Faldforebyggelse konstrueret som medicinsk overvågning og selvovervågning
Fall Prevention Constructed as Medical Surveillance and Self-Surveillance

➤ This study explores the understanding of falls and investigates how fall prevention is managed, administrated and practiced in a Danish fall prevention program. Methods: A discourse analysis inspired by Foucault is constructed. The material consists of a field study conducted at a falls clinic including participant observations, conversations and documents. Results and conclusion: The understanding of falls ranges from preventable and predictable accidents to natural and inevitable events. Fall prevention was managed, administrated and practiced through medical surveillance and self-surveillance, which produced and reproduced biomedical understandings of falls drawing on medical surveillance and health discourses. Older adults were constructed as pre-patients, passive/active fall patients and responsible self-caretakers. The study is intended to provide health professionals with a deeper understanding of the complexity of fall prevention in late life and to inspire the development of new fall prevention services.

Keywords: fall prevention, accidental falls, discourse analysis, older people, field study, medicalization

Lotte Evron og Lene Tanggaard

Lotte Evron, Professionshøjskolen Metropol
Sygeplejerske, Ph.d. og adjunct, Det Sundhedsfaglige og Teknologiske Fakultet, Institut for Sygepleje
loev@phmetropol.dk

Lene Tanggaard, Aalborg universitet
Cand.psych., Ph.d., professor og centerleder, Det Humanistiske fakultet, Institut for Kommunikation
lenet@hum.aau.dk

Introduction
Falling in late life is described as one of the five giants of geriatric medicine (1) and as the fifth leading cause of death in older adults, after cardiovascular disease, cancer, stroke, and pulmonary disease (2). Additionally, it is outlined as a serious health problem for older adults and an economic burden for society (1–3). It is estimated that one in three adults above 65 years old annually experiences a fall, and a consequence is that 20–30% of these adults become less mobile or increase their risk of dying before time (3). In total, falling is
associated with more than 400 risk factors such as being old, having previous falls, age-related loss of muscle mass, impaired balance/gait or being in need of walking aids (3–4). In addition, for the past 30 years, multifactorial fall prevention (MFP) programs have shown that falls among home-dwelling older adults can successfully be prevented (4).

From 2002, falling has been targeted as one of eight main health problems in the Danish population (5). Annually about 350,000 adults above 65 years old experience a fall: of those, 41,000 visit an emergency clinic, 13,000 are hospitalized, 10,000 sustain a hip fracture, while about 550 die in connection with a fall (6). During the past 10 years, an increasing number of clinical guidelines and governmental recommendations have been produced to reduce falls in the older population (5–10). From 2011, all municipalities have been obligated to work systematically with fall prevention strategies (9, p. 8). The aim is to prevent 50% of all falls in the municipalities (10). A challenge is that many older adults are reluctant to participate in the fall prevention programs (6,11).

Older adults’ reluctance to participate in fall prevention programs is seen in many other western countries (4). Recent research show that participation rates in such programs range from less than 30% to around 50% of the invited participants (11). An increasing number of qualitative studies exploring barriers of participation in fall prevention programs indicate that the relatively high refusal rate is associated with: older peoples’ low self-perceived risk of falling (12–14), poor knowledge about fall prevention strategies (14–15), lack of support for access to programs (16–17) and lack of belief that fall prevention programs may help older people to solve their individual falling problems (17–18). Sociological studies exploring understandings of falling and older adults’ views of fall prevention programs show that a fall seems to symbolize the entrance to old age (19), which categorizes adults who have fallen as old (1, 14, 19–22) and confronts older adults with their lived identity (1, 19–20).

Despite the growing number of studies exploring barriers of participation and older adults’ views of fall prevention programs, only few studies have actually investigated how fall prevention is managed, administrated and practiced in such programs. A pioneer study of Ballinger and Payne’s (21) explores the ways in which the risk of falling is realized and managed in a falls clinic and a day hospital in United Kingdom. Using discourse analysis, the authors explore constructions of risk of falling among and by older adults who had sustained a hip fracture. The study includes 50 hours of observation, 15 interviews, and analysis of policy documents. Ballinger and Payne identify two underlying and conflicting understandings of falls related to the user and provider positions in the day hospital. First, the provider position draws on a biomedical and reductionist understanding of falls, which articulates falls as preventable accidents orientated to the management of physical risk and risk reduction in the environment. Second, the user position draws on a moral understanding of falls, which articu-
lates falls as unpredictable events orientated to the management of risk of their personal and social identities. The empirical data suggest that attention to older adults’ emotive and moral concerns might increase the participation rate in fall prevention programs.

Another discourse analysis exploring representations of older people in 33 fall prevention websites finds that older adults who fall are constructed as: 1) passive recipients characterized as being ill-informed, vulnerable and ignorant victims of the aging process; 2) rational learners and problem solvers responsive to information; and 3) empowered decision makers characterized as being autonomous and responsible evaluators of health advice (22). These studies show how discourse analysis not merely helps us to understand the underlying perspectives on falls, but also makes the available roles of the older adults visible in the domain of fall prevention. To our knowledge, no study has actually investigated understanding of falls and how fall prevention is managed, administrated and practiced in a multifactorial fall prevention program in Denmark or in other countries.

**Aim of the study**

The aim of the study is to explore understandings of falls and how fall prevention is managed, administrated and practiced in a multifactorial fall prevention program in a Danish context. Using field study and discourse analysis as the underpinning methodology enables us to explore the different positions of speech and fall prevention practises.

**Methodology**

**Field study with discourse analysis**

The field study design was chosen to get a first hand view of fall prevention practices (23). It includes participant observation, conversations and document analysis to gain multiple insights into the fall prevention practices from different positions throughout the program. This design allows access to different types of knowledge constructed in the program. We use discourse analysis inspired by Foucault to analyze how understandings of falls and fall prevention practices can be perceived as products of discourses. Discourse analysis enables us to see dominant understandings in the construction of meanings about falls and fall prevention, and helps us to identify perspectives which are not represented or might be silenced in the program.

The discourse analysis draws on perspectives from postmodern theories that propose that our conceptions of reality go through language. We understand discourse as «a way to interpret the world (or parts of the world)» (24, p. 9), that is, a specific way «to give meaning to the world or aspects of the world that makes alternative discourses less plausible and natural or completely exclude them» (25, p. 265). Each discourse constitutes itself in relation to what it excludes and provides the subject with different and perhaps conflicting positions to speak from. The different discourses produce different subject positions. Certain expectations are related to the subject via the subject position indicating how to behave, speak and act within a given discursive
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framework. Accordingly, each subject position is seen as a product of a particular discourse, however the subject is not viewed as locked into a certain position. The subject always has the opportunity to choose between several available positions from which to speak and act. A quality of discourse analysis is that the discourses may be viewed as recourse to provide a different way to look at the empirical materials, which go beyond the way the material presents itself as such (25–26). Using discourse analysis as a framework for exploring understandings of falls enable us to explain how the interactions between the older adult and health professionals were constructed and managed in the program.

Empirical materials

The field study design is conducted at a falls clinic from June 2006 to June 2007. On selected days, the first author followed meetings between participants and health professionals through a MFP program from the recruitment to the treatment processes (17,27). Participant observation was conducted during the assessments, the training sessions, and the multidisciplinary staff conferences. This included locations such as the waiting room, examination rooms, staff rooms, hallways and training rooms. Observation was performed 1–10 days a month and included about 100 hours of meetings between 40 participants (65–94 years old) and eight health professionals. The conversations included unstructured dialogues with participants and health professionals.

Documents include the national fall prevention policies and guidelines five years prior to the study period and were selected by a literature search at the websites for The Ministry of Health and The Danish Health Medicine Authority 2002–2008 (7,9,30). Falls clinic documents included: screening schemes, action plans, referral lists, patient trajectory schemes, patient records and timetables/calendars. Figure 1 shows the different sources, materials and positions in the analysis.

Figure 1. Sources, positions and empirical material

<table>
<thead>
<tr>
<th>Source</th>
<th>Position</th>
<th>Material</th>
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<tr>
<td>Participant</td>
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<td>Observation</td>
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<td>professional</td>
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<td>Conversation</td>
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<td>Documents</td>
<td>Politician</td>
<td>The National Health Program, 2002</td>
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<td>The National Board of Health Project on Major Non-communicable Diseases, 2004</td>
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<td>The Fall Patient in Clinical Practice, 2006</td>
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<td></td>
<td></td>
<td>Screening schemes, action plans, referral lists, patient trajectory schemes, patient records, timetables, calendars</td>
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Site
The falls clinic was located at a university hospital as a part of the geriatric outpatient department; it was a separate service with dedicated staff time and training facilities. The clinic was open for adults above 65 years old who had fallen or sustained dizziness problems. Referrals were accepted from emergency units, home care services, preventive home visits, general practitioners and other hospital departments. Self-referral was not accepted. Annually the clinic assessed between 200–300 patients. The program consisted of a comprehensive geriatric assessment followed by individualized multifactorial interventions including treatment of relevant medical problems, medication optimization, exercise (strength and balance training), guidance and counseling in fall prevention and possible housing changes. The clinical team included two physicians, four nurses and two therapists.

The analysis process
Participant observations were recorded when approved (54 hours); in other cases, scratch notes were taken (46 hours). Records were transcribed verbatim and scratch notes transformed into detailed texts by the first author. In total, the text material consisted of 318 pages. First, the texts were naively read to understand what was said. Then all texts were reread to identify segments of falls and fall prevention. During this process, the selected segments were coded according to who represented the segment – to whom it was said and what was said. The following principles guided the data interpretation: (a) attention to the details and construction of the text; (b) focus on contradictions and disjunctions in texts; (c) identification of objects and subjects, and how texts were rhetorically constructed around and through them, and (d) examination of the ways in which specified institutions and categories of person were reinforced or disempowered in texts (26). The coded text segments were then reread and constructed into patterns of understandings of falls. Focusing on similarities and coherence versus contradictions and disjunctions in the texts made it possible to identify patterns of different and similar meanings of falls. The analysis presents the understandings of falls according to these patterns. The patterns and the borders between the understandings are formed according to how it was possible – and not possible – to talk about falls in the fall prevention program.

Ethical considerations
The ethics committee of the municipality approved the project (KF 07 301912). Study participants gave verbal informed consent to participate in the field study: they were promised confidentiality and anonymity. During the research process, the first author was reflexively aware of the asymmetrical power relation between researcher and research participants; e.g. participants may feel obliged to take part in the study project, and may hesitate to withdraw their consent to participation (23). To address this problem, all participants were asked several times dur-
Results
Speaking positions and understandings of falls
On the basis of observations, interviews and document texts, we constructed five speaking positions representing the dominant discourses of the older adults (participants), the nurses, the therapists, the physicians and the politicians. To guard the confidentiality and anonymity the nurse, therapist and physician perspectives were constructed into an overall health professional position. There were differences between the health professionals’ positions, however. For example, advice about weight and social activity was expressed frequently as fall prevention in the nurse’s position but rarely in the therapist’s and the physician’s positions. Our focus on similarities and coherence versus contradictions and disjunctions in text descriptions and excerpts allowed us to construct two dominant understandings, which supported each other:
1. Falls articulated as a preventable and predictable disease in old age
2. Falls articulated as a preventable and predictable lifestyle problem in old age

The results are constructed according to these two main understandings of falls and how they unfold through the program.

Falls articulated as a predictable and preventable disease
This understanding was the most dominant in the program and represented in all three positions, yet it was unusual or silenced in the older adult’s position. Falls were articulated as a complicated and dangerous disease that could and should be controlled by medical surveillance and expert help. First, participants were recruited through systematic fall screening and referral to the program. The recruitment practices assured that all eligible falls in home-dwelling older adults in the community were registered and monitored in databases at the falls clinic. Fall diagnosis codes (R29.6, W00-W19), building on the international classification system of diseases (ICD-10), were used in patient records to provide evidence for revenues to the clinic. Political documents (7) and screening schemes (check box) categorized older adults who had fallen, as ‘falls patients’. The category implies that these older adults are constantly at risk of falling and therefore particularly vulnerable. The use of ‘falls diagnosis codes’, ‘falls screening’, ‘falls assessment’ and the ‘falls patient’ category subordinated falls to the regimes of treatment and disease control. We identified these practices as directed by an underlying medical surveillance discourse where the idea is to predict and control diseases through surveillance of the bodies of a targeted population. However, the underlying idea of medical diagnoses providing revenue for the clinic suggests that the medical discourse was supported by an economic discourse.
On the initial visit, a comprehensive geriatric assessment was performed where all parts of the older body were examined in details for difficulties in activities of daily living, reduced peripheral sensation, impairments in posture and gait, cardiovascular problems, lower extremity problems, cognitive dysfunction, urinary incontinence, visual problems, and signs of depression. In total about 25 functional tests were conducted and more than a hundred questions were asked, such as:

- How would you say your health is?
  (a) Excellent, (b) very good, (c) good, or (d) less than good.

- Are you worried about getting up from a chair?
  (a) Not at all, (b) somewhat worried, (c) pretty worried, or (d) very worried.

- Do you wash your upper body yourself?

- Do you wash your lower body yourself?

- How much of the time within the last four weeks have you felt so down that nothing could cheer you up?
  (a) Always, (b) most of the time, (c) some of the time, (d) a little of the time, or (e) at no time?

These questions indicate that it was not expected of older adults to be able to manage activities such as washing their own body or to get up from a chair by themselves. The expectation of decline of older adults' functions along with the aging process indicates that a decay discourse was present. The discourse constructed older adults who had fallen as passive and uninformed ‘falls patients’ in need of expert help, whereas older adults perceived as at risk of falling were constructed as pre-patients.

The older adults were not only constructed, but also constructed themselves, as patients in the program. An example was a 78-year-old woman, who expressed relief after the thorough examination: «I thought falls merely were about age.» Referring to age as a natural cause of falling indicates that falls were commonly understood as connected to the aging process in the older adults' viewpoints. The comprehensive examination seemed to make some older adults realize that falls had to do with medical problems, but also to make some adults feel sick even when they were not. This perspective was articulated by a 91-year-old woman, who received bad test results and was referred to specialized assessment at a clinic for dementia. She explained: «To be honest, this visit made me sicker than I was before;» she did not want to participate in the program any more.

**Falls articulated as a preventable lifestyle problem**

This was the second most dominant discourse in the program, which was represented in all three positions. The understanding of lifestyle is directed by an underlying health discourse drawing on principles of responsibility. The idea is that good health includes a responsible lifestyle with lots of physical activity, healthy food and little/no alcohol, smoke and stress (5,7,28). According to the
A politician’s position a healthy lifestyle would not only ensure older adults a long and good life, but also a life without falls (5,7,28). A fall could therefore be interpreted as a sign of bad lifestyle and irresponsible behavior (5,7). We identified the core elements of the program as training and teaching participants to be physically active in a cautious way.

Participants were expected to transfer the programs’ exercises into daily activities at home. For example, climbing stairs, sitting and getting up from a chair 10 times in a row numerous times a day, and to stand on a foam mattress with open and closed eyes for a minute or more. Together the training practices created an environment in which the participants were encouraged and supported to cross individual limitations of their aging bodies through expert supervision, and continually to improve or maintain their functional level though an active lifestyle.

Many participants spontaneously affirmed that they were physically active outside the clinic. During a training session, a participant said to the health professional: «I’ve put your drawings up on the refrigerator and every time I open the door, I remember what I should do.» She referred to 3–4 drawings this health professional frequently produced to help participants remember how to exercise at home. The excerpt illustrates the extension of the program into the homes of the patients. One explanation is that the health professional continuously praised the participants for their exercise efforts. Yet, it may also reflect that many participants consciously or unconsciously started to care of their older bodies the way the health professionals suggested. This implies that though the practices the participants actually adopted an active lifestyle.

At the end of the program, professionals and participants created a written action plan with future goals for physical activity. Through conversation, participants were encouraged to think of ways to integrate physical activities and a healthy lifestyle into their daily lives. A difference between the written and spoken plan was that besides advice about being physically active, the conversation included systematical advice about being socially active (e.g. joining senior clubs or volunteer corps), avoiding alcohol, ceasing smoking and eating a diet according to their (under/over) weight. This health advice mirrors the health principles presented in political documents (7,9). Even though simply goals for physical activity were printed on the official action plan, the required conversation between health professionals and participants implies that advice about healthy lifestyle was an important and integrated part of this program.

During the program, the health professional assisted and supported the participants in reaching their full potential through their own efforts. After the program it was up to the participants to keep up the healthy lifestyle as shown in a conversation between a participant (P23) and a health professional (HP3) at the final visit.

HP3: You say you want to keep exercising?
P23: Yes, to keep myself fit by joining gym classes – and then to lose weight even
though that it is difficult with a sweet tooth. Fat is not my problem, sugar is. Yes, it is difficult (laughs).

The woman was not only aware of the importance of being physically active; she also cared about her health in other ways, such as by paying attention to diet and losing weight. Her comment about fat and sugar indicates that she knows about the unhealthy and healthy elements in her diet, but it is hard for her to live healthily all the time. The health professionals’ expectation of the participants to improve and maintain a functional level through self-surveillance after the program suggests that the participants were viewed as responsible (self-) caretakers after completing the program. The participant’s comment about her difficulties in living healthily implies that the principle of responsibility, which is based on a moral discourse, is associated with guilt and shame.

An underlying medical surveillance discourse seemed to not only to lie behind, but also to dominate the health discourse in that the practices in the training program were based on first expert surveillance and later self-surveillance. Through the exercise program, we identified a shift from the passive patient role to the active patient role. At the beginning and end of the program, the participants’ functional levels were measured, and throughout the program, exercise was monitored. For example, participants were instructed to count and register numbers of exercises to compete with themselves and other participants. Participants expected and demanded expert supervision at the clinic: e.g. if the health professional did not spontaneously supervise the individual performance, some participants would call him/her and ask for individual advice. Other participants needed approval of their exercise diary each session. When a participant had difficulties performing an exercise, not only would the health professional encourage her/him to continue, also co-participants would join in supporting and praising her/his efforts.

Even though many participants portrayed themselves as active, they also acknowledged the physical decline of their aging bodies. In this perspective, physical decline was not considered a limitation to physical activity. Nevertheless, many of the participants talked about their difficulties exercising in association with the aging process and bodily decline. The following excerpt is from a conversation between a health professional (HP5) and a woman in her eighties (P31), who exercises on a bike.

P31: I have gone from biking 13 km to 8 on my three-wheeled bicycle at home during the past years.
HP5: Hmm.
P31: It is because of old age, you know there is also something called old age? Yes, there is something called age! You just don’t know about it yet.
HP5: Hmm [moves to another participant].

Here the aging process seems to put a limit on physical activity even in a very active partici-
The woman relates to her age describing her active lifestyle. She exercises but feels a physical limit, which she sees as a sign of old age. Her emphasis on old age indicates that even though she thinks it is important to be active, she also finds it important to accept the aging process as a natural part of life, along with some acceptance of physical decline. By moving to another participant, the health professional indicates that it is difficult to talk about aging and bodily decline in the program. There might be other explanations. However, the excerpt shows that there are cracks in the health discourse and that decay and age discourses seem to speak against it.

Patterns of resistance
Evident patterns of ‘non-acceptance’, ‘no-show’ and ‘dropout’ made the dominant medical surveillance discourse lucid. Of the 271 eligible referrals to the MFP program in the project period, 68% (184/271) agreed to participate, 25% (69/271) never showed up, 27% (49/184) dropped out, while 39% (72/184) completed the program (count from trajectory schemes). The majority of the invited participants who never showed up, explained (by telephone) that they simply did not wish to attend the program or had no energy (registered on patient trajectory schemes by the nurses). When qualified participants first accepted and later declined participation (by not showing up) it indicates that some participants did not feel confident enough to turn down the offer when asked face-to-face by health professionals during the recruitment procedures. It also indicates that some participants may agree to participation due to acceptance of authority. The explanations of lack of energy illustrated that an underlying frailty discourse was present and spoke against the medical discourse.

Non-acceptance of referral was identified too through the screening program performed by preventive home visitors (HPV). During a three month-period, 526 health visits were performed where 57 older adults had falls, which were qualified for referral: 67% (38/57) of the older adults instantly (face-to-face) declined to the offer of referral (count from screening schemes). Some explained that they wished «to contact their GP» or «manage by themselves» (registered by HPV at the screening schemes). Such statements indicate that some of the older adults, who declined referral, were involved in their own health situation and considered themselves as capable of managing their falling episodes without expert help. The ‘non-acceptance’ pattern indicates too that relatively many older adults felt confident enough to decline participation to the fall prevention program when asked by health professionals face-to-face. Reasons for dropout were not registered at the trajectory schemes, yet as shown earlier in this paper, one participant explained that she dropped out because the program made her feel sicker than before.

Discussion
In the MFP program, the dominant understandings of falls were articulated as a disease and a lifestyle problem, which de-normalized falling in late life. A few other studies have de-
scribed the medicalization of falls (1, 12), but have not associated it with de-normalization of falls in old age. Together, fall prevention was managed, administrated and practiced as disease control. First all parts of the older bodies were measured and registered; then the participants' health was continuously monitored by medical experts and later by the older adults themselves. According to Foucault's idea about 'conduct-of conduct' the surveillance mechanisms in the MFP program may have gained the efficiency and ability to penetrate into the participant's behavior and made the participants monitor each other and themselves in a continuous self-discipline to live a healthy and active life (30).

Health professionals were constructed and constructed themselves as experts who provided expertise to assess, identify and treat underlying diseases in older adults' bodies, and as health educators who re-educated older adults to live a healthy life. The dominant subject positions constructed older adults as passive patients, active patients and responsible self caretakers.

These roles had similar characteristics as the 'passive recipient', 'rational learner' and 'empowered decision maker', which are explained in the beginning of the paper (22). Like Nyman and colleagues, we identified the 'passive' (patient/recipient) role as dominant. A difference was that representations of the 'responsible self caretaker'/'empowered decision maker' were consistent in the MFP program, but infrequent in websites.

The paradoxical nature of the patient's role was that the older adults were seen as in need of expert help and supervision, assumed to be dependent on personal assistance in activities of daily living, and to suffer from underlying pathologies in the older body. However, at the same time they were also expected to go through a comprehensive program and change behaviors, which demanded considerable physical and mental strengths. A contradiction was that participants were expected to be passive and uninformed about fall prevention, but at the same time to mobilize power and willingness to change lifestyle and systematically monitor their own health for the rest of their life. Like Ballinger and Payne (21), we demonstrate how the dominant biomedical understanding of falling silenced or camouflaged alternative understandings of falling in the domain. Our analysis adds further knowledge about the paradoxical nature of the patient role and how it reproduces the biomedical perspective.

In the decay discourse the aging process is understood as a natural and inevitable part of life in the way that physical decline puts limitations on the aging body. In the decay discourse falling is understood as an inevitable and natural part of late life. As in many other studies (1,13–21), this understanding was quite explicit in the older adult's positions; however, it was silenced in the position of the health professionals and absent in the politicians' position. A paradox is that the political documents describe 'advanced age' as the most important risk factor for falls (3–10). In the beginning of the paper, it was mentioned how other studies have shown that the moral discourse produced feelings among older
adults such as guilt and shame (14, 21). Likewise, our study shows how some older adults expressed feelings of guilt and shame if they failed to improve or maintain an active and healthy lifestyle.

Study limitations and clinical implications

The findings in this study cannot be generalized to all multifactorial fall prevention programs. However, it contributes to a small but developing body of research exploring the consequences of falls and fall prevention services from a critical perspective in the domain of fall prevention. Even though data were collected up to eight years ago in the program, the political recommendations and guidelines from 2014–2015 still recommend multifactorial fall prevention as the best way to prevent falling in late life (6, 10). Another strength is that no other study has actually explored understandings of falls and falls prevention practices in a multifactorial falls prevention program before.

A weakness is that the preventive home visit unit was the only site that systematically registered ‘non-acceptance’ of referral throughout the screening process and shared their screening schemes with the falls clinic. It is therefore not known if similar ‘non-acceptance’ patterns exist at all the other sites in the program. However, national and international studies show that ‘non-acceptance’ is a well-known pattern in fall preventive services (5–11). The results are considered consistent; they contribute new knowledge and may provide health professionals with a deeper insight into the complexity of falls prevention.

Conclusion

The dominant medical surveillance and health discourses supported each other in the MFP program and produced falls as a lifestyle disease that could be predicted through systematic surveillance and monitoring of older adults’ health in the community. In the program, participants were transformed from irresponsible passive patients to responsible active patients, who learnt to monitor and care for their own health in a lifelong perspective. This analysis suggests that older adults’ reluctance to participate in fall prevention programs might be connected to unwillingness to undertake the patient role. However, the health professionals’ motivating strategies and the older adults’ willingness to monitor their health in different ways identified in this program may be used to develop new surveillance and self-surveillance strategies targeting patients with different chronic diseases.

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