

**PIONEERING A NEW APPROACH
TO HOME EXERCISE:
PHYSIOTHERAPY FOR OLDER ADULTS
THROUGH COMMUNITY TELEVISION**

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in Partial Fulfillment of the Requirements
for the Degree of Master of Adult and Continuing Education
in the Department of Educational Foundations
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ABSTRACT

The purpose of this case study was to describe my experience, as a physiotherapist, producing a chair exercise program for older adults through community television in Weyburn, Saskatchewan, between 1996 and 1998. Because television production by a physiotherapist has not been previously documented, I also sought to determine the acceptability of the television program by viewers and other physiotherapists.

This study was based on a qualitative research design. I used documents, program video tapes, and personal journal entries to tell my story. Data was collected through interviews with twelve older adults and five physiotherapists. I represented the data as a town hall meeting. I created a "moderator" to facilitate the discussion, and a "panel expert" to provide analysis and interpretation based on the literature. The findings were highlighted throughout the discussion as "key points."

The older adult participants spoke about the convenience of televised exercises. They indicated that exercises on television were easier to follow than on handouts. The benefits of the exercise program were less stiffness and joint pain resulting in greater ease of movement. Another key point was ongoing motivation and adherence: some viewers continued to follow the exercise program three to four years later. They indicated they would like to see the television program continue; the production of new shows was recommended. These findings were of interest to the physiotherapists. Even though they accepted televised exercises within the scope of physiotherapy, they expressed concern for the safety of the participant. They discussed the importance of being able to screen and monitor viewers, and evaluate the program.

The results of this study indicate that community television is an effective and appropriate means of delivering an exercise program for older adults; this program could be of value in other communities with an aging population. Finally, the use of television expands the delivery of physiotherapy beyond the traditional treatment paradigm to one of health promotion and prevention.

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CHAPTER ONE

MAPPING THE TERRITORY

As any writer knows, the only thing that keeps you holed up in the library or hunched over the computer is the excitement of learning more about your subject and inadvertently yourself.

-Sandra Martin

Introduction

"Tape rolling. . . ready in 3,2,1. . ."

"Good morning and welcome to Chair Exercises for Older Adults. My name is Velda Coulter, and I'm Sharon Elliott, Community Therapist for the South Central Health District. . ."

What was I doing? I had been in Weyburn less than a year; not only was I producing a television show, I had taken the liberty to include it in my work as the community-based physical therapist. Is television production even a role for a physical therapist? At the time, I did not question it. Once the camera was rolling, I never turned back. There was a sense of permanence and importance with television production. For me, television was an ideal vehicle to reach the frail, housebound, and institutionalized elderly. It allowed me to deliver a message about the importance of exercise to maintain mobility as one grows older. As I reflect back on my experience, I realize I was pioneering a new area of practice within the physiotherapy¹ profession. How did that

¹The terms physiotherapy and physical therapy are considered synonymous, as are physiotherapist and physical therapist (Canadian Physiotherapy Association, 2000).

happen? What was it all about?

This study is about my experience of producing² a television program while I worked as the community therapist in Weyburn, Saskatchewan, from 1996 to 1998. The program, *Chair Exercises for Older Adults*, was developed to provide housebound seniors³ with the opportunity to participate in an exercise program broadcast on the community channel⁴ every weekday morning. Twenty-six half-hour programs were produced; each show included approximately twenty minutes of chair exercises plus a short interview segment.

As the producer, I included over seventy people from the community—many of whom were older adults—as host, guest, and exercise participants. As a physical therapist, I instructed the exercises and provided educational information throughout the series. The program was first aired in September, 1997, and continued to be broadcast on the community channel in an edited format featuring the exercise segment, up until September, 2001, when new programs were produced.

²A producer co-ordinates the entire project, controls the content of the program related to the overall vision/mission statement, works with members of the production team, and delegates tasks to members of the team. Our team in Weyburn had just three people: myself; Brent Allin, the director from the television station; and Velda Coulter, a retired teacher, who hosted the program.

³The terms seniors, older adults, older people, elders, and elderly are used interchangeably and will refer to persons sixty-five years of age and older (MacKeracher, 1998).

⁴The community channel is synonymous with community television, local cable television, and local access cable television.

Purpose of the Study

The purpose of this study was two-fold. The first purpose was to document my experience of pioneering and producing the television program entitled *Chair Exercises for Older Adults*. Television production is a new territory for physiotherapists, and therefore, documenting how and why the program was produced is an important first step in exploring this field of practice. The second purpose of this study was to determine the acceptability of this program to older adults in Weyburn and physiotherapists. Thus, feedback from both groups will provide future direction for the television show, as well as for physiotherapy practice.

Research Questions

This study addressed three key questions. First, “What was my experience as a physical therapist in producing the TV program, *Chair Exercises for Older Adults*?” Essentially, describing this process provided me with an opportunity to reflect on and analyze the scope of the profession and the borders which I believe can, and perhaps should, be expanded.

Second, in an effort to explore the initial question, I included other physical therapists in the study: “How do physical therapists respond to my involvement in producing a chair exercise program on TV?” In other words, I wanted to know if television production is an acceptable role for a physical therapist.

The third research question was: “What are the experiences of viewers who have watched, or continue to watch *Chair Exercises for Older Adults*?” The program was

produced for a specific segment of the older adult population in Weyburn, mainly those who are frail, housebound, and institutionalized. Informal feedback indicates people are watching the program, but exactly who is watching? Are they participating in the exercises? Why or why not? What are their impressions of the program? Feedback from viewers is essential to guide the future of the program: either new programs are produced or the show is taken off the air.

The staff at Weyburn's cable access station have been reluctant to take the program off the air because they still receive phone calls from people who follow the exercises. (Most often this occurs on days when the program does not air due to technological difficulties or a live community event.) Ideally, the staff of Weyburn's community television station would like new programs: the original shows were taped on VHS and the broadcast quality pales in comparison to programs on the community channel now taped on digital.⁵ Until new chair exercise programs are produced, however, the staff have no other choice but to broadcast old episodes—a seemingly endless repetition of old shows. Results of this study pave the way for new programs.

⁵VHS (Very High Frequency) refers to a band of the electromagnetic spectrum over which television signals are transmitted. Digital signals are numbers that encode and process information in binary digits or bits, similar to a computer disk. Digital signals convey information exactly as they were recorded or transmitted (Ellis, 1992).

Staking the Boundary: Research Design

...all forms of study have the potential to add to knowledge and understanding.
-Domholdt, E., 2000, p. 60

Approval from the University Advisory Committee on Ethics in Behavioural Science Research was received before initiating the research process (Appendix A).

A qualitative case study approach is used as it allows reflection and understanding of a particular phenomena: a specific, unique, bounded system (Stake, 2000). In this study, the phenomenon, or case, is the television show. A case study offers room for a detailed description of the program. This is particularly important since (1) televised chair exercises have not been documented in the research literature to date, and (2) television production as a role for a physical therapist has not been explored. This uncharted territory calls for a method of inquiry that allows discovery through description.

I have chosen a qualitative research design over a quantitative design for a number of reasons. First, the focus of this study is on discovery, insight, and understanding, rather than hypothesis testing or prediction. Second, the collection of data is derived from documents, and the interviewing and observing participants in the field or natural setting, rather than the use of inanimate measurement instruments in a controlled environment. Third, the analysis is primarily of words, and not numbers; an inductive research strategy is used rather than a deductive mode of analysis using statistical methods. Finally, the end product is a “rich description” rather than a document which contains precise, numerical findings (Merriam, 1998).

I use a narrative approach to describe my experience of television production, as well as the experience of viewers and the opinion of physical therapists. This form of inquiry can contribute to the knowledge base of physiotherapy, gerontology, health promotion, adult education, and communications. Two methodologies that reach across multiple disciplines are story-telling and interviewing. Both methods are used in this research study.

Story-telling

I begin with a description of my experience of producing the television show by using the four stages of story-telling (Feather & Labonte, 1995):

- (1) a rich or detailed description of what happened,
- (2) explanations for what happened,
- (3) reflections on the practitioner's role in the story's events, and
- (4) action planning as to what the practitioner did right and what might be done differently in the future.

Story-telling as a method of inquiry is used by the Prairie Region Health Promotion Research Centre at the University of Saskatchewan and provides a local connection. It allows reflection on practice-based knowledge, and serves as a form of research into health promotion practice. My reflection on practice includes excerpts from program video tapes, program documents, and personal journal entries.

In telling my story, I document the concrete details of my experience with attention to "my physical feelings, thoughts, and emotions" (Ellis & Bochner, 2000, p. 737). Throughout this process, I have had to recall elements of my experience which were less than positive. Conflict and tension existed. There were painful moments.

And, I have some regrets. Labonte, Feather, and Hills (1999) encourage health promotion practitioners to identify tensions or strained relations that exist in practice. Ellis & Bochner (2000) support and guide researchers when the researcher's experience is the topic of investigation, where personal writing is a method of inquiry.

Personal Writing in Physiotherapy: A Pioneering Process

It doesn't even occur to most authors that writing in the first person is an option. They've been shaped by the prevailing norms of scholarly discourse within which they operate.

-Ellis & Bochner, 2000, p. 734

I am influenced by the growing number of educators, sociologists, and anthropologists who use personal writing in their research. It is engaging and connects me with the researcher. For me, personal writing bridges the gap between researcher and reader.

I struggle with physical therapy research articles written in the third person. It is as if the researcher is not even there. And yet, the researcher's presence is fundamental to the entire study. The presence of the researcher seeps through every component: it underlies the research question(s), and shapes the methodology; it lingers in the analysis, and the way in which the findings are presented. Behind a rigorous scientific approach and formal academic writing is the researcher.

Who is the researcher? The only information I can glean in reading a research article is the person's name, credentials, and place of employment (usually a hospital, a clinic, or academic institution). There is little to connect me with the researcher. As a

result, I rarely read a research article in its entirety. Personal writing, on the other hand, includes the researcher's position and perspective. Not only do I read the entire text, but I begin to relate it to my own experience. For me, this is the link between theory and practice which I have been looking for.

Personal writing is not limited to social scientists. Those in the "helping professions" can also benefit from exploring personal writing (Ellis & Bochner, 2000). Physical therapists are just beginning to use personal writing as a form of inquiry. For example, Carol Schultz (1998), an Australian, reflects on her twenty-five years of work as a physiotherapist in her Master's thesis in education. The purpose of her autobiographical research is to understand the use of her hands as a means of facilitating health improvement, restoration, and maintenance. She uses techniques such as "sketching," "poetising," and "visual imaging" to describe and reflect on her experiences.

Sue Stone (1991) pleads for creativity in research. She encourages physical therapists to expand their methods of inquiry beyond the quantitative research paradigm to include qualitative research. There is room for more than one approach, and yet, in the "profession's quest for objective evidence to use in evidence-based practice, the value of qualitative research has been ignored and disproportionate emphasis has been placed on quantitative research designs" (R. Henderson, personal communication, Oct. 12, 2001).

Physical therapists "have been more conservative over the years, when it comes to new frontiers. . .[because of] our 'growing up' under the wings of the medical

system” (C. Schultz, personal communication, Aug. 23, 2001). The nursing profession had a similar past, but it has successfully broadened the dimensions of the research process (Parse, 2001). I believe that physical therapists can as well; however, this is not without challenge.

Schultz (1998) recognizes that “researching the self carries an element of risk and, as such, presents a personal challenge. . .in negotiating the process and weathering its varied responses” (p.117). I can relate. I am the researcher and also the subject of the study. I am both the pioneer and the new territory. There is a feeling of vulnerability.

Ellis (1999) and Behar (1996) support the vulnerable researcher: “If you let yourself be vulnerable, then your readers are more likely to respond vulnerably, and that’s what you want, vulnerable readers” (Ellis, 1999, p. 675). Vulnerable readers are more likely to connect with the research and, hence, apply it to their own experience and knowledge base.

In this study, I am not only exposed to the reader, but also to the participants whom I interview. For example, I know three of the physical therapists (the physical therapy community in Saskatchewan is small) and they know me, especially since I assumed the position of president of the provincial professional association at the same time as I conducted the interviews. I am a physical therapy leader conducting research on a professional issue that has personal meaning to me. There is an element of vulnerability being in multiple positions. I also know five of the older adults in Weyburn who agreed to participate in this study. I cannot distance myself from the research process, nor do I try. Instead, I identify and describe this layer of the research

(Moch & Gates, 2000).

Rounding up the Participants: Sample Size

I hand-picked five physiotherapists to participate in this study: two clinicians, a government consultant, a professional leader with community-based experience, and an educator. They were purposely chosen to provide a broad representation of the profession. All participants are female. I contacted these women either in person, by telephone, or e-mail.

The recruitment of older adults in Weyburn required a variety of approaches. I purposely visited one public and two private long-term care homes where I knew that some of the residents followed the exercise program. I approached the owner or staff member on duty and introduced myself (if we did not know each other) and explained why I was there. At one care home, I sensed a sigh of relief from the staff members: *“Finally, the person who produced the program has come to find out what the residents have to say.”* They even hinted that they would not have to listen to the residents complain about the repetition of the television program any longer. I recruited five participants from three care-homes.

I also recruited participants from a list of names of people who had written or telephoned the television station a few years ago to offer their support of the program. Two people agreed to participate in this study. At this point, I planned to use the “snowball” sampling technique to expand sample size (Merriam, 1998). I asked the participant to refer me to someone else who also watches the program, however, the

response was similar: "*I don't know one person that has ever mentioned that they do them.*" This remark surprised me. My perception of a close-knit community, especially within senior's residences, was wrong. There was a greater degree of isolation amongst older adults than I had anticipated.

Realizing I needed another pool of participants, I put an announcement on the Community Channel's Bulletin Board requesting feedback about the chair exercise program. I provided my first name and home phone number in Weyburn. I received a total of six phone calls. Some individuals left their name and phone number while others did not. Information from call-display (name, phone number, and time called—usually right after the program, i.e., 10:29, 10:31 a.m.) indicated a potential participant. I contacted everyone that called. Two callers were happy to talk with me over the phone but were not willing to meet in person: "*That's all I have to say,*" was their response. Four agreed to be interviewed in person.

I recruited one more person when I was delivering Meals on Wheels (a service I fulfill when I am in Weyburn and they need a spare driver). This person was a past client of mine when I was the community therapist. Eleven women and one man between the ages of 75 and 95 were included in this study. A sample size of approximately ten to fifteen persons is estimated to reach saturation or a point when no new information is forthcoming (Kvale, 1996). No one withdrew from the study.

Interviewing

Upon meeting the participant, I explained the nature of the study and obtained written consent. Three separate consent forms were prepared in advance: one for physical therapists, one for older adults, and a modified consent form for older adults (Appendix B). The latter form was for a third party to sign on behalf of the participant in the event that the participants were physically unable to sign for themselves. One person used the modified consent form.

I conducted semi-structured interviews with both the physical therapists and the older adults. Separate “interview guides” were prepared ahead of time (Appendix C). All interviews were taped. I individually met with three of the physical therapist participants at their place of work. The other two physical therapist participants were from out-of-province and were attending a continuing education course; I met with them together at the hotel where they were staying. I met with the older adult participants in their home. All interviews were held individually, except at one long-term care home where I met with three women together in the dining room.

The interviews took approximately 30 to 45 minutes, longer if the conversation strayed to other topics that did not necessarily contribute to the purpose of the study. This happened with both the physical therapists and the older adults, but more often with the latter group. One woman in her 90's realized she was straying off topic: *“I can never keep quiet when I’m suppose to!”* The need to talk to someone was appreciated.

Researcher as Learner: Elders as Teachers

The interviews with the older adult participants were a source of learning for me. For example, I was greeted with a willingness I had not anticipated. It was as though they had been waiting to be asked, and rightly so. After all, the program was about them and for them. They had lots to say. On more than one occasion, some of the older adult participants were so eager to tell me what they thought of the program that they began talking right away: this was even before I could pull out my tape recorder and inform them about consent. I learned that my seeking feedback on the television program was long overdue.

A few of the older adult participants expressed concern that this was an interview for a university research study. One participant related how she felt self-conscious about her lack of education and ability to give an answer that was worthy of a study. The “ivory tower” image was intimidating. I learned to downplay the words *interview* and *research study* to decrease any anxieties. I explained that I simply wanted to talk with them about the television program. I learned to shape the interview into a conversation.

Kvale (1996) describes the interview process as a conversation between two people. Within this conversation, I learned about their activity level when they were younger: “*Farm people don’t need exercise especially when you have to stook like I did.*” I learned about their current level of physical activity: “*I used to love walking and I can’t hardly walk anymore.*” Several people talked about how they were unable to get out anymore, and that few friends or relatives came to visit. The topic of loneliness surfaced on more than one occasion. I learned that the interview served a

greater purpose than collecting data for a study: it provided a connection with another human being.

Some participants were hard of hearing, and I learned to slow down and lower the volume of my voice as I repeated or reworded the question. One woman in her 90's was tired before we began and, even though she remained attentive and gave thoughtful answers, the volume of her voice gradually diminished. My voice-activated tape recorder missed some of our conversation and so, I learned to use a different tape recorder and position it where it would not be distracting yet still pick up the conversation.

Some of the older adult participants recognized me by "the voice" on the exercise program. A few did not make the connection at all and referred to the instructor of the television program as *she* or *the woman*. Those who knew me (five altogether) tried to remain candid and objective with their responses: "*And it's not just because it's you I'm talking to.*"

At the care home where I met with the triad, I learned there was support for one another. For example, at one point during the interview, they questioned whether they should be truthful, especially if they had something negative to say: "*Of course, that's what she wants,*" they reassured one another.

I learned that some of the participants wanted to know what others had said about the program: a reassurance that they were not alone in their opinions, or that they were the only viewers. As far as they knew, they were the only ones following the exercises. A family member of one of the participants was present during the interview

and told me, *"If it's going to help someone else then use it whatever way you need to."*

I was amazed at the resounding interest in, and commitment to, the television program.

Data Analysis and Synthesis

I conducted the seventeen interviews between late April and early August, 2001. After each interview, I made notes about each participant, the setting, and any thoughts that arose at the time. I transcribed each tape and replayed it a second time to ensure accuracy and correct any errors in the transcript. I provided the participants with the opportunity to review the transcripts. While this was done by e-mail for the physical therapists, for the older adult participants, I suggested a second visit to review the transcript. Six of the elderly participants agreed to this.

I used the second visit to confirm initial findings and to gather further information if I felt there were gaps after the initial interview. (In the initial interview, I made notes of questions I should have asked or places in the conversation where I could have probed a little deeper rather than going on to another question). During the second visit, I verbally reviewed the initial interview with the participant by using phrases such as *"we talked about this and you said. . ."* or *"one point that you mentioned was. . ."*⁶ The older adult participants confirmed what they had said and often added further information. I taped and transcribed the second interview and included this

⁶The majority of the older adult participants declined the opportunity to read the typed transcript. This could have been related to their level of education (Grade 5 to Teacher's College), when they were educated (over 50 years ago), vision and hearing impairments, how they perceived a university research study, or perhaps a combination of these factors.

information in the analysis. Permission to use the data for this study was sought using a Data-Release Form (Appendix D).

Data analysis occurred simultaneously with data collection. I chose to organize the data by hand, rather than through the use of a computer program, because this was my first qualitative research study—I wanted to work directly with the data. I felt the amount of data was manageable by hand, and it was. Also, I learn through a hands-on approach. Besides, a computer program would have added additional costs, not to mention the time required to learn the program.

On the transcripts, I underlined and highlighted key words or phrases, and made notes in the margins of potential themes and important points. Feedback from members of my research committee validated findings as they emerged, generated additional questions to be addressed, and provided direction as the research progressed. At this point, I did not have a vision as to how I would present the data in the written text.

Initially, I worked with the transcripts of the viewers and those of the physical therapists simultaneously but separately. I was on two different paths at the same time—no wonder I felt as though I was not getting anywhere. Similar themes surfaced from the transcripts of both groups. I decided to merge the two sets of data analysis.

Immediately, a dialogue emerged between the older adults and the physical therapists. Sometimes the conversation was complementary, while at other times it was juxtaposed.

Ellis (1999) states that “analysis can come through story and dialogue” (p. 676). Coffey and Atkinson (1996) describe the construction of a conversation between separate interviews as an alternative literary form. Although I was encouraged, it was

still not clear where this path was leading. I put the chapter aside. It was August, 2001. Then, the events of September 11th, 2001 occurred.⁷

People needed to talk. One night, as I was talking with a friend in Toronto (she was preparing to defend her Ph.D. dissertation), she ended the conversation so she could watch “a town hall meeting” on the Canadian Broadcasting Corporation (CBC) television that was starting in a few minutes. Town hall meetings were appearing on national television and in local communities across the country as a forum to discuss the terrorist attacks of September 11th. After I hung up the phone, I, too, turned on the television and watched.

The town hall meeting was set up in a CBC studio in downtown Toronto, Ontario. A studio audience was seated in a horseshoe shape; a panel of “experts” (primarily politicians and academics) were seated in chairs on a low stage. A large screen television connected guests from other Canadian cities. Peter Mansbridge, anchor for the CBC nightly news, was moderator. After two hours of discussion and debate, the underlying message for me was: life must go on. Indeed. I continued to teach physical therapy students, work on my thesis, and fulfill the demands and duties as president of the provincial professional association. The analysis section of my thesis continued to elude me, and, once again, I put this chapter aside.

In October, 2001, I was preparing a class for final year physical therapy students at the University of Saskatchewan. I had just attended a session on teaching techniques

⁷September 11, 2001: Terrorist attacks on the World Trade Center, New York City, New York, and the Pentagon, Washington, DC.

at the university. One technique that was discussed was the debate. Although I thought a debate would work, I wanted something more creative. Then, the idea of a town hall meeting came to me. I reflected on the town hall meeting that I had watched on television the month before and I decided to design the class as such.

At the beginning of the two hour class, I gave a one-page handout to the students that described the purpose and format of the class. I listed the roles needed to turn the class into a town hall meeting: moderator(s), panel experts on two different views about exercise (the experts were given written documents to formulate their positions), physiotherapy experts, and a studio audience. The final year students easily and evenly divided themselves into the different roles and eagerly began to prepare for this unique learning experience.

Two male students shared the role of moderator. They introduced the town hall meeting from a small town in Saskatchewan and indicated that it was being “televised.” They gave “air time” to the two groups of students who were panel experts on exercise with differing views. Two of the students even prepared an entertaining “television commercial” that featured the benefits of exercise. The students who were the physiotherapy experts responded to the different viewpoints. The moderators invited the “studio audience” to ask questions, but only if they used the imaginary microphone they had set up in the middle of the room. It worked beautifully! All sides of the issue were presented and everyone was actively involved and engaged. This class was the turning point for my thesis.

Energized by this positive experience, I immediately took the constructed

conversation that had emerged in my data analysis several months earlier and developed it into a town hall meeting. I intuitively knew it would work. I added a moderator, a panel expert, and a studio audience; a regular font was used to depict these roles. The text of the twelve older adults and the five physical therapists was italicized to indicate direct quotes from the research interviews. It worked beautifully! All sides of the issue were presented and everyone was actively involved and engaged.

Merriam (1998) describes the importance of achieving a balance between description and interpretation when writing up qualitative research. The role of the panel expert was to analyze and interpret the descriptive data based on my readings of the literature. Key points emerged. I highlighted the key points as they appeared during the discussion by enclosing them in boxes.

In the context of this study, the town hall meeting allowed the voices of the older adults and those of the physical therapists to be expressed as a group in one location (some of the housebound participants were “connected” to the hall by interactive video). The town hall meeting strategy also allowed me, the researcher, to stand back and observe. I participated only when necessary.

However, there were limitations with this method of writing. I had to ask myself, what does the town hall meeting not allow? A town hall meeting is a public forum where voices are heard equally. In reality, older adults do not have this equal voice with other stakeholders. We are a youth-oriented society, and, although seniors are the fastest growing segment of the population, they still tend to be marginalized. I like to think this will change. I like to think that this study will help in this regard.

One final note: generalizability, the ability to generalize from this single case, is not possible, precisely because of the uniqueness of the study (Merriam, 1998). As such, this needs to be considered a limitation of my study. However, by providing a rich, thick description of this case study, there is the possibility that readers, i.e., other health care practitioners may be able to match their situation with my research experience—in which case, some of the findings of this study could be transferred.

Land Titles: Naming the Sections

A pioneer theme shapes this thesis: it is both the journey and the new territory. I have always felt a strong connection with prairie pioneers. My grandparents came to the Canadian prairies in the early 1900's, and I grew up on the family farm in Saskatchewan where I heard and experienced the stories of my ancestors. My connection to pioneers continues to this day, perhaps because I am one of them.

The chapters are like sections of land. The first section (Chapter 2) describes the history of physiotherapy in Canada from its pioneer roots to present day practice. Included is a theory of physical therapy which provides a framework to explore the new territory of television production. A part of the section explores how physiotherapists can be creatively involved in promoting fitness, health, and wellness—also new territory for the profession. I reflect upon my path within the physical therapy profession: the trail that leads up to the television program in Weyburn, Saskatchewan.

In Chapter Three, Weyburn is named and local landmarks of this prairie city are highlighted. We observe Weyburn as a retirement community, and we discover the role

that television plays in the lives of older people. This section explores the history of cable television and the roots of community television. Examples of innovative community-based television programs are highlighted, including those that are produced by and for older adults. This section ends by naming television programs that have been produced by health professionals, as well as the few televised chair exercise programs that exist now.

Chapter Four is devoted to my pioneering experience in producing the television program, *Chair Exercises for Older Adults*. Chapter Five takes us to the town hall meeting where the interview data and analysis interweave into a discussion between the physical therapists and older adult participants of this research study. In the concluding chapter (Chapter Six), the results are summarized, theoretical implications are discussed, and recommendations are made based on the findings of this study.

Shall we begin?

CHAPTER TWO

PIONEERS AND NEW FRONTIERS

*Pioneer (1) an initiator of a new enterprise, an inventor, etc.,
(2) a settler in an unsettled land. . .*

-Canadian Oxford Dictionary (Barber, 1998)

*Physiotherapy is grounded in the belief that, to be effective,
its services must respond to the changing needs of populations.*

-Canadian Physiotherapy Association, 2000

Breaking Ground: Physiotherapy in Canada

The roots of physiotherapy in Canada reach back to World War I when wounded soldiers returned in need of physical rehabilitation. British-trained therapists established intensive training courses across Canada in 1917 (Cleather, 1995). Rehabilitation personnel were trained in one of four areas: (1) masseuses and masseurs, who administered light, heat, hydrotherapy, and electrical treatments, as well as massage and passive exercises; (2) muscle function trainers, who did muscle tests as well as active and resisted exercises with apparatus; (3) occupational therapists, who kept convalescents busy with handwork, i.e., basketry and carpentry; and, (4) sergeants, who led gym classes for men who were either ready to rejoin their units or to be demobilized (Cleather, 1995).

The profession of physiotherapy was pioneered by those who were trained in massage and its adjunct therapies. In 1920, the Canadian Association for Massage and

Remedial Gymnastics (CAMRG) was formed as a sign of solidarity and professionalism. Then, in 1935, CAMRG became the Canadian Physiotherapy Association (CPA) and remains the national organization that provides leadership and representation to the physiotherapy profession and physiotherapists in Canada (Canadian Physiotherapy Association, 2000).

A challenge for physiotherapists during the early years was to demonstrate the value of physiotherapy to the medical profession. Every therapist at that time was a pioneer as they worked—and in some cases, volunteered—their way into hospitals, children's ward, and private clinics in the community. The medical establishment gradually accepted the need for physiotherapy departments and looked to the CAMRG for administrative help. "CAMRG's tasks included monitoring the training of new therapists, arranging interning for students, and maintaining a register of certified therapists" (Cleather, 1995, p. 4). The new profession could not risk to lose ground through unqualified practitioners.

During World War II, Canadian physiotherapists served overseas and in post-war rehabilitation. At the same time and in the post-war period, they responded to the polio epidemic and provided treatment to reduce pain and deformity in the limbs of children affected with the disease. In the 1950's, physiotherapists established a role in helping injured workers return to work. They were also called to work in newly established hospital-based and mobile clinics for the treatment of arthritis (Cleather, 1995).

Physicians who had been sceptical, even resistant, gradually acknowledged the benefits of physiotherapy. The demand for physiotherapists across the country

increased. Beginning in the 1940's and onwards, "each province brought in legislation to regulate the profession through licensing boards, which were responsible for ensuring that only qualified physiotherapists were registered to practice" (Cleather, 1995, p. 36).

Even though the profession was gaining recognition and acceptance as a health discipline, professional issues plagued its growth. Physiotherapy intervention was deemed a "technical" orthopaedic approach and this diminished the professional status that was deemed so important in the early years. The female staff were uniformed like nurses; this blurred the lines of duty between the professions and prevented the development of an autonomous profession. Mandatory physician referral along with a prescribed treatment regime limited freedom of practice.

The 1960's and 1970's were more progressive. A team approach emerged where paramedical personnel, i.e., occupational therapists, speech-language pathologists, and social workers, worked together in the clinical setting to enhance rehabilitation practices and the quality of patient care (Rothberg, 1981). Scope of practice broadened to include an even wider spectrum of patients in rehabilitation, acute, and long-term care.

Three areas of practice were firmly established: neurology, i.e., cerebral palsy, spinal cord injuries, head injuries, strokes; cardiorespiratory care, i.e., intensive care units, post-operative patients, out-patient care for chronic bronchitis and cystic fibrosis; and, orthopaedics. Physiotherapy practice encompassed all age groups from newborns to the very old.

Meanwhile, concern over their technical status prompted physiotherapists to move toward scientific-based theory and practice. Beginning in the 1960's, the CPA

encouraged physiotherapists to carry out research activities relevant to their clinical practice (Cleather, 1995). To further their professional status, university-based diploma programs were replaced by baccalaureates; graduate programs in physical therapy and rehabilitation medicine emerged and continue to grow to this day. Provincial licensing boards lobbied governments so that clients could see a physiotherapist without a physician's referral. Today in Canada, physiotherapy is an autonomous, self-regulated health discipline.

The 1980's saw an increase in demand for physiotherapy services, not only in hospitals and rehabilitation centres, but also in home-care programs. In 1985, the Executive Director of the Canadian Physiotherapy Association (CPA), Nancy Christie, identified three emerging trends in health care: gerontology, community-based services, and health promotion.

A decade later, Christie reflected on how these areas "had indeed become important, but she suggested that, with a few exceptions, physiotherapists had not taken new initiatives in dealing with them" (Cleather, 1995, p. 190). Furthermore, she stated that "[t]he emphasis on research and strengthening of physiotherapy credentials in traditional ways, which fit the medical model, seem to have resulted in less energy being directed to non-traditional, creative outlets for physiotherapy skills" (Cleather, 1995, p. 190).

To utilize physiotherapy skills in non-traditional ways is to pioneer a new path of practice. A recent theory put forth by physical therapy researchers at the University of Toronto supports practice beyond the traditional borders.

Broadening the Borders: A Theory of Physical Therapy

Cott, Finch, Gasner, Yoshida, Thomas, and Verrier (1995) proposed the Movement Continuum Theory of Physical Therapy. This theory establishes that *movement* is the foundation of physiotherapy. Physical therapists specialize in movement and function. The theory goes on to state that movement is a multidimensional continuum from a micro level (molecular) to a macro level (person in society). Physiotherapy interventions—to restore, improve, maintain, or prevent loss of movement—can be directed at any point along this continuum.

In practice, physiotherapy interventions “are usually specifically addressed at the middle range of the continuum, from the tissue level to the movement of the individual in the environment” (Cott et al., 1995, p. 93). In other words, physiotherapy treatment is traditionally provided directly to individual clients—most often, in medical and rehabilitation settings. The macro end of the Movement Continuum Theory of Physical Therapy, however, accommodates prevention, wellness, and health to individuals and groups at a community level and beyond.

The Canadian Physiotherapy Association’s definition of physiotherapy includes the promotion of fitness, health, and wellness (Canadian Physiotherapy Association, 2000). The Competency Profile for the Entry-Level Physiotherapist in Canada also includes health promotion in wellness and disability as one field of client service (Canadian Alliance of Physiotherapy Regulators, Canadian Physiotherapy Association, & Canadian University Physical Therapy Academic Council, 1998). It should be noted that this latter document refers to “client” as the person, group, community, or

organization receiving physiotherapy services, products, or information.

Promoting fitness, health, and wellness at a community level appears to be within the scope of the practice of a physical therapist; however, as evident in the literature, this area of the profession has yet to be fully developed.

New Territory for Physiotherapists: Promoting Fitness, Health, and Wellness

Francis (1999) reviewed the objectives outlined in the document, *Healthy People 2000*, a strategy developed in 1990 to improve the health of Americans by the year 2000. One of the objectives is to “increase to at least 50% the proportion of primary care providers who routinely assess and counsel their patients regarding the frequency, duration, type, and intensity of each patient’s physical activity practices” (Francis, 1999, p. 411).

Francis believes that physical therapists are in an excellent position to promote an active lifestyle to an otherwise sedentary population. He suggests integrating “physical activity counselling” to patients during their regular visits, which could be as simple as suggesting a brisk walk. This approach, the author states, is “[o]ne of the most effective means by which a physical therapist can have an impact on the patient’s ability to change his or her health behaviour. . .” (p. 412). One limitation with this approach is the number of people who can be reached within the traditional treatment model of individual visits.

Rimmer (1999) envisions physical therapists actively participating in community-based health promotion for people with disabilities. He invites physical

therapists to act as consultants at fitness centres in the community where it is expected that more and more people with disabilities will engage in regular physical exercise. A challenge for the physical therapist is to transfer clinical skills from the institution to the community. Rimmer sees the physical therapist as a collaborator, educator, researcher, and program provider in the community. In addition to new skills, a shift from disability prevention to health promotion is necessary.

Carter and O'Driscoll (2000) from the U.K. call for physiotherapists to take an active role in promoting regular physical activity, and not just to those in rehabilitation, but to healthy adults as well. Specifically, they suggest that education and exercise promotion should be targeted at the forty to fifty-year-old age group. This approach would enable them to maintain well-being, reduce the risk of falls and potential fractures, preserve functional ability, reduce medical problems, and save health-care costs in their later years. The authors further suggest "that physiotherapists at a professional level are well placed to be involved in developing, launching and co-ordinating a national exercise campaign aimed at promoting health in the workplace and the community" (Carter & O'Driscoll, 2000, p. 91). Specific examples of programs in which physiotherapists are involved are not provided.

Henley, Twible, and Kremer (1995) encourage physiotherapists to be pro-active in the promotion of health whether it be through working one-to-one with clients, a community population, or a national health policy. They refer to the Australian document, *Heath for All Australians* (1988) which includes health promotion for older people. General advice for physiotherapists is given that explains how to actively

engage in health promotion for the senior segment of the population. However, specific and concrete examples of what can be (or has been) done by physiotherapists in this area are lacking.

Bernard (2000) and Keller and Fleury (2000) provide excellent examples of health promotion programs for older people in various cities and countries, including Canada, but physiotherapists are not included as part of this process. The National Advisory Council on Aging (1999) encourages creative approaches to promote health, particularly for groups who are hard to reach. The challenge is to “[m]ake health information readily accessible and attractive to a large audience” (p. 34).

Community physiotherapists are in an ideal position to educate and promote health and fitness. A study conducted by the School of Rehabilitation Therapy at Queen’s University in Kingston, Ontario, determined that physical and occupational therapists who worked in the community evenly divided their time between the provision of clinical services and acted in a consultant/educator role to a mainly aging population (Pickles, Topping, and Woods, 1994). The therapists, however, indicated a need for additional training in consulting and networking skills, as well as health promotion strategies to increase physical activity. To address these concerns, an undergraduate course has since been developed entitled “Community Practice in Rehabilitation.”

In Saskatchewan, a Commission on Medicare⁸ was appointed in 2000 by the past

⁸Medicare is the publicly funded, publicly administered health-care system. It was first created in Saskatchewan four decades ago and has since been adopted by other provinces in Canada.

premier, Roy Romanow. Then, in 2001, a report was provided to the Provincial Government with recommendations to improve the medicare system (Fyke, 2001). The report, *Caring for Medicare: Sustaining a Quality System*, suggests that innovative approaches to health services are needed, particularly with Saskatchewan's demography and geography: an aging population in a rural province. One area the report focuses on is the promotion of health and wellness.

In the report, health promotion activities are referred to as "upstream" activities. It is suggested that investing in such activities improve health and can prevent the need for costly treatment "downstream" (Fyke, 2001). Pro-active and far-sighted initiatives not only have the potential to "improve the quality of life of the public, but they will also mitigate future costs to the health system" (Fyke, 2001, p. 38).

Individuals and groups responded to the report on medicare via public hearings. Recommendations from these hearings, as well as those from the Commission on Medicare, were incorporated into a government report entitled *The Action Plan for Saskatchewan Health Care* (Saskatchewan Health, 2001). Here, health promotion is taken seriously: an entire section of the report is devoted to promoting healthy communities.

One area of concern documented in *The Action Plan for Saskatchewan Health Care* is physical inactivity and its association with heart disease, diabetes, and other health related problems. The report states that the province is working with schools, municipalities, and recreation groups to encourage Saskatchewan residents to be more physically active. Specific health practitioners involved in the new fitness strategy are

not mentioned.

Physiotherapists possess the skills, ability, expertise, and creativity to engage more actively in the promotion of fitness, health, and wellness. Producing a program of televised chair exercises for older adults is my contribution to this area of practice. As I retrace my steps as a physical therapist, I realize that I have developed and utilized skills in community-based health promotion to the exclusion of traditional, hands-on interventions that have defined the profession over the decades. Interestingly, it all began with undergraduate training.

My Path in Physical Therapy

During my undergraduate training, I adored everything about physical therapy—everything except the classes in orthopaedics that demonstrated how to mobilize a vertebrae in someone's neck, or the respiratory class where we learned to insert a plastic tube down our partner's nose in preparation to suction nasal and chest secretions from a patient who was too ill to cough and spit. I was not too keen on paediatrics either even though I had a positive clinical placement at a children's rehabilitation centre. Electrical modalities such as ultrasound and interferential were extraneous to me. . .and still are. My focus was, and still is, the elderly—and exercise. Upon reflection, I probably could have been trained back in the days of massage and remedial gymnastics and would have been quite contented. Instead, I graduated with a Bachelor of Science in Physical Therapy from the University of Saskatchewan in 1987.

I assumed short-term employment at a hospital and a retirement home in Saskatoon, Saskatchewan, prior to an extended trip to Europe. On return, I was too restless to stay in my home province and moved to Toronto, Ontario, where I was hired by a two-site, long-term care and rehabilitation facility. I worked in geriatric rehabilitation with a dynamic team of social workers, occupational therapists, recreation therapists, speech-language pathologists, audiologists, nurses, and physicians.

The occupational therapist and I conducted home visits with our patients to ensure a safe and functional return upon discharge from the hospital. Many of these clients returned for further rehabilitation to an on-site day hospital and I was able to follow them through the day hospital program. These experiences were my first taste beyond the institution and into the community.

Working in geriatric rehabilitation enabled me to see a bigger picture—one that extended beyond the treatment of only a knee or a shoulder. Lesley Bainbridge, President of the CPA from 1993 to 1995, suggested “that physiotherapists should continue to move away from the treatment approach and the medical model to a more holistic and social model of intervention or management, looking at the whole person rather than focussing only on physical care of the older adult” (Cleather, 1995, p. 191). While working in Ontario, I received a Post-Graduate Diploma of Gerontology from the University of Toronto; this, too, promoted a holistic approach.

The next stage of my career took me overseas—an interest I had since my undergraduate days. I travelled to Thailand and volunteered in two hospitals: first, a public facility and then, a private one. Interestingly, I saw the technical orthopaedic

approach that was problematic to Canadian physiotherapists some fifty years earlier. To extend my stay in Thailand, I joined HelpAge International, a non-government organization that campaigns for disadvantaged elderly with professional expertise and financial support.

I was placed in an institutional-based village of elderly who had leprosy and was available as a consultant to the medical staff as well as to a group of community-development students from a local university who were also there on a placement. One of our activities was a chair exercise group that was initiated by an Australian volunteer. Movement and mobility, or at least the importance of this was promoted as much as possible.

My second “assignment” through HelpAge International was with a World Health Organization four-country research study on the determinants of healthy aging; I was the field supervisor for the Thailand component of the study and oversaw the administration of a questionnaire to older Thais living in urban and rural settings. Another opportunity took me to Sri Lanka where I developed a training course on “active living” for elders through HelpAge Sri Lanka. The course was piloted to caregivers who worked in long-term care institutions and day centres.

All of these experiences expanded my role beyond a clinician to that of a consultant and educator at a community level. The impact of these experiences was pivotal in shaping my philosophy as a physiotherapist. I believed in the promotion of fitness, health, and wellness not just to individuals but to an entire segment of the population, such as older adults. For me, education appeared to be a key component of

this practice.

During those six-months in Sri Lanka, I had a strong sense that rural Saskatchewan was in need of physical therapists, more specifically, in need of my services. A Canadian friend sent me a newspaper clipping advertising for community therapists in my home province. I responded. After I arrived back in Saskatoon, I ventured to the four rural communities that called requesting interviews.

I accepted a position as the community therapist in Weyburn, but something about it was not right. I withdrew my acceptance the following day. I worked in Saskatoon over the summer in community therapy; fall employment in the city was limited. I contemplated attending graduate school, but the timing did not feel right. I did not apply. The position in Weyburn was offered to me once again. This time I accepted. I began work in October, 1996. Although the position was full-time, I asked for, and was granted, four days a week. I still did not feel one-hundred per cent right about this job. In retrospect, I was not ready for Weyburn, and Weyburn was not ready for me.

CHAPTER THREE

WESTWARD HO!

Putting Weyburn on the Map

Weyburn is a city of approximately 10,000 people and is located in southeastern Saskatchewan, Canada. The provincial capital, Regina, is just over 100 kilometres to the northwest. Three highways intersect at Weyburn and provide access to and from the United States and the Alberta and Manitoba borders. Farms and fields consume the land; oil wells dot the landscape further south and to the east of Weyburn.

Landmarks from a distance include two giant concrete structures at each end of the city: Saskatchewan Wheat Pool Terminal to the northwest and the Weyburn Inland Grain Terminal to the southeast. The highest landmarks are four communication towers on the peak of South Hill, a slight rise in the land from the otherwise flat prairie. The oldest landmark, also on the peak of South Hill, is a well-kept water tower built in 1909 (Eaglesham, 1963).

At the foot of Signal Hill, the highway, the shallow and narrow Souris River, and the Canadian Pacific Railway run parallel to one other. A classic wooden grain elevator—orange and yellow paint faded over the years—still lingers over the downtown. A community entrance sign reads: “Welcome to Weyburn...The Opportunity City.”

Weyburn was a city of opportunity for the settlers and land speculators who arrived in the late-nineteenth century. The land was fertile and farming looked promising for the immigrants from Europe and Great Britain who arrived via Ontario and the northern United States. The river, the Soo Line Railway, and the Red Coat Trail (the original trail of the Northwest Mounted Police across the prairies) intersected the landscape and provided a place for the pioneers to settle.

Weyburn was founded in 1898 and was incorporated as a village four years later. It became a town in 1903, and a city in 1913 with a population of 5,000 (Eaglesham, 1963). Not until 1986 did the population reach the 10,000 mark for the first time. This slow growth is indicative of an uncertain economy in agriculture, oil production, processing, and manufacturing.

Even though Weyburn may not be a metropolis, the city strives to reflect growth and progress. There has been a recent flux of construction, including the renovation of existing structures such as the Co-op food store, the Credit Union, and the local and regional libraries. At the same time, private businesses struggle to survive.

A new giant warehouse-style food and clothing store forced the closure of two family-owned grocery stores in the downtown core. The shopping mall, built in 1980, has a twenty-six store capacity but, several units always seem to be vacant. There are empty storefronts throughout the small downtown area. Attracting new businesses and old customers is difficult, especially when many residents drive or take the bus to Regina for shops and services.

To Weyburn's credit, attempts are made to maintain some of its historical buildings. These include the house where writer W. O. Mitchell was born and raised, the original church of Tommy Douglas (now a museum and venue for live theatre), the Court House, and the old Power House (converted into the local historical museum). The most expansive architectural structure in Weyburn is the original psychiatric centre. The Saskatchewan Hospital opened in 1921 to offset the growing demand felt from the sister institution in North Battleford in the northwest part of the province. Once a self-contained community on thirty acres of land, it housed as many as 2600 psychiatric patients in the 1940's (Eaglesham, 1965).

The hospital had a renowned psychiatric history that attracted staff from around the world. It was the biggest employer in the community up until the early 1960's when deinstitutionalisation began (Robillard, 1986). Today, the complex is only partially used by various organizations including the South Central Health District, various non-governmental organizations, and as a training and development centre for SaskPower. Long-term care is provided in one wing of the building; however, this facility will move to a new site that will be built on the grounds in 2002. More and more of the aged complex is being abandoned.

Weyburn is part of the South Central Health District, an area of approximately 13,866 square kilometres located in the centre of south Saskatchewan. The district extends south to the United States border and approximately 150 kilometres to the west. Half of the residents in the district reside in or near Weyburn (South Central Health District, 2000). Medical services in Weyburn include a 50-bed acute-care hospital, long-

term care facilities, a mental health centre with a 14-bed in-patient unit, public health, emergency services, and community care. Community care offers meals on wheels, homemaking, personal care, nursing services, a day respite program, a diabetic education program, a cardiac rehabilitation program, and palliative care. The health district is the largest employer in Weyburn.

Although Weyburn is a multi-cultural city with over thirty ethnic groups, the majority of people have a British Isles or European background reflecting the settlement period over 100 years ago. There is a rich cultural and civic life; whether people make Weyburn their home for a few years or their entire life, there is ongoing involvement and support at the community level. A weekly newspaper, a radio station, and a local cable access television station actively promote and support community events and the people involved.

Weyburn as a Retirement Community

Weyburn is a retirement community. Twenty-two percent (22%) of the population are 65 years of age or older (Saskatchewan Health, 2000). This is higher than the provincial senior population of 14.6%; the national average is 12.3% (Statistics Canada, 2000). The majority of older persons are women: 65% of those 80 years and older in Weyburn are women (Saskatchewan Health, 2000). Those over age 75 are the fastest growing segment of the population (Green, 1999).

Aging trends reflect low fertility rates, enhanced medical technology, and improved lifestyles. Weyburn's higher than average aging population can also be

attributed to the exodus of young people who leave for education and work-related opportunities elsewhere. As well, older adults who live in rural areas tend to remain in the community they have been associated with all or most of their life rather than relocate to another city or province where their children may reside (United Nations Population Division, 1994).

Weyburn's aging population tends to increase during the winter months when seniors from surrounding rural areas move into the community. Many take up permanent residence in Weyburn for easier access to amenities such as medical, postal, and shopping.

The majority of seniors in Weyburn live in their own home or apartment. Social housing for low-income seniors is available through the Weyburn Housing Authority (WHA). There are three facilities with a total of 197 units: Heritage Place, a two story building built in 1968, has 37 suites; Legion Towers, built ten years later, has 76 suites; and Bison Manor, a modern five story building built in 1984, has 84 suites. Optional support services include a weekly meal in the common lounge, laundry, and house-keeping all at an additional cost to the tenant's rent (A. Dubnyk, Housing Services Manager, Weyburn Housing Authority, personal communication, January 15, 2001).

There are two public long-term care facilities in Weyburn: Souris Valley Extended Care Centre (SVECC) has 128 beds and is situated in a wing of the former Saskatchewan Hospital, and Weyburn Special Care Home (WSCH) with 109 beds. Private or personal care homes have flourished over the past decade.

Crocus Plains Villa, originally a government care facility for the elderly in the 1960's, was converted to a personal care home in 1992. A recent expansion now accommodates the maximum forty beds allowed for a private care home. Parkway Lodge was built on South Hill in 1996 and has also expanded to accommodate thirty people. Eden Home was established in 1997 in a private residence and can house nine people. Hilltop Manor, also on South Hill, opened in 1999 and has room for forty people. The newest and smallest place is called Doris' Happy Home; it opened in 2000 with a capacity for five people.

Like most prairie cities, Weyburn is dependent on private automobiles. There is no public transportation, but there are two private taxi companies and a specialized van sponsored by community service groups for wheelchair users. In winter, transportation can be a challenge. Snow may fall as early as October and lasts until at least March. Temperatures can be frigid, particularly if there is a wind; frostbite at -40 degrees Celsius, for example, is a safety concern for everyone, not just seniors. The City of Weyburn does not have a policy for shovelling snow; sidewalks covered with snow and ice make walking in the winter months treacherous, if not impossible, for some older adults. The fear of falling keeps many seniors housebound during the winter months.

"Inactivity increases with age; by age 75 about one in three men and one in two women engage in no physical activity" (Haber, 1999, p. 90). Inactivity is associated with a decline in function and mobility. A greater use of health services to the point of a public health burden can ensue (Katzmarzyk, Gledhill, & Shepherd, 2000; Keller & Fleury, 2000). Physical activity is the antithesis.

Programs to promote physical activity for older adults in Weyburn are limited. There is one senior recreational centre which provides a place for recreation and fellowship. Attendance is often dependent on the weather and availability of transportation. The local mall supports an informal early morning mall walking program which attracts a handful of seniors (K. Mitchell, personal communication, Dec. 18, 2001). Public long-term care facilities employ recreation staff, but the private homes do not. As of April 2000, a full-time social and recreational person was hired for all three Weyburn Housing Authority buildings (A. Dubnyk, personal communication, January 15, 2001).

“Societal strategies are needed to make convenient sites for exercise available on a large scale for older persons” (Keller & Fleury, 2000, p. 66). The use of television to deliver exercises is one such strategy.

Homesteading With TV: Television Viewing by Older Adults

Television is a convenient source of information and entertainment for older adults. It requires less concentration than reading a newspaper, and less effort and imagination than listening to the radio. Television is affordable, accessible, and easy to use. The larger colour screens, volume control, and closed-captioning enables those who have hearing or visual impairments to remain connected to the outside world. For those who are frail, housebound, or institutionalized, television may be their only window to the world (Davis & Davis, 1985; Hajjar, 1998).

Television viewing is the prime activity of older adults (Davis & Davis, 1985;

Horgas, Wilms, & Baltes, 1998; Chafetz, Holmes, Lande, Childress, & Glazer, 1998; Riggs, 1998; Hajjar, 1998). Women watch an average of 37 hours of television a week and men watch 33 hours (Gorman & Crompton, 1997). Older women who live alone and are in poor health—often associated with low income and a lower level of education—appear to watch the greatest amount of television (Dan, 1992). Female nursing home residents watch an average of six hours a day (Hajjar, 1998). It is estimated that 25% of seniors watch over five hours a day (Statistics Canada, 1997).

Why do seniors watch so much television? The prime reason for watching television is to obtain information and remain up-to-date about people and events locally, nationally, and internationally (Davis & Davis, 1985; Goodman, 1992). Some seniors gather information from television in an effort to converse with others. Television also serves to fill the voids for those who lack mobility, contact with other people, or resources for creative and intellectual stimulation (Davis & Davis, 1985). For some, “watching the movement of others is an important way that the aged counter the sense of restriction” (Hajjar, 1998, p. 108). And for many, television is simply a convenient and inexpensive way to fill in time, whether it is day or night.

Television programming specific to the needs of older people is limited (Hajjar, 1998). Commercial television continues to cater to a younger, more affluent audience as the target market. However, one channel that appears to attract an older audience is the local community channel affiliated with cable television.

Cable Television

Serving neglected audiences, championing unadulterated interaction, and disseminating diverse messages, cable access could constitute the single most democratic influence on television since the medium's invention.

-Riggs, 1998, p. 121

Canada is the most heavily cabled country in the world. Practically every community, no matter how remote, has access to cable television (Harris, 1993). Cable television was developed in the United States in the 1950's in a community that was unable to receive signals from a nearby television station because of a mountain. Businessmen built an antennae on the mountain to receive the original signals which they then transmitted to people's home via a coaxial cable (Heinich, Molenda, Russel, & Smaldion, 1999). Customers who paid an installation fee and a monthly subscription fee received this cable connection which was referred to as community antennae television or CATV, more commonly known as cable television.

Cable television arrived in Weyburn in 1962 and was one of the first cable systems in Western Canada. Weyburn's close proximity to the United States border was a key factor; a thousand foot antenna erected on South Hill enabled the small community to receive signals and, hence, U.S. channels from Minot and Williston (B. Allin, personal communication, August 10, 2001).

Regulation of the cable industry was established in the late 1960's by the Canadian Radio-television and Telecommunications Commission (CRTC). In the 1970's, the CRTC held public hearings across the country to clarify rules and regulations for the cable industry. At one hearing in Nova Scotia, a cable operator not only made a

presentation to the Commission, but invited members of the Commission to witness the broadcast of a local program: a bingo fundraiser from someone's home. Members of the CRTC saw this as a valuable service and subsequently regulated the cable industry to include a community channel (B. Allin, personal communication, August 10, 2001).

The inclusion of community programming as a condition of license is one way to balance the "onslaught of programming from external sources" (Harris, 1993, p. 19). However, in January, 1998, new regulations dropped this mandatory condition (Canadian Cable Television Association, 2000), but, despite this, many cable companies remain committed to community television.

Community Television

[S]ome of the most exciting and innovative programming in the country today is appearing on community cable systems.

-Davis and Davis, 1985, p. 75

Programming at the local level through cable-access television provides a direct link to the lives of older people in a community. Local television has a positive appeal with older adults. Hajjar (1998) discovered that "the preference for local television seems to encompass a larger desire for community affiliation, and a desire to stay in touch with local affairs" (p. 51). For those who are housebound, particularly in the winter, the local channel appears to serve as a vehicle for social interaction rather than social isolation. Older people tend to be committed to their community, particularly if they have lived there all their lives. Older adults are strong supporters of the community channel as it allows them to remain connected to the community (B. Allin, personal

communication, October 9, 1998).

In Weyburn, community television has been operating since the mid-70's from a small studio at the top of South Hill (B. Allin, personal communication, October 9, 1998). Ninety percent (90%) of the programming on the community channel is local; regular programs include, for example, Kinsmen Bingo and City Council meetings. Special events such as parades, concerts, lectures, and sporting events in Weyburn are also featured. Most of the programs are scheduled in the evenings. Throughout the day the channel features a Community Bulletin Board that announces upcoming events in Weyburn.

The community channel in Weyburn has a strong following. A survey sent to the approximately 3600 cable subscribers indicated that 81% of the respondents enjoyed the community channel—a positive standing compared to commercial channels which also received a high rating: ABC (89%), CBC (90%), NBC (92%), and CKCK TV (96%).⁹ The goal of community programming is “to try and touch everyone’s life at least once in a year” (B. Allin, personal communication, August 10, 2001).

Community television appears to be the greatest outlet for programming community needs. However, programs have tended to follow a traditional model of television *about* communities rather than television *by* communities. Also, watching television tends to be a passive activity which may (or may not) be an appealing feature of television. A few communities have made significant and innovative attempts to use

⁹Cable Weyburn, 1999 Subscriber Survey, Weyburn Survey Summary. Although this was not a scientific poll, it did provide information about subscriber’s viewing habits.

community television interactively, an activity which benefits everyone.

Community Television Initiatives in Canada

Local television, if used as a tool to engage a community in making decisions, can lead to empowerment of a community as a whole. "Such transformations require three ingredients—communities with problems that its residents want to solve, communities with innovative adult educators committed to citizen empowerment, and cable operators who honour the spirit of the policies and regulations of their industry" (Harris, 1993, p. 22).

In 1986, the residents of Buchans, Newfoundland, lost the town's only industry and faced an uncertain future for the survival of the community. Over a period of several months, members of the small community, along with adult educators from the now disbanded Extension Service of Memorial University, used community television to review the town's capacity to engage in economic renewal. Community residents were trained in basic video skills and television transmission. They used television to review their past and present resources, and examine their chances of success with a new endeavour. Not only did this method help them through the crisis situation of losing their homes and community, but it helped restore their capacity to survive in rural Newfoundland (Harris, 1993).

In Fort McMurray, Alberta, an initiative to blend safe community programs with occupational safety by using marketing strategies was developed. The Fort McMurray Demonstration Project in Social Marketing began in 1991 with the goal to reduce injury

in the community (Guidotti, Ford, & Wheeler, 2000). A key player in the project was the local cable television station. Public service announcements were locally produced on safety themes and aired several times a day. These provided direct public education. A life-size mascot designed specifically for the project was featured both on television and through frequent appearances in the community. Video clips were also developed in response to pertinent issues within the community as the need arose. For example, layoffs by a large employer in the community prompted an increase in calls to the local crisis telephone service. A televised message on coping with stress was produced within a few days highlighting the telephone service for those in need of support.

As a result of this initiative, Fort McMurray received international recognition: in 1995, it became the first city in North America to receive membership in the World Health Organization's Safe Community Network. On a local level, the city was able to shed its original image as an industrial-based "boom town" for a "stable, progressive, and affluent community with effective civic institutions" (Guidotti et al, 2000, p. 169).

Community Television and Older Adult Initiatives

There are numerous examples of successful programs on local television in the United States which are produced by and for seniors in the community (Davis & Davis, 1985; Riggs, 1998). Experimentation using cable television within the field of aging began in the early 1970's.

One example was a weekly program for older adults which was developed in New York City. A limited group of senior centres and individuals in their homes were

targeted to receive specific programs that combined information and entertainment. The goals were to provide: (1) information about services and resources available in the community, (2) information that enabled individuals to be better prepared for dealing with the problems of old age, and (3) a forum for advocates and membership groups to encourage individuals to engage in collective action to address the needs of the aging population (Monk, 1988). This project did not survive because it was found to be economically prohibitive at that time.

Another program was developed in the 1970's by staff members from the Division of Communication within the Department of Community Medicine of the Mount Sinai School of Medicine, New York (Wallerstein, Marshall, Alexander, & Salzer, 1975). They used cable television to reach a group of seniors in a high-rise apartment in East Harlem. Each apartment was installed with a cable outlet (a service provided by the funding agency); and, a small television studio was set up in the basement of the apartment building. Programs were made by and for the seniors in the apartment complex and were delivered either live or by videotape.

The organizers envisioned the use of CATV to: (1) encourage maximum tenant involvement in the project as viewers, assistants in program development, and on-camera appearances—the hope was to encourage a sense of community and reduce isolation; (2) produce programs with specific information about community, neighbours, health, and available resources in health and the social services; and (3) evoke an active behavioural response from tenants by encouraging them to attend a club, make a clinic appointment, or do a simple exercise.

This project was reported in the literature one year after its inception and just prior to an in-depth evaluation. Informal evaluations, according to the organizers, indicated that the project was a success after just nine months of operation. For example, attendance at a weekly health activity increased from an average of 15 to 50 people based on regular advertisements on the channel. Goals of the project were primarily directed towards the health of the residents. In reality, programs often included more engaging topics such as Bingo, oral histories, and the coverage of birthday parties in the building. Ultimately, the organizers wanted to add a two-way system so that each resident was connected to the local medical centre through their television and could access information as needed.

Two-way TV using cable television allows for interaction and exchange of information between two or more different sites. It was assumed that two-way CATV would enable seniors to remain at home, and encourage nursing home residents to return to the community—factors which would reduce the enormous health care costs of the elderly that was already being felt. The use of CATV with and for an aging population did not make the big impact that was expected. One community, however, did manage to successfully use two-way television.

Two-Way TV Initiatives

A remarkable project in Reading, Pennsylvania, was developed in the mid-1970's and involved local senior citizens (Burns, 1988). The National Science Foundation issued a request for proposals to explore the use of television for the delivery of social

services. Senior citizens were specifically encouraged to be involved since Reading had a higher than average senior population; they were also heavy consumers of social services. A partnership was initially set up between New York University (the Alternate Media Centre and the Graduate School of Public Administration), and the Reading community which included the local housing authority, a senior citizens council, and the local cable TV company (Burns, 1988).

Three senior-specific sites were set up to televise daily programs. A garden apartment complex, a seniors high rise, and a seniors recreation centre were the main locations. Each site was able to originate and receive video and audio in order to communicate between sites. More importantly, they were connected to several remote origination sites and approximately 125 homes. Viewers were able to interact between the three or more centres, and were able to join the discussions by phone.

Programs focussed on providing social service information, i.e., Medicare, Medicaid, food stamps, and social security entitlements and regulations. The overall goal was not TV production but, rather, to encourage discussion and exchange. The two-way television series focussed on the exchange of information among seniors in the community on topics relevant to them. No longer were television viewers passive and isolated. This new approach to interactive television promoted socialization and interaction of the viewers with the host and guest on each program. And it worked! Feedback from the home viewers (in the form of unsolicited phone calls and letters) showed enthusiasm, support, and interest in the system.

A key feature of this project was that senior citizens were involved in every aspect of programming. They spent two hours each weekday and were involved in the programming, operating, and financing of their own two-way television system using the local cable television operation. Money to cover the cost of \$2,000 a week was raised within the community with the help of small grants; long-term funding came from federal agencies.

At first, an important hurdle to overcome was the initial fear of technology felt by many of the older adult participants. Another challenge was allowing people who were not media professionals to experiment and to be involved with telecommunications technology. With time, the creative talents of the seniors involved with the program emerged and this ultimately shaped the series over the years. The results that were achieved and the interest the programs created contrasted sharply to societal stereotypes of older people.

The program eventually received community-wide support and was able to sustain itself without involvement from the university. The program ultimately expanded and included the community hospitals and local arts groups. Evaluators of the program determined that a minimum of three years is needed for a major innovation to become rooted in a community. The overall experience in Reading, Pennsylvania, suggests that if tools, support, time, and encouragement are provided, people will design a workable system for themselves. The key to Reading's success was the people: not only those who were involved, but also those who were served by the program.

Another example of the use of interactive television was a one-day seminar for

150 elders in the State of Vermont (Chamberlain & Fetterman, 1999). The goal of the seminar was to provide information on senior housing. (The topic was identified as a pertinent issue via questionnaires completed by elders.) Interactive television allowed elders in rural areas of Vermont to experience the educational event simultaneously and interact through questions and discussion.

Rieske, Holstege, and Faber (2000) describe a project funded by the Michigan Department of Community Health and the Office of Services to the Aging. The project produced “monthly, ninety-minute, live interactive television programs specifically designed to educate older and younger persons in a community on how to grow older independently and successfully” (p.755). The program, *Successful Aging*, is apparently successful due to the collaboration between senior organizations, community colleges (specifically departments on aging, and media technologies), and health organizations.

TV Production by Health Professionals

The involvement of a health professional in television production with and for older adults is cited in the literature in only a few examples. Ora DeJesus (1988) was an Associate Professor of Nursing at Southeastern Massachusetts University when she worked with a local cable company on a program that featured services, educational opportunities, and general topics of interest to older adults. The program, *Coming of Age on Television*, was designed to disseminate information to elders throughout southeastern Massachusetts and Rhode Island. She advocated local cable programming to help combat the negative images of aging frequently portrayed on commercial

television.

In Winnipeg, Manitoba, Doug Wasyliw, a social worker, was the co-ordinator of an innovative health promotion and educational outreach service for homebound seniors and their caregivers (Penning & Wasyliw, 1992). The service, Homebound Learning Opportunities (HLO), was developed in 1988 by Creative Retirement Manitoba, a nonprofit community-based organization. HLO was developed to meet the intellectual, emotional, and creative needs of homebound seniors and included one-on-one or small-group learning at the person's home or seniors' residence.

An educational television series for and about shut-ins was produced and broadcasted on local public access television. Topics included: exercise routines for those with special health challenges, nutrition and cooking suggestions for those with special needs or those living alone, information on medical advances that pertain to shut-ins, arthritis management, and coping with isolation. Television series audiences were estimated to include between 300 and 500 shut-ins in the beginning; this increased with added publicity about the series. Copies of the television shows were made available to rural television systems throughout the province. The program, HLO, is no longer in operation due to the lack of federal and provincial funding.

A program not specifically targeted for seniors, called *CableQuit*, is a 6-week, 13-session local access cable television smoking cessation program (Valois, Adams, & Kammerman, 1996). One series ran during the Fall of 1990 in a Texas community; each program was one hour—the first half-hour was a studio-format telecourse to participants (5 in the studio and 53 at home) who were trying to quit smoking. The second half-hour

was a live interactive call-in show often with a guest. The host, a public health educator with post-doctoral training in smoking cessation, facilitated the “live” sessions. The percentage of participants who quit smoking was greater than, or comparable to, the average cessation rate reported in the literature. The results suggested that the combination of mass media, i.e., local cable television, with face-to-face programs “is a promising and efficient way in which to administer smoking cessation programs” (Valois et al., 1996, p. 496).

Closer to home, in 1993, La Ronge, Saskatchewan, was chosen as a project site for an Elder Abuse Prevention Education initiative specific to northern and Aboriginal needs in northern Saskatchewan (Blaser, 1993). Funded through Health Canada and co-ordinated by the Seniors Education Centre from University of Regina’s Extension Division, the project focused on positive relationships among generations. One part of the project included a panel discussion from an Elder and Youth Workshop which was taped by and broadcast on the local cable television station.

Returning to Weyburn, a partnership between the health district and Weyburn’s cable access station was initiated in 1996 to produce a new television series. The program, *A Healthy Community. . . A Mutual Goal*, was a half-hour weekly program broadcast (in repeat form) three evenings a week. Initially, the programs were produced by a social worker from mental health; colleagues and board members took turns hosting the program.

The original program goals were to build confidence in the locally delivered health care services, present information on prevention, promote healthy lifestyle

choices, inform the public of changes to the health care system, provide viewers with information on how to access the health-care system, and slow or reverse out-migration. Over 150 programs were produced; documents and tapes are available. This program warrants a study to describe an innovative local initiative using community television.

Televised Exercises for Older Adults

Televised exercise programs have been broadcast since the 1960's: first, with Ed Allen and then, Richard Simmons. One of the ground breakers specifically for seniors was called *Exercise with Billie*. Billie Kirpich, a professional dancer and a senior, developed a twelve-part series in conjunction with the Dade County Area Agency on Aging. The program consisted of chair exercises for homebound elderly persons with a progression of exercises that could be done in standing. The half-hour program was distributed to 185 educational television stations nationwide in 1987, and again a few years later (United States Department of Health and Human Services, 1991).

At the same time, *Sit and Be Fit*, was developed and produced by Mary Ann Wilson, a registered nurse by training. Wilson started her career in television production in 1985 with the idea of providing homebound seniors with a chair exercise routine via television. The challenge was to convince broadcasters to produce such a program. In 1987, she produced her first series of *Sit and Be Fit*.

Thirty half-hour programs were taped and broadcast on public television. The response was so positive that she developed a second series in 1988, and subsequent series in 1991, 1993, and 1995, for a total of 150 programs. The series was designed

and researched with the help of a team of physical therapists, doctors, and exercise specialists (Wilson, 2001). In 1997, physical therapist Lori McCormick joined the program as co-host. While Wilson does the exercises standing, McCormick shows a modified version while sitting. A sixth series was produced in 2000. The programs continue to be aired nationally on public television.

The *Sit and Be Fit* programs are based on theory and not empirical data (J. Rimmer, personal communication, December 12, 2000). Although research to measure the effects of chair exercises on viewers who participate in the program has not been done, positive feedback from viewers serves as evidence alone to continue broadcasting the programs (L. McCormick, personal communication, April 24, 2001).

A series of *Sit and Be Fit* videos has been developed and includes specialty exercises for people with chronic or physical limitations, or both, such as Parkinsons and arthritis. Further spin-offs include seminars on developing a geriatric chair exercise program. *Sit and Be Fit* became a non-profit organization in 2000 (Wilson, 2000).

A similar but less ambitious program in Canada comes from North Vancouver, British Columbia: it is called *Chair Aerobics*. A series of television fitness programs was produced in partnership between the North Vancouver Recreation Commission and the local Rogers Cable station, and targeted to seniors and others who are unable to get out regularly to exercise in the community. The instructor/producer was not a health professional by training; however, she did receive support and advice from a physical therapist in Vancouver (M. Hicks, personal communication, October 30, 2000).

Chair Aerobics was taped in the studio and featured the instructor who performed the exercises, alongside two older adults from the community. Thirty programs have been taped and aired on the local community channel since 1995. One drawback is that *Chair Aerobics* is not broadcast at the same time every day (sometimes it is in the middle of the afternoon, sometimes it is in the middle of the night). The program has been syndicated to other cities in Canada such as Toronto and Montreal. Videos are also available for purchase by the general public; these have made their way to aging relatives in other parts of the world through family members living in Canada (M. Hicks, personal communication, October 30, 2000).

In Victoria, British Columbia, Blanche Black (a nurse by training) has her own business producing chair exercise videos for seniors. She tried to sell the idea to a local commercial television station, but they turned her down with the explanation that her audience “do not go out and shop.” She had not considered the community channel as a vehicle to reach her target audience (B. Black, personal communication, November 1, 2000).

Documents and reference material for these chair exercises programs are available, but there is no research literature to date related to these or any other exercise program on television. The only information I could find with reference to television and exercise for seniors is the use of television to promote an exercise program in the community (O’Brien Cousins, 1998; Allen, 1999). It appears as though studies have skipped this generation of technology. Literature on the use of interactive computer technology, however, is rapidly emerging.

The internet as a delivery modality to promote physical activity, particularly to those who are sedentary, is claimed to have tremendous potential. Studies show that people access the internet for health-related information (Marcus, Nigg, Riebe, & Forsyth, 2000). Based on success with smoking-cessation programs on the computer, there is an untapped potential for individualized, tailored programs related to physical activity.

The use of the internet to provide exercise programs for seniors with specific needs, however, has not been suggested or addressed. Even though a growing number of seniors are becoming computer literate, cost and complexity of use can inhibit some older adults from utilizing this technology as a form of entertainment and for information (Lamdin, 1997). Clearly, television remains the most effective delivery system to reach older adults (Hanks, 1996; Chafetz et al, 1998).

Channeled Learning

Adult educators have long recognized the use of television as a vehicle to deliver information, but few have tapped into this for the purpose of adult learning (Kidd, 1961; Hendrickson, 1973; Robinson, 1979). Research that links television and learning amongst older adults is limited. Instead, adult education literature has focused on older adults enrolled in traditional learning environments such as institutional-based classes, seminars, and workshops. In this context, the participation rate of older adults is very low (Clough, 1992).

Lifelong learning *does* include older adults, but it needs to take a broader view and include a wide variety of learning styles and preferences. Within this perspective, watching television *is* considered a learning activity by older adults (Lamdin, 1997). However, television is merely the vehicle that delivers information: it can only deliver—it cannot teach (Kozma, 1991; Clark, 1994). It is the use of adequate instructional methods within the context of television that can influence learning (Clark, 1994). Although the connection between television and learning is not the main focus of this study, insights and discoveries in this area are considered. Such findings will be of interest to the fields of educational technology and adult education.

I believe that television can be an excellent vehicle to deliver a message about physical activity to older adults who may be at risk from a sedentary lifestyle. Why has this phenomena never been documented before? Here one story is told.

CHAPTER FOUR

LITTLE TV SHOW ON THE PRAIRIE

There is a purpose [for me] going community-based: with more than a rehabilitation focus. . .with more than a physiotherapy background.

-Personal journal entry, September 28, 1996

When I arrived in Weyburn in October of 1996, I had no intention of producing a television show. The prospect had not entered my mind. I did not even *own* a television –an attempt to maintain a simplified life I had valued overseas. And yet, a mere six weeks after I started work, someone in the community suggested to me the idea of a televised program of chair exercises. I immediately put the idea into action. I did not stop to wonder whether I should be doing this, or even if I could.

Looking back, the television show was the most creative, thoughtful, and fruitful project I had ever accomplished in my physiotherapy career. However, there was conflict between my supervisor and I. Apparently, I had ventured too far from the treatment paradigm of physiotherapy. And so, by the end of my first year in Weyburn, my practice of community-based physiotherapy was called into question. My creativity and enthusiasm diminished as a physiotherapist and as a person. I could not wait to leave that job.

It is the summer of my thesis. I am in Weyburn. I am privileged to have an office space in the privately-owned physical therapy clinic. The view from my desk overlooks facades of old and new brick buildings in the downtown core. As I sift through data collected from viewers, I am amazed. There are people who continue to watch the program and follow the exercises to this day. How did this happen? What events and emotions were involved that created, on the one hand, something apparently important to the community, and, on the other, such conflict with my supervisor? I retrace my steps to when I arrived in Weyburn.

An “Absolutely Perfect” Place

A pivotal part of my life in Weyburn was my living accommodation. I considered myself fortunate to have met Isabelle Butters. Isabelle owned an eleven-suite apartment building located on the edge of the downtown city core. The residence was next to the United Church on the corner; the Credit Union, the post office, and the City Hall complete the four-way stop intersection. All needed amenities were within a few blocks. But even more important than this convenient location were the occupants. The tenants of “Belle Court” were all elderly women except for myself and two others. Four were in their 80's and 90's; some had lived there for years—even decades—in this exceptional building.

Isabelle was a key person, not only in Belle Court, but in Weyburn itself having served as city mayor and manager of the Co-op. Although she is retired, she has remained an active volunteer in numerous local and provincial organizations, and this

involvement has earned her the Order of Canada. As a landlady, she created a unique support network and a close-knit community amongst her tenants. A Statistics Canada survey reports people living in Rosetown, Weyburn, and Swift Current live longer than the national average because of strong family and community support (Statistics Canada, 1999). Living in this particular residence confirmed this finding. I was immediately embraced by the tenants. I wrote in my journal, “. . . *it feels absolutely perfect.*” My job, on the other hand, was not so perfect.

The History of Community Therapy in Weyburn

A province-wide community therapy program was implemented in 1986 by Saskatchewan Health. The mandate was to offer consultation, education, and rehabilitation services aimed at improving the independence, productivity, and quality of life for people with physical and functional disabilities in rural Saskatchewan. A community therapist could be either a physical therapist or an occupational therapist. Community therapy is usually a sole position; the ability to work independently is often included in job advertisements for this position. Both general and specific therapy skills for a wide variety of ages and conditions are required. The job often covers a wide territory.

Between 1986 and 1993, community therapy for southeastern Saskatchewan was under Public Health. Retention and recruitment had been difficult: four therapists filled the position over the eight year period and then it was left vacant. In 1993, provincial health reform divided the province into 32 districts: the southeast region of the province

became three separate districts each with a community therapy position available. The South Central Health District had not been able to recruit a community therapist until I arrived in 1996.

Upon my arrival in October, 1996, the community therapy position had been moved from Public Health to Rehabilitation Services in order to consolidate the rehabilitation therapies (physiotherapy, occupational therapy, and speech-language pathology) under one umbrella. The job description for the community therapist, however, remained unchanged from the last time the position was under Public Health (Appendix E).

The job description that I followed stressed conducting needs analysis, and developing and delivering treatment programs for individuals and groups. The training and consultation of care-givers was emphasized over providing direct therapy. Preventive and maintenance programs to individuals and groups were included in the scope of the community therapy position.

Even though this job description of a community therapist matched my philosophy of physiotherapy, I now realize that it did not accurately reflect the paradigm of the rehabilitation department. These differences in paradigms were a source of concern and discomfort for me soon after I began the job. This discomfort never changed and, in fact, worsened over the two years I was there. After I left, the job description was changed to reflect the treatment paradigm of physiotherapy practice that was expected by the supervisor of the rehabilitation department (Appendix F).

Carving a Space

At first, the job felt rather challenging for there had not been a community therapist in Weyburn for so long. Fortunately, the position provided freedom and flexibility—at least in the beginning. I felt I was able to re-invent the position—and myself. I was able to create a job that not only suited who I was, but (in my opinion) what was needed in the community.

Based on my past experiences, my current living situation amongst older women, and my work that allowed me into people's homes, I observed Weyburn to be without apparent poverty or illiteracy; health problems appeared minimal. From my perspective, this was a community of white, educated, middle-class, comfortably settled, conservative people. I was comparing Weyburn to what I had just come from overseas. I was aware of the pressing needs in countries less fortunate (the lack of food, clothing, and shelter, just to name a few). I failed to find an initial purpose for myself in Weyburn and had difficulty identifying my role as the community therapist:

There doesn't seem to be a community need for me yet. Have to carve my own space—I suppose this is better for me. . . What can I contribute that is unique, innovative, and new for seniors? Creating ideas for tomorrow. . . (Journal entry, October, 16, 1996).

I am feeling impatient for a job that will challenge me in new ways—this will, and I seem to be able to create what I want and need. . . and yet, there is something about it that frustrates me—the paperwork, the politics. . . I try to be a physio, but somehow, it just does not fit so well these days (Journal entry, October 17, 1996).

I was hesitant to re-engage in traditional practice, the one-on-one-doing-something-to-someone. It seemed to create passivity and a sense of dependency in the client. This traditional practice did not equate to my professional practice goals. I

envisioned promoting health to an entire population: a vision that evolved from my experiences overseas. Yet, at the same time, I had to accept the reality of being a community therapist and attend to the growing number of individual clients who were referred to me both in Weyburn and the rural communities within the district. However, I felt that there was something more I could be doing. . .and needed to be doing.

I think of ways to pass on skills to others—to empower those who live here—so that my departure will not cause a gap, assuming I fill one and it seems I have (Journal entry, October 18, 1996).

... keeping people interested in taking care of their health. . . (Journal entry, October 20, 1996).

Opportunities to provide health education to individuals and groups materialized immediately and never ended. For example, while I was establishing my presence in the community, my supervisor referred to me three grade-six students for information about aging and the importance of physical activity. I was pleased to assist them with their project and provided ideas, resources, and support. In light of this teaching opportunity, I took it as a signal from my supervisor to develop the community therapy position as I saw fit. The verbal feedback I received in the first few weeks was full of praise:

[My supervisor] thinks I am doing a tremendous job (Journal entry, October 19, 1996).

Initially, the position of community therapy allowed me to engage in numerous health promotion projects. I thrived, not only because it was who I was, but what I wanted to do. More importantly, it was what the community called for. I enjoyed being in the community as it allowed me to physically remove myself from the hospital-based treatment model.

I was still accountable to the system that I was hired into. My statistics and month-end reports appeared to satisfy this component of the job— at least, in the beginning. Within my month-end reports, I not only included what I was doing, but also the direction that I, as community therapist, wanted to go:

Future areas to expand role: . . .liaise with Community Care re: clients who return from hospital with an exercise program; are they continuing to follow the exercises? Are they functional? Are there other avenues in the community to maintain and promote functional mobility? (Excerpt from month-end report submitted to supervisor, October, 1996).

Throughout my work, I took the initiative to find out what was available in the community so that I could connect people with resources and other people. But I felt there was something more I could be doing and needed to be doing. Whatever it was, I intuitively knew it probably would not fit into the traditional practice of physiotherapy. In light of this, I realized this was not a permanent position for me. There was graduate school or perhaps another assignment overseas. In light of these thoughts, I wondered what I could do that would be sustainable. . .very much like being in another country:

I hesitate for I'd rather work with someone who knows the place, the town, the people, the needs. To pass on skills, motivate, facilitate. Going solo won't work right now. . . (Journal entry, November 1, 1996).

I felt the same as I did when I was overseas—frustrated when I was left alone to provide therapy once a week or once a month for a person who needed ongoing maintenance exercises. I did not see the point of working on my own in isolation. I found many similarities between rural Saskatchewan and the countries where I had worked. In both places, I was on my own when I felt I should have been working with someone who could provide the ongoing support. (For example, if only I had a full-time

physiotherapy assistant).

Promoting Exercise

Based on what I saw in the community, and who I was as a person and as a physiotherapist, I concluded that promoting physical activity was the right direction. In particular, I saw a group of sedentary seniors—the frail, the housebound, the institutionalized—with limited opportunities for exercise. One of my firm beliefs as a physical therapist is the importance of exercise with aging.

It is documented that “aging adults and especially older women continue to be the most sedentary adults in North American society” (O’Brien Cousins,¹⁰ 1998, p. 72). One reason for this is “that people are poorly informed about the many benefits of regular exercise and how serious the risks of being sedentary are” (O’Brien Cousins, 1998, p. 71). A sedentary lifestyle affects physical and mental health and can produce a downward spiral of events resulting in a loss of independence. This is difficult but not impossible to reverse.

“Regular physical exercise is generally considered to be the ‘best medicine’ because it is inexpensive, has no side effects, can be shared with others, and is health promoting as well as disease-preventing” (O’Brien Cousins, 1998, p. 62). Research indicates that “a regular, gentle movement program is not only possible and helpful to the continued mobility of the frail elderly adult, but that physical movement is key to

¹⁰Dr. Sandra O’Brien Cousins is a professor of Physical Education and Recreation at the University of Alberta in Edmonton, Alberta. She is a prominent social scientist in the area of exercise gerontology.

independence and the survival of the spirit” (O’Brien Cousins, 1998, p. 112).

MacKeracher (1998) states that “[a] health care system designed to deliver acute care services proved inappropriate for treating the chronic health problems of older adults, problems which respond better to improved self-care, fitness, prevention[,] and community support services” (p. 262). The National Advisory Council on Aging (1999) advocates “ongoing and substantial support at the federal, provincial/territorial and local level for health promotion initiatives that empower individuals and communities to improve health practices. . .” (p. 32). The Active Living Coalition for Older Adults, a partnership of 26 organizations with an interest in the field of aging and active living in Canada, produced the document, *Moving Through the Years: A Blueprint for Active Living and Older Adults*. On reflection, my aim to promote physical activity amongst older adults parallels the philosophy of the *Blueprint*.

Physical therapists are situated in an ideal position to promote physical exercise for older adults. I was originally drawn to the possibilities in Weyburn.

I could have stayed hospital-based and done ortho[paedics] forever or neuro[logy]. It is needed. . .but then these skills of innovativeness, of being creative, with knowledge and ideas—there is no room in the traditional mode. Which is why I go elsewhere—searching for something to fit who I am. . . (Journal entry, November 11, 1996).

Had I been a therapist in a clinic or the hospital, I would not have had the time, flexibility, or freedom to even begin to envision an innovative project. It was through the details of day-to-day practice that I emerged into the bigger picture.

There is a multitude of details (ordering equipment, prescribing exercises). I stumble and by-pass details so I can get to the bigger picture—the functional individual, the community, the population. . . (Journal entry, November 22, 1996).

The Saskatchewan Commission on Medicare (Fyke, 2001) reports that many health-care providers have skills and abilities that are not being used to their fullest potential. I agree. Here I was, transporting walkers and wheelchairs to housebound clients and those in care homes, when an assistant could have done this. The Commission on Medicare advocates the use of therapy aides to free up the time of physiotherapists who are in short supply. The full use of a health-care provider's skills perhaps "could result in better patient outcomes and savings to the health care system" (Fyke, 2001, p. 64).

A Broader Vision

I cannot stand still, I cannot stand to see the lack of vision. . . (Journal entry, December 11, 1996).

I was aware of the limited opportunities of physical activity for older adults to maintain their level of mobility. I found many of my older clients just wanted and needed someone to coach and encourage them through a routine of simple exercises. Many needed to be shown what exercises to do and how to do them. I was willing to instruct and encourage people with an exercise routine, but it was not feasible for one therapist to be a personal coach for a growing number of individuals.

Whenever possible, I tried to support and instruct caregivers, for example, family members and home care workers, to oversee exercises and walking. Although certain clients required a specific therapeutic exercise program, many just needed maintenance exercises to sustain their current level of mobility. With even a small amount of gentle

exercise, stiffness can decrease sufficiently to improve one's physical mobility and function (O'Brien Cousins, 1998).

In November, I paid a home visit to Mrs. C.¹¹ who lived in the Legion Towers. She was in her late 70's and had chronic health problems. She was housebound unless a family member took her out. I suggested a few exercises that she could do sitting in a chair to offset the effects of a sedentary lifestyle. All I could do for people like Mrs.C. or, so I thought, was to leave a few handwritten exercises or a prepared page of generic general exercises to follow if they were so inclined. I was never happy about this; I never really expected clients to take an interest in exercise—never mind comply—just because I paid them a home visit. Nevertheless, Mrs. C.'s daughter, Alice appeared encouraged by the potential of exercise to help older adults like her mother.

It was Alice who suggested to me the idea of putting an exercise program on the community channel. She related how many seniors in Weyburn stayed at home, especially in the winter, and the majority had the local community channel on throughout the day. Her work as an Admitting Clerk at the hospital also appeared to be a significant factor. I believe this position made her a specialist as to the needs of the community. Also, because she was from the community, she was an “insider” and had certain insights that I, as an “outsider,” did not have. If it was not for Alice, I honestly would have never thought about producing a program of televised exercises.

¹¹The names in this chapter are pseudonyms except for Isabelle Butters, Brent Allin, and Velda Coulter.

Testing the Waters

The first step I took was to call the local TV station and arrange to meet the program manager. Why did I not consult with my supervisor first? Had I done this, I am certain the program would never have materialized beyond an idea. I must have known—albeit unconsciously—that our paradigms did not match. By-passing what some would consider an important first step was deemed intuitively appropriate in my mind, at that time, and even now as I reflect upon this.

At the end of November, 1996, I met with Brent Allin, Programming and Community Relations Manager for Estevan/Weyburn Cablenet, a division of COGECO Communications.¹² He was enthusiastic about the idea from the beginning. Weyburn was home for him, and his career in community television meant that he was also an insider. On reflection, I believe he was more attuned to the needs of the community, particularly those who may be marginalized, in light of his own challenge of being dependent on crutches his entire life due to a debilitating disease. Brent was a key player throughout the production of the television show.

Met with Brent from Cablenet TV 5 to begin discussion about a project of a senior's chair exercise program on Channel 5. Original suggestion offered by Alice. . .whose mother is housebound and needs activity to keep mobile. Have written an initial proposal draft (see attached). Hope to get as many people interested involved that will sustain the program should it take effect (Month-end report, November, 1996).

I wrote a short proposal that described the concept of televised chair exercises for older adults in the Weyburn community. The proposal was merely putting an idea on

¹²The station has since changed hands. It is now owned by Access Communications out of Regina, Saskatchewan. Although Brent Allin oversees community programming in Weyburn, he is not as involved in the hands-on production.

paper and testing the waters. The waters appeared still and quiet. Over the next few months, I revised the proposal and continued to circulate it amongst key people in the health district (namely, managers and administrators). No one objected or even questioned it. One manager not only approved the idea, but provided me with further information, i.e., resource people and funding sources if needed. I proceeded on and included updates of the chair exercise program in my month-end reports to my supervisor:

Cablenet Exercise Program: to film one 15 minute session at studio on January 14th. Will redraft proposal after this trial as to how program will develop. Once up and running, local physicians have suggested putting posters up in their offices to inform public about the exercise program on Channel 5. Have informed [the occupational therapist, head of the Weyburn Special Care Home, nurse supervisor at the hospital, community care staff, and the head of Public Health] about the project. Plus have asked clients I see if they would be interested in such a program on TV. So far the response is positive (Month-end report, December, 1996).

I added a piece to my month-end report forecasting where I, as a physiotherapist, needed to be heading:

... I also know where my strengths are in these new and expanding areas, we, as physiotherapists can and should be exploring, i.e., education, counselling, health promotion.

It was obviously important to me that I sell my vision of physiotherapy to this supervisor. At the very best, I was probably an enigma to her; at the very worst, I was a threat to her belief system and way of practice.

Even though my working relationship with my supervisor was difficult,¹³ I easily established communication with key persons in the community and the health district. I

¹³Face-to-face communication with her was not something I wanted to do. When we did meet, I felt intimidated, dismissed, and discouraged.

was very much into networking as it came easy to me. A community therapist is in a great position to network. Pickles et al. (1994) found that occupational and physical therapists working in the community “identified the need for additional training in consultation and networking skills as their highest priority” (p. 186).

Networking was an effective means to gain visibility and in turn, support. At the same time, I often received unsolicited feedback related to my presence in the community. One health worker described me as “a race horse who was chomping at the bit.” Others said that I was ahead of my time. Another message I received was, “Sharon, if you can do it in Weyburn, you can do it anywhere!”

I cannot help but feel Weyburn is not ready for me—my ideas, my background, my being. . . (Journal entry, January 17, 1997).

Weyburn was actually a difficult place for me. I felt that I was too creative, and too energetic. At times, it appeared as though I was pushing the borders and all the wrong buttons. I was frustrated by the routines that rarely changed, particularly in the public institutions. Fortunately, home visits provided me with the opportunity to explore other possibilities—to be creative, to educate, to empower, and to engage on the front line. I was always thinking of ways in which physiotherapy could be delivered differently—more effectively and efficiently.

I think about what I'm doing in the community and what's important. . . phone calls to follow-up people's programs—anyone could be designated. . . an assistant would go a long ways in the community. There is always another way of doing things: of maintaining mobility, of monitoring mobility (Journal entry, December 6, 1996).

Setting my sights on a distant shore. . . community involvement, empowerment of people (especially women), client self-responsibility. . . (Journal entry, January 22, 1997).

As much as possible, I wanted the television program to be community-based. One way of achieving this was to tape the programs on location versus in the studio. Another approach was to include the target audience as participants on the program.

Lessons in Leading

Early on in producing the program, I had one major question: who would lead the exercises? At that time, I thought a lay person with exercise experience could lead the program. As much as possible, I wanted to remain in a position to oversee it—not to actually *be* the program. However, because it was a new idea, I found I needed to be involved in every aspect of the show.

Cablenet Chair Exercise Program: will be using a lounge at the WSCH for filming on Thursday, Feb. 13th at 9:00 a.m. Have lined up a few people to come in and operate camera, hold cue cards, etc. Will involve a few residents from WSCH - written consent to be obtained from Carmen (an administrator with the health district who oversaw Rehabilitation Services). Program to be aired in early March. Will inform Community Care staff, local physicians, and senior centres about the program and at what time it will be on Channel 5. [My goal is to] . . . create a sustainable community-based program for older adults with a health promotion component (e.g., Cablenet.TV project) (Month-end report, January, 1997).

I had invited the exercise leader from Wheatland Seniors to host the program and lead the exercises. She had been trained through the Canadian Red Cross “Link to Health” program—a physical activity program for older adults. In February, we ran a trial session at the Weyburn Special Care Home. Instead of falling into place, everything fell apart. She had prepared and rehearsed a chair exercise routine that was, in my mind, too vigorous and too choreographed for the targeted audience. Immediately, she sensed the differences in our visions. A few days later she pulled out citing personal reasons. In

retrospect, this was probably fortunate; it was apparent that chair exercises for older people had to be led by someone with the training and knowledge base of the target audience. This concept was far too important to leave in the hands of someone else (at least, in the beginning). Wasner and Rimmer (1997) evaluated exercise programs in long-term care facilities and concluded that the person who instructs exercises for seniors should have a strong background in exercise science and formal training in working with older adults.

Brent and I discussed the options: find a new leader, or have me instruct the exercises. The latter was the most obvious choice. Why had I not thought of this before? Once again, I did not want the program to be about me—I had hoped it would be *by* and *for* older adults. On reflection, I wanted to be a “helper, guide, encourager, consultant, and resource—not that of transmitter, disciplinarian, judge and authority” (Knowles, 1980, p. 37). However, in practice I found that older adults looked to me for leadership and guidance.

I have since discovered that older adults have a distinct learning style referred to as *geragogy*, which means the guided learning of persons in old age (Schuetz, 1982). Geragogy emphasizes instructor-directed learning because “elders often lack the educational background and the practical knowledge that would enable them to design programs suited to their needs and capabilities” (Schuetz, 1982, p. 342). On reflection, it seems okay that I was as highly involved as I was. The target audience was, for the most part, unaccustomed to formal exercise programs, never mind televised ones.

At this point, the most time consuming task of the TV show was compiling appropriate music. I spent most of one day at the television studio listening to and taping music onto a cassette from their music library of compact discs. (Community television programs are mandated to use music provided by the cable company.) The time spent in the studio was my first sense of guilt of veering too far away from the role of a physiotherapist. This was probably not a good use of my time, but on the other hand, it was a one-time task.

Brent outlined the structure of a thirty-minute program (Appendix G), and provided a list of the various roles needed to produce this project (Appendix H). The twenty-minute exercise segment would be the body of the program; an educational segment was deemed valuable, but then a host and guests were needed.

Cablenet Arm Chair Exercises Program on hold. [The Red Cross Trained] leader [and potential host] resigned from program for personal reasons. Have discussed next step with Brent from Cablenet [community television]. He still wants to go ahead with the program although March is a busy month for him. Have asked clients who I see in the community to be "models" for the chair exercises. I will be the off-camera leader. Still would like to have a local older person as the host of the program. To plan a taping schedule with Brent in April (Month-end report, February, 1997).

As I became more and more involved in the television show, I could not understand the restrictions place upon health professionals. I believed that I was actively involved in health promotion, even though I was a physiotherapist. Why were certain people hired to be health promoters when everyone could be involved in health promotion in some capacity? This train of thought was directly influenced by a health promotion conference I had recently attended in Winnipeg.

*Why can't everyone be a health promoter within their own sphere of work/of being?
Why the job titles, job descriptions, classification. . . (Journal entry, March 18, 1997).*

On reflection, I was not only promoting health, but I was inadvertently following a model for community capacity building.

Building Community

Community capacity building is often associated with health promotion and disease prevention. It has been used by public health nurses in Canada and the United States for years (Moyer, Coristine, MacLean, & Meyer, 1999). Community capacity building can be described as “a generic increase in community groups’ abilities to define, assess, analyze and act on health (or any other) concerns of importance to their members” (Labonte & Laverack, 2001, p. 115). According to Moyer et al. (1999), the health practitioner is the key player in community capacity building.

The health practitioner links the needs of a target population with community groups and agencies. Moyer et al. (1999) describe four stages of building collective capacity within a community: (1) identifying common ground, (2) establishing self as community player, (3) working on a common project, and (4) working on a multi-agency, multi-sectoral project. The goal is “to establish a community-based health promotion program and concurrently increase the capacity of the community for future collaborative actions” (Moyer et al., 1999, p. 207). The process can be used to inform the planning, implementation, and evaluation of not only the health promotion program that was initiated, but other health promotion programs as well.

In Saskatchewan, the government report, *The Action Plan for Saskatchewan Health Care*, encourages building better communities through health promotion programs. It is recognized that participants from outside the health sector, including education, business, charitable, and religious organizations, are often involved in the process (Saskatchewan Health, 2001). The document states that a number of health promotion projects have been initiated in Saskatchewan: I wonder if health practitioners were the key players in its development. I also wonder if the practitioner purposefully entered the community not only with a health promotion initiative, but with a strong basis in the theoretical background of community capacity building.

I naively, perhaps intuitively, implemented a community capacity building model without the formal training in community capacity building. Personally, I think that formal training can obstruct the development of health promotion projects at the community level. From my experience in Weyburn, personal qualities and not academic degrees, are valued at the community level. On the other hand, I could not have accomplished what I did without my educational background and experience. Indeed, there lies a fine balance between theory and practice.

Location, Location, Location

By now, I had established a good working relationship with Brent Allin and a number of community people and agencies. My next task was to decide where to tape the initial programs. I went to Bison Manor where I had several clients, many of whom

supported my quest to promote physical activity amongst seniors. I approached the Residents' Council and gained their support. Although this was an appropriate route at the time, I now wonder about the differences in power that existed and continue to exist.

I am younger, able-bodied, and educated. My status grants me a certain degree of privilege. I wonder how this may have influenced the older people that I worked with throughout the development of the television program. Capacity building in health promotion advocates power-sharing, as well as recognizing and analyzing power dynamics in internal and external relationships (Labonte & Laverack, 2001). On reflection, the television program could be considered a power-sharing activity.

Cablenet Chair Exercise Program: presented outline of program to residents at Bison Manor. Appeared interested but not particularly keen about being on camera. Arranged to lead a sample exercise program to a group who regularly exercise together in the lounge area. Will also link with Kathy of Red Cross who co-ordinates program of teaching seniors to be fitness leaders for their cohorts (Month-end report, March, 1997).

At the same time, I met with the staff at the Weyburn Housing Authority to inform them of the program and to gain support and permission to tape some programs at Bison Manor. Their response was positive; all we had to do was acknowledge the housing authority in the credits.

In April 1997, I presented the in-service, "Falls and Fear of Falling," to residents of Bison Manor at their request. Brent acknowledged this as an opportunity to discuss the television show with the residents who appeared supportive and willing to help out.

Cablenet Program: have met with residents at Bison Manor and staff from Weyburn Housing Authority re: potential use of lounge at Bison Manor for filming chair exercise program. Meeting set up with Brent from Cablenet and residents of Bison Manor for May 6th. Met with Kathy, Co-ordinator of Red Cross and Link to Health Program

(training seniors as fitness instructors for seniors) re: local trained instructors, package materials, etc. (Month-end report, April, 1997).

This contact with the Red Cross led me to a woman in a neighbouring town. We talked over the phone, but we never met in person. A strong advocate of exercise opportunities for seniors, she told me that seniors in rural Saskatchewan did not realize the value of exercise. She cited that younger generations were better informed, but the older generation was not. The risk of physical immobility with age was a major concern. Her advice was that seniors needed leadership, music, and encouragement. I tried to recruit her to help with the show, but she was too busy. Her words of wisdom, however, were encouraging.

First Day of Taping

Just prior to our first day of taping, I wrote in my journal:

I am tired, fatigued, worried about planning too much work this week re: the cable exercise program. Not saying no. . . (Journal entry, May 11, 1997).

I was struggling with how involved I had become with the program. I did everything, yet, I am still not sure what I could have done differently. The television show was a new idea for us. All the pieces were not necessarily in place, and our resources were limited.

As I reflect on this now, I am reminded of a speaker at a recent Canadian Physiotherapy Association Congress who, as a physiotherapist, advocated for entrepreneurship and innovation. "The entrepreneur makes decisions without having all

the facts, sees the picture of the puzzle without having all the pieces, is willing to take a risk, and never, ever gives up!” (Lydia Makrides, Ph.D., personal communication, June, 2001).

Our first day of taping was in May, 1997. We spent the morning at Bison Manor and taped two exercise segments. I had recruited six of the residents to participate: three on each show. The set-up took the longest. First, the equipment needed to be carried from the community television van into the building. Brent was physically limited, and he did not always have a technical assistant to help—I was it.

The equipment lays cluttered across the room: tripod, cables, lights, monitor, mikes, more cables, camera. Brent is the expert and puts everything together from a seated position. I assist under his directions: plug in cables, hoist the camera onto the tripod, set up the television monitor so Brent and I can see it. Three armless chairs in front of the camera arranged in a V-formation, “like Canada geese,” Brent would say, whenever a participant pushes their chair forward or backward to try and straighten out the line. Plants and lamps are arranged in the background to create depth; lights are positioned; shadows are reduced. A chair for Brent at the camera; a chair beside the camera for me. A ghetto blaster is by my feet. A lapel mike connected to my collar. Organize the participants. “Quiet on the set!”

The first day of taping was new for everyone. There was hesitation but compliance amongst the participants. My job was to ensure calmness and to provide direction and encouragement. Three women from Bison Manor were seated. The

lounge was warm and inviting. We began with a warm-up and proceeded through a series of gentle exercises for the arms, legs, and trunk. I described and demonstrated the exercises to the participants at the same time.

I tried to include the viewers at home when I had a moment by saying: "*Are you doing this at home? You're not just sitting there watching us!*" or, "*For those of you at home just sitting and watching, I want you to get moving,*" and, "*Do what is comfortable for you.*" Sometimes I asked the participants questions, but their answers were lost as we had not given them a lapel mike. We had set-up a monitor to the side and the participant closest to this spent more time watching herself on the monitor than watching me. We learned to position the monitor away from the participants so they would not be distracted.

The morning ended, and I resumed my other duties as a community therapist for the afternoon.

Arm Chair Exercises: Two chair exercise sessions were taped at Bison Manor on May 13th with 3 women participating in each session. Footage of "seniors in action": gardening, walking outdoors, etc., to be filmed on Monday, July 7th in and around Bison Manor. [The] final section to be taped will be someone introducing the show and discussing a "health tip" re: importance of activity with aging (Month-end report, May/June, 1997).

I also included in that month-end report observations of clients I was seeing:

[The] majority of my clients are elderly, living alone, with a general debility (post-illness, fracture or injury, or disuse). Most are housebound and consequently lonely. My role is to promote functional mobility (walking, stairs, outdoors, bathtub transfers). These activities are generally avoided due to fear, not being aware of the potential to rehabilitate, and perhaps family or formal caregivers discouraging mobility. Giving permission to do these activities along with practice is the turning point it seems. Follow-up by phone appears to reinforce this process.

I wonder if the TV show was a form of giving permission. I wonder if the frequency and regularity was a form of providing motivation and, therefore, adherence.

Meeting Velda

I attended a spring tea at a nursing home where I met Velda Coulter, a retired teacher, and an active member of the community, particularly with seniors. I told her about the television show; she showed a keen interest. I asked her if she would be the host, and she agreed! She was just as eager as I was to try new opportunities.

Velda quickly became part of our team that now included a few of the residents from Bison Manor who were supportive of our endeavour. We met as a collective to discuss the progress of the program and to determine what else needed to be done. I loved this type of planning and organizing, the team-work, and the creativity it involved. It was refreshing.

Brent and I returned to Bison Manor to tape shots for a generic introduction to the show. We set-up the camera in the courtyard, and a group of residents gathered to watch and participate as needed. The scenes that become the opening program included: two women strolling down the path; a man sitting on a bench while his wife stands with her walker and holds a bouquet of flowers from the garden and engages in conversation with him; a woman watering the grass with a garden hose; and a gentleman in a wheelchair wheeling himself down the path with the man from the previous shot walking by his side.

Now the day is done and it was a success. The folks at Bison Manor are enthusiastic, involved, helpful, hopeful. The future is bright with leaders of all ages and all places. I wonder how can I leave when I just arrived (Journal entry, July 7, 1997).

My thoughts of leaving were imminent as I began the process of applying for graduate school. At the same time, I was feeling that my skills and abilities were finally being utilized. A conversation with one of my elderly neighbours revealed that older women (she for one) can also feel under-utilized without having a stimulating and vibrant community that promotes sharing, learning, and growth. Perhaps—including the seniors from Bison Manor—for this television project gave them a sense of inclusion and worth.

Nursing homes are filled to capacity. Staff have limited creativity/problem solving. The elderly have limited say in their care. Loneliness and isolation account for the greatest use of medical services it seems, i.e., home care. Departments and people operate on automatic because it's been done this way for a "100 years." Leadership lacks. Seniors seek permission (Journal entry, July 17, 1997).

The public deserves a physio of tradition while I surge ahead with other ideas/interests. [I need to be] in a position to teach, to facilitate, to learn. . . . I can see myself working with populations. . . (Journal entry, July 22, 1997).

The final piece needed to complete the first two shows was an introduction and a closing. It would have been more efficient to have taped all of this in one day, but for scheduling reasons, it did not work that way. Once more we returned to Bison Manor to tape the segments that would open and close the program. This time it was easier in that Brent had a technical assistant who set up the equipment. Under Brent's guidance, Velda and I rehearsed the "intro" and the "extro" (exit) of the first two programs.

When it comes to taping, the experience is more stressful than I could ever have anticipated: the camera rolling, countdown, "3, 2, 1," facing the camera, introducing ourselves, and the purpose of the program. I engage Velda in a conversation about the benefits of exercise from her perspective. She is poised and thoughtful. Her years of experience as a teacher are evident. I am a physiotherapist—not a television personality.

In the afternoon, Brent began the editing process at the studio. I was included in this process to provide feedback and suggestions to format the show as it would appear to viewers. We discussed the responsibility of the viewer, and we added a disclaimer just before the exercise segment: "Consult a physician before starting this or any other exercise program." I was excited to see how the raw video clips being edited became a final project. The editing process intrigued me.

I go to Bison Manor for our filming the intro/extro as host. [Gordon, a volunteer] is there. I am so glad Brent has him to set up instead of me lugging equipment around. . . I hate taping and being on camera. I thought I'd love it—get right into the act. . . Velda has a good time, and it seems to boost her up. . . Brent is so good, so calm, reassuring. I relax and feel a bit guilty for spending so many hours on the project. But, without it, I would be so frustrated and unhappy. . . (Journal entry, July 28, 1997).

Clearly, working in television production with people like Brent, Velda, and the residents of Bison Manor was the vital connection I needed to remain afloat in my work environment.

Two 30 minutes programs entitled, "Chair Exercises for Older Adults" have been completed and are ready to air Sept. 1/97. We will try to send out a Press Release under the direction of [the Communications Officer of SCHD] to the local media regarding the upcoming program. Further shows will be taped at the end of August at Bison Manor. At that time, a local committee will be arranged to sustain the project, redirect, or change as needed (Month-end report, July, 1997).

Brent, Velda, and I remained the local committee. When we met, we included participants from the program—they provided feedback and ideas—but the “official” committee never extended beyond the three of us. I always thought it was important to have an active committee to oversee the operation of the program. I thought greater community input was necessary, and yet did we not have community input from Velda, Brent, and I? We accomplished more than what we ever intended to do. Between the three of us, new ideas for programs were never lacking. Perhaps, keeping it small was the key to keeping it functional. Perhaps, a larger committee would have held up the process. In addition, there may have been financial obligations with a large committee whereas with the present format, there was not even a budget.

A Supportive Environment

My thoughts are on this job: how much I need a setting with colleagues to share ideas/explore options. A supportive environment. A sense of leadership. How grateful I am to have met someone on the job who shares my vision, unfolds my future, and my talents. How much I have appreciated working with Brent. . . (Journal entry, August 13, 1997).

The television show was more than providing a product for a segment of the Weyburn population. It was an opportunity for me to use a growing number of my skills and abilities; I was motivated by ideas and creativity. The television program fostered this. The television show gave me purpose.

Our goal was to tape two sets of thirteen programs.¹⁴ We planned to return to Bison Manor to tape four or five more programs. To recruit participants, I had posted a schedule on the bulletin board in the lobby of Bison Manor hoping residents would sign-up. I would not do that again. Instead, I would approach people in the building to participate as I had done previously. I learned from one of my key informants in the building that residents were unwilling to sign-up because they did not want their name on a public poster. Because of a lack of participants that day our full day of taping was reduced to two programs in the afternoon (programs three and four).

We taped the third and fourth programs outdoors on the back patio of Bison Manor. As pleasant as it sounds, exercising outdoors this particular summer was not a positive experience. Bugs were abundant to the point of being a nuisance. The participants were more concerned with swatting the insects than following the exercises. The sunlight shone in a manner that made the bugs appear like snow!

Two of the participants had been on the program before; they were familiar with the routine. The third woman struggled with the exercises due to language and hearing barriers. (She was hard of hearing, and English was not her first language.) I lowered my voice, exaggerated the movements, and slowed the exercises to try and help her understand what we were doing. She had limited movement in her shoulders, and she was unable to lift her arms over her head. I had conflicting feelings about portraying

¹⁴Twenty-six programs was equivalent to a year of programming: thirteen were aired from September to December; thirteen from January to April. A new program was aired every Monday and re-broadcast the rest of the week.

seniors in light of this. On one hand, it was probably okay because it showed different levels of ability. On the other hand, I heard criticism from viewers because the participant was not as able-bodied as the other two. They were comparing her to the others, and I felt bad about this.

Tudor-Locke, Myers, Jacob, Jones, Lazowski, and Ecclestone (2000) developed a video for a home support exercise program for frail older adults in Ontario. The video featured age-appropriate role models who, although having mobility impairments, were successful in performing the exercises. The Ontario video was only used for preliminary instruction of the exercises. It was not distributed to the participants since few participants owned a VCR. Feedback from the participants prompted organizers of the Ontario program to reproduce the video with role models from different ethnic groups. Tudor-Locke et al. (2000) concluded that an exercise program for older people should include cohorts as participants.

At this point, the first program of chair exercises was to be aired soon; media coverage was deemed important to inform people of the new series on the community channel. During that afternoon of taping, I arranged for a local newspaper reporter to join us. As a result, a photo with information about the program appeared in the newspaper the first week of September, 1997. The health district also distributed a press release and I was contacted by the local radio station for a phone interview. The interview became an hourly news item the day the program was first aired.

I was energized by the television show. I wrote about it in my daily journal as a way of making sense and justifying what I was doing and why:

Why a TV show? Emphasis is taking responsibility for your health. In order to do so: (1) need to be informed, (2) need to be inspired. It is hoped this program will accomplish and tap into older people in the community who realize [that] the benefits of regular activity can be the motivating factor for those who have adopted a sedentary lifestyle. . .easy after an illness to become sedentary especially for elderly. But, it is possible to recover, to regain strength and mobility. The process may be slower, but the time invested is worthwhile (delay or offset institutionalization). What's next for the project? There will be changes and modifications. I see myself stepping back (literally out of the picture). There is success if the project sustains itself, if the people say, "look at what we've accomplished ourselves" (Journal entry, August 29, 1997).

That never happened—my stepping back—while I was in Weyburn. Instead, I continued to be involved in every aspect of the program's production. I was the driving force behind the program.

Birth of the Program, Death of a Princess

The first program aired as planned on Monday, September 1, 1997, which happened to be Labour Day. We probably could have postponed it a week as the death of Princess Diana was also on television at the time. And yet, people did watch the exercise program. I received feedback from my 90-year-old neighbour. She said the program was supportive and informative. The program was repeated during the rest of the week. We aimed to put a new show on the community channel every Monday.

On September 10, 1996, we returned to the courtyard of Bison Manor one more time, and we taped the opening and closing segments for the third and fourth programs. Velda invited a retired teacher she knew to come on the program to talk about the

personal benefits of exercise. She was 87-years-old and remarkable. For the fourth program, Velda and I co-hosted an educational segment on the use of walkers. During this week, I also appeared on the television program on the community channel, *Healthy Community*. . . *Mutual Goals*, to talk about the exercise program for older adults.

From the beginning, we received positive feedback by word of mouth—at the grocery store, at work, and on the street. We heard statements such as “I feel part of a group,” “it is a safe, supportive environment,” and “the information as to ‘why’ to exercise is good.” Despite the positive feedback, I was feeling anxious about the program. My September journal entries were a plague of discomfort:

. . . how this TV show is both the driving force and misery of my life here (Journal entry, September 4, 1997).

. . . this project sparks a theme of images, fears, problems, absolutes. The dismal failure I feel after taping. Wanting to go back and confess, but what. . . I do not know (Journal entry, September 9, 1997).

Awake into this TV show which causes fear, anxiety, stress, and grief, and a terrible sense of loss, of insecurity. . . (Journal entry, September 11, 1997).

I go to sleep and wake up cringing with bad feelings about myself and this TV show for what I see happening is reviewing my life in a way. Being exposed to myself in a different media (TV) and forced to see myself, my behaviour, mannerism, voice all at once. It is as if the TV project is a metaphor for my life. . . (Journal entry, September 12, 1997).

For me, being on television was a painful process. I stumbled with the opening and closing segments. The count-in provoked anxiety. It required a sense of confidence and ability. Television as a form of reflection was powerful and overwhelming.

Set-backs and Regrets

We moved our location for taping to the Weyburn Special Care Home in September, 1997, and taped five shows over two different days. Once again, I made all of the arrangements. Once again, I incorporated this into my work. (As community therapist, I provided assessments and consultations at the nursing home one day a week.) The physiotherapy assistant at the care home and I recruited residents of the home to participate on camera and—they did—willingly.

One morning, everyone and everything was ready for taping, or so I thought. A major technical problem ensued—the camera would not work. It had been left in the van overnight and condensation had formed on the lens. I borrowed a hand-held blow dryer from the hair dresser's salon in the nursing home. Brent spent the better part of an hour unsuccessfully trying to fix the problem. He likened the stress of the moment to that of a farmer trying to repair a combine right in the middle of harvest. His only option was to take the camera to Regina for repairs. The day was over before it had begun. The residents returned to their rooms, and we rescheduled for another day.

At the end of September, we returned to the Weyburn Special Care Home for taping. I had recruited two teenage girls to be my program assistants. (They were Venturers with the Scouts organization.) They helped by transporting residents to and from their rooms to the lounge where we were set-up, had participants sign a waiver prepared by and for the health district, and assisted in setting up and taking down the equipment. For the first time, it felt like an inter-generational community-based project.

All but one program featured residents of the nursing home: women who were physically active as they were able. One lady was 90-years-old, and it was probably her first and last time on television. Unfortunately, I cannot go back and ask her to reflect on this experience as she, and many of the other participants, have since passed away.

As I re-watch those programs, I see elderly women with different levels of ability. Some are in wheelchairs. Some can lift their arms over their heads while others cannot. One woman is paralyzed on one side by a stroke. Another very enthusiastic participant has one leg missing from an amputation. She is in a wheelchair and appears comfortable with her ability and mobility on camera. In fact, she appeared on the program twice, and she was always well-dressed wearing black pants and a bright blouse.

One positive aspect of having elderly participants perform the exercises on television was that it enabled me to gear the exercises to the target audience while taking into consideration the vast differences in ability. I was challenged to instruct exercises that the participant could do, especially in light of an impairment such as a stroke, an amputation, or hearing-loss. However, if I were to produce a new series of programs, I would not put the target audience on television. One show in particular brought this to the light: a negative experience that remains a lesson in television production of this kind.

We are ready to tape one more show, but I do not have the additional three participants which I need: I only have one woman in her 80's, a resident of the nursing

home, who appears happy to come on the program. I ask the head of housekeeping and a housekeeping staff if they want to do the exercises on television and they enthusiastically agree. Unfortunately, even the gentle exercises are too much for Mrs. J., the older resident. She does what she can, but she is struggling. I feel very uncomfortable with this.

I awake having regrets re: filming one show at the WSCH. . .portraying one of the residents was in poor taste. She struggled. This program is to portray seniors in a positive, healthy light. Wouldn't you be embarrassed if that were you? I feel the older people of Weyburn are proud, modest, but also critical of appearance, protective of privacy. Fearful of change, of anything new. We have all stepped out of our comfort zones (Journal entry, September 28, 1997).

Friday, October 7, 1997. It is a grey drizzly afternoon, a cold and wet autumn day. Velda and I meet at the studio to tape an intro and extro for one of the programs. Afterwards, Brent, Velda and I are in the edit suite discussing the program. The discomfort felt with the program with Mrs. J. surfaces. Brent speaks from his own personal experience. He painfully recalls the day when he saw himself walk on camera for the first time. Up until then he did not realize how impaired his mobility appeared. Not only was that a difficult moment for him, but recounting it to us that day in the studio appears just as painful. Our experience at the nursing home has brought up memories of that moment for him and all the emotion attached to it. In light of his experience, Brent does not want to jeopardize this woman's dignity, or that of any of our participants. Airing that program is an ethical issue in our hearts. We never use it.

I wake up thinking of the TV show. I realize it's okay to have our people on. We are exposing people to impairments, and maybe they are having trouble with that, but it is reality. Reality hurts. We are pushing people's comfort zones and that hurts. But the pain subsides, and people grow whether they like to or not. There is merit in this project (Journal entry, October 9, 1997).

A New Direction

For the first eight programs, Velda or I, or both of us hosted the programs and included health-related themes. Our eighth program took a different direction. This particular program coincided with Weyburn's Communiton in October—a local annual event which raises money for the United Way by featuring local talent on the community channel for a 29-hour-period.

Brent was on the Communiton committee and came up with a great idea. He invited two members of the committee to be exercise participants on the program: the Manager of the Co-op, and the Chief of the Weyburn Fire Department. I instructed the exercises on camera this time and conducted an informal interview with the guests about the Communiton while we exercised. The show was fun to do—silly, actually. For example, at one point the Co-op Manager left the set to answer his cell phone! There is something about community television that captures the realities of a community and its people.

We received more positive feedback than usual from people in the community after this particular program was aired. This show was pivotal for us because we had cast two high profile members of the community into a different context thereby tapping into another dimension for the program. It gave us the insight that we did not have to

focus on the target audience in every aspect of the program. Younger and able-bodied participants were just as effective as cohorts of the target audience in engaging viewers with the exercise segment of the program. As well, it appeared that the program was more than just an exercise show. Somehow, it appeared to connect the viewers to the community.

Receive two spontaneous compliments about the TV show today (Journal entry, October 17, 1997):

I am at the out-patient physiotherapy department. A middle-age woman has just finished her therapy appointment (with my supervisor) and stops to talk to me. She praises the program. The other compliment is when I am in my office. My door is wide open: a woman knocks and comes in to tell me that she thinks the TV show is very good. I do not know her except that she is a staff member in long-term care. She gives me many compliments about the program. Her words are very positive. Encouraging.

No Pain, No Gain

We changed location and moved to the Legion Towers, a building similar to Bison Manor. I gained entry and acceptance through the Residents' Council. By this time, the program had been on television for six weeks and residents who supported it agreed to perform the exercises on television. Velda had a 90-year-old friend at the Legion Towers, and she encouraged him participate in the exercises on the program. Although reluctant, he finally agreed. When the taping was finished, he e-mailed his children across the country to tell them of his accomplishment.

The programs now included a guest who was associated with a service for seniors in Weyburn. Many of the guests were from the health district: the head of the respite day program, the public nutritionist, the podiatric nurse, and the volunteer coordinator. Velda hosted all the programs at this point.

It worked well leaving Velda and the nutritionist to discuss the interview, and I actually could stand back and produce a show (Journal entry, October, 22, 1997).

I took the initiative and sent personalized thank-you cards to the participants and the guests. The administrator for Rehabilitation Services, Carmen, had her secretary produce them on her computer for me. The inside message read: "_____ (name), your participation in the filming of 'Chair Exercises for Older Adults' is greatly appreciated. On behalf of the South Central Health District, we thank you."

I continued to include progress reports of the exercise program to my supervisor:

Chair Exercises for Older Adults: the half hour program was first aired on Monday, September 1, 1997. A new show is on every Monday and repeated the rest of the week. Shows for September were filmed at Bison Manor. Shows for October were filmed at WSCH, and two shows for November filmed at the Legion Towers.

Communiton Week (October) was celebrated with two members of the Communiton Committee and myself doing the chair exercises while talking about the Communiton. The two gentlemen, [fire chief], and [manager of Co-op] created both an entertaining and informative program.

Velda Coulter continues to help with hosting the program. She has interviewed guests such as [the head] of the Respite Day Program, and [the public nutritionist]. Velda and I co-hosted the first series of shows discussing topics such as how to use a walker, how to measure a cane, basic wheelchair use and safety, and car transfers. The message is the same: keep active, especially as you grow older.

As of October 31st, nine shows have been filmed. The next step will be to form an advisory committee. . .to plan the future of the show, i.e., cancel the show, continue with the same format, or change the show as members see fit. Members of this committee

would be those people who have been involved and are interested in offering input to the show, as well as anyone interested in the project. The original vision of piloting the program for seniors over the winter months still exists. Evaluation of the program to be arranged. So far, [positive] verbal feedback has been received by staff of COGECO Community Television, and staff of SCHD (Month-end report for August, September, and October, 1997).

My vision of the television program fluctuated:

Sometimes I look back and scratch my head how this TV show project has flown from an idea to an actual event now watched widely. . . what's the long-term vision? I would say programs for the winter months, i.e., Nov-March or Oct.-April (Journal entry, November 1, 1997).

I feel some stress with the TV show in that I have no more ideas, initiative, desire to get together another session (Journal entry, November 4, 1997).

There were moments when the task to co-ordinate and organize another program seemed overwhelming, especially when plans did not always work out. We planned to tape two more shows at Legion Towers in November, but the arranged day did not work for Brent.

The stress of setting up folks for the TV show to only have it disarranged with Brent going off to Grey Cup. . . (Journal entry, November 11, 1997).

I had already scheduled a guest as well as participants from Legion Towers.

Rather than reschedule the taping, I proceeded ahead with Brent's program assistant as the director. Velda was also unavailable that day so I hosted the programs. The podiatric nurse from public health was the guest and talked about footcare on one show and footwear on the other. The nurse was willing to do the exercise segment on one program with two residents from Legion Towers. This seemed to work well as it provided a continuity between the interview segment and the exercises. As a result, we

began to incorporate the guest into the exercise segment.

While I was making progress with the television show, I was being prodded back into the treatment paradigm of physiotherapy. One incident stands out. I was given a referral by my supervisor to see a teenage boy with a sports injury even though I had limited experience (and interest) in this area of physiotherapy practice.

I want to tell them at work, "you have a geriatric therapist on board and now you want me to do orthopaedics when I have never done such formal training. . ." (Journal entry, November 12, 1997).

To make matters worse, I was told by my supervisor to pay a home visit to this young individual. I did not agree with this paradigm of physiotherapy. When I consulted the referring physician about having to do a home visit for this client he said, "that's ridiculous."

At this point, the only thing that kept me interested in my work was the television program.

This TV show has encompassed my energy and talents. Working with Brent has given me confidence [in my] abilities (Journal entry, November 25, 1997).

Where is the need in rural Sask? The problem is I don't see a need having been overseas and back. I see a need for health promotion, education, community involvement. Help people help themselves. . . (Journal entry, November 30, 1997).

I only have 8 months before I start university—my Masters. Chair exercises for Older Adults on SCN, an idea that seems inevitable (Journal entry, December 5, 1997).

Already I have a long-term vision of a province-wide program. . . . Without the TV program I feel under-utilized at work. It is frustrating. Yet, in the community of Weyburn, it is an excellent place for me to use my skills: leadership, communication, networking, and consulting (Journal entry, December 10, 1997).

I am thrilled with the recent increase in connection with cohorts at work—multi-disciplinary teams and co-operation. And still, I falter within the physio profession as a whole and those who need to be within a rigid and limited border or region when I am ready, “biting at the bit” to soar above the limiting borders (Journal entry, December 11, 1997).

In the previous quotation, I was referring to working with people from public health and community care. As compared with my supervisor and her boss, Carmen, who by now had begun to put limitations on my activities. Up until this point, this administrator appeared genuinely interested in my abilities and my efforts. After all, the apparent success of this television program reflected well on the health district.

Cablenet [Chair Exercise] Project: 13 shows have been taped so far; an evaluation has been distributed through Community Care and the institutions for feedback (see attached). An advisory committee is being formed to provide future direction for the program. I see myself letting go of the project and handing it to the community for sustainability.

Carmen has asked that I attend a patient service meeting on Thursday, January 8th, to present the project to the nurse managers: perhaps a strand of Community Care, i.e., the Day Respite Program, could help in co-ordinating the project if the project is to continue (maybe the show will be cancelled, although verbal feedback tells us to continue for now, perhaps even running it twice a day on Ch. 5).

[Two staff members] represented SCHD at a health district conference in Saskatoon in early December. They set up a table and presented the video series, ‘Health Community . . . a Mutual Goal,’ and ‘Chair Exercises for Older Adults.’ . . . feedback was positive and we are definitely one of the few, if not the only district, working on such projects (Month-end report, November & December, 1997).

Initial Evaluations

In early January, 1998, I distributed a one-page questionnaire to viewers in an attempt to obtain some written feedback. Even though this was not a valid and reliable tool (as I discovered in my graduate courses), it was an initial attempt to evaluate the

program. The feedback was positive, and the benefits of the exercise program—such as less stiffness or able to move better—were described.

Formal evaluation of the television program needs to be considered for the future. But how? *The Action Plan for Saskatchewan Health Care* acknowledges that the “benefits of health promotion and disease prevention initiatives are not immediately apparent. They occur over an extended period of time and they can be difficult to measure” (Saskatchewan Health, 2001, p. 17). Indeed, this is true.

How would I go about gathering evidence about the television program, and what would I measure? Michael Collins supports the use of a participatory approach for needs assessment, program planning, and evaluation rather than a professionalized discourse:

Instead, a concern for uncovering real needs through face-to-face interaction becomes an integral part of the participatory research project which is evaluated on a continuing basis in the form of collective analysis. The problem of needs, the project at hand, and evaluation are part of the interweaving of theory and practice...The emphasis is on working with, and within a group, not on *dealing with* individuals in isolation as part of an aggregate.

-Collins, 1994, p. 127

If I were to evaluate the television program at some point in the future, I would consider participatory evaluation, as suggested by Collins, and further described by Garaway (1995) in which a team approach is used. The evaluator is part of the group, rather than an outsider as with other responsive evaluations. The group is kept small in order to engage all participants in the process of evaluation. I would try to include retired professionals within the community, such as Velda, as part of the evaluation

process as I believe that it is important for members of a community to gain a sense of ownership in the project.

Methods used in participatory evaluation are often creative. Perhaps I could utilize the community channel to solicit feedback from viewers. For example, an invitation for viewers to phone or write the station could be added at the end of every program. A live phone-in show could also be periodically programmed where members of the evaluation team are in the studio to take calls. Verbal and written information from viewers could then lead to in-person interviews and functional assessments (for example, the ability to get in and out of bed, and on and off the toilet, both critical movements in the lives of older people).

I believe the key to evaluation is the ability to remain flexible. "Careful reflection on the educational processes calls for a predisposition to *create* strategies, a willingness to *modify* them when appropriate, and the *courage* to identify where they are going wrong" (Collins, 1994, p. 122).

Ethical Considerations

Of the three on-location sites thus far, Bison Manor felt the best. We returned there and taped three more programs in January, 1998. The women who were previously on the program agreed to come on again. For two of the programs, I had another instructor take my place while I produced the program from the sidelines. She worked for the health district as a home health aid, and also at the respite day program at

the Weyburn Special Care Home where she conducted a chair exercise class. She had a calming voice, and her approach was slow and gentle.

Once again, I was trying to expand the program to include others who could perhaps carry it forwards after I left. However, for her to be involved on a regular basis would have meant the creation of a new job within the health district, and posting and hiring someone (not necessarily her since it would have been a unionized position). Ultimately, I needed the support from my supervisor. That never happened.

At the end of January, 1998, we taped one program at the Mental Health Resource Centre where Velda was an active volunteer. She initiated the location and made all the arrangements. However, it was a difficult time. The participants included a woman who worked at the centre and two were older men who attended activities there. One fellow was not attentive but rather distracted in a way. He seemed to be out of breath and often sat not doing anything. I felt bad I had him on.

I could have stopped the taping as I had done once before when one of the participants, an elderly gentleman at the nursing home, fell asleep during the exercises! Even though I assessed the movement abilities of the participants before we taped, this was not enough. Once again, I felt the guilt of possibly jeopardizing a person's dignity. He ended up in hospital a few weeks later with respiratory problems, and he has since been admitted to a long-term care facility.

Is it ethical to even have older adults on television in light of the eventuality of death? We wrestled with this time and again. Programs where a participant had died

were taken off the air. But is this enough? What other measures should we have considered before and during this project?

We did not tape any new programs in February because of Brent's busy schedule. In March, we moved to a new location. It was not our last move, but it became our best choice for location.

Moving to the Mall

Brent suggested our next location: the Weyburn Square Mall. He had seen an aerobic exercise program on television that had been taped at a large city centre in the United States. Moving to the mall seemed like a great opportunity to increase visibility of community programming in Weyburn (B. Allin, personal communication, August 10, 2001). I made the arrangements with the manager of the mall, and she allowed us to use an empty store space to tape the programs. Our requirements after that were few: five chairs—three for the participants, one for Brent, and one for myself.

In early March, 1998, we set up the equipment and taped three programs. We arranged the set so that the three participants had their backs to the mall corridor. Only Brent and I were cognizant of the mall patrons who strolled past the set, peered in with quizzical expressions on their faces for a few moments before realizing *they* were on camera! This set with unrehearsed background action provided a different dimension—a much more interesting picture—than a still set with plants or a lamp.

Brent, Velda, and I felt positive about the location. It was spacious and bright.

Because the back of the set opened up to the mall, it changed the entire feel of the program. For the first time, it felt as though we were truly *in* the community. The passer-bys in the mall became part of the action:

The men who sit on the bench in the background and visit—oblivious to the foreground activity. The people going for coffee, those who are shopping, and those who are just walking by. It seems to open up the purpose of the program much wider than the original vision. As we are taping one show, a maintenance man from the mall sets up a tall ladder in the background of our set. He climbs up and works on the light fixture, then climbs down, folds the ladder, and walks off screen.

One episode featured the Mall Walking Program and Velda interviewing the woman who volunteered her time to co-ordinate this service. They sat on one of the wooden benches in the mall. The background of the frame included a kiosk in the aisle of the mall and, on each side of the frame, were seniors who were participating in the morning mall walking program. For the exercise segment, I appeared on camera with two of the mall walkers. This was only the second program in which I did the exercises on camera.

I always thought it was more important to portray the community than myself. Also, it was easier for me to monitor the participants by facing them. When I was the instructor on camera, I could not tell what the two participants were doing to each side of me unless I turned to look. However, because the participants were capable, I need not have worried. If I were to do more programs, I would go on camera to be both

visually and verbally present as the instructor.

Another successful program was with the Rotarians. Two members plus the exchange student, an 18 year-old from Australia, came on the program. One of the members, a man in his 60's, was highly enthusiastic about the exercises and brought energy and humour to the program. For example, one piece of music was ragtime piano, and I sometimes used this to pretend we were playing the piano. He had a good time exaggerating his imaginary piano talent. It was fun and light.

The third program featured three women who delivered "Meals on Wheels" in Weyburn. They, too, appeared to enjoy the exercises. Part of the sense of success at the mall was the inclusion of younger and healthier seniors as participants. Also, because participants for each program were associated with a service club or organization, they knew one another and were more comfortable being on camera together.

We returned and taped three more programs a week later. One program featured the Mayor of Weyburn who did the exercises along with two council members. The second program featured two members of the Quota Club for the exercise segment. (Quota is a woman's organization who raises funds to support community projects both locally and beyond.) Since they were unable to recruit a third person to be on, Velda sat in and performed the exercises. The final program at the Mall featured the Alzheimer's Support Group. A member of the group (who was also the City Council member who appeared on the program with the mayor) was interviewed by Velda and then participated in the exercises along with two other members of their group. A member of

each program was interviewed by Velda.

The combination of the mall location and the participants were positive experiences. Verbal feedback from the target audience and the general public were encouraging. In fact, if new shows were to be made I would use this formula again.

Chair Exercises for Older Adults: goal is to finish 2nd block of programs (13 shows). Have been filming the shows at Weyburn Square Mall as the location and environment are ideal for the program it seems. Recent participants on the show have included: Rotarians, MOW drivers, Quota Club, Mayor Don Schlosser, and Alzheimer's Support Group members. Would like to invite Lee Spencer (CEO of health district) and the Board Chair to be participants/guests. Carmen thinks this is a good idea and will approach them with the suggestion. Three more programs are needed to finish this part of the series and will be done in May.

Long term goal is to have Community Care take over the program (Volunteer Services). Have discussed this with and will arrange to talk with [the head of Community Care]. Feedback, both verbal and written, is very positive. The long-term benefits could be measured, i.e., number of visits to physician's office, number of hospitalizations. . .if someone was interested in adding some research data to [SCHD's] name (Month-end report for January, February, and March, 1998).

Despite the accomplishment of the television program, my initiative, skills, and abilities as a community-based therapist with a health promotion focus were diminished by my superiors.

The memos and meetings begin in December, 1997, and climax at the end of April, 1998. I am told by my supervisor to stop all my activities as community therapist except direct patient care. It is a devastating moment for me. I am ready to quit then and there. I have kept up with all the client referrals I receive. The television show is an extension of what I see as community therapy. My statistics indicate that I spend an average of one day a month for taping. I probably spend a second day a month to make

all the arrangements. Most of this is a matter of ongoing networking that I am already doing as part of my job. My words fall on deaf ears.

By now I had planned to start graduate studies in the fall. I had nothing to lose at that point and so, I took a six-week leave of absence and journeyed to Thailand for a holiday. When I returned to Weyburn, Brent, Velda, and I taped the last three last programs that would complete the 26-program series. I did this on my own time.

Final Series

In May, 1998, we taped the last three programs at Wheatland Seniors, a thriving recreation centre. We used a lounge area to tape in, but it was a small space to comfortably accommodate the three participants, myself, the camera, and the lights—especially on a warm spring day.

The first program featured three members of Wheatlands who were regulars at the fitness classes there. The second program featured Volunteer Services of Community Care and three volunteers were the participants—one of whom was the Chair of the South Central Health District board. The final program featured the CEO of the health district. The highlight was at the end when the CEO, a fit and healthy 60-year-old, did a head-stand much to our surprise. He brought a chair onto the set, bent over, placed his head on the chair, lifted his trunk and legs into the air and held this position for a few moments. Then he returned to a standing position. “Don’t try this at home” was his parting advice!

Chair Exercises for Older Adults: completed filming final three shows on Friday, May 22nd at Weyburn Wheatland Seniors. Please refer to memo sent to Carmen on May 25th, 1998. [She] has given verbal approval for a formal thank you to be sent to the local newspaper for those who have participated on the program. She has asked that I send the ad to the Weyburn Review [local newspaper] which will be sponsored by SCHD (Month-end report, May, 1998).

I sent a memo to the administrator to conclude my involvement with the project.

There was nothing else I could do but suggest the continuation of the program with the support of the health district. I also submitted a summary of the program's evolution to the Communications Officer of the health district at the request of the CEO. He believed it was worthy information for the province-wide health district newsletter entitled, *Contact*. But once I left in June, 1998, there was no further action. The TV show was on its own. It would either live or be taken off the air.

Feedback Comes in Many Forms

Brent wanted to find out what the viewers thought. In June, he added a segment to the program in which he personally asked viewers for their feedback to determine whether or not the program should keep running. Within a few weeks, two letters and over twenty phone calls were received in support of the program. Brent indicated that this number can theoretically translate to several hundred people who watch the program.¹⁵ In light of this, he was reluctant to take the program off of the air.

¹⁵Brent had attended a Canadian Cable Television Association conference where a presenter introduced a way to gage the size of a viewing audience without polling. It was suggested that one contact from the viewing audience could equate to 30-50 other people with the same thought (B. Allin, personal communication, August 10, 2001).

As I prepared to move back to Saskatoon, the tenants at Belle Court held a going-away party for me. A hand-written letter by my 91-year-old neighbour reminded me that my efforts were not in vain:

*Belle Court, Weyburn
June 29, 1998*

Sharon, it has been a joy to have you here in Belle Court to light up our lives with your ever ready smile and cheerful ways. We have enjoyed following your capable directions on T.V. as you have guided us in a way of retaining some of what is left from our youthful moves. . . . We wish you happiness and success in all of your future projects and endeavours.

*Very sincerely,
All of us in Belle Court*

I kept in touch with the residents of Belle Court, especially with one woman who was in her late 80's. In October, 1998, I received a note from her that read:

This morning. . . I turned on the T.V. to get the temp. and found your exercise program in progress. I stayed and joined your "class." As a rule I'm busy or off to the Co-op at this hour, but decided I'd try to change and be one of your followers - if my will holds, maybe I'll come into a helpful "change of life"—and you'll be responsible. I'll let you know how it goes.

Worth Repeating

Repeats of the television program continued to air until December, 1998. Many of the programs were seasonal and some of the comments made during the exercises related to events of that particular day; and so, this made it difficult to re-run certain programs. Plus, the repeats were becoming "stale." Brent edited three of the original programs that were taped in the mall and these were aired from January 1, 1999, onward. He removed the interview segment, and just kept the exercise segment with additional

public service announcements at the beginning and end.

The station has since undergone new management and a new structure. Brent took a position higher up, but he is still based at the Weyburn station. Two different people have filled the position of community programmer. The equipment has since changed to digital. As a result, the chair exercise programs, originally taped on VHS, had to be played on old malfunctioning machines. The quality was poor.

Normally, old programs are rarely broadcast years after they were first produced—but this was different. The staff at Weyburn's television station received phone calls when the program was not broadcast due to technical problems (the tape was jammed in the machine, or the machine broke down). Sometimes the show was not aired due to human error: the technician forgot to put the exercise tape in the machine on Friday for the Monday morning broadcast. On rare occasions, a local program was aired live (such as the parade), and the exercise program had to be cancelled. Still, viewers called in to find out what happened to their program (personal communication, B. Allin, August 10, 2001).

It is the summer of my thesis. The program, Chair Exercises for Older Adults, remains on the air. However, one program has been continually broadcast for the past year. As a result of this repetition, I would be surprised if anyone has anything positive to say about the program.

I am indeed surprised.

CHAPTER 5

TOWN HALL MEETING

A Viewer's Guide to the Participants

Moderator: This person is not identified by name, age, or gender. However, he or she could be thought of as a well-known national radio or television host.

Older Adults:

- | | | |
|--------------|----------------|----------------|
| - Jean (95) | - Gwen (88) | - Jenny (76) |
| - Agnes (91) | - Sylvia (88) | - Loretta (76) |
| - Jane (90) | - Martha (87) | - Bob (75) |
| | - Bernice (80) | - Mary (75) |
| | - Ruby (80) | |

Physical Therapists:

- Diane
- Terry
- Barb
- Matty
- Donna

Panel Expert: Not identified by name or age. Represents a person of academic status who has expertise in gerontology, physiotherapy, adult education, and media communications. This person is in Saskatchewan as a visiting professor to the University of Saskatchewan and the University of Regina.

Studio Audience: Interested members of the community. Included is Sharon Elliott, Producer of *Chair Exercises for Older Adults*.

Format: This town hall meeting is held at the Royal Canadian Legion Hall in Weyburn, Saskatchewan. It is being taped by the local television station, Access Communications, for future broadcast. Some of the older adult participants are connected by two-way cable at their place of residence.

The moderator begins by introducing all of the guests. The older adults are introduced by name, age, and place of residence. The moderator has met with everyone ahead of time, and has invited the guests to tell something about themselves during their introduction (in italics).* The number of years and frequency of following the television program are also noted.

The physical therapists (PT's) are identified by their name, number of years within the profession, and their current area of practice. They have agreed to share their gerontological philosophy, particularly in relation to the role of physiotherapy and community-based activity programs for older adults (also in italics).*

*Note: (in italics) Everything that is italicized indicates direct quotations from the research interviews. Brackets are used to enclose text which have been added in an effort to clarify content.

.....

Introductions:

Moderator: Good day and welcome to our town hall meeting in Weyburn, Saskatchewan. The topic for today's discussion is the television program, "Chair Exercises for Older Adults: Do you accept it or reject it?" Participants of today's session include older adults of Weyburn, some of whom are joining us from their residence by two-way TV. Also joining us are five physical therapists, a panel expert, and the producer of the exercise program, Sharon Elliott.

As the discussion unfolds, key points will be projected on the television monitors throughout the studio, and on your television screen at home. This will help focus the discussion and summarize key points. Questions from the studio audience are welcomed, but I ask that you please use the microphone in the centre aisle. Without further adieu, I will begin by introducing the participants starting with the older adults.

Agnes, Bernice, and Ruby live in a forty-bed private care home. Agnes is 91-years-old; Bernice and Ruby are both 80-years-old. Ruby uses a wheelchair because she has Multiple Sclerosis. Agnes and Ruby have followed the exercise program on television every weekday morning since they moved into the home. Ruby has been there since it first opened two years ago; Agnes has been there for one year. Bernice has only been at

the home a few months. She participates in the exercises on occasion.

Jane is 90 and lives in a nine-bed private care home. A fall was the turning point: *"Two years past, last November, I fell and broke this collar bone, and I couldn't do anything. I was living alone in the house so I couldn't stay there alone. But I never thought that once I came here, I'd be still here."* Jane has been active all of her life: *"I have a bicycle still at the house, but I quit riding two and a half years ago (laughs)."* Jane has been doing the exercises on TV since they began.

Martha, age 87, has lived at a public long-term care home for the past four years. She uses a wheelchair and propels it with her arms and legs. Complications from a hip fracture several years ago prevent her from walking. She did the televised chair exercises in her room every morning until approximately six months ago when she fell and broke her other hip and shoulder.

Jean is the oldest participant. She is 95, and lives on her own in an apartment. She tries to remain independent despite being blind in one eye and having failing vision in the other. The only formal assistance she receives is home care every two weeks for cleaning. She has considered Meals on Wheels: *"I could sit here and wait for my meals to come in front of me, but I don't think that would be good for me."* She is a firm believer in keeping physically active: *"I think it's very important to continue to be active. I really do believe that."* In winter, she is housebound. *"I had a little taste of it this winter. You see, I was afraid of the ice because I'm quite—a little—wobbly, you know. And I thought a fall would put me in a nursing home for sure you know. So I had a little understanding of what it's like."* As for the TV show, *"I would say for the first three years, I watched fairly regularly. But I've become rather lazy about it lately. . . . I've had more birthdays I suppose. That's why I'm lazy" (laughing).*

Sylvia lives in the Legion Towers and is 88-years-old. *"I've been pretty active all my life. I did everything I wanted to until I was over 80. I golfed, and bowled, and danced, and everything else. I hurt my knee so then I had to quit."* She used to go to the exercise class at the Wheatland Senior Centre. . . *"theirs are a little bit more strenuous."* Her main activity now is watching television. *"I watch TV from morning to night. . . I sit and crochet and watch so I get most of the programs."* She has been doing the TV exercises since they started and does them at least four times a week.

Gwen is also 88, and lives at Bison Manor. Gwen was supportive of the chair exercise program when it was first introduced. She even appeared as a participant on several programs when the program was taped at Bison Manor. She even convinced her husband to be on camera. He has since moved to a long-term care facility in Weyburn. Gwen had been a regular follower of the exercises from the beginning: *"Oh, before, I did them every day for many days after you [the interviewer] had even gone. . . well, I*

don't do them now for the last year, or maybe the last year and a half because Gordon being sick. . ."

Jenny is 76, and lives independently in an apartment. She attends the exercise class at the Wheatland Senior Centre three times a week, and follows the chair exercise program on alternate days. She has been doing the exercises on television since the program began.

Loretta is also 76, and lives with her husband in a condominium. She is also very active, and remains independent. She reports that she has been doing the televised exercises every day for the past three years. She misses a program only when, *"I'm really busy doing something that has to be done, or away."*

Bob is 75-years-old, and lives with his wife in a bungalow. He has Multiple Sclerosis and uses a wheelchair to get around. Once a week he attends a day respite program at a public nursing home. The rest of the week he follows the exercise program on television: *"Oh I've been pretty well watching from the beginning as soon as I heard about it. . .oh pretty well every day. I very seldom forget, and the only time I don't do it is when I'm going to the respite there, and when we happen to be away, and then you don't get the chance—the opportunity—to do it."*

Mary is 75, and lives with her son in a bungalow. She had a hip replacement four years ago, and depends on a walker to get around. Her son farms so she is alone during the day. She wears an alert bracelet in case she falls. She receives assistance from home care including Meals on Wheels. She is housebound unless her son is available to take her out. Medical appointments are her main outing. The frequency of her outings vary: *"Well, sometimes three times a week, sometimes only once, sometimes not at all."* She is familiar with the exercise program on TV, but does not follow the exercises.

Now, to introduce the physical therapists.

Diane has been a physiotherapist for thirty-eight years. She is currently the director of an inner-city community health clinic. She is also on the board of the Canadian Physiotherapy Association, the national organization that provides leadership and representation to physical therapists. *"I think seniors certainly deserve quality of life: that they should be prioritized as high."* She sees one role of a physiotherapist as providing public information, *"about general activities that seniors could participate in."*

Terry has been a physiotherapist for sixteen years. She is now working as a program consultant for the provincial government. *"I think the role of the physiotherapist, as to their level of skill and training, would be advisory in terms of setting up a generic*

program versus being the person that would lead the program."

Barb works in private practice and owns her own physiotherapy clinic in a mid-sized Prairie city. She was trained in the U.K. thirty years ago. Her philosophy is straightforward: *"Do you think there's anyone that's old that doesn't need physiotherapy?"*

Matty is also foreign trained; she has been a physiotherapist for fourteen years. She works part-time in a private practice clinic, and part-time with a primarily geriatric population in a hospital and home-care setting. *"People don't know what physiotherapy can do for them. There's so many things as in day to day mobility they could do easier."*

Donna has been a physiotherapist for twenty-nine years. She teaches undergraduate physical therapy education. She sees the role of physiotherapists, *"in terms of maintaining physical fitness and prevention of falls. There is a big role to play in teaching [older adults] safe ways to do certain activities."*

Our Panel Expert is currently a visiting professor at the University of Saskatchewan and the University of Regina. She has an undergraduate degree in physiotherapy, a graduate degree in adult education, and a doctorate in education specializing in media and health promotion. It is good to have you here. Last, but not least, Sharon Elliott, producer of the exercise program. Sharon is a physiotherapist and is completing a Master's degree in Adult and Continuing Education at the University of Saskatchewan. Welcome everyone!

Before we begin the discussion, I draw your attention to the television monitors in the studio, or to your television set at home. We are going to watch a report prepared by Sharon Elliott [SE] entitled, "It's 10 o'clock in the morning. . ." Let's watch (lights dim, television monitors come on).

"It's 10 o'clock in the morning. . ."

At the private long-term care home where Agnes, Bernice, and Ruby live, there is a message board at the entrance to the living room. Handwritten in black letters it reads: **"Come Join Us for Chair Exercise Classes. Every Mon.-Fri. at 10 a.m. Stay Fit. Stay Active. Everyone Welcome."** The "classes" refer to the television show. The television set in the living room is tuned to the community channel. Announcements of upcoming events in Weyburn are set to a background of instrumental music and play to an empty room.

Just before 10 o'clock, Ruby leaves her bedroom. Using her arms, she slowly pushes her wheelchair to the living room next door. As she enters the room, she bends over and swings the foot pedals to the side of her wheelchair so that her feet are free to move. She positions her wheelchair in preparation for the exercises. A staff member assists another woman with a walker into an easy chair. The theme music for "Chair Exercises for Older Adults" comes on. A third woman is escorted from her bedroom to a corner chair in the living room. Just as the exercises begin, Agnes walks swiftly and ably to her seat, a padded dining room chair that a staff member has placed next to Ruby. Agnes is hard of hearing despite having a hearing-aid in each ear, and is often absorbed in word puzzles or a card game in her room at 10 o'clock:

Agnes: I always forget about it. The girls always have to come and get me. Once or twice I have remembered, and I keep looking out to see if anybody was out there. But, mostly, I forget about it. When there's nobody out there, I very seldom go. But then, when the exercises start, well of course—they all come out. Most of them just wait until the last minute. . . Today the girl came and told me, and they were just starting. I had forgotten about it. I was doing my word puzzles.

An average of two to five residents follow the exercise program on a regular basis.

At the other end of town, Jane foregoes the morning coffee break to do the exercise program:

Jane: Well, some of them, at 10 o'clock in the morning. . . [go] and they have coffee. But I can get my coffee afterward so, I mean, it's important to the people that I get the chance [to exercise] and it always has been. The program's arranged so that I can be free at that time.

SE: So, you make the effort to be able to do the exercises at 10 o'clock?

Jane: Yes, uh huh, I do it right here in my room. I'm the only one doing it. And I've tried to talk others into it, but I don't know, they're not too active. . . can't get them walking out and so on. I walk out by myself most of the time.

I ask Bob what happens at 10 o'clock in his house:

Bob: Well around that time I like listening to the radio. I listen to the radio quite a bit. I listen to this talk show that comes from Regina, and then, well, you know, as soon as it gets to be 10 o'clock I say, 'Well, gee, it's time to go for the TV to do those exercises,' so I just shut the radio off and go and turn the TV on. . . I mean, you never forget.

He does them in his wheelchair in front of a small TV in the kitchen. At the same time, his wife watches another program in the living room:

Bob: I often ask her why she don't do it. . . she comes into the kitchen sometimes, does something or other, and I say, 'why don't you do it too?' (laughs). She likes to watch her stories, [but] I don't think they're that important that you can't take a half hour off. . . I think there are a lot of people that do it too that are able to get around and all, but they still like doing them too.

On days when Sylvia does not go out, she has her morning mapped out based on what's on television:

SE: What happens at 10 o'clock for you?

Sylvia: Oh, well I've been watching Bob Barker—Price is Right— then at 10 o'clock I turn it onto Channel 7 to watch my exercises and then I go to Matlock.

SE: And do you do the exercises?

Sylvia: Yes, I do. I pull my chair out there (laughs as she points to the place in front of the TV where she places the dining room chair she is sitting on).

Jenny follows the TV exercises on the days when she does not go to the senior's center:

Jenny: Tuesdays and Thursdays I usually watch it and do it. And I do my walking outside, or in the building, or whatever, depending on the weather.

SE: So do you make a point at 9:50 and say, 'It's on. I've got to get organized.' You fit it into your schedule?

Jenny: Certainly. If I'm doing something else, I let it wait until after it's over.

At 10 o'clock, Loretta is usually preparing the noon meal for her and her husband and states that, "we're early eaters here:"

Loretta: If I'm making dinner, well, I stop and do the exercises. I'm usually getting lunch about that time so I have to stop and get my exercise done too. I can hear it come on, you know, the music.

Gwen turns on the community channel when she gets up to check out the time and the temperature. When she hears the opening theme music of the chair exercise program, she pulls a chair in front of the television. She has two TV's: one in the bedroom, and one in

the living room. She does them in either room:

Gwen: I bring my chair out of the bedroom. I sit it down here (points to the spot in the living room). If I get up in the morning and feel a little stiff. . . then I won't dress, see. I'll just do it in my chair even in there (refers to bedroom) at 10 o'clock. But when that station's on at 10 o'clock, which I usually have it on, and then I'm ready for it. When you hear that music it does something for you. It makes you feel 'well I better get busy and do those exercises, yeah.'

Martha was involved in many of the organized activities at the public nursing home before she fell this past year. Her morning routine reflected this:

Martha: Depends on what there was. If there was tone bells or exercise or anything, I'd go to that. Or 10 o'clock there's exercises on TV so that's what I did first. Come to think of it, it's 11 o'clock the other ones (referring to the group exercises offered in the lounge).

Her morning routine was to turn on the community channel after breakfast, "to see the weather there and to make sure what day it was." At 10 o'clock, she would participate in the exercise program on television. She states that she rarely watches TV: "I turn it on mainly for the exercises." On the days when group exercises were offered in the lounge at 11:00 a.m., she would participate in those as well. Her morning routine changed after she fell. Sometimes she may be back in bed after breakfast because, "I'm just so tired." However, on occasion, the staff have noted that she has been doing the chair exercises on TV.

Jean reflects on her morning routine when she used to watch the program:

Jean: I set the time always. . . I just enjoyed whatever it was they were doing. . . . I just enjoyed being part of something that was happening. . . it was an effort to do them on my own, you know.

Her energy level has decreased considerably, and she is often asleep on the couch between meals.

Mary's morning begins with breakfast, and then she returns to her bedroom to take her pills. She is able to wash and dress on her own, but it takes considerable effort. By 10 o'clock, she states that she is exhausted and ready for a rest. She has a recliner in the living room where she stretches out in front of the TV. She is familiar with the local exercise program, but does not engage in it:

Mary: I turn it on and watch it for a few minutes, and, uh, I didn't think I should go for it. What's it doing for me? . . . I'm usually ready to relax. I don't usually feel like exercising.

Thus, she turns to watch another program.

In conclusion, seven of the viewers—Bob, Loretta, Jenny, Jane, Agnes, Ruby, and Sylvia—continue to follow the exercise program on a regular basis. Many of them have done so since the program began in 1997. Gwen, Martha, and Jean were regular viewers at one time; Bernice is the newest viewer. Mary represents those who do not watch the program. Each person provides a perspective on the acceptability of the program. It is this perspective that is the subject of the town hall meeting. For Access Communications, I'm Sharon Elliott (fade to black, credits roll).

(TV monitors turned off; lights come on in studio).

Moderator: Thank you for that report Sharon. As indicated, a number of viewers continue to follow the exercise program on a regular basis. Many of them have done the exercises since the program began in 1997. Initial comments or reactions?

Matty (PT): I think this is wonderful. I've never thought of it.

Terry (PT): I think it's quite remarkable that you would have regular viewers three years after the fact and should be commended for that, and there's probably something here.

Moderator: Yes, there probably is something here. What is it about this exercise program that keeps you watching and doing the exercises? Sylvia?

Sylvia: I just enjoy doing them so I do them practically every morning. Well, sometimes I get my hair done on Friday or something, or if you got a doctor's appointment you don't always get there [to the exercises]. . . . Oh, I never forget, I'm sure. I know I never forget. It's like I have to put drops in my eyes, and I never forget that either.

Moderator: So, the program is a routine?

Sylvia: That's right. At 10 o'clock I'm watching and doing exercises. Fits in between jobs, I guess.

Moderator: And what about this comparison of watching the exercise program to putting drops in her eyes. It makes it sound important (turns to panel expert).

Panel Expert: The exercise program is promoting an important and positive health behaviour. Sylvia equates the program to the prescribed schedule of medication. She faithfully “takes” her exercises at 10 o’clock every morning. Once you are familiar with the schedule and know that it’s important, you don’t forget. For many of the participants, the program provides a scheduled routine. If it is 10 o’clock, it is time to exercise. As a result, we see this ongoing commitment—this adherence to exercise.

Key Point: Routine

Moderator: Gwen?

Gwen: See, people, they turn their TV’s on and they work around, and when that music comes on, you can tell every time with me—I can. Even Gordon says, ‘Well, there’s your music’ (laughs). . . When you get every day that you feel as if, well, that music’s on, and you better be doing the exercises!

Moderator: What Gwen is saying is that the music is a cue. It’s time to exercise.

Panel Expert: The theme music can be cue, as Gwen pointed out. It could also be the opening scene. The time (10 o’clock) is also a cue. Cues are important factors. They promote participation with the exercise program. In other words, the cues promote a positive behavioural response.

The Premak Principle suggests associating a low probability behaviour (exercise) with a high probability behaviour (watching television) to enhance the low probability behaviour. “After repeated pairings, television becomes an effective cue or trigger for exercise” (Stevens, Hornbrook, Wingfield, Hollis, & Greenlick, 1991/92, p. 62). Studies have used watching television as a cue to exercise. The strength of this program is that the television is not only the cue, but also delivers the exercises.

Moderator: That is a very interesting point. Before we talk further about television as a method of delivery, I want to go back to an earlier point you made about routine. Just how important is having a routine?

Panel Expert: Routine in daily living is an important consideration for older adults (Reich & Zautra, 1991). Routine provides structure, and it also provides motivation (viewers nod their heads in agreement).

Moderator: Mary?

Mary: *I usually have a routine every night. That's a faithful thing I do. I sit on the edge of the bed and do foot exercises.*

Panel Expert: Whether it's morning, noon, or night, exercise, like medication, needs to be scheduled. Otherwise it is easy to miss a day. For some viewers, the televised exercises provides the routine and structure they need to remain physically active.

Moderator: Agnes?

Agnes: *To me it's good because for us people that need exercise—and we don't get it—so it's good. 'Cause for the last few days I was going to go for a walk every day. 'Well I can't right now,' I 'd think. 'I'll have to wait for a little while' and that goes on and on all day. Yesterday I didn't go for a walk again.*

Jenny: *If you don't turn it on—miss it—'oh well, I'll [exercise] after dinner or I'll do it before I go to bed,' and you may not. If you don't watch it, it's pretty easy to put things off. But then it makes a difference how important you think exercises are. I enjoy it. I think it is important.*

Loretta: *I try to [walk everyday], but, of course, I don't. And then I do the exercises [the ones on TV].*

Panel Expert: The exercise show on television provides not only the opportunity to exercise, but the discipline that some need. A lack of discipline to adhere to an exercise program is a barrier to the practice of regular exercise for people of any age, including older adults (Elward & Larson, 1992). Strategies by health professionals to encourage older adults not only to adopt healthy behaviours, but to maintain these over time, are limited and often unsuccessful (Ory, 1992). I'm sure the physical therapists can attest to that.

Diane (PT): *I always remember an orthopaedic physiotherapist who said she did home visiting, and it taught her not to give a lot of exercises. She'd walk up to some homes—she could see in and they would have the list [of exercises], and they knew she was coming—and they'd be madly doing them—and she said that was probably mainly when they did them. So I think the video is a great idea.*

Moderator: So, what I hear is that a regularly scheduled televised program of exercises promotes adherence on an ongoing basis and not just before the next appointment.

Panel Expert: Right. In fact, you could say it's not about appointments anymore. This program allows a shift away from the treatment model of appointments and toward a model of personal choice and control by the participant. This is especially important

considering choice and control are not always an option as one ages. The viewer has a choice: they can turn on the program and watch it, or not.

Moderator: (Turns to viewers). Okay. It's 10 o'clock in the morning. You can choose to watch the exercise program, or you can choose to watch something else. Or, you can choose to not watch television at all. Why do you watch this particular program?
Sylvia?

Sylvia: *I have [always done the exercises] because I don't have anything else to do. And it's good. I like it. I think it's good for me.*

Bob: *Well, I think it's very good, you know, and you have to do something. You know, I can't just sit around all day and lay around all day or something. And this is a very good opportunity to get up and do something, you know, and watch how people are doing it.*

Agnes: *I always go, yeah, because I've got to do something.*

Martha: *I used to go to the other group too. Well, there were nothing else to do anyway at that time. . . I still did them here though. It seemed to be something more to do. More to do and it's exercising. Something to do than just sit around. And they say you should have exercise, so why not? It's just that everybody's been saying on TV and in the papers and all that.*

Panel Expert: The viewers raise two important points: first, the program provides something to do in an otherwise long and perhaps uneventful day; and second, they do it because they experience some kind of benefit. We will undoubtedly hear more from the viewers about the benefits as we go along, but, to emphasize the first point, this television program provides something to do. It provides activity when there is little opportunity elsewhere in their daily routine.

Moderator: Jane?

Jane: *They're good because they keep me active a little bit. . .there is not enough activity, no housework to do.*

Panel Expert: Perhaps we need to question why there are limited opportunities for some older people to be active. These participants talk about the human need to be doing something. They purposefully participate in the exercise program to be active. They are not content with sitting and doing nothing—nor should they be! Care homes are great at taking care of *everything*—to the point that the resident is left with nothing to do. They may be left in their room staring at the wall—literally.

Key point: Something to do/Doing something

Moderator: So the program provides something to do. It is doing something. You know, before the program started, Ruby and I were chatting and she told me about a woman at her care home who is brought to the communal living room every morning at 10:00 a.m. Now, from what I gather, this person does not, or perhaps cannot, do all the exercises. But according to Ruby, the program provides this woman with a half hour of respite from staring at the wall in her room. It is a stimulus.

Panel Expert: Absolutely. “[A]n event is some form of a stimulus” (Reich and Zautra, 1991, p. 162). The television program is an event that provides a necessary stimulus, whether the person participates in the exercises or not. For some, it is better than the alternative: staring at the wall alone in your room. So, for some, the television program provides activity when there is limited stimulus elsewhere in their environment. For others, it may provide a change of activity.

Moderator: Gwen?

Gwen: It's something else to do. Something else to do, not just to get busy and get the dishes done, or you have to make a pie, or you have to make a few tarts.

Loretta: Sometimes, I'm just glad to sit down because I've been busy in the morning, so I'm glad to sit down and do them. Like you've been vacuuming or something, you know.

Panel Expert: Whether their day is empty or filled, the television program provides something to do. It indicates that people, no matter what their age, need to be doing something.

Moderator: So the program provides a routine, and it provides something to do! What else? Jean?

Jean: It gives you an opportunity to keep moving. I think it's very important to keep moving. I hadn't moved enough this winter. I know I hadn't, you see, on account of the ice and snow, and I know there's a difference. It's harder to move. I think it's necessary for anybody of any age to keep moving. I think especially when you get older it's very bad not to move.

Loretta: I'd rather stay sitting, but I have to get up and get moving.

Panel Expert: We have been hearing from the participants about the importance of being physically active. This exercise program supports their personal belief system. Research indicates that the belief system is an important factor to explain late-life exercise (O'Brien Cousins, 1998). Those who believe in the importance of exercise are more likely to actually engage in physical activity, particularly as one ages (Stead, Wimbush, Eadie & Teer, 1997).

Moderator: Show of hands: How many believe that exercise is important? (One hand does not go up.) Mary?

Mary: I think you're more tired than retired (laughs). You know, this is how life goes. You have to take life easier.

Panel Expert: That would be nice. (Everyone laughs.) However, you cannot "retire" from physical activity. "Spending the bulk of one's day resting, for instance, would generally indicate a person who is aging less well than an individual who engages in a variety of activities, some obligatory and some discretionary, during the day" (Horgas et al, 1998, p. 567). Older adults who actively engage in activities have greater life satisfaction than those who participate in passive activities (Iannuzzelli & England, 2000). At present, television is generally considered a passive activity. What is really amazing about this program is that it has turned a passive activity into an active one.

Moderator: So, it's not just talking about exercise. It encourages the viewer to actually participate. As Jean said earlier, the program promotes movement.

Key Point: Promotes movement

Panel Expert: Exactly.

Diane (PT): [Our nurse] talks to other public health nurses, and I've talked to physiotherapists as well and I think seeing it on video or on TV is certainly much more likely to have people participate and be interested in it. It's more active. It's more exciting, and to make it fun for them is probably a good way, and I'm sure it must be fun for them to do it with your program, or else they wouldn't do it.

Moderator: And is it fun? Jean?

Jean: Oh, I just enjoy them. I just thought they were kind of fun (laughs). . .and then if you shut off the TV, it wouldn't be nearly so much fun. You are actually doing it with people. They still are on the monitor, on the screen, but you are still doing it with those

people. That means quite a lot. It makes it more worthwhile. I could have turned the television off if I didn't like it.

Moderator: Right, and did you?

Jean: No.

Moderator: What kept you watching it then?

Jean: *Human interest, I think. It's always interesting to watch people doing something. In the mall, you know, I was always interested in the people walking by and that kind of thing. Life goes on, you know. It's all a part of life.*

Panel Expert: Jean makes an excellent point. The program is about people. There are people doing the exercises on camera. There are people walking by in the background. This provides a connection with the viewers even though, "they are on the monitor," as Jean points out. You are not alone anymore. You turn on the television and there's the program! You have visitors for thirty minutes, and they are often people you know.

Bob: *I have to tell you that I get a few laughs out of it. At the mall when you see the people walking by in the background, and some of them kind of wonder what's going on—the way they look at you! You know, they hesitate, and look, and keep on going (laughs). You know, if you look close enough there's people you recognize even. I seen my nephew walking by there all the time (laughs). He's in the background and just happens to be walking through the mall while you're doing that.*

Loretta: *I saw my husband walk by as we are doing those (laughs). He's one of them walking by.*

Moderator: So the people on the program are a key point. They provide human interest. Anything else?

Key Point: Provides human interest

Matty (PT): *When I saw this, I never thought about it. 'Wonderful,' I am thinking. I think it's wonderful even if you're not only delivering exercises but also talking about little topics like this and that, it wakes them up. It just puts a bug in their ear, 'Hey, I could do that.' I wouldn't focus on exercises only. I would just take a topic, and talk about something that they can do. Aim for it. You don't even have to go outside and walk, just sit outside, just go outside. Make them aware that you don't have to have*

pain, and old age doesn't hurt. It doesn't hurt. . . I would focus more on things like that.

Moderator: The social aspect. Terry?

Terry (PT): *The video makes it more of a social activity, incorporating activity into daily routine. The participant also benefits from the socializing.*

Panel Expert: Part of the success of this program is this “virtual socializing.” It is easier to socialize with people you recognize than with strangers. This recognition of people—whether it is the participants who are doing the exercises, or those in the background—provides a connection with the community. The local connection is important.

Moderator: Does it make a difference that it's local? That it's from Weyburn? Gwen?

Gwen: *Yes, I believe it does because you always say, 'Well, there's Betty and there's so-and-so,' and 'oh, she's doing it much better.'*

Bob: *If you have it locally, you're going to watch the local one.*

Jenny: *It's kind of interesting to know these people.*

Moderator: So it appears that this exercise program provides a local connection.

Key Point: Provides a local connection

Panel Expert: One of the strengths of the program is its source of origin. Local community channels hold a special appeal, particularly for older adults, because it helps them remain connected to the community (Hajjar, 1998). For example, a televised bulletin board of upcoming events and announcements is an important source of information. It helps older adults keep up-to-date on what's happening in the community even if they are unable to attend due to poor mobility, weather, and the like.

Moderator: But there are a hundred other channels out there. (Turns to viewers) Why do you watch the local community channel when there are so many other channels to watch? Jenny?

Jenny: *Because it's local. And there's a lot of garbage on the other stations, and it's much more interesting to hear what's going on right here. If there is something on in town that you haven't seen or you weren't at, you can see it on there.*

Loretta: *It's either that [the community channel], or the weather channel. There isn't anything else much [on TV].*

Jean: *I turn it on nearly every day, find out what's going to be happening—just so I don't miss anything (laughs). It's a lot easier to put on the television—my sight is very poor. I can see what's on the television very well [versus reading a newspaper].*

Moderator: Anyone else? Mary?

Mary: *Oh, I watch it quite often about different things, you know. . . like they interview different people. . . well, when Dr. J. talked about vision. . . I found it interesting because one of my closest friends has been having trouble with her eyes since she's gone blind.*

Panel Expert: The local channel can be a viable source of health information within a community. Health professionals take note! If people are watching, which they are, is it not better for a qualified person to share pertinent health information on television rather than someone without the appropriate background and level of expertise? Besides, it could promote your profession.

Matty (PT): *(Turns to Sharon Elliott) You're a celebrity there. I think that's wonderful! When I read this [consent form] I thought, 'Wow, some physiotherapist out there is going to promote our profession,' because we are not like this. This is not us—because we are restricted—you can't go and advertise. We are very restricted. This is a clever way of advertising and you got a hole in the market (laughing). So, this is great. I'm thinking, 'Wow, wonderful, go for it, go on the TV, let more people hear about us because the only people, the massage therapists, can advertise, come to this, come to that, we can't do that.' I find that the massage therapists can go on TV and say, 'for dizziness, come to me.' We cannot go on TV [and promote ourselves]. You can't do that. This would be wonderful to make people aware there is something like that.*

Barb (PT): *We did a forum on incontinence. On the same day we also co-ordinated a TV program as a local phone-in show and that was kind of fun. We managed to get the doctor, with one of the local gynaecologists, plus myself, and then we had a phone-in. Hardly anyone wanted to phone in because it was incontinence. But there was a lot of people listening who heard the show. There are definite needs out there, and although very few people came to the public library to hear the program there. . . when it was broadcast on television— it went on [the local cable station]—many, many people phoned in to ask for repeat of the program many, many, many, many times, and it was shown again and again and again. . . I think there is a real need out there, and people are interested, and they do turn the TV on, and when they hear about it, they then tell their friends, and they phone in to request it to be rerun. It was incredible because people wouldn't come out. Sometimes, they are scared to come out and admit a need, but when*

they sit in their home, they are quite prepared to phone their friend and say, 'I heard a really good program, you should phone them and ask them if they'll play it again.'
[Television is a] sneaky way to promote the profession.

Moderator: Relating this to the exercise program, television can provide health information and promote the profession.

<p>Key Points: Provides health information Promotes health profession</p>

Panel Expert: Yes. One feature of local television is that it can and will broadcast repeats of the same program based on viewer demand. Local programs on the community channel appear to provide a valuable service. It delivers local information to a person's living room. As I mentioned earlier, television is the delivery vehicle. It is an incredible resource, particularly for seniors who cannot or choose not to go out. The delivery of chair exercises can be viewed as a valuable home service, just as home delivery of groceries, or Meals on Wheels. For the viewer, this is very convenient. For the health professional, it can be cost-effective.

Moderator: I think we should talk about these two points you just made: (1) television is convenient for the viewer, and (2) television may be cost-effective for the health professional. Let's start with the convenient factor. Diane?

Diane (PT): *Because it's a senior population, it may be not as easy for people to get out and participate, so they could participate quite comfortably in their home.*

Loretta: *I think it's a good idea for those that can't get out. They can just do it. It's good.*

Jenny: *Well, I think it's very good because any people, older people, people who are homebound or whatever, and they don't have to be homebound, they're home in the mornings watching it and can do those exercises. I like it because it's there. I know it's there. I know I can turn it on and these people are exercising, and I'll exercise along with them.*

Gwen: *It is something that you can pick your chair up, and you can come and sit down there and do your exercises.*

Panel Expert: It is easy to turn on the TV and do the exercises. Anything else can be an effort.

Moderator: Is this true? Jean?

Jean: When you get older, everything is more of an effort. When you get older, going somewhere, doing something, is an effort and sometimes you don't feel capable of it. . . because sometimes it's either difficult or impossible to go out really, isn't it, on account of the weather or walking conditions and so on and so forth. If something comes right into your room then you appreciate that. . . I think those exercises are good. It was an effort to do them on my own. . . There must be a lot of people in that situation, you know, that have to be in their homes a lot. But, if exercises come to them, that's good. They are more likely to be interested in them.

Panel Expert: The program is convenient for those who are housebound by physical limitations, or environmental factors such as weather. Snow, ice, and frigid temperatures in winter. Heat in the summer. Wind.

Jean: Weather affects us more than we like to admit, I think. You know, it does affect us.

Loretta: [I have a granddaughter who is a personal trainer.] She's always asking me to come and do some [exercises], but I don't want to do that. It seems like it's a set time, you got to go, and everything. Well, then of course, this is too. But this is right at home—and so right at home—you can do what you want. [In winter] well, putting on clothes, you can hardly move when you get them on and trotting through the snow and what not.

Panel Expert: I was talking with Martha earlier, and she told me that she enjoyed the formal group session in the lounge, but the effort to get to the lounge was a factor in whether she would attend or not. Often, she was dependent on a staff member to push her in her wheelchair if she was not feeling able to "paddle," i.e., propel herself.

Moderator: Martha?

Martha: But if I here now have a hard time paddling or one thing or another, well, they may come and get me, but then you got to worry about getting back usually. And I say, 'If you take me,' I says, 'I'll get there, but you got to bring me back, otherwise I'd be stuck.'

Panel Expert: For Martha, doing the exercises in her room promotes a sense of independence. She does not have to rely on anyone to take her out to exercise and then bring her back to her room. Her worries are alleviated.

Martha: Well, you see, you can do it on TV, and then you don't have to go out.

Moderator: So another strength of the program is the convenience.

Key Point: Convenient

Panel Expert: Absolutely. Research indicates that simple and convenient exercise routines promote greater adherence than complex and inconvenient ones (Friedrich, Cermak, & Maderbacher, 1997). The convenience factor is significant. The televised exercise program is convenient for the viewer. However, this convenience could interfere with efforts to establish a group program in a senior's residence.

Sylvia: They tried to start one [an exercise group] and nobody's interested. And I didn't go because I do these here, and I'd just as soon do them by myself.

Moderator: So, this televised exercise program appeals to those who prefer not to join a group program in the community. Loretta?

Loretta: I think I'd just as soon do it myself. I just like being by myself.

Panel Expert: The television program provides another option to exercise. It's great that people have this option, but it could have direct implications on certain health care services.

Moderator: Bob?

Bob: I could probably go twice a week [to the day-respite program], I guess, but it seems to be filled up. Always somebody waiting to get in, so I might as well give them a chance to do it too. As long as I get there once a week, I can always do the exercises at home.

Moderator: And when you do go to the day-respite program, do they offer exercises?

Bob: They give us exercise there and it's something the same, you know. I often wonder why they don't just turn the TV on, and do the ones you're giving there (chuckles). But they have different ways of doing things sometimes and a few other things, and we do a few extra things.

Panel Expert: The television program is a convenient source of exercise that can be tapped into in a variety of settings: private care homes, public long-term care facilities, and personal residences. It reaches places where staff and programs are not available. It has the potential to replace existing programs or prevent new programs from starting.

In a province where geography and weather can be challenging, and where trained personnel and resources are limited, the convenience factor is crucial and needs to be considered.

Moderator: If television is this convenient for the client, what does this mean to physiotherapists who may consider television as a “modality?” Terry?

Terry (PT): *I think you can probably reach more people than what you could otherwise if you looked at your alternative. . .[of] having each of those individuals come into your clinic for a visit. That means they have to transport there, they have to walk down the corridor to get to where you are, they have to check in at the clerk, and probably even have to get a physician referral to begin with, and then spend an hour with you, and then get home again, and then do it. So, I think you can reach a large number of people with this modality in a non-specific way—in a generic way.*

Moderator: Jean?

Jean: *TV reaches more people. Otherwise, you can only reach a limited number of people. Old people are not going to go down to the physiotherapy department [because of the effort it takes].*

Moderator: But a physical therapist can come to you. You can receive exercises by a physiotherapist in-person or via television. Is television within the scope of practice of a physiotherapist?

Donna (PT): *(Directed to Sharon Elliott) Well, I think what you have done is very much within the scope of practice of physiotherapy, and it's probably an under-serviced area. Providing endurance programs, strengthening programs, flexibility programs to at-risk individuals. . .[is] under-serviced—and we are not going to get more therapists—we know that. The dollars are not going to go to rehabilitation. They never have and never will even though it's a really important area. They keep saying they will, but so far we haven't seen it. So a way of reaching people with fewer dollars is certainly the way of doing that.*

Diane (PT): *Well, I think it's an excellent way to get the education across to people because as you say with the caseload you had, you just didn't have time (gestures to Sharon Elliott). Was it a good use of your time to be reinforcing or supervising maintenance exercises? No.*

<p>Key Points: Reaches more people Cost-effective</p>

Moderator: So, television reaches more people, and it can be a cost-effective approach. What do you think, Terry?

Terry (PT): *That's pretty remarkable. That's reaching people that you wouldn't reach otherwise. You wouldn't reach those people that consistently with one visit, and then the expectation, 'Well, here's your hand-written program, go and do it.' People may be more inclined to follow a video than read an exercise sheet.*

Moderator: You have touched upon an interesting point. From my experience, physiotherapists often provide an exercise program in the form of written material. (Turns to the viewers). Would you follow a sheet of exercises three, even four years later? Sylvia?

Sylvia: *No, it wouldn't be the same at all. 'Cause I've had books of exercises and 'forget it' I didn't do them. . . I'm just sure I wouldn't do them.*

Moderator: Gwen?

Gwen: *No, I don't think I would. You wouldn't see people. . . I don't know, I like that TV stuff. I was really interested in that. I would get a program to do when I would go to my chiropractor. You know, that was all we had in Weyburn see, and he would give me pamphlets on the exercises. Well, I wouldn't even look at them because I couldn't figure them out. I couldn't figure them out. They were just a loss to me.*

Jean: *I think I like doing them with somebody. It's kind of nice with somebody. Besides, I would probably forget where the paper is anyways (laughing).*

Bob: *As a matter of fact, I did some exercises that they [the physiotherapists] put on paper, but you know, I took some up there [to the respite program] and I don't know what happened to them, but they couldn't find them: the paper that the exercises were on.*

Panel Expert: A brochure or pamphlets with exercises on it is used for administrative and so-called cost-saving reasons; however, research indicates that patients do not always carry out the exercises correctly when following a brochure (Friedrich et al, 1996).

Moderator: Or by the sounds of it, do the exercises at all!

Panel Expert: True. An exercise video or program on television, on the other hand, encourages one to exercise when written material cannot. The visual cues are important. We know that reading is not a highly preferred learning style for older people. Iconics,

the desire to learn by viewing media such as slides and film, however, is rated favourably by older adults (Theis & Merritt, 1994). For those who may not be comfortable with reading, videos and television may provide equality amongst learners.

Diane (PT): *We use videos a lot here [at work]. . . as a teaching tool and an inspiration to show marginalized people that they can be current with the latest information, and access it exactly the way that those in better life circumstances do.*

Panel Expert: In a sense, television provides equal opportunity. This program does not discriminate. The mode of delivery is the same for everyone, provided one has a television set and subscribes to cable: both of which are common amenities in today's society. On a larger scale, equality is an important factor in determining health in populations (Fyke, 2001).

<p>Key Points: Preferable to a handout Equality amongst learners</p>

Moderator: For the viewers then, exercises on TV are preferred to a handout. And from a professional perspective, television can, in effect, provide a "level playing field." This particular program provides equal access to the older adult population in Weyburn provided they have a television and subscribe to cable. Interesting.

Let's take a closer look at the people who are on the program—those who perform the exercises. What is it about the people doing the exercises on the program that makes it preferable to a handout of exercises? Bob?

Bob: *Like they had different ones on there. Remember this guy's name, with the health district there, he was on. He was kind of comical. This idea about, 'Turn your head this way and this way,' and he said, 'It looks the same on both sides.' I used to have to laugh about that (pause). You are watching them doing it, and, you know, you can do it. You can carry on the way they are. . . . Well, it's just the idea of being able to watch how they do it so you know you are doing it right. . . . You can remember what they are doing, but it always seems to me better if you watch them, you know. You seem to get more out of it if you watch somebody doing it you know, hear your voice at the back. It's like somebody was there telling me what to do. You know, I'm just watching them, and you know you are doing them right.*

Panel Expert: The fact that one can watch and follow people on television is a form of guidance which encourages accuracy in performing the exercises.

Moderator: Is there danger in following these people on TV?

Diane (PT): *Well, I suppose it's always, it's a danger if you were handing out some generic exercises to do in paper form that sometimes people can misinterpret. On TV, to me there is a lot less chance of misinterpreting them because they can see. The visual is really helpful. I think it's great because written material just doesn't cut it. On TV there is a lot less chance of misinterpreting them because they can see. The visual is really helpful. I think, how is your client population going to best understand how to do the exercises? They can certainly see it and work along with it [on television].*

Panel Expert: The viewer observes someone else doing the exercises and this provides a sense of knowing that they are doing the exercises right. The program provides guidance: it tells the viewer what to do and shows them how to do it. The people who are demonstrating the exercises on television are a form of feedback and support.

Bob: *Well, as I said, I know some of the people that are doing it so they're helping out, and, you know, they help you out. It seems like they are helping myself. I'm getting help out of it.*

Moderator: So, the people on television are extending themselves. They are, as Bob says, helping him out. Interesting point. Without this guidance, this television program, what would happen? Bernice?

Bernice: *Well, I wouldn't do it if it wasn't on TV. I wouldn't even do it.*

Agnes: *No, I wouldn't do it either.*

Ruby: *No, no, that's right. Well, because there is somebody telling you what to do, you know. I mean, otherwise, there's nobody telling you what to do, and you don't do it. You're lost.*

Bernice: *You wouldn't stop and do it.*

Ruby: *No. You're lost.*

Agnes: *That's right because you wouldn't know what to do.*

Moderator: What you are telling me is that if this program was not on TV, you would not exercise?! (Several of the viewers nod their heads in agreement). Sylvia?

Sylvia: *I wouldn't do it if it wasn't on TV. It gets you going. I wouldn't do it on my own. . . I guess maybe it's just the company, or what would you say, participation, if*

that's the word, isn't it?

Gwen: *And I think maybe sometimes that [the program] gives you a little encouragement. . . knowing that there's other people doing it, see. The people on TV are doing it.*

Loretta: *I like doing them along better on TV. It gives you some incentive there I think.*

Jenny: *There are lots of people who don't get out at all so it is a way of looking at exercises and seeing somebody else do it. [This provides] the motive.*

Jean: *I think it's very nice because you do it with other people. You could exercise at home, but you are more likely to put forth an effort to do it with someone else who's interested in it.*

Moderator: If the program wasn't on, would you be motivated to do exercises?

Jean: *I probably wouldn't. I would probably think, 'Oh, I get my exercise tidying up the place and one thing or another,' but, you see, when you turn that on, you make an effort then to do it.*

Moderator: So the program provides encouragement and incentive. It provides the motivation.

<p>Key Point: Provides encouragement and incentive → motivation → adherence</p>

Panel Expert: Yes. The two major determinants that keep seniors from being physically active are: "(1) insufficient feelings of capability and experience to succeed or participate (self-efficacy), and (2) inadequate encouragement or downright disapproval from physicians, family members, and close friends" (O'Brien, Cousins, 1998, p. 72). This program provides a sense of feeling able to do the exercises, and it provides encouragement.

Moderator: How does the program do this?

Panel Expert: "Chair Exercises for Older Adults" utilizes motivational strategies that address the needs of older learners. There are four strategies and I will mention them briefly. First, the attention of the learner needs to be gained and maintained. Second, the instruction must have a perceived relevance to the personal needs of the learner. Third, the instruction must provide for the confidence of the learner. And finally, the

learner should feel a sense of satisfaction and accomplishment (Bohlin & Milheim, 1994).

These strategies contribute to the ongoing adherence we have seen amongst the viewers of this exercise program. This is remarkable, especially since “[f]ifty per cent of dropout occurs between 6 and 12 months in both supervised and unsupervised exercise programs” (Dishman, 1990).

Moderator: We have a question from the studio audience. Go ahead.

Audience Member: You refer to the viewers as learners and suggest that learning is taking place. Exactly what are they learning?

Panel Expert: Exercises on television or on video allow the viewer to not only learn what exercises to do, but how to do them. The instructional methods, as I just mentioned, support this learning process. The mode of delivery is the television. We touched upon this earlier on in the meeting.

I should add that an important component of the learning process is providing positive feedback to the learner. One recommendation I have for this program is a mechanism where feedback can be given directly to the person at home who is doing the exercises. For now, there are visual and verbal cues which can provide feedback.

Moderator: So the instruction is a form of feedback. What if someone has difficulty hearing? Agnes, you said that you have trouble hearing. What do you do if you cannot hear the instructions for the exercises?

Agnes: I watch that front girl. She's good—that front one is really good. I follow her because I can't understand what the woman says. All I can hear is 'up' or 'down' or something like that. And once in a while, I can hear 'other foot' or something like that, but I don't know. I have a lot of trouble hearing because I think my hearing is getting a lot worse the last couple of years.

Moderator: So being able to watch the person on TV is important to you. Do you know anyone who cannot see, but who still does the exercises?

Agnes: [One of the residents where we live] she's got her eyes shut all the time but I think she can hear the woman which I can't. She must hear it because she never looks that way [at the TV].

Panel Expert: The physical and verbal guidance of this televised exercise program contributes to the ongoing motivation and adherence. It also ensures accuracy. It is like

a dossette (a weekly pill box). The container is a visual reminder that ensures accuracy.

Moderator: Gwen?

Gwen: *[I know older women who take the wrong medications. I have the home care nurse fill my weekly dose kit so I know I'm taking the right pills at the right time.] As I said to the nurse, 'If you didn't do them for me everyday like that I would [take the wrong pills like others have done]. I would slip on that, I think.' But I might get used to it just like I did with the exercises.*

Panel Expert: The guided exercises on TV provide accuracy (just as guidance with one's medications provides accuracy), and ultimately they decrease the probability of a mistake.

<p>Key Point: Promotes accuracy Sense of accomplishment</p>

Moderator: Right. So there is a sense of accomplishment. I wonder if this explains why some of the viewers try to promote the program to others. Remember the video at the beginning of this meeting where Bob tried to promote the program to his wife? And Jane tried to get the other residents where she lived to do the exercises. Does anybody else promote the program to others? Jenny?

Jenny: *I keep telling the girls up at the center [Wheatland Seniors], 'When you're not here you can do it [the televised exercises], and you're not working out by yourself.' In talking, some will say 'maybe,' or 'sometimes,' or 'I always forget.' Like how can you forget if you're interested?*

Gwen: *And I used to ask different ones in here if they did, would do it you know, and they'd say, 'Oh yeah, we do it a little bit, but we don't seem to think it's doing any good because we don't do it all the time.' Well, I said, 'When that 10 o'clock comes on and you hear that music you should just go and do it. Wherever you're doing it that's comfortable for you, do it.' And I say to them also, I would say, 'Work yourself that 15 or 20 minutes you have now because you know, you felt like you got a good workout.' Well, you hear of some people saying 'Oh, look at that. What good is that going to do you?' Well, I say, 'You just try them for awhile, and you'll see what it'll do for you. It loosens up your bones, your body.'*

Moderator: Gwen, did you to convince your husband to participate?

Gwen: *I used to say, 'Well, do them Gordon. I can feel these muscles in here (squeezes the back of her upper arm). They're not so wobbly' (laughs). And he would say, 'Oh, I don't know.' But he sat there and watched me. Lots of times. Watched me do these things.*

Moderator: Anybody else?

Sylvia: *I don't think there's many in here that do them either, and a lot of them should be doing it. . . .I don't know one person that has ever mentioned that they do them. . . .A lot of them have a poor excuse. They've got this wrong or that wrong, you know.*

Moderator: You know that others could benefit from exercising, but they do not. Any suggestions? Jenny?

Jenny: *I think [television] puts [the exercises] in front of the public, in front of people who, if they see it often enough, or get interested in it, or can be made aware of it too. They might not even think of it otherwise.*

Gwen: *It is good advertising for seniors. It's good for younger people. They'll see it there, 'Oh, they're old alright. Sure.' But maybe their mother's maybe doing it.*

Key Point: Positive message with regards to aging
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Moderator: So it sends a positive message about aging. Okay. Let's move on. We have covered a number of key points that obviously discuss the strengths of this exercise program. Now we are going to look at the other side of the coin. We have just heard that a feedback mechanism is lacking. Let us look at this, and other concerns and considerations. Donna.?

Donna (PT): *First, a question comes to mind right away is, what happens when someone falls off the chair during this program and fractures a hip? Is anybody liable? Or, is there some disclaimer at the beginning of this program that says, 'Before you begin participating in this program, perhaps check with your family doctor and make sure that there aren't any restrictions to participate.' Now the family physician would have to know what the program consisted of.*

Moderator: Does a participant of the program want to respond? Bob?

Bob: *Well, they kind of warn you ahead of time to see a doctor before you do these exercises. They have that before the program so that helps. Well, you kind of start*

thinking, 'Gee, I wonder if I can do all this or should do all this,' and you go and ask your doctor. . . I told him at first there were these exercises, and I mentioned one time I was doing these exercises, and he thought it was okay. . . I wouldn't say they are too easy or too hard.

Moderator: Did you tell your doctor that you were doing these? Loretta?

Loretta: *No. They're not very strenuous.*

Jane: *It's just a short program that comes on about 10 here and well, it's exercises more or less on the spot. You don't have to run around or do anything. It's just about right for the stage I'm at. It's not too vigorous at all.*

Jean: *Oh, it's not that difficult. It's a pleasant effort. I think everyone is interested in physical exercises in some way. And those are quite within the reach of any of us. Any older person can do those. Certainly, very suitable for the age group. Anything physically they are asked to do, they can do.*

Sylvia: *Well, they could maybe be a little more difficult. They're not too difficult.*

Moderator: Donna?

Donna (PT): *And if you make the program so generic and so safe, is it benefitting half of the people who might be accessing it?*

<p>Key Points: Safety and Liability versus Benefits</p>
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Moderator: So, on the one hand there is concern about safety, and on the other hand, if the exercises are too easy the participant may not benefit from them. Ruby?

Ruby: *When I started the exercises I couldn't do this (lifts arms overhead). I could only do about (demonstrates lifting arms up slightly), and now I can do this (demonstrates again how she can lift her arms all the way over her head). So you know it helps. It helps to keep the function in your body. . . I can comb my hair now.*

Bob: *I think they are really good. They keep you limbered up. Well, it pretty well gets all your muscles moving any ways, and you just have to sit in a chair and do them. Well, you know, they do pretty well all you can possibly do, I think.*

Bernice: *[The exercises] loosens the muscles. [I do them] to keep in shape.*

Jane: *But really, I think it's good for a person. I feel that it is necessary you know. If I don't do it for a couple of days then I can feel it after that. I'd be stiff as a board. Even if I miss just one day I am stiff. I can feel various muscles pulling. You know, if you keep at it and do it. . . .I try and do it as strenuously as I can. I don't miss it very often, but once in a while I have to miss it.*

Jenny: *It helps keep me mobile. I know I become more agile in a number of things through exercise. . . .It gives you something to do with every part of your body.*

Sylvia: *Well, I said I had trouble with my neck, and I went to the chiropractor and he said, 'Oh, you've got arthritis and all this.' But, ever since I've been doing like that (demonstrates turning her neck to look over her shoulder as is done on the program) it really helped my neck, that I'm sure of, because at one time if I went like that (turns her head again), it would hurt like everything, and now it doesn't (laughs).*

Panel Expert: Some of the benefits of this program appear to be less stiffness, greater mobility, and even gains in movement and function. What may seem like a small task—the ability to comb your hair—is actually significant! It means being less dependent on caregivers.

Moderator: We have a question from the audience. Go ahead.

Audience member: Yes. I was just wondering if there are any data to show that doing the exercises makes the participants less dependent on family members, staff, and health care services in general?

Moderator: Sharon?

Sharon Elliott: One limitation of this study is that it does not include people or services beyond the participants themselves. I agree that it would be very interesting to note statistics such as the number of hospital admissions, or the number of visits to the physician, and compare those who participate in the exercise program to those who do not. I did not look at specific function and mobility, except what you are hearing from the participants about less joint pain and stiffness—essentially, descriptive data. Certainly, measurements of function and mobility would be important to have. I would then want to compare this with the actual content of the program, that is, the exercises and the routine that is performed.

Moderator: Does anyone have anything else they would like to add? Sylvia?

Sylvia: *I would miss it if they didn't have it. I think that it helps. It helps your ankles and I know I can feel it in my shoulders because I'm a great one to sit there and crochet for hours, eh, and it helps my shoulders because I can feel that when I'm doing it. It just feels good to get moving around. It exercises your shoulders and keeps them, I think, from getting stiff. . . . Well, I think it's pretty good, and I think that it covers everything right from your neck to your ankles. It gets your feet and ankles and your wrists and everything. It exercises every part of your body. I just kind of enjoy doing them. That's all.*

Moderator: Gwen, why do you do the exercises?

Gwen: *To keep myself active so that I wouldn't get too stiff because this is what happens with me like with crocheting if I don't do it [the exercises]: my hands get stiff; and I like the movement of my hands because I bake, I sew. . . . two or three weeks to do an article of crocheting or a craftwork [and] I'm right out of it. I got to stay right with it [the exercises]. . . . I think it's very good for our health for elderly people especially the hand exercises. Keeps you very active.*

Moderator: Loretta?

Loretta: *Well, you sit around too much. If I don't do something, I feel it. I do handwork so I will sit and do that longer than I should, I guess. I know myself—you should keep exercising. I get stiffened up if I don't move around; you seize up, I think (laughs). You feel "draggy" if you don't do something—listless.*

Panel Expert: I think an important point is that there are benefits resulting from doing chair exercises. We should never underestimate the benefits for older adults. Unfortunately, there is a dearth of literature on chair exercises—not to mention, lack of televised information. Hopefully, this program will move us forward in this area.

Moderator: Loretta?

Loretta: *I think it's real good 'cause otherwise, just walking, you don't do this (demonstrates turning her head side to side). It gets your neck. Those neck exercises I can hardly do them, you know. It's still hard to turn my head. But it must be arthritis probably, isn't it?*

Moderator: Don't ask me. Ask your physiotherapist! (Everyone laughs). Anyone else?

Gwen: *I bring my chair out of the bedroom and I would sit here and I would do them when I get depressed (laughs). I would just sit here and do them because I wasn't thinking about him (refers to husband) or I, or anybody, you know.*

Panel Expert: Gwen makes an important point. The program can provide a temporary respite from day to day worries. And it's doing something for yourself. As a caregiver, this is an excellent opportunity to take care of yourself. The exercises provide physical, psychological, and social benefits.

Jean: *They're even relaxing.*

Moderator: So it sounds like there are many benefits to this program. But does this answer the concern about safety and liability? I sense that the physical therapy community is not yet fully satisfied. Barb?

Barb (PT): *I think if they are going to take part in any activity, it's a smart idea for them to go to their doctor and discuss it with him [or her], and what limitations would he [or she] want to set on them. But then, the physiotherapist could also screen—you could ask for screening by a physical therapist.*

Donna (PT): *I was thinking before being able to commence this program, you have to go through a screening assessment, but, if it's on television, there is just no way. I don't know how you could do it with a television program. I just don't how you could do it. I would rather see it be a video tape, and it involves screening first.*

Moderator: Okay, what do you think about the suggestion of a video? Gwen?

Gwen: *Like myself, I have no VCR. I haven't got one. See! (Gestures to television stand in her living room where she is sitting).*

Bob: *I myself never used the VCR too much.*

Mary: *[I have a VCR, but it's downstairs. My son uses it.] There would be no point in you giving me that (refers to an exercise video).*

Moderator: Loretta, do you ever follow a video tape of exercises?

Loretta: *No, I don't. Do they [the library] have any like that—these easy ones? Most are like aerobics or a few of them that I've followed on TV when they were on—they were hard.*

Moderator: But let's suppose video is a possibility. Donna?

Donna (PT): *You screen and decide, 'Is this program that we've developed appropriate for this person?' So the person is housebound and can't get out so they can do it in their home. I am still concerned about liability, and is a person going to be doing this*

who shouldn't be doing it, and how do you control for that? Maybe I'm over concerned about litigation, but it seems to be becoming more common. And, I like the idea [of the exercise program]. I don't think everything has to be individualized hands-on, but you have to kind of know the population.

Panel Expert: I want to suggest that perhaps physical therapists cannot be in control for everything that a person does. A new paradigm of practice needs to be considered. But first, we need to be aware of where we are now with respect to the physiotherapy profession. I believe we could start by noting key words in the medical vocabulary: *control, concern, screen, develop, teach, decide, know the population, know their program, discharge*. This language isn't the fault of the health professional. I want to read a quote from Art Bochner:

One learns that entering a discipline means stepping into a world that has its own language; if you want to live in that world, you better be able to speak that way. We learn to tell our version of the lives we study by translating the terms ordinary people use into the categories and jargon that comprise our field's theoretical language.

-Bochner, 1997, p. 423.

Moderator: In other words, professionals learn the language of their discipline.

Panel Expert: Physical therapists work within the medical paradigm. This contributes to the foundation of the traditional treatment model: the one-on-one appointment. The health professional is able to address accuracy and, hence, safety when instructing therapeutic exercises in a one-on-one clinical approach.

Moderator: Does anybody want to describe a typical session where exercises are taught to a client? Barb?

Barb (PT): *We teach exercise programs not to groups actually, but we have thought of doing groups, but we teach [back care and knee care] individually to patients. I never leave it once, but have them do the exercises, do three of them, go home, see if you can reproduce them, when you come back next time add three more, and then discharge them when they know their program.*

Moderator: And does the client do the exercises?

Barb (PT): *Depends on how much you emphasize it and how well you teach them.*

Panel Expert: Within the traditional treatment paradigm, patients defer to authority, the professional expert. To design and deliver a program of generic exercises on television, where participants are virtually unknown, is a new dimension of physiotherapy practice. The physical therapist is responsible to design and deliver a program that is appropriate

and safe to the participant. But, if it's on television, is this task possible? And, how can this be accomplished? I believe that physical therapists can design and deliver programs for a population without necessarily knowing each and every individual who accesses the program.

In a preventative model, the physical therapist needs to be aware that they cannot have control for everything and everyone. In a preventative model of health care, the participant (or, in this case, the viewer) is responsible for their involvement and their participation. To a large extent, the onus is on the viewer. The viewer decides whether to watch the program or not.

<p>Key Point: Screening - Onus on viewer</p>
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Moderator: So the original concern about being able to screen. . .you suggest that the onus is on the viewer. Mary?

Mary: I turn it on and watch it occasionally, and then I turn it off because it. . .may be fine for anyone sitting, but I'm not sitting all the time. And I'm up and I'm reasonably active because I go do different things, uh, to look after myself even though I have to have help.

Panel Expert: I am concerned about those who underestimate the effects of exercise. My concerns are of those who are inactive and sedentary as they are at risk of injury. Part of the problem reflects back on health practitioners who have been overly cautious in prescribing exercise for older adults. It has only been in the past decade that resistance training (using light weights, for example) has been included in the prescription of exercise for older adults (Pollock et al., 2000).

Moderator: Good point. Anyone else? Terry?

Terry (PT): I think there would always be the challenge, as there would be if someone were reading *Chatelaine* magazine [and] starting up a new exercise program. There should be some discussion about precautions like: be at a fairly healthy point where you're starting from, discuss with your family physician (but some of these people may not see a family physician with any regularity, others may go once a week). I'm not sure, but I would think some of that general information in a positive way, because precautions sometimes seem so negative and discouraging. And yes, safety—because elderly and falling—if you're doing reaching, stretching, whatever it is, you want to make sure balance and safety are addressed.

Panel Expert: A suggestion may be to have a few yes/no questions at the start of the program that the person could answer as a screening mechanism. The revised PAR-Q (Physical Activity Readiness Questionnaire) for older adults could be used (Cardinal, Esters & Cardinal, 1996). And yes, address precautions before and during the exercises.

Moderator: Does this television show of exercises include precautions? Bob?

Bob: *I think it's very good the way you are giving the instructions and all that. 'Do what you can,' and like when you say, 'keep breathing.' Well, you don't get as tired if you breathe properly.*

<p>Screening Suggestions: Revised PAR-Q Precautions</p>
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Moderator: Terry?

Terry (PT): *Maybe there needs to be different videos, or maybe, in the same video, different subjects who are participating and have different levels of ability. So you could demonstrate a person who is seated and a person who is standing. Educating people to know how to modify things for themselves.*

Moderator: Comments?

Jenny: *Sometimes I stand for part of them.*

Moderator: Anyone else? Loretta?

Loretta: *I suppose you could do those standing up—most of them anyways. It's more tiring. I think it's more strenuous standing up wouldn't it be? I sit because they're sitting (laughs).*

Sylvia: *I sit because the rest of them are sitting. I have stood up and did them the odd time or two, but it's just easier to sit (laughs).*

Moderator: So, the televised program could provide opportunities to participate at different levels of ability. The actual content of the program is an important consideration.

<p>Key Point: Content</p> <ul style="list-style-type: none">- Instructions- Levels of ability

Donna (PT): *If you did this by video tape you could take three stages: housebound-chairbound, and then housebound, and then community ambulators. But, somehow, having a way of monitoring how things are going. Monitoring: are they doing it at all? So getting them to keep an exercise log or just checking off when they do it. Then you could evaluate: here's compliance with the program, and then here's outcome for compliers, noncompliers. . . monitoring to see if the people who could be benefitting from the program are using it, are they at the right level, are they running into any difficulties so that you might be able to say, 'well, here's how you would modify this one.' So monitoring every so often. It's a little bit more costly, but less costly than one-on-one. That would be my thought.*

Moderator: Are the viewers who follow the televised program being monitored? Are there people who know that you are doing the exercises on TV? Bob?

Bob: *Well, like when I go to the respite, I tell them I watch this program and do them.*

Sharon Elliott: Indirectly and informally, I believe that the viewers can and are being monitored. It may simply be a check-in with a health professional, a family member, a friend, or a neighbour. For example, Gwen's physician is aware of her participation with the exercise program on television and gave her advice about her activity level after she fell. Gwen?

Gwen: *After I fell, I got the old chair out and I started to do them see, but then the doctor said, 'You really don't need therapy, and I don't want you to even do those' [the TV exercises]. I was doing those and he said, 'No, not for awhile. You don't take those off the TV.' So I said 'Well, that's alright then. I won't do it.' He said, 'In three weeks time, it'll be fine. You're going to be okay because you do enough of your own work, and you walk enough and you're out enough and all that.'*

Sharon Elliott: She is also indirectly monitored by her home-care nurse which is another source of informal monitoring.

Gwen: *Sometimes I think, 'Well now why did we do that?' It was slow, and as the nurse said one day as I was doing them, and she came in and I was doing this with my hands, and she said 'Well Gwen, you go so fast!' I says, 'Yes, sometimes Sharon, I can go ahead of her!' (laughing). . . Dr. [M.], said too that do it slow, you know, because I was doing it a little fast.*

Moderator: It sounds like the client has to monitor him or herself.

Sharon Elliott: To some extent, yes. They are responsible, and I do not think this is an unrealistic expectation.

Moderator: Anybody else? Sylvia?

Sylvia: Well, one of the gals comes in, and 'Oh,' she says, 'It's 10 o'clock. I should of known you were doing your exercises' (laughing). . .well, she comes in for something and I had the TV on so she knows that I do them.

Panel Expert: As we saw in the video, some of the viewers are not only monitored, but are also encouraged to attend the program, particularly those in long-term care facilities. The staff at the care home where Jane resides keep the coffee pot on while she does the exercise program at 10 o'clock. The staff at the home where Agnes lives remind her when the program is starting, and escort other residents to the living room area for the exercises. There is even a poster on the wall to remind residents (and visitors) of the exercise program.

Moderator: Martha?

Martha: . . .one of them nurses aides would come in and say, 'Yeah, you used to do those exercises before and now you don't feel like doing nothing' (laughs).

Panel Expert: Viewers are responsible. They know when they are doing the exercises and when they are not. I think the onus can and should be on them. Look at it as an empowerment strategy.

Moderator: Jean?

Jean: I think I'm going to be a little more particular about the exercises and watch more regularly again. I use to watch very regularly and then I felt, you know, when you do certain things for a long time, you become very careless about it. I suppose there probably is more need to do it now as I'm getting older (laughs). And certainly, I can't go out and walk the way I could. So there's probably more need.

Moderator: Has the concern about monitoring been addressed then? The participant may be informally monitored by a health professional, a family member, a friend, or a neighbour. Throughout this process, self-monitoring is also occurring.

<p>Monitoring: Health professional Family, friend, neighbour Self</p>
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Panel Expert: Perhaps the producer of such a program could periodically visit care homes and individual residents. Make an announcement on the televised bulletin board, for example, of your time and date of arrival and be prepared for participants to come with their questions and concerns. Meet with them individually or as a group. The key point is that you are there in person. Look at it like a book signing session of a well-known author! Another suggestion is to make phone calls to a random number of participants. Or, you could request feedback from health care professionals that interact with the participants, i.e., the physician, the home care nurse, the staff at long-term care homes.

Moderator: Comments or questions from the studio audience. Go ahead.

Audience Member: Maybe you could have a live phone-in show at the television studio. Once a month, you go on the air and take calls right after the exercise program. If there are specific concerns, you could go and see them in-person. I just know the local cable station is doing more phone-in shows than before. I kind of like those shows where people phone in.

Moderator: There's an idea. From a professional perspective, do these approaches of monitoring work for you? Donna?

Donna (PT): I think the licensing body might have some headaches associated with that method [television]. I think it might be something that should be run by them to see if it's legal because they are going to be worried about [whether it's] legal and they are going to be worried about protection of the public.

Barb (PT): But, will they injure themselves with [Richard] Simmons, or will they injure themselves more easily with us, or will they injure themselves more easily with the other people who are out there doing the exercises, [and say], 'come on, make it burn.' I think we have more of a role. We have to say, 'Who else would do that kind of a thing?' That will be the fitness guys. Now you see, he [Ed Allen] gave us lots and lots of business because he would do these exercises that the seniors would try and do, and they couldn't do and they used to hurt their backs. I think the seniors have some medical challenges, and they can't follow the fitness experts because they don't have a health background, whereas we do.

Moderator: So, on the one hand physical therapists are in a good position to be instructing televised exercises. However, on the other hand, this may not be legal according to the licensing body. Has anyone investigated this issue of legality? (The room goes quiet).

Panel Expert: Legality refers to a civil court issue. The topic we are discussing here concerns the professional body. The professional body, or the provincial College under which physiotherapists are licensed, is in place to ensure protection of the public. To date, the Colleges in this country do not have a position statement on the use of television as a method for delivering exercises. The Canadian Physiotherapy Association does not have a position statement either, even though they include the promotion of fitness, health, and wellness in their definition of physiotherapy. This is not surprising since this area has not been fully explored until now.

Moderator: Do you think the licensing bodies or the professional association will develop position statements in this area?

Panel Expert: Possibly. If television production is deemed to be a health promotion initiative that is best carried out by a physical therapist, then it is in the interest of the physiotherapy profession to secure their foothold in this area. Otherwise, it could very easily be lost to someone without the expertise needed.

***Diane (PT):** In my role on the Board with the Canadian Physiotherapy Association, is that there are worries that maybe exercise therapists are eroding some of our role. But I think we just have to show that we are the people that can do it best. Physiotherapists have the expertise that they can guide seniors to exercise in an appropriate way. You see a lot on television about activities that maybe haven't been well thought out necessarily.*

Moderator: Jean?

***Jean:** And, of course, those exercises are carefully planned. There's a reason for those exercises. And they do a certain job, don't they?*

Moderator: What kind of job, would you say?

***Jean:** Everything is structured. The instructor knows what [to do]. I think it's good to have an instructor. Someone who knows something about it. The reason for doing these things.*

Moderator: So the instructor is an important consideration. Gwen?

Key point: Instructor

Gwen: *(Refers to an instructor of another exercise program) She didn't have the music, she didn't have the voice, she didn't have the training. That's right. And it didn't last. I don't think they've got anybody that has any idea what to do. But see now, you're getting a little bit of the education and you've had [the experience]. . . (gestures to Sharon Elliott).*

Panel Expert: The person who instructs exercises for seniors should have a strong background in exercise science. However, research indicates that exercise sessions in senior living facilities are often led by people without the appropriate training (Wasner & Rimmer, 1997).

Barb (PT): *Everybody is becoming more aware of exercise, and often old people ask you to do them. They're going to do somebody's exercises. Better if they do it from somebody who has a training in looking after their medical challenges, and better that they do it from somebody who is well-educated rather than a recreational person who is thinking of a completely different emphasis than the functional emphasis of the needs of the older person. So, I think it's really important. I just think the reason why that it hasn't been done is that there aren't very many therapists around, and we've made it quite difficult for therapists to get trained actually.*

Moderator: If there are a limited number of physical therapists, my question is this: is producing an exercise program on television a role for a physiotherapist? Terry?

Terry (PT): *I think it's a very valid role for a physiotherapist, and I think it shouldn't be such a far stretch from what a therapist does, because teaching is a big part of what a therapist does. And what are some teaching tools? Well, video happens to be a teaching tool just like written information as a teaching tool, and why not share it that way? So I think it's within our realm. And then, why doesn't it happen more often? Well, I wonder if it happens with more specific disease groups, or treatment methods, or [it is] more treatment or diagnostic based—rather than preventive. I think that health promotion is very much the role of a physiotherapist in terms of promoting healthy activity. And therapists are knowledgeable in terms of adapting that for specific population groups, and elderly people just happen to be a population group, nothing different than that.*

Moderator: Is there a component in physiotherapy training now that uses video and television for prescribing exercise?

Donna (PT): *I talk a lot about using video tape for assessment purposes and for teaching purposes, but as a home program: emphasizing it as a method of providing a home program. I've taught mostly about written and still pictures like stick men diagrams. I probably don't emphasize video tape very much in that regard. Probably*

could do more.

Panel Expert: Another area that requires further consideration is the role of physiotherapy in community-based programs and preventative care.

Barb (PT): *If we are going to talk about preventative care (about people having less muscle power as they get older), and we want to keep them active as long as possible—I think they need [a physiotherapist] in a different role than reparative. They need one prophylactically, if you like.*

Terry (PT): *I wonder, “Is it in our training?” Maybe not so much.*

Panel Expert: The idea of health promotion and prevention could be part of a physical therapist’s role, particularly community therapists.

Donna (PT): *Are there any more community therapists services in Saskatoon and Regina? I don’t think they’ve hired any more people. So I think it looks good on paper, but I don’t think it’s being done—not very extensively anyway. And this whole concept of prevention, i.e., prevent of falls in the elderly. So we’re talking about education materials and making them relevant to talk about prevention. Health and wellness—the ways you do that I see is through prevention. I see [physical therapists involved] in prevention of falls, maintenance of functional independence, and physical independence.*

Matty (PT): *Our profession is not like, ‘Well, let’s screen everyone and get them up to par.’ We’re not like that at all, right? Or, that’s not how we’re functioning. How are we going to do this ‘cause that means we are going to start promoting ourselves and we are not the kind that promotes ourselves. . . .So, you have to find a way to promote yourself if you want to get into that field.*

Moderator: I wonder if one of the challenges of the profession is the tradition of treating clients one-on-one?

Donna (PT): *I think that is changing, and it has to change. We’re going to Masters entry-level and to expect that someone comes out with a Masters degree is going to be the person who actually delivers the program on an ongoing basis, I think it’s just not going to happen. There’s going to be change in terms of hands-on. And I know that’s a dilemma because many people join the profession for that specific reason of hands-on.*

Panel Expert: I agree. The roles of physiotherapists are changing. At present, there are non-physiotherapists in the community who are involved in setting up and carrying out exercise programs for people with medical concerns. Who is the best person for the job? Exercise programs in the community that are carried out by non professionals may

not be the best program for the recipient.

Matty (PT): *There are [exercise] groups starting [and to recruit people] they come into the hospital and say, 'Okay, if you have people on your list—the older people, the stroke people—let us have them and we'll do exercises with them,' and I'm thinking these people need proper treatment.*

Key Points: Instructor

- Qualified
- Role in community
- Training

Moderator: So this role as a television producer just very well may be a new area of practice for physiotherapy. Donna?

Donna (PT): *So when you're trying to break into an area of practice, well, I think what you have done is very much, I think, within the scope of practice of physiotherapy and it's probably an under-serviced area. But, in terms of breaking into new areas, I'm hoping that physio is going to stop adding new areas pretty darn soon. We've extended well beyond what we can do well, I think. . .we should marshal our resources and emphasize exercise and the benefits of exercise for endurance, flexibility, strengthening. That's what we're suppose to do best. That's suppose to be our "bread and butter." I really see us forgetting where our strengths lie and the benefits that we can provide. We are getting off into all sorts of tangents, and we're going to get lost. We're going to become obsolete because we don't know what the heck we want to do.*

Matty (PT): *We can't protect ourselves. Is physio a "cop-out" really? We don't want to take a stand on what's us.*

Moderator: Donna?

Donna (PT): *Then there's the whole thing of remuneration for knowledge. I understand the reason for doing it is to reach those people who aren't getting services, but were you paid for it? I would be very worried about it if it were all on a volunteer basis because if you start giving things away for free, they just aren't valued that much anymore. And some people can't afford to make use of their expertise for free. If you start doing things like that, who's going to pay me to do it? Knowledge is worth something. It should be, otherwise why did we all go to school for as long as we did? (laughs) I think it would be important to get it funded. And then too, you also have a sponsor that comes up on the screen which gives it credibility as well. I think that would be very important. If it's funded, then you have an obligation to make it evidence-based*

and to evaluate the program in some way. Have you thought about how you would evaluate the effectiveness of this program? Even a way of knowing how many people utilize the service.

Sharon Elliott: I agree that these are important issues. The original series I produced was within my position as community therapist and the health district sponsored the programs. After I left the health district, I applied for a rural initiatives health promotion grant to produce new programs, but the district said they were unable to provide funding for any programs at that time. Eventually, when I planned to produce new programs, I received a small grant from the Southeast Saskatchewan Association for Culture, Recreational and Sport. (They support local projects that promote physical activity at the community level.) That, however, was a one-time source of funding. To produce future programs, I will need to secure other sources of funding. But, you know, I don't mind volunteering my time to this project. I am reminded of physiotherapists in the early stages of the profession and the ways in which they volunteered their way into the health-care system.

Donna (PT): *But we're way past that now. We're much more sophisticated as a profession now, and I don't think we should go back that way.*

Sharon Elliott: Good point. With respect to evaluation, phone calls to the television station indicate that the program is still being watched; however, the exact number of viewers is not known. Perhaps another means of evaluation could be to consider the suggestions with respect to monitoring participants.

Moderator: Donna?

Donna (PT): *I think if physios are going to get into sharing information—treating by television—because really, that's what it is, it should be evidence-based primarily as opposed to anecdotal or empirical.*

Panel Expert: We heard from the participants. Individually, each story is an anecdote. Collectively, the evidence appears. Their statements support the research which suggests that the elderly, sedentary, obese, and disabled individuals are the groups most likely to benefit from low intensity exercise programmes (Shephard, 1997). According to the responses from the viewers, the benefits appear to outweigh the risks. No injuries were reported. Exercises that have a minimal potential for injury are important for ongoing participation (Keller & Fleury, 2000).

Moderator: (To the viewers) Is there anything you do not like about the program?
Mary?

Mary: *It was satisfactory, but there was so much repeat. I just turned it on, and it was the same old thing.*

Moderator: Okay, so you see the same old thing, and then what do you do?

Mary: *You turn it off (laughs).*

Moderator: How come?

Mary: *Well, you're not interested in what they're showing because you've seen it so many times.*

Moderator: Loretta?

Loretta: *Well, the only thing I don't like about it like when you watch it all the time it's the same-repeat, repeat-I even know what you say, you know. I don't know if you called it bored. It's just the same over and over. I turn it to mute because I don't like listening to it every day and every day the same thing (laughs). So I mute it, and just watch it, and do it. Sometimes I put tapes on or something [refers to the radio].*

Bob: *About the tapes, they have the same one all the time which is all right. It's just that well, we laugh and say, 'Gee I wonder if that tape's going to wear out one of these times' (laughs).*

Moderator: Anybody else? Gwen?

Gwen: *Well, the only time I used to say, 'I think it's time that we were taking it off,' because there was nobody else to come on, see.*

Jenny: *The thing is, it's the same people they watch every day. This group that has been on now, I'm not seeing it every day, but I think it must be the same one for the past year. . . .I know exactly what you are going to say and when you're going to say it!*

Sylvia: *I think I could sit there and do them myself now without anybody. But I don't (laughs).*

Moderator: Obviously, repetition of the same program is problematic. Are fewer people watching the program because of this? Is this occurring at the care homes? Agnes?

Agnes: *There used to be a lot more people here that come to exercises and now there's only very few. Can't remember who all it was anymore, but I know the chairs were all*

full.

Ruby: *[They've] passed away or moved to Level 4.*

Moderator: Jane?

Jane: *There were more people who could do the exercises and things then, and they used to do them down in the living room, but they've gone. Two of them, I don't know why, but they went to another home. Well, sometimes people die and sometimes people go into another institution or something. We've lost a few.*

Panel Expert: Attrition due to age and poor health is inevitable. I want to know if attrition is due to a loss of interest in the program.

Moderator: Does anyone want to comment on this loss of interest? Jean?

Jean: *You know, it's very foolish not to do it. I should do it everyday. There is no reason why. I just became careless about it.*

Panel Expert: You need to build in mechanisms in an effort to keep people interested. Clearly, updating the programs and producing new ones is very important.

<p>Key Points: Attrition Repeats</p>

Moderator: So, new programs are needed in order to keep the viewers interested and participating. We have a question from the studio audience. Yes?

Audience Member: If this program has been repeated for so long like they say it has—and now there are new programs—are you going to find out what the viewers think now?

Sharon Elliott: Unfortunately, the ongoing nature of producing new programs and then evaluating them requires funding. Funding is my biggest challenge right now.

Moderator: Another question. Go ahead.

Audience Member: Have you considered the possibility of going on a commercial channel?

Sharon Elliott: Actually, no, I haven't. If I take this project further I want to approach an educational channel such as Saskatchewan Communications Network (SCN). Ideally, I would like to see interactive television in place where there would be some communication among viewers and the instructor. However, the program would have to be live then, wouldn't it? As mentioned earlier, none of the viewers seem to know anyone else who is doing the exercises, and yet, many people are following the program. The program is one-way communication. It appears to provide a connection with the community, but there is no connection among the viewers. I would like to explore interactive television further.

Moderator: Terry?

Terry (PT): I think it's a good modality. If you have a community station that will help you with some of the production.

Sharon Elliott: I believe that a community station is always interested in promoting the community. I still see the local community channel as being an excellent choice for now. However, the way the cable industry is set up, a community channel only serves the one community where the television station is located. The channel does not even reach the surrounding rural areas! Older adults who live in small towns and farms cannot receive the community channel from their nearest centre. Clearly, there are limitations to airing through community television.

Moderator: What if a commercial channel were willing to air an exercise program for seniors?

Donna (PT): [If commercial] television is the medium then, who monitors? Who gets to develop the program and air it on TV? What sort of quality assurance measures are in place? Or, can anybody buy time on the air and do it? And how do you prevent someone from having their products sell at the end of the program?

Panel Expert: Those are very valid questions. Moving to a commercial channel poses more challenges. The initial goals and objectives might get lost in the process. The program would take on an entirely different perspective. Right now, I do not think that this is what you want as a health professional, especially when there are no practice guidelines in place from the licensing bodies or the professional association.

Moderator: We can take one more question from the studio audience. Go ahead.

Audience Member: I was just wondering, why not use computers instead of television? You could have an interactive exercise program that the person would follow and you could be more specific to the individual. For example, you could have a program for

someone with arthritis, or Parkinsons. There could also be a screening mechanism, and a mechanism to monitor.

Moderator: Does anyone want to comment on the use of computers to deliver an exercise program? Jenny?

Jenny: I suppose that's good, but there are some of us that are never going to have a computer.

Terry (PT): In almost all households or institutions there would be TV; there may not be a computer. There are lots of elderly people who are very comfortable with computers, but TV might be a more accessible modality.

Panel Expert: I agree. Television remains convenient and accessible. Although the next generation of seniors may be very well prepared to do an exercise program via their computer, this generation of seniors are content to tune into TV. I want to return to something that Sharon had said earlier about interactive television. I think interactive television is the future of television for seniors, especially here in Saskatchewan with the challenges of weather and geography.

Moderator: Okay. We only have a few minutes left. Final comments about the exercise program on TV. Jane?

Jane: Keep it going.

Jean: I hope it continues because I'm sure a lot of people enjoy it and find it helpful. I'm sure there are people who have nothing to do that really look forwards to that. . . . Are you going to set up a new series? A set with different people in it for interest.

Jenny: There isn't anything I would say I didn't like. I think it's good as it is. Just keep it up.

Sylvia: Well, there's nothing to dislike about it. I'm quite happy with it. I hope they keep it going. Because like I say, I wouldn't do it on my own. But when it's on there, then I do it (laughs). Sometimes I kind of wish they would change them. . . I just think that even if you had another one and then changed off like you used to there, well, just for variety.

Bob: There's nothing I can say that I don't like about it at all. It's good all the way through.

Moderator: Should there be new programs?

Bob: *It don't really matter I guess. At first, they were kind of alternating with different ones but this last while they've had the same ones on and we always laugh and say, 'Well, they are going to wear out the tape on this one' (laughs). I think it's a real good thing the way it's going now. The exercise and all that.*

Loretta: *Oh, I would like to see it keep going. As long as you don't come ask me to go on it! (laughing) Of course you wouldn't have to change it much would you? Maybe if it was one day and one another, you know. I suppose it could be around 20 minutes. Get more different things into it maybe.*

Mary: *I think it's probably fine for somebody making use of it. No, I don't think I want to be on TV either. I'm not very photogenic.*

Matty (PT): *I support you fully and will give you lots of idea, but not me [as to having my own show (laughing)]. You're doing a real service for the profession. Maybe you should go national like those Body Break commercials!*

Moderator: *I'm afraid we've run out of time. (Turns to camera) This brings us to the end of our town hall meeting from the Royal Canadian Legion in Weyburn, Saskatchewan. Thank you to everyone who participated. Good-bye!*

CHAPTER SIX

FOLLOWING THE FURROW

A furrow is a narrow trench made in the ground by a plow.

-The Canadian Oxford Dictionary (Barber, 1998)

Conclusion

Documenting the events of this television program is like plowing new territory.

I follow the plowed furrow and produce new programs in August, 2001. We return to the mall; I am on camera this time along with two people from the community. A new name is created: Local Motion. The programs air in September, 2001. The staff at the local television station are pleased. I discover that the viewers are satisfied as well:

August, 2001. It is my last day in Weyburn before returning to Saskatoon to teach a class at the School of Physical Therapy. I am at the physical therapy clinic where I have been writing my thesis, and I am talking with one of the staff at the receptionist's desk in the waiting room. An older woman waits for her appointment. She is in a wheelchair as one side of her body is paralyzed. At the end of her treatment, the physical therapist comes out of the treatment room to tell me this client asked her who I was: she recognized my voice from the TV program. "Really?" I ask. "Go and talk with her," I am told. I find out she has been doing the exercises from the beginning—even before she had a stroke. She still does them. She shows me how she clasps her hands together and lifts them up over her head. She says the exercises really help, and is pleased to hear new programs are on the way. I wish I had my tape-recorder. Or a video-camera.

November, 2001. I attend the United Church Women's Annual Fall Tea and Bake Sale. As I sip tea and sample the fancy sandwiches and dessert squares, I am approached by a woman who is serving another table. I do not know her by name and only vaguely recognize her face. It is obvious that she knows me.

"I see you every morning!" she exclaims. I immediately know what she is referring to. She says that the new programs are just great. We exchange a moment of pleasantries before she disappears into the kitchen with an empty coffee pot. Another story remains unearthed.

December, 2001. I am at the health district Christmas party with my husband, an employee of the district. The woman next to me is an acquaintance; a semi-retired public health nurse. She informs me that she often does the chair exercises on television. If her joints are stiff, the exercises help to loosen her up before she begins her day. I am trying to conclude my thesis. Instead, I gather more data.

I am continually reminded that the program has had a greater impact than I could ever have anticipated.

Acceptability by Older Adults

Two findings with respect to this research initially stand out. First, the television program appeals to a wide age range: the older adult participants of this study range in age from 75 to 95. But, there are people who follow the exercises that are younger, like the woman at the Christmas party. There may be a few viewers who are older. Should health promotion programs specify an age range? Is a twenty year age range amongst older adults an appropriate guideline?

Second, levels of ability are widespread: from the fit to the frail; from those who are ambulatory to those who are wheelchair-bound. I can understand how the television program is of value for those who cannot get out on their own (like Jean, Ruby, and Jane); for those who need exercise but do not have the opportunity elsewhere (like Agnes, Gwen, and Sylvia); or for those who follow the program to supplement the

exercises they receive elsewhere (like Bob, Martha, and the woman at the physical therapy clinic). But, I am also surprised that the program is utilized by those who are active, fit, and independent (like Jenny, Loretta, and the woman at the church tea). I had not anticipated this.

Specific features of the program appear to be of value to the viewers. I believe that television is the key feature. The delivery of exercises via television is convenient, affordable, and accessible. The exercises are delivered into the comfort of their home, and viewers seem to appreciate this. There is no cost to the participant beyond owning a television set and subscribing to cable (the latter, however, is an ongoing and potentially rising cost).

The program is available for up to five days a week; fifty-two weeks a year. It provides a regular and reliable routine of exercises. (Few community-based programs have an ongoing schedule throughout the year.) Initially, I thought the program only needed to be aired during the winter months when many seniors are housebound because of the cold and snowy weather, but I learned that the heat of the summer keeps many older people indoors. The wind does too. This television program reduces the barriers to exercise: weather, transportation, cost, accessibility, and availability are negated.

Television has the advantage, over written handouts, of demonstrating to the viewer what exercises to do, and how to do them. The visual and verbal cues are easier to follow than a pamphlet or a handout (a common educational tool used by physical therapists). Exercising with familiar faces in familiar places provides incentive and

motivation. Some older persons (like Bernice, Ruby, Agnes, Sylvia) would not exercise at all if the program were not on television. Together, these factors contribute to the adherence of an exercise regime. Some viewers (Jane, Sylvia, Jenny, Loretta, Bob) have followed the televised program for as long as three to four years. This adherence is significant.

The older adults discussed the benefits of exercise. They reported feeling better; feeling like they were able to move easier. They spoke about less stiffness and pain, and increased joint range of motion. Gentle exercise should not be underestimated in the lives of older persons, even those who are apparently active and able-bodied. Exercise has the potential to maintain and improve movement, and to offset the effects of a sedentary lifestyle. The benefits of the exercises on function and subsequently, independence, were not fully examined in this study and thus, need to be further explored.

Televised exercises send a positive message to the public about the importance of exercise, especially as one ages. However, not everyone is convinced of this. There are some people, like Mary, who do not value the program, nor the importance of exercise with age. It is not clear whether televised exercises can influence one's attitude or behaviour as to whether they will participate in the program or not. Further research to determine which viewers follow the televised exercises versus those who do not is warranted.

Overall, the acceptability of this television program is high. However, program

repeats are problematic. New programs with a variety of exercises are recommended to enhance ongoing engagement in exercise.

Acceptability by Physical Therapists

For the viewers, the television program is concrete; it is a tangible event. For some physical therapists, however, the television program is still a concept. The concept of televised exercises produced by a physical therapist received mixed reviews, and not just from the participants of this study. For example, when I utilized an international physiotherapy list-serve early in my research, I received personal opinions rather than the professional advice I was seeking:

It seems incongruous that you would sit an elderly person in front of a TV to exercise—a bit like those exercise programmes for computer users—the objective is to get them away from the computer not anchor them there a bit longer! I suppose if one is anchored to the TV, it is, so to speak, a captive audience and may be a way of getting the message across. . . (A. Lee, personal communication, January 19, 2000).

Feedback from leaders in the profession fluctuated from one end of the spectrum to the other:

Not only do I think that this is well within the scope of practice of physiotherapists, I think it is an essential element of what we do and one of the greatest values we can add to the system (S. Holstein, Executive Director, Ontario Physiotherapy Association, personal communication, October 29, 2001).

Some consideration should be given as to whether demonstrating exercises on TV is practicing physiotherapy. . . (R. Hamilton, Director of Policy and Communications, College of Physiotherapists of Ontario, personal communication, November 28, 2001).

Since the purpose of this study is to explore television production as a potential area of physiotherapy practice, the question, “is a program of televised exercises

physiotherapy?” needs to be addressed. In the traditional framework of the profession where physical therapists treat patients one-on-one, then televised chair exercises are not physiotherapy.

However, consider the description of physical therapy, as defined by the Canadian Physiotherapy Association, that includes the promotion of fitness, health, and wellness. Also, consider the Movement Continuum Theory of Physical Therapy as proposed by Cott et al. (1995) that accommodates prevention, wellness, and health to individuals and groups within a community and beyond. And, consider the physical therapy literature that states physical therapists could be doing more, need to be doing more in terms of promoting fitness, health, and wellness. Televised chair exercises *can* be considered physiotherapy. More specifically, it is a new method of delivering physiotherapy.

Producing televised chair exercises for seniors is an initiative that addresses the growing trends in health-care: gerontology, community-based services, and health promotion. It is the “non-traditional, creative outlet for physiotherapy skills” that Nancy Christie (Executive Director of CPA in the mid-80's) cried out for. But, is it acceptable to physical therapists?

All the physical therapy participants in this study accepted televised exercises as part of the scope of physiotherapy. The degree of acceptability, however, varied from enthusiasm and support of the idea (Diane and Matty), to neutrality (Barb); from positive with suggestions (Terry), to conservative and cautious (Donna).

The production of televised chair exercises by a physical therapist needs to consider screening, monitoring, progressing to more difficult exercises for some, less difficult exercises for others, measuring, and evaluating. In other words, the program cannot be left unattended. A mechanism is needed to determine who the clients are, and how they are doing with the exercise regime. With feedback from the viewers, one can begin to measure achievable outcomes and glean evidence that supports this type of programming.

The physiotherapists discussed safety of the participant. Protection of the public is crucial. If a physical therapist is at the helm of a televised chair exercise program, then licensing bodies and the professional association need to know that this type of programming is being carried out. This study serves to inform these organizations of the use of television as a method of delivering exercises to older adults.

Implications

The results of this study indicate that television is an effective and appropriate means for delivering an exercise program to older adults in Weyburn, Saskatchewan. In light of this discovery, televised chair exercises for older adults could be of value in other communities in the province, particularly those with a high proportion of seniors. Many seniors remain rural-based—some are farm-bound—and this is a hard to reach segment of the population. There are limited opportunities for some older adults to remain physically active. Initiatives to promote exercise in the older adult population

have not been fully embraced. One needs to question why this is the case.

At present, studies to suggest the use of television as a possible vehicle to deliver exercises to seniors are missing. Why hasn't television been considered as a medium to reach this segment of the population? Why are television programs specific to older persons lacking? In a province with a high percentage of seniors, so much more could be done, and needs to be done. In this sense, this study has plowed the first furrow.

The results of this study provide the groundwork to explore the delivery of chair exercises not only within Saskatchewan, but beyond the province as well. I am reminded of the homes for the aged, the day centres, and the individual homes in Thailand and Sri Lanka that I visited. These countries have a rapidly growing aging population. Television is very much a part of their lifestyle. Physiotherapists dedicated to working with and for older persons are few in number. As a delivery system of generic exercises, television can be a creative use of limited human resources. One physical therapist can reach a large number of seniors, particularly the hard to reach: the frail, the housebound, and the institutionalized.

Will the profession eventually embrace this new area of practice? At present, a medical paradigm shapes and mandates physiotherapy. Within this philosophy, patient populations are created and categorized according to their illness, injury, or disease status. The emphasis on promoting fitness, health, and wellness is not mandated in the academic or clinical setting. This school of thought needs to change. It is changing.

In Saskatchewan, there is a political thrust toward health promotion activities.

The Action Plan for Saskatchewan Health Care, for example, calls for health promotion initiatives as a province-wide strategy (Saskatchewan Health, 2001). Clearly, the physiotherapy profession would do well to move in this direction if it wants to remain viable and visible in the health-care system. Televised exercises have the potential to do this as they promote mobility, encourage physical activity, are cost effective, and promote health. It is the type of upstream activity that governments seek.

Television programs for older adults have the potential to be powerful and effective health education tools in contrast to the use of exercise hand-outs. There has been limited exploration of the potential of television. The profession of physiotherapy needs to advance its practice as health educators by using technologies such as television, video, and computers to relay health information to people.

The internet, an interactive approach, is already being used to encourage sedentary individuals to become more physically active. The recent advent of internet access through telephone lines and onto people's television screens (Silverthorn, 2001) adds another unique and promising dimension, particularly for older adults who are more comfortable with television than computers.

I hope this study encourages physical therapists to take action now. I also hope this study inspires physical therapists to be visionaries and to prepare for the future. Future generations of older adults, for example, will have more education than past generations and a lifetime of information technology use. Are physical therapists prepared to respond to the change taking place in technology? Are they ready to use

these technological advances to meet the needs of an aging population?

There is opportunity to expand physiotherapy practice and become community-based health promotion experts by using a variety of telecommunication modalities to deliver health-related information and education to the public. As a profession, I believe it is imperative that physical therapists expand their scope of practice to include these new and pertinent directions.

Recommendations

For the Televised Chair Exercise Program in Weyburn

Locally: The program of chair exercises in Weyburn has been broadcast since 1997. Programs on the community channel often have a limited lifespan; rarely are programs continued within the broadcast schedule this long. Based on the results of this study, this particular chair exercise program has merit. However, the program is not sustainable unless it is periodically updated based on feedback from the viewers. A local advisory committee is recommended to provide human and financial support if the program were to be sustained.

Provincially: Two possibilities exist: the first option is to distribute the current program to other community television stations in the province that are aware and interested in this type of programming. With a broader network of human and financial resources, more options are available. For example, taping of new programs could be done from the different participating communities. However, the main limitation of

continuing to utilize the community channel is the limited viewing audience. Only those who live in the city limits have access to the community channel. Seniors who live in smaller communities and those who live on farms are excluded.

A second option is to move from the community channel connection toward an educational channel, for example, Saskatchewan Communications Network (SCN). Programming by and for the people of Saskatchewan is a priority for SCN (L. Epstein, personal communication, January 18, 2002).

Broadening the program to the provincial level could open the financial support needed: government and non-government agencies, academics and community activists, gerontologists, adults educators, senior's organizations, and, of course, the broadcaster. Stakeholders could potentially include SCN, Saskatchewan Population Health Evaluation and Research Unit (SPHERU), Seniors Education Centre (University of Regina), School of Physical Therapy (University of Saskatchewan), Link to Health (Canadian Red Cross), Saskatchewan Seniors Association Inc., Saskatchewan Seniors Mechanism, and local councils on aging. Funding from government and non-government organizations like the Heart and Stroke Foundation and The Arthritis Society could be attained.

Nationally: Based on the program from Weyburn, and with input from other televised chair exercises programs, I would like to see a "Production Guide" developed at a national level. Stakeholders could include the Canadian Physiotherapy Association, the Active Living Coalition for Older Adults, and the Canadian Centre for Activity and

Aging. This template could be adopted and adapted by other countries.

Internationally: National and international programs such as the Asia Training Centre on Aging and HelpAge International are already partnered to improve the quality of life for older adults in Asia. Similar liaisons exist in other countries. The International Training Centre on Aging in Malta, and the World Confederation of Physical Therapists are potential places to promote the possibility of using television as a means to deliver exercise opportunities to elders. International ties are already established through the Saskatchewan Institute of Applied Science and Technology (SIAST) and the Universities of Saskatchewan and Regina.

For the Physical Therapy Profession

(1) Embrace the theory of physical therapy that supports the promotion of fitness, health, and wellness. Place this theory on the academic and the clinical practice agendas of the three major stakeholders: the Canadian Physiotherapy Association, the Canadian Alliance of Physiotherapy Regulators, and the Canadian University Physical Therapy Academic Council. A greater awareness of health promotion initiatives at the community level is needed to examine questions such as: What has been done? What can be done by physiotherapists?

(2) Develop national policies that commit the profession to health promotion strategies. Be specific. Include the use of television as a method to deliver chair exercises to older adults. Expand this concept to include the internet and other

technologies. Embrace the possibilities as health promoters and educators.

(3) Mandate the promotion of fitness, health, and wellness locally, provincially, and nationally. Clinical and academic leaders need to provide resources and direction that encourage physical therapists to engage in health promotion activities. Physical therapists must be prepared to consult, advise, plan, and implement programs—not just for individuals, but for an entire population. Training in these areas could occur either within the entry-level physiotherapy curriculum, or as continuing physical therapy education.

Post-script

The furrow is not perfect. It may never be. But it is opening up a new territory. The territory of television production challenges the physical therapy profession to extend itself beyond the traditional borders. For some physical therapists, this concept may challenge their comfort zones. For others, it may just be the calling they have been waiting for.

As a pioneer, producing this television program has utilized my skills and abilities to their fullest capacity. Although there have been disappointments and setbacks, I have also experienced the excitement and exhilaration of settling in a previously unsettled land. Producing the television program and documenting my journey for the purpose of this study, have been the greatest achievements of my career so far. I hope my next endeavour will be just as challenging and fulfilling.

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APPENDIX A

ETHICS APPROVAL



**UNIVERSITY ADVISORY COMMITTEE
ON ETHICS IN BEHAVIOURAL SCIENCE RESEARCH**

NAME: J. Lyons (S. Elliott)
Department of Educational Foundations

BSC#: 2001-63

DATE: April 16, 2001

The University Advisory Committee on Ethics in Behavioural Science Research has reviewed the Application for Ethics Approval for your study "Physical Therapist as Television Producer: 'Gero-techno Pioneer' (01-63).

1. Your study has been APPROVED subject to the following minor modifications:

- Please revise your consent form as follows:

- i) Specify the length of time entailed by participation.
- ii) Indicate that the participant will have the opportunity to review the transcripts and to add, alter, or delete information from them.
- iii) State that the research has been approved by the University of Saskatchewan Advisory Committee on Ethics in Behavioural Sciences Research

- When it is not possible to obtain written consent, there should be a third party available (e.g., a member of the participant's family) who is authorised to give consent, and who signs the consent form on behalf of the participant. This person's signature should reflect the fact that the participant has understood the information provided, and has agreed to participate. Thus, you will need to have a modified version of the consent form available for situations in which the participant is unable to sign the form for his/herself.

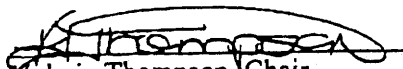
2. Please send one copy of your revisions to the Office of Research Services for our records. Please highlight or underline any changes made when resubmitting.

3. The term of this approval is for 5 years.

4. This letter serves as your certificate of approval, effective as of the time that you have completed the requested modifications. If you require a letter of unconditional approval, please so indicate on your reply, and one will be issued to you.

5. Any significant changes to your proposed study should be reported to the Chair for Committee consideration in advance of its implementation.

I wish you a successful and informative study.


Valerie Thompson, Chair

University Advisory Committee
on Ethics in Behavioural Science Research

Office of Research Services, Ethics Committees, University of Saskatchewan
Kirk Hall Room 207, 117 Science Place, Saskatoon SK S7N 5C8 CANADA
Telephone: (306) 966-4053 Facsimile: (306) 966-8597 <http://www.usask.ca/research/>

APPENDIX B

LETTERS OF CONSENT

Letter of Consent for Physical Therapists

Dear _____,

Thank you for participating in the research study, *Physical Therapist as Television Producer: Gero-techno Pioneer*. This study is based on a television program that was produced by a physical therapist; the program provides chair exercises for inactive older adults. Television production is a non-traditional role of a physical therapist. This study will examine the role of a physical therapist as television producer. This research has been approved by the University of Saskatchewan Advisory Committee on Ethics in Behavioural Sciences Research.

I will meet with you for an interview; this will take approximately one hour. The interview will be audio-taped, transcribed, and analysed by myself. You will have the opportunity to review the transcripts and to add, alter, or delete information from them. There are no foreseeable risks, side effects and discomforts.

You may choose not to participate in the interview. If you have been interviewed and you wish to change or withdraw your responses you may do so at any time.

Your identity in the written research report will be protected by using a pseudonym of your choosing, unless otherwise stated.

Transcripts and audio-cassettes of the interviews will be securely stored at the University of Saskatchewan and be viewed only by the researcher and the research supervisor.

The results of this study will be reported in my master's thesis. I may present the results of the study in a scholarly journal and present it at a conference. Any unanticipated future use of the research data not stated above will occur only with your informed consent.

If you have any questions with regard to this study or your right as a participant in this study, please feel free to contact myself, Dr. Lyons, or the Office of Research Studies (966-4053).

Thank you for participating in this study.

I acknowledge that the research and contents of this consent form have been explained to me. I understand the contents and have received a copy of this form.

Signed:

Participant's Signature

Date: _____

Researcher's Signature

Date: _____

Researchers:

John Lyons, (Research Supervisor)
University of Saskatchewan
College of Education
Dept. of Educational Foundations
Phone: 966-7515
E-mail: lyonsj@duke.usask.ca

Sharon Elliott, (Graduate Student, M.C.Ed.)
University of Saskatchewan
College of Education
Dept. of Educational Foundations
Adult and Continuing Education Program
Phone: 96-5252
E-mail: sje266@mail.usask.ca

Letter of Consent for Older Adults in Weyburn

Dear _____, I appreciate your participation in the research study, Physical Therapist as Television Producer: Gero-techno Pioneer.

This study is based on the television program, *Chair Exercises for Older Adults*, aired on Weyburn's community channel each weekday morning. My research will explore the role of a physical therapist in producing such a program as this is a new area of physiotherapy practice. This research has been approved by the University of Saskatchewan Advisory Committee on Ethics in Behavioural Sciences Research.

I will be seeking feedback from you about the television show. I will conduct an informal interview with you; this will take approximately one hour. The questions will all be related to the television program. With your permission I will tape-record the interview. After the interview I will transcribe the tape; you may have a copy of the typed transcript if you like. I will analyse the transcripts to find themes and insights about the television show. You will have the opportunity to review the transcripts and to add, alter, or delete information from them.

The results of this study will be reported in my master's thesis. I may present the results of the study at professional and scholarly meetings and in published papers. Any unanticipated future use of the research data not stated above will occur only with your informed consent.

There is no anticipated harm from participating in this study. Interviews will take place at a time and place that is convenient for you.

You may choose not to participate in the interview. If you have been interviewed and you wish to change or withdraw your responses you may do so at any time.

Transcripts and audio-cassettes of interviews will be securely stored at the University of Saskatchewan and will be viewed only by myself and my research supervisor. Your identity will not be revealed in my research without your permission. You may choose a pseudonym or initials to identify yourself.

If you have any questions about being in this study, you may contact me in Weyburn at 848-0527, or my advisor, John Lyons at the University of Saskatchewan, 306-966-7515. You may also contact the Office of Research Services at the University of Saskatchewan (306-966-4053) to clarify your role as a participant in this study.

I, _____, acknowledge that the research and contents of this consent form have been explained to me. I understand the contents and have received a copy of the form.

Signed:

Participant's Signature

Date: _____

Researcher's Signature

Date: _____

Modified Letter of Consent for Older Adults in Weyburn

Dear _____, I appreciate your participation in the research study, Physical Therapist as Television Producer: Gero-techno Pioneer.

This study is based on the television program, *Chair Exercises for Older Adults*, aired on Weyburn's community channel each weekday morning. My research will explore the role of a physical therapist in producing such a program as this is a new area of physiotherapy practice. This research has been approved by the University of Saskatchewan Advisory Committee on Ethics in Behavioural Sciences Research.

I will be seeking feedback from you about the television show. I will conduct an informal interview with you; this will take approximately one hour. The questions will all be related to the television program. With your permission I will tape-record the interview. After the interview I will transcribe the tape; you may have a copy of the typed transcript if you like. I will analyse the transcripts to find themes and insights about the television show. You will have the opportunity to review the transcripts and to add, alter, or delete information from them.

The results of this study will be reported in my master's thesis. I may present the results of the study at professional and scholarly meetings and in published papers. Any unanticipated future use of the research data not stated above will occur only with your informed consent.

There is no anticipated harm from participating in this study. Interviews will take place at a time and place that is convenient for you.

You may choose not to participate in the interview. If you have been interviewed and you wish to change or withdraw your responses you may do so at any time.

Transcripts and audio-cassettes of interviews will be securely stored at the University of Saskatchewan and will be viewed only by myself and my research supervisor. Your identity will not be revealed in my research without your permission. You may choose a pseudonym or initials to identify yourself.

If you have any questions about being in this study, you may contact me in

Weyburn at 848-0527, or my advisor, John Lyons at the University of Saskatchewan, 306-966-7515. You may also contact the Office of Research Services at the University of Saskatchewan (306-966-4053) to clarify your role as a participant in this study.

I, _____, acknowledge that the research and contents of this consent form have been explained to the participant. The participant understands the contents and has received a copy of the form. As a third-party (e.g., relative, friend, health-care worker) to the participant, I will sign the form on the participant's behalf to indicate consent.

Signed:

Third-party Signature

Date: _____

Researcher's Signature

Date: _____

APPENDIX C

INTERVIEW GUIDES

Interview Guide for Physical Therapists:

During this discussion I want to focus on older adults, particularly those who are inactive and living in the community. If they do not require one-on-one physiotherapy intervention...

- Do you think we have a role with this segment of the population?
- What should that role be?
- How could we fulfill that role?

Let's say they have received physiotherapy and now need basic and general exercises. Perhaps something simple that could be done in a chair...

- Do you think we have a role with this segment of the population?
- What should that role be?
- How could we fulfill that role?

I produced a television program of chair exercises for inactive older adults on a local community channel...

- what do you think of this? That is, a physiotherapist being involved in television production to promote fitness and health to community-based seniors.
- what challenges (or problems) do you see with this approach?
- what are some positive aspects you can think of?

Is there anything else you would like to add?

Interview Guide for Older Adults:

I'm interested in your impressions of the television program, *Chair Exercises for Older Adults*. There are no right or wrong answers. The goal of the study is to find out what viewers think of the program.

General guiding questions to begin with:

- Tell me about your impression of the program. What do you think about it? (Tell me anything you want about the program).

Specific Questions that may be used to gather further information:

- How long have you been watching the program?
- Do you do the exercises?
 - How many times a week do you follow the exercises?
 - Have you always done the exercises?
 - What is your main reason for doing the exercises?
- What do you like about the program?
- What do you not like about the program?
- What is your main reason for watching the program or not watching the program?
- How important is this program to you?
- Do you have any suggestions for the program...?

Age:

Place of Residence:

APPENDIX D

RELEASE OF TRANSCRIPT FORM

RELEASE OF TRANSCRIPT FORM

Thank you for participating in this research study. You have the opportunity to review the transcripts of your audio-taped interview. Please read and recheck the transcripts for accuracy of information. You may add any information to clarify what you intended to say. You may also delete any information that you may not want to be quoted in the study.

I, _____, have reviewed the complete transcript of my personal interview in this study. I acknowledge that the transcript accurately reflects what I said in my personal interview with Sharon Elliott. I hereby authorize the release of this transcript to Sharon Elliott to be used in the manner described in the consent form. I have received a copy of this Transcript Release Form for my own records.

Participant

Date

Researcher

Date

APPENDIX E

SOUTH CENTRAL HEALTH DISTRICT
POSITION DESCRIPTION
COMMUNITY THERAPIST

SOUTH CENTRAL HEALTH DISTRICT - POSITION DESCRIPTION

POSITION: Community Therapist

ORGANIZATION: S.C.H.D.

DIVISION/DEPT: Patient Services

HEALTH DISTRICT: South Central

DATE: November 1995

INCUMBENT:

APPROVAL SIGNATURES:

_____ **Incumbent**

_____ **Supervisor**

GENERAL ACCOUNTABILITY

The Community Therapy plans and delivers community therapy services to individuals, families and groups.

ORGANIZATIONAL STRUCTURE

This position reports to the Coordinator of Physical Therapy.

NATURE AND SCOPE

1. Completes comprehensive needs analysis for individuals and groups within designated areas of District.
2. Based on needs assessment, plans, develops and delivers treatment programs. This may include providing direct therapy to clients but most often involves training and consulting to other care givers who provide direct patient care.
3. Organizes community therapy services in the District in accordance with the philosophy, objectives and policies of the community therapy program.
4. Consults, either on request or voluntary basis with a variety of people to promote the aims of community therapy.
5. Participates in regular and special monitoring and evaluation activities related to community therapy programs.
6. Participates and presents programs of staff education/development within the District.
7. Participates in preventive and maintenance therapy programs to individuals and groups.
8. Maintains clear, detailed records and reports on aspects of services provided to designated population.
9. Maintains confidentiality of clinical records as prescribed by the agency/or institution for which community therapy services are provided.
10. Develops and maintains effective working relationships with physicians and other health care providers utilizing and/or referring individuals/groups to community therapy services.
11. Participates in and supports programs for students education and experience in community therapy within the District.

NATURE AND SCOPE - CONTINUED

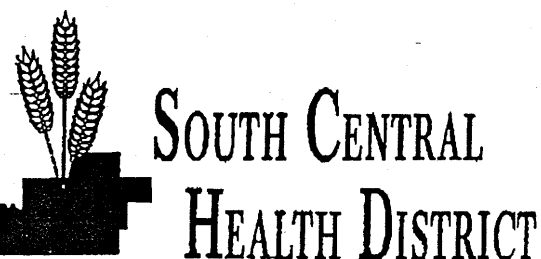
12. Assists in identifying areas requiring study, and participates in study and research.
13. Participates in setting priorities of service and plans work to meet approved priorities.

QUALIFICATIONS AND EXPERIENCE

1. Bachelor's degree in Physical Therapy combined with experience in clinical procedures and administration.
2. Eligible for licensure with the Saskatchewan College of Physical Therapists.
3. Ability to work independently and in cooperation with other members of the health team.
4. Strong interpersonal, organizational, and communication skills.
5. Ability to travel.

APPENDIX F

SOUTH CENTRAL HEALTH DISTRICT
POSITION DESCRIPTION
DISTRICT PHYSICAL THERAPIST



Human Resource
P.O. Box 200
Weyburn, Saskatchewan
S4H 2Z9
Tel: (306) 842-8725
842-8727
Fax: (306) 842-8740

AMENDED COPY**POSITION AVAILABLE**

LOCATION: SOUTH CENTRAL HEALTH DISTRICT

POSITION: DISTRICT PHYSICAL THERAPIST
(FULL-TIME) - PERMANENT

HOURS OF WORK: MONDAY - FRIDAY (8:00 A.M. TO 4:00 P.M.)

HOURLY SALARY RATE: \$17.615 - \$21.469

GENERAL ACCOUNTABILITY:

The District Physical Therapist is accountable for all aspects of physical therapy patient care consistent with the Mission Statement, philosophy, goals and objectives of the District using a participative team approach, in accordance with the Scope of Practice established by the Canadian Physiotherapy Association.

The District Physical Therapist is a member of a professional health discipline whose education and knowledge qualify him/her to make decisions and accept responsibility for all aspects of physical therapy patient care.

The objective of physical therapy is to assist the patient to regain or maintain his/her optimum level of functioning, and to participate in preventive medicine by the use of appropriate means.

All patients are assessed and treated in keeping with the By-Laws, Code of Ethics, the Standing Rules of the Canadian Physiotherapy Association and the Saskatchewan College of Physical Therapists. The District Physical Therapist is responsible for all of his/her actions.

ORGANIZATIONAL STRUCTURE:

The District Physical Therapist reports directly to the South Central Health District Director of Rehabilitation Services.

DUTIES AND RESPONSIBILITIES:

1. Assess and treat patients throughout the Health District and occasionally outside the District as assigned by the District Director of Rehabilitation Services.
2. Contribute to the provision of quality care by treating patients in the most effective manner, constantly reassessing goals and changing aims of treatment programmes to meet the needs of the patients.
3. Exchange information with colleagues and other members of the health care team through records and/or direct consultation.

**JOB POSTING - DISTRICT PHYSICAL THERAPIST
PAGE 2**

DUTIES AND RESPONSIBILITIES CONTINUED:

4. Establish and maintain liaison with Medical Staff and other health care professionals concerning the progress of patients
5. Maintain adequate treatment and progress records in accordance with the institution and South Central Health District policies and procedures.
6. Provide a high level of quality care and, as appropriate, be involved in quality improvement through chart audits, programme evaluation and performance evaluation
7. Provide support to patients at home through supplying or ordering of equipment that will be necessary to maintain them in their homes for as long as possible.
8. Perform other related duties as assigned.

QUALIFICATIONS:

The District Physical Therapist must be licensed to work in Saskatchewan by the Saskatchewan College of Physical Therapists.

Membership in the Canadian Physiotherapy Association is encouraged.

Show sound professional judgement and initiative based on education and experience in the field of physical therapy.

Have the potential ability to organize all types of patient care.

Have the ability to work harmoniously and effectively with others, and to display a willingness to communicate the philosophy of the practice of physical therapy to others.

Show respect for and a willingness to learn from the professional knowledge of other members of the health care team.

Demonstrate an ability to appreciate the importance of, and be open to new concepts and trends, in the academic and clinical field of health care knowledge.

Be physically able to perform assigned duties.

PLEASE FORWARD APPLICATION/RESUME TO HUMAN RESOURCES

DATE POSTED: SEPTEMBER 24, 1998

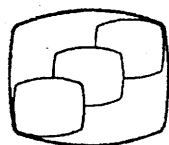
CLOSING DATE: OCTOBER 1, 1998

***ONLY THE INTERVIEWED/SELECTED APPLICANT WILL BE CONTACTED**

c: HSAS

APPENDIX G

PROGRAM OUTLINE SAMPLE: CHAIR EXERCISE PROGRAM



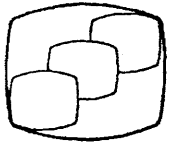
cablenet
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CABLENET TV 5 PROGRAM OUTLINE SAMPLE 1/2 HOUR CHAIR EXERCISE PROGRAM

- 00:00 - COLOUR BARS
- 00:50 - COUNT IN GRAPHIC
- 01:00 - P.S.A. OR STATION ID
- 01:30 - GENERIC SERIES INTRODUCTION (30 - 45 SEC.)
- 02:00 - PROGRAM INTRODUCTION - BY HOST / S
 - THIS SERIES IS DESIGNED TO
 - PREVIEW SHOW (tonight we will)
 - WELLNESS TIP ?
 - COME OUT AND JOIN US IN
PERSON AT _____ ?
 - GET READY WE WILL BE RIGHT
BACK
(1 - 5 MIN.)
- 04:30 - BUMP OUT - (15 SEC.)
- 04:45 - P.S.A. OR STATION ID
- 05:15 - SEGMENT # 1 - EXERCISE REGIMEN (15 -20 MIN)
- 23:30 - BUMP OUT - (15 SEC.)
- 23:45 - P.S.A. OR STATION ID
- 24:00 - PROGRAM CLOSING OR RAP UP
 - DONE BY HOST/S
 - POINTS TO REMEMBER
 - JOIN US NEXT WEEK
 - QUESTIONS OR COMMENTS PLEASE CALL
 - GOOD NIGHT
 - (3 - 5 MIN.)
- 28:00 - SERIES GENERIC EXTRO- CREDITS ROLL
- 28:30 - P.S.A. OR STATION ID
- 29:00 - FADE TO BACK - F.T.B.

APPENDIX H

PRODUCTION CREW FOR CHAIR EXERCISES



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COGECO TV 5

CHAIR EXERCISE PROGRAM

PRODUCTION CREW FOR CHAIR EXERCISES:

Producer: Coordinates the entire project; controls the content of the program related to vision of mission statement; works with members of production team; delegates tasks to members of team (e.g. 'health tips' to host)

Director: Implements producer's ideas; translates content for television viewing; responsible for technical elements of production, e.g. camera, lighting, audio, etc.

Host: Acts as viewer's guides through the program; welcomes and introduces program, explains purpose of show, and what's upcoming in program; welcomes and introduces guest; conducts short interview; closes each segment of show

Guest: In the format we are currently using, the role of the guest is to present information from their area of expertise. The guest appears in two short segments of the program, before and after the exercise session. The first segment is 5-6 minutes long; the conclusion is 2-3 minutes long. The host will conduct the interview with the guest.

Instructor: Leads participants through exercise session. Selects music. Instructor may be on or off camera; the viewers and participants take direction from the instructor.

Participants: 3 participants are on camera throughout the exercise session and are videotaped; no close ups will be used. Viewers will see all 3 participants from the start to the end of the session.

Production Assistant: helps with setting up and taking down equipment on location; helps producer and director with a variety of tasks (e.g. setting up chairs, ensure participants and guest sign waiver)

Editor: packages the various segments of the program for airing on tv.