners received referrals through a common referral organizing system, which collects referrals primarily initiated by family practice physicians who identify older people as requiring additional services to remain living independently in the community. However, occasionally referrals were received for older people living in long-term and group home care settings. Outreach practitioners were provided with a referral, and were then responsible for completing a comprehensive geriatric assessment of physical, mental, and

social well-being. The referral generally contained client contact information as well as the primary reason the person was referred for care by the outreach team. Upon completion of the comprehensive geriatric assessment, service providers reviewed and discussed each client with their inter-professional colleagues at the weekly outreach team meeting. Providers then established service recommendations regarding how to help keep the older person living independently in the community or how to help them transition to a different living environment. Service providers were permitted to arrange the number and duration of client visits at their own professional discretion. As such these service providers functioned as independent care providers but were able to bring in other professional disciplines represented on the outreach team at their discretion on a client-by-client basis, thereby co-constructing a shared meaningful experience of engaging older people in fall prevention.

The geriatric community outreach team from which participants were recruited consisted of highly experienced service providers from a variety of professional disciplines. While each service provider practiced in an autonomous role, they engaged other team members in collaborating for the care of particular clients when they felt such collaboration would be beneficial in achieving clients' goals. The team leadership fostered a collaborative, appreciative context that encouraged such working relationships among team members, positioning the outreach team to excel at providing client-centered, inter-professional care. As such, the particular outreach team that was the focus of this study may have enacted community-based fall prevention in ways that opposed the primary finding of the literature review in this domain – that service providers have tended to focus on their own professional discourses of safety and risk (Ballinger &

Payne, 2000; Mackenzie, 2009). Focusing on this particular high-performing outreach team provided the opportunity to explore the meaning of the experience of enacting fall prevention among experienced practitioners who worked within a client-centered, inter-professional context.

Participant Recruitment

Participants were recruited from a community outreach team, which consisted of 11 full and part time health care providers representing physiotherapy, occupational therapy, nursing, and social work. Potential participants were informed of the study purpose and time commitment during a brief presentation at a staff meeting. Interested participants were invited to contact me via email directly.

I recruited a purposeful sample (Coyne, 1997; Patton, 1990) with a focus on achieving variation amongst participants' professional disciplines, including participants from physiotherapy (two participants), occupational therapy (two participants), social work (one participant), and nursing (one participant). Such diversity of service provider disciplines was sought within this study as the social context of contemporary fall prevention programming is increasingly demanding the effort of many different professional disciplines to work collaboratively in the prevention of falls (Scott et al, 2007). As such, illuminating the meaning of the experience of enacting fall prevention may require input from a diverse group of health professionals. Furthermore, I sought to recruit participants from within a single community outreach team in order to explore in greater depth the meaning of the experience of engaging older people in fall prevention. As professionals working on the community outreach team participate in the co-construction of the meaning of fall prevention within the same social context, sampling

from a single team would foster richer interview data that illuminates the meaning of the experience of engaging older people in fall prevention in this particular community outreach context in greater depth. A total of six participants were recruited. All participants had over 15 years experience providing health care, and at least three years of experience working on the geriatric community outreach team. All participants were registered with their professional college, and all were women. For additional participant information see Appendix J.

Data Collection

I co-constructed in-depth, individual interviews with each of the six service provider participants. Interviews ranged in length from 65 – 95 minutes and took place between January and April 2012. The first interview with each participant maintained a phenomenological focus as described by van Manen (1990), emphasizing narrative descriptions of concrete experiences involving enacting fall prevention services. In these interviews my open ended questions focused on experiences working with older people to prevent falling; participants' thoughts and feelings about engaging older people in fall prevention; and what the experience of engaging older people in fall prevention meant to them. As participants conveyed their concrete lived-experiences, I sought to ask additional questions that would foster the hermeneutic co-construction of my emerging interpretation of the meaning of the experience of engaging older people in fall prevention.

After initial interviews were completed with all six participants, I engaged in follow-up interviews with two particularly insightful participants to encourage hermeneutic reflection and further co-construction of my emerging interpretation (van

Manen, 1990). In these interviews I described my interpretations to participants and we engaged in discussion regarding whether and how my interpretations resonated with their experiences. Through this relational hermeneutic reflection, I refined my interpretations to resonate more strongly with participants as re-presenting an experience they did have or could have had (van Manen, 1990). As such, further interpretive insight was achieved to inform the phenomenological writing and analysis of the essence of the meaning of the experience of enacting fall prevention.

Data Analysis

Following van Manen's (1990) discussion exploring three different levels of analysis for phenomenological data, I integrated wholistic/sententious, selective/highlighting, and detailed/line by line methods for analyzing the interview data. An additional method of analysis, mind mapping (Burgess-Allan & Owen-Smith, 2010; Northcott, 1996), was used to augment the free imaginative variation process as themes began to emerge. Upon completing each interview I listened to the audio recording while creating reflective memos regarding participants' stories of concrete lived-experiences, my emerging interpretations, and ongoing reflexivity of my presuppositions. After each interview was transcribed, I read and re-read each interview while highlighting particularly rich segments and making notes of interpretations in the page margins. I created codes for emerging interpretations of common-sense everyday experiences, actions, decisions, thoughts, and feelings to re-present potential themes. As essential themes were co-constructed within and between interviews, I held these themes in question through imaginative variation to explore whether they were essential or merely incidental to the lived experience of engaging older people in fall prevention.

Through the mind mapping method, I created a visuo-spatial re-presentation of the themes for each interview in order to better explore the relationships between them (Buzan & Buzan, 2002; Northcott, 1996). This provided an opportunity for further critical reflection regarding the free imaginative variation process, exploring whether themes ought to be considered essential to the experience of engaging older people in fall prevention. Creating these mind maps also helped to facilitate reflective discussion with senior researchers regarding my emerging interpretations.

Having read and re-read the transcripts multiple times, engaged in reflective discussion with senior researchers regarding my emerging interpretations, and created mind-maps to augment the free imaginative variation process, I then engaged in hermeneutic phenomenological writing. In putting the primary themes that hermeneutically emerged into written prose, I brought the interpretation of the meaning of the experience of enacting fall prevention into being (van Manen, 1990; 2007). A senior researcher was consulted at each step of this process of analysis and interpretation of the interview data in order to foster coherence and cogency.

Rigour

Consistency and coherence between the philosophical underpinnings and the knowledge claims made in this research study were sought as the means of promoting rigor throughout the research process (Caelli, 2001; Holloway & Todres, 2003). To accomplish such consistency and coherence, I drew upon a hermeneutic phenomenological approach to human science research that resonates strongly with my epistemological position (van Manen, 1990; Rorty, 1979). I focused on the social nature of meaning in engaging older people in fall prevention services (Schutz, 1953), seeking a

gestalt hermeneutic understanding of the meaning of this experience amongst community outreach service providers (Merleau-Ponty, 1962). Furthermore, the interpretation of the findings emphasized both the gnostic (cognitive) and pathic (non-cognitive) elements of the gestalt meaning of the experience of engaging older people in fall prevention, re-presented through phenomenological writing that seeks resonance with experiences the readers have had or could have had (van Manen, 1990). The language in which the findings were written emphasizes the interpretive nature of this research study, fostering further coherence with the epistemological and methodological orientations that underpin the inquiry.

In re-presenting the findings of the study I have sought to be transparent, disclosing all decisions made throughout the research process and the reasons for making them, when appropriate (Meyrick, 2006). Finally, I sought to engage in this phenomenological study in a systematic way, returning to my research question, data, and emerging interpretations in establishing the hermeneutic gestalt of the experience of engaging older people in fall prevention in the community (Meyrick, 2006). As such, I have integrated consistency and coherence between the philosophical and methodological underpinnings and the knowledge claims made in the study, in a transparent and systematic way, to promote its rigor as qualitative inquiry.

Findings: The Meaning of Enacting Fall Prevention in the Community

For geriatric community outreach team members, enacting fall prevention meant *enacting careful practice*. The essence of enacting careful practice was composed of four major themes. The first theme was *caring fully*, which was constituted by two further sub-themes: *attending to clients' concerns* and *re-cognizing risk* as a meaningful and

important aspect of clients' daily lives. The second theme was *carefully seeing the older person-in-context*, re-presenting the broad lens through which participants viewed their older clients. The third theme was *enacting therapeutic relationships*, which was also constituted by two sub-themes: *fostering relational trust*, which enabled practitioners to *engage in reflective dialogue* regarding meaningful risk and meaningful caution in older peoples' daily lives. The final theme was *experiential learning in an inter-professional team*, re-presenting the ways in which participants learned and continued to learn how to enact careful practice.

Enacting Careful Practice

Harper's online etymology dictionary (2012) suggests that the term *careful* derives from dual related meanings, including both "full of care or woe; anxious; full of concern", and "applying attention, painstaking, circumspect". The meaning of the experience of engaging older people in fall prevention was characterized by these dual meanings of the term *careful*. In one sense, service providers lived-through an orientation toward their older clients that was in essence one of *caring fully*; their experience of co-constituting community fall prevention services was full of care. In the other sense, service providers judiciously engaged in a *careful seeing of the older person-in-context*, closely attending to the broader life situation and many interactions amongst medical, contextual, and personal meanings that characterized the older person's experiences of health and quality of life in aging. Such fully caring and carefully seeing were put in to practice by service providers through enacting therapeutic relationships, enabling an approach to fall prevention that emphasized trusting dialogue between clients and

providers. Participants experientially learned to enact such careful practice through their practice experience with the inter-professional geriatric outreach team.

Major Theme One: Caring Fully

Service provider participants conveyed the essence of their passionate and empathic experience of engaging older people in fall prevention in the community as being *full of care*. Participants' caring orientation toward their practice with older people meant *attending to clients' concerns* and *re-cognizing meaningful risk*. The following sub-sections describe the interpretation of attending to clients' concerns and re-cognizing meaningful risk as they were co-constructed to constitute the theme of caring fully.

Sub-theme one: Attending to clients' concerns. In enacting careful practice community outreach providers engaged older people in dialogue to understand how to best express care *for* them, which meant inquiring about and attending to the meanings that constituted their clients' most important concerns. For outreach practitioners, this authentic and focused attention on subjective concerns was essential to caring fully. One participant, reflecting on how she integrated her caring orientation into her outreach practice, stated:

> Laura: I think for [older people], feeling purposeful in some way, you know, having some meaning [is most important]… and I think as a clinician that's our job to try and find out what that is, what's that meaning and that purpose for them? Yeah.

This participant suggested that her role as an outreach team member was to come to understand what constitutes a meaningful and purposeful life for her older clients. It was only upon understanding what constitutes meaning in a client's life, and thus what

constitutes well-being and quality of life, that she felt she would be enabled to help her clients achieve their goals. As such, understanding this lived-through meaning and purpose in her clients' lives was essential to her capability to *fully care* for her clients.

Another participant emphasized the importance of orienting her careful practice to helping her clients achieve a sense of quality of life while maintaining their dignity:

> Andrea: Thinking more about the bottom line I think for most of the families we see is [that] we want to, I always kind of go back to improving quality of life and keeping their dignity intact along the way.

Here this participant re-cognized an additional important element to caring for her older clients: the felt importance of dignity. Attending to dignity, while helping clients to continually achieve quality of life, was for this participant an essential aspect of *caring fully* for her clients.

Understanding the importance of the older person's views and experiences for informing the co-construction of therapeutic goals that are authentically focused on their meaningful concerns, this same participant discussed what she believed ought to be the starting point when enacting community outreach care:

> Andrea: I think the starting point is really what's best for the client and the family, so what do they feel is their most [important] concern at this moment? I think that's where we should start as a team, where the client wants to start or where the family wants to start and then you kind of, you know, carry on from there. An example, you know… well if you use the example of falling, we had someone yesterday who falls two to three times a week okay and so pretty lucky, no hip

> fracture, no trip to the ER yet, so I think that would be [the] first priority for the client and probably for the family, that would be the starting point.

Here this participant conveyed her understanding that she as a service provider ought to focus first and foremost on what the client and his or her family identify as the primary concern, orienting her careful practice to attend to the client's priorities. Only when the occurrence of falls was the primary concern for the client and family would fall prevention serve as the starting point for community care. While fall prevention would be suggested by providers as a means of further improving quality of life when appropriate, participants also felt it was necessary to understand that some risk for falls is inherent in daily activities and thereby essential to making one's own choices about engaging in activities, living independently and therefore achieving quality of life.

Sub-theme two: Re-cognizing risk. As some risk was understood by participants to be essential to achieving and maintaining quality of life for older people, service providers also felt they had to re-cognize meaningful risk. Re-cognizing risk meant reflecting on and re-interpreting the meaning of risk in the lives of older people, in order that meaningful risk could be affirmed in clients' lives as contributing to the continual constitution of quality of life.

Participants emphasized that fall prevention was only one part of *careful practice* and that it must fit within the broader experience of caring in the community more generally. In this way, efforts to minimize risk of falling had to be balanced with efforts to achieve meaningful quality of life that integrated meaningful risk-taking for the client. Emphasizing this point, one participant stated:

> Karen: You can never really totally eliminate [fall risk], and you have to balance out that risk with the quality of life and what the person wants. If you overprotect somebody and you're way too protective and they have no quality of life, what's the point?

Service provider participants understood that a certain level of risk-taking was important for older people to achieve continued quality of life, and did not seek to entirely eliminate fall risk from their clients' daily lives. As opposed to an overly paternalistic approach that might seek to limit fall risk entirely, these service providers recognized and valued their clients' decisions with respect to living with risk.

> Natalie: Certain patients will choose to live with a degree of risk, it might be a high degree, it might be a lower degree, but that is their decision, right?... we don't want to patronize older folk who actually are capable of making their own decisions and may decide to live with a certain degree of risk.

Another participant gave what she believed to be an extreme example of an older client who was capable of making his own decisions and chose to engage in what she considered to be highly risky activities.

> Judy: I remember seeing a guy years ago, an older man who, you know, had his wood working shop down in his basement, the washer and dryer were down there… he would go down these very rickety basement stairs that had no railing to hang on to and he would go down to this basement that was piled high with stacks of wood, power cords all over right where he needed to walk, and you know, I was concerned about what happens if you fall down those stairs, you know, who's going to find you? How are you going to get help? What happens if you trip and

> fall in the basement?… and this guy said, "If I fall and hurt myself, so be it, if nobody finds me for a few days, so be it, if I die in the process, so be it"… and for him, because he hadn't been declared incapable, that was a risk he was willing to take.

The service provider participants in this study conveyed the meaningful experience of *caring fully* as involving the re-cognition of the centrality of older clients' meaning, purpose, and quality of life to the essence of their community outreach practice. As opposed to a superficial effort to minimize risk wherever possible, these practitioners sought to understand the degree of risk that was important for their older clients and provide education and support to more authentically meet their clients' needs. In order to enact their careful practice, these service providers also conveyed the need to *carefully see* their clients' lives-in-context in order to understand how to help them remain safe while engaging in risky activities that were essential to their continual achievement of meaning, purpose, and quality of life.

Major Theme Two: Carefully Seeing the Older Person-in-Context

Service provider participants described feeling compelled to *carefully see the person in his or her life context* as an essential part of enacting careful practice. For participants in this study, it was only through interpreting and understanding the complex interplay between the many factors and meanings that influenced a person's current personality, functioning, and quality of life that authentic, effective, and careful practice could be enacted. Understanding this interplay meant seeing how biomedical elements of health and function interact with more social, personal, and historical elements, which together were seen to constitute the person's current situation that led to the initiation of

community outreach care. Participants believed that their experiences were unique to members of their geriatric-specific community outreach team, providing them with the unique capabilities to see the older person-in-context with a broader and more understanding lens.

One participant, a physiotherapist, addressed how working with seniors was very different from a typical outpatient physiotherapy practice and why:

> Karen: It's a matter of knowing what you look for and how wide, how far, how big a lens maybe is the best way of putting it. And with seniors it's not straight forward. It's not like the guy who comes in because you know he slipped shoveling his driveway and broke his ankle, so really all you need to look at is the ankle… with seniors you cannot for the most part piece out one little thing. They are so complex for the most part, not everybody but a lot of them. A lot of years of wear and tear going on, brain related changes, their bodies aren't the same as they were when they were 20, 30, or 40 years old, how they manage medications, their mobility, their judgment, their history, the social package that comes with them. I think this team has the ability to look at things with a bigger lens than maybe some other people do.

Here this participant emphasized her learned capability to see the interplay of biomedical, historical, and social elements that constituted an older person's life situation. By distinguishing her view, or lens, of her older clients through an example of outpatient physiotherapy, she highlighted her self-understanding of how her broader view of an older person-in-context optimally positions her for community-based care for older

people. In so doing, she suggested that carefully seeing the older person in his or her life context is essential to enacting careful practice.

Another participant discussed a specific case about an older man who refused to engage in cognitive testing, and how understanding his life context was crucial to understanding his refusal:

> Laura: I really try and think about "where is this coming from?" and "why is this so anxiety provoking?" and "why is this such a big deal?" Again, that's why it's so important [to understand] the person's point of view, what happened in the past, what really is meaningful for them, you know, all those kinds of things that puts it into context: why is this a really big deal? I've got one gentleman who was a driver all his life and he doesn't want the cognitive testing because he knows deep down that something is up, and he associated [driving] with his whole life, that's his being. We talk about our careers as being such an important part of who we are, if that's taken away, I'm not a good driver anymore, oh my goodness, then that's a big part of him that's being taken away! So you just have to kind of keep thinking about that and try to empathize a little bit about what that might feel like.

For community outreach providers in this study, seeing the older person-in-context enabled them to understand how and why a given client's current health and quality of life were presenting in a particular way. Through achieving this greater understanding, they were enabled to care more fully for their clients by enacting meaningful fall prevention that fit within the context of the client's own function and meaningful life activities.

Major Theme Three: Enacting the Therapeutic Relationship

Community outreach providers in this study conveyed the therapeutic relationship as an essentially *constitutive* element of fall prevention in the community. Participants understood that any education or discussion with respect to health promotion and fall prevention was co-constructed in dialogue with the older person, and that the meaning and quality of the dialogue arose from the meaning and quality of the relationship in which it was situated. As such, enacting fall prevention strategies in meaningful ways meant enacting a meaningful relationship in which such strategies could be situated. For participants in this study creating and re-creating the therapeutic relationship in order to enact careful practice for fall prevention meant *fostering relational trust* and *engaging in reflective dialogue*.

Sub-theme one: Fostering relational trust. Service provider participants suggested that trust was central to efforts to construct a meaningful therapeutic relationship. Trust was seen to foster meaningful and constructive dialogue that could contribute to education regarding appropriate and effective fall prevention in a particular person's life context. One participant discussed the centrality of trust to the therapeutic relationship, addressing how such trust enabled clients and providers to better understand one another. Establishing and re-establishing this trusting relationship was seen to take consistent effort.

> Andrea: the client and the family, they have to trust you… you have to have that relationship that you're listening and understanding them and I think as you listen and understand them they are more likely to listen and understand you. And that

> can happen on the first visit or that can, you know, take numerous visits to connect with that.

Yet another participant discussed how relationships fundamentally constituted the services she enacted with her older clients, exploring why it was so important to conversationally engage with older people in order to build trust as opposed to trying to provide services and implement interventions in a linear manner:

> Judy: The work that we do with anybody, and certainly as a social worker, it's all relationships. A lot of people we see over time and if you fly in and tell them all the things they have to do to change, and you don't really spend the time talking with them about [it], why you're suggesting it, risk-benefit scenarios, and asking people what they think about it… they're going to shut you off pretty quickly. Because [clients will think] "it's somebody telling me what to do, it's somebody not being respectful of me, it's somebody not asking me my opinion of what I think."

Sub-theme two: Engaging in reflective dialogue. Enacting the therapeutic relationship to achieve caring practice oriented toward fall prevention meant engaging older people in reflective dialogue about their risk of falling, their mobility, and their quality of life. Service provider participants sought to construct a trusting and caring therapeutic relationship in which they engaged clients in conversation that encouraged critical reflection about the risks they take in their daily lives. This meant continuing to advocate for the client's quality of life while posing reflective questions regarding fall risk. Engaging in this conversation and posing meaningful questions to elicit such reflection was seen as a creative endeavor.

> Sally: I have to advocate for the patient, but I have to also be creative and at the same time try to have that conversation with them, you know, what do you think might happen if you fell? Let's talk about the balance. What if the PSW just came and stood outside the door while you have your bath? Well that would be okay. So you kind of have to work in degrees. I think that's where the creative side of the job has to come into play. It's not like a dialysis patient, [where] you need dialysis or you're going to die, period. I think that's for me what makes geriatric care interesting because there's a need to be creative. We have to be creative all the time and come up with different ways to manage behaviours, manage falls risks and respect what [the client] wants as well.

One participant relayed her understanding of the dilemma facing an older woman client regarding whether or not to use a rollator walker. This participant felt it was her job to help her client through this dilemma by engaging her in discussion and encouraging critical reflection. The participant did not seek to make the decision for the client, but in the context of their trusting therapeutic relationship sought to pose questions that would elicit critical reflection about meaningful risk and meaningful caution in the client's daily life.

> Judy: She could see it, she could intellectually see it both ways, you know, part of her could say "Yes I realize this is something for safety and allows me to do more and allows me to actually walk better than I'm walking. So I recognize it is a safety thing and that other people will accept me for it." The other part of her was [saying] "well people will now just see me as another old lady. My status or my role with my group of friends was the person who was always kind of in charge

> and in control. Things were going well, I helped look after other people, but now here I am in the same position." So it's really about spending time, helping them look at, you know, what are the benefits of having a walker, what are the disadvantages?

In this way, relational dialogue was central to service providers' educational efforts at fall prevention, seeking to help older people re-cognize the reasons for taking meaningful risks in their daily lives. Through dialogue and reflective question-posing, service provider participants helped older people navigate through their decision-making with respect to meaningful risk-taking. Community outreach providers did not seek to directly minimize the risks in the lives of their clients, but helped their clients to come to a more reflective understanding of which risks were important and meaningful and which risks could be reduced to help prevent falling.

Major Theme Four: Experiential Learning in an Inter-Professional Team

Service provider participants conveyed a strong passion and interest in enacting geriatric-specific community outreach care specifically in an inter-professional context. Through their experiential learning over years of collaborating in inter-professional care for older people, participants had come to broaden their understanding of the issues that confront older people in the community, including fall risk and fall prevention. While participants had tacitly and explicitly learned to enact careful practice with their older clients they also re-cognized the importance of continued support and collaboration with others in the context of the inter-professional team. Such inter-professional experiential learning and continued inter-professional support enabled service providers to understand

when to question their skills, knowledge, and approach to fall prevention, and thus seek out help from other team members.

One participant, a social worker, explored how she had come to have confidence in understanding what constitutes fall risk, despite her lack of explicit training in this area, through her experience working with the inter-professional team.

> Judy: I have certainly over the years picked up a lot of knowledge I guess, you know, from other team members just working on a multidisciplinary team. Just, you know over time gaining a better understanding of what is a falls risk, what are the different kinds of things that can put a person at risk for falls? So everything from just environment, how their home is set up, scatter mats, different levels, stairs, just the condition of the home to, you know, their footwear or lack thereof to getting a bit of a better understanding of medications, how some medications may contribute to falls.

Participants re-cognized the profound benefit of working in a team environment that fostered and valued inter-professional care, feeling encouraged to learn from other team members at every opportunity. They felt that the community outreach team of which they were a part was a safe and open forum in which they could admit to being unsure about how to care for a particular client. One participant stated:

> Natalie: it's a very big bonus to be a part of a team here where we can run things by other people and say "What would you do? Have you thought of this? I'm worried about that." So the ability to review cases and to share ideas and knowledge is very supportive to me. It's kind of like the older you get and the more you practice the more that you know you might not know.

Experiential learning in an inter-professional team had led participants to understand the interplay amongst the many elements that impact an older person's risk of falling, enabling a broader and more thorough view of fall risk in their older clients. Such experience and support offered by the inter-professional outreach team was essential to the meaning of service providers' experience of enacting fall prevention in the community.

Discussion

The findings of this phenomenological study suggest that *enacting careful practice* re-presents the gestalt meaning of the experience of enacting fall prevention amongst geriatric community outreach service providers. While the findings of this study are not generalizable across health care contexts in the traditional post-positivist sense, they may provide unique insight into the centrality of careful practice to enacting fall prevention services amongst community outreach practitioners. As such, they may help to understand the taken-for-granted meanings that characterize fall prevention services in community outreach care. The following sections discuss the implications of the key insights from the findings of this study.

Enacting Careful Practice

Enacting careful practice characterized the essential theme in this phenomenological study, re-presenting the gestalt experience of service providers judiciously seeking to *fully care* for their clients by *carefully seeing the older person-in-context*. In order to enact careful practice service providers sought to *enact therapeutic relationships* with their clients. The ways in which service providers learned to fully care,

carefully see the older person-in-context, and enact the therapeutic relationship evolved from their *experiential learning with an inter-professional team.*

Related Meanings: Caring Fully and Carefully Seeing the Older Person-in-Context

For participants in this phenomenological study, the *careful practice* that characterized their experiences of enacting fall prevention was essentially pathic or emotional in nature. The feeling of desire to fully care pervaded their experience of engaging in community outreach, orienting their practice to emphasize and focus on their clients' most important concerns. The phenomenological ethics of care developed by Emmanuel Levinas suggests that we implicitly experience a felt-desire to care for others whom we encounter in our immediate time and space (Levinas, 1998; van Manen, 2002). Such felt-desire to care is a primordial, experiential phenomenon that transcends our social presuppositions about others, and characterizes our immediate gut reaction to seeing others in need of our help (Levinas, 1998). This desire to care is not rooted in an understanding of social roles (such as health care provider and client), but is rooted in a primordial phenomenological connection that unconsciously persuades us to care (Levinas, 1998; van Manen, 2002). Such a pervasive, existential drive-to-care was essential to the meaning of the experience of participants in this study, understood through the theme of *caring fully*.

Such a primordial desire to care may contribute to motivating people to seek out the vocational role of health service provider as a life career (Nortvedt, 2003). Indeed, this primordial and phenomenological felt-desire to fully care for clients or patients is considered by some to be the primary foundation on which all of health care rests (Kottow, 2001; Nortvedt, 2003; van Manen, 2002). Understood this way, and in keeping

with the ethics of care of Emmanuel Levinas, such pathic, phenomenological felt-desire to fully care is central to the experience of engaging clients or patients in health promoting practice (Kottow, 2001). Service provider participants in my phenomenological study conveyed this desire to fully care for their older clients, and indeed it was central to their experience of enacting fall prevention care for older people in their home and community-life context.

The centrality of caring fully within the essence of enacting careful practice in this study meant that service providers sought to carefully attend to their clients' entire life situations, exploring how medical, personal, and social meanings (for example, fall risk factors, preferred activities, and family situations, respectively) interact to influence their health, subjective concerns, and quality of life. Service providers sought to understand the interactions of fall risk factors that put older people at risk of experiencing a fall, but also looked beyond these risk factors to understand how risky activities were situated in their clients' lives in meaningful ways. Understanding older clients' risk of falling, but also how such risk may contribute to their overall quality of life, meant carefully seeing the older person-in-context. In this way, in order to be caring fully for their older clients service provider participants felt they had to carefully see the older person-in-context, re-presenting the related meanings of these two senses of the term *careful*.

Carefully Seeing the Older Person-in-Context

Participants in this phenomenological study understood that not only conventional biomedical fall risk factors, but the personal needs, desires, and expectations of older clients and their families needed to be considered in order to comprehensively assess fall

risk. That is, they understood the complex interaction between many diverse types of fall risk factors situated in a particular environment at a particular time as causing older people to fall (Rubenstein & Josephsen, 2002). Viewing fall risk factors in isolation may be insufficient to understand how they interact with one another in impacting the chances that an older person will fall (Rubenstein, 2006). Rather, seeing the interplay among risk factors, a highly complex process that is inherently difficult to predict or control, may be essential to understanding and enacting fall prevention (Scott et al, 2011; Rubenstein, 2006). While service provider participants in this study expressed a broad understanding of the complex interactions amongst many fall risk factors, they looked beyond the assessment and minimization of risk to understand the person's life context within which this risk was situated. As such, participants sought to carefully see the interactions amongst particular risk factors for their older clients, but also sought to carefully see how such risk was meaningfully situated in their clients' lives. This meant re-interpreting risk in non-biomedical terms, tacitly opposing the conventional understanding in health care that risk ought to always be avoided (Clarke, 2006).

Reflecting on Risk

Risk is generally considered to be a negative state or action associated with uncertain outcomes that could potentially have adverse consequences for particular people (Clarke, 2006; Titterton, 2005). The growing prevalence of this negative understanding of risk in health and social care often leads professionals to deny and minimize risk in their practice for fear of the potential consequences (Lupton, 1993; Titterton, 2005). The emphasis on safety and accountability in contemporary health care tend to orient service provider practice toward the judicious minimization and avoidance

of risk in order to meet the perceived demands of public safety (Clarke, 2006). With respect to risk of falling, this would mean the reduction or elimination of as many risk factors as possible to prevent the interactions amongst risk factors that lead older people to experience a fall (Edwards, 2011; Rubenstein & Josephsen, 2002).

While best practice recommendations for fall risk assessment and fall prevention maintain the implicit assumption that the reduction and minimization of fall risk will improve clients' quality of life (Clarke, 2006; Laybourne, Biggs, & Martin, 2008), participants in this study did not adopt this conventional view. Participants' orientation toward enacting careful practice, and thus to carefully seeing the older person-in-context, meant that they sought to understand how risk was considered a meaningful and important aspect of their clients' quality of life. As such, they did not maintain the reduction of risk as the primary motivator of their experience of enacting fall prevention, but instead emphasized the centrality of enacting careful practice that took the clients' most important concerns as its primary focus. Such a positive understanding of risk is essential for service providers to authentically focus on clients' subjectively meaningful concerns, understanding how risk might be positively positioned in older people's lives as an important part of their meaningful activities (Titterton, 2005).

Qualitative studies exploring how health service providers conceptualize risk in relation to community-based health care with older people have emphasized the client- or patient-centeredness that focuses health professionals' community care on clients' quality of life (Green & Sawyer, 2010; Taylor, 2005; Mackenzie, 2009). Specifically with respect to fall prevention in the home, Mackenzie (2009) found that service providers sought to affirm and support activities that may be considered risky for older people, such

as weeding the garden, if they were important to maintaining the client's quality of life. Qualitative studies by Green and Sawyer (2010) and Taylor (2005) also found that community-based service providers maintained an emphasis on the overall quality of life of older people in the community, recognizing that strategies to decrease risk would have to fit within meaningful activities that were important to the client. These findings taken together suggest that community-based service providers may re-cognize the importance of risk to performing meaningful activities for older people, believing that certain risk-taking activities ought to be affirmed in older peoples' lives even in the context of community-based fall prevention. The ways in which service providers negotiate the tension between affirming meaningful risk and educating about fall prevention in practice has not been previously explored in the literature, and was understood by participants in this study through enacting the therapeutic relationship.

Therapeutic Relationship and Client-Centered Fall Prevention

In the context of a trusting therapeutic relationship, service providers in this phenomenological study engaged older people in reflective dialogue about meaningful risk and meaningful caution in their daily lives. Inspired by their caring orientation toward their older clients, service providers sought to understand which risk-taking activities were important to their clients and which they could help to minimize or limit in order to prevent falls. As opposed to simply providing education and recommendations to prevent falls, and leaving the decision-making and implementation of fall prevention strategies to the client, service providers in this study explored the meaning of potential fall prevention options in their clients' lives. In so doing service providers moved away from a traditional "banking metaphor" of education for fall prevention (Friere, 1970;

Robertson, 1996), which would seek to simply "deposit" knowledge of fall prevention strategies into older peoples' minds, and toward a dialogic approach that garnered further trust in the therapeutic relationship. Such a dialogic approach to education encouraged service providers to act as *facilitators of learning* as opposed to *disseminators of knowledge* (Robertson, 1996), enabling greater trust in the therapeutic relationship and continued dialogue regarding risk-taking and caution in the daily lives of older clients.

A traditional "dissemination of information" approach to providing recommendations for older people, for example through individualized fall risk screening results (Ness, Gurney & Ice, 2003), educational pamphlets (Hakim, Roginksi, & Walker, 2007), and home modification suggestions (Wyman et al, 2007), is conventionally applied in community-based fall prevention care (Peel et al, 2008). In this approach educational material is given to the older client who is then instructed to use the material to make changes in his or her fall risk behaviour and home environment. While this strategy has shown benefits at reducing the risk of falling amongst older people in the community (Ness, Gurney & Ice, 2003; Hakim, Roginski, & Walker, 2007; Wyman et al, 2007), it does not address the potential importance of risk-taking in older peoples' lives. Instead, this approach focuses solely on reducing the risk of falling by minimizing risk-taking behaviour and eliminating risks in the home environment.

Such neglect of meaningful risk-taking as an important aspect of fall prevention initiatives may re-present the greatest difference between the educational strategies seen in many conventional approaches to community-based fall prevention, such as those just discussed, and the way preventive activities were enacted amongst service provider participants in this and other community-based studies (Green & Sawyer, 2010;

Mackenzie, 2009; Taylor, 2005). In this phenomenological study service providers were inspired by a caring orientation toward their older clients, encouraging meaningful risk-taking that affirmed important activities in their clients' lives. By educating older clients in ways that encouraged dialogue and critical reflection about the meaning and importance of risk-taking activities, service providers enabled older people to make informed decisions about fall risk and fall prevention as opposed to simply providing them with information and instructing them to make changes in their lives (Titterton, 2005). Through the co-construction and enactment of a trusting therapeutic relationship, service providers enabled themselves to act as *facilitators of learning* (Robertson, 1996) and participate in older clients' decision-making with respect to risk-taking and lived-caution for fall prevention. In so doing, service providers helped older clients to understand and negotiate the tension between affirming meaningful risk-taking and integrating caution into their everyday lives.

The experience of enacting careful practice for fall prevention conveyed by participants in this phenomenological study, as a facilitator of learning who encourages reflective dialogue on meaningful risk and caution in older peoples' daily lives, resonates strongly with a client-centered approach to care (Hughes, Bamford, & May, 2008; Law, 1995; Sumsion & Law, 2006). Client-centered care has been developed within the past few decades primarily in the occupational therapy literature (Hughes, Bamford, & May, 2008), and has come to include themes of seeking to balance power in the therapeutic relationship, communicating to enable informed decision-making, partnering with clients to encourage their active roles in care, and fostering hope that therapeutic goals will be met (Sumsion & Law, 2006). While client-centered care offers advantages over a

traditional biomedical approach to health care, it also should not be accepted as doctrine in the absence of critical reflection (Hughes, Bamford, & May, 2008; McWilliam, 2009). Specifically, client-centered care may neglect the ways in which social, political, and economic contexts shape the care decisions made by clients and the particular knowledge provided by the practitioner. As such, it may lead to the reification of existing paradigms of risk, health, and wellness, discouraging deeper reflection on the justifications older people believe they need for engaging in particular fall risk or fall prevention activities.

An approach to fall prevention education that moves beyond client-centeredness is one that emphasizes *transformative learning* for fall risk and fall prevention (Robertson, 1996). Transformative learning is understood as learning that facilitates deep critical thought regarding the very ways in which a learner understands a topic, transforming the paradigm or perspective from which the content or topic is viewed (Robertson, 1996). In transformative learning, learners understand the differences between their new paradigmatic orientation toward the topic in question and their old orientation, judging the new perspective as a more reflexive, self-aware approach to understanding important issues. Applied to educational approaches to fall prevention, taking a transformative learning approach would not only involve encouraging critical reflection on meaningful risk and meaningful caution in older clients daily activities, but would encourage a broader level of reflection on the social constructions of aging that contribute to the ways in which older people seek to live their lives. By encouraging such critical reflection as a *facilitator of transformative learning*, service providers may enter into an educational helping relationship with their older clients in order to foster a paradigm shift in the way they view fall risk and fall prevention (Robertson, 1996). In so

doing, service providers may enable older clients to understand fall risk and fall prevention in the context of a reflexive awareness of the social pressures they feel when making informed decisions regarding risk, caution, and fall prevention activities in their daily lives. Such an approach moves beyond fostering informed decision-making within an existing paradigm to foster an informed understanding of why such decisions are viewed as positive or negative in a particular paradigmatic context.

While service provider participants in this study were motivated by a phenomenological ethics of caring for older clients, encouraging further reflection on the ways in which they enact such care in their practice may foster a more transformative approach to fall prevention education (McWilliam, 2007; 2009). As service providers come to understand the social, political, and economic contexts that may impact their own approaches to community care, they may be better able to integrate their own critical reflection into the enactment of fall prevention services (McWilliam, 2007). In so doing, they may draw on more diverse bodies of evidence and ways of knowing to augment those typically underpinning biomedical or client-centered care, attending to qualitative inquiry exploring the centrality of identity to older peoples' experiences of living with fall risk and better understanding the non-rational or pathic ways in which older people comprehend fall risk and fall prevention (Ballinger, 2002; Hallrup et al, 2009; Hanson, Salmoni, & Doyle, 2009; Yardley et al, 2006). Integrating such insight into their fall prevention practice, service providers may be able to encourage older clients to engage in a deeper level of critical reflection regarding their motivations for taking risks and being cautious in their daily lives, promoting transformative learning of the ways in which older people understand fall risk and fall prevention. In so doing, service providers may enable

older people to shift their understanding of risk-taking and caution to devise personally relevant means of preventing falls that simultaneously affirm meaningful activities, reduce risks that are not situated in their lives in meaningful ways, and foster an *appreciative* understanding of the self-in-aging.

As such, implications of this phenomenological study for fall prevention knowledge translation initiatives suggest a larger role for critical, transformative reflection on the reasons service providers enact fall prevention in particular ways. Such critical reflection may enable the enactment of a more reflexive careful practice, encouraging both service providers and older people to understand their views of fall risk and fall prevention as situated within particular paradigms of risk, health, and well-being. Understanding the contexts that shape the paradigms from which we approach fall risk assessment and fall prevention may foster a transformative learning approach to fall prevention, encouraging a more appreciative perspective and mode of being for older people in the context of aging.

Conclusion

This study explored the meaning of the experience of enacting fall prevention services with older people in community outreach care, providing unique insight into how physiotherapists and other health service providers approach fall prevention with their clients. Findings suggest that taking a client-centered educational approach to fall prevention that emphasizes the importance of meaningful risk-taking to clients' quality of life and encouraging more trusting therapeutic relationships between clients and providers are important components of the meaning of the experience of enacting fall prevention with older people in the community. Emphasizing the centrality of caring to

service providers' experience of enacting fall prevention, this study provides unique insights into the ways in which service providers enact their caring orientation through carefully seeing the older person-in-context and enacting a trusting therapeutic relationship. Building upon these insights, deeper critical reflection on the reasons for engaging in particular fall risk assessment and fall prevention activities may encourage service providers to facilitate transformative learning with their older clients, achieving more reflexive and sensitive approaches to fall prevention education. Knowledge translation initiatives for community-based fall prevention may benefit from encouraging such reflection on the paradigms from which fall prevention is approached, moving beyond client-centeredness and toward a more critically reflective enactment of careful practice in community-based fall prevention.

References

American Physical Therapy Association. (2003). Guide to Physical Therapist Practice. Available at: http://guidetoptpractice.apta.org/content/current

Ballinger C. (2002). The construction of the risk of falling among and by older people. *Ageing & Society*, 22, 305-324.

Ballinger, C. & Payne, S. (2000). Falling from grace or into expert hands? Alternative accounts about falling in older people. *British Journal of Occupational Therapy, 63*(12): 573-579.

Baxter, P. & Markle-Reid, M. (2009). An interprofessional team approach to fall prevention for older home care clients 'at risk' of falling: Health care providers share their experiences. *International Journal of Integrated Care*, *9*: 1-12.

Brown, C., Gottschalk, N., van Ness, P., Fortinsky, R., & Tinetti, M. (2005). Changes in physical therapy providers' use of fall prevention strategies following a multicomponent behavioral change intervention. *Physical Therapy, 85*(5): 394-402.

Burgess-Allen, J. & Owen-Smith, V. (2010) Using mind mapping techniques for rapid qualitative data analysis in public participation processes. *Health Expectations,* 13, 406-415.

Buzan T. & Buzan, D. (2002) *The mind map book*. London: BBC Books.

Caelli, K. (2001). Engaging with phenomenology. Is it more challenging than it needs to be? *Qualitative Health Research, 11*: 273-281.

Campbell, J., & Robertson, M. (2006). Implementation of multifactorial interventions for fall and fracture prevention. *Age & Ageing, 35*: 60-68.

Canadian Physiotherapy Association. (2009). The Essential Competency Profile for Physiotherapists in Canada. Available at: http://www.physiotherapy.ca/PublicUploads/224032Essential%20Competency%20Profile%202009.pdf

Clarke, C. (2006). Risk and aging populations: Practice development research through an international research network. *International Journal of Older People Nursing, 1*(3): 1748-3743.

Coyne, I. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing, 26*: 623-630.

Edwards, N. (2011). Preventing falls among seniors: The way forward. *Journal of Safety Research, 42*: 537-541.

El-Faizy, M. & Reinsch, S. (1994). Home safety intervention for the prevention of falls. *Physical & Occupational Therapy in Geriatrics, 12*: 33-49.

Fortinsky, R., Baker, D., Gottschalk, M., King, M., Trella, P. & Tinetti, M. (2008). Extent of implementation of evidence-based fall prevention practices for older patients in home health care. *Journal of the American Geriatric Society, 56*: 737-743.

Friere, P. (1970). *Pedagogy of the Oppressed*. Continuum: New York

Green, D. & Sawyer, A. (2010). Managing risk in community care of older people: Perspectives from the frontline. *Australian Social Work, 63*(4): 375-390.

Hakim, R., Roginski, A., & Walker, J. (2007). Comparison of fall risk education methods for primary prevention with community-dwelling older adults in a senior center setting. *Journal of Geriatric Physical Therapy, 30*: 60-68.

Hanson, H., Salmoni, A., & Doyle, P. (2009) Broadening our understanding: Approaching falls as a stigmatizing concept for older adults. *Disability and Health Journal*, 2, 36-44.

Harper, T. (2012). Online etymology dictionary. Available at: http://www.etymonline.com/

Holloway, I., & Todres, L. (2003) The status of method: Flexibility, consistency and coherence. *Qualitative Research*, 3(3), 345-357.

Hughes, J., Bamford, C., & May, C. (2008). Types of centeredness in health care: Themes and concepts. *Medicine, Health Care, and Philosophy*, *11*; 455-463.

Kottow, M. (2001). Between caring and curing. *Nursing Philosophy, 2*: 53-61.

Laybourne A., Biggs, S., & Martin, F. (2008) Falls exercise and reduced falls rate: Always in the patients' interest? *Age and Ageing*, 37(1), 10-13.

Levinas, E. (1998). *Entre-nous: On thinking-of-the-other*. Columbia University Press: New York.

Lupton, D. (1993). Risk as moral danger: The social and political functions of risk discourse in public health. *International Journal of Health Services, 23*(3): 425-435.

MacKenzie, L. (2009). Perceptions of health professionals about effective practice in falls prevention. *Disability and Rehabilitation, 31*(24), 2005-2012.

McWilliam, C. (2007). Continuing education at the cutting edge: Promoting transformative knowledge translation. *Journal of Continuing Education in the Health Professions, 27*(2); 72-79.

McWilliam, C. (2009) Patients, persons, or partners? Involving those with chronic disease in their care. *Chronic Illness*, 5(4), 277-292.

Merleau-Ponty, M. (1962). *The phenomenology of perception*. Routledge: New York.

Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology, 11*(5): 799-808.

Ness, K., Gurney, J., & Ice, G. (2003). Screening, education, and associated behavioral responses to reduce risk for falls among people over age 65 attending a community health fair. *Physical Therapy, 83*: 631-637.

Northcott, N. (1996) Cognitive mapping: An approach to qualitative data analysis. *Nursing Times Research*, 1, 456.

Nortvedt, P. (2003). Levinas, justice, and health care. *Medicine, Health care, and Philosophy, 6*: 25-34.

Patton, M. (1990). *Qualitative evaluation and research methods*. Sage: California.

Peel, C., Brown, C., Lane, A., & Milliken, E. (2008). A survey of fall prevention knowledge and practice patterns in home health physical therapists. *Journal of Geriatric Physical Therapy, 31*(2); 64-70.

Robertson, D. (1996). Facilitating transformative learning: Attending to the dynamics of the educational helping relationship. *Adult Education Quarterly, 47*(1); 41-53.

Rorty, R. (1979). *Philosophy and the mirror of nature*. Princeton: Princeton University Press.

Rorty, R. (1982). *The consequences of pragmatism*. Minneapolis: The University of Minnesota Press.

Rorty, R. (1989). *Contingency, irony, solidarity*. Cambridge: Cambridge University Press.

Rubenstein, L. & Josephsen, K. (2002). Risk factors for falls: A central role in falls prevention. *Generations, 3*: 15-22.

Rubenstein, L. (2006). Falls in older people: Epidemiology, risk factors, and strategies for prevention. *Age & Ageing, 35*(S2): 37-41.

Scott, V. Lockart, S., Gallagher, E., Smith, D., Asselin, G., Belton, K. et al (2007). *Canadian falls prevention curriculum (CFPC)*. Vancouver: BC Injury Research & Prevention Unit.

Schutz, A. & Luckmann, T. (1973) *The structure of the life-world: Volume 1*. Northwestern University Press: Evanston.

Schutz A. (1953) Common-sense and scientific interpretation of human action. Philosophy *and Phenomenological Research*, 14(1), 1-38.

Scott, V., Gallagher, E., Higginson, A., Metcalfe, S., Rajabali, F. (2011). Evaluation of an evidence-based education program for health professionals: The Canadian Falls Prevention Curriculum. *Journal of Safety Research, 42*; 501-507.

Sumsion, T. & Law, M. (2006). A review of evidence on the conceptual elements informing client-centered practice. *The Canadian Journal of Occupational Therapy, 73*(3); 153-161.

Taylor, B. (2006). Risk management paradigms in health and social services for professional decision making on the long term care of older people. *British Journal of Social Work, 36*: 1411-1429.

Titterton, M. (2005). *Risk and risk-taking in health and social welfare*. Jessica Kingsley: London.

van Manen, M. (1990) *Researching lived experience: Human science for an action sensitive pedagogy*. The Althouse Press: London.

van Manen, M. (1999) The pathic nature of inquiry in nursing. In I. Madjar & J. Walton (eds) *Nursing and the experience of illness: Phenomenology in practice*. 17-35. London: Routledge.

van Manen, M. (2002). Care-as-worry, or "don't worry be happy". *Qualitative Health Research, 12*(2): 262-278.

van Manen, M. (2007) Phenomenology of practice. *Phenomenology & Practice,* 1(1), 11-30.

Wyman, J., Croghan, C., Nachreiner, N., Gross, C., Stock, H., Talley, K., & Monigold, M. (2007). Effectiveness of education and individualized counseling in reducing environmental hazards in the homes of community-dwelling older women. *Journal of the American Geriatric Society, 55*: 1548-1556.

Yardley, L., Donovan-Hall, M., Francis, K., & Todd, C. (2006) Older people's views of advice about falls prevention: A qualitative study. *Health Education Research*, 21(4)508-517.

Chapter Six: Discussion

The overall aim of this two-phase study was to enhance understandings and reflective awareness of the taken-for-granted meanings that characterize fall prevention services in community outreach care. In so doing I hoped to encourage and enable critical reflection on instrumentalist biomedical approaches to fall prevention, that consider only the fall and its consequences, inspiring approaches to community-based fall prevention wherein practitioners seek to affirm older peoples' dignity and worth. While the findings of this dissertation are relevant across professional disciplines, the primary aim was to provide insight into edifying the practice of physiotherapists enacting fall prevention with older clients.

This study took place within a medium-sized city in Ontario, Canada. Members of a community outreach team, who served older people residing in this medium-sized city as well as a larger catchment area including both rural and urban communities, participated in this study. The older people who participated in the study resided within the urban community served by the outreach team. While the findings from this two-phase study are not generalizable across contexts in the conventional post-positivist sense, they provide unique insight into the pre-reflective meanings that characterize the natural attitude of fall risk assessment and fall prevention as they unfold in community outreach care.

Summary of Study Findings

The findings of the first phase of this study re-present the gestalt meaning of the experience of anticipating falling amongst older people as confronting *lived-identity* in the context of aging. Older people sought to continually enact their identities in aging by

performing meaningful activities and *inter-subjectively portraying their self image*. It was through engaging in these dual methods of constituting lived-identity that older people were enabled to continually *strive for health and independence*. Older people *experientially learned* the meaning of falling, emphasizing the salient experiences they or others close to them had lived-through in understanding falls and their consequences. Participants experienced the meaning of anticipating falling integrally with their experience of confronting their lived-identity. Hence, they described the experience of *vulnerability, anxiety, and/or caution,* seeking out ways to continue to enact their lived-identity along with and despite living with risk of falling. Enacting lived-caution enabled older people to continue to live-through their identities in aging.

The findings of the second phase of this study re-present the gestalt meaning of providers' experience of enacting fall prevention with older people in the community as one of *enacting careful practice*. Careful practice was understood in relation to the dual etymological meanings of the term "careful", including both *caring fully* and *carefully seeing the older person-in-context*. Caring fully meant *focusing* community outreach practice on older peoples' *meaningful concerns* as well as *re-cognizing risk* to understand the meaningful everyday risk-taking that may contribute to older people's quality of life. Enacting careful practice meant *enacting the therapeutic relationship,* which was essential to the experience of engaging older people in fall prevention. Service providers *fostered relational trust* with older clients in order to *engage in reflective dialogue* focused on helping older people to understand meaningful risk and meaningful caution in their everyday lives. Enacting careful practice was learned experientially by service providers through their experience of *practice within an inter-professional team,*

encouraging their continued reflection on their approaches to engaging older people in fall prevention.

Summary of Key Insights

The findings of this two-phase study give rise to a number of key insights that will be the focus of this discussion chapter. The first key insight I will address from the study findings is the centrality of a pathic sense of caring to the experience of enacting fall prevention with older people, re-presenting service providers' understanding of and reflection on their older clients' lived-experience of aging and fall risk. Inspired by authentic caring for older clients, service providers were enabled to *ethically* enact fall prevention practice. When service provider participants enacted fall prevention that was inspired by and arose out of their ethics of caring for older clients, they moved beyond instrumentalist approaches that neglect to consider the broader implications of fall prevention interventions in the meaningful lives of older people. Additional critical reflection on the implications of a phenomenological ethics of caring in older peoples' lives may support a more critically reflexive and understanding approach to fall prevention in the community.

The second key insight I will address is the centrality of lived-identity to the experience of anticipating falling amongst older people living in the community. Findings emphasize the importance of service providers broadening the focus of their community-based practice and understanding how risk-taking, caution, and other fall prevention activities may relate to lived-identity and quality of life for older people. This insight reveals the criticality of moving beyond the instrumentalist concern to reduce risk and

prevent falls, taking a more critically reflective approach toward emphasizing lived-identity throughout fall prevention activities.

The third insight illuminates the importance of meaningful risk-taking. As findings in both phases of this dissertation addressed the importance for older people of performing meaningful activities, even when such activities may put them at risk of falling, affirming *meaningful* risk-taking may be an essential element of enacting a more sensitive, tactful approach to fall prevention. While such a client-centered approach to fall prevention has advantages over traditional biomedical approaches, further critical reflection on social constructions of aging may encourage service providers and older people to better understand the tacit assumptions involved in striving to engage in particular risky and cautious activities.

Finally, the centrality of experiential learning to understanding the meaning of falling for older people may be instructive for service providers in the assessment of fall risk, which these insights suggest may require more sensitivity than the assessment process characteristically reflects. As the anticipation and consequences of falling are understood by older people in both cognitive and non-cognitive ways, it may be important for service providers to explore older clients' previous experiences related to falling and their pathic understanding of these experiences. Understanding the salient, meaningful nature of experiential learning with respect to falling and fall risk may help service providers to better understand their clients' meaningful concerns, particularly with respect to risk-taking and caution in daily life.

Overall, these insights suggest the importance of moving beyond biomedical and client-centered approaches to education for fall prevention to serve as a *facilitator of*

learning, fostering *transformational learning* (Robertson, 1996) amongst older people related to fall prevention. A transformational learning approach, seeking a shift from a "having" paradigm to a "being" paradigm in relation to lived-identity (Fromm, 1976; Robertson, 1996), may foster the co-construction of fall prevention strategies that affirm older peoples' subjective experience while encouraging a more *appreciative* understanding of risk-taking, caution and lived-identity in daily life. In the following sections I address each of these insights in the context of other literature on these topics, and then bring the findings from the two phases of the study together to establish implications for community-based fall prevention amongst physiotherapists and other service providers. I will then discuss these key insights in terms of their implications for fall prevention best practices, knowledge translation, education, and policy for physiotherapists in contemporary community-based health care.

Study Limitations

This study was completed within a particular socio-political community health and falls prevention programming context at a particular time in a medium-sized Canadian city, and must be understood within this context. The findings cannot be considered generalizable to older people or service providers more broadly, as they have been co-constructed in collaboration with participants and senior researchers within this particular context. The first phase of the study included older people living independently in the community as participants, and thus the insights derived from this first phase are primarily relevant for older people who live independently at home. The second phase of the study included members of a geriatric-specific community outreach team as participants. Thus, their experience was contextualized by different socio-political and

funding pressures than typical community-based health care funded by the Community Care Access Centers (CCAC). While insights may be gained from this two-phase study to inform the practice of physiotherapists working in primary and community-based health care settings more generally, the findings cannot be said to re-present the experience of physiotherapists or other service providers who work in the context of CCAC-funded health care. In addition, the findings of this dissertation did not raise the issue of structured exercise and other approaches to fall prevention that may be relevant in community care, as participants did not address such specific elements of fall prevention programs as meaningful aspects of their experiences in the community. Finally, in applying an interpretive phenomenological approach in this study I re-cognize the ineffable character of the meaning of lived-experience, and will thus always fall short of re-presenting the experience as it is genuinely lived by participants. Through evocative writing I have attempted to achieve resonance with readers. However, no claims to the accurate re-presentation of the lived-experiences may be made in the context of interpretive phenomenology.

Key Insights

The Centrality of Caring to Community-Based Fall Prevention

The experience of caring fully was essential to engaging older people in community-based fall prevention for participants in the second phase of this study. While practitioners were engaged in the co-construction of fall prevention services to encourage safe and independent living, it was a pathic orientation toward caring for the client that drove their efforts toward fall prevention as opposed to an instrumental orientation toward changing the older person's behaviour. Such an orientation toward caring for their

clients focused practitioners' attention on older peoples' wants and needs as understood through meaningful dialogue. It was only after engaging in dialogue and coming to understand the meaningful concerns of older clients that service providers began to inquire about risk-taking and fall prevention in daily life. Service provider participants' experience of caring resonates with a phenomenological ethics of care (Levinas, 1998; Nortvedt, 2003; van Manen, 2002), placing the pathic notion of care at the center of their efforts to enter into their clients' life-contexts in order to enact fall prevention while better understanding and caring for their clients. Emphasizing and cultivating this caring orientation may encourage a more ethical, reflective approach to fall prevention for physiotherapists working with older people to prevent falls.

The experience of authentic care and concern for clients' well-being has been suggested as central to expertise in physiotherapy practice (Jensen, Gwyer, Shepard, & Hack, 2000; Resnick & Jensen, 2004), raising questions about the meaning of caring amongst physiotherapists. Caring is fundamentally constituted by affective, emotive dimensions that are put into practice in the course of physiotherapy care (Greenfield, 2006). Such affective drive to express care and concern for clients is intimately bound up with a strong ethical orientation toward understanding and meeting clients' needs (Davis, 2005; Peloquin, 2005). While ethical behaviour is typically understood in terms of conformity to conventional ethical principles such as autonomy, justice, and beneficence (Peloquin, 2005), a less principled and rationalistic tone is expressed by therapists in the context of a caring orientation toward physiotherapy practice (Davis, 2005; Greenfield, 2006; Greenfield & Jensen, 2010). Exploring this pathic caring orientation as understood in physiotherapy may help to provide further insight into the ethical enactment of fall

prevention, fostering approaches to preventing falls that emphasize and attend to the meaningful concerns of each unique older person.

In an interpretive narrative study of the meaning of caring among five physiotherapists with over 10 years of practice experience, Greenfield (2006) found that participants lived-through an ethics of caring in their everyday practice. This meant fostering meaningful affective connections with clients in order to better understand their experiences of illness and disability (Greenfield, 2006), hence, more sensitive understanding of their clients' needs. Consistent with the findings of my phenomenological study, an ethics of caring did not mean conformity to external ethical principles, but rather an orientation toward creating an emotional and cognitive understanding with clients in order to best meet their needs.

The uncovering of such emotional and cognitive understanding as central to an ethical orientation to care has also occurred in the context of *empathy* as a moral disposition toward physiotherapy practice (Davis, 2005; Peloquin, 2005). In a phenomenological study on the experience of empathy among physiotherapists, Davis (2005) found that it was only when therapists lived-through the experience of authentic empathy with clients that they moved beyond a rule-based ethical model toward a true caring relationship with their clients. Empathizing with clients was not understood in a simplistic or instrumentalist way, but in terms of an authentic emotional and cognitive connection and understanding with clients as the focal point of physiotherapy care (Davis, 2005). Consistent with the findings of my study, this research suggested a truly empathetic approach involves "crossing over into the lived experience of the other"

through dialogue and imagination (Davis, 2005, p. 216), and then returning to one's own lived-experience with a deeper sense of understanding that informs efforts to care.

The process of seeking to understand the lived-experience of the client in affective, empathetic ways, as conveyed by service providers in this dissertation, resonates strongly with a phenomenological ethics of care. The phenomenological ethics of Emmanuel Levinas (1998) suggests that an affective sensibility is crucial to understanding the lived-experience of the other, and this empathetic understanding is the foundation on which ethical health care rests (Nortvedt, 2003; 2008). As such, an ethical orientation toward caring in physiotherapy may not be best understood as focused on conformity to ethical principles, but as emerging from the affective, empathetic understanding of the lived-experience of the client. As the findings of my study reveal, enacting a phenomenological ethics of care may enable physiotherapists to better understand their clients' life-contexts and needs, and thus provide more sensitive and tactful fall prevention services. In so doing, they may move away from approaches to fall prevention that focus solely on the outcome of preventing falls, and instead seek to understand and address the meaningful concerns of their clients in more authentic ways. Furthermore, encouraging additional critical reflection on the implications of a phenomenological ethics of caring may foster a deeper understanding of the social constructions of aging bound up in fall prevention care, encouraging a more reflexive approach to enacting fall prevention with older people in the community.

The Centrality of Lived-Identity to Anticipating Falling

For older people living independently in the community in the first phase of this dissertation study, the experience of anticipating falling meant confronting their lived-

identity in the context of aging. As described in earlier chapters of this dissertation, the term anticipation is being used to refer to the thoughts and emotions that characterize the experience of expecting an event to occur in the future (Poli, 2010). The thoughts and emotions that characterized the experience of expecting falls to occur were understood in relation to older peoples' capability to continue enacting their lived-identities while living with the impression that they may be at risk of falling. In this way, preserving and enacting their identities was conveyed to be the most important consideration in aging, and anticipating falling was understood in terms of its possible consequences for the ability to continue to preserve and enact identity. Re-cognizing the centrality of lived-identity to the experience of anticipating falling may help health service providers to better understand the lived-experience of the older people with whom they work in the community to prevent falls, encouraging a more sensitive, caring, and ethical approach to engaging older people in fall prevention services.

A number of other qualitative studies exploring older peoples' views and experiences of fall risk and fall prevention have found identity to be a central concern in understanding the meaning of falling (Ballinger, 2002; Horton, 2006; McInnes, Seers, & Tutton, 2011; Stewart & McVittie, 2011; Yardley et al, 2006). In a meta-ethnography synthesizing qualitative studies exploring older peoples' views of falling and need for fall prevention interventions, McInnes, Seers, and Tutton (2011) found that older people were focused on lifestyle and identity in their views of fall risk, in contrast to health professionals' focus on assessing risk and implementing prevention strategies. Consistent with my dissertation findings, these authors found that older people felt that admitting their risk of falling would mean recognizing a change in their identity. Together with my

findings, this research illuminates how and why older people might ignore or reject suggestions that they may be at risk of experiencing a fall. Findings from other qualitative studies also have suggested that older people feel as though health care providers neglect to consider their most important concerns when seeking to help them prevent falls, as actions of service providers may create further difficulties in older peoples' efforts to preserve and enact their sense of self and identity (Ballinger, 2002; Stewart & McVittie, 2011; Yardley et al, 2006). Thus, the findings of this dissertation reinforce previous research suggesting that critical reflection on and understanding of the centrality of lived-identity to older peoples' experience of anticipating falling may help health service providers to engage older people in fall prevention in ways that *affirm* their lived-identities, enacting a more caring practice in community care.

While previous qualitative studies have suggested that identity is an important consideration for older people in the context of fall risk and fall prevention, the findings of this dissertation study provide further insight into a specific understanding of lived-identity that may be of concern for older people in their experience of anticipating falling. The theme "lived-identity" in this dissertation study re-presents the active living of identity in daily life, conveying the ongoing constitution of identity for older people as they act in ways that reinforce and re-create their sense of self. Participants described two primary ways in which they lived out their identities: performing meaningful activities and inter-subjectively portraying their self-image. Neither of these dual methods of constituting lived-identity could be considered to be generally more important than the other, as it was through the continual enactment of both methods that it was possible for older participants to live-through their identity.

In this dissertation, older participants' experience of anticipating falling meant confronting these elements of lived-identity and their continual constitution in everyday life, understanding falling and fall prevention in terms of threats to their capabilities to continually enact their lived-identity. These findings suggest that physiotherapists working with older people to prevent falling may refine their practice by re-cognizing that their actions with respect to fall risk assessment, fall risk education, and fall prevention interventions are integral to older peoples' lived-identity. Furthermore, integrating into fall prevention practice a reflexive understanding of the ways in which social constructions of aging may contextualize the imagined ideals of lived-identity for older people may encourage an approach to fall prevention that fosters a more reflexive understanding of lived-identity in daily life. Such reflexivity and re-cognition of the social construction of lived-identity and its centrality to the experience of anticipating falling may be an important element of an authentic caring orientation toward fall prevention services.

Meaningful Risk-Taking

Best practices for fall prevention in the community suggest the limitation of risk-taking activities in order to decrease the chances an older person will experience a fall (Scott et al, 2007). Such an instrumentalist orientation to removing risk from older peoples' lives neglects to consider how risk-taking may be an essential aspect of older people's meaningful activities, and thus an essential element of their embodied lived-identities (Katz, 2011).

A number of qualitative studies have suggested that older people may choose to engage in activities that put them at risk of falling despite their awareness of the

consequences of falling (Ballinger, 2002; Hallrup, Albertsson, Tops, Dahlberg, & Grahn, 2009; Lee, Mackenzie, & James, 2008; Ward-Griffin, Hobson, Melles, & Kloseck, 2004; Yardley, Donovon-Hall, Francis, & Todd, 2006). Consistent with the findings of this dissertation, Ward-Griffin et al (2004) found that older people experienced conflicting forces driving their actions related to fall prevention, as they sought to remain cautious in daily activities in order to prevent falling while maintaining their independent activities. The ability to maintain activities at times meant taking risks, as risk was seen as inherent in many important life activities (Ward-Griffin et al, 2004). Furthermore, such risk-taking was viewed by some older participants as central to their enactment of identity in social contexts (Ballinger, 2002; Yardley et al, 2006), further supporting the findings of this dissertation that risk-taking may be essential to the experience of enacting lived-identity in the context of aging.

In the second phase of this dissertation study, health service providers suggested that they re-cognized risk in the context of the meaningful lives of their older clients, such that meaningful risk-taking was affirmed in their lives for its contributions to quality of life. Such an orientation suggests critical reflection about the meaning of risk-taking in older peoples' lives and an emphasis on authentic caring for older clients' quality of life. Additionally, however, as opposed to merely affirming risk-taking in older peoples' lives, participants in the second phase of this study engaged older people in dialogue in order to ensure that they understood the risks they were taking in their daily lives and the potential implications of experiencing a fall. This approach to education through dialogue in the context of the therapeutic relationship sought to enable "voluntary risk-taking" (Titterton, 2005), in order that older people may understand the implications of the risks they take in

daily life when making informed decisions about activities deemed "risky" by health service providers.

While the approach taken by service providers in the second phase of this dissertation study reflects a focus on older clients' meaningful concerns from a client-centered perspective, service providers neglected to consider the broader social constructions of aging that contribute to older peoples' understandings of identity, risk and caution in daily life. Engaging in deeper critical reflection regarding the social, political, and economic contexts that may construct older peoples' ideals of identity and risk may help health service providers to approach fall prevention in more sensitive, tactful ways. By understanding the ways in which older clients may seek to live up to socially constructed criteria for "successful aging", service providers may be enabled to encourage deeper critical reflection through dialogue with older clients regarding their tacit assumptions involved in seeking out particular risk-taking activities. In so doing, service providers may be able to encourage deeper critical reflection in dialogue with their clients, affirming a more reflexive and appreciative understanding of the inter-relation between lived-identity and risk-taking in older peoples' daily lives.

Experiential Learning

As the findings of this dissertation suggest, having lived through a fall constituted the most profound learning informing older peoples' immediate experience of anticipating falling. In addition, observational or vicarious learning from witnessing peers or similar others experience a fall and its consequences also contributed to their understanding of the meaning of the experience of anticipating falling. As falling led to the observable disruption of lived-identity, and in extreme cases death of similar others,

participants came to understand how experiencing a fall may impact their own lives. By contrast, those who had not experienced a meaningful fall that interrupted their ability to enact lived-identity, and had not witnessed similar others experience a fall and its consequences, did not discuss anticipating falling in terms of expecting a fall to occur. Instead, they denied the experience of thinking about or imagining a fall occurring, undermining caution in daily activities that may help to prevent falls.

Findings from other qualitative studies exploring the experience of living through a fall have suggested the profound impact a fall may have on the lives of older people. A number of studies have suggested that the consequences of falling are understood by older people primarily in an emotional context, evoking feelings of shame, embarrassment, anxiety, and powerlessness (Aminzadeh & Edwards, 1998; Host, Hendrikson, & Borup, 2011; Kong, Lee, Mackenzie, & Lee, 2002; Mahler & Sarmivaki, 2010; Porter, 1999; Stewart & McVittie, 2011). Such emotional interpretations of the experience of falling resonate with the pathic nature of the meaning of the experience of anticipating falling found in this dissertation, suggesting that consideration of the non-cognitive, emotional aftermath of falling is an essential element of understanding the experience of falling and anticipating falling. Studies exploring fear of falling amongst older participants found that those with the most salient fear of falling had experienced an injurious fall (Huang, 2005; Lee, Mackenzie, & James, 2008; Porter, Mustada, & Lindbloom, 2010; Tischler & Hobson, 2005), further resonating with the findings of this dissertation. Understanding the emotional experiential response to living through a fall, particularly that of fear of falling, may be crucial to supporting older people in efforts to prevent falls in sensitive and tactful ways. When working with older people who have

experienced a fall, health service providers may enact more sensitive fall prevention by seeking to understand the pathic experience of previous falls and anticipating falling and the ways in which these experiences inform older peoples' actions and decisions with respect to risk-taking and caution in daily life.

Qualitative studies also have suggested that some older people neglect to consider fall prevention advice because they believe it does not apply to them personally (Calhoun et al, 2011; Evron, Schulz-Larson, & Fristrup, 2009; Yardley et al, 2006). A key insight uncovered by this dissertation is that without having experienced a fall themselves, or having witnessed similar others experience a fall, older people may not re-cognize their potential susceptibility to falling and thus may not understand the relevance of fall prevention education. In addition, some older people may believe that falls are simply not preventable, and as such fall prevention activities are not worth the time and effort required (Evron, Schulz-Larson, & Fristrup, 2009; Huang, 2005). As physiotherapists and other community-based providers engage older people in dialogue regarding fall risk and fall prevention, understanding the meaning of any previous experiences with falling and subsequent beliefs about fall risk and fall prevention may help them to approach fall prevention in more understanding, empathetic, and sensitive ways.

Implications of Key Insights

Implications for Fall Prevention Practice

An interpretive approach to social inquiry suggests that the social, political, and economic contexts and social practices that shape our interpretations ought to be reflexively understood by researchers as we engage in qualitative research (Schwandt, 1998; Finlay, 2002; van Manen, 1990). An approach to the practice of fall prevention that

emphasizes the pathic understanding, or interpretation, of the meaningful experiences of older people may also be advanced by a more reflexive understanding of the ways in which such contexts shape the assumptions and paradigm(s) that underpin fall risk assessment and fall prevention practice. Inspired by a phenomenological ethic of caring, service providers in this dissertation sought to engage older people in dialogue in order to understand how fall risk may be situated in clients' lives in meaningful ways. Such dialogue may be understood in the context of efforts to "cross over" into the experience of the other (Davis, 2005) in order to more fully understand the meaning of their experience of fall risk and fall prevention, drawing upon a fundamentally interpretive and relational process (McWilliam, 2009). Bound up in this interpretive process are not only interpretations of the meaning of the experience of fall risk and fall prevention for older people, but the social, political, and economic meanings that inform and shape both practitioners' and older peoples' interpretations of fall risk and fall prevention.

The phenomenological ethic of caring that inspired service providers' approach to community outreach care in this dissertation encouraged a client-centered approach to fall prevention, in which service providers engaged older clients in dialogue to affirm voluntary risk-taking and encourage lived-caution whenever possible. The client-centered approach to care involves the practitioner-as-expert, who applies his or her professional knowledge to enact client-determined interventions *to* and *for* the client in the context of the therapeutic relationship (Hughes, Bamford, & May, 2008; McWilliam, 2009). While a phenomenological ethic of caring for older clients may seem to encourage such an expertise-driven model of care, in which practitioners provide their skills and knowledge in order to *help* the client, deeper reflexivity and reflection regarding the social

constructions of aging and fall risk may help to inform approaches to fall prevention care that move beyond the provision of expertise through dialogue.

Specifically, placing the experience of anticipating falling in the context of social constructions of lived-identity and risk-taking for older people may help practitioners to re-cognize how fall prevention interventions may reproduce particular ideals and understandings of identity in aging. By re-cognizing such insight, practitioners may be encouraged to move beyond a client-centered approach to fall prevention and engage older clients in dialogue in order to foster *transformative learning* (Robertson, 1996) for fall prevention. In so doing, service providers may foster a more *appreciative* understanding of risk-taking and caution for their contributions to constituting a *being mode* of lived-identity as opposed to a *having mode* (Fromm, 1976) in everyday life. Such an approach to fall prevention that fosters a paradigm shift toward a *being mode* of lived-identity may encourage a more appreciative understanding of fall prevention activities, understood in terms of how these activities *enable* lived-identity for older people as opposed to what they *prevent* from occurring (i.e. falls).

For Fromm (1976), the social, political, and economic contexts of a consumerist-driven society tend to orient peoples' understanding of the world toward the *having* mode, or paradigm, of existence. When lived-identity is commodified and sought as a consumerist indicator of status or value, the self may only be appreciated when living up to socially-derived expectations of the performance of particular activities and portrayal of self-image in particular ways. This image of lived-identity in the having mode of existence is supported by empirical and theoretical work in social gerontology exploring social constructions of identity in aging. By orienting their understandings of self and

efforts to enact lived-identity toward achieving and accumulating indicators of "positive aging", older people are positioned in the *having mode* of existence and reify consumerist-derived understandings of identity in aging (Biggs, 2001; Gilleard & Higgs, 2000; Katz, 2005; Katz & Laliberte-Rudamn, 2005; Twigg, 2006). When such consumerist-derived ideals of identity in aging are taken-for-granted by practitioners and older people in community-based fall prevention, the opportunity to enact a more reflexive and meaningful ethics of caring that focuses on older peoples' lived-identity is lost. Furthermore, taking the social construction of "positive aging" for granted may reinforce service providers' and older peoples' understanding of risk-taking and caution in the context of a *having mode* of lived-identity, further commodifying identity in aging and limiting possibilities for a more *appreciative* understanding of risk-taking, caution, and lived-identity.

Conversely, by emphasizing authentic and meaningful lived-experience in daily life a person may be able to orient him or herself toward the *being mode* of existence (Fromm, 1976) and appreciate his or her activities and portrayal of self-image (and thus lived-identity) without relying on dominant recourse to consumerist-derived comparators. For physiotherapists and other health service providers working with older people to prevent falling in the community, such an emphasis on meaningful lived-experience focused on *appreciation* as opposed to social comparison may contribute to the development of an educational helping relationship that enables older peoples' transformative learning.

By understanding fall risk in terms of empowering meaningful activities through lived-caution (as in the *being mode*) as opposed to the possession and elimination of risk

(as in the *having mode*), physiotherapists and other service providers may enable lived-identity by affirming meaningful risks in older clients' lives. Such affirmation of meaningful risk-taking and lived-identity in the lives of older people emphasizes and affirms subjective experience, enabling the co-construction of fall prevention strategies that seek to minimize (as opposed to eliminate) fall risk that does not contribute to lived-identity in meaningful ways. Furthermore, service providers may encourage deeper critical reflection on the meaning of risk-taking activities in older peoples' lives, encouraging them to consider their most fundamental orientation toward understanding risk and caution. Through critical reflection, the client and provider in partnership may affirm risk-taking that resonates with an appreciative *being mode* of existence and minimize risks resonating with a *having mode* of existence, thus fostering a transformative approach to education for fall prevention. In so doing, fall prevention may be enacted in ways that encourage lived-caution in daily life while nonetheless encouraging meaningful risk that contributes to the appreciative experience of lived-identity for older people.

For service providers in the second phase of this dissertation, engaging older people in dialogue was central to enacting the therapeutic relationship, and thus to enacting fall prevention in the community. The language used to interpret and describe fall risk with older people, essential to dialogue regarding fall risk and fall prevention, constitutes particular understandings for older people in their experience of anticipating falling. Understanding the potential importance of the fall risk and fall prevention language service providers use in dialogue with older people may help practitioners to re-cognize the ways in which they shape older peoples' lived-identities in the context of a

having mode or *being mode* through interactions regarding fall risk and fall prevention. In so doing, service providers may seek to re-orient the language they use when engaging older people in dialogue regarding fall risk and fall prevention in order to foster lived-identity in the *being mode* as they enact fall prevention in the community.

While the differences between these two "modes of existence" or paradigmatic orientations toward being-in-the-world (*having* versus *being*) are presented as dichotomous, it is important to remember that no person is ever entirely situated within either paradigm exclusively (Fromm, 1976). Instead, we are situated in the tensions between these contrasting ways of being. As such, service providers might understand their approaches to educational dialogue for fall prevention as encouraging movement toward the *being mode* in the context of the many other competing forces that contextualize our understandings of lived-identity, risk-taking, and caution in daily life.

Implications for Fall Risk Assessment

Within the conventional biomedical paradigm, fall risk assessment is discussed in terms of identifying risk factors and understanding their cumulative and interactive effects on increasing the likelihood that a fall will occur (Tinetti, 2003; Rubenstein, 2006). Many approaches to fall risk assessment discussed within the physiotherapy literature predominantly rely on identifying physiological and behavioural risk factors in order to separate "fallers" from "non-fallers" (Lord, Menz, & Tiedemann, 2003). Such approaches to assessing and understanding fall risk amongst older people rely on abstract quantitative thresholds to determine whether a person is at risk, assuming a naively simplistic conception of meaningful life activity for older people. By labeling meaningful risk-taking amongst older people as a mere behavioural risk factor for falling, biomedical

approaches to fall risk assessment strip life activity of its personal meaning and neglect the impact of the drive to enact lived-identity on an older person's risk for falling.

Service provider participants in the second phase of this study suggested that an assessment in community outreach care is an ongoing dialogue with older people in an effort to understand how medical, social, historical, and experiential meanings interact to put a person at risk for falling. This dialogue, inspired by an ethics of caring fully for the client, was focused on understanding how an older person had come to present in a particular way and the ways in which the service provider could help to affirm his or her lived-experience while contributing to the prevention of falls. As suggested by the findings of this study, fall risk assessment ideally includes understanding the interplay between fall risk factors, but also a deeper level of understanding the meaning and significance with which older people experience those "risk factors" in their lives.

A major implication for fall risk assessment practice is that "history of falling" would ideally be transformed from a simple quantitative risk factor into a conversation about the *pathic, non-cognitive* meaning and significance of the fall experience and its implications for risk-taking and lived-caution in the older person's life. Framing fall risk assessment as understanding the meaning and significance of the interplay of "fall risk factors" in the lived-experience of older people may help health service providers to carefully see the older person-in-context, seeking a deeper understanding of the meaning of fall risk and fall prevention in his or her everyday life. Such a deeper understanding may be essential to gaining insight into how an older person views their enactment of lived-identity, thus providing a starting point for fall prevention dialogue that seeks

transformative learning and fosters a shift from a *having mode* to a *being mode* of lived-identity in daily life.

Implications for Fall Prevention Best Practices

Best practice models for fall prevention, such as the Canadian Falls Prevention Curriculum (CFPC) discussed in the introduction to this dissertation, place behaviour change at the center of fall prevention practice (Scott et al, 2007). Key insights from this dissertation suggest that such approaches to fall prevention lack resonance both with the meaningful experiences of older people anticipating falling and community-based service providers who enact fall prevention services. As described in the introductory chapter to this dissertation, the CFPC encourages practitioners to assess biological/intrinsic, behavioural, social/economic, and environmental fall risk factors, considering how interventions may be organized to address risk factors in each of these categories (Scott et al, 2007). However, the CFPC neglects to consider how these risk factors may be situated in older peoples' lives in meaningful ways, and hence how they may contribute to older peoples' enactment of lived-identity and quality of life. As such, best practice models such as the CFPC may obstruct efforts to encourage service providers to enact a more sensitive, artful and tactful approach to fall prevention practice, wherein meaningful experiences of risk are affirmed for their contributions to lived-identity and quality of life.

Health service providers in this dissertation suggested that caring fully for older clients was more essential to their experience of enacting fall prevention than the instrumentalist motivation to simply decrease instances of falls, and as such they sought to affirm meaningful risk-taking in older clients lives. In the context of a transformative

learning approach to fall prevention, service providers would further encourage meaningful risk-taking that contributes to a *being mode* of lived-identity for older people. Such approaches to fall prevention are inspired by a phenomenological ethic of caring, which precludes an instrumentalist orientation toward changing risk-taking behaviour in order to prevent falls. As such, best practice documents such as the CFPC may be contrary to the ethical orientation of community-based service providers, and may need to be revised to consider a more reflexive understanding of the ethical elements of enacting fall prevention with older people. In order to accomplish this goal, developers of best practice guidelines may need to consider the social, political, and economic contexts that shape their decisions regarding the particular types of evidence that are considered as valuable contributions to best practices for fall prevention. In so doing the may seek to integrate evidence that reflects the meaningful lived-experiences of older people and health service providers with the conventional biomedical body of literature that composes best practice guidelines.

Implications for Fall Prevention Knowledge Translation

While a great deal of research exists regarding effective ways to prevent falling amongst older people living in the community (Scott et al, 2007; Edwards, 2011), when and how this body of research is applied is in dire need of critical debate. Conventional discussion in academic literature about the evidence base for fall prevention practice by health service providers takes a distinctly instrumentalist tone, focusing primarily on how to foster better uptake of existing research as opposed to critically questioning when, why, and how to apply such research with older people in the community. Findings from this dissertation suggest that critical reflection regarding the implications of a

phenomenological ethic of caring, the centrality of lived-identity to the experience of anticipating falling, the importance of meaningful risk-taking, and the meaning of experiential learning may contribute to more sensitive, artful, and tactful approaches to fall prevention. As such, approaches to knowledge translation that encourage critical reflection on the primarily biomedical body of evidence for fall risk assessment and fall prevention, and further reflection on the above-stated key insights of this dissertation, may more aptly contribute to promoting more informed and understanding approaches to community-based fall prevention.

Knowledge translation initiatives that seek to encourage critical reflection to foster more sensitive, artful, and tactful approaches to fall prevention may take a transformative approach, emphasizing attention to the social, political, and economic contexts that mediate service providers' interpretations of research evidence, aging, fall risk, and fall prevention. Transformative knowledge translation (McWilliam, 2007) is an approach that considers critical reflection to be central to the knowledge translation process, understanding that research evidence will always be situated within the experiential knowledge and social and organizational contexts in which health service providers practice. Drawing on tenets of transformative knowledge translation, community-based service providers may be encouraged to engage in critical reflection regarding the ways in which the social contexts of health care inform their approaches to fall prevention practice. This may involve reflexive discussion and self-reflection exploring the social, political, and economic assumptions that are integrated into their taken-for-granted meanings of aging and fall risk. In so doing, practitioners may develop a broader understanding of the nature of research evidence, conscientiously integrating

quantitative biomedical research evidence and qualitative evidence exploring older peoples' lived experiences into their experientially learned practice knowledge. Such an approach to knowledge translation may be integral to fostering service providers' understanding of the differences between a *having mode* and a *being mode* in relation to fall risk and fall prevention, encouraging a more transformative approach to community-based fall prevention.

Implications for Education of Physiotherapists

Encouraging the depth of critical reflection necessary to achieve a transformative approach to fall prevention that emphasizes lived-identity and affirms meaningful risk in clients' lives may be best situated within a broader understanding of the various types of knowledge practitioners may use to inform their practice. Contemporary entry-level education for physiotherapists does not emphasize the difference or complementariness of various ways of knowing as they apply to physiotherapy practice (Edwards et al, 2004; Greenfield et al, 2008), and as such does not encourage critical reflection on the application of conventional biomedical knowledge in relation to experiential, reflective, or narrative ways of knowing. As a diversity of ways of knowing have been suggested as central to physiotherapy practice more generally (Edwards et al, 2004; Edwards & Richardson, 2008; Shaw & DeForge, 2012), entry-level physiotherapy education may better serve physiotherapists by more thoroughly introducing the different types of knowledge that inform and arise from physiotherapy care. In so doing, educators may enable physiotherapists to better understand the value of critical reflection and alternative ways of knowing that focus on understanding the experience of the client, fostering

greater sensitivity to concerns such as lived-identity and meaningful risk-taking in physiotherapy practice.

Notwithstanding the potential challenges associated with encouraging critical reflection and understanding of such transformative approaches to fall prevention amongst entry-level physiotherapists, the critical reflection that arises from an emphasis on lived-identity is relevant to the education of physiotherapists beyond fall prevention specifically. While this dissertation found that lived-identity was central to understanding the experience of anticipating falling, it may be an important consideration in the rehabilitation process more generally (Davis, 2005; Nichols & Gibson, 2010). Encouraging entry-level physiotherapy students to inquire as to how their clients' lived-experiences with illness or disability impact their lived-identities may help to foster a more sensitive and empathetic approach amongst physiotherapy students (Davis, 2005; Peloquin, 2005). While further inquiry will help to illuminate the importance of identity to the experience of rehabilitation, emphasizing lived-identity may help to provide guidance to students in their experiential learning of an empathic and person-centered approach to physiotherapy care.

Implications for Fall Prevention Policy

The findings of this dissertation present unique challenges for health care policymakers. The first major challenge is that an authentic phenomenological ethics of care cannot be legislated, managed, or controlled (van Manen, 2002). While knowledge translation initiatives have been developed to foster health service providers' critical reflection and transformative learning necessary to encourage approaches to health care that build upon a deeper understanding of care (McWilliam, 2007), policy cannot dictate

a more caring orientation toward community-based health services. However, by funding research projects and health care delivery programs integrating such knowledge translation initiatives, policy makers may be able to encourage health care practitioners to engage in the critical reflection necessary to foster transformative approaches to fall prevention.

The second major challenge for policymakers is that a transformative approach to fall prevention requires service providers to spend time and build relationships with older people in order to foster a transformative helping relationship. Considering the limitations in resources that tend to characterize contemporary health care delivery systems, providing practitioners with the opportunity to spend additional time with older clients may not seem plausible. However, such investments may be necessary in order to encourage a broader impact on meaningful approaches to fall prevention over longer periods (Scott et al, 2007). As resource limitations are such a pervasive issue in the context of contemporary health care, ethical, practical, and political debate is warranted regarding the allocation of scarce resources toward various approaches to fall prevention. While further inquiry into the impact of a transformative approach to fall prevention is necessary before any specific policy changes may be recommended, this dissertation research may help to inform the debate regarding the ethical and practical dimensions of the allocation of both human resources for care and research resources for the critical study of fall prevention.

Future Research

A number of potential research questions arise out of the findings of this dissertation research. While the ethical implications of a transformative approach to fall

prevention have been addressed in this discussion chapter, the ethics of fall risk and fall prevention merit further attention. The findings of this two-phase study suggest that a phenomenological ethics of care is essential to service providers' experience of enacting fall prevention, however such an ethical orientation focuses on ethical action at the persons' level in the current context of increasing attention to the effects of falling and fall risk at the population-level. The ways in which such an individually-focused ethical orientation toward fall prevention may be compatible with and enhance the population-focused ethics of policymakers merits further investigation.

The practical impact of a transformative approach to fall prevention in the course of community-based care merits longitudinal inquiry. Such longitudinal investigation would not only explore fall risk and prevention as outcomes, but would focus qualitatively on the experiences of the older people and health care practitioners involved in the fall prevention initiative. In so doing, further investigation might explore the ways in which the initiative was meaningful for older people and health care providers, and seek to understand issues with its practical implementation in a particular health care context. Longitudinal study may substantiate the need for a transformative approach to fall prevention to augment conventional biomedical approaches, providing necessary support to advocacy efforts for health policy that recognizes the legitimacy of such an approach to fall prevention.

Further research might also focus on the ways in which physiotherapists and other health care providers may learn to understand and enact a transformative approach to fall prevention. Considering the critical reflection and dialogue that characterizes such an approach to fall prevention, research investigating alternative strategies for educating

service providers about this approach is likely warranted. The impact of an adult education approach to facilitating the practical understanding of transformative fall prevention amongst physiotherapists and other providers might be explored in further research.

Conclusion

The aim of this dissertation has been to enhance understandings and reflective awareness of the taken-for-granted meanings that characterize fall prevention services in community outreach care. In undertaking this work, I have hoped to inform approaches to community-based fall prevention that are sensitively oriented toward the meaningful concerns of older people. The findings of this dissertation have given rise to a number of key insights that may inform a more tactful, sensitive orientation to enacting fall prevention in community care. By building upon the centrality of caring to the experience of enacting fall prevention amongst community-based practitioners, a transformative approach may foster an ethical and sensitive orientation toward enacting fall prevention practice. Enacting such an approach, physiotherapists and other service providers would re-cognize the centrality of lived-identity, risk-taking, and experiential learning to older peoples' experience of anticipating falling, engaging older clients in reflective dialogue in order to foster transformational learning in relation to meaningful risk-taking, caution, and lived-identity in daily life. Such an approach to fall prevention requires critical reflection regarding the instrumentalist goals of conventional best practice guidelines for fall prevention that seek to minimize the risk of falling without consideration of the meaningful concerns of older people themselves.

Returning to an important question posed in the introduction to this dissertation, regarding whether or not we should be approaching fall prevention within community-based health care at all, the answer seems to be both "yes" and "no". We should *not* be approaching fall prevention in the community in instrumentalist ways that reproduce a *having mode* of existence among older people and limit their possibilities for enacting lived-identity in daily life. However, approaches to fall prevention that facilitate transformative learning in relation to fall risk and fall prevention, fostering a *being mode* of existence in relation to lived-identity and meaningful risk-taking, may take older people's subjective experience as their highest priority and constitute sensitive, artful, and tactful approaches to community-based fall prevention. In efforts to more authentically and ethically support the lived-identity of older people, such transformative approaches to fall prevention may be warranted in the context of community-based health care.

While the question of whether and how we should be approaching fall prevention in contemporary community-based health care should be continually re-visited, I have interpreted the findings of this dissertation as suggesting that ethical, sensitive approaches to fall prevention are indeed possible in community practice. Reflection and debate on the ethical rationale for particular approaches to fall prevention over others seem central to efforts to develop, explore, and enact fall prevention with older people, re-cognizing the many different perspectives and voices involved in such debate. None of these voices is more important than those of older people themselves. By asking reflective questions and listening closely to the answers we may be able to understand and enact fall prevention services in ways that may help to prevent falling amongst older people while

simultaneously affirming an *appreciative* understanding of lived-experience and lived-identity.

References

Aminzadeh, F., & Edwards, N. (1998). Exploring seniors' views on the use of assistive devices in fall prevention. *Public Health Nursing, 15*(4), 297-304.

Ballinger C. & Payne S. (2000). The construction of the risk of falling among and by older people. *Ageing & Society*, 22, 305-324.

Biggs, S. (2001). Toward critical narrativity: Stories of aging in contemporary social policy. *Journal of Aging Studies, 15*: 303-316.

Biggs, S. (2004). In pursuit of successful identities and authentic aging. In E. Tulle (Ed.) *Old age and agency*, pp. 137-156. New York: Nova.

Calhoun, R., Meischke, H., Hammerback, K., Bohl, A., Poe, P., Williams, B., et al. (2011). Older adults' perceptions of clinical fall prevention programs: A qualitative study. *Journal of Aging Research, 2011*, 86-91.

Clemson, L., Cusick, A., & Fozzard, C. (1999). Managing risk and exerting control: Determining follow through with falls prevention. *Disability and Rehabilitation, 21*(12), 531-541.

Davis, C. (2005). Educating adult health professionals for moral action: In search of moral courage. In R. Purtilo, G. Jensen, & B. Royeen (Eds.) *Educating for moral action: A sourcebook in health and rehabilitation ethics*, pp. 215-224. Philadelphia: F.A. Davis

Deandrea S, Lucenteforte E, Bravi F, Foschi R, Vecchia CL, Negri E. (2010). Risk factors for falls in community-dwelling older people: A systemic review and meta-analysis. *Epidemiology*, *21*: 658-668

Edwards, I., Jones, M., Carr, J., Braunack-Mayer, A., & Jensen, G. (2004). Clinical reasoning strategies in physical therapy. *Physical Therapy, 84*: 312-345.

Edwards, N. (2011). Preventing falls among seniors: The way forward. *Journal of Safety Research, 42*: 537-541.

Fixsen, D., Scott, V., Blasé, K., Naoom, S., & Wagar, L. (2011). When evidence is not enough: The challenges of implementing fall prevention strategies. *Journal of Safety Research, 42*: 419-422.

Fromm, E. (1976) *To have or to be?* London: Continuum.

Gilleard, C. & Higgs, P. (2000). *Cultures of ageing: Self, citizen and the body*. London: Prentice Hall.

Greenfield, B. (2006). The meaning of caring in five experienced physical therapists. *Physiotherapy Theory & Practice, 22*: 175-187.

Greenfield, B. & Jensen, G. (2010). Understanding the lived experiences of patients: Application of a phenomenological approach to ethics. *Physical Therapy, 90*: 1185-1197.

Hanson, H., Salmoni, A., & Doyle, P. (2009) Broadening our understanding: Approaching falls as a stigmatizing concept for older adults. *Disability and Health Journal*, 2, 36-44.

Horton, K. (2006) Gender and the risk of falling: A sociological approach. *Journal of Advanced Nursing*, 57(1), 59-76.

Høst, D., Hendriksen, C., & Borup, I. (2011). Older people's perception of and coping with falling, and their motivation for fall-prevention programmes. *Scandinavian Journal of Public Health, 39*(7), 742-748.

Huang, T. T. (2005). Managing fear of falling: Taiwanese elders' perspective. *International Journal of Nursing Studies, 42*(7), 743-750

Hughes, J., Bamford, C., May, C. (2008). Types of centeredness in health care: Themes and concepts. *Medicine, Health Care, and Philosophy, 11*: 455-463.

Jensen, G., Gwyer, J., Shepard, K., & Hack, L. (2000). Expert practice in physical therapy. *Physical Therapy, 80*: 28-43.

Katz, S. (2005). *Cultural aging: Life course, lifestyle and senior worlds*. Peterborough: Broadview Press.

Katz, S. (2011). Hold on! Falling, embodiment and the materiality of old age. In M. Casper & P. Currah (Eds.) *Bodies of Knowledge: Interdisciplinary Studies* (pp. 187-206). Minneapolis: University of Minnesota Press.

Katz, S. & Laliberte-Rudman, D. (2005). Exemplars of retirement: Identity and agency between lifestyle and social movement. In S. Katz (Ed.). *Cultural aging: Lice course, lifestyle and senior worlds*, pp. 140-160. Peterborough: Broadview Press.

Kong, K. S., Lee Fk, F. K., Mackenzie, A. E., & Lee, D. T. (2002). Psychosocial consequences of falling: The perspective of older hong kong chinese who had experienced recent falls. *Journal of Advanced Nursing, 37*(3), 234-242.

Laybourne A., Biggs, S., & Martin, F. (2008) Falls exercise and reduced falls rate: Always in the patients' interest? *Age and Ageing*, 37(1), 10-13.

Lee, F., MacKenzie, L., & James, C. (2008) Perceptions of older people living in the community about their fear of falling. *Disability & Rehabilitation*, 30(23), 1803-1811.

Levinas, E. (1998). *Entre-nous: On thinking-of-the-other*. Columbia University Press: New York.

Lord, S., Menz, H., & Tiedmann, A. (2003). A physiological profile approach to falls risk assessment and prevention. *Physical Therapy, 83*: 237-252.

Mackenzie, L. (2009) Perceptions of health professionals about effective practice in fall prevention. *Disability & Rehabilitation*, 31(24), 2005-2012.

Mahler, M., & Sarvimäki, A. (2010). Indispensable chairs and comforting cushions—Falls and the meaning of falls in six older persons lives. *Journal of Aging Studies, 24*(2), 88-95.

Mcinnes, E., Seers, K., & Tutton, L. (2011). Older people's views in relation to risk of falling and need for intervention: A meta-ethnography. *Journal of Advanced Nursing, 67*(12), 2525-2536.

McWilliam, C. (2007). Continuing education at the cutting edge: Promoting transformative knowledge translation. *Journal of Continuing Education in the Health Professions, 27*: 72-79.

McWilliam, C. (2009) Patients, persons, or partners? Involving those with chronic disease in their care. *Chronic Illness*, 5(4), 277-292.

Mezirow, J. (1978). Perspective transformation. *Adult Education, 28*: 100-110.

Ness, K., Gurney, J., & Ice, G. (2003). Screening, education, and associated behavioral responses to reduce risk for falls among people over age 65 attending a community health fair. *Physical Therapy, 83*: 631-637.

Nichols, D. & Gibson, B. (2010). The body and physiotherapy. *Physiotherapy Theory & Practice, 26*: 497-509.

Nortvedt, P. (2003). Levinas, justice, and health care. *Medicine, Health care, and Philosophy, 6*: 25-34.

Nortvedt, P. (2008). Sensibility and clinical understanding. *Medicine, Health Care, and Philosophy, 11*: 209-219.

Peloquin, S. (2005). Affirming empathy as a moral disposition. In R. Purtilo, G. Jensen, & B. Royeen (Eds.) *Educating for moral action: A sourcebook in health and rehabilitation ethics*, pp. 11-20. Philadelphia: F.A. Davis

Poli, R. (2010). The many aspects of anticipation. *Foresight, 12*: 7-17.

Porter, E. J. (1999). 'Getting up from here': Frail older women's experiences after falling. *Rehabilitation Nursing : The Official Journal of the Association of Rehabilitation Nurses, 24*(5), 201-6, 211.

Roe, B., Howell, F., Riniotis, K., Beech, R., Crome, P., & Ong, B. N. (2008). Older people's experience of falls: Understanding, interpretation and autonomy. *Journal of Advanced Nursing, 63*(6), 586-596.

Rubenstein, L. & Josephsen, K. (2002). Risk factors for falls: A central role in falls prevention. *Generations, 3*: 15-22.

Rubenstein, L. (2006). Falls in older people: Epidemiology, risk factors, and strategies for prevention. *Age & Ageing, 35*(S2): 37-41.

Robertson, D. (1996). Facilitating transformative learning: Attending to the dynamics of the educational helping relationship. *Adult Education Quarterly, 47*: 41-53.

Schwandt, T. (1998). Constructivist, Interpretive Approaches to Human Inquiry. In N.K. Denzin & Y. S. Lincoln (Eds.) *The Landscapes of Qualitative Research: Theories and Issues*, pp. 221-259. Thousand Oaks, CA: Sage.

Scott, V. Lockart, S., Gallagher, E., Smith, D., Asselin, G., Belton, K. et al (2007). *Canadian falls prevention curriculum (CFPC)*. Vancouver: BC Injury Research & Prevention Unit.

Shaw, J. & DeForge, R.T. (2012). Physiotherapy as bricolage: Theorizing expert practice. *Physiotherapy Theory and Practice, 28*(6); 420-427.

Stewart, J., & McVittie, C. (2011). Living with falls: House-bound older people's experiences of health and community care. *European Journal of Ageing, 8*(4), 271-279.

Sumsion, T. & Law, M. (2006). A review of evidence on the conceptual elements informing client-centered practice. *The Canadian Journal of Occupational Therapy, 73*: 153-162.

Tinetti, M. (2003). Preventing falls in elderly persons. *New England Journal of Medicine, 348*: 42-49.

Titterton, M. (2005). *Risk and risk-taking in health and social welfare*. Jessica Kingsley: London.

Tischler, L., & Hobson, S. (2005) Fear of falling: A qualitative study among community dwelling older adults. *Physical & Occupational Therapy in Geriatrics*, 23(4), 37-53.

Twigg, J. (2006). *The body in health and social care*. Basingstoke: Palgrave McMillan.

van Manen, M. (1977). Linking ways of knowing with ways of being practical. *Curriculum Inquiry, 6*: 225-228.

van Manen, M. (2002). Care-as-worry, or "don't worry be happy". *Qualitative Health Research, 12*(2): 262-278.

Ward-Griffin, C., Hobson, S., Melles, P., Kloseck, M., Vandervoort, A., & Crilly, R. (2004). Falls and fear of falling among community-dwelling seniors: The dynamic tension between exercising precaution and striving for independence. *Canadian Journal on Aging*, *23*(4), 307-318.

Yardley, L., Donovan-Hall, M., Francis, K., & Todd, C. (2006) Older people's views of advice about falls prevention: A qualitative study. *Health Education Research*, 21(4)508-517.

Appendix A

Letter of Information and Consent for the Research Project:

Investigating the Construction of Fall Risk Perceptions

Primary Investigator:
Dr. Denise Connelly, PhD, MSc, BScPT
Assistant Professor, School of Physical Therapy
The University of Western Ontario

Co-Investigator:
Jay Shaw, BKin

You are invited to participate in a research study that is being done in order to better understand how older adults living in the community develop their understanding and perceptions of falling and fall risk. Falls are a major problem in adults over the age of 65, and investigating how individuals learn about falls can help health professionals to design educational materials that are relevant and appealing to community living older adults. In order to do this effectively, research needs to be done that focuses on the opinions of older adults who live in the community.

<u>You will be asked to participate in 1 interview</u>

If you agree to participate in this study, you will be asked to complete one interview with the co-investigator to discuss your opinions and perspectives about developing knowledge of fall risk. The interview will also include questions about your activity levels, social network, and any fear of

falling that you might experience. With your permission these interviews will be audio recorded and transcribed to be read by the researchers. The first interview will be approximately one hour in length, and will be conducted either at your home or at Elborn College at the University of Western Ontario, whichever location you prefer. Between 10 and 15 people will be participating in this study.

Your interview and information will be kept confidential

The recorded interviews and typed transcripts will only be examined by members of the research team. The identities of all participants will be kept strictly confidential in any analysis of the interviews, by using a participant number that will assigned to your interview information instead of your name. The research may be published, but your name will not be used in the final written report. The interviews and transcripts will be kept in a locked filing cabinet at the University of Western Ontario at all times. You may withdraw your interview data from the research study at any time up to one month after the final interview. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may require access to your study-related records or may follow up with you to monitor the conduct of the research.

Risks and Benefits of Participating in the Study

You will be discussing personal information regarding your typical daily activities, your social support network, your perceptions of feeling at risk of falling, and your opinions of fall prevention activities. This discussion may make you think about your daily routine and social and physical

activities, as well as your likelihood of experiencing a fall. This has the potential to cause a fear of falling. Because of this potential for fear of falling, each interview will end with the researcher briefly summarizing the current research on falling and fall prevention for you. This involves a discussion of the importance of physical and social activity, to encourage you to stay involved in your activities. You will have the opportunity to ask any questions you may have about falls at the end of both the first and second interviews.

Withdrawing your interview and information from the study

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time during the interview(s). You may also withdraw your interview data at any point up to one month after your final interview. By the time one month has passed after your final interview, data analysis will already have occurred, and your interview data will not be able to be withdrawn. There will be no compensation for participating in the research project. However, participants will be reimbursed for parking costs that they may have as a result of participating in the interview.

Consent to be contacted for future studies

Finally, the research team would like to know if you are willing to be contacted in the future for any other related research projects that might arise. This would require the research team to keep your name and telephone number on file. If you agree to be contacted this in no way signifies a

commitment on your part to participate in future projects, only to be informed of them and asked to participate. Your participation in these future studies would be completely voluntary as well. A check-box is available on the consent page for any participants who are willing to be contacted in the future regarding new research projects.

If you have any questions about your rights as a research participant or the conduct of the study you may contact the Office of Research Ethics at 519-661-3036 or at ethics@uwo.ca.

If you have any questions regarding this study, please contact:

School of Physical Therapy o Faculty of Health Sciences o The University of Western Ontario

Elborn College o London, Ontario o N6G 1H1 o Canada o Telephone: (519) 661-3360 o Fax: (519) 661-3866

Consent Form

Study Title: Investigating the Construction of Fall Risk Perceptions

I have read the Letter of Information and have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Print your name:_____

Signature of Participant:_____

Date:_____

Name of Person Obtaining Informed Consent:_____

Signature of Person Obtaining Informed Consent:_____

Date:_____

Secondary Consent

Are you willing to be contacted in the future for any new research projects that may arise?

If yes, place a checkmark in the box: ☐

School of Physical Therapy o Faculty of Health Sciences o The University of Western Ontario

Elborn College o London, Ontario o N6G 1H1 o Canada o Telephone: (519) 661-3360 o Fax: (519) 661-3866

Appendix B

Letter of Information and Consent for the Research Project:

Exploring Fall Prevention in Community Outreach Teams

Version Date: October 16th, 2011

Primary Investigator:
Dr. Denise Connelly, PhD, MSc, BScPT
Associate Professor, School of Physical Therapy
The University of Western Ontario

Co-Investigator:
Jay Shaw, PT, PhD (Cand.)

You are invited to participate in a research study that is being done in order to better understand how service providers who engage in community outreach activities with older adults approach fall prevention. Falls are a major problem in adults over the age of 65, and investigating how service providers approach and understand fall prevention will help provide insight into how to improve health services for fall prevention. If you have at least one year of experience working with older adults as a service provider in their homes or in the community in order to prevent falls, you may be able to help by telling us about these experiences.

If you agree to participate you will be asked to participate in 1 interview. With your permission, you may be asked to participate in a second interview to clarify your input from the initial interview and comments on the researcher's interpretations. A total of 4 or 5 participants will be asked for a second interview.

If you agree to participate in this study, you will be asked to complete one interview with the co-investigator to discuss your opinions and perspectives as a health care professional about aging, fall risk, and fall prevention. The interview will also include questions about how you assess fall risk and which interventions you use to help prevent falls. With your permission these interviews will be audio recorded and transcribed to be read by the researchers. The first interview will be approximately one hour in length, and will be conducted at your home, workplace, or at Elborn College at The University of Western Ontario, whichever location you prefer. If you agree to be contacted for a second interview, the researcher may contact you for a second interview at a later date. The second interview would be less than one hour in length, and would address your thoughts and opinions on what other anonymous participants have said. You may decline to participate in the second interview if you choose. Between 10 and 15 people will be participating in this study.

Please initial here indicating you have read and understood this page:_____

Your interview(s) and information will be kept confidential

The recorded interviews and typed transcripts will only be examined by members of the research team. The identities of all participants will be kept strictly confidential in any analysis of the interviews, by using a participant number that will be assigned to your interview information instead of your name. The research may be published, but your name will not be used in the final written report. The interviews and transcripts will be kept in a locked filing cabinet at the University of Western Ontario at all times. You may withdraw your interview data from the research study at any time up to one month after the final interview. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may require access to your study-related records or may follow up with you to monitor the conduct of the research.

Risks and Benefits of Participating in the Study

You will be discussing personal views and opinions regarding your approach to fall prevention, experiences you have had in preventing falls, your thoughts about aging, and how you see fall risk and health in older adults. This discussion will likely encourage you to think critically about previous experiences with clients when providing fall prevention and your current approach to fall prevention. This may or may not lead you to believe that changes to your current approach to fall prevention are needed. You will have the opportunity to ask any questions you may have about research relating to fall risk assessment and/or fall prevention at the end of both the first and second interviews (if applicable).

Withdrawing your interview and information from the study

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time during the interview(s). You may also withdraw your interview data at any point up to one month after your final interview. By the time one month has passed after your final interview, data analysis will already have occurred, and your interview data will not be able to be withdrawn. There will be no compensation for participating in the research project. However, participants will be reimbursed for parking costs at Elborn College that they may have as a result of participating in the interview.

Please initial here indicating you have read and understood this page:_____

Consent to be contacted for future studies

Finally, the research team would like to know if you are willing to be contacted in the future for any other related research projects that might arise. This would require the research team to keep your name, telephone number, and email address on file. If you agree to be contacted this in no way signifies a commitment on your part to participate in future projects, only to be informed of them and asked to participate. Your participation in these future studies would be completely voluntary as well. A check-box is available on the consent page for any participants who are willing to be contacted in the future regarding new research projects.

If you have any questions about your rights as a research participant or the conduct of the study you may contact the Office of Research Ethics at 519-661-3036 or at ethics@uwo.ca.

If you have any questions regarding this study, please contact:

Please initial here indicating you have read and understood this page:_____

Consent Form

Study Title: Exploring Fall Prevention in Community Outreach Teams

I have read the Letter of Information and have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Print your name:_____

Signature of Participant:_____

Date:_____

Name of Person Obtaining Informed Consent:_____

Signature of Person Obtaining Informed Consent:_____

Date:_____

Secondary Consent

Are you willing to be contacted in the future for any new research projects that may arise?

If yes, place a checkmark in the box: ☐

Please initial here indicating you have read and understood this page:_____

School of Physical Therapy o Faculty of Health Sciences o The University of Western Ontario

Elborn College o London, Ontario o N6G 1H1 o Canada o Telephone: (519) 661-3360 o Fax: (519) 661-3866

Consent to Second Interview

This form is to be signed before you begin your second interview.

Study Title: Exploring Fall Prevention in Community Outreach Teams

I have read the Letter of Information and have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Print your name:_____

Signature of Participant:_____

Date:_____

Name of Person Obtaining Informed Consent:_____

Signature of Person Obtaining Informed Consent:_____

Date:_____

Please initial here indicating you have read and understood this page:_____

School of Physical Therapy o Faculty of Health Sciences o The University of Western Ontario

Elborn College o London, Ontario o N6G 1H1 o Canada o Telephone: (519) 661-3360 o Fax: (519) 661-3866

Appendix C

Appendix D

Study Two Interview Guide: The Meaning of Enacting Fall Prevention in Community Outreach Care

1. Can you please describe what definition of a fall you use in your practice?

2. Tell me about a recent experience where you helped an older client to prevent falls?
    a. What were your most important priorities in this interaction?
    b. Tell me about an experience when you felt your intervention was ineffective.

3. Tell me about how you approached fall prevention in a recent experience with an older client that you thought was successful?
    a. What were your priorities when providing fall prevention services?
    b. Which assessment strategies did you use and why?
    c. Which intervention strategies did you use and why?

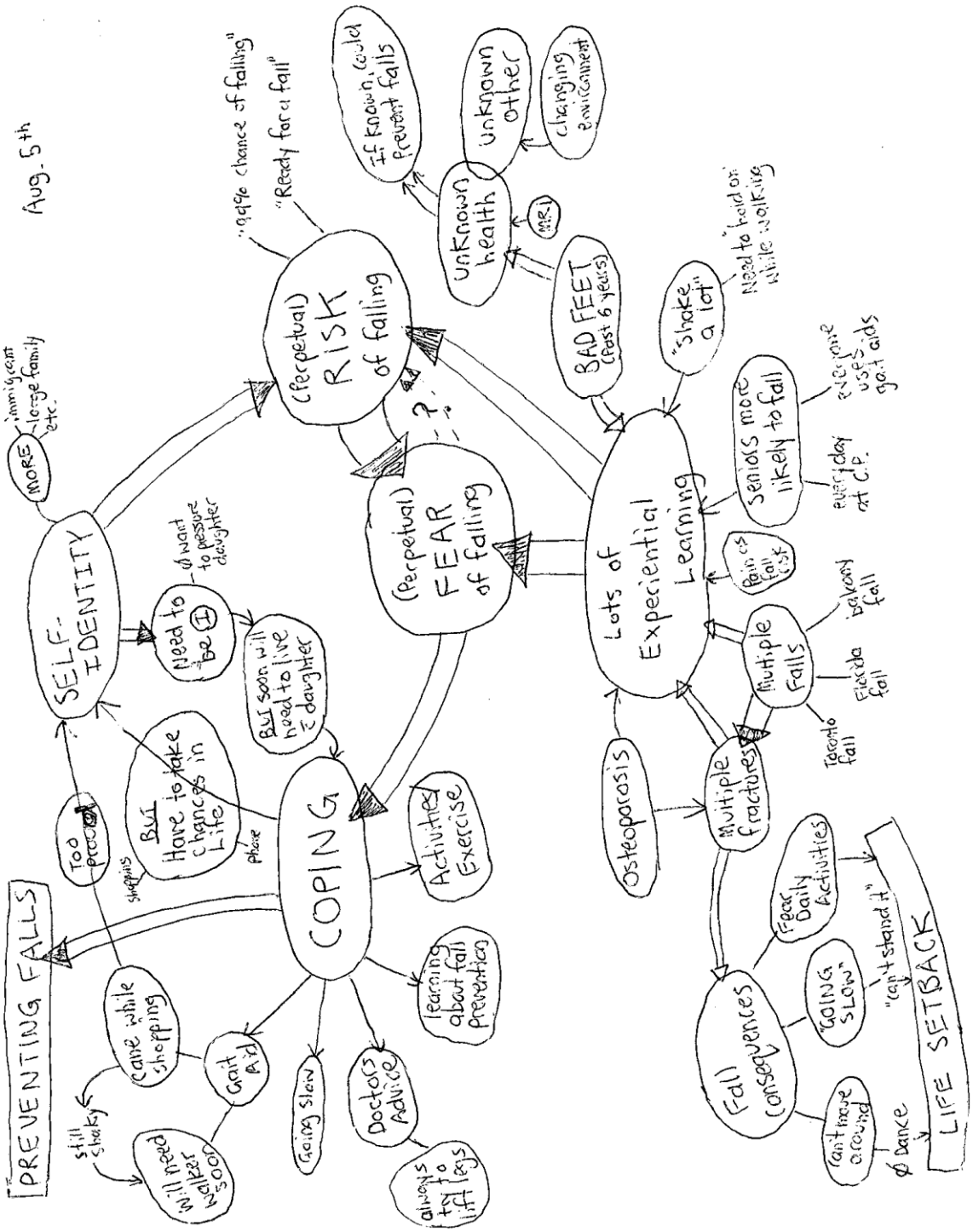
4. What do you think is most important to successful fall prevention?
    a. What experiences have informed your thoughts about what is most important to fall prevention?
    b. What experiences have informed your feelings about what is most important to fall prevention?
        i. Tell me about an important experience that informed your approach to fall prevention.
    c. How does research evidence fit into your practice of fall prevention?
        i. Tell me about a time when research evidence helped you in your efforts to prevent falls.

5. What do you think is most important to the older adult clients you serve?
    a. Tell me about an experience where you integrated a client's priorities into your approach to fall prevention.
    b. How did you try to integrate their priorities into the services you provided?

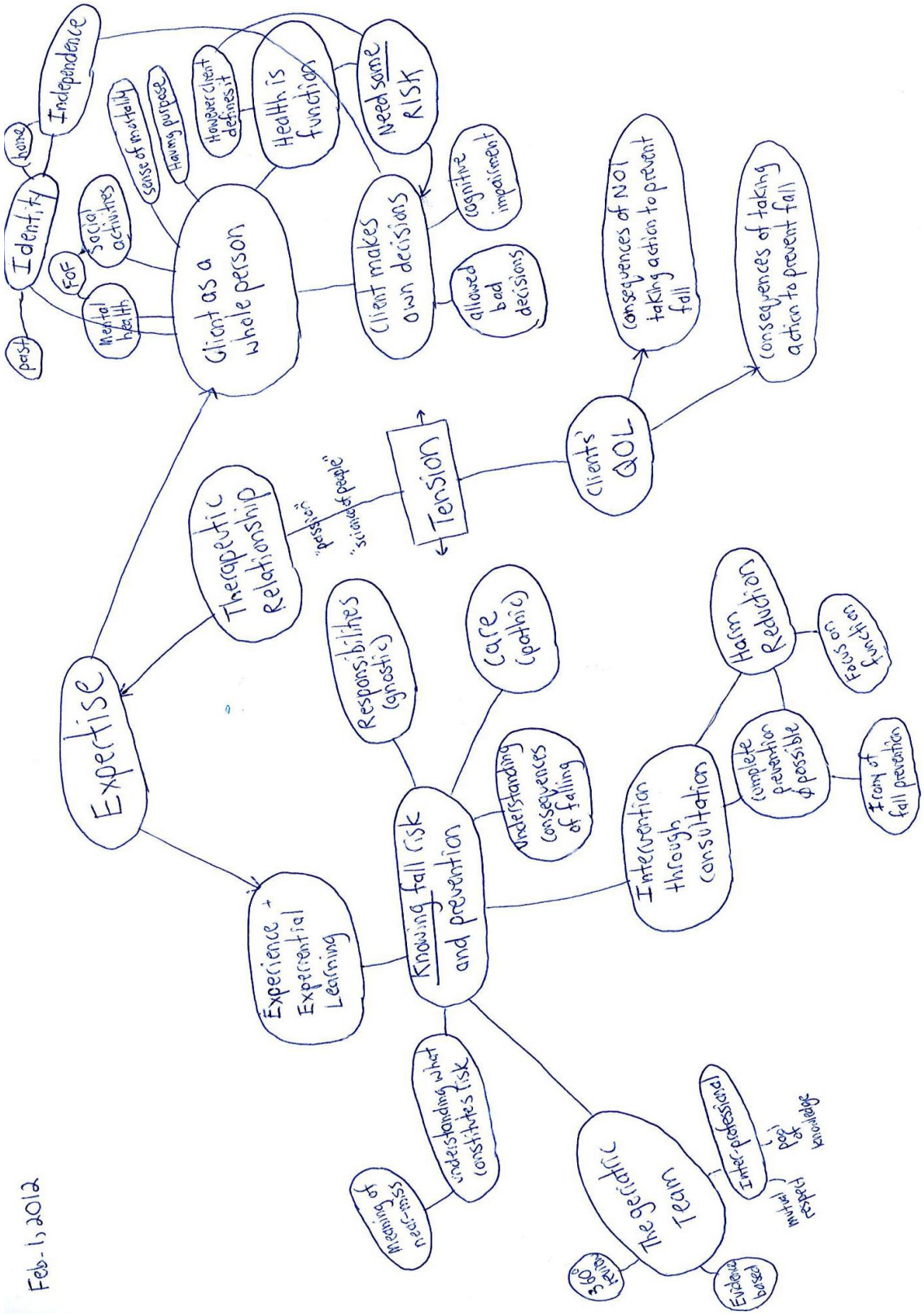
6. How do you see health?
    a. How do you think aging is related to health?
    b. How do you think fall risk is related to health?

7. Tell me about your training and experience as a service provider?
    a. Tell me about any specific fall prevention training you have had?
    b. What are important ways that you continue to improve at fall prevention?

Appendix E


Aug. 5th
PREVENTING FALLS
SELF-IDENTITY
MORE immigrant large family etc.
Too proud
Shopping
Still shaky
Will need walker soon
Cane while shopping
Gait Aid
Going slow
Doctors Advice
always tell keys
Learning about fall prevention
Activities/ Exercise
COPING
But Have to take chances in Life
Phone
But soon will need to live w/ daughter
Need to Be (I)
Don't want to pressure daughter
(Perpetual) FEAR of falling
(Perpetual) RISK of falling
"1 in 2 chance of falling"
"Ready for a fall"
If known, could prevent falls
Unknown other
Changing environment
Unknown health
etc.
BAD FEET (Past 6 years)
?
Lots of Experiential Learning
"Shake a lot"
Need to hold on while walking
Seniors more likely to fall
Everyone uses grab aids
Everyday at C.P.
Pain as fall risk
Multiple Falls
Balcony fall
Florida fall
Toronto fall
Multiple fractures
Osteoporosis
Fall consequences
Fear Daily Activities
GOING SLOW
"can't stand it"
can't move around
Dance
LIFE SETBACK

Appendix F


Feb. 1, 2012
Expertise
Therapeutic Relationship
"passion"
"science of people"
Tension
Clients' QOL
Consequences of NOT taking action to prevent fall
Consequences of taking action to prevent fall
Client as a whole person
Client makes own decisions
Cognitive impairment
Allowed bad decisions
Health is function
Need some RISK
Independence
Identify
Home
Past
FOF
Mental health
Social activities
Sense of mortality
Having purpose
How does client define it?
Experience + Experiential Learning
Knowing fall risk and prevention
Responsibilities (agnostic)
Care (pathic)
Understanding consequences of falling
Meaning of medicines
Understanding what constitutes risk
Interventions through consultation
Harm Reduction
Focus on function
Complete prevention $ possible
Irony of fall prevention
The Geriatric Team
360° feedback
Evidence based
Inter-professional
Mutual respect
Pool of knowledge

Appendix G

Office of Research Ethics
The University of Western Ontario
Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. D.M. Connelly
Review Level: Expedited
Review Number: 15105E
Revision Number: 4
Review Date: August 27, 2010
Approved Local # of Participants: 20
Protocol Title: Investigating the Construction of Fall Risk Perceptions
Department and Institution: Physical Therapy, University of Western Ontario
Sponsor:
Ethics Approval Date: August 27, 2010
Expiry Date: August 31, 2011
Documents Reviewed and Approved: Revised study end date.
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert
FDA Ref. #: IRB 00000940

Ethics Officer to Contact for Further Information			
☐ Janice Sutherland (jsutherl@uwo.ca)	☐ Elizabeth Wambolt (ewambolt@uwo.ca)	☑ Grace Kelly (grace.kelly@uwo.ca)	☐ Denise Grafton (dgrafton@uwo.ca)

This is an official document. Please retain the original in your files.

cc: ORE File

Appendix H

Research Western

Use of Human Participants - Ethics Approval Notice

Principal Investigator: Dr. Denise Connelly
Review Number: 18557E
Review Level: Delegated
Approved Local Adult Participants: 15
Approved Local Minor Participants: 0
Protocol Title: Exploring Fall Prevention in Community Outreach Teams
Department & Institution: Physical Therapy, University of Western Ontario
Sponsor:
Ethics Approval Date: November 10, 2011 **Expiry Date:** August 31, 2012
Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
UWO Protocol		
Letter of Information & Consent		2011/10/16
Other	Consent for 2nd Interview	
Advertisement	Telephone Script	
Advertisement	Email Script	

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

The Chair of the HSREB is Dr. Joseph Gilbert. The UWO HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Signature

Ethics Officer to Contact for Further Information

Janice Sutherland (jsutherl@uwo.ca)	Grace Kelly (grace.kelly@uwo.ca)	Shantel Walcott (swalcot@uwo.ca)

This is an official document. Please retain the original in your files.

LAWSON HEALTH RESEARCH INSTITUTE

FINAL APPROVAL NOTICE

RESEARCH OFFICE REVIEW NO.: R-11-592

PROJECT TITLE: Exploring Fall Prevention in Community Outreach Teams

PRINCIPAL INVESTIGATOR: Dr. Denise Connelly

DATE OF REVIEW BY CRIC: February 9, 2012

Health Sciences REB#: 18557E

Please be advised that the above project was reviewed by the Clinical Research Impact Committee and the project:

Was Approved

PLEASE INFORM THE APPROPRIATE NURSING UNITS, LABORATORIES, ETC. BEFORE STARTING THIS PROTOCOL. THE RESEARCH OFFICE NUMBER MUST BE USED WHEN COMMUNICATING WITH THESE AREAS.

Dr. David Hill
V.P. Research
Lawson Health Research Institute

All future correspondence concerning this study should include the Research Office Review

cc: Administration

LAWSON
HEALTH RESEARCH INSTITUTE
Aging, Rehabilitation & Geriatric Care

ST JOSEPH'S HEALTH CARE LONDON

January 4, 2012

Dr. Denise Connelly
School of Physical Therapy
Elborn College

Dear Denise:

Re: Exploring fall prevention in community outreach teams - REB# 18557

We wish to acknowledge receipt and thank you for your response to the Parkwood CRIC review query. We are, therefore, pleased to provide you with this Parkwood Hospital Clinical Research Impact Committee Letter of Approval.

This approval has been forwarded to the Lawson Health Research Institute Administrative Office, who will issue the **final** approval as projects may not be started until this final approval is received.

Yours sincerely,

Dalton Wolfe, PhD
Chair, Parkwood Hospital Clinical Research Impact Committee

cc ARGC Administration Office
Lawson Administration Office

Aging, Rehabilitation, and Geriatric Care Research Centre
Lawson Health Research Institute - Parkwood Hospital
801 Commissioners Rd. E., London, Ontario N6C 5J1
Tel: (519)685-4292 ext. 42957/42983 • Fax (519)685-4060 • email: dwolfe@uwo.ca
Administrative Assistant – bonita.stevenson@sjhc.london.on.ca

Appendix I

Table 1

Participant Characteristics

Participant Name (Pseudonym)	Age	Months since last fall	Injurious Fall	Highest level of education	Health Condition(s)	Gait Aid	Preferred Recreation
Robert	65	8	No	College Diploma	Skin cancer	No	Line dancing
Nell	94	14	No	College Diploma	Hip replacement (3 years)	Rollator Walker	Walking
Paula	84	2	Multiple	Grade 8	High blood pressure	Cane	Group exercise
Maurine	77	3	No	High School	Hip replacement (2 years)	No	Swimming
Nancy	78	24	No	College Diploma	Arthritis	No	Walking, swimming
Doug	89	2	One	University degree	Charcot-Marie Tooth Disease	Rollator walker	Walking, weights
Shirley	86	36	One	High School	Arthritis	No	Walking
Wendy	82	22	One	High	Heart	No	Group

				School	Disease		exercise
Rachel	78	8	No	High School	None	No	Walking

Appendix J

Table 1

Community Outreach Participant Characteristics

Participant Name (Pseudonym)	Years with outreach Team	Years in practice (total)	Highest level of education	Professional discipline
Sally	4	30	MSc. Nursing	Nursing
Karen	5	19	MSc. Rehabilitation Science	Physiotherapy
Judy	5	26	BA Social Work	Social Work
Laura	4	15	BSc. Physiotherapy	Physiotherapy
Natalie	8	35	BSc. Occupational Therapy	Occupational Therapy
Cheryl	2	12	BSc. Occupational Therapy	Occupational Therapy

James Shaw, BKin, MPT, PhD (c)

Curriculum Vitae

Education

September 2007 – current

University of Western Ontario, London, Ontario

Concurrent Master's of Physical Therapy with Doctor of Philosophy in Health and Rehabilitation Science

Master of Physical Therapy, September 2008 – August 2010
Doctor of Philosophy, September 2007 – Current
Supervisor: *Dr. Denise Connelly, PT, PhD*

September 2003 – June 2007

Brock University, St. Catharines, Ontario

Honours Bachelor of Kinesiology (with First Class Standing)

Employment Experience

Research Associate, VHA Rehab Solutions, (London Ontario) - Sept. 2010 - current
Consulting on, designing, and carrying out research projects related to the direct improvement of patient care services and home health care management.

Physiotherapist, VHA Rehab Solutions, (London Ontario) – August 2011 – January 2012
Providing direct physiotherapy care to community care clients in their homes on a part-time/casual basis.

Physiotherapist, St. Marys Community Rehabilitation, (St. Marys Ontario) – Sept. 2010 – September 2011.
Providing direct physiotherapy patient care in outpatient orthopaedic, home care, and long term care settings.

Research Awards and Scholarships

Canadian Institutes of Health Research Doctoral Research Award – Awarded to doctoral students demonstrating academic excellence based on grades, letters of reference, accomplishments, and thorough descriptions of the research project (September 2010 – August 2012; $21,000/year over 2 years)

Ontario Graduate Scholarship – Awarded to students demonstrating academic excellence based on grades, letters of reference, and statement of intent regarding research project (September 2009 – August 2010; $15,000; September 2008 – August 2009; $15,000)

Canadian Institute of Health Research Health Professional Student Award – Awarded to students enrolled in a health professional pre-licensure program that are concurrently training in a research capacity at a registered university (August 2008 – July 2009; $1,300)

Physiotherapy Foundation of Canada and Canadian Institute of Health Research Institute of Aging Scholarship for Physiotherapy in Mobility in Aging – Awarded to a single doctoral student across Canada based on academic excellence, career goals, and a description of intended research (July 2008 – June 2009; $5,000)

University of Western Ontario Deans Entrance Scholarship (Health and Rehabilitation Science) – awarded to ten most highly qualified applicants to the Doctor of Philosophy program in Health and Rehabilitation Science (September 2007 – August 2008; $5,000)

Honours and Studentships

Graduate Education

Ontario Physiotherapy Association's Special Award for Students – Awarded to a single student each year who has demonstrated leadership and commitment to promoting the profession of physiotherapy both locally and provincially (January 2011)

Master of Physical Therapy Graduating class 2010 Valedictorian Award – voted by graduating students based on leadership, integrity, and inclusivity in contributing to professional and personal class activities (October 2010; $50 honorarium)

Canadian Physiotherapy Association Award – Awarded to the graduating Master of Physical Therapy student at each University with the best academic standing in clinical and course-based physiotherapy subjects over the entire program (October 2010; complementary membership to Canadian Physiotherapy Association in the following year)

Canadian Physiotherapy Association's Helen Saarinen Rahikka Student Leadership Award – Awarded to a single student in Canada who is nominated by peers to recognize outstanding contributions to the physiotherapy profession (March 2010; complementary membership to the Canadian Physiotherapy Association in the following year)

National Initiative for the Care of the Elderly (NICE) Student Mentorship – Awarded to students demonstrating academic excellence, research experience and commitment to improving health and health care for the elderly (February 2009 – January 2010; February 2008 – January 2009; $1,000)

Undergraduate Education

Brock Undergraduate Student Research Award recipient – awarded based on academic record, research experience, and students statement of interest and intent regarding research (September 2006 – April 2007; $3,250)

Canadian Millennium Scholarship recipient – awarded based on community *innovation* and *leadership* while maintaining honours academics (September 2005 – August 2006; $4,000)

Publications

Peer Reviewed

Journal Articles

1. Physiotherapy as bricolage: Theorizing expert practice. (2012). **J.A. Shaw** and R.T. DeForge*, Physiotherapy Theory and Practice* (28), 420-427.
2. Effects of age and pathology on stance modifications in response to increased postural threat. (2012). **J.A. Shaw**, L. Stefanyk, J. Frank, M. Jog, and A.L. Adkin. *Gait & Posture* (35), 658-661.
3. Back- and fore-grounding ontology: Exploring the linkages between critical realism, pragmatism, and methodologies in health & rehabilitation sciences. (2012). R.T. DeForge and **J.A. Shaw**. *Nursing Inquiry* (19), 83-95.
4. The Effect of Skill Focused Instructions on Walking Performance Depend on Movement Constraints in Parkinson's Disease. (2011) **J. A. Shaw**, J. Huffman, J. Frank, M. Jog, A. Adkin. *Gait & Posture* (33), 119-123.
5. Pragmatism in Practice: Mixed Methods Research for Physiotherapy. (2010) **J. A. Shaw**, D.M. Connelly, A. Zecevic. *Physiotherapy Theory and Practice* 26(8), 510-518.
6. Manipulating Balance Perceptions in Healthy Young Adults. (2009) L. L. Lamarche, K. L Gammage, **J. A. Shaw**, and A. L. Adkin. *Gait & Posture* (29), 383-386.
7. Child-Adult Differences in Muscle Strength and Activation Pattern During Isometric Elbow Flexion and Extension. (2009) B. Falk, C. Usselman, R. Dotan, L. Brunton, P. Klentrou, **J. A. Shaw**, and D. Gabriel. *Applied Physiology, Nutrition, and Metabolism*, 34, 609-615.

Non-Refereed

Journal Articles

1. Looking Beyond the System for Sustainable Change Within. (2008) **J. Shaw**, T. Shaw, and P. Shaw. *Healthcare Quarterly*, 11(2), 8-9.

Professional Memberships

Canadian Physiotherapy Association (2008 – current), membership #2010578
College of Physiotherapists of Ontario (2010 – current), membership #14381