DILEMMAS OF PRACTICE IN REHABILITATION SETTINGS AS EXPERIENCED BY PHYSICAL THERAPISTS

by

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ABSTRACT

Little research has explored the dilemmas of practice experienced by practitioners working with rehabilitation clients who are assimilating disabilities, resulting from injury or chronic conditions, into their lives. Consequently, there is limited literature to support educational initiatives or clinicians' decision-making in these settings. Accordingly, this qualitative study was designed to explore 'expert' physical therapists' perceptions of dilemmas of practice in rehabilitation settings. Using an ethnographic design, multiple interviews were conducted over a period of six months with each of ten participants. The researcher's theoretical background and 'insider' role were thoroughly explicated. Interpretive analysis was grounded in three overarching themes that emerged from the participants' accounts and compared with relevant theoretical constructs and research in physical therapy and other health professions.

In the first theme the 'authority' of the concept of evidence-based practice as it is currently promoted within physical therapy was questioned. A need was identified to develop rigorous alternative sources of 'evidence' to support current practice that are more congruent with the multifactorial and client-centred nature of rehabilitation service provision. A second theme explored situations interpreted as causing moral distress in which the participants found themselves prevented from acting effectively on behalf of the clients, as a result of admission and discharge decisions and perceived misuse of rehabilitation resources within the organization and health system. The third theme related to the advantages and disadvantages of being involved with the interdisciplinary team. A lack of understanding of different professional philosophies of practice was perceived as a contributing factor to conflict and miscommunication.

These themes are related to issues of professional accountability and suggest that physical therapy needs to develop a clearly articulated philosophy and conceptual models, including the concept of client-centred practice, that would reflect practice, serve to guide research and promote interdisciplinary collaboration. Alternative sources of 'best' evidence need to be
developed that more realistically reflect complex 'practice' knowledge. In addition, the profession needs to commit to developing a comprehensive ethics curriculum offered in education programs and through interdisciplinary learning opportunities, by which physical therapists will be better prepared for the moral deliberations inherent in their professional role.
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CHAPTER ONE: INTRODUCTION

There is a scarcity of research exploring the dilemmas experienced by health care professionals working in rehabilitation settings with clients who have disability resulting from injury or a progressive neurological condition. This is particularly true with respect to my own profession, that of physical therapy. As a result, there is limited literature available to support clinicians' decision-making in rehabilitation practice or educational initiatives in professional programs. Dilemmas in rehabilitation are not grounded simply in the individual professional's approach to practice but arise more from the interface between the individual professional and client, and between professionals, the rehabilitation culture and the health care system. The rehabilitation institutional culture impacts on clients and professionals alike. It represents a system of policies and practices to which clients adapt and are socialized (Trieschmann, 1988) and which govern and influence the everyday practice of health care professionals (Townsend, 1998).

Rehabilitation can be characterized in a number of ways that serve to differentiate it from the acute care setting. The goals of rehabilitation practice are usually articulated in terms of enhancing the quality of life following an injury or the onset of a progressive condition (Albrecht & Devliger, 1999) and preparing and enabling clients to adequately resume life in the community (Trieschmann, 1988; Caplan & Reidy, 1996). Ideally rehabilitation is client-centered with therapeutic activities designed and decisions made with the aim of assisting clients to achieve their goals (Caplan & Reidy, 1996; Law, 1998). Each individual client's situation is multifaceted and achievement of their goals clearly requires a holistic approach. Rehabilitation

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1 I will use the terms 'client' and 'patient' interchangeably throughout this thesis; however, the term 'patient' is in more common usage in rehabilitation settings.

2 Physical therapy is the term used in the United States and physiotherapy outside North America. In Canada, and in this thesis, both terms are used and can be considered synonymous.
is, therefore, an inherently collaborative enterprise involving the client, the interdisciplinary team, and the client's support group (family, friends and caregivers). Rehabilitation therapy is a lengthy process during which the client requires considerable emotional, psychological and physical support, and which involves close contact with a diversity of health care professionals. Rehabilitation care rarely results in the dramatic 'cures' characteristic of medical and surgical interventions in acute care.

Over the past fifteen years new theoretical models of practice have been developed as an alternative to the traditionally accepted 'biomedical model' imported from acute care. In this model interventions are "primarily directed towards the remedying of a physical impairment with little regard to the context within which the impairment is experienced" (Crichton & Jongbloed, 1998, p. 151). The social model (Oliver, 1990, 1996), the biopsychosocial model (Trieschmann, 1988) and the educational model (Caplan, Callahan & Haas, 1987) are examples of models which highlight the interplay between an impairment, self-identity and the social context in which the personal experience of disability is constructed (Carpenter, 1994). To be effective, rehabilitation needs to empower the clients and create complex linkages with non-medical and community support services and advocacy groups.

The move towards client-centered care, and the emergence of alternative models of care have not been incorporated into rehabilitation services without difficulty. The 'biomedical model' continues to exert an influence in rehabilitation. Issues associated with the 'biomedical model' still remain; for example, physician gate-keeping, clinicians making decisions 'in the patient's best interest,' and institutional policies which favour health care professionals rather than clients (Caplan & Reidy, 1996). Discussions in the health care ethics literature continue to primarily focus on issues arising between the client and physician; for example, divulging information to the client, genetic testing, withdrawal or withholding treatment, or issues of access to medical personnel or services. As a result, what is obscured are the concerns of an array of other health care professionals; for example, occupational therapists, pastoral care
workers, physical therapists, respiratory therapists, orthotists and social workers, all of whom contribute in essential ways to the provision of rehabilitation care.

Changes in recent years at all levels of the health care delivery system have also had an impact on the practice of individual health care professionals and on interdisciplinary team functioning. In British Columbia adult rehabilitation programs have most commonly been established within acute care facilities with a few specialized rehabilitation centres being located in Vancouver; for example, the B.C. Rehabilitation Society, The Arthritis Society, Worker's Compensation Board and Holy Family Hospital. Provision of rehabilitation services traditionally means that the client is involved with a diversity of service providers in the institutional setting, community resources, third party payers, and government ministries. Since 1994 this system has undergone a number of reviews and organizational restructuring. Core health care services were decentralized through the establishment of regional health districts, and a 'closer to home' philosophy emphasized a move to early discharge from acute care and enhanced provision of services in the community. Factors such as health care funding constraints, increasing population and the downsizing of primary care services have resulted in changes in admission and length of stay policies in rehabilitation centres. In addition to a shorter length of stay in rehabilitation centres, it is difficult for certain client groups, for example, individuals with head injury or the elderly living at risk at home following a stroke, to access appropriate resources to support them in the community. A Vancouver/Richmond Health Board (2000) review of adult/older adult rehabilitation services identified a lack of co-ordination of existing services and inadequate resources invested in community services as two of the major problems facing rehabilitation provision of care in British Columbia at this time.

A number of health service institutions have moved away from a department-oriented structure to a program management structure. As Crichton and Jongbloed (1998) explain “the departmental organization that brought professional teams of physicians, therapists and social workers into contact with the whole range of patients is now altered to facilitate focusing on particular problems (p. 301).” Programs based on medical diagnoses, such as, patients who have
sustained a spinal cord injury, stroke or head injury have been established in many institutions providing rehabilitation care. Crichton and Jongbloed (1998) suggest that many questions regarding team function within the program structure have yet to be resolved: "Who leads the team? How do its members work together? How are physicians to be made accountable for the quality of their work (p. 301)?" The program structure also means the loss of the professional support inherent in the existence of a department in terms of leadership and mentoring by more experienced practitioners. Physical therapists assigned to specific programs are required to specialize to a greater degree and perhaps more quickly in their career than under the departmental structure. They interact with a smaller group of colleagues and usually report to a member of another discipline in the role of program manager (G. Parker, personal communication September 2000).

Physical therapy as a profession has traditionally been aligned with medicine and the 'biomedical model;' physicians were responsible for the early development of physical therapy training, held managerial positions over physical therapy departments and prescriptions for patient referrals were mediated through them (Parry, 1995). The autonomy achieved by physical therapy in the past ten years is part of a shift in balance of power between the professions and between the professions and the clients. Professional practice is now based on accountability and collaboration with others. The trend towards outcome measurement and evidence-based practice has drawn attention to the paucity of researched evidence for many of the commonly used physical therapy approaches in rehabilitation. Most research in rehabilitation has focused on the attainment of outcomes valued by individual health care professionals (Oliver, 1996) and has failed to capture the complexity of rehabilitation interventions and outcomes. Little interdisciplinary research has been conducted to explore the interrelated practices and beliefs that shape how things are done in rehabilitation and what they mean to members of the group; that is, to clients and professionals.

Rehabilitation clients are engaged in a transformational process, one that will shape their future. This is a process involving the close collaboration of family, friends, administration and
the health care team, as well as the individual health care professional in a therapeutic relationship that is premised on respect for the autonomy of the client. The reality of health care practice for professionals in rehabilitation involves a responsibility to individual clients, a responsibility to colleagues, to their particular profession and to the rehabilitation institution. It is my hope that the complex nature of this practice can be informed by exploring the dilemmas of practice as articulated by one of these professional groups – physical therapy. Throughout my career in rehabilitation, I have been impressed by my colleagues' dedication to providing the best possible service to their clients and their commitment to acquiring new skills and clinical knowledge. This research study represents my attempt to recognize their expertise and ongoing struggles to adapt to changes in health care while providing the best possible care for their clients.

In developing this specific research interest, I am informed by my own clinical background as a physical therapist practicing for over twenty years in rehabilitation settings, primarily with clients who had sustained spinal cord or brain injury. More recently as an educator and in my role of academic coordinator of clinical education (ACCE), I have come to recognize the limitations of the physical therapy undergraduate program in preparing students for the complexities and realities of institutional practice. As a profession we have focused traditionally on the acquisition of knowledge and skills with the aim of improving our ability to assist clients. In developing an approach to practice which derives from experience, physical therapy has undervalued the contribution of theory in explaining why a profession does what it does. Physical therapists have not been encouraged, until very recently, to reflect on the impact on patient care of their own beliefs and values, to develop the skills of communication and empathy, nor to become involved in the larger ethical and political discussions prevalent in today's health care. Where theory has been adopted, physical therapists have primarily looked to other disciplines such as anatomy, physiology, counseling psychology, sociology, and medical anthropology. The traditional organization of physical therapy education in terms of compartmentalized diagnostic domains – orthopedic, cardio-respiratory, neurology – has made it
difficult to re-create the complexity of 'real-life' clinical situations. As Roberts (1994) said “a profession which is attempting to define its own knowledge base without an explanation of the fundamental beliefs which underpin it is bound to be confused. This confusion has manifested itself in conflicts and tensions in practice, management, education and research (p. 365).”

Through my close connections with clinicians in rehabilitation practice I became aware of the 'conflicts and tensions' involved in their practice and it is these that I wanted to explore with them in a more concerted manner.

The role of ACCE also provided me with the opportunity to learn from seasoned clinicians about the impact that health organization changes, issues of accountability and changing models of practice are having on the profession of physical therapy. Interestingly, their input into curricular design and decision-making has consistently focused on the need to emphasize the skills of communication, instruction, collegiality, management, and resource allocation, and it was in these areas that I anticipated 'tensions and conflicts' would be identified. These clinicians rarely commented on the students' level of competence in performing physical therapy assessments and treatments. Instead they advocated a humanities approach to practice, placing an emphasis on the 'art' versus the 'science' of professional practice.

The real world of clinical practice in rehabilitation involves multiple, conflicting and overlapping factors related to direct client care, professional accountability and the institutional and health care system context. It is the interaction of these elements of practice that result in 'dilemmas' for members of my profession. My own experience as a therapist, my conversations over the years with colleagues and students, and my exposure to the literature of a number of disciplines led to my desire to contribute to the growing dialogue about rehabilitation from both the perspective of the client and the health care professional. Accordingly, the focus of this qualitative study arose from the following general questions: What are the dilemmas experienced by physical therapists working in institutional rehabilitation settings? How do they make sense of or interpret them and what strategies do they use to resolve them? For the purposes of this research I have defined the concept of 'dilemma' as a problem, tension or difficult complex
practice situation which causes individual clinicians to question their professional capabilities, causes them to spend an unusual amount of time and mental energy pondering on it, or simply causes them undue personal anxiety or distress. For an individual clinician such dilemmas are the sort that are taken home at the end of the day; they can be agonizing and call into question values and beliefs both professional and personal.

The term dilemma is most frequently associated with ethics in the health care literature and clearly many dilemmas may be interpreted as ethical or moral. Scott (1998) suggests that dilemmas "entail situations wherein decision makers are faced with two (or more) equally favorable or unfavorable alternative options for possible implementation" (p. 2). An example of such a situation would be a physical therapist deciding whether to accept or challenge a physician who claims therapeutic privilege in refusing to fully inform a client about their condition. Beauchamp and Childress (1994) suggest that "facing and reasoning through dilemmas to conclusions and choices is a familiar feature of the human condition" (p. 11). Their discussion focuses on 'moral' dilemmas which they identify as occurring in at least two forms. (1) When some evidence indicates that an act is morally wrong, and some indicates that it is morally right, but the evidence on both sides is inconclusive. (2) It is clear to the decision-maker that on moral grounds they both ought and ought not to take a certain action. According to Purtilo (1993) an 'ethical' dilemma is "a common type of problem that involves two (or more) morally correct courses of action but you can't do both " (p. 39). Clearly these authors differentiate in some way between 'ethical' and 'moral' dilemmas and other problems and issues arising from clinical practice. For Scott (1998) defining a situation as an ethical 'problem' and 'issue' generally means it is less complex than a situation defined as an ethical 'dilemma.' ‘Problems’ involve questions of conduct which are relatively straightforward, temporary in nature, and readily resolvable, and 'issues' involve points of debate or controversy having strong sentiments on two (or more) sides, which are normally resolved through compromise by finding a middle ground (p. 2). It may be hard, given these broad definitions, to imagine a situation encountered in health care that could not be approached from an ethical standpoint.
In this study I wish to be cautious about the use of the words 'ethical' or 'moral' for two reasons. First, physical therapists have widely varying exposure to health care ethics literature, and frequently have been introduced only to 'textbook' cases that reveal the complexities of, for example, withholding or withdrawing treatment, abortion and the status of the fetus, or surrogate decision-making. These cases have limited relevance to physical therapy rehabilitation practice. Secondly, I am concerned that these primarily acute care issues have become associated with ethics and that situations encountered in rehabilitation practice are rarely identified by physical therapists as 'ethical' or 'moral'. By using a broad definition of 'dilemmas' encountered in practice, I felt that physical therapists participating in this study would be less likely to censor the situations they chose to share with me.

In conducting this research I wish to give public voice to the issues my professional colleagues share with each other, and which I have experienced myself in clinical practice but which are not reflected in our professional literature. A review of the physical therapy literature, particularly *Physiotherapy Canada*, *Physical Therapy*, and the *Australian Journal of Physiotherapy* reveals research which continues to be primarily quantitative and directed towards developing outcome measures and an evidence-base for practice. The few studies which address complex issues, such as, ethical dilemmas and stress (Barnitt, 1997; Broom & Williams, 1996) suggest that the high standards physiotherapists set for themselves and their tendency to seek solutions internally rather than consult with colleagues compounds problems and issues in practice. The need to shift to a more holistic model is recognised within the profession. However, a tension exists between the need to value and validate the 'art' of professional practice and the need to be credible as applied scientists in health care (Hunt, Adamson & Harris, 1998; Pratt, 1989; Shepard & Jensen, 1990).

I began this chapter by identifying the lack of discussion in the interdisciplinary literature of dilemmas related to the rehabilitation provision of care in institutional settings and, specifically, to dilemmas experienced by physical therapists in their practice in those settings. I base this statement on my review of relevant literature from a diversity of sources. In conducting
this review I tried to anticipate the contextual factors related to rehabilitation and the profession of physical therapy which might prove problematic to the participants in the study. As a consequence, the literature review, summarized in the next chapter, reflects my interest in the physical therapy professional culture, the institutional environment, the provision of rehabilitation services, the rehabilitation interdisciplinary team concept, the model of client-centered care, and dilemmas in rehabilitation practice. It is my hope that this literature review will further explicate how I came to this study, and how the study findings could potentially benefit the physical therapy profession.
CHAPTER TWO
SITUATING THE STUDY: THE LITERATURE REVIEW

The aim of this chapter is to examine the literature related to physical therapy practice in the rehabilitation setting that I considered might shed light on dilemmas identified by my profession in their everyday practice. My exploration of the literature is interdisciplinary in nature and draws from work in physical therapy, occupational therapy, nursing, medicine, health care ethics, medical sociology and anthropology, and health education. My rationale for the eclectic nature of the literature sources accessed in this review is that it more adequately reflects the interdisciplinarity and complexity of rehabilitation practice. Where possible I will draw on discussion papers or research undertaken within physical therapy, or relating directly to physical therapists. However, the scarcity of physical therapy research and scholarly activity in the area of professional issues, including standards of practice, practice trends, work place issues, health care delivery and education issues (Klassen, Grzybowski & Rosser, 2001) made it imperative for me to review a broader scope of literature.

Identification of Dilemmas of Practice in Physical Therapy

Little research exploring dilemmas of practice in physical therapy has been published and the studies reviewed in this section involved physical therapists as participants rather than as researchers. Barnitt (1994), an occupational therapist, collected information about ethical dilemmas encountered by occupational and physical therapists working in the National Health Service in the United Kingdom. She identified three major issues related to truth telling in the therapeutic relationship: withholding information from patients, usually about diagnosis or prognosis or about services; telling lies to patients for apparently honorable reasons; and telling lies to patients for apparently bad reasons. Therapists’ concerns focused on the need for the patient to be given information by the ‘appropriate’ person, not necessarily the physician. With regard to diagnosis giving, the issue of power within the interdisciplinary team may have been significant. Barnitt suggests that there is still some uncertainty over role boundaries, and that
there are consequences when therapists or nurses are seen to trespass on medical territory. In parallel with these findings, a number of therapists in Barnitt’s study, who found fault with the doctor for not telling the patient the diagnosis or prognosis, tried hard to engage the doctor in discussion that might result in the patient being told. This study draws attention to the fact that there does not appear to be a commonly agreed foundation for the belief that only physicians can discuss such information with patients. To date, there has been no similar research with therapists in Canada. The participants in Barnitt’s study also expressed concern that they had to tell lies or to collude with lies told by others. These situations appeared to be interpreted from a paternalistic stance, that the outcome for the patient would be better if the information was withheld, and therapists felt compelled to conform to the decision. Their concerns were founded in the fear that eventually the lie would be detected and that this would harm the therapeutic relationship. The dilemmas Barnitt discusses perhaps represent the residual effects of the dominant ‘biomedical model’ prevalent until recently in rehabilitation and the legal uncertainties entailed in how responsibility for providing information (for example, about surgery, diagnosis, medications or prognosis) to patients should be delegated or assigned.

Barnitt (1997) also chose to explore ethical dilemmas in occupational and physical therapy for her doctoral degree as a result of ethical problems identified by students during fieldwork, and requests from clinical colleagues for literature and education about law and ethics. She conducted a series of four studies. In the first two studies, over 500 stories of ethical dilemmas were collected from occupational therapists and physical therapists working in the National Health Service. The therapists participating in these studies represented a diversity of practice settings ranging from outpatient clinics, private practice and the institutionalized care settings of rehabilitation, long term care and acute care. In the preliminary study Barnitt chose not to provide definitions or descriptions of 'ethical' dilemmas to the health care professionals participating in her study, but rather "to allow the participants to select the meaning unencumbered by textbooks definitions" (p.93). Semi-structured interview technique was used in this study and a postal questionnaire was designed for the second study. Some differences were
found between the two professions, with the major concerns for occupational therapists being 'difficult or dangerous behavior in patients' and 'unprofessional or incompetent staff' and, for the physical therapists, being 'working within limited resources' and the 'effectiveness or appropriateness of therapy'. Both groups were equally concerned about not harming patients and of respecting patients' views. A third study looked at how therapists reasoned and made judgments about ethical dilemmas, and the fourth study surveyed all therapy courses to find out what students were being taught about ethics during their undergraduate education. An important factor identified in this research was the inappropriateness of biomedical or 'heroic' ethics to the therapists, and the need to develop the field of health care ethics for both students and practitioners in health science professions. Conclusions were drawn from these studies that therapists in the health service were becoming increasingly concerned about ethical issues at work and being able to practice to personal moral standards. Concerns centered on being able to behave 'well' in the face of increasing demands from patients, their relatives and caregivers. Therapists also referred to feelings of powerlessness in the face of changing management structures and to the lack of education in ethics.

Triezenberg (1996), a physical therapist, reported the results of a study designed to identify the current issues facing physical therapists and ethical issues that may be faced in the future. A series of three questionnaires were sent to members of the Judicial Committee of the American Physical Therapy Association. By employing a Delphi technique the first questionnaire consisted of broad questions designed to elicit a wide range of responses, and these contributed to the subsequent questionnaires. Sixteen issues were identified and divided into three categories: issues that relate to patient rights and welfare, issues associated with professional responsibility and role, and issues involving business relationships and economic considerations. The first two categories relate to rehabilitation practice. Six issues were identified as relating to patient's rights and welfare, and dealt with the therapist interaction with the patient: informed consent, confidentiality, sexual and physical abuse, social characteristics, and personal relationships. Of the ethical issues identified by Triezenberg in this category, the issue of the
patient’s right to informed consent has been most frequently discussed in physical therapy literature (Coy, 1989; Purtilo, 1984; Banja & Wolf, 1987). Professional issues, Treizenberg’s second category, dealt primarily with the delivery of physical therapy services and with physical therapists’ interactions with other health professionals and included: overutilization of services, maintaining clinical competence, supervision of personnel, the environment, and reporting the misconduct of others. The only issue that has been discussed in the physical therapy literature related to this category is reporting the misconduct of colleagues by Banja (1985). Treizenberg’s study makes a significant contribution to the discussion of descriptive or normative ethics in physical therapy. In reviewing the literature Treizenberg noted that the profession of physical therapy has been slow to generate data which could focus a discussion of ethics relevant to physical therapy practitioners working in a diversity of settings. Such a focus, he contends, would help practitioners and policy makers in their efforts to create ethical practices and policies for the profession.

Two discussion papers, published in Physical Therapy, by Bruckner (1987) and Purtilo (1988) discussed the issues of divided loyalties experienced by physical therapists. Using a hypothetical case study as an illustration, Bruckner (1987) discussed the conflicts that physical therapists could encounter between loyalty to their patients and loyalty to their employers or as she called it ‘the dilemma of the double agent.’ In her article Purtilo (1988) addresses the constraints imposed on practice experienced by physical therapists when treatment must be refused or discontinued because patients lack the financial resources to pay for their services. These articles, written in the 1980’s, with the intent to introduce physical therapists to ethical concepts and theories, succeeded in raising the profession’s awareness of the contribution that an ethical discussion could make to the realities of practice. Regrettably, few studies to date have been conducted with the aim of exploring ethical issues as perceived by physical therapists or their clients.

Murray (1997), a researcher with a doctorate degree in English Literature, explores issues in health care through the lens of medical humanities and describes how using literary texts on
medical topics can stimulate discussion. This approach, in her experience, usually prompts a mixture of personal and professional reflections, and it can reveal patterns of interpretation, habits of thought and deep-seated values and assumptions which are not consciously recognized in day to day practice. She reports the experiences of an interdisciplinary group of health care professionals, including several physical therapists, who meet on regular basis. Over months a number of themes emerged as issues that seemed to most concern the group. These were not generated by the group on demand or in advance, and did not shape the group's weekly discussions. They included death and dying, aging, cancer, power differences, gender, sexuality, disability and institutionalization. Topics identified by the group as being useful to discuss, and which often corresponded with medical subjects in the media at that time, guided the selection of texts by the group facilitator. These included abortion, bullying, euthanasia, health policy, ways of dying, feminist analysis, racial discrimination, hormone replacement therapy, alternative medicine and genetic engineering. What was particularly interesting were “the daily dilemmas” (p. 42) which cropped up again and again as the texts were discussed. These included whistle blowing, record audits, doing research, asserting oneself and/or the profession, communication, the health team dynamic, management styles, time constraints, and clinical instruction. Unlike the 'big issues,' reference to these ‘daily dilemmas’ appeared to be triggered by any text; "they seemed to be universal, relevant to any text, any medical experience" (p. 42). Murray speculates that these 'daily dilemmas' form a kind of undercurrent running through all of the group's discussions "because each of the dilemmas exposes the values- in - action of each professional" (p. 42). These ‘daily dilemmas’ seem to bear some relationship to what Garvin (cited in Christensen, 1991) describes as ethical choices which "seldom appear in the abstract or otherwise undisguised; more often, they are embedded in the mundane and parochial, linked inescapably to our daily affairs" (p. 287). Most physical therapists, in my experience, steer an unrecognized or uninformed course through these seemingly small decisions.

These recurring dilemmas are similar to the stressors identified in research, particularly in the nursing literature, on the burnout of health care professionals. The literature related to
physical therapy is limited. Some authors (Broom & Williams, 1996; Shuster, Nelson & Quisling, 1984 and Yoshida, 1992) have conducted research which investigates the issues of stress, burnout and attrition as experienced by physical therapists. The qualitative study conducted by Broom & Williams (1996) to investigate issues of occupational stress as experienced by neurological rehabilitation physical therapists is of particular relevance to my work on dilemmas in rehabilitation practice. The findings of these studies all discuss 'stressors' identified with situational constraints more common to institutional employment, such as excessive workload, interdisciplinary team communication problems, lack of autonomy and poor management coupled with the physical demands of the work, all of which impact on the physical therapists' ability to maintain the standard of care they consider essential. The high standards that physical therapists set for themselves might have compounded the problems, resulting in self-recrimination, frustration and disappointment. Evident in these study findings was the degree of taboo and personal guilt associated with stress. Physical therapists saw stress as a personal weakness and sought solutions first at an individual level rather than with colleagues. Work-based counseling services were uniformly rejected by physical therapists working in acute neurological rehabilitation in Broom and Williams' (1996) study even though communication between them and management, and other members of the team and low interpersonal support at work were perceived as sources of stress. It is clear that while pressures on physical therapists were associated with an emotionally demanding environment, coping with stress was viewed as an individual rather than a collective responsibility. The nature of the stressors identified in these studies, and the coping strategies employed, may reflect some of the characteristics of the physical therapy professional culture.

**Physical Therapy Professional Culture, Practice and Education**

Physical therapy can be seen to be operating from a professional cultural system possessing its own knowledge, skills, values and beliefs and which has evolved from its history, theoretical underpinnings, education and contemporary developments in practice. Culture is not static, but involves processes by which beliefs are constructed and maintained. These processes
happen between people as individuals and as groups within organizations and society, and confer meaning and significance (Waxler-Morrison, 1990). In this section I would like to briefly trace the changes in practice and education that have shaped the evolution of the physical therapy profession.

Physical therapy has grown, from its roots in massage and remedial exercise, as a practical therapy and in this sense is empirical in nature. Professional education has moved in most countries, over the last decade, from the traditional hospital and college-based diploma programs to the university-based Bachelor of Science degree programs as the entry level to practice. This has demonstrated a definite shift towards an academic versus a training model, and this will be further accentuated by the move since 1998 in the United States and Canada towards a Master's degree as the entry-level qualification for physical therapy.

Learning in physical therapy has been achieved in the past almost entirely by tactile experience. The effectiveness or non-effectiveness comes from within the task itself. Hence 'hands-on' experience and an 'action-oriented' approach were of paramount importance in developing entry level competence and specialist expertise. Physical therapy academic and continuing education courses supported the 'belief in what is seen to work' approach. Professional linkages between physicians and physical therapists have been strong, and the health care system in which both functioned over the years was stable (Richardson, 1999a). As a result the theoretical framework for physical therapy practice has been loosely based on the biomedical model (Engel 1977; Pratt 1989; Roberts 1994; Sim, 1990). The biomedical influence in physical therapy practice is probably most pervasive in two ways. First, there is a continued emphasis on medical diagnosis and dysfunction as the key that orients the physical therapist in practice. As a result, clients perceive therapists as focusing on the disabled 'self' rather than the whole person, and as valuing physical well-being and capabilities over the spiritual and less tangible indicators of well-being and quality of life (Carpenter, 1994). Second, there is a strong emphasis on 'fixing' discrete physical deficits and a dependence upon treatment modalities designed to improve those physiologically-based deficits. This 'parts' or 'atomistic' approach remains prevalent and is supported by the focus of physical therapy research,
reimbursement schedules, and medical discourses (for example, chart documentation, clinical case presentations, third party payer reports and medico-legal reports).

Fish and Twinn (1997) build on Schon's work (1983, 1987) and describe this traditional type of health care delivery as the 'technical-rational' model of practice. It is a view of professionalism which characterizes professional activities as essentially simple, describable and able to be broken down into their component parts (skills) and thus mastered. Competencies (or performance outcomes) are learnt in academic courses and practiced in the clinical setting under the supervision of a qualified practitioner. Little emphasis in this model is placed on the professional judgment needed to determine when or how to incorporate these competencies, and there are increasing reservations about its educational qualities and its longer term advantages. This model of practice is reflected in the various versions of the physical therapy problem-solving process which have been used as a framework for practice in physical therapy academic education (Schenck, 1980; May & Newman, 1980; Olsen, 1983; Burnett et al, 1986; Jones, 1992) since the late 1970s. These problem-solving frameworks clearly reflect the biomedical model, providing as they do a sequential approach to gathering objective information about a problem, assessing, implementing treatment, re-assessing the problem and determining whether the goal has been met. Physical therapy academic programs and practitioners are aware that this picture is no longer representative of the profession or the health care system within which we operate (Stachura, 1994). Changes in health care administrative structures, direct access to physical therapy services, and involvement with third party payers all demand greater autonomy and accountability on the part of individual clinicians. Consequently, there is a growing interest in understanding clinical reasoning and critical reflection as applied in real clinical situations (Fish & Coles, 1998; Higgs & Jones, 2000; Shepherd & Jensen, 1990) and in expert physical therapy practice (Jensen et al, 1999). As Rothstein (1999) says "our need to understand and enhance expertise is particularly acute today because physical therapy finds itself amongst the health professions being challenged to provide evidence that our services meaningfully change people's lives" (p. xix).
Physical therapy, in the past ten years, has willingly aligned itself with the evidence-based practice movement and its culture of accountability (Harris, 1996; Jette, 1995). However, the problem has been the scarcity of high quality evidence generated by the profession. Evaluations of the effectiveness and efficacy of different types of physical therapy treatment are consistently made according to the levels of evidence and grades of recommendations published in 1989 by David Sackett. His framework has been a central feature of evidence based medicine, but some concerns are being raised within physical therapy about the wholesale adoption of this definition of evidence founded, as it is, on the gold standard of the clinical randomized trial (Bithell, 2000; Bury & Mead, 1998; Ritchie, 1999). As Bithell (2000) says "there is no intrinsic reason why a clinical experiment developed to prove pharmacological efficacy should be the best way to demonstrate effectiveness of therapies which depend so much on human interaction and purport to be client-centred" (p. 59). Alternative approaches to defining 'best' evidence, such as rigorous clinical reasoning (Bury & Mead, 1998) and qualitative research (Ritchie, 1999) are slowly being introduced into the evidence-based practice debate. However, the trend in physical therapy research continues to be primarily linked with 'scientific' quantitative methods.

The close linkages between physical therapy and medicine has influenced not only practice and research, but also the development of a theoretical framework specific to the profession which determines the uniqueness of our practice (Roberts, 1994). In addition physical therapy, until the 1990s, was in such high demand that there was little incentive to explore the interplay between theory and practice. The active, practical nature of physical therapy tends to make practitioners impatient of the notion of theory. Too often, as Tammivaara and Shepard (1990) suggest, "physical therapists are much less interested in why things happen the way they do than in discovering how to effect desired results" (p. 579). The why entails a broader understanding of the system of wide-ranging ideas that physical therapists hold about their practice, and their interaction with clients and other professionals. An explicit discussion of these theoretical underpinnings, and the values and beliefs held by the profession has been largely neglected. De Souza (1998) suggests that complex therapy practice is rather like 'a black box',
the contents of which are tacitly understood and applied by therapists. However, what guides their judgments is not clear.

There is a growing interest within the professional literature in developing theoretical frameworks unique to physical therapy (for example, Cott et al 1995; Dean 1985; Hislop 1975) and these have placed an increasing importance on the larger socioeconomic and psychological context of client care. To date, physical therapy has mostly sought explanation and support for practice through theories and models developed outside the profession. For example, theories of neuroplasticity are incorporated into brain injury rehabilitation practice to support therapy approaches such as that developed by Bertha Bobath. The disablement model is seen to typify physical therapy practice and is the model of choice for understanding and organizing practice. Influential models of disablement have been consistently incorporated into the Canadian curriculum and include Nagi’s model of disablement (Guccione, 1991), the World Health Organization (ICIDH\(^1\)) International Classification of Impairments, Disabilities and Handicaps (1980) and more recently the (ICIDH\(^2\)) International Classification of Functioning, Disability and Health (2000). These models are based on the interactions between pathology, impairment, functional limitation (or capabilities) and disability and their impact on the individual client’s context and lifestyle. According to the American Physical Therapy Association (2000) “physical therapy practice includes the five essential elements of client management (examination, evaluation, diagnosis, prognosis, including the plan of care; and intervention) which incorporate the principles of the disablement model” (p. S19). Physical therapists most often quantify and qualify the signs and symptoms of impairment associated with movement and consequently, depending which model is being used, practice primarily within the domains of impairment, disability and functional limitations.

At both undergraduate and graduate levels, inclusion of theoretical material is frequently dependent on the particular values and interests of the faculty. Richardson (1999a) investigated the development of a physiotherapy paradigm by a cohort of students in two schools of physical therapy. Questionnaires were administered to the students in each year of the three-year program.
Early in the first year students from one school were oriented towards a scientific view of physical therapy while students from the other school acquired a more humanistic view, and these orientations remained unchanged throughout the program. Large numbers of third-year students in both schools were unable to pinpoint a unique or essential part played by physical therapy in health care. While these findings may not represent the outcomes of all physical therapy education programs, there is enough concern within the profession to warrant an increasing debate about the theoretical foundations of physical therapy (Jensen et al, 1999; Richardson, 1999a; Roberts, 1994; Roskell, Hewison & Widman, 1998; De Souza, 1998).

Similarly, the literature discussing ethical issues germane to physical therapy practice has increased in the past ten years (Banja & Wolfe 1987; Bruckner 1987; Clawson 1994; Geddes, Finch & Larin, 1999; Purtilo 1986; Robinson 1994; Sim & Purtilo 1991; Triezenberg 1996), however, most address dilemmas arising from professional behavior and not institutional practice. A number of Canadian physical therapy academic programs have conducted informal studies of the ethical content in their curriculum (Universities of McMaster, British Columbia and Toronto). The development of methods of incorporating ethical and moral reasoning in the physical therapy curriculum has been the focus of two unpublished studies at McMaster University (Geddes & Finch 1997, Graham et al 1997). The results indicate that ethics content is not incorporated into the curriculum in any systematic way and that print resources, for example, a self-directed learning resource package, had limited impact on the students' ability to identify and analyze ethical issues in tutorials.

In general, at the undergraduate level broader content that supports the 'art' of the profession, by which I mean, for example, issues of power, gender, culture, ethical decision-making, societal issues impacting women's health and disability, team functioning, negotiation skills and conflict resolution remains subsumed by the perceived weight of 'scientific' knowledge and competencies to be taught. These curricular inadequacies are recognized, but have been exacerbated by the lack of relevant teaching material, and the lack of individuals in the profession with the requisite teaching expertise. Thow and Murray (1995) discuss how physical
therapy education at the undergraduate level generally addresses 'humanities' issues within the collective subject title of behavioral sciences covering sociology, psychology and communication studies. Their concern is the lack of value attributed to this type of curricular content. They question where and how these elements of practice are addressed for clinicians given that continuing education courses are predominantly geared towards developing and enhancing clinical skills. Hunt, Adamson and Harris (1998) identified the need for physical therapists to develop "knowledge and skills additional to those directly pertaining to the client - therapist interface but that there are few data on which to base decisions for curricula changes" (p. 125). They investigated the perceptions of 239 physical therapists regarding the adequacy of their undergraduate education in equipping them for their current workplace. The results indicated that physical therapists perceived important gaps, particularly in the areas of communication with clients, coping in the work place, knowledge of the health industry and workplace management. Communication skills are a widely accepted dimension of physical therapy education but Murray (1997) suggests that the recurrence of 'communication' as a problem or issue in clinical practice is a denial of the complexity of communication in health care settings. She poses the question "are we being taught to make interpretations of the illness not of the words which people use to describe their experience of it" (p. 26)?

The 'art' of physical therapy might be defined as those skills and abilities that facilitate the therapeutic relationship between client and therapist. These skills and abilities are, increasingly, being considered as competencies 'shared' by health professionals that facilitate interprofessional shared decision-making in the clinical setting (Bainbridge & Harris, 2001). However, perhaps because of the shift of practice to the private sector and the trend towards evidence based practice, many academic programs have found it hard, in an overburdened curriculum, to carve out the time to consistently integrate this type of material into the course work. This alternative view of practice can be called the 'professional - artistry' model (Schon, 1987). Authors, both in physical therapy and other health care disciplines, (Fish & Coles, 1998; Higgs & Titchen, 2001; Shepard & Jensen, 1990; Thow & Murray, 1995) have suggested that
adoption of this type of model of practice will better prepare clinicians for the increasingly complex health care issues to be faced in the future. It is at this point in professional development that physical therapy finds itself in the new millenium. However, there are considerable differences in the curricular decisions made by individual academic programs, and curricular change; and the acquisition of faculty with different areas of expertise occurs slowly.

The Characteristics of Rehabilitation Care

Definitions of Rehabilitation

A typical definition of rehabilitation is provided by Heruti and Ohry (1995) as the development of a person to the fullest physical, psychological, social, and vocational potential consistent with that individual's impairment and environmental limitations. Rehabilitation services are generally conceptualized as providing support across the health continuum and are defined in relation to the World Health Organization (ICIDH) International Classification of Impairment, Disability and Handicap (1980). In this service model, impairments require medical and restorative interventions and maintenance rehabilitation; disabilities require adaptive equipment and reduction of physical and attitudinal barriers; and handicaps require support services and advocacy for independent living. In a broader sense, rehabilitation incorporates primary care in acute care facilities, health promotion and prevention of injury, disease, and disability, and in a global sense, it incorporates advocacy and collaboration with other agencies to address more general societal issues and policies. There are some inherent problems in aligning rehabilitation services with classification systems such as the ICIDH\(^1\) (and its successor ICIDH\(^2\)) as they are fundamentally concerned with defining and differentiating difference, and present disability as a static state (Oliver, 1996). Badley (1998) outlines the potential uses for a system of disability classification, for example, clinical record keeping, assessment of disabilities, and determining eligibility for services and programs; all of which appear to benefit health care professionals rather than clients.

These concerns reflect, in my opinion, the degree to which rehabilitation continues to be influenced by the ‘biomedical model.’ In recent years, partly in response to the growth of the disability movement, there has been a call for the development of new models and theories
which could contribute to a different conceptualization of rehabilitation (Hammell, 1992; McColl, Gerein & Valentine, 1997). Examples of such theoretical alternatives are the 'social theory of disability' and the 'educational model of rehabilitation.' The social theory of disability (independent living model) locates the problems faced by people with disability in the institutions of the societies in which they live. According to Oliver (1996) this theory must derive its meaning from “within the experience of disabled people themselves and their attempts, not only to define disability but also to construct a political movement amongst themselves and to develop services commensurate with their own self-defined needs” (p. 11). Disability, from this theoretical perspective, results from failure of the social environment to adjust to the needs of people with disabilities rather than from their inability to adjust to the requirements of society (Barnes & Mercer, 1996). This theory has had a major impact on the development of disability policy, and on consumer participation in decision-making and advocacy.

The educational model of rehabilitation focuses attention on re-defining the role of the client and health care professional in the rehabilitation process. Bartlett & Windsor (1985) defined the educational model in terms of the devolution of power to the client. Caplan, Callahan & Haas (1987) considered the goal of the educational model to be the restoration of the client’s long-term autonomy with early decisions being made by professionals guided by the principle of beneficence. The aim of the educational model is to discourage client dependence and promote the assumption of individual responsibility. It requires a realignment of the power and authority traditionally invested in the physician and other health professionals. The power of the client and clinician is seen as essentially equal. However, their power has a different basis. The practitioner’s power comes from having the knowledge of health and disease, from being a resource and from being able to provide assistance as required by the client. The client’s power, in this model, derives from the fact that they can ultimately decide whether the advice and information is relevant to them (Bartlett & Windsor, 1985). The social theory of disability and the educational model of rehabilitation, in different ways, challenged the biomedical model of service provision. These theoretical perspectives can be linked to the evolution of client-centered practice and the enhanced role of the interdisciplinary team in current rehabilitation practice.
Client Centered Care.

Enzmann (1997) suggests that the traditional understanding of a professional is being undermined because the market has experienced a radical change from technology-driven to customer-driven. In a technology-driven market, professionals understood and had control of the development, production, delivery, cost and use of the technology. According to Enzmann (1997) "the halcyon days of health care were an example of a technology driven market" (p. 7). Evidence is rapidly accumulating that health care has shifted to a customer-driven market (Bainbridge, Matthews & Ryan, 1996; Enzmann, 1997; Sutherland & Fulton, 1994; Rachlis & Kushner, 1994). Members of society are better educated, are facing issues of chronic disability and aging, and can access much more information. Health care professionals are finding that many of their recommendations are being questioned or challenged. In addition, the shift from institutional to community care places the onus of responsibility on the client and their support system (Sutherland & Fulton, 1994). These changes did not happen overnight; in fact, the transition from professional oriented service to client-centered care has been (and continues) in process for several decades. More active patient involvement in health care was first noticeable in the legal arena with the shift towards informed consent and the primacy of patient autonomy. In British Columbia precedents have been set in civil proceedings which suggest that full disclosure of relevant information must be tailored on an individual basis, and legislation such as the Freedom of Information and Protection of Privacy Act of BC enacted in 1995 begins to shift the power from professional to client.

The concept of client-centered health care is changing society's understanding of professional practice. Client-centered practice has been described as a collaborative approach to practice that encourages client autonomy, choice and control and that respects clients' abilities and supports their right to enact these choices (Canadian Association of Occupational Therapy, 1997). Each health care profession is currently engaged in discussions about how clients should be effectively involved in the therapy process. There is a proliferation of theoretical models of client-centered care in the health care literature; however, little is written, particularly in the physical therapy literature about how it can be realistically incorporated in practice. There is
considerable ambiguity related to the terms used, which include client-centered, client-driven, patient-centered, and patient-focused care. The use of the word 'patient' appears to emanate from an institutional or hospital setting whereas the word 'client' refers to people receiving services in the community or from a specific health care professional, such as physical therapy. Gage (1995) addresses the confusion over professional use of the terms 'client-centered care' and 'patient-focused care,' each of which represent a different interpretation of professional practice. She describes 'patient-focused care' as representing an attempt to decrease the number of personnel associated with each patient and to "... increase the skill set of each employee through cross-training" (p. 201). She hypothesizes that this model of care stems from a management source rather than from expressed client needs or wishes. The confusion over terminology contributes to the anxiety being created among health care professionals who see professional autonomy and scope of practice being eroded (Bainbridge, Matthews & Ryan, 1996).

What is evolving is an enabling model rather than a prescriptive model of health care delivery in which the professional will serve more as an educator and consultant (Baum, 1998). However, a major issue for physical therapists, who are aware of the need to provide service that is relevant to individual clients’ expressed goals, is how they can incorporate the concepts of client-centered practice into their daily work and resolve the potential conflict with the demands of evidence-based practice (Sumption, 1997). The latter is also an ambiguous term variously used with reference to evidence of effectiveness, efficacy, outcome measures, client satisfaction with services and clinical research. Interestingly, in contrast to a dearth of physical therapy literature related to client-centered care, there is a profusion of work published on evidence-based practice. I suggest that this is, in part, the result of the profession’s close ties to medicine. There are considerable pressures exerted on professionals to ensure that their interventions and practice is based upon sound research evidence (Bainbridge, Matthews & Ryan, 1996; Harrison, 1998). Harrison (1998) suggests that outcomes research provides knowledge of what is likely to work based on probabilistic models, rather than how or why it works. In rehabilitation, where clients are attempting to assimilate the effects of injury and disease into the continuum of their lives, therapy decisions based on the 'best available evidence' may not correspond with care plans
which focus on the client’s wishes, short and long term goals, lifestyle and social support. It is my opinion that given the theory – practice gap in physical therapy, little in our education has prepared us either for client-centered or evidence-based practice, and certainly not for the dilemmas arising from trying to incorporate them simultaneously into practice.

I have discussed up to this point the professionals’ role in client-centered care. However, this model of care demands a level of responsibility from clients accessing health care services which may be unrealistic given the exigencies of their illness or injury, and their resulting dependence on health care professionals. Nowhere is this more evident than in rehabilitation settings. The rehabilitation process is a lengthy one. Initially, clients and their support group typically lack the basic knowledge to grasp the probability of permanent disability (as when a person sustains a spinal cord injury or cerebrovascular accident) or the uncertainty of prognosis (as with progressive neurological conditions like multiple sclerosis). Compounding this lack of knowledge is, at best, a marginal understanding of the content and process of rehabilitation. Clients’ expectations of recovery and their future capabilities are more likely to derive from hearsay or the media depictions of individuals with disability than from fact (Caplan and Reidy, 1996). As Caplan, Callahan and Haas (1987) suggest, clients at this stage are typically trying to accommodate to a new or exacerbated impairment, and are vulnerable because of pain, fatigue, anxiety or depression. In the early stages, their ability to integrate new and frequently distressing information is further compromised by a variety of medications and sleep deprivation. Self-esteem and confidence in their capabilities may initially be lost making clients particularly dependent for a period of time on health care professionals (Carpenter, 1994). Rehabilitation professionals encourage clients to assume an active role in designing their programs but the situation described is hardly an ideal one in which to engage in optimal learning or assume responsibility for defining goals and decision-making.

The client is required to interact, and take into account the opinions and values of a diversity of other individuals; their family and friends, the interdisciplinary team members, third party payers, and legal counsel to mention but a few. The values of health care professionals, while not always explicitly acknowledged, are inextricably present at every step in the
formulation of treatment plans (Caplan, Callahan & Haas, 1987). Wegener (1996) identifies a rehabilitation ethic, "the medical counterpart of the Protestant work ethic," (p. 6) which emphasizes performance-oriented goal attainment where civility, cooperation, and independence are highly valued. Physical therapists, in particular, are oriented to improving physical capabilities and mobility, and functional independence. Enhancing quality of life is considered rehabilitation's ultimate goal, but quality of life is an elusive and intangible concept and one only identifiable by each individual client. This goal may be lost in the focus on performance, outcome and cooperation (Gerhart & Corbet, 1995).

In addition, as Gerhart and Corbet (1995) suggest, "many health care professionals - those who work to preserve quality of life - have ambiguous feelings about life after [a disability such as] a spinal cord injury is sustained" (p. 111). There is evidence that health care providers are simply incorrect in the assumptions that they make about disability and that these values, shaped by society at large, have a negative impact on individuals' ability to assume responsibility for their rehabilitation goals (Carpenter, 1994; Gerhart & Corbet, 1995; Hammell, 1998; Johnson, 1993; Lys & Pernice, 1995; Spencer et al, 1994). Dilemmas for the clients and health care professionals are rife in these situations, and can invariably be traced back to a lack of genuine communication, divergent expectations or outcomes, and unacknowledged values and beliefs about disability held by health care professionals (Meier & Purtilo, 1993). Literature describing the 'insider's' view of disability clearly articulates the desire of individuals with disability or chronic illness to make their own decisions. Their expertise lies in their experience of disability and their knowledge of what is meaningful about their lifestyles, social supports and context, and the amount of energy they wish to expend on therapy and rehabilitation. Jennings (1993) suggests that there are two ways of interpreting the goal of rehabilitation: (1) protecting the person with reduced capacity or expectations from failure, and (2) presenting hope that involves risk and hard work. He argues that each interpretation has moral implications related to the therapeutic relationship between client and professional. In his view, the second interpretation requires a mutually caring type of relationship, unique to rehabilitation, which is inconsistent with common bioethical definitions of client autonomy. Facilitating the assumption
The role of the interdisciplinary team in rehabilitation may be distinguished from other health care teams by the prolonged period of time within which they customarily interact with the client and by the diversity of outcomes addressed, for example, psychological, social and vocational outcomes, as well as medical outcomes. The team has traditionally involved physicians, occupational and physical therapists, speech language pathologists and audiologists, psychologists, social workers and nurses, with the physician assuming the leadership role. The idea is that the rehabilitation program is synergic, producing more than one professional group could accomplish alone (Caplan, Callahan & Haas, 1987). It is often asserted that the client is the most important member of the team; however, most rehabilitation clinicians are well aware that the ideals of effective team functioning and client centered care are fraught with difficulties (Caplan & Reidy 1996).

Clients, for example, may be excluded, often unintentionally, from assuming an active role in team decision-making. Members of a successfully functioning team develop feelings of collegiality towards each other. They frequently share common values and beliefs upon which their practice is based, and have an understanding of the role each discipline plays in the larger rehabilitation context. In contrast, the clients find themselves 'outsiders' within the team dynamics, and in unfamiliar territory in which they are not viewed as being 'sick' but are nonetheless unable to resume their normal lives (Strasser, Falconer & Martino – Saltzmann, 1994). Purtilo (1988) has described these structural components of the team as 'saboteurs' of clients' striving to stay involved in rehabilitation planning. Many professionals are aware of how daunting and demoralizing team involvement can be for clients but they are constrained by multiple individual and institutional forces, for example, scheduling issues, loyalty to other team members, managing roles and power differentials within the team, perceived lack of congruency
of the client's goals with those of the team, and official policies (Caplan, Callahan & Haas, 1987; Caplan & Reidy, 1996).

Teams operate with varying degrees of shared responsibility and accountability. Dysfunctional teams are not uncommon: teams which are characterized by, for example, a hierarchical structure, 'turf wars' between team members, fragmented communication, perceived alignment of one team member with the client and their family, disparate values, and conflicts over scarce therapy hours (Caplan & Reidy, 1996; Keith, 1991; Purtilo, 1988). Purtilo & Meier (1993) identify tensions which interdisciplinary teams may face when their goal to be client-centered comes into conflict with institutional constraints and third party payer policies. Strasser, Falconer and Martino-Saltzmann (1994) suggest that "although team care is central to rehabilitation, there is little consensus and few empirical studies [from the clients' or health care professionals' perspectives] on this inherently complex subject" (p. 177).

Banja (1992) draws attention to the comparative isolation in which health care professionals are educated which, as he points out, does not reflect the interdisciplinary context within which rehabilitation occurs. A number of authors (Banja, 1992; Drinka & Clark, 2000; Mariano, 1989; Purtilo, 1988; Thomasma, 1982) have written in support of the concept of interdisciplinary health care education. The concept of interdisciplinary education would seem to make all sorts of sense, however, while interdisciplinary initiatives (course, seminars or clinical fieldwork) involving physical therapists are increasing at universities in Canada they are still relatively few compared to the traditional discipline specific course offerings.

Working together on teams is an integral component of rehabilitation service that is not reflected in research or interdisciplinary education. An understanding of the everyday practices, values and beliefs of interdisciplinary colleagues and a recognition of the organizational constraints, shared by all professionals, that shape not only individual clinical practices but also the institutional environment, are learnt through experience in a serendipitous fashion. Conflict and fragmentation in decision-making in health care arises from the diverse and often seemingly incompatible perspectives of different health care providers (Geddes, Finch & Larin, 1999;
Grundstein-Amado, 1993). Some authors have explored different approaches to ethical reasoning (Grundstein-Amado, 1993; Uden et al, 1992) but their insights focused primarily on the differences between nurses and physicians. These differences were attributed to the two professions being educated to perform different tasks and assume different responsibilities. Barnitt (1997) drew some comparisons of the ethical reasoning of physical therapists and occupational therapists and attributed the differences to the socialization process to the respective professions inherent in the different academic and clinical education programs. Kevin Murphy, an ethicist at Providence Health Care in Vancouver suggested that, in addressing conflict situations, the role of the consulting ethicist was primarily one of creating a moral space by identifying organizational factors and the diverse opinions held by the disciplines involved rather than applying ethical principles or rules. Murphy characterizes different health care units and professions as different cultures that have to learn to speak cross-culturally (M. Burgess, personal communication, April 16, 2001). Dilemmas related to team functioning are, therefore, exacerbated by a limited understanding of the workings of the interdisciplinary process, different approaches to patient care and an absence of interdisciplinary education in health care (Strasser, Falconer & Martino-Saltzmann, 1994).

**Dilemmas in Rehabilitation Practice**

As discussed earlier in this chapter the literature addressing dilemmas of practice experienced specifically by physical therapists is limited. Discussions of dilemmas in the rehabilitation literature fall into three categories; staff-patient-family conflicts (Caplan & Reidy, 1996), ethical issues in rehabilitation medicine (Bach & Barnett, 1995; Banja, 1992; Banja & Bilsky, 1995; Callahan, 1995; Caplan, Callahan & Haas, 1987; Haas, 1993; Kuczewski & Fiedler 2001; Wegener, 1996) and the consumer perspective on biased decision-making following spinal cord injury (Gerhart & Corbet, 1995). The authors in the first two categories all acknowledge that “their exploration and analysis is a conceptual - anecdotal one” (Caplan & Reidy, 1996, p. 3).

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22) and that much more investigation of the issues in rehabilitation is needed. Banja (1992) explained this need for research by saying that "the field of rehabilitation not only struggles with problems over patient autonomy, informed consent, allocation of health care resources, discontinuation of treatment and other familiar bioethical issues, but also encounters a host of other concerns that are not commonly presented in acute care medicine" (p. 269).

Caplan and Reidy (1996) discuss some of the 'other' factors that can foster or hinder the development of good working relations among patient, staff, and relatives following a spinal cord injury. These included influences on staff such as institutional and professional demands as well as patient and family emotional response to injury, and disparities in knowledge leading to differences in expectations for rehabilitation. The issues raised in this article reflected my own experience as a clinician working in a rehabilitation setting, and is the only article I have read to date that offers a realistic analysis of the problems and strategies required to minimize conflict and maximize client involvement with the rehabilitation program.

Ethical dilemmas in rehabilitation settings have only recently received careful consideration. As Caplan, Callahan and Haas (1987) state "rehabilitation therapy is a long process, often allowing much time for moral struggles to unfold and play themselves out and as a result moral and ethical dilemmas in rehabilitation are different from those presented in acute care" (p.1). In contrast to acute care practice, the literature linking practice in rehabilitation to ethical considerations is singularly small. Dilemmas characteristic of rehabilitation arise from the interaction of the client with a number of factors. These factors include poorly defined model(s) of rehabilitation service delivery (Caplan, Callahan & Haas, 1987), the ideology or unstated goals of rehabilitation, and the biases and values held by health care professionals about disability and quality of life following injury or disease onset. Complex relationships between the client, family, support group, and the health care team members requires an attention to ongoing communication and provision of information not experienced in acute care (Bach & Barnett, 1995; Banja & Bilsky, 1995). Patient autonomy is challenged, certainly in the early stages of rehabilitation, by the 'biographical disruption' (Barnes & Mercer, 1996) experienced as
a result of onset of chronic illness or disability. The rehabilitation process is made more complicated by the number of professionals and the length of time involved. Admission and discharge criteria raise issues of resource allocation, which are poorly understood by both clients and health care professionals. Callahan (1995) suggests that the vulnerability of clients receiving rehabilitation services and the inadequate funding of rehabilitation compared to acute care, means that these decisions can be particularly difficult and demoralizing for all involved.

Wegener (1996) suggests that these issues and concerns, many of which are analyzed through an ethical lens in the literature, "will resonate for experienced clinicians" (p.7). This is undoubtedly the case, but the analysis to date has been mostly confined to authors whose focus is on the larger issues inherent in rehabilitation policy and the role of medicine in decision-making, and who assume a normative 'principled' ethics approach as the basis for interdisciplinary discussion. The cases selected for inclusion in biomedical ethics textbooks and courses pertain primarily to the acute care hospital settings and medically oriented issues (for example, Beauchamp & Childress, 1994; Beauchamp & Walters, 1992; Jonsen, Siegler & Winslade, 1992; Kluge, 1992; Parsons & Parsons, 1992; Sumner & Boyle, 1996). The result is a distancing of biomedical ethics from the realities of clinical practice as experienced by non-physicians. Despite the growing literature in health care ethics there has been little interest in collecting case material about ethical practice as experienced by practitioners in rehabilitation settings.

In summary, little is known about the types of dilemmas which physical therapists encounter at work and even less is known about the problems and issues related to rehabilitation provision of care. Without the articulation of this case material it is difficult for professional organizations to advise their members, for educational programs to prepare students adequately for practice, and for clinicians to benefit from the experience of others. Dilemmas of practice can arise from a diversity of sources, for example, interdisciplinary conflict, personal involvement with a client, issues of professional autonomy, resistance to administrative policies, resource allocation, and perceived client non-compliance. Simply describing complex and largely unresolved dilemmas would be less than useful in enhancing practice. Complex dilemmas are not
constituted in a vacuum and they are, in reality, frequently experienced in common with other health care disciplines working in the same setting, and related to contextual factors, such as, the organizational structure, interdisciplinary relations, and the interaction between individual professional cultures. This review of the literature has demonstrated that information on dilemmas in rehabilitation practice, particularly as experienced by physical therapists, is sparse and inconclusive. This review and my own clinical experience in the rehabilitation setting have lead directly to my perceived need for this study.
CHAPTER THREE: LOCATING THE RESEARCHER

The purpose of this chapter is to 'locate' myself as the researcher in this study by articulating the assumptions, beliefs, and knowledge about the physical therapy culture and practice and the context of rehabilitation that I brought to the research process. By relating these premises to the philosophical and methodological considerations that inform this study, it is my intention to provide a consistent justification for conducting the research and for the interpretative decisions I made in analyzing the data. This relationship of premises, philosophical and methodological considerations constitutes the theoretical lenses through which I viewed this research endeavour. In this chapter I will outline the premises that I brought to the research process as a result of being an experienced physical therapist, and discuss these in relation to the philosophical approaches of Alfred Schutz and interpretivism, and to ethnography as a methodological choice.

Exploring Physical Therapists' Experiences of their Everyday Practice

The physical therapists who agreed to participate in this study shared in common the larger context of the physical therapy professional culture; that combination of knowledge, skills, and values that serve to characterize the profession. It is this specialized expertise which confers status on the profession, and to some degree, defines the physical therapist's role in relation to the client or patient. Equally important components of the 'culture,' though perhaps more difficult to define, are the "internalized norms of the profession which create a form of self accountability or professional conscience" (Eraut, 1994, p. 227). This study specifically explored dilemmas of practice in rehabilitation settings as experienced by physical therapists. As a result the participants were all employed in settings that provide care for clients who have either acquired a progressive condition or sustained an injury which has resulted in disability. I suggest, later in this chapter, that the institutional rehabilitation setting represents a health care delivery system that is different from that provided in, for example, the acute care or long term care settings. The participants chose to practice in this specific type of setting and consequently share a particular health care delivery experience. It has been my experience, however, that even within this shared
work environment, individual physical therapists will name different practice issues as dilemmas, and that when the same situation or event poses a dilemma to several physiotherapists, they will each have different perceptions and assign a different significance to that dilemma. These differences can be expected because each individual brings to each situation their own unique experiences, values and beliefs. My interest in exploring dilemmas of practice in rehabilitation and the meanings practitioners attribute to them is congruent with an interpretivist approach to inquiry.

At the core of the interpretivist approach is an interest in understanding the complex world of lived experience, and a respect for the perspective of those individuals who live and interact within that world. The goal of interpretive inquiry is the grasping or understanding of the ‘meaning’ of social phenomena. It was Alfred Schutz (1962, 1967) who analyzed this core concept of interpretive understanding (verstehen) in attempting to bring together phenomenological subjectivity and scientific objectivity. Schutz argued that inquiry should focus on the world of lived reality. This idea of a life world encompasses “the whole sphere of everyday experiences, orientations, and actions through which individuals pursue their interests and affairs by manipulating objects, dealing with people, conceiving plans, and carrying them out” (Schutz, 1970, p. 14). The life world is the common-sense world that every person takes for granted. For Schutz (1967) this everyday world is the realization of a philosophy of mundane reality or a phenomenology of the natural attitude. The natural attitude, according to Schutz (1970), is a stance by which the individual operates in the life world. This is a stance that posits experience – the matrix of daily life – as fact rather than raising serious or persistent questions concerning the nature of the everyday world experience.

This common sense reality is comprised of historical and cultural forms held in common by individuals, but the manner in which these forms are translated in each individual’s life depends on an individual’s total experience. This totality includes for Schutz (1967) each person’s “biographical situation” which includes special interests, motives, desires, aspirations, religious and ideological values, through which each individual interprets what they encounter in
the world of social action. It is important for Schutz (1967) that this world be recognised as intersubjective, that is, a world where people come into relationship with each other and try and come to terms with each other as well as with themselves. He takes this world as the paramount reality in which communication has its primary locus.

Schutz (1967) provides a descriptive analysis of the typifications inherent in the common-sense world to shed light on the nature of intersubjectivity. Everyday life is interpreted in typical ways within a framework of familiarity. What is perceived as unusual or troublesome arise against this background of the ordinary and familiar. Whilst individuals cannot directly adopt the perspective of another individual it is possible to attribute to another a reciprocity of perspectives. It is this that makes it possible to share a reality, and take much of the life world for granted. The participants in this study shared a commonality of context and professional education, and as a result some of the dilemmas identified resonate for others involved with the study. I anticipated that in the data analysis phase of this study, common themes or categories of dilemmas would be identified but that, within those themes, individual interpretations of the dilemmas would be different.

In asking the participants in this study to share their personal understanding of dilemmas of practice I assumed that the dilemmas they described were uniquely defined by each individual through a process of reflection. Boyd and Fales' (1983) definition of reflection seems to be particularly apt for the process I asked the participants to engage in:

Reflection is... the process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective (p.100).

Reflection is often triggered by a realization that the knowledge that we are applying to a situation is not in itself sufficient to explain what is happening. It is argued (Argyris & Schon, 1974; Eraut, 1994; Fish & Coles, 1998) that the use of reflection encourages practitioners to make explicit the knowledge that helps them interpret practical situations (theories-in-use), and compare them with potentially valuable publicly acknowledged or espoused theories which are
rarely aired. The underlying assumption is that reflective practice can promote the links between theory and practice; that it can assist professionals to reconstruct their theories of practice especially when this is facilitated by interaction with colleagues. In this way theory emerges from practice and conversely, by being theorized practice gains meaning.

Much of the literature on reflective practice can be traced to Schon's (1983, 1987) development of a model of professional problem solving in which he differentiates two types of reflection: reflection-in-action and reflection-on-practice. He describes the former as the process by which a practitioner reacts to the inconsistencies inherent in a situation by rethinking their tacit knowledge, re-framing the situation, and making new action decisions. In contrast, reflection-on-practice takes place after the event, or we may pause in the midst of action, allowing more time to consider action options and their potential consequences. According to Schon (1987),

[reflection-on-action] has no direct connection to present action, [whereas reflection-in-action] occurs in an action-present - a period of time, variable with the context, during which we can still make a difference to the situation at hand - our thinking serves to reshape what we are doing while we are doing it (p. 26).

In practice, however, the difference between the two types of reflection is blurred. Argyris and Schon (1974) also posed an earlier theory of reflective practice based on the concepts of single-loop and double-loop learning. By their definition, single-loop learning represents a feedback mechanism that links behavior and pre-existing expectations, and this probably represents most of the routine decision-making that occurs in everyday practice. Double-loop learning, on the other hand, focuses on understanding not only what we do but also on why we do it, and involves a process of self-reflection about the assumptions that influence action. I assumed that as a result of participating in this study, the physical therapists involved would be encouraged to reflect on the dilemmas they experience in the course of their everyday practice by, to use Schon's terminology, engaging in reflection-on-practice and double-loop learning.

Using reflection to develop practice knowledge can at times be problematic. Eraut (1994), I think, echoes the experience of many clinicians when he suggests that the daily reality of professionals is one where deliberation may be more the exception than the rule. Many
of professionals is one where deliberation may be more the exception than the rule. Many professionals are "confronted with waiting clients, loaded in-trays and calls for efficiency gains [and as a result] plans get 'cobbled together' in a hurry, decisions are made 'on the hoof' and symptoms are treated instead of attending to the problems they disclose" (p. 149). This is not an environment conducive to reflective contemplation of dilemmas arising from practice but one which, in my experience as a clinician, mirrors the reality of practice in rehabilitation delivery of care. Another problem may be that experience and the resultant insights and expertise may be devalued and also the knowledge generated is considered less credible because of the taken-for-granted and commonsense nature of practice. In this study I asked the participants to identify, describe and critically analyze these unique practice situations. Their willingness to be involved in the study suggested both the desire and ability to reflect on situations they perceived as dilemmas of practice, and that they shared with me the assumption that reflection about practice is important. At the same time, my expressed interest in learning about dilemmas of practice in rehabilitation settings and my involvement with them over time may have facilitated this reflective process by providing a space and more time than is readily available in the 'everyday' world of health care.

For some authors, Schon's account of professional practice is lacking consideration of other contextual features of professional life, for example, resource allocation, economic, legal and advocacy issues (Eraut, 1994). These features did form part of the participants' discussions of their dilemma experiences. Incorporation of such considerations into the process of thinking about dilemmas has been described as critical reflection (Brookfield, 1987; Mezirow, 1990, 1998). Critical reflection is a form of critique which is capable of analyzing and challenging the habitual ways of thinking and acting and the stereotypical notions about human action and social organization that underlie our actions, and questioning the universal truths inherent in some authoritative statements, policies or justifications (Brookfield, 1987). Mezirow (1998) sees critical self-reflection as involving a critique of the assumptions upon which an individual has defined a problem. Issacs (quoted in Qualters, 1995, p. 50) considers that it is dialogue which takes reflection through the extra step to critical reflection. He refers to this step as 'triple-loop
In order to move to understand a particular social action, Schutz (1962, 1967) seeks to grasp the meanings that constitute that action, that is, to gain an understanding that goes beyond the taken-for-granted. Action here is differentiated from an act. Action is a series of experiences being formed in the concrete and in individual consciousness and which takes place in internal time – consciousness (1967, p. 39). The idea of discovering the ‘meaning’ of actions is central to Schutz’s approach to inquiry. He is clear in defining the use of ‘meaning’, not as a way to indicate “a new, additional, and secondary experience which is somehow attached to the first… [or as] a predicate of an individual experience (1967, p. 42) as in ‘having meaning’ or being ‘meaningful, [but] that meaning is a certain way of directing one’s gaze at an item of one’s own experience” (p. 42). As Schutz (1967), drawing on the work of Husserl, suggests “it is only after I bracket the natural world and attend only to my conscious experiences within the phenomenological reduction, that I become aware of this process of constitution” (p. 37). Schutz (1967) suggests that “this act of attention [directing one’s gaze] presupposes an elapsed, passed away experience, one already in the past regardless of whether the attention in question is reflective or reproductive” (p. 51) or simply apprehended. In other words, the meaning of an experience “only becomes visible to the reflective glance.” (p. 52).

This reflective glance can change something that was taken for granted to a phenomenon which is problematic. The meaning attributed to a phenomenon is essentially subjective and is, in principle, confined to the self-interpretation of the person who lives through the experience to be reflected upon and interpreted. Schutz (1967) defines interpretation as “the referral of the unknown to the known, of that which is [merely] apprehended in the glance of attention to the schemes of experience” (p. 84). These schemes “consist of material that has already been organized under categories,” they constitute “what one knows” or “what one already knows” (p. 84), or our stock of knowledge. In this sense schemes of experience are interpretive schemes. In this study the focus of each interview was to encourage the participants to critically analyze the dilemmas they described in as much detail as possible. In order to do this each participant drew
on their own unique professional experiences as well as their personal framework of beliefs and values.

This might suggest that interpretive inquiry, and gaining an understanding of another’s experiences, is impossible. Schutz (1967), however, simply views it as underscoring the uniqueness of each individual’s interpretations, as he says “the point is that the meaning I give to your experiences cannot be precisely the same as the meaning you give to them when you proceed to interpret them” (p. 99). In ordinary life we call a halt to the process of interpreting other people’s meanings when we have found out enough to answer our practical questions. This study aimed to expose to scrutiny a diversity of dilemmas as experienced by physical therapists in the rehabilitation setting. I suspect that the participants initially viewed these dilemmas as an integral part of their everyday life and not as the topic of a research study. Dilemmas in rehabilitation tend to be taken for granted as compared to those more debated ones arising from practice in an acute care setting. As Schutz (1967) says “the taken for granted is always that particular level of experience which presents itself as not in need of further analysis” (p. 74). As an inquirer, therefore, I was interested in making these taken for granted dilemmas problematic. For the purpose of this study, I provided a definition of dilemma which was couched in as broad terms as possible. My aim in doing this was to discourage the participants from dismissing or censoring situations which they might have judged as being too mundane to be the focus of discussion or research.

The final assumption, related to the participants, that I brought to this study is that I viewed all the dilemmas described by them as being equally valuable. I purposely used as broad a definition of 'dilemma' in this study in order to avoid coming to the research with an a priori concept of what constitutes a dilemma. I endeavoured to adopt a non-judgemental approach believing that the participants were sharing in good faith with me their interpretations of their dilemma experiences. The ontological premise underlying this assumption, congruent with a qualitative approach to research, is that participants in research construct the 'reality' not the researcher. The assumption in this study is that 'knowledge' and 'reality' cannot be separated from the values and interpretations of the individual participants, their professional context, personal
interests, and reasons for being involved in the study. This premise is congruent with the notion, central to interpretivism, that all human behaviour or action is purposive. As Schwandt (1994) says “social agents are considered autonomous, intentional, active, goal directed; they construe, construct, and interpret their own behaviour and that of their fellow agents” (p. 120). Interpretivism is concerned with the context of the status quo, it has as a central goal the understanding of the here and now reality, and that reality can never be known apart from the interests, purposes, and theoretical dispositions of those involved in the inquiry.

**The Context of the Physical Therapy Culture and Practice in Rehabilitation Settings**

Schutz (1962) conceptualized the act of scientific inquiry as requiring the cognitive style of the ‘disinterested’ observer. However, this does not necessarily deny the fact that in order to understand the intersubjective meanings that participants’ attribute to actions, the inquirer may have to “as a methodological requirement, ‘participate’ in the lifeworlds of others” (Schwandt, 2000, p. 193). It was, therefore, important that as the inquirer, I clearly articulated the assumptions which influenced my understanding and experience of the physical therapy culture and of clinical practice in rehabilitation settings. These assumptions and experiences mean that I had an ‘insider’s’ understanding of the participants’ everyday reality and the context in which they operated and made achieving a neutral or disinterested attitude unrealistic.

My experience as a member of the physical therapy culture, like the participants in this study, is based on the history of the profession and contemporary developments in education and practice. These have been described in detail in Chapter Two and I have summarized what I consider to be the major assumptions that, as a result, I (and potentially the participants) hold about the profession and which I brought to this study in Table 3.1.

These basic assumptions held by the physical therapy profession have led to a number of ‘tensions’ between the ‘art’ and ‘science’ of practice, and client-centred care and evidence-based practice, and are related to maintaining ‘ideal’ standards of care in the current health care environment. Physical therapists frequently speak of the ‘art’ of their practice by which they mean the complex integration of clinical decision-making and judgements, communication skills and empathy that constitute their professional expertise. Curricular content supporting the ‘art’
Table 3.1

Assumptions held by the Physical Therapy Profession

<table>
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<th>The physical therapy profession is:</th>
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<td>• an applied science with theoretical traditions related to the biomedical model (Pratt, 1989; Richardson, 1999b; Roberts, 1994; Sim, 1990);</td>
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<tr>
<td>• committed to evidence-based practice (Bithell, 2000; Cole, Finch, Gowland &amp; Mayo, 1994; Harris, 1996; Jette, 1995);</td>
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<td>• empirically or 'action-oriented' rather than theoretically based (Roskell, Hewison &amp; Wildman, 1998; Tammivaara &amp; Shepherd, 1990);</td>
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<tr>
<td>• client-centred (Bainbridge, Matthews &amp; Ryan, 1996; Sumson, 1997);</td>
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of practice is frequently subsumed by the 'scientific' dimension of physical therapy knowledge (Hunt, Adamson & Harris, 1998; Thow & Murray, 1995). The latter has been further reinforced by the recent emphasis on strategies, such as outcome measures, evidence-based practice, and clinical practice guidelines, derived from 'valid' and 'reliable' research (American Physical Therapy Association, 2000; Cole, Finch, Gowland & Mayo, 1996; Klassen, Grzybowski & Rosser 2001). Harrison (1998) reflects my own experience when he points out that health professionals are caught in a conflict between accountability strategies based on an empiricist/positivist epistemology that is used to support treatment and allocation of resources, and the client-centred/community approach being implemented in health care.

The concept of client-centred care is radically different from the patient-oriented approach of the past and is linked with a new pattern of involvement of the client with health care. In the past, as a physical therapist working in rehabilitation, I defined my role in terms of
the time I spent on one-to-one treatment with the patient. However, in reality, treatment decisions were based almost solely on my interpretation, as a health care professional, of what would benefit the patient. Client-centred care has redirected attention to the centrality of the client and/or their family’s goals as the focus of all health initiatives. The transfer of services to a community base from the more traditional acute care base has had a major impact on client and community involvement in decision-making at all levels and is requiring a new approach by health care providers (Bainbridge, Matthews & Ryan, 1996).

The move to establishing care in the community began in the 1970's partly in response to the de-institutionalization movement and partly to the increase in elderly persons needing care (Crichton & Jongbloed, 1998). Community care includes such services as, for example, home attendant care, home nursing, physical and occupational therapy services, palliative care, adult day care, respite care, short stay assessment and treatment centres (Vancouver/Richmond Health Board, 2000). Concomitantly, regionalization and rationalization of resources have resulted in new ways of delivering services at reduced cost, involving downsizing of institutional facilities, flattened organizational structures, multiskilling, and decreased length of stay for patients (Bainbridge, Matthews & Ryan, 1996). In my experience, clients with chronic conditions or disability frequently require care or services which are not medical, and physical therapists are required to not only negotiate with clients but also to form collaborations with a diversity of groups involved with institutional and community delivery of services.

Clients and their families are becoming better informed and have increased access to health related information through the internet and advocacy groups (B. C. Paraplegic Association, 2001). The community approach expands those involved in health care delivery beyond the traditional interdisciplinary team to include, for example, people with disabilities, their families and advocacy groups, third party payer representatives, personal care assistants, massage practitioners, alternative therapies, recreation and exercise therapies, medical equipment and transportation specialists. As a result, the boundaries between specialist knowledge and skills and the professional scope of practice become blurred as more professionals (from both mainstream and complementary health care) interact with increasingly well-informed clients.
(Bert Forman, Director of Rehabilitation Services, B.C. Paraplegic Association, personal communication, February 2001). It is apparent from my discussions with practitioners in rehabilitation settings that current physical therapy practice involves less 'hands-on' treatment than in the past and more activities, such as, liaising with other service deliverers, discharge planning, seeking funding and ordering equipment and teaching care givers. As the boundaries between service provider and client knowledge become more permeable the physical therapy profession appears to be responding by becoming more focused on developing practice guidelines, outcome measurements and generating evidence for the efficacy and effectiveness of specific interventions.

This discussion reflects my understanding of the values which underpin the practice of physical therapy and some of the assumptions I hold about the effects on physical therapy practice, particularly in the rehabilitation settings, resulting from recent changes in health care service delivery. These seem to me to reflect central features of the ideology of physical therapy professionalism – specialist knowledge, autonomy and clinical expertise, and echo an underlying concern about what counts as knowledge in the profession and who can claim to be the knower. In a sense these assumptions and beliefs represent what I take for granted about physical therapy practice. Interpretive inquiry relies on the language by which informants convey typical activities and knowledges. In this way ‘knowledge’ and ‘reality’ can not be separated from the values and subjective interpretations of the informants, their specific social context or from the interests, purposes and assumptions of the inquirer.

Informants adopt a reflective attitude, describe with their own words what is going on their worlds, and in answering the questions that the inquirer asks of them, they interpret what is usually taken for granted. The inquirer then explains and interprets what has been heard in relation to their own theoretical interests. This is the first step towards the construction of what Schutz (1967) calls ‘second-order constructs,’ the insider’s interpretations of the social world as received through the inquirer’s interpretations. In this way, Natanson (1967) explains, “the method of verstenhen [Schutz's core concept of interpretive understanding] is employed in order to come to terms with the full subjective reality of the human beings [the inquirer] seeks to
comprehend" (p. xxxvi). For interpretivists there is no theory-free observation, and the practices and decisions inherent in scientific inquiry presupposes value judgements on the part of the informer and inquirer about what is known and important to know.

In this study, I was specifically interested in physical therapy practice within the 'social world' of rehabilitation delivery of care in institutional settings. In Chapter Two I discussed in detail the characteristics of rehabilitation provision of care which distinguish it from acute and long-term care settings. As a physical therapist with many years of experience in rehabilitation settings I have developed opinions about aspects of rehabilitation practice that I perceive as problematic, primarily, those related to the concept of client-centred care as it has been operationalized in rehabilitation settings. I felt that it was important to make these transparent early in the research process.

Rehabilitation, as described in Chapter Two, is characterized by the provision of service for individuals who have acquired a life-changing disability resulting from a traumatic injury or the onset of a progressive medical condition. As a result, rehabilitation is usually based in an institutional setting and clients generally spend a much longer period of time in these settings than, for example, in an acute care orthopedic unit following a hip joint replacement. This longer time period, which can be up to six months, allows physical therapists to develop a close relationship with their clients, and to more often adopt an advocacy role. The nature of this relationship requires that the physical therapist find an optimal point on what is a continuum of professional and personal involvement. This can be confusing and difficult for both the client and therapist, and while professional behavior guidelines are available these are frequently too abstract to be relevant to any but extreme infringements (Purtilo & Haddad, 1996). Rehabilitation is also characterized by interdisciplinary teamwork which exposes the client to a multiplicity of health care professionals in the course of their rehabilitation process.

This involvement, often of an intimate nature, with this diversity of specialists makes it difficult for clients, newly struggling to assimilate disability into their lives, to assume control over decision-making, and the self-responsibility which are central goals of a client-centred model of care. Typically, while there is a philosophical commitment to client-centred care in
rehabilitation, many practitioners are well aware of the difficulties of making implementation of such a model a reality (Caplan & Reidy, 1996). Their clinical experience with clients who have sustained disability makes them skeptical about the ability clients possess to develop 'realistic' goals and make informed, deliberative and reasoned choices concerning risks and benefits of treatment. These concerns are often used as a rationale to support perpetuation of a more traditional paternalist approach. Paternalism casts the health team members in the role of advocating for the client's best interests. They are, it is presumed, in a better position, as a consequence of specialized skills, knowledge and clinical experience, to determine which interventions are the most appropriate (Caplan, Callahan & Haas, 1987; Caplan & Reidy, 1996).

There is a resulting tension between the client-centred model of care and this more traditional approach to rehabilitation practice. According to client accounts of rehabilitation (for example, Carpenter, 1994; Eisenberg & Saltz, 1991; Hammell, 1998; Klein, 1997; Martone, 2001; Reeve, 1998) clinicians continue to experience difficulty reinforcing independent decisions on the part of clients particularly when those decisions or behaviors run counter to professional opinions. As Caplan and Reidy (1996) comment "this is ironic in view of the fact that the raison d'etre of rehabilitation is to foster independence" (p. 22). In my opinion, this tension continues to have an impact on team functioning and effective practice in the rehabilitation setting as perceived by individual clinicians, and on the experience of clients and their families. Physical therapists "analyze the impact of injury, disease or disorders on movement and function" (Canadian Physiotherapy Association, 2000, p. 1). They have traditionally focused primarily on impairment and disability rather than handicap, that is, on loss or abnormality of physiological or anatomical structure or function, and the resulting restriction or lack of ability to perform an activity in a normal manner (World Health Organization, 1980). This focus has been reinforced by a 'scientific' approach to practice and a tendency to prescribe what ought to be done. This tendency, in my experience, creates a tension for those in rehabilitation who genuinely desire to be more client-centred and to address the disadvantages (handicaps) due to impairment or disability that limit or prevent the client's fulfillment of social roles (World Health Organization, 1980).
The characteristics of rehabilitation service discussed in Chapter Two represent the context of physical therapists' everyday practice in rehabilitation. They are the often taken for granted 'reality' of rehabilitation as experienced by those, myself and the participants included, who function within it. This 'reality' is really a number of constructs (or types) that are shared by those who choose to practice within this type of setting. These 'typifications' constitute the social world within which the participants apply their unique beliefs, values, theories and attitudes in making their experiences meaningful and giving them a semblance of familiarity. Typification then "organizes the flux of life into recognizable form, making it meaningful. In turn, as experience is given shape, the stock of knowledge is itself elaborated and altered in practice" (Gubrium & Holstein, 2000, p. 489). In designing and implementing this study it was my premise that physical therapists share a common professional culture and interact with one another in a rehabilitation institutional environment that is concurrently constructed and experienced in fundamentally the same way by them all. This is not to imply that individual participants in this study would interpret situations or problems in the same way but I took for granted that we intersubjectively shared the same reality and that we used and understood a common language in this particular context. The participants in this study did not necessarily visualize the profession in the same way I did; however, they did refer to my 'insider' knowledge of rehabilitation during their individual interviews. They did at times, in their discussions of specific issues, assume the existence of a shared understanding between us.

Intersubjectivity is thus "a social accomplishment, a set of understandings sustained in and through the shared assumptions of interactions and recurrently sustained in processes of typifications" (Gubrium & Holstein, 2000, p. 489-90). It forms the background against which individuals struggle to make sense of problems and unsettling situations. By exploring dilemmas of practice as they are currently experienced in rehabilitation I hoped to gain a more nuanced and contextualized understanding of how physical therapists experience the tension in their professional identity in relation to clients and other professionals in the 'reality' of rehabilitation care settings.

Smith (1993) suggests that it is useful to think of interpretivists as nonrealists. In his
view, they do not deny that reality exists independently of human thought (the realist approach) nor do they take the idealist position that reality exists only if perceived by a human mind. They argue that there is not much to be gained in continuing to hold on to the assumption of realism (in any of its forms) as a means of establishing an external referent point for distinguishing knowledge from opinion (pp 122-123). Rather, because the focus of inquiry is an understanding of ourselves in relation to others, 'truth' or knowledge becomes an expression of agreement among those concerned with an issue. Schwandt (1994) suggests that understanding through interpretation is to accept a particular way of being in the world or way of life, and that it is this ontological condition which puts the inquirer on the same plane of understanding as the informants.

My purpose, in discussing the assumptions I brought to the research in conjunction with the philosophical sources from which I drew, is to support the interpretative decisions I made during the data collection and analysis phases of this research. One of the criticisms leveled at the interpretivist approach is that of relativism, that all interpretive accounts are equally good or bad, worthy or unworthy, or true or false, in other words that there are no criteria or standards against which these accounts can be compared or evaluated. Since the concept of relativism is dependent on the acceptance of ‘true’ knowledge, which Smith (1993) defines as an “ahistorical phenomena dependent on the accurate representation of an external, independently existing reality” (p.130), interpretivists have difficulty addressing this criticism. There is an inherent tension between the interpretive research process and a concept of evaluation that implies standardized procedures and modes of reporting (Baxter & Eyles, 1997). There is, however, a need to assess the ‘truth value’ or ‘goodness of fit’ (Lincoln & Guba, 1985) of the interpretive decisions being made. The ‘truth value’ of research, for interpretivists, lies in the presentation of faithful descriptions or interpretations of human experience that the people having the experience would immediately recognise from those descriptions or interpretations as their own. This rigorous detailing of process also assists other researchers or readers to recognize the experience (Sandelowski, 1986). Of importance to interpretivists then are values such as openness, transparency and self-reflection that guide the research process.
The Researcher's Role

Ensuring that the researcher's role in the research process is clearly articulated is one way of establishing the rigor of qualitative research. I brought considerable clinical experience as a physical therapist in rehabilitation to my role as researcher. As a result my position as researcher, in relation to the participants, was one of an informed and knowledgeable 'insider.' While I have not practiced clinically for a number of years I have maintained my connections with rehabilitation practice through the clinical instruction of students, provision of workshops and seminars and involvement on a number of committees. The participants in this study knew of my interest in rehabilitation. I am also a long-standing member of the physical therapy professional culture.

One advantage of this experience is that I share a common language with the participants. As Taylor (1987) suggests "convergence of belief or attitude or its absence presupposes a common language in which these beliefs can be formulated" (p. 57). Much of this common language in a society (and health care can be thought of as a micro – society) is rooted in its institutions and practices and, therefore, constitutive of these institutions and practices. Intersubjective meaning gives people a common language to talk about social reality and a common understanding of certain norms that are frequently not articulated. I assumed that the participants and I would share some common meanings based on our shared experience of the everyday world of rehabilitation physical therapy practice. Taylor (1987) suggests that these common meanings are the basis of community but that they do not automatically represent consensus, rather "they can subsist with a high degree of cleavage," (p. 60). Common meanings can, therefore, be articulated differently by different groups and individuals within a society or group. It is this epistemological notion of meaning, as not simply being that of the individual but also of the communal, which is at the heart of Schutz’s social phenomenology and interpretivism.

It has been proposed, that in qualitative research, the researcher must be viewed as the key instrument (Bogden & Biklen, 1998). Many theorists, for example feminists and poststructuralists, demanded a critical evaluation of the researcher's role in the research process.
This debate has evolved as a direct response to those elements of qualitative research which reflected the concerns of the dominant quantitative paradigm, such as, the researcher being neutral and uninvolved, guarding against bias, and ensuring objectivity. Schutz (1962), for example, espoused the idea of the inquirer as one of disinterested observer, uninterested in shaping the world, but passionately interested in observing it (pp. 137 – 138). At the core of this stance was the idea of ‘bracketing’ or what Husserl called ‘phenomenological suspension’ (or epoche). The major criticisms of this detached approach are that participants are objectified, and it is unrealistic to trust in the elimination of the researcher as a person from the research process, or to divorce the process and final results from how and in what arena the results will be utilized. Ann Oakley (1981) in the conclusion of 'Interviewing Women,' calls this "the mythology of 'hygienic' research with its accompanying mystification of the researcher and the researched as objective instruments of data production" (p. 58). Her argument, which set the scene for challenging conventional approaches in qualitative research, is that scientific detachment "be replaced by the recognition that personal involvement is more than dangerous bias - it is the condition under which people come to know each other and to admit others into their lives" (p. 58).

From a positivist standpoint my 'insider' orientation as researcher would be labeled as 'bias,' and every effort would be made to eliminate it from the study design and implementation. Qualitative researchers consider ‘bias’ to be a misplaced term. Rather than biases, the researcher's knowledge and experience are seen as resources that can be used to guide data gathering and to understand their own interpretations and behavior in research (Olesen, 2000). The key is, as researcher, to critically evaluate how one is located with respect to the research topic and to the participants involved. Such an evaluation has been framed in terms of two concepts: positionality and reflexivity. Positionality is an issue of identifying the extent to which the research process, write up and dissemination, reflects the relationships between the researcher and the informants, the environment in which the research is conducted, the academic institution and publishers. This relationship needs to be critiqued in terms of influence, effects, power dynamics and imbalances, and veracity (Lather, 1991). Reflexivity entails articulation of
the deep-seated views and judgements that affect the research topic, including a full assessment of the influence of the researcher's background, perceptions and interests on the research process. This chapter is my attempt to clarify how my presence in the research influenced all phases of the research process. Other strategies designed to enhance rigor and ensure meaningful inferences are made from the study are described in more detail in Chapter Four.

**Ethnography – A Methodological Choice**

My research questions were formulated in terms of 'what' (what dilemmas are experienced?) and 'how' (how do therapists make meaning of these dilemmas or come to understand them?). The nature of my research questions meant that I wished to understand the subjective experiences of physical therapists as they are located within the real world of their practice. A qualitative research approach was chosen as most appropriate to address the complexity of the topic and to provide a detailed view of the therapists' perspectives. 'Qualitative research' is frequently used as an umbrella term to refer to a number of theoretical perspectives that share certain assumptions or characteristics (Carpenter, 1997). Some concerns have been raised in health care (for example Thorne, 1991, 1997) that this general use of the term has meant a loss of the fundamental theoretical underpinnings of qualitative research, that method has taken precedence over methodology. As my own profession begins to conduct qualitative research as a means of addressing some of the questions that arise in practice, it will be important to ensure that the theoretical and philosophical traditions from which the qualitative approach has evolved are incorporated into methodological decisions. It is not that one would like to see theory imposed to the detriment of research flexibility, but that the necessity for methodological integrity in developing knowledge will be undermined. In addition, there is some confusion in the literature regarding the terms ‘method’ and ‘methodology.’ For clarity, I shall use Harding's (1995) definitions of the terms as a basis for my discussion. According to Harding, *methodology* is the "theory and analysis" of the application of disciplinary knowledge (p. 112) while "a research method is a technique for gathering evidence." (p. 111).
Most researchers who work within the context of a recognized professional field adopt a theoretical or conceptual orientation. An example of this might be cultural anthropologists who are committed to a cultural interpretation and, in addressing the methodological question, frequently choose to conduct research using an ethnographic methodological tradition. Physical therapy, which is traditionally aligned with medicine and a positivist research approach, lacks a conceptual orientation or definitive theory which could guide the researcher to a particular qualitative methodology. Instead, qualitative researchers in physical therapy draw from other social sciences, in the case of this study, primarily education, sociology and anthropology in choosing an appropriate methodology.

According to Guba and Lincoln (1994) the methodological question is: how can the inquirer go about finding out what it is they believe can be known? In this study, I drew from the research methodology of ethnography as the most appropriate for gaining a detailed understanding of dilemmas of practice specifically as experienced in the rehabilitation institutional environment (for more details see Chapter Four). The term ethnography, confusingly, is used both to encompass a distinct methodology and as a description of a method of inquiry. Ethnography is a methodology that historically emerged from cultural anthropology with an emphasis on small scale societies. Traditionally, ethnography has been concerned with producing a detailed description and interpretation of the complex meaning systems people use to organize their behavior, to understand themselves and others, and to make sense of the world in which they live. Ethnography as a method has been co-opted by other disciplines (for example, health care professions) in recent years to examine phenomena experienced by groups of people in health care settings, for example, participants may share a profession, work site, a diagnosis or a lifestyle. These differ from the traditional concept of culture, but clearly an ethnographic methodology lends itself to the investigation of individual and shared experiences in these contexts.

There are a number of characteristics that are considered distinctive of an ethnographic methodology which I will briefly discuss. These are (a) the holistic and contextual nature of
ethnography, (b) the reflexive nature of ethnography, and (c) the end product that is called an ethnography (Boyle, 1994; Denzin, 1997; Hammersley & Atkinson, 1995).

(a) The Holistic and Contextual Nature of Ethnography

A central tenet of ethnography is that people’s behavior can only be understood in context (Hammersley & Atkinson, 1995). Ethnography is based on the fundamental importance of understanding the social world from the perspective of the interacting individual (Denzin & Lincoln, 1994), and that culture is learned and shared among members of a group and as such can be described and interpreted. For Tedlock (2000) “ethnography involves an ongoing attempt to place specific encounters, events, and understandings into a fuller, more meaningful context” (p. 455). For this reason, ethnography demands detailed descriptions of the concrete experience within a particular culture, and the social rules or patterns that constitute it. Boyle (1994) describes “fieldwork as the hallmark of ethnographic research – working with people for long periods of time in their natural setting” (p. 163), and Agar (1986) suggested that there is always an emphasis on direct personal involvement with the people in the study. While I did not, in this study, engage in observations in the field, I did choose to conduct multiple interviews with each participant to facilitate our mutual reflective process and collection of ‘rich’ data (see Chapter Four).

(b) The Reflexive Nature of Ethnography

Traditionally ethnography has been considered to be reflexive in character, implying that the researcher is a part of the world being studied and affected by it. Ethnographers strove to maintain their objective stance but were, at the same time, expected to analyze their unintentional impact on those being observed. Hammersley & Atkinson (1995) said that the recognition that we are part of the social world we study is not a matter of methodological commitment, it is an existential fact. In their view, researchers cannot avoid relying on their ‘common – sense’ knowledge of the informants nor can they avoid having an effect on the social phenomena being studied. The purpose of ethnography then is demonstrating understanding of a social world by producing valid and accurate descriptions of it, and developing an explanation of the common sense knowledge inherent in that world. These ethnographic accounts are therefore seen as a
combination of two knowledges – the participant's and the researcher's (Hammersley & Atkinson, 1995). The ethnographer cannot presume to be able to present an objective, dispassionate, distanced, non-contested account of other individuals’ experiences. As Denzin (1997) says “self-reflexivity is no longer a luxury” (p. xiii).

(c) The End Product that is called an Ethnography

Werner and Schoepfle (as quoted by Boyle, 1994) suggest that the current trend in ethnography has resulted in the ethnographic, holistic approach being applied to any social unit or isolatable group. My research interest appears to correspond to what Morse (1994) describes as focused ethnography, meaning a topic-oriented, small-group ethnography. In her view these ethnographies have generated descriptive theories about phenomena of interest and concern to health professionals. In this study, dilemmas of practice were not phenomena that I, as a researcher, could directly observe. They were the result of the reflective process engaged upon by the participants. The findings of this study did reflect, however, a combination of my own ‘insider’ knowledge of the rehabilitation and physical therapy practice milieu with a process of ongoing reflection and dialogue about dilemmas with the participants. The dilemmas experienced by physical therapists in a rehabilitation setting cannot be experienced or resolved in isolation of these contexts or the other health care professionals involved in providing rehabilitation service in that setting. For these reasons I have chosen to ground my research approach in an ethnographic methodology. By drawing on an ethnographic methodology, I hoped, not only to be exposed to a diversity of dilemmas in the course of my interactions with therapists but also, through their interpretations, to learn more about how the practice context and circumstances contributed to those interpretations.

Conclusion

This chapter represents my attempt to make accessible to the reader the assumptions and pre-dispositions I brought to this research and which contributed, hopefully in a positive way, to the outcome of this study. In this chapter I built upon information provided in Chapter Two in discussing generally held assumptions and values in relation to, first, the physical therapy culture and practice, and second, the characteristics associated with rehabilitation care which are
considered to differentiate it from acute care (see also Chapter Two). Embedded in my discussion of the physical therapy culture and practice are epistemological issues being currently debated within the profession of physical therapy. These are issues concerned with how, and by whom, physical therapy specialist knowledge is defined; the need to generate a sound theoretical foundation for the profession which is grounded in practice values; and, the development of evaluation and accountability strategies that reflect clinical practice realities and expertise. The characteristics of rehabilitation services are assimilated by practitioners as a result of exposure to the institutional setting and are directly related to the everyday experience of the practice. They define physical therapy practice in terms of relationships with clients and other professionals. The institutional system - the hierarchies, policies, and structures - frame individual practice. These assumptions are ontological issues concerned with the nature of the 'reality' in which the participants in the study practice and what can be known about it. In discussing these assumptions I drew from the theoretical work of Schutz and the interpretivist approach to inquiry and I chose an ethnographic methodology to support this study. My aim, in making transparent how, as the researcher, I was located in the research process was to enhance the integrity and rigor of this study.
CHAPTER FOUR: RESEARCH DESIGN: IMPLEMENTING THE STUDY

In Chapter One I introduced the topic of this thesis and my rationale for embarking on the study. The literature I reviewed in Chapter Two was drawn from a number of interdisciplinary sources in an attempt to capture the complex and unique nature of rehabilitation practice. The purpose of this review was to illuminate aspects of rehabilitation practice that could potentially contribute to a more structured exploration of dilemmas of practice which this study represents.

In Chapter Three I addressed my position as researcher in terms of the theoretical perspectives and the assumptions I hold about physical therapy practice in rehabilitation and which informed my choice of a qualitative methodology for this research. In this chapter I will give an account of how I implemented the study and what I learnt during the interview and data analysis process. I will describe the organization of the study in terms of data collection methods, ethical approval, informed consent, and how I recruited the participants. Finally, I will describe my approach to data analysis and the strategies I employed to enhance the rigor and trustworthiness of the research.

Research Methods

Data Collection

Interviews

The primary research method used in this study was the one-to-one ethnographic interview. In McCracken’s (1988) opinion the ethnographic or ‘long’ interview is one of the most powerful of qualitative research methods. It enables the researcher to have insight into the logic by which the participant sees the world and into the patterns that shape the life world and everyday experience of the individual. McCracken suggests:

That time scarcity and concern for privacy, stand as important impediments to the qualitative study of modern life. It is precisely these impediments that make the long interview so valuable as a means of inquiry. This research strategy gives us access to individuals without violating their privacy or testing their patience. It
allows us to capture the data needed for penetrating qualitative analysis without participant observation, unobtrusive observation, or prolonged contact (p. 11).

This study was dependent on the participants' engaging in reflection on their everyday experiences of dilemmas of professional practice, and sharing those reflections with me during the interviews. I chose to conduct a series of four interviews with each participant at intervals of approximately two months. Ten physical therapists participated in the study, each over a period of approximately eight months. The research process and timeline is outlined in Table 4.1 and the process of recruiting these individuals is described later in this chapter. It was my hope, by conducting interviews over a period of time instead of just one in-depth interview, that the reflective process would be enhanced both for myself and for the participants. It also seemed unlikely that dilemmas would be finite and that a series of interviews would give us the opportunity to re-visit and track ongoing situations.

I chose not to engage in participant observation ‘in the field’, given that the focus of the study was on the individual experiences of dilemma in rehabilitation settings rather than the situated production of problematic situations. Many of the dilemmas described by the participants were complex, evolved over a lengthy period of time, and involved a diversity of other people. These dilemmas were dependent on each participant’s interpretation of the unique circumstances and characteristics of each situation identified as problematic. Situations deemed problematic by one participant may not have been so for another. Many qualitative researchers differentiate between ethnographic interviewing and participant observation but as Fontana and Frey (2000) point out “the two go hand in hand, and many of the data gathered in participant observation comes from informal interviewing in the field” (p. 652).

All the interviews were conducted at locations chosen by the participants. Locations included my home and back garden, a workplace office, participants' homes, and a café. With the participants’ permission all the interviews were recorded and transcribed. I used a regular tape recorder and was fortunate that the participants were universally helpful in situating themselves in relation to the nearest convenient electrical outlet. I was also fortunate, that in the
Table 4.1: The Research Process and Timeline

<table>
<thead>
<tr>
<th>PARTICIPANT</th>
<th>INTERVIEW #1</th>
<th>INTERVIEW #2</th>
<th>INTERVIEW #3</th>
<th>INTERVIEW #4</th>
<th>FURTHER INVOLVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>KATE</td>
<td>PILOT STUDY</td>
<td>PILOT STUDY</td>
<td>January 13, 2000</td>
<td>March 16, 2000</td>
<td>August 1999 \nVerbal feedback on interview #1</td>
</tr>
<tr>
<td>Senior</td>
<td>July 29, 1999</td>
<td>August 18, 1999</td>
<td>Researcher’s home</td>
<td>Researcher’s home</td>
<td>September 1999 \nVerbal feedback on interview #2</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>July 31, 1999</td>
<td>September 6, 1999</td>
<td>Sent interview #2 transcript for review</td>
<td></td>
<td>January 2001 \nWritten feedback on initial definitions of emerging themes</td>
</tr>
</tbody>
</table>

| BARBARA     | September 24, 1999 | January 14, 2000 | March 20, 2000 | May 1, 2000 | January 2001 \nWritten feedback on initial definitions of emerging themes |
| Staff       | Participant’s home | Participant’s home | Participant’s home | Participant’s home | |
| physiotherapist | | | | | |

| SOPHIE      | November 15, 1999 | February 1, 2000 | May 1, 2000 | June 15, 2000 | January 2001 \nWritten feedback on initial definitions of emerging themes |
| Staff       | Facility office | Researcher’s home | Researcher’s home | Researcher’s home | |
| Physiotherapist | | | | | |

| VERONICA    | September 29, 1999 | January 5, 2000 | March 9, 2000 | May 11, 2000 | January 2001 \nWritten feedback on initial definitions of emerging themes |
| Staff       | Researcher’s home | Researcher’s home | Researcher’s home | Researcher’s home | |
| Physiotherapist | | | | | |

| Senior      | Participant’s home | Participant’s home | Participant’s home | Participant’s home | |
| Physiotherapist | | | | | |

| DAWN        | October 28, 1999 | January 24, 2000 | April 27, 2000 | June 19, 2000 | January 2001 \nWritten feedback on initial definitions of emerging themes |
| Staff       | Participant’s home | Participant’s home | Participant’s home | Participant’s home | |
| Physiotherapist | | | | | |

| RUTH        | November 24, 1999 | January 26, 2000 | April 5, 2000 | June 22, 2000 | August \nSeptember \nRequested copies of transcripts – no feedback provided. |
| Staff       | Facility office | Facility office | Facility office | Participant’s home | |
| Physiotherapist | | | | | |

| MICHAEL     | November 18, 1999 | February 15, 2000 | June 20, 2000 | Declined last interview | |
| Staff       | Facility office | Facility office | Facility office | | |
| Physiotherapist | | | | | |

| MARGARET    | September 22, 1999 | December 2, 1999 | May 19, 2000 | June 23, 2000 | |
| Staff       | Participant’s home | Participant’s home | Restaurant | Restaurant | |
| Physiotherapist | | | | | |

| JANINE      | September 22, 1999 | December 2, 1999 | March 14, 2000 | May 15, 2000 | January 2001 \nWritten feedback on initial definitions of emerging themes |
| Senior      | Researcher’s home | Researcher’s home | Researcher’s home | Researcher’s home | |
| Physiotherapist | | | | | |
course of the interviews, I had no recording mishaps as are so often reported by qualitative researchers dependent on the tape recorder and their own ability to operate it effectively under pressure.

The interviews were semi-structured, in-depth and interactive. By semi-structured I mean that they were loosely based on a series of open-ended, broad and non-directive questions (See Appendix 1: Sample Interview Questions) that initially defined the area of my research interest. Creswell (1998) notes that, whereas quantitative questions “ask ‘why’ ...with the intent of establishing an association, relationship, or cause and effect, in a qualitative study the research often starts with the question ‘how’ or ‘what’, so the initial foray into a topic describes what is going on” (p. 17). ‘Why’ questions require justification and are aimed at reinforcing an ambivalent point of view, whereas ‘how’ questions encourage story telling, or narrative and leave space for the narrator to make choices. With this in mind, the questions I developed were intended to provide some structure to the interview within which either the participant could diverge in order to pursue an idea or I, as the interviewer, could probe a topic more thoroughly. The core questions were informed by the insights I had gained from my discussions with colleagues, from my own experience and reviews of the literature. In conceptualizing these interviews I found Hammersley and Atkinson’s (1995) description to be useful. They suggest that the semi-structured interview is 'reflexive,' and closer in character to a complex conversation. The interviewer may be an active listener or on occasions 'steer' the direction taken by the interview as required to sustain the flow of the conversation. During the interviews I was able, in the most part, to respond to the participants' narrative ‘reflexively’ and ask more detailed questions as necessary. Throughout the interviews the participants’ descriptions of ‘dilemma’ situations were very detailed. It became apparent that these situations had many layers. As Janine said:

Your questions helped me to pick out the different levels of a situation that I’ve never thought about before. They make me think about what is it that is really bothering me, about the different aspects that contribute to it.
By re-listening to the earlier taped interviews I was able to recognize times when I had failed to encourage a deeper exploration or where my line of questioning had drawn a blank. In subsequent interviews I became more aware of how my own assumptions were impacting on my questioning and I was able to better encourage the participants to uncover the layers and to clarify what the core issue in the situation was for them.

Fontana and Frey (2000) suggest that "the use of language, particularly the use of specific terms, is important in the creation of a 'sharedness of meanings' in which both interviewer and respondent understand the contextual nature of specific referents" (p. 660). The participants all knew of my involvement in physical therapy and the field of rehabilitation. I had known four participants professionally for many years and the others knew of me through my role as Academic Coordinator of Clinical Education. We clearly shared a common understanding of the physical therapy culture and jargon and this contributed to gaining trust and establishing rapport in the initial interviews. The participants viewed very positively the fact that I had chosen to make their dilemmas of practice the focus of my Doctoral thesis and they took for granted that I understood the rehabilitation context. I had anticipated the latter and considered my 'insider' knowledge to be an advantage in the data collection process as it allowed me to gain a greater insight, and made the interviews generally more productive.

My aim in these interviews was to be an 'active listener' and to use my contextual knowledge to facilitate an in-depth exploration of the dilemma experiences identified by the participants. Feminist researchers (Oakley, 1981; Reinharz, 1992) have challenged traditional qualitative interviewing techniques. As Fontana and Frey (2000) observe "the emphasis is shifting to allow the development of a closer relationship between the interviewer and respondent; researchers are attempting to minimize status differences and are doing away with the traditional hierarchical situation in interviewing" (p. 658). Interviewers can engage in the interview 'conversations' more fully, by reacting empathetically, and using their own experience and theoretical background to formulate probing questions. The interview, in this way, becomes
part of a reciprocal interaction between the interviewer and the individual who is describing their
everyday reality (Reinharz, 1992).

In framing the interviews I spoke with the participants about my desire to listen to them as much as possible. In the initial interviews participants did solicit my opinion or ask me questions about my experience but this decreased as the interviews progressed and they became more caught up in explaining their dilemmas to me. Before the later interviews we invariably engaged in conversations before the taping was commenced (as tea was being made) and after the participant had declared the interview ended and the tape recorder was turned off. On several occasions we recognized that the topic of these conversations would be useful to capture on tape and the tape recorder was turned on again. At other times I jotted down the gist of the conversation in the form of a field note after the participant had left or sitting in the car. With more experience I consistently left the decision to terminate the interview or to turn the tape on to the participants. After some interviews the participants and I shared resources or information in response to a topic raised or to a query made by the participant during the interview. As Oakley (1981) points out, in interviewing there is “no intimacy without reciprocity” (p. 49).

The purpose of the initial interview was to solicit baseline information and begin the discussion of the participants’ understanding of a practice dilemma. The baseline information included their age, years of professional experience, undergraduate education and continuing education interests. These questions were useful ice-breakers since they were familiar to the participants and easy to answer, and their responses assisted me in building a profile of the participants. I also asked them to explain the rehabilitation context in which they work, what their practice entailed and why they chose to work in this setting as opposed to another specialty area of physical therapy such as private practice or acute care. I discussed the definition of ‘dilemma’ I had constructed for the purpose of this study with each participant, and I concluded this first interview by asking each participant to describe a dilemma they were currently experiencing or had experienced in the past. Three subsequent interviews were scheduled with each participant at approximately two monthly intervals during which they discussed dilemmas
with me. In the fourth and final interview I also asked each participant to talk about the reflective process they had engaged upon during the study.

Preserving the viewpoint of the participants expresses a commitment to preserving the integrity of the phenomena being investigated and comes closer to the phenomenological 'sensibility' (Holstein & Gubrium, 1994). With this in mind I offered each participant the options of reviewing their transcripts so that they could add or change the text if they wished and being involved at the data analysis stage in reviewing the initial themes. Ruth was the only one who chose to review her transcripts. She felt that reading her interview transcripts would help her trace her thought processes through the interviews but she did not, however, choose to change or add anything to the transcripts. Five participants provided written feedback on the initial definitions of the emerging themes and this strategy will be discussed in more detail later in this chapter.

**Transcription of Interviews**

The majority of the interview tapes were transcribed within ten days of the interview. Initially I engaged a transcriber who transcribed six interviews. In an effort to maintain confidentiality I chose a person who had no connections with physical therapy or the health care system and this individual signed a transcriber's confidentiality statement (See Appendix II). We discussed the purpose of the research and the type of information that the participants would likely share with me during the interviews. I was aware that transcribers are drawn into the lives of research participants through hearing the details of their everyday lives (Gregory, Russell, Phillips 1997; d'Agincourt-Canning & Cox, 2000). I did not anticipate that the information on the tapes would be of a disturbing nature but I felt it important to prepare the transcriber as adequately as possible for the task.

Easton, McComish & Greenberg (2000) recommend that when someone else transcribes an interview, the researcher should never assume it was transcribed correctly. They consider it essential that the researcher “listen to the tape and check and re-check the transcript for accuracy prior to beginning analysis” (p. 707). Despite the expertise of the transcriber, I found that I spent
considerable time reviewing the completed transcripts and making corrections to improve the overall meaning of the text. The participants, at times, engaged in a sort of stream of consciousness and used jargon and abbreviations which made it difficult for the transcriber, whereas as the interviewer and as an 'insider' I was able to more easily capture the meaning intended by the participants. I made the decision to transcribe the remaining interviews myself. It proved a lengthy and often tedious task but I felt that the benefits outweighed the disadvantages. The process of transcription facilitated my immediate immersion in the data. The common errors that occur during the transcription process, such as, the misinterpretation of entire sentences, misunderstanding of words or as a result of jargon use were avoided (Easton, McComish & Greenberg, 2000). I was able to ensure the accuracy of the transcripts, but more importantly, by listening intently to the interviews again, and as a result of making interpretative decisions as I transcribed, I gained an intimate knowledge of the data. Throughout the transcription process I documented the dilemmas that were being described and revised my ongoing analysis in terms of the hunches, data themes and patterns that were emerging. I documented this intellectual process in the form of 'analytic memos' (Hammersley & Atkinson, 1995) in a journal or directly on the transcripts. These memos served as memory aids, and helped me to monitor my progress, make linkages between data and identify the gaps in my understanding. This analysis then informed subsequent interviews, particularly in terms of my choice of probing questions.

Journal Keeping.

I chose to incorporate a second data collection method – that of participant journal keeping - in this study. Each participant was asked to record 'critical incidences' (Flanagan, 1954) as they occurred, related to an experience or set of circumstances which they considered to represent a dilemma for them. Given that at least two months would elapse between interviews, I hoped that keeping a journal would encourage them to record dilemmas as they occurred over time not just situations that arose close to an interview. Also, I hoped to use the journal material as a focus for each interview.
Janesick (2000) considers the act of journal writing to be a rigorous documentary tool, useful for focusing individuals on the project in hand and for facilitating reflection. Health diaries have been used in research and clinical practice to examine perceptions of health and illness, to track symptoms and efficacy of treatments (Burman, 1995), and as an alternative data collection method in ethnographic studies (Rosner, Namazi and Wyke, 1992). Rosner, Namazi and Wyke (1992) are of the opinion that it is important to critically analyze the phenomenon of interest to ensure that it can be captured using a diary, and they recommend clear and focused instructions on how they are to be used. These authors agree that maintaining a diary enhances client understanding of their disease, treatment or life situation. This corresponds with Clandinin and Connelly's (1994) view that journals are an effective alternative method of keeping "ongoing records of practices and reflections on those practices" (p. 421). In their experience with teachers, journals were used to "weave together their accounts of the private and the professional, capturing fragments of experience" (p. 421) which would otherwise go unrecognized. Dyck and Forwell (1997) found that journals provided a day-to-day account of incidents which occurred during student placements, and acted as a memory aid for post-placement interviews. Given these authors' experiences I hoped, that by using journals to capture the intermittent experience of dilemmas rather than requiring day-to-day entries, I might enhance the richness of the data while at the same time decreasing the likelihood of inconsistent use or 'fading' of the information obtained.

To that end, I provided each participant with a small notebook and written suggestions about how to structure their journal entries (See Appendix 111: Suggestions for Journal Use) and the definition of dilemma I had developed for the study. In addition to describing the circumstances of the dilemma, they were asked to record the strategies and rationale they used to resolve it with the understanding that these entries needed to be legible and written with enough detail to make them useful for us in the interviews. Given the greater access to home computers I anticipated that the participants might choose to use word processing software to keep their journal entries. I planned to copy the journal entries after the final interview and return the journal to the participants.
The strategy of journal writing proved useful to only three participants, and only one participant sustained it throughout all four interviews. The other participants, when explaining why they did not find journal keeping useful, made comments like: “writing my thoughts down didn’t come naturally,” “I didn’t seem to be able to find the time” or “I never had the notebook there when I needed it.” As a colleague Isabel Dyck, an experienced qualitative researcher, said “this type of sustained journal writing requires a considerable time commitment and the possibility exists of a ‘fading’ of the richness of the journal content over time” (personal communication, March 9, 1999). The three participants who did find journal writing a useful reflective tool approached it quite differently. Kate carried the notebook with her and jotted in it during the day. Her entries took the form of a short hand made up of abbreviations and point form. As she laughingly observed, even to her they were almost illegible. However, these were sustained through all four interviews. Margaret used a computer to write full accounts of the dilemmas she proposed to discuss in each interview and provided me with a copy for my files. Janine used the notebook which she kept on her desk at work. Her entries recorded numerous ‘incidences’ some of which she chose to raise during the interviews. She appeared to find keeping a journal most useful in facilitating her reflection on ‘dilemmas’ of practice. As she said:

Everyone always says that what you should do to de-stress is to write a journal but I never have until now. I can really see the value of it. When you write it down it helps to sort it out, pinpoint what’s really bothering you. It’s helping me clarify things.

While journal writing can clearly be a useful tool for encouraging reflection and the articulation of meanings in qualitative research, my experience in this study would appear to suggest that there are limitations associated with it. My assumption that it would be useful was quickly dispelled by most of the participants who, by the second interview, made it clear that they had no interest in this aspect of the study.

Field Notes

Field notes can take many forms and according to Richardson (2000) should be a more
creative process than simply recording thoughts that are already known, organized and outlined. I chose to use two forms of field notes in this study to supplement the data and to facilitate my own reflective process. First, as mentioned previously, I kept a journal in which I recorded 'analytic memos' (Hammersley & Atkinson, 1995). I started using this journal early in my Doctoral program. These journal entries relate to insights and ideas I gained from reading literature, attending courses and discussions with fellow students. More recently it has helped me make connections between literature, other research, and my own evolving ideas on data analysis. I continued to write memos throughout the study although I did not take it with me to the interviews.

Second, I wrote rough notes immediately after approximately two-thirds of the interviews, including topics raised in the ad hoc conversations held after the tape recorder was turned off. In these notes, perceptions and impressions of the interview process, the dynamics of the interaction between the participants and myself and any problems encountered during the interview were recorded. On occasion I wrote additional notes as I reviewed the interviews during the transcription process. This type of field note allowed me to capture, from my perspective as interviewer, the unique details of each interview. I adapted elements of a checklist for recording field notes suggested by Morse and Field (1995, p. 115) and found these helpful in organizing my notes. These elements included:

- location of interview
- description of the environment
- content of interview (key words, topics, focus, what stood out?)
- non-verbal behaviour (voice, emotions, gestures, eye contact)
- researcher's impressions (discomfort, feelings of inadequacy)
- technological issues
- impact of researcher's positioning
- analysis (questions, hunches, familiar themes, emerging patterns?)

I formatted these notes as computer files (See Appendix IV: Sample Field Notes) identified by participant pseudonym and interview number so that they could be accessed independently but also linked with the interview data as needed.
In this study the data collection took several forms: the interview tapes, the interview transcriptions, participant journal entries and researcher field notes. It is essential that the methods used to manage this data, that is, collection, storage and retrieval be systematic and well documented. The role that data management strategies play in establishing the credibility of the research will be addressed in more detail later in this chapter.

**Recruitment of Study Participants**

The aim in a qualitative study such as this is to select people by a process of 'purposive sampling.' This is a sampling technique used in which the researcher chooses the sample on the basis of known characteristics or experiences (Clifford, 1997). In this case, the participants were physical therapists working in a diversity of rehabilitation facilities in the Lower Mainland. Ten participants were recruited, including one individual – Kate – who agreed to be interviewed twice as part of an initial pilot study. These two interviews were then included in the final total of thirty-nine interviews conducted in the study. Michael chose not to complete the fourth interview as his work environment had changed and he felt he had nothing further to contribute at that time.

The criteria for inclusion in the study were simply that the participants be physical therapists who planned to continue working in a rehabilitation setting in the Lower Mainland for the duration of the research. Estimating the number of participants in a study, according to Morse (2000), “depends on a number of factors, including the quality of data, the scope of the study, the nature of the topic, the amount of useful information obtained from each participant, the use of shadowed data, and the qualitative method and study design used” (p. 3). The topic of this research, ‘dilemmas of practice,’ required the participants to reflect on their practice. In designing this study I was eager to explore a range of experiences but not so many that I sacrificed the depth which is an integral element of qualitative research. By interviewing each participant a number of times I anticipated acquiring a large amount of data and therefore I needed fewer participants in the study. It was these considerations that directed my decision to limit the number of participants.
I initially solicited participants by making five-minute presentations about my research project to groups of physiotherapists working in a diversity of rehabilitation programs and physiotherapy departments in the Lower Mainland. In the presentation I explained my proposed research and the commitment required should they decide to be involved, and I responded to questions about the study. I developed an information sheet (see Appendix V) that included my phone numbers and email address which I left with each program or department. Eight participants responded following these presentations by phoning me at home. Two participants heard about the study through colleagues and phoned me at the School of Rehabilitation Sciences to express interest. The participants represented six different rehabilitation programs and four different institutions. A more detailed profile of the participants is provided in Chapter Five.

Confidentiality

My first contact with the participants individually was when they contacted me by phone to express interest in being involved with the study. During that conversation I explained my perceived need for the study and what their involvement would entail. In all cases they stated their willingness to participate and a first meeting was scheduled with the understanding that this would constitute the first interview of a series of four. At this meeting I explained in detail the research process and gave them the Informed Consent Form (see Appendix VI) to read. Once I was satisfied that they had read the form thoroughly and had no unanswered questions we both signed the form. The participants were given a copy of this form and informed that they could withdraw from involvement in the study at any time.

Given the 'small world' of physical therapy particularly in rehabilitation I was concerned about issues of confidentiality. The participant's descriptions of dilemmas could potentially have involved other colleagues known to those involved, including myself, in the research. I considered it important that I maintain the anonymity of the participants both during the interview phase and when documenting the findings. I had worked in the past as a clinician on the same programs and in the same institutions as four of the participants, and at the time of the interviews, two of these individuals were sessional lecturers teaching at the School of
Rehabilitation Sciences. As Academic Coordinator of Clinical Education at the School of Rehabilitation Sciences I provided workshops and seminars and consulted with clinicians about student fieldwork supervision. In this capacity I had interacted with all the participants during the past ten years. None of the participants were personal friends or had graduated from the School of Rehabilitation Sciences since I was employed there in 1989.

I reassured the participants that their names would at no time be used, and that names of facilities and other health care professionals would not be transcribed. I explained how in qualitative research the data is abstracted from individual informant’s interviews and that the findings would represent an amalgamation of what was discussed by each participant. I repeated this explanation several times during the interviews. I also stated my preference not to conduct the interviews in the facility where a participant was employed. Interviews with two participants were conducted in work place offices but after hours when all other staff had gone home. Interestingly, however, it became apparent from our conversations before and after the interviews that the participants knew other physical therapists who were involved in the study, and that they were taking pleasure in discussing their involvement with each other. Some participants told others about their involvement and encouraged those individuals to phone me. Throughout the period of time the interviews with the ten participants were conducted other physical therapists continued to phone expressing an interest in being involved. I perceived this to be an endorsement of the research rather than a confidentiality issue. However, I remained careful not to talk about the study when I encountered the participants in the rehabilitation settings in the presence of their colleagues. I was gratified by their enthusiasm and their obvious comfort in talking with their colleagues about their involvement in the project.

**Ethical Approval**

In accordance with the University of British Columbia requirements, approval was sought to conduct this research project. A certificate of approval was granted without amendment by the Behavioural Research Ethics Board (Number B99-0210) on June 2, 1999.
Data Analysis Process

In qualitative research the analytical process begins during the collection phase as the data already gathered are analyzed and fed into, or shape, the ongoing data collection. This is what Huberman and Miles (1994) call ‘interim analysis.’ Earlier in this chapter I described the data collection methods and how I engaged with the data while continuing to conduct interviews. This ongoing involvement with the data enabled me to check and interpret the data and to develop tentative themes based on the data already collected, or hypotheses for subsequent investigation in further interviews. The interview transcripts and field notes provide a descriptive record but they cannot provide explanations, that is the role of the researcher. Through this ‘interim analysis’ process I began to make sense of the data. It allowed me to go back and refine interview questions and to pursue emerging themes in greater depth, and to relate what I was learning to my own knowledge and my reading of relevant literature. “This type of continuous analysis is almost inevitable in qualitative research; because the researcher is ‘in the field’ collecting data, it is impossible not to start thinking about what is heard and seen” (Pope, Ziebland & Mays, 1999, p. 77).

This study has been framed by an interpretivist methodology as discussed in Chapter 3. The central features of this perspective are that human action is inherently meaningful and that to understand that meaning it is essential to take into account the individual’s lifeworld and context. Knowledge, from an interpretivist approach, is socially constructed, negotiable through dialogue and context and dynamic. I have found that the mechanics of managing data within this methodology are not well explicated in the research literature. The grounded theory approach, developed by Glaser and Strauss (1967) perhaps provide the most detailed data analysis procedures; however, this approach focuses on the task of theory construction and verification and is therefore different from the descriptive, inductive process I proposed for this study. I found Huberman and Miles’ (1994) definition of the basic analytic cycle to be the most congruent with my chosen theoretical perspective and stated research purpose.
They define data analysis in terms of three linked processes: data reduction, data display and conclusion drawing and verification (Miles & Hubermann, 1994). The data collection was focused by the study implementation decisions I made, and once the interview tapes and transcripts, journals and field notes were available, data reduction began in earnest. “Data summaries, coding, finding preliminary themes, clustering and writing stories are all instances of further data selection and condensation” (Huberman & Miles, 1994). For me, this process consisted of reviewing the interviews as I transcribed them, reviewing and writing my field notes, and writing ‘analytic memos’ in my journal. In re-reading the interviews I began to ‘index’ sections of the interview by summarizing the content by a word or phrase which represented emerging patterns within one interview. These words or phrases became familiar as they occurred in other interviews. These patterns were at first conceptualized in my mind as the following list of questions:

- How can I be an effective advocate for my patients?
- Am I providing best care?
- What evidence supports my practice?
- How can I prove what I know?
- Why is there conflict between physiotherapy and certain other disciplines?
- Who makes admission/discharge decisions and why?
- What is the optimal therapeutic relationship?
- How can interdisciplinary team functioning be improved?
- How are my communication skills impacting the team and patient?
- Who can legitimately make decisions for patients?
- How can I manipulate/manage the system for the benefit of my clients?

The dilemmas being described by the participants were involved and detailed and could frequently be associated with more than one of these patterns. Huberman and Miles (1994) define the next inevitable part of analysis as data display when “the researcher typically needs to see a reduced set of data as a basis for thinking about its’ meanings” (p. 429). This is achieved by organizing and compressing the information. I chose to write summaries of the approximately sixty dilemmas described by the participants. In effect I categorized them. These summaries were abstracted but could be easily traced back to the respective transcripts. Indexed words and
phrases were highlighted in the summaries. In this way a number of categories began to take shape and the original indexed words and phrases began in this way to be associated with certain categories. At this stage there was considerable overlap and repetition between the categories. I then chose to create a sort of spreadsheet of all these dilemmas or categories on large sheets of paper, again identifying them by participant initial and interview number. By displaying the dilemmas in this way I was able to compare and contrast them and to establish relationships between them.

In this way, categories became condensed and those that seemed related were clustered under a theme. For example, many categories pertained to physiotherapy knowledge, expertise, lack of evidence to support knowledge, erosion of their knowledge by other professionals etc. In this way, a 'theme' became an umbrella concept which encompassed several categories that were inter-related. At this stage I wrote descriptions of these initial themes and solicited feedback from five participants who were interested in being involved in the analysis process. I also involved a knowledgeable colleague in analyzing two transcripts and relating the material to the themes I had identified up to this point. I will discuss these strategies of 'member-checking' and 'peer review' in greater detail in the next section of this chapter. I incorporated their feedback and began to re-define the themes, attempting to develop an interpretive framework for each theme through comparison and reference to the literature and other theories. As Miles and Huberman (1994) suggest once the researcher identifies a set of themes or concepts, the next step is to identify how these are linked to each other in a theoretical model.

In this way the themes were induced from the participants' narratives. Miles and Huberman (1994) note that the researcher's general theoretical orientations, the richness of the literature, and the characteristics of the phenomenon being studied influence the themes researchers are likely to find. These are arguments for ensuring that the location of the researcher is fully explicated. In Ryan and Bernard's (2000) opinion “no matter how the researcher actually does inductive coding, by the time he or she has identified the themes and refined them to the point where they can be applied to an entire corpus of texts, a lot of interpretive analysis has
already been done” (p. 781). Once the interpretive framework began to take place I began to recognize the need to pay attention to “negative cases – those cases that don’t fit the model” (Ryan and Bernard, 2000, p. 782). These either challenge the emerging interpretive framework or suggest alternative connections and linkages. In either instance “negative cases need to be accommodated” (p. 782).

It had been my original intention to use a software tool for qualitative data analysis, specifically NUD•IST 4. To that end, I familiarized myself with the software program and how it could facilitate the analysis process, particularly coding, storage, search and retrieval of data and data ‘linking.’ However, early on in the study I made a decision not to use this software. I found making use of Microsoft Word ’98’s capacity to word process, work in several files simultaneously, and find key words better matched my analysis approach. This may have been partly the exponential learning and time needed for me to feel fully proficient on NUD•IST but, in my opinion, it had more to do with the way I conceptualized the data. I needed to ‘handle’ the data, create visual representations and spreadsheets to facilitate the process of identifying themes. Whilst perhaps considered somewhat old-fashioned, this repeated physical contact and handling of the various forms of data has much to recommend it. By constantly re-reading the data and sorting it into categories, combined with transcribing the interviews, I developed an intimate knowledge of the data even if the process was somewhat laborious. Using Microsoft Word I allocated chunks of text out of individual transcripts into files created for each emerging theme. In this way, I was able to examine each theme in its entirety and ensure that the data within each was complementary and congruent with the meanings associated with that theme. In orienting myself to NUD•IST I felt that the software itself – the structure it provided - was a distraction. I found that the advantages of immersing myself in the data analysis process were that I remained connected to the meanings and context inherent in the interview material, and it facilitated my ongoing reflection on the interpretive framework that I was developing to account for the data.
What became clear to me was that writing a thesis of this nature is an interpretive act, and although it will appear as a finished product, it will tell only some of the possible meanings. I am primarily concerned that my colleagues, who agreed to share their expertise and reflections on practice, will feel that the findings of this study have enriched their understanding of practice and reflected their experiences of dilemmas in the rehabilitation context. To that end, I have endeavoured to ensure the integrity and rigour of this research by incorporating a number of strategies in the research design and implementation.

**Strategies Used to Enhance the Rigour of the Research**

Altheide and Johnson (1995) pose the critical question:

> How should interpretive methodologies be judged by readers who share the perspective that how knowledge is acquired, organized, and interpreted is relevant to what the claims are? (p. 485)

This question has been at the core of considerable debate about the necessity or feasibility of developing criteria by which qualitative methodologies can be evaluated. Hammersley (1990) identified two broad, opposing positions. First, there are those who consider that the diversity of qualitative research generates a different kind of knowledge from quantitative research and therefore different criteria need to be developed. Second, there are those who argue that there is no separate knowledge associated with qualitative research and consequently the same criteria should be applied to both research paradigms. The need for a “logic for assessing and communicating the interactive process through which the investigator acquired the research experience and information” (Altheide & Johnson, 1995, p. 485) has evolved as a result of new trends in qualitative research. The concept of reflexivity has focused critical attention on the need to articulate, throughout the research process, the deep-seated but often poorly recognized views and judgments held by the researcher which impact on the integrity of the research. In addition, concerns have been raised about representation and legitimation (standpoint or voice) (Lather, 1991; Reinharz, 1992; Olesen, 2000). Criteria for assessing the quality and merit of research have long been an integral component of quantitative research design. However,
development of criteria to assess qualitative research has been fraught with controversy. One of the reasons Baxter and Eyles (1997) suggest is that:

There is an apparent tension between the creativity of the qualitative research process – which implies contingent methods to capture the richness of context-dependent sites and situations – and evaluation – which implies standardized procedures and modes of reporting (p. 505).

Another reason is the pluralistic nature of qualitative inquiry that makes it unfeasible to apply the same criteria or evaluation strategies to all qualitative research. As Sandelowski (1986) noted, the term ‘qualitative research’ is imprecise and refers to many dissimilar research methods.

Qualitative researchers have put forward a number of assessment frameworks utilizing a variety of different terms, including authenticity and plausibility (Atkinson, 1990), relevance (Hammersley, 1992), trustworthiness (Guba, 1981), and credibility, transferability, dependability and confirmability (Lincoln and Guba, 1985). Despite the problems implied by this ‘tension’ and the ‘pluralistic nature of qualitative research’ rigorous evaluation of qualitative research is deemed essential by most disciplines. Smith and Deemer (2000) suggest that “criteria should not be thought of in abstraction, but as a list of features that we think, or more or less agree at any given time or place, characterize good versus bad inquiry” (p. 894). In their view “this is a list that can be challenged, added to, subtracted from, modified, and so on, as it is applied in actual practice - in actual application to actual inquiries” (p. 894).

In health care, a number of strategies have been identified by which these criteria can be met and which can be used by qualitative researchers in their efforts to enhance the rigour of their studies (Carpenter & Hammell, 2000; Law et al, 1998; Pope & Mays, 1999). These strategies need to be selected for specific studies as not all are appropriate to every qualitative study. As Baxter and Eyles (1997) observed:

Evaluation is critical if qualitative evidence or findings are to gain acceptance outside the community of practitioners, especially given the widespread recognition of the appropriateness of different approaches to investigation (p. 505).
Their comment is particularly apt for researchers in the rehabilitation sciences where the concept of 'best' evidence continues to be primarily associated with experimental research designs. The overall goal of these strategies is to enhance the integrity of qualitative research by making the research process transparent and open to all readers (including the participants). Huberman and Miles (1994) suggest that the 'same needs' for 'transparency of method' exist for both quantitative and qualitative methods. In their view, both approaches require clear, explicit reporting of data and procedures. This is expected so that “(a) the reader will be confident of, and can verify, reported conclusions; (b) secondary analysis of the data is possible; (c) the study could in principle be replicated; and (d) fraud or misconduct, if it exists, will be trackable” (p. 439). In other words, the reader should be able to follow the 'decision trail' of the researcher in concept development and presentation of findings. By incorporating the following strategies related to data collection and analysis, participant selection, and the researcher’s role into the design of this study I hoped to accomplish this goal.

Strategies related to data collection and analysis help to ensure the quality and rigor of the findings. Central to data collection is the care and precision with which the information is captured. Careful taping and transcription of the interviews avoided the need for me to take notes while attempting to respond reflexively during the interviews. In this way the conversations could be preserved in their entirety for subsequent in-depth analysis or peer review. I conducted a pilot study before embarking on participant recruitment. This involved a volunteer colleague Kate, who had worked for many years in rehabilitation settings, and who allowed me to try out my proposed open-ended questions with the purpose of revisiting the questions as necessary. She was willing to read the first interview transcript and she responded to the following questions which I asked her to consider in formulating feedback for me:

- Can you critique the questions I asked and suggest more appropriate ones?
- Were there any questions I could have asked to establish the context of rehabilitation more thoroughly?
• Anything major you would like to add or change after reading the transcript?

• Does the definition of dilemma hinder or help? Would it have been helpful to have received the consent form ahead of the first interview?

• What instructions (if any) about using the journal to record dilemmas would be useful?

Kate’s feedback was taped before the second interview and proved invaluable in refining my broad questions and identifying useful probing questions, for example, ‘do you find that feasible?’ and ‘in an ideal world how would you resolve this dilemma?’ After the second interview Kate chose to continue as a participant in the study and her first two interviews were included as data in the study.

Lather (1991) suggests that conducting sequential interviews over a period of time allows for a deeper probing of the research issues. I chose to conduct four interviews with each participant in the hope that new ground would be covered and that it would encourage the participants to reflect about their practice. Participants stated that they ‘looked forward to the interviews,’ that ‘it made them think in more depth about their work related frustrations’ and that ‘we should be doing this as part of our job.’ As Morse (2000) suggests “the greater the amount of useable data obtained from each person (as number of interviews and so forth), the fewer the number of participants required” (p. 4). By interviewing each person several times I acquired a large amount of data sufficient, in my opinion, to reach saturation, that is, to confirm the data over time.

Qualitative researchers, according to Sandelowski (1986) need to be concerned with determining if “the findings of the study, whether in the form of description, explanation, or theory, ‘fit’ the data from which they are derived” (p. 32). Readers should be able to follow the progression of the research in terms of how the data was converted into theoretical constructs, how effectively verbatim quotations were used and whether the interpretations were justified (Carpenter & Hammell, 2000). Krefting (1991) considers the ability of the participants to recognize their own voice in the research findings as central to establishing credibility of
qualitative research. Member checking can involve participants in a number of ways: they may be given the opportunity of reviewing and editing their transcripts at an early stage, or they can be asked to react to a draft of the major themes being developed in the data analysis process.

The latter strategy proved most useful in this study. In the data reduction stage of data analysis I identified and wrote a detailed description of each theme (initially six) that I perceived to be emerging from the data. Five participants had expressed an interest in reviewing these theme descriptions. I sent this material to them with a letter explaining that this was one stage in the data analysis process and asking them to consider the following questions in their deliberations:

- In what ways do these themes capture (or not) your own experiences of dilemmas (as described during the interviews or currently)?

- Is there a way, based on your experience, that you could more precisely state these dilemma themes?

- Is there anything you would add to these theme descriptions which would make them more relevant to your experience?

Each of the five participants returned the descriptions with detailed written comments and suggestions and these were incorporated into the next phase of data analysis. The strategy of involving all or some of the participants in a review of the research materials ensures that the researcher has accurately translated their perspectives and decreases the chances of misrepresentation or appropriation (Carpenter & Hammell, 2000). It was my hope that by employing this strategy I would strengthen the linkages between my interpretations and the original data.

I also asked a colleague who had experience working in health care and knowledge of qualitative research methods to review the theme descriptions in conjunction with two clean transcripts. The aim was to see if she identified the themes as I had described them within the data. As Lincoln and Guba (1985) suggest peer review is one way of keeping the researcher honest. My colleague was diligent in reviewing the documents I gave her, and her insights and
searching questions helped me step back and reconsider some of the analysis decisions I was making at that time. Peer review is an example of triangulation. Triangulation is a critical group of strategies used to enhance trustworthiness. It is “based on the premise that the convergence of a number of perspectives will confirm the data obtained and ensure that all aspects of the phenomenon have been investigated” (Carpenter & Hammell, 2000, p. 110). Using different sources of data is another type of triangulation. My plan to use participant journal entries and researcher field notes as an alternative sources of data was conceived with this in mind.

**Conclusion**

I have attempted in this chapter to clearly describe the procedures I used to recruit participants, to ensure that data was recorded accurately, and how alternative data sources, such as field notes and journal entries were used to enhance the rigor of the research. Huberman and Miles (1994) clearly state the need for researchers “to keep analytic strategies coherent, manageable, and repeatable as the study proceeds” (p. 439). It was my intention, hopefully fulfilled, to provide a detailed overview of how I managed the data in terms of collection, storage, and retrieval, and of the analytic strategies I used. In addition, I have attempted, throughout this thesis, to use key data to support the study conclusions.

Qualitative research involves the ‘researcher as instrument’ and as such it is essential that the researcher’s role be critically examined in terms of reflexivity and positionality. Reflexivity entails the articulation of the researcher’s background, interests, and assumptions to ascertain their influence on the research topic. Positionality is related to the imperative to make transparent the relationship between participants and researcher, particularly as this affects both the process and purpose of the research (Carpenter & Hammell, 2000). It has been my intention, particularly in Chapters One and Three, to address these concepts in order to contribute to the overall rigor of this research. The chapters up to this point have been defined primarily by my voice. However, the idea for this study started with the words and insights of my physiotherapy colleagues. By employing a qualitative research approach I sought to profile the participants’ understanding of dilemmas they experience in rehabilitation practice. The following chapters will redress the
balance and be primarily defined by their voices. In Chapter Five I will introduce the participants and the context of rehabilitation practice as described by them. Chapters Six through Eight will explore in depth the themes that constitute the study findings through the participants' insights and through application of relevant literature and theories that have informed the data.
One of the most gratifying aspects, for me, of conducting this research was the enthusiasm with which the participants became involved in the interviews, and the willingness of five participants to provide feedback during the data analysis phase. This enthusiasm was reflected in their responses to questions I asked them about their physical therapy background and experience in rehabilitation, the nature of their work, the attraction of rehabilitation practice for them and what learning opportunities supported their practice. In accordance with the ethnographic perspective informing this study, I wanted to understand the institutional and practice context in which their experiences of dilemmas are derived. The participants' responses helped me to establish this rehabilitation context. Pseudonyms were chosen by the participants and these names will be used throughout this thesis. This chapter represents my effort to profile their interpretations of their role and practice in rehabilitation and my attempt to thoroughly ground these insights in the interview data.

The Participants

Nine women and one man volunteered to participate in this study (see Table 5.1). This proportion of women to men reflects that of physical therapists practicing in rehabilitation settings in British Columbia where there are approximately eleven times more women practicing than men (Health Human Resources Unit, 2000). The participants in this study ranged in age between 31 years and 55 years. Their ages reflect the majority of registered physical therapists in British Columbia. According to the Health Human Resources Unit (2000) in 1999 sixty-two percent of physical therapists in British Columbia were between the ages of 34 – 55 years. Forty percent of the participants in this study had a diploma in physiotherapy as their highest qualification, were educated in the United Kingdom and graduated before 1983. Five participants (50%) had Bachelor of Science (Physical Therapy) degrees. Three participants acquired their degrees from Canadian universities and one from Australia. One individual had completed a Bachelor of Science degree several years after her original diploma in
Table 5.1 Profile of the Participants

<table>
<thead>
<tr>
<th>Participant selected pseudonym</th>
<th>Year of graduation</th>
<th>Educated in- or outside Canada¹</th>
<th>Level of education</th>
<th>Years in rehabilitation</th>
<th>Type of clients treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kate</td>
<td>1985</td>
<td>Outside Canada</td>
<td>M.Sc.</td>
<td>15</td>
<td>General Neurotrauma Inpatients</td>
</tr>
<tr>
<td>Senior Position</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jill</td>
<td>1983</td>
<td>Canada</td>
<td>B.Sc. (PT)</td>
<td>17</td>
<td>Spinal cord injury Outpatients</td>
</tr>
<tr>
<td>Senior Position</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michael</td>
<td>1990</td>
<td>Canada</td>
<td>B.Sc.(PT)</td>
<td>9</td>
<td>Stroke/Head injury Outpatients</td>
</tr>
<tr>
<td>Ruth</td>
<td>1992</td>
<td>Outside Canada</td>
<td>B.Sc. (PT)</td>
<td>8</td>
<td>Spinal cord injury Inpatients</td>
</tr>
<tr>
<td>Veronica</td>
<td>1990</td>
<td>Canada</td>
<td>B.Sc.(PT)</td>
<td>10</td>
<td>Stroke/Head injury Spinal cord injury Inpatients</td>
</tr>
<tr>
<td>Janine</td>
<td>1977</td>
<td>Canada</td>
<td>B. Sc. (PT)</td>
<td>22</td>
<td>Stroke/Head injury Inpatients</td>
</tr>
<tr>
<td>Senior Position</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Margaret</td>
<td>1968</td>
<td>Outside Canada</td>
<td>Dip (PT)</td>
<td>13</td>
<td>Stroke Inpatients</td>
</tr>
<tr>
<td>Barbara</td>
<td>1973</td>
<td>Outside Canada</td>
<td>Dip (PT)</td>
<td>29</td>
<td>Spinal cord injury In/Outpatients</td>
</tr>
<tr>
<td>Sophie</td>
<td>1974</td>
<td>Canada</td>
<td>Dip (PT)</td>
<td>15</td>
<td>General Outpatients</td>
</tr>
<tr>
<td>Dawn</td>
<td>1983</td>
<td>Outside Canada</td>
<td>Dip (PT)</td>
<td>17</td>
<td>Stroke Inpatients</td>
</tr>
</tbody>
</table>

¹ In the interests of maintaining confidentiality the specific universities or colleges have not been identified.
physiotherapy and both were acquired at a Canadian university. One person (10%) had a Master’s degree in motor learning from an Australian university.

Three individuals graduated in the early 1990s, three in the early 1980s, three in the 1970s and one in 1968. All the participants had chosen rehabilitation as their area of specialty within two years of graduation with the exception of two individuals who had worked as physical therapists for over 25 years. They both had experience in a diversity of clinical areas before becoming committed to rehabilitation in the last 13-15 years. The length of time spent by the participants working with clients with disabilities resulting from neurotrauma or progressive conditions varied from 8 to 29 years (the average being 19.7 years).

All the participants were employed in institutional settings in which rehabilitation services are organized and administered in terms of the client diagnosis, for example, spinal and acquired brain injury programs, acute stroke team, and a neurosciences unit. Services were also provided specifically for older adults. Clients older than 65 years were usually referred to the programs offered by a specific rehabilitation facility. All the participants had worked throughout their careers primarily with adults, and that they continued to do so, was one of the criteria for their inclusion in the study. At the time of the interviews the participants were working with clients who had sustained a spinal cord injury, brain injury, cerebrovascular accident (stroke) and with a small number of clients with neurological deficits resulting from spinal or brain tumours. The participants were employed in specific units or programs and, as a result, felt that they had developed a recognisable expertise with a specific client group which they shared with their physical therapy colleagues on the same program.

Rehabilitation Services

This research study focuses on the dilemmas of practice experienced by physical therapists providing care in rehabilitation settings as opposed to an acute care delivery of services model. The literature (see Chapter Two) supports the central premise of this study that the dilemmas experienced by health care professionals and clients in rehabilitation settings are substantially different from those in acute care settings. The rehabilitation institutional setting
therefore forms the context for the findings of this study.

The characteristics of rehabilitation and institutional care as defined in the literature were described in detail earlier in this thesis (see Chapters One and Two). Rehabilitation is centered on the management of chronic disability resulting from the onset of a neurological condition or trauma. Such disability is not amenable to ‘cure’ and, as such requires a more comprehensive and complex approach to health care delivery. According to the Vancouver/Richmond Health Board (2000) rehabilitation services in the Lower Mainland provide access to and delivery of:

- physical, mental, social, vocational, preventive, recreational, avocational, psychosocial, living and educational measures, to enable individuals with an impairment or disability to achieve their highest attainable level of functional ability, social and behavioral adjustment,
- training in various compensatory techniques for those areas in which recovery is insufficient,
- appropriate equipment such as wheelchairs and orthoses, and
- adaptive environmental modifications, including those in the workplace (p.4).

Rehabilitation services are characterized as involving a diversity of health care professionals working together as an interdisciplinary team to address the goals of individual clients. The participants spoke, during the interviews, about their involvement with an interdisciplinary team. The teams they described typically involved a physiatrist (a physician specializing in rehabilitation medicine), and representatives of nursing, physical therapy, occupational therapy, speech language pathology and social work. Representatives of psychology, recreational therapy, vocational counseling, and sexual health services frequently acted as consultants to the team. The rehabilitation process customarily entails the client spending a lengthy period of time in a specialized facility, unit or program during which their condition or injury is medically stabilized and the consequences of impairment or disability are addressed.

Rehabilitation is characterized as having a complex and long-term quality not generally associated with acute care services. Sophie, whose role involves liaising with agencies and families providing support in the community, described rehabilitation this way:
In rehabilitation I think we need to move – I see this as our role – people from formal physiotherapy treatment to incorporating that treatment and physical mobility into a functional day, integrating it in a relevant and meaningful way. It’s a continuum not a building but a life long process for persons with brain injuries.

This complexity was reflected in the participants’ descriptions of the every day tasks that constitute their practice and in the reasons they gave for their commitment to rehabilitation. Participants described their patient care activities as being direct and indirect. Everyday direct involvement with clients included assessment and implementing treatment interventions, leading exercise classes (for example, balance and coordination, arm strengthening, pool and tilt table exercises and wheelchair management), facilitating equipment trials particularly manual wheelchairs, seating and walking aids, and making home visits. All the participants identified that their practice had progressively shifted during their careers from a predominantly 'hands-on' treatment orientation to an educational approach to client care. The latter involved teaching patients, family and caregivers skills (e.g. transfers from bed to wheelchair, applying spinal and leg braces and wheelchair safety) and techniques (e.g. passive range of movement exercises, positioning in bed and assisted coughing) related to movement and function. The participants were engaged in a diversity of activities that indirectly related to client care. These activities included, for example, exchanging information with other professionals, attending meetings, communicating with other community and resource agencies and liaising with third party payers on behalf of their clients, advising and ordering equipment, following up on discharged clients, keeping records, doing home visits, providing education classes for clients, community support groups and other professionals and writing reports.

Three participants - Kate, Jill and Janine - were designated senior therapists and their role involved a greater variety of administrative responsibilities. One of the primary functions of this role was to act as a liaison between middle management and the staff therapists in a specific unit or program. These individuals spent more time (and often after official work hours) attending meetings, developing work schedules, addressing staffing issues, planning education sessions
and performing staff evaluations. These participants identified their role as stressful particularly when communication broke down between them and other staff, and they felt that their effectiveness was compromised by a perceived lack of power and support within the organization. They also frequently questioned their preparation for the role citing their lack of management background as a barrier to them resolving situations within their programs or units.

During the initial interviews with the participants I sought to understand their perceptions of physical therapy practice in rehabilitation. I explored with them their commitment to their chosen area of clinical specialty and asked them to discuss their practice and what contributed to their continuing enthusiasm for working in rehabilitation settings. They clearly articulated their commitment to providing knowledgeable and skilled care for their clients, their interest in learning and in reflecting on their practice and their use of self in establishing therapeutic relationships with their clients and collaborative relationships with other health professionals. All the participants had developed considerable expertise in their chosen rehabilitation specialty. The relationship between theory and practice in physical therapy has not been the focus of sustained analysis within the profession (Roskell, Hewison & Wildman, 1998; Tammivaara & Shepard, 1990). In reviewing the literature (see Chapter Two) it was evident that we know very little about how experts practice in physical therapy, that is, what knowledge they bring to bear in practice, how they engage in clinical reasoning and decision-making, and what values and beliefs influence their work. A theoretical model of expert practice in physical therapy has recently been developed by Jensen et al (1999, 2000) and I chose to use this model as an organizational framework for this discussion of the participant’s descriptions of their practice. Underlying my decision to capitalize and build on the work of Jensen and her colleagues was my assumption that the application of theory in physical therapy will enhance our understanding of effective professional practice and guide research (see Chapter Nine).

**Theoretical Model of Expert Practice**

This theoretical model is the product of a large rigorous qualitative study conducted over a period of two years, involving multiple methods and four physical therapy researchers. The
participants were physical therapists who were identified by their peers as experts and who specialized in the practice areas of geriatrics, neurology, orthopedics and pediatrics. Four dimensions of practice are identified in the model (see Figure 5.3) as being representative of physical therapy expert practice. These include: (1) a dynamic, multidimensional knowledge base that is client-centered, (2) a clinical reasoning process that is embedded in a collaborative, problem-solving interaction with the client and other professionals, (3) a central focus on movement assessment linked to client function, and (4) consistent virtues seen in caring and commitment to clients.

The integration of these core dimensions by the expert therapist is described by Jensen et al (1999) as the physical therapist’s “conception of practice” or philosophy. This philosophy “represents a therapist’s vision of practice – that is, what it means to practice physical therapy, including the therapist’s beliefs about the purpose of physical therapy and his or her goals” (p. 181). Jensen and her colleagues have chosen to label one dimension as knowledge; however, it is my opinion that all four dimensions represent the epistemological underpinnings of the profession, that is, the different forms of knowledge utilized by practitioners in clinical practice. The concept of a philosophy of practice unique to physical therapy is introduced in the model but no clarification or in-depth analysis of the meaning attributed to the concept is provided. The concept of a professional philosophy emerges as an element of dilemma experiences related to interdisciplinary team functioning (see Chapter Eight) and I will discuss it in more depth in Chapter Nine. The philosophy is constitutive of an integration of the four dimensions – knowledge, clinical reasoning, movement and virtues.

**Knowledge**

Jensen et al (2000) identify four domains of knowledge pertinent to physical therapy practice. These are knowledge specific to the specialty and physical therapy; knowledge of human behaviour or insights about clients, knowledge related to teaching clients and lastly, knowledge of self in the professional role. These domains of knowledge are embedded in the
Figure 1 Core Dimensions of Expert Practice in Physical Therapy (from Jensen et al, 2000, p. 37)

Characteristically their descriptions of specific physical therapy knowledge focused on analysis of movement and physical compensations to promote function - range of motion and coordination - and less on the more traditional physical therapy goals of strength and endurance. As Kate said:

From my perspective, any of the skills and knowledge I have were learnt with the intent to be of benefit to my patients. I may be interested in the quality of movement but it is because it will give them more variability in their movement patterns, increase their function in various environments.

Most of the participants compared their practice in rehabilitation to other areas of practice, like orthopedics, which they described as requiring more concrete knowledge applied to specific joint
I feel in rehab that you take everything you've learned - neuro, ortho everything - so it's more of a challenge. In rehab you look at all perspectives of the client's care and problem solve. It's the complexity and seeing them as a whole person, it's not a blinkered view of their problem.

Barbara, in contrast to the others, perceived her work in spinal cord injury as more "cut and dried" than other rehabilitation areas such as brain injury. She had developed an interest in specific techniques and approaches (functional electrical stimulation and tendon transplantation) and was involved in a related research project and this may have fulfilled her expressed desire to 'be more concrete' and focused in her practice.

All the participants enjoyed the challenge of the 'complex cases' which were seen as typical of rehabilitation and which required a holistic approach which takes into account individual client’s goals, lifestyle and social context, not simply their physical condition. Michael described it like this:

I like the flower diagram as a way to visualize how multifaceted people and our work is. I think it was experience that really has helped me to understand that more is required of me than just the treatment skill, it's recognising those other factors and how they interact in a given situation.

The participants all described their practice as requiring global thinking, creativity and a combination of cognitive and psychomotor approaches that they found fascinating and challenging. As Karen said:

They [rehabilitation clients] are multifaceted - it's a combination of chronic pain, emotional, physical, psychological. You have to consider how they are using movement and that movement pattern affects their personality, so you're dealing with the whole person. You can explain things in terms of the whole person. All this holistic stuff that has come into vogue has always existed in rehab.

The participants perceived themselves as increasingly assuming the role of educators or facilitators of learning. As Sophie said:
We teach clients, their caregivers, families, other professionals, funding groups and support agencies. I think throughout my career as a physiotherapist I’ve been a teacher but it is more recognized now. We educate people – to look after themselves, to move again, what the pathology is behind a particular injury or condition. We do a lot of education and I think it starts day one in rehab.

This gradual shift of practice from an emphasis on treatment to an education approach was attributed in part to the pressure within the system for rehabilitation beds and the move to community care. These health care system changes have meant a substantial shortening of the length of stay of all rehabilitation clients. As a result, the participants felt that there was an increased need to support clients in learning about their disability or condition and in taking responsibility for their own care.

Those participants who had graduated in the past ten years considered that their education programs had prepared them well for the fundamentals of physical therapy practice, particularly related to the specific skills and knowledge required to assess and treat clients. However, all the participants spoke of the importance of learning from peers and colleagues in other disciplines and from a diversity of clients in order to ‘keep up with all the changes in clinical practice.’ All the participants took the responsibility of maintaining their professional knowledge and standards of practice very seriously and were involved in formal continuing education. The courses the participants appeared to value most focused on the acquisition of clinically related skills and knowledge perceived as directly relevant to their role as a physical therapist in rehabilitation. Such continuing education courses are held infrequently in Vancouver and are limited in enrolment and expensive. Seven of the participants had spent considerable time and resources attending these courses both in Vancouver, Toronto and England, and their enthusiasm particularly for the neuro-developmental approach to treatment was evident in all their interviews. These courses were valued because the material being taught enhanced their ‘handling’ skills and was grounded in current basic science theory and research. These courses are generally taught by physical therapy ‘gurus’ (for example, Mary Lynch, Bobath instructor) who use extensive demonstrations with individual patients as a primary teaching technique. As
She (Mary Lynch) doesn't actually give the rationale as she's demonstrating, that is hard, but she has the theory to back it up. Nevertheless it's gone beyond a science; it's become an art form.

This course material was shared and reinforced by practical sessions and case discussions with peers. The participants were unanimous in their opinion that these courses “made them better therapists” and, therefore, of greater benefit to their clients.

Three participants regularly attended conferences, such as, the annual Canadian Physiotherapy Association Congress and the annual American Spinal Injury Association (ASIA) Conference. These were seen more as opportunities to learn about recent research developments in the profession or specialty and to network with others rather than as a chance to acquire ‘hands on’ skills. This was particularly important to Barbara who said:

I started going to conferences and I found out that there was a whole sort of network - what was going on in North America - and there was a very definite group. It was a specialty and you felt like you were almost part of a community when you were in spinal cord injury.

Three participants had completed formal certification programs in acupuncture and manual therapy as a method of extending their professional repertoire. Although these new skills were not specifically related to the client population with whom they worked they all felt that the application of the new skill and knowledge greatly enhanced their current practice. Five of the participants spoke of recent efforts to relate the content of these practically oriented courses and programs to current neurophysiology theories and research. As Veronica said:

You know acupuncture is hugely successful in spinal cord for treating pain. There are numerous studies to support its’ use. It’s so fulfilling to see the results and to know that its use has been validated.

The participants all acknowledged their responsibility to ensure that the knowledge and skills they used in practice was evidence based and grounded, when possible, in rigorous
clinical research. As Margaret said:

There is much more of an expectation that that evidence is available. I've always felt that whatever I do I must have a reason for doing it yet I don't know whether I necessarily have as good a scientific reason as I might, but I do have to justify to myself why I'm doing it. I try and make that make sense from my knowledge of anatomy, physiology, neurophysiology. I don't feel that I should ever just do something because it might work so that responsibility is always there for me.

They all felt clinical research should be an integral component of their practice but, with the exception of two individuals, they did not feel it was realistic given their workload, time constraints, and what they perceived as their lack of research expertise. The two individuals involved in research acknowledged the extra commitment in terms of time and effort that it required of them but both felt that these were outweighed by the professional gains they experienced. As Barbara commented:

I would say that it was a bit of a turning point for me getting involved in research because it gives you a bit more of an identity, and you get a bit more respect or self respect for what you are and what you're doing. You can say 'now I'm a researcher' I don't have to just believe in that, I can find out whether it's doing anything or not.

The participants spoke of the importance in their practice of generic skills and competencies, such as communication, interpersonal skills, professionalism, and critical thinking. Many of the participants felt that, because of this diversity of skills required in rehabilitation practice, they could have benefited from a broad range of courses in management, communication, counseling skills and conflict resolution, in addition to those they felt would directly enhance their physical therapy skills. This was particularly an issue for the senior therapists who felt their physical therapy academic programs had not adequately prepared them for their administrative role. However, the difficulty perceived by most of the participants was how to allocate their limited resources in choosing courses given the lack of institutional funding or support for education. Invariably they chose courses that were perceived as enhancing their
'hands-on' skills and their ability to facilitate improved physical function for their clients. Only two participants – Dawn and Veronica - appeared to have purposively explored how their own personalities influenced their approach to practice and their interactions with clients and other health care professionals. The types and sources of knowledge the participants identified as important to their practice reflect the domains identified by Jensen et al (2000) and might be described as the more ‘formal’ knowledge underpinning physical therapy practice. This knowledge base, gained from experience, from each other and the clients, and through being engaged in continuing education, is applied in each therapist – client interaction.

**Clinical Reasoning**

The application of knowledge and the judgements made by clinicians in each clinical situation is at the core of clinical reasoning, the second dimension of the model of expert practice. Mattingly and Fleming (1994) suggest that clinical reasoning is practical reasoning; it “involves deliberation about what an appropriate action is in this particular case, with this particular patient, at this particular time” (p. 10). According to Jensen et al (2000) it involves collaboration with the client and other professionals and an integration of technical knowledge and skills with the contextual features unique to each client.

Without question close collaboration – the development of a therapeutic relationship between client and therapist was of primary importance to the participants. Rehabilitation practice allowed them to take time with each client and gave them the opportunity “to establish rapport” and “get to know them better.” The individual patient was central to the descriptions provided by the participants of their clinical reasoning processes. Almost all the participants emphasized the need to address individual clients’ needs and goals in planning the rehabilitation program. That they could use their knowledge and skills to assist clients to assimilate acquired disability into their lives and to achieve their goals was the foundation for their commitment to rehabilitation practice. Dawn’s comment probably best captures this commitment:

I find people fascinating. I like to find the switch that turns them on, so they want to get out of here. I love motivating people. Each person is different, sometimes
it's the family. It can be getting a husband to put his arm around a stroke patient as she stands for the first time in three months, getting them to talk about their work, the things that worry them about their disability or returning to some activity. People have such fascinating experiences, are very interesting, rehab and physiotherapy allows me the opportunity to get know and help a lot of people.

The participants used their specific knowledge to solve problems in collaboration with their clients and this required a clear understanding of the client's lifestyle and context. All the participants felt that their multifaceted involvement with clients contributed to their own expertise and that, as Sophie said:

Everyday I learn something new from my clients, I'm sure I learn as much from them as they do from me.

By reflecting on these clinical experiences in terms of the effectiveness of their knowledge and skills and the impact of their own personal qualities on each clinical situation they felt that their clinical reasoning abilities were enhanced. As Margaret said:

I have come to realise that in learning to be an effective physiotherapist you have to analyse yourself and how you practice. You have to be able to recognize all the components of a day's work, it isn't just patient skills, it's all the other things that make us effective.

Several of the participants spoke of their clinical reasoning process as "instinctive," "an experiential thing" or "more of a gut feeling" and this was seen, to some degree, to be problematic as it detracted from their ability to account for their clinical decisions with clients and other health professionals. As Jill said:

You've got the intellectual stimulation of trying to keep up with what's the newest and latest in treatment, but then you're also physically active doing the more routine things with people and you're also developing communication skills and dealing with people in a very emotional situation. It's a whole package and difficult to tease out. It's why I love having students because it forces me to put what I'm doing into words and that's a challenge!
The participants all recognized that rigorous transparent clinical reasoning was important both in providing the best care for the client and in upholding the reputation of the profession.

As Kate said:

My practice is really the dilemma. I can take into account what I can feel and see but these things cannot be measured in the clinic or lab – it’s too hard or subtle to measure in the clinic. But I can still address them, as long as I’m conscious about being as objective as I can, to see if it’s made any difference overall to their [the client's] function. Most of the time I feel OK about it, I spend a lot of time thinking about it and I try to explain the reason for what I do.

By consulting with clients, physical therapy peers and mentors and other health professionals participants felt that their clinical reasoning processes were rendered more effective and relevant.

All the participants perceived their clinical decision-making as occurring within the context of the interdisciplinary team. Their involvement as members of teams was identified as an integral part of their practice and a unique feature of working in rehabilitation. As Sophie explained:

Working with others is essential. Rehabilitation cases are just too complex for a single profession approach. Working within an interdisciplinary team, I think, is both the biggest reward and the biggest challenge I think about rehabilitation.

Involvement with team functioning was both formal and informal. Formal interaction with the team revolved around a variety of scheduled meetings of the whole team, with or without the client being present, during which each client's progress, goals and discharge plans were discussed. All the participants spoke of the value they placed in the informal functioning of the team. This entailed exchanging information, discussing problems, and developing shared strategies on a one-to-one basis with other team members as needed to facilitate achievement of an individual client's goals. The success of this type of collaboration was attributed to the personalities involved and, even when some conflict existed between professionals, the participants agreed that interacting formally and informally with other disciplines was one of the professional rewards of working in rehabilitation. As Janine said:
It's what keeps staff coming back. They say that it's the friendships and connectedness that brings people back to work. You spend a lot of time and you really care about the other people that you work with. The interdisciplinary approach is central to rehab, it's different from other areas I've worked in. It makes work most enjoyable, for the most part, as long as you get along with everyone.

Earlier in this chapter I discussed the knowledge identified by the participants upon which they considered their practice was based. It was apparent that it was derived from a number of different sources - their peers and colleagues, their academic and continuing education, their every day experience in providing client care - and related where possible to scientific evidence and relevant theories. The participants gave priority to the knowledge and skills that enhanced their direct client care. They valued education courses that provided them with the opportunity to learn practical skills from 'experts.' Clinical reasoning reflects a different characterization of knowledge. It requires applying, what I will call for want of a more apt term, this 'formal' knowledge in order to identify problems, understand the client's context, negotiate goals of treatment with the client, and collaboratively problem solve with the client, family and interdisciplinary team members. Integral to effective clinical reasoning is the expertise and experience, innovation and ongoing reflection that the therapist brings to each clinical situation. Clinical reasoning as described by the participants embodies 'practice' knowledge and as such is often tacit, poorly articulated and sometimes intuitive. In contrast, the participants had no difficulty articulating the centrality of movement to their professional practice.

**Movement**

The movement dimension of the model of expert practice is based on the data – gathering process engaged upon by physical therapists that incorporates 'hands-on' skills and assessment of movement through palpation and touch. The participants in this study all enjoyed the physicality of their work and their perceived ability to analyze movement. Kate's enthusiasm is clear in her comment:
I find movement very interesting, and that's totally what I'm doing all the time. Working on movement so that they can get back the functional things they want to do. It's stimulating from a learning perspective, and it's stimulating from an emotional and personal perspective.

All the participants experienced considerable personal reward and professional reinforcement from their one-to-one treatment sessions with their clients. An integral part of these sessions was their physical contact or touch with the client. The forms of touch identified by the participants included touch used to assess movement and gain information, touch to guide or stabilize the client and touch to reinforce caring and empathy. Margaret perhaps captured the importance of touch in practice when she said:

Certainly my approach with students is to get them handling. They need to establish that comfort in holding and moving and then work out the rationale for what they are doing. In the final analysis being able to touch, feel the client's body and the way it moves is a big part of our work.

Direct care with clients who were overcoming serious obstacles in their lives but who were none the less motivated and appreciative of their professional contribution was clearly the most satisfying component of their work. The fact that the participants saw consistent physical improvement and beneficial changes in the client's status over time, in part due to their interventions, was considered to be an exciting and rewarding characteristic of rehabilitation. As Michael explained:

Treating people with neurological damage, you can make phenomenally big changes in treatment sessions. Even though we can't measure the changes and document them appropriately (which we're going to get to eventually I think), you can make observable physical changes and changes in the way the client perceives it, and see these carry over from treatment session to treatment session. For me it illustrates just how powerful the human body is, what a wonder it is...It's why it's such an exciting field and profession to work in.

Physical therapy was viewed as 'making a difference' to the quality of client's lives. As Janine said:

I also enjoy it when they come back to see me and tell me what they can do and
what they've done. It's that sort of reinforcement, that you did make a difference that I find so rewarding.

The facilitation of movement was not just seen as an end in itself. All the participants clearly articulated that it was the translation of physical changes into functional gains for the client that was at the core of their practice. They were consistently trying to maximize their clients' capabilities in the hope that improved function would contribute positively to their quality of life. It would, however, be erroneous to label these physical therapists as only being interested in the physical. As Kate said:

There's no question that physical capability is an integral part of the person's quality of life and the more they can do for themselves the more psychological benefit there is. But physical capabilities do not mean quality of life in all cases, there are many other factors that are absolutely essential. If you look at only the physical you're only touching the tip of the iceberg it seems to me.

It is the ability of physical therapists to analyze the impact of injury or disease on movement and subsequently on function that defines physical therapy as a profession (Canadian Physiotherapy Association, 2000). The skills and knowledge utilized in analyzing movement and planning therapeutic courses of intervention are based in anatomy and the movement sciences, for example, kinesiology and exercise physiology. The participants' descriptions of their knowledge of movement, however, focused on skills gained through experience, practice and observing others. This reliance on first hand experience and observation, on 'knowing' through practical experience, rather than on theory, what is appropriate for an individual client has to some degree defined physical therapy in the past (Pratt, 1989). Jensen et al's (2000) study, upon which their model of expert practice is based, describes physical therapy practice that is increasingly complex and responding to ongoing changes in health care. The participants' accounts of their practice in rehabilitation captured the multifaceted nature of the knowledge and skills they incorporated into their practice. Their desire to treat clients as unique individuals and
contribute, through their practice, to the overall quality of their client’s lives were consistent themes in their accounts.

**Virtues**

The dimension of virtues in the theoretical model of expert practice, according to Jensen et al. (2000), refers to the personal character traits and attributes which therapists bring to bear in practice. It involves establishing a respectful relationship with the client based on professional integrity and the therapeutic use of self. Titchen (2001) suggests that the concept of therapeutic use of self involves the complex interplay of intuitive and rational judgement and theoretical and practice knowledge. In my experience it is the balance of knowing, being, doing and feeling that clinicians bring to each clinical situation and which are determined by the particulars of the situation. Jensen and her colleagues do not explain their rationale for using ‘virtues’ as a descriptor of practice. In applying the descriptor ‘virtues’ to the participants’ perceptions of practice I assumed, drawing from ethical theory, the focus of this dimension of the model to be the physical therapists’ role as moral agent. MacIntyre (as cited by May, 1994) defined a virtue as “an acquired human quality, the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods” (p. 79). Pellegrino (1995) considers this idea of virtue as important for the health professions because it involves excellence in traits of character which are oriented to ends and purposes, an excellence of reason not emotion, practical judgements and learning by practice (p. 256). One of the emerging dilemma themes concerns situations that cause moral distress and the participants’ fulfillment of the role of moral agent and these are discussed in Chapters Seven and Nine of this thesis.

Many of the participants involved with this study spoke of the ‘artistry’ of their practice. By this they seemed to mean the non-physical aspects of their practice, such as, communication, listening, counseling, empathizing and ‘tuning in to the patient,’ in other words establishing a therapeutic relationship with the client. They were deeply invested in providing committed and caring service to their clients. As Michael said:
I chose to be a physiotherapist rather than a doctor because I would rather hang out with the patients than be harried and go through a day without getting to know one person. A more personal approach is definitely needed .... There's an art to it. When you work artistically you're working from the soul and in most instances you're interacting at all levels with your patient. In physiotherapy we see people who have problems - both emotional and physical - and they open up to you.

The participants considered central components of that service to be the development of collaborative relationships with the client and other disciplines and the assumption of the role of advocate for clients. These commitments entailed significant efforts that went beyond the more formal continuing education activities in which they participated. They expended considerable time and energy on initiating and participating in informal learning opportunities with peers and colleagues. These initiatives included in-service education, practical sessions, case presentations, and anatomy/physiology reviews that were organized on a specific unit or program basis. They provided a forum in which knowledge could be shared and, more importantly, in which they could critically reflect on their practice. Observing peers and experts considered particularly effective therapists provided role models for establishing a therapeutic relationship with clients and their families. Four participants mentioned how instrumental Mary Lynch, a Bobath course instructor, had been in not only adding to their knowledge base but also facilitating reflection about their own practice. Michael described how he learnt from his colleagues in this way:

The team I work with – brilliant physiotherapists – are my mentors. They are close at hand for consultation with a client, I can observe them working and through reviews and practical sessions with them I add to my knowledge all the time. It's also that we have a free enough arrangement that we can accept criticism from each other and question each other. It pushes me to be better!

Barbara seemed to be more isolated from her peers. In her case this consultation occurred more with colleagues outside physical therapy, such as, biomedical engineers and prosthetists. For the others working closely with their physical therapy colleagues, questioning and critiquing each other's practice kept them challenged and motivated. The importance of learning from colleagues is reflected in Kate’s comment:
I still do regular practical sessions with friends, I treat patients with friends – a friend who does private practice – and I deliberately go and work with her sometimes so we can treat patients together, to keep on pushing and developing the skills. For me I’ve needed guidance, people to help me tune in.

All the participants consistently expressed that the challenges of “being holistic” and of ‘keeping up professionally’ with developments and changes in their chosen specialty areas represented primary reasons for their interest in rehabilitation. The learning environment described by the participants enhanced clinical skills but also encouraged personal development and growth.

Conclusion

The questions I asked about the participants’ everyday practice in rehabilitation focused on their positive experiences. All the participants were employed by institutions providing rehabilitation services. Four dimensions of practice, outlined in the theoretical model of expert practice developed by Jensen et al (1999, 2000), have been used as a method of framing the participants’ descriptions of their practice. Their descriptions reflected a complex interweaving of client-focused care, interdisciplinary decision-making and a commitment, on their part, to lifelong learning and maintenance of their own standards of professional practice. It is from this context and conception of practice that the study findings - dilemmas that physical therapists experience in rehabilitation settings - emerge. Practice in rehabilitation settings is also affected by the broader Canadian health care context, for example, how provincial governments allocate funds to rehabilitation institutions; but a discussion of these influences are beyond the scope of this study. In the past physicians prescribed the interventions that physical therapists applied in client care; however, physical therapists now work autonomously. They make decisions about the content, type and amount of physical therapy intervention appropriate to an individual client’s circumstances and, as a result, a client centered approach is possible and clinical reasoning becomes central to the standard of physical therapy practice (personal communication, Lyn Jongbloed, October 2001).
During the process of interviewing these individuals I developed an enormous appreciation for the depth and breadth of their knowledge, their commitment to their clients and their belief in what physical therapy had to offer. They had all weathered administrative upheavals in their respective organizations and major changes in the larger health care system, but few spoke of these as a source of personal anxiety or professional frustration. Instead the dilemmas they articulated, in relation to these system changes, related entirely to the impact on client care that they perceived these changes had caused. These concerns reflect a common understanding, shared by all the participants, of their role as physical therapists in rehabilitation, regardless of institution or program. Their practice began and ended with their clients. Whether they were speaking about research, professional development, interdisciplinary involvement or their everyday practice, the client was the raison d'etre, the focus of clinical practice. The participants in this study set high standards for themselves and were highly motivated to remain current in their neurosciences specialty. They seemed stimulated by the challenges of clinical practice and committed to doing their best for the client. Regardless of which dimension of expert practice the participants were describing it was clear that they valued opportunities, whether formal or informal, to enhance their practical skills and knowledge. Tensions were evident in their accounts of ‘what works’ in practice and the need to justify their practice through the generation and integration of evidence in their clinical reasoning and decision-making. These tensions are a foreshadowing of a major dilemma theme that will be discussed in the next chapter.

Interdisciplinary involvement was perceived by the participants as a central feature of their practice in rehabilitation and was also experienced as a source of dilemmas. This theme will be discussed in Chapter Eight. The participants’ interdisciplinary experiences are not reflected, to the same degree, in Jensen et al’s (1999, 2000) discussion of the four dimensions of expert practice. Their model is based on the practice experiences of physical therapists in a diversity of clinical areas and specialties, whereas this study focuses specifically on rehabilitation provision of care. It may be that, as the literature suggests, a more definitive interdisciplinary team
approach developed in rehabilitation in response to the complexity of practice addressing chronic illness and disability.

The age of the participants in this study does reflect the largest group of physical therapists working in British Columbia and in rehabilitation settings. I was, however, surprised that none of the more recent graduates I met, during my visits to the rehabilitation settings in the Vancouver area, had volunteered for the study. The answer may lie in the different priorities held by newly qualified and more experienced practitioners. Newly qualified physical therapists are characterized as being more concerned with developing their professional proficiency and expertise through immersion in the complexities of practice. They are in the process of acquiring confidence in the legitimacy of their own perspectives and interpretations and establishing themselves in their professional culture (Daley, 1999; Eraut, 1994; Richardson, 1999; Sternberg, 1998). In contrast, the more experienced physical therapists, as represented in this study, wanted time to reflect on how to promote best practice, how to ensure the clients' health and well-being in the long term and how to be proactive in a dynamic health care system. Involvement in the study appeared to give them the opportunity and 'space' to engage in that type of reflection.

This chapter provides a snapshot of the participants' perceptions of their practice in rehabilitation settings and the knowledge base they value as relevant to that practice. The rehabilitation institutional setting is the context in which this practice takes place. Three main themes of dilemmas emerged from the data and will be presented in Chapters Six through Eight. A brief overview of the themes is provided to assist the reader to see them as connected rather than in isolation. These connections and the implications for practice will be discussed in Chapter Nine. The primary dilemmas experienced by the participants arose from perceived barriers – personal, professional or institutional – which interfered with them effectively applying their knowledge for the benefit of individual clients. The first theme can be broadly defined in terms of their responsibility to justify their professional knowledge base. The need to be accountable for their practice caused them to question and reflect on how they could reconcile the knowledge they valued in practice with the implementation of the concept of evidence-based
practice. The second theme is defined in terms of perceived adverse effects on the client resulting from their inability to apply their skills and knowledge effectively in specific situations. In such situations the participants felt unable to advocate effectively on behalf of their clients and experienced considerable moral distress. The final theme relates to the interaction of their knowledge and practice with other health professionals in working effectively as a team in the clinical setting on behalf of the client. The first theme will be presented and discussed in the next chapter.
CHAPTER SIX: JUSTIFYING PHYSICAL THERAPY KNOWLEDGE IN REHABILITATION PRACTICE

The findings of this research study will be presented in the following three chapters. In line with the interpretivist assumptions upon which this study is based, and which are discussed in Chapter Three, these findings represent interpretations made by both the participants and myself in the course of the research process. The theme presented in this chapter focuses on a number of epistemological issues - how the profession values, generates and justifies different kinds of physical therapy knowledge - which the participants experienced as dilemmas in their practice.

In Chapter Five the nature of rehabilitation practice, perceived by the participants as client-centered and holistic, was presented and insights were gained about the knowledge and skills they valued and considered essential to their practice. The term practice, as used by the participants and in this discussion, has two meanings. In one way it refers to the activity of each participant as they engage on a day-to-day basis with clients and other professionals in the rehabilitation setting. It also describes a "whole tradition in which particular activities are related together as part of a social project or mission" (Golby, 1993, p. 4). The practice described by the participants is a dynamic process embedded in the rehabilitation context and provision of service for particular client groups. It involves a complex integration of theoretical knowledge, technical skill, intuition, common-sense, professional judgements, experience and the therapeutic use of self applied in the rehabilitation setting to each unique client situation. Although the details of their everyday practice were not the same, the participants appeared to share with each other a common understanding of the intricacies of practice in rehabilitation. These common interpretations of their practice in rehabilitation were derived from, and reinforced by, the support they received from their peers and colleagues.

In a sense, the rehabilitation setting provides the social environment in which certain patterns of interpretation are established. The central concern of Schutz’s work in The Phenomenology of the Social World (1967) is how the experiences of the everyday life of the
commonsense world or the ‘arena of social action’ are apprehended and made meaningful. By developing ‘schemes of experience’ a degree of order can be brought to a person’s life. The participants, who share the professional culture of physical therapy and a commitment to rehabilitation practice, appear to have developed a reciprocity of perspectives about their knowledge and practice which are in general taken-for-granted. However, when these taken-for-granted perspectives become problematic they require conscious re-interpretation or critical reflection. In this way the participants’ concerns about the nature of their ‘practice’ knowledge emerged as a series of related dilemmas that I will discuss under the theme entitled: justifying physical therapy knowledge in rehabilitation practice.

The participants’ commitment to practicing in rehabilitation and their strong belief that the application of their physical therapy knowledge and skills to individual clients’ circumstances are justified in terms of improvement of client function and quality of life has been described in Chapter Five. The participants all acknowledged the importance of basing their clinical reasoning and decision-making on the best available evidence in order to ensure optimal outcomes and high standards of practice. However, they found themselves in the unenviable position of experiencing the value of their practice, yet not being able to justify the effectiveness of it in terms of the dominant evidence – based paradigm. These dilemmas may represent to some degree a crisis of confidence in physical therapy knowledge or, at the very least, a failure of the profession to acknowledge different kinds of knowledge in evaluating practice. These dilemmas are not unique to the profession of physical therapy as evidenced in the literature in medicine (Maynard, 1997), nursing (Mowinski, Jennings, & Loan, 2001) and occupational therapy (Law & Baum, 1998). In this chapter I will explore these dilemmas from the participants’ perspectives, linking their interpretations with relevant theoretical work in education and current debates in the health care literature and particularly that of physical therapy.

The Need to Justify Practice

Evidence – based practice, according to the Council of Directors of Physical Therapy
Academic Programs and the Canadian Physiotherapy Association (1995), has a theoretical body of knowledge, and uses the best available scientific evidence in clinical decision-making and standardized outcome measures to evaluate the care provided. All the participants were well informed about these concepts and were clearly critical readers of the physical therapy and related disciplines’ literature. They welcomed the fact that the instructors of continuing education courses in which they participated were attempting to incorporate current theoretical and research advances in such areas as central nervous system plasticity, axonal regeneration and motor learning. It was this combination of theoretical information and clinically relevant skills that contributed to their enthusiasm for their professional practice and their belief in the value of their ‘practice’ knowledge. As a generally older and more experienced group they had graduated from physical therapy academic programs before the concepts of evidence-based practice, outcome measurement and the drive to conduct clinical research had been conceived and integrated into the curricula. As Margaret said:

We had a sort of belief in what we were doing back then. It was all very practical, we spent hours with patients. The theory stuff was mostly anatomy and physiology, we didn’t do statistics or research courses. That all came later. The experience of the students today is very different from ours.

The participants all perceived the need to legitimize their practice as part of their professional responsibility. As Dawn commented “we really have to work much harder to provide some rationale for what we are doing clinically.” Four participants spoke of the clients’ increasing access to detailed sources of information, primarily through the internet. Clients were frequently well informed and consequently the participants felt the responsibility to be increasingly accountable for their practice. As Barbara observed:

I think we have to be careful what we base our clinical decisions on because unfortunately a lot of what we do doesn’t have direct research. I think people are much better informed and have trouble believing in the effectiveness of approaches because there is no scientific evidence.
The participants identified a tendency for physical therapists in rehabilitation to become enthusiasts of specific treatment approaches, for example, neurodevelopmental techniques (Bobath) or functional electrical stimulation. In their view, although these approaches had not as yet been substantiated by research they exerted considerable influence over outcome expectations and how the therapists' interpret the clients' goals. Eight participants expressed concerns about the lack of standardized physical therapy approaches to client care in rehabilitation and these concerns are captured in Margaret’s comment:

I think we [physical therapists] go about treating patients in pretty individual ways – nothing is really standardized about our intervention choices, when and how we approach patient care. I mean you would hope that if you went to Dr. A and Dr. B with the same symptoms, same diagnosis, both of them would give you the same treatment but that definitely isn’t the case in rehabilitation. That sort of standardization is perhaps more likely in an orthopedic setting where the outcomes and problems are less complicated.

All the participants were troubled by the lack of ‘scientific’ evidence to support aspects of the ‘practice’ knowledge that they valued highly and utilized in making intervention decisions and in their everyday interactions with clients. As Veronica said:

I came into rehabilitation because of all the different treatment approaches – Bobath versus PNF, using FES or acupuncture, traditional strengthening/stretching, different approaches to spasticity and contracture management etc. – and I observe other physiotherapists and judge for myself which approaches are effective but I really want to know which is the best. Research evidence would help in making those choices but it’s just not out there.

Research evidence for many of the treatment approaches and procedures used by physical therapists in rehabilitation is either absent, inconclusive or flawed. Several of the participants pointed out that ‘gurus’ in physical therapy like Berta Bobath and Shirley Saruman based much of their respective work on observation and experience with large numbers of clients and have contributed significantly to the knowledge and practice of physical therapy. They questioned
whether the same advances would have been made if these individuals had been required to produce research 'evidence' before their approaches could be adopted by clinicians. As Kate said:

Do you hold back practice because of research or the lack of it? Really in my mind that's what is being asked of us nowadays.

Ruth, who instructed students in the clinical setting, was concerned that the evidence-based practice focus of courses in the academic program would cause the students to be skeptical of her clinical expertise. As she said:

We've not done a lot of research in this area and what there is relates more to outcomes like wheelchair functioning or distances achieved using KAFO's [knee-ankle-foot orthoses]. It makes it really difficult to convince students, who are taught to base their practice on evidence, that what you are doing is actually effective. It's no use saying to them 'well in my experience....'

Kate and Sophie both taught as sessional instructors in the academic program and, in effect, attempted to bridge the often perceived gap between the academic and clinical realities by interpreting their clinical reasoning for the students. As Kate said:

My own practice approach becomes the dilemma. As a teacher I feel a responsibility to defend the Bobath approach – it's really difficult – clinically I know it's effective, it's evolving and we need to show in rigorous ways why it works for our patients. But the question is with so little supporting evidence should we be teaching it?

All the participants acknowledged that relatively few of the interventions they used had been subjected to rigorous research and analysis. They recognised that this inevitably led to an ethical dilemma (rarely acknowledged publicly in the past), wherein, as Banja (1998) suggested, clients were dependent upon the reliability of a therapist's 'best guess' or whim to inform interventions.

All the participants discussed, in one form or another, the concept of evidence-based practice and what it meant to them and to their practice. From one perspective they appeared to
welcome the challenge to ‘what they believe works’ that the concept of evidence-based practice represents and desired the opportunity to defend their clinical decisions by judicious use of evidence. However, they appeared to be living with a degree of uncertainty that to some extent was exacerbated by the perceived pressure to engage in evidence-based practice. As Veronica said:

Well the central questions I ask myself all the time are: are we doing the best for our patients? Are we missing something? Can we justify what we think is working for our patients? Or are we wasting people’s time?

They identified an intrinsic gap between the basic science and clinical research by which ‘best evidence’ is generated and the realities of clinical practice. In this next section I will explore the participants’ perceptions in more detail and relate them to the concept of evidence-based practice as it is currently discussed in the physical therapy literature.

The Gap Between Evidence-Based Practice and Clinical Practice

The concept of evidence-based practice, as adopted in physical therapy, represents a broadening of the concept of evidence-based medicine to include other health care professional groups. Evidence-based medicine evolved from a problem-based learning strategy developed in 1992 at McMaster University in which valid sources of knowledge were located and critically evaluated to aid rational decision making. In 1996, Sackett et al, major proponents of the concept, defined evidence-based medicine as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (p. 30). The interpretation of this definition appeared to ‘de-emphasize’ alternative forms of medical knowledge, such as clinical expertise and experience or the patient's goals and opinions (Bury & Mead, 1998). In 2000, Sackett and his colleagues re-defined evidence-based medicine as "the integration of best research evidence with clinical expertise and patient values” (p. 1). This current definition perhaps represents a shift in thinking that acknowledges the more inclusive reality of medical practice. However, ‘best’ evidence is still primarily associated with ‘scientific’ evidence derived from experimental quantitative research, and evidence-based practice continues.
to be defined as “the process of systematically finding, appraising, and using contemporaneous research findings as a basis for clinical decisions” (Rosenberg & Donald, 1995, p. 1122).

The participants, in several of the comments documented earlier, alluded to the lack of relevant research evidence for many aspects of their practice. Physical therapists do not have a long history of research, although there has been considerable growth in the past two decades. The current evidence available is limited to a small number of discrete interventions, is of variable quality and can be difficult to obtain. The lack of suitable standardized outcome measures5 “used to document change in one or more patient characteristics over time” was identified as a major problem for the profession by Cole, Finch, Gowland and Mayo (1994, p.22). They evaluated twenty-one adult motor and functional activity measures appropriate for use with elderly clients and those with disability. Dawn’s comment reflects the problem participants experienced in incorporating such standardized instruments into their decision-making:

I really agree with the idea of objective measures, with objective outcomes appropriate for the client, but if they haven’t been thought out for that individual then it’s a waste of time. It’s a waste of time saying I will do the FIM or the Chedoke-McMaster® as an objective measure of a client’s improvement or function because it’s generally not appropriate for that person’s circumstances.

An outcome, according to the Canadian Physiotherapy Association (2000), is “the result of physiotherapy management” and a successful outcome “ improves or maintains physical function when possible, slows functional decline where the status quo cannot be maintained, and/or is considered meaningful to the client (p. 5).” Six participants spoke of their concern that the ease with which the outcomes could be measured tended to influence the research that is undertaken. Kate felt that this encouraged the use of standardized outcome measurement tools

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5 Published measurement tool, designed for a specific purpose in a given population, with detailed instructions provided as to when and how it is to be administered and scored, interpretation of scores and results of investigations reliability and validity (Cole, Finch, Gowland & Mayo, 1994, p. 22).

6 Standardized outcome measures: Functional Independence Measure (FIM) and Chedoke-McMaster Stroke Assessment.
that lacked the sensitivity needed to accurately capture the client’s level of function. She gave
this example to illustrate her concerns:

The items on the Barthel Index\(^7\) are too gross but it is used extensively just
because it has been standardized and fits experimental criteria. However, in this
particular study the findings suggested that patients reached a plateau at a certain
stage post-stroke but they reach a plateau because the tool can’t register the
changes that are occurring.

Cole, Finch, Gowland & Mayo (1994) broadly defined a physical therapy intervention as
“the purposeful and skilled interaction of the physiotherapist with the client, using various
methods and techniques to produce changes in a client’s condition and to meet established client
– centered goals and health outcomes” (p. 5). The participants contrasted the relative ease of
measuring the effect of specific interventions aimed at treating an acute orthopedic problem,
such as tennis elbow, with the less clear cut longer term outcomes of interventions for people
who have sustained a brain injury. This comparison is symbolic of a fundamental difference
between acute and rehabilitation care. In acute care, there is more likely to be a more linear,
causal relationship between an intervention and the outcome. In contrast, rehabilitation
interventions are designed with the client’s larger context and goals in mind and in collaboration
with other disciplines. The participants all spoke of their practice in rehabilitation as a complex
mixture of assessment, planning, prevention of complications and health promotion and of the
unique quality of each client interaction. The methods and techniques they described using in
rehabilitation included a diversity of approaches to re-educate movement, exercise prescription,
equipment use and client education and information provision.

The participants identified a number of characteristics of their interventions with clients
that, in their view, made effectiveness difficult to quantify. Proficiency in the
neurodevelopmental approaches (for example Bobath) to treatment used in rehabilitation comes
with experience and being involved in specialist courses. As Kate explains:

\(^7\) Standardized outcome measure developed to monitor functional independence before and after treatment.
These types of approaches are based on the stages of motor learning and helping clients move through these stages requires them to utilize tactile, verbal, visual and proprioceptive cues. I'm providing, particularly in the early stages, those perceptual cues with my hands, helping them discover what is required to perform a task. It's a total body proprioceptive re-education and based on a thorough evaluation of a person's movement strategies and determining which can be changed and re-learnt.

These approaches are considered specialist knowledge and are difficult to standardize. The desired outcome of treatment is often achieved in collaboration with other health care professionals. Rehabilitation outcomes, particularly given the decreased length of stay in centres and programs, may only be achieved in the client's own environment after discharge from rehabilitation. In addition, because of the nature of the condition, for example brain injury or stroke, the client's physical status and capabilities may change over a prolonged period of time. Given the relatively short admission period – approximately 6 – 8 weeks – and the lack of formal follow up programs, assessing the effectiveness of specific interventions in achieving functional goals and outcomes, given the current emphasis on 'best' evidence derived from experimental research, is frequently unrealistic. These issues, raised by the participants in relation to their practice, contributed to their perception of the "lack of functional relevance" of evidence-based practice as it is currently conceived to their clinical reality.

The participants were concerned that the "research tail was wagging the dog" meaning that, in their view, researchers were unduly influenced by the availability of certain standardized instruments or that the research questions were being shaped by the feasibility of implementing the desired research design. Jill's comment reflected these concerns:

The scary thing is we're being pushed to do research, to be accountable and objective and that's appropriate, but only certain types of research are acceptable – certain tools – and we're being told we must use something. So people are grabbing on to established tools because they're supposedly reliable etc. but the question is what is really being measured? Is it just expediency or is something worthwhile going to be learnt and who really will benefit?
For most of the participants their practice reflected a complex integration of a diversity of variables making it difficult to evaluate using a quantitative paradigm based on reductionism, controlling variables, testing hypotheses, and establishing a causal relationship between their interventions and client outcomes. That is not to say that some aspects of physical therapy practice in rehabilitation do not lend themselves to this mode of investigation. Barbara was very excited about the potential for research related to the use of functional electrical stimulation (FES) in gait retraining following spinal cord injury. As she said:

You know the people who develop the FES technology need people like physiotherapists to test it in practice. There’s definitely a need to find out how it works for patients as compared with other systems in the short and long term. There’s a study there but at the moment we don’t have enough patients to make it worthwhile.

Michael’s comment, however, reflected the difficulties felt by the majority of the participants in relation to the need to justify their practice through the incorporation of ‘best’ evidence:

We need to be more objective about our practice. There is place for quantification but at the same time so little research has been done related to rehabilitation or it doesn’t contribute much to making us better therapists. I mean we talk about the patient’s quality of life as being the goal of our efforts but it’s dependent on so many factors.

There is an increasing realization, reflected in the literature, that the current body of research knowledge is not necessarily useful in guiding clinical practice. As Rosenberg and Donald (1995) observed: “We are confronted by a growing body of information, much of it invalid or irrelevant to clinical practice” (p. 1122). The participants equated the current definitions of ‘best’ evidence with an oversimplification of their everyday practice. Kate expressed her wariness about the ethics of basing practice on evidence generated from research that appeared to undervalue ‘practice’ knowledge:
There's this push to do perfect research but it's always a compromise and I don't think researchers have been encouraged to make those things overt. It's a major game. Play the game, get published, get funding, build the reputation. What I've seen of that whole process is that it's driving a lot of what becomes available as evidence, what is chosen as a topic of research, driving what we are allowed or not to do in practice. At the same time it excludes those of us in practice who might have a more relevant line on research which would be useful.

These same questions are being raised in the medical literature (Green & Britten, 1998; Harrison, 1998; Maynard, 1997; Naylor, 1995; Pellegrino, 1999; Tonelli, 1998) and in the physical therapy literature (Bithell, 2000; Sumsion, 1997). A primary criticism, reflected in the participants' concerns, is the overwhelming reliance on rigorous experimental research designs that are more appropriate in appraising new technologies or drug efficacy than attending to the "many smaller-ticket items in routine practice" (Naylor, 1995, p. 840). The evidence-based practice concept is based on judgements being made about the relative values of research evidence. To that end hierarchies of scientific evidence, based on the work of Sackett (1993), have been developed (See Table 6.1).

Such hierarchies provide frameworks by which the evidence resulting from different types of levels of experimental, quasi-experimental, and pre-experimental research designs can be evaluated. As a result, the randomized control trial (RCT) is viewed as the 'gold standard' among designs used to evaluate interventions. In some respects, evidence-based medicine is a logical development of the traditional medical model approach to patient care (Tonelli, 1998) in which the emphasis is on isolating the cause and effecting a cure. The underlying assumptions of evidence-based practice are that quantifiable differences between individuals can be controlled and accounted for in well-designed clinical research. But as Veronica said:

I get frustrated – randomized control studies are just so hard with this rehab population – like how do you get incomplete spinal cord injuries that are the same to even put them in groups?

The participants were concerned that 'best evidence' generated from quantitative research, designed and implemented by professionals, both obscured the non-quantifiable elements
Table 6.1

Levels of Evidence (Adapted from Sackett, 1993)

<table>
<thead>
<tr>
<th>I</th>
<th>Strong evidence from at least one systematic review of multiple well-designed randomized controlled trials</th>
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</thead>
<tbody>
<tr>
<td>II</td>
<td>Strong evidence from at least one properly designed randomized trial of appropriate size</td>
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<tr>
<td>III</td>
<td>Evidence from well-designed trials without randomization, single group pre-post, cohort, time series or matched case-controlled studies</td>
</tr>
<tr>
<td>IV</td>
<td>Evidence from well-designed non-experimental studies from more than one centre or research group</td>
</tr>
<tr>
<td>V</td>
<td>Opinions of respected authorities, based on clinical evidence, descriptive studies or reports of expert committees</td>
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</tbody>
</table>

of clinical practice and addressed questions raised by them and not by the clients. In their view, evidence-based practice, based on a hierarchy of 'acceptable' experimental research, effectively silences the client's voice and that this is antithetical to the client – centered model of care promoted in rehabilitation institutions. As Veronica said:

I think we have to be careful, before we go looking to see if our therapy can produce some change, to identify what kind of changes we are trying to make. Are there some trends of things that patients with spinal cord injury or acquired brain injury value more than others. I mean we've really never found out. I think that would be interesting and useful to guide our treatments.

The primary goals of physical therapy practice and similarly those of other health professions, have been defined in terms of benefit to the individual client. Sackett et al’s (2000) recent inclusion of 'patient values' into the definition of evidence – based medicine is laudable. They identified patient values as "the unique preferences, concerns and expectations each patient brings to a clinical encounter" and which, in their opinion, "must be integrated into clinical decisions if they are to serve the patient" (p. 1). However, little guidance has been provided as to
how clients' needs, rights and preferences can be incorporated into the evidence that informs practice. The participants felt that evidence-based practice, initiated, implemented and interpreted by professionals, tends to devalue the tangible differences between clients, and in turn to devalue the individuals themselves. As Dawn said:

It's a shame that physiotherapists can't find an appropriate way to support their practice – but all this push for objective measurement (which to some degree I agree with) really lacks respect for the human being – the patient. I mean the fact that they feel differently about their body after treatment, are more in touch with the environment is an outcome that can't be measured but is so important.

Sophie, speaking from the perspective of supporting the client in the community, felt that:

The client's driving it and that's the way it should be. That can prove difficult sometimes when, for example, parents of a person with disability want treatment that you know won't actually help. It's difficult because we have no body of supporting evidence for what we do. Anecdotally – from our collective experience – we know things work or not but...

The participants' dilemmas related to evidence-based practice did not represent their rejection of the concept but rather a resistance to the uncritical adoption of the concept as it is currently defined and implemented within physical therapy. Michael articulated the problem like this:

I fight against objective measures and research. The problem is that physiotherapy has been following the medical model. We haven't valued all the other skills that are part of our practice, e.g. communication and counseling, and we need to find other ways of doing research - producing evidence - which better fits rehabilitation patients and our own skills and practice.

Several participants cited the physical therapy literature as reflecting the evidence-based practice trend and containing few research articles relevant to practice in rehabilitation. Reviews of physical therapy literature in the 1990's, primarily of the Canadian, Australian, British, and American journals (Mitchell, 1992; Robertson, 1995) revealed the increasing use of 'group comparison designs' or 'experimental trials' in physical therapy research study design. In the 1990's a number of authors (for example, Basmajian & Banerjee, 1996; Harris, 1996) urged the
adoption of Sackett's (1993) Levels of Evidence as a means of evaluating the 'best' evidence to support physical therapy practice.

More recently, Klassen, Grzybowski & Rossner (2001) suggested that a decrease in published 'experimental' research in the physiotherapy literature may be due to the fact that "the experimental group design does not lend itself as readily to the investigation of physical therapy interventions" (p. 46). They identified the main difficulties as recruiting sufficiently large numbers of homogeneous subjects and in maintaining experimental control, and ethical dilemmas created by the need to allocate patients to treatment and control groups. These same authors observed that "the profession explicitly and implicitly promotes the true experimental design as the standard of excellence to which the profession should aspire" (p.46). They recommended that, in light of the difficulties in implementing a true experimental design, physical therapy researchers should reconsider their "attitudes toward quasi group experimental, pre-experimental and single subject designs" (p.46). In their opinion, these alternative approaches, while at a lower level in the hierarchies of evidence, do "represent increasing levels of practicality when undertaking human research" (p. 46). These authors' comments may indicate a move within the profession towards a more critical approach to the concept of evidence - based practice.

Embedded in the participants' discussions about their role in the provision of rehabilitation care and in their descriptions of the 'particularities' of their everyday practice were examples of alternative sources of evidence that they were using to support their clinical decision-making. Veronica considered that qualitative research methods would provide detailed descriptions of practice issues not otherwise captured by quantitative methods but she felt ill-prepared to instigate such research. Kate suggested that evidence might be generated by rigorously documenting the specifics of clinical cases. Barbara, on the other hand, felt that collaborating with other disciplines, specifically in her case, biomedical engineering and orthotists would inform her practice. Sophie felt that a more systematic approach to her clinical reasoning processes – how she made judgements – might contribute to the physical therapy body
of knowledge. Janine talked about the value of building consensus about clinical approaches with her peers, within and outside the institution, as a means of generating evidence to support practice in specific clinical areas.

The participants all recognized that questions raised about the efficacy of specific interventions in achieving the desired outcomes could be best addressed using an experimental research design. However, they were concerned that an over-emphasis on the importance of quantitative evidence belied the fact that other sources of evidence may be more suitable depending on the clinical questions and setting. The gathering of evidence to support the effectiveness as well as the appropriateness of rehabilitation practice clearly requires a wide range of different types of evidence in addition to the narrow range of acceptable evidence espoused by evidence-based practice. Increasingly there is a public acknowledgement that judicious use of current best evidence in making health care decisions requires a balancing of risks and benefits of these alternative sources of evidence (Bury & Mead, 1998). The participants, in the course of their everyday practice, instinctively incorporate such a balancing of diverse sources of evidence. These alternative sources of evidence, in combination with evidence derived from “accepted” sources, would potentially reflect more comprehensively the participants’ clinical practice and the complexity of clinical situations in rehabilitation.

However, the dilemmas the participants experienced clearly related to the pressure to conform to the evidence - based approach in justifying their practice. This pressure appears, in Canada at least, to be emanating primarily from within the profession. It is my intention to explore the profession’s preoccupation with evidence-based practice in more depth in Chapter Nine. All the participants identified difficulties relating the knowledge derived from research and the use of standardized outcome measures in a relevant way to an individual client’s circumstances. They were concerned that the current focus on incorporating ‘best’ evidence failed to address the client’s perspective and contributions to achieving desired outcomes. At the same time the participants endorsed the importance of developing a more standardized approach to treatment and being accountable for their practice.
same time the participants endorsed the importance of developing a more standardized approach to treatment and being accountable for their practice.

There was, it seemed to me, a paradoxical quality to the participants’ discussions of their practice and of the dilemmas they experienced related to the gap they perceived to exist between research and the ‘best evidence’ derived from it, and the priorities of clinical practice. This gap, in my opinion, may be viewed as an epistemological one. Underpinning their discussions was a sense that the concept of evidence-based practice as it is currently conceived inherently undermines the credibility of their ‘practice’ knowledge and expertise.

Valuing ‘Practice’ Knowledge

Scientific evidence is just one piece of the practice puzzle. Evidence does not make the everyday decisions in the clinical context. These are made as clinicians seek to meet individual client goals. This clinical reasoning utilizes a wide range of information sources of which ‘best’ evidence derived from research is just one and even ‘best’ evidence can lead to bad practice if applied unthinkingly or uncritically (James McCormack, October 2001, personal communication). In addition, “while research may not have shown interventions to be effective, this does not equate to evidence of ineffectiveness” (Bury & Mead, 1998, p. 7). As Naylor (1995) suggested “the craft of caring for patients can flourish not merely in the grey zones where scientific evidence is incomplete or conflicting but also in recognition that what is black and white in the abstract may rapidly become gray in practice” (p. 841). This kind of clinical reasoning requires that the therapist bring to bear their ‘practice’ knowledge in taking into account a diversity of sources of ‘evidence’ and weigh the relative advantages and disadvantages in making a judgement about how to proceed. Kate offered this description of how she applied her ‘practice’ knowledge:

It’s a kinesthetic experiential thing, starting to get a sense of the patterns of movement, start making connections but being cautious about jumping to conclusions too quickly, and missing what is important for the client because you assumed too much.
Eraut (1994) suggests that clinical judgement "involves practical wisdom, a sense of purpose, appropriateness and feasibility and its acquisition depends, among other things, on a wealth of professional experience" (p. 49). Margaret explained how important her clinical experience was in making clinical decisions on behalf of her clients:

I've seen enough patients with strokes and although they are all different, something will cue me into where I'd like to start. It's really an educated decision and I have to trust it will achieve what I hope it will for the client. It's a subtle thing, difficult to explain.

Tonelli (1999) argues that expert opinion and clinical judgement could easily be regarded as the highest form of evidence and that it is misplaced in current hierarchies of evidence. He argues that experienced practitioners, although at times fallible, are best placed to fill the gap between the evidence derived from clinical trials and the delivery of care to the benefit of the individual client. In his view, without appeal to alternative forms of clinical knowledge the results of research that apply to the non-existent 'average' patient will lack relevance.

The participants' complex 'practice' knowledge was described in Chapter Five and framed by the four dimensions of the theoretical model of expert practice in physical therapy (Jensen et al, 2000). This model represents the first attempt to conceptualize expert practice in the profession. The concept of 'practice' knowledge, as described and enacted by the participants, is not a new one. Schon (1983) and Eisner (1993) articulated that professional practice requires more than technical competence and they sought to understand this complexity which they respectively called the 'artistry' and 'connoisseurship' of professional practice. Schon (1987,1991) introduced the concept of reflection as a means of investigating practice and theorizing about it. In his view, this concept was not only an individual psychological process but also an action oriented social process.

A number of epistemological concepts have been developed in an attempt to describe, explain and analyze the different types of knowledge relevant to professional health care practice. Titchen and Ersser (2001) analyzed a number of the concepts that have been developed,
that in combination, define professional knowledge and which they consider form the epistemological underpinnings for health care practice. A summary of their analysis is provided in Table 6.2. The authors conclude by expressing concerns that, confusingly, there are considerable variations in the health care literature in the way that concepts of professional knowledge are defined and applied and that attempts to differentiate them may detract from the subtlety and overlapping nature of many of these concepts.

The propositional knowledge incorporated into the physical therapy professional knowledge has been extensively documented (Council of Directors of Physiotherapy Academic Programs and the Canadian Physiotherapy Association, 1995) and is relatively easy to recognize and define. The 'practical' knowledge applied by physical therapists in decision-making in the 'real' clinical settings has not proved as easy to capture (Bithell, 1999; Fish & Twinn, 1997; Higgs & Titchen, 1995, 2001; Richardson, 1999, 2001). Traditionally clinical knowledge has been passed on orally from one practitioner to another in an apprenticeship model of clinical supervision. Unless an expert clinician also taught in undergraduate or post-graduate courses, or contributed to textbooks, their clinical expertise or 'practice' knowledge was not passed on in any coherent manner (Bithell, 1999). As a consequence physical therapy academic curricula are largely based on propositional knowledge. Hunt et al's (1998) study found that recently graduated physiotherapists perceived important gaps between knowledge and skills acquired as a result of their university education and those valued and considered essential in the clinical settings. These findings suggest that 'practice' knowledge, reflected in the other concepts summarized in Table 6.2, is acquired 'on the job' and 'through learning from peers.'

There is also a sense that physical therapy lacks the theoretical underpinnings upon which a comprehensive body of knowledge could be based (Roskell, Hewison & Wildman, 1998). In effect a theory – practice gap has been identified. This has resulted in physical therapy adopting specific theories drawn from other disciplines, for example, medicine, anatomy, physiology, and neurophysiology, that validate various physical therapy practice approaches and
Table 6.2
Epistemological Concepts Related to Professional Knowledge  (Adapted from Titchen & Ersser, 2001, pp. 37-39)

<table>
<thead>
<tr>
<th>Epistemological Concepts</th>
<th>Nature of Knowledge</th>
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<tbody>
<tr>
<td><strong>Propositional Knowledge</strong></td>
<td>Formal and explicit knowledge arising from theory and research. It is the public, collective or shared knowledge of a profession and provides the basis for analyzing patients’ physical and psychosocial problems.</td>
</tr>
<tr>
<td><strong>Practical Knowledge</strong></td>
<td>‘Knowing how’ to perform a task or operation or to exercise practical skill. Developed through skill acquisition.</td>
</tr>
<tr>
<td><strong>Knowing-in-practice</strong></td>
<td>As above, plus practical know-how is imbued with theoretical knowledge.</td>
</tr>
<tr>
<td><strong>Experiential Knowledge</strong></td>
<td>Knowledge derived through direct encounter with something: a subject, person or thing, an observation of events.</td>
</tr>
<tr>
<td><strong>Aesthetic Knowledge</strong></td>
<td>Concern with the particular, form and style. Professional artistry.</td>
</tr>
<tr>
<td><strong>Intuitive Knowledge</strong></td>
<td>Understanding or belief without rationale. ‘Gut feeling.’</td>
</tr>
<tr>
<td><strong>Ethical / Moral Knowledge</strong></td>
<td>Knowledge of right and wrong. Focusing on moral obligation and what ought to be done in the clinical situation and managing conflict.</td>
</tr>
<tr>
<td><strong>Embodied Knowledge</strong></td>
<td>Knowing by the body not the mind. The body itself as knower and interpreter.</td>
</tr>
<tr>
<td><strong>Personal Knowledge</strong></td>
<td>Understanding and evaluating self in context of caring for patients. Awareness of how self influences the client – therapist interaction.</td>
</tr>
<tr>
<td><strong>Craft Knowledge</strong></td>
<td>Knowledge which is improved through experience of everyday practice. Knowing what to do, how and when, what may be achieved, and what the outcomes might be in a particular situation.</td>
</tr>
</tbody>
</table>
Specific neurodevelopmental approaches to treatment, for example Bobath, offer a theoretical approach to specific neurological patient populations and do guide specific interventions used primarily by physical therapists, but which are also utilized in other professional practice, for example, occupational therapy. Attempts have been made to develop overarching theories of physical therapy (for example, Cott et al, 1995; Dean, 1985; Jensen et al, 2000). These apply to all types of clients and all fields of physical therapy practice. They provide an overview of practice but are not specific enough to guide particular interventions (Lyn Jongbloed, October 2001, personal communication). These theories have not, as yet, resonated with or been perceived as relevant to clinical practice. As a result, knowledge and theories generated from within clinical practice have not made a significant impact on physical therapy education (Higgs & Titchen, 1995; Bithell, 1999; Roskell, Hewison & Wildman, 1998).

Eraut (1994) points out that discipline-based, propositional or theoretical knowledge “does not usually depend on the field of professional action” and consequently “the functional relevance of a piece of theoretical knowledge depends less on its presumed validity than on the ability and willingness of people to use it” (p.43). Propositional knowledge can be generated in any research paradigm, whether positivist, interpretive or critical but, in physical therapy, it continues to be most commonly associated with the ‘scientific’ positivist approach to research. It is this type of knowledge that is most clearly reflected in the evidence-based approach to practice as it is currently conceived in medicine and physical therapy. The participants did discuss the importance of grounding their practice theoretically, for example, knowledge of pathology or anatomy and incorporating ‘best’ evidence in their decision-making. This type of knowledge allowed the participants to recognize the meaning of the results of client observation and assessment in terms of underlying pathology or neurological deficits. Interpretation of this knowledge enabled them to make intervention choices appropriate to an individual client’s case. However, the ability to place the clinical problem within the client’s context, and to design personalized care and interventions that take the client’s experience and wishes into account, was recognized as the key element of expertise that develops from the acquisition of clinical
'practice' knowledge. As Ruth explained:

I like the idea that it's a holistic approach, that you get to know the patients so well, that everyone on the team contributes their [expertise] to do the best they can for the person. I'm interested in all aspects of the patient, in the areas that aren't specifically physiotherapy related. It's so multifaceted, part of the whole picture.

Professional knowledge, according to Williams (1998) represents an integration of propositional, process and personal knowledge. Process knowledge is the knowledge of how to do something. Cervero (1992) describes process knowledge as “a repertoire of examples, images, practical principles, scenarios or rules of thumb that have been developed through prior experience” (p.98). It incorporates a range of knowing and doing in professional practice and includes professional and interpersonal interactions with others - clients, family and health care professionals. Eraut (1994) suggests that process knowledge also “includes knowing how to access and make good use of propositional knowledge” (p. 107). Janine described her ‘process’ knowledge by contrasting her experience with that of students:

I mean when you graduate it seems so cut and dried – you learn what you think are the correct ways of doing things, such as teaching some one with a stroke to transfer to and from a bed. In reality there are so many other factors to take into consideration not the least that I now think it is best to go with what the person thinks is easiest for them. You know it’s quite different from what they are taught in school but I guess they have to start somewhere...

Personal knowledge arises from personal life experience and includes intuitive (Dewey, 1960), moral, aesthetic and artistic (Eisner, 1993; Schon, 1987) knowledge. The participants described drawing on their personal knowledge in order to effectively empathize, communicate, and interpret their clients’ concerns and problems. This kind of knowledge enables practitioners to tailor their interventions to meet the client’s unique and specific needs, and is a key element of the concept of client – centered care. "Inherently fragile and in need of verification from other knowledges, this is nevertheless the knowledge that enables us to imaginatively understand
history, other lives and cultures” (Higgs & Andresen, 2001, p. 16). It appeared to be difficult for
the participants to articulate, but it was evident in the language they used in describing their
practice; words like ‘emotional,’ ‘responsibility,’ ‘motivating,’ ‘rewarding,’ ‘making
connections,’ ‘important to listen,’ ‘working from the soul,’ and ‘helping people make choices.’

This kind of knowledge is reflected in the virtues dimension of the theoretical model of
expert practice in physical therapy (Jensen et al, 2000). The model suggests that over time and
with experience, expert physical therapists become responsible for the moral dimensions of
professional action and virtuous behaviours are integrated into practice enabling practitioners to
use themselves therapeutically. Personal knowledge is not, however, necessarily consciously
recognised. This may change through a process of self-evaluation and critical reflection engaged
upon after the event (Brookfield, 1987; Mezirow, 1990). Smith (2001) suggests that
professionals use ‘critical friends’ as a strategy to increase personal awareness and knowledge of
practice. He suggests that ‘critical friends’ provide an environment of trust in which each can
speak honestly and openly, not just about perceptions of events, but particularly about beliefs and
feelings (p. 175). The strategy of ‘critical friends’ was reflected in the participants’ accounts of
their practice and may have facilitated re-examination of taken-for-granted beliefs, assumptions,
principles and practices, thus enhancing their personal and process knowledge. Personal and
process knowledge often represent what is tacit – the decisions or actions the practitioner simply
‘knows’ to take in a particular situation; however, practitioners are often unable to make explicit
the ‘knowledge’ that underpins their actions (Schon 1983, Eraut, 1994).

Kate’s comment that “my practice is really the dilemma” is telling. It reflects the central
issue that limiting the type of evidence generated to support practice to that derived from
research and scholarship, that is, propositional knowledge does not provide a decision-making
model that is feasible or reflective of the complexity of practice (Bury & Mead, 1998). There is a
need, as Eraut (1994) suggested, for research into professional practice in order to make
“practical knowledge more explicit, and thus more capable of being disseminated, criticized,
codified and developed” (p. 47). Typically ‘practice’ knowledge is taken-for-granted and
not generally articulated in consistent, reproducible ways.

All the participants identified specific clinical scenarios that forced them to closely examine their practice through a process of reflection, consulting others, and seeking alternative sources of evidence and information. These clinical situations called into question their ‘practice’ knowledge and as a result were considered dilemmas of practice. Typically, in these situations their expertise failed to produce the expected outcomes and benefits for their clients and they could not be resolved by recourse to ‘scientific’ evidence. Kate found herself unable to prevent the formation of lower extremity contractures (severe loss of range of joint movement) in the case of a young client admitted to the unit in a coma. As she said:

...seeing someone in this state and seeing them deteriorate whilst under my care... like I’m failing – it’s usually such a simple goal for physiotherapy to achieve – so there’s a sense that there’s got to be something that I can do about it.

Michael felt that he had in some way misjudged a situation in which, while acting as a consultant for another therapist, he performed a comprehensive client assessment. On the second appointment the client became upset, angry and abusive towards him. As he said:

You know I’ve spent more time questioning my communication and my abilities in this situation than I care to think about. It was a new situation for me. I know professionally I did everything O.K. but it seems like I can’t get away from this personal sense that I missed something for her.

Janine found herself unable to control the shoulder pain her client was experiencing. Despite all her best efforts the pain continued and he lost range of shoulder joint movement. As she said:

It is a dilemma because I feel responsible. I feel a responsibility to the patient. Being of benefit to the patient is a professional role and duty and somehow I wasn’t fulfilling that responsibility when I should have been able to.

This situation was exacerbated when the client was switched to another program and began treatment with another physical therapist. This person used a completely different treatment
approach and the client appeared to improve quite rapidly. As Janine observed:

These situations are really good learning experiences. Maybe I just got so caught up in the whole thing that I lost my perspective, maybe I focused too much on the shoulder pain and missed some of the larger issues that the other physiotherapist caught. It’s so frustrating at the time because I really wanted to help him get moving. It certainly made me reflect. I guess that’s how we go on learning.

These briefly described situations are representative of crises of confidence in ‘practice’ knowledge that were an integral part of all the participants’ experience of everyday practice. They saw these kinds of situations as ‘milestones’ in their careers. As Ruth said:

The only person who can really know is yourself. It’s sort of situation specific. You really have to consistently look at your own practice, your motives, evaluate how what you are doing is affecting your client.

It was these so called ‘failures’ or ‘upsetting’ encounters which triggered the participants to re-examine and reflect on all aspects of their knowledge base. These situations, and individual clients, were outside the participants’ experience and triggered them to seek further evidence. However, in the absence of the best available scientific evidence they explored other sources to guide their clinical decisions. As Donaghy and Morss (2000) suggest, gathering evidence of critical reflection and enquiry on the part of clinicians about their practice would allow knowledge that is normally tacit to become more explicit and available for critical appraisal. Such an approach could potentially provide information or an alternative form of evidence to offset the limitations of positivism in explaining practice.

Conclusion

This chapter has explored the participants’ perceptions that the physical therapy profession has uncritically adopted the concept of evidence-based practice and a number of reasons for this were posited related to the history and current status of physical therapy education and research. The participants acknowledged the need to justify their practice in more rigorous and explicit ways but the concept of evidence-based practice as it is currently interpreted in academia was
experienced as antithetical to their interpretation of their practice in rehabilitation settings. The dilemmas experienced by the participants were related to incongruities between the type of knowledge generated through experimental research and the knowledge upon which their clinical decisions were based in rehabilitation practice settings. In essence, they identified a gap between evidence-based practice and clinical practice and a concomitant undervaluing of their ‘practice’ knowledge and the client’s perspective on service provision.

The participants recognised their professional responsibility to be accountable for the service they provided to rehabilitation clients but were concerned that research decisions were influenced by the research methods and design and availability of standardized outcome instruments. They felt that evidence generated under these circumstances frequently failed to capture the complexity and interdisciplinary nature of treatment approaches, the client’s perspective or the multifaceted nature of the client-therapist interaction. Other authors were cited who shared some of the participants’ concerns and who are also calling for a more critical approach to evidence-based practice and a broadening of the definition of ‘best’ evidence and the research agenda in medicine and physical therapy. The study participants described alternative sources of evidence that they either utilized or considered could be more congruent with their practice, for example, consensus building, evaluation of clinical reasoning, experience, analysis and documentation of the assessment and treatment process and qualitative research. They felt that alternative sources of evidence could potentially contribute to justifying their ‘practice’ knowledge and to addressing the dilemmas they identified related to evidence-based practice as it is currently conceived and promoted within the profession. The next chapter will continue the discussion of dilemmas experienced by physical therapists in rehabilitation settings. This second broad theme explores dilemmas related to constraints that the participants perceived as impeding their delivery of care to rehabilitation clients and which contribute to the experience of moral distress.
CHAPTER SEVEN: THE EXPERIENCE OF MORAL DISTRESS IN REHABILITATION PRACTICE

In the previous chapter I discussed the issues raised by the participants related to valuing and justifying ‘practice’ knowledge. In this chapter I will explore the dilemma experiences described by the participants associated with situational constraints which were perceived as hampering their ability to utilize their ‘practice’ knowledge on behalf of their clients, in other words, to fulfil their professional role and responsibilities to clients. These situational constraints included admission and discharge to rehabilitation, policies and decision-making, interprofessional conflicts, organizational structures and fragmentation of rehabilitation services, which the participants perceived as undermining the quality of client care. I chose to use the concept of moral distress to frame my discussion of these dilemma experiences.

The Concept of Moral Distress

The phenomenon of moral distress has been identified and explored in the nursing literature. It is, however, not a concept found in the physical therapy literature. It may be an important component of occupational stress associated with burnout, which has been addressed in the physical therapy literature. Two studies investigated factors associated with burnout as experienced by physical therapists working in rehabilitation settings. Stress was identified as an individual adaptive strategy in response to the ‘particularities’ of clinical practice and the demands of the work environment. Donohoe et al (1993) found that feelings of lack of connectedness with clients and colleagues, a sense of diminished personal achievement and, to some extent, loss of control over daily events that take additional time, seemed to be factors that play an important role in burnout. Broom and Williams (1996) identified that primary sources of stress were workload, fulfilling the clinical role adequately, dealing with the expectations of patients, and coping with administrative and policy changes. Burnout can be defined as “a syndrome of physical and emotional exhaustion involving the development of both a negative self-concept and a poor or negative attitude towards one’s job” (Donohoe et al, 1993). In both these studies, the high standards which the physical therapists set themselves – possibly an
unrealistic self-expectation – was the single most prominent factor leading to burnout. It can be argued that burnout represents an extreme response on the part of an individual to work related stresses that are perceived as irresolvable. Proposed strategies by which stress can be managed and burnout prevented generally focus on the individual, and neglect what Rodney (1997) calls the ‘morally untenable’ context of practice.

By interpreting these dilemmas as the source of moral distress I hope to encourage a broader discussion of physical therapy clinical practice as an inherently moral endeavour. This is a discussion that has not as yet been engaged upon in any consistent manner by the profession (Barnitt, 1993; Barnitt & Roberts, 2000; Solomon & Geddes, 2000; Triezenberg & Davis, 2000). Barnitt and Roberts (2000) suggested that, in general, the teaching of ethics in physical therapy undergraduate courses has been subsumed, over the past two decades, by the desire of these professions to be recognized within academia as applied sciences and, more recently, by the adoption of the concept of evidence-based practice. For similar reasons, little attention has been paid to the larger systemic issues that affect the decisions that health care practitioners must make as well as their relationships with one another and with their clients (Brockett, 1996; Drinka & Clark, 2000; Townsend, 1998). It was clear from the participants’ accounts that they were engaged in moral reasoning although none of them explicitly articulated their reasoning processes as such. Given when and where the participants acquired their physical therapy education, it is unlikely that they had been formally instructed in health care ethics or moral theory. However, Jensen et al (2000), in their analysis of expert practice in physical therapy, have identified that in reality individual physical therapists act morally in the context of their own practice.

Morals refer to the personal beliefs, principles, and values held by individuals about what is right and wrong (Scott, 1998). In striving to ‘do the right thing’ an individual acts with moral virtue or character. The nature of the dilemmas, upon which I have based this chapter, arise from situations in which the participants were dealing with multiple working relationships, involving differing loyalties and moral disputes that arise in the contexts of the rehabilitation organization
and the contemporary health care system. In these situations the participants perceived themselves as being unable to use their practice knowledge and expertise effectively on behalf of their clients. They recognized that in these situations there were rarely any clear answers that would satisfy all those involved and that, in some instances, their ability to use their expertise—to make moral choices—was rendered impotent.

Such situations, and the concomitant feelings of frustration, anger, powerlessness and sadness they cause, have been conceptualized as moral distress in the nursing literature. Moral distress “arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1984, p.6). Wilkinson (1988) further defined moral distress as “the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated in that decision” (p. 129). Webster and Baylis (2000) consider that these definitions, although appropriately oriented, are too narrow. They suggest that “moral distress may also arise when one fails to pursue what one believes to be the right course of action (or fails to do so to one’s satisfaction) for one or more of the following reasons: an error of judgement, some personal failing or other circumstances truly beyond one’s control” (p. 218). Moral distress then is a concept that is associated with conflicting loyalties and responsibilities, the power structure within health care institutions, and the desire to act as an advocate for the client within the broader health care system.

The participants identified working with other professions on interdisciplinary teams as both rewarding and as a source of dilemma experiences. These are discussed in more detail in Chapter Eight. It will be increasingly important for health professionals to be able to reflect on the important differences, as well as the similarities, that exist between them, and to analyze how these are influenced and changed by the organizational environments in which their practice takes place (Drinka & Clark, 2000). The concept of moral distress offers one mechanism by which the power dynamics and conflicts, characteristic of professional practice and which contribute to the distrust that is, too often, a feature of interprofessional and professional/client
relationships, can be examined. The primary purpose of such an examination, as I envision it for
the profession of physical therapy, is to assist practitioners to better evaluate the moral
dimensions of their practice and learn to practice in a work environment of moral ambiguity
while maintaining their own sense of moral integrity. It is unlikely, in the context of a rapidly
changing practice and health care environments, that the situational constraints that contribute to
moral distress can be eliminated. However, I will argue later in this chapter that physical
therapists, by engaging in a dialogue with other health professionals on the ethical implications
of practice and public policies, could make a more active contribution to policy decision-making.
All the participants shared problematic situations, perceived as characteristic of rehabilitation
services, which involved the inaccessibility of rehabilitation services for many clients and the
undermining of trust between clients and health care professionals within the system. The
participants frequently experienced these situations as irresolvable and it was this characteristic
that led me to frame these situations as causing moral distress.

Moral Distress in Rehabilitation Practice

Admission Decisions

Clients are referred to a specific rehabilitation centre, program or unit by physicians
working in a diversity of settings, for example, acute rehabilitation units, neurology and
orthopaedic surgical wards, family practice /medical wards and occasionally long term care
facilities or the community. The decision to admit a client to a rehabilitation facility is usually
made by a physiatrist. Kate, Dawn and Ruth worked in acute rehabilitation units and, as a result,
were under pressure to discharge their clients quickly. This frequently meant trying to get them
admitted for a longer course of rehabilitation in another facility. They found particularly
frustrating the admission decisions made by physiatrists as they tended to assess clients for
rehabilitation admission on one occasion only, would fail to consult with any rehabilitation team
members prior to or during that visit or read the team's documentation of the client's status.
Consequently these decisions were frequently difficult to rationalize and demoralizing for the
clients and their families. As Ruth said:
When you’ve been seeing someone for several weeks you tend to get a pretty clear picture of them. You feel that you want to get the best for them that you can but there’s just nothing out there available for people who aren’t going to change enough to be independent. I’m thinking of one client who with more rehab would be able to do more for herself, which in turn, would help the family. But if you’ve got a push for beds [in rehabilitation] guess which type of client they’re going to take?

Kate framed the problem like this:

Because of the fiscal restraints and the push for beds those people are being given less and less opportunity to maximize their potential. The decision is made that they’re headed for a care facility or the family can take them home and you feel, probably with reason, that they will never get back into the [rehabilitation] system to access resources again once they are shifted out like that.

The participants frequently questioned the rationale by which these admission decisions were made. Criteria for admission appeared to have been established in most rehabilitation centres, for example, the ability of a client to sit and stand unaided, to sit in a wheelchair for a specified number of hours, be medically stable, and have an established discharge destination. However, these criteria were not consistently applied to individual cases. As Dawn said:

There is no clear, consistent rationale or protocol with regard to who does or does not go to rehab. The connection between rehab services and physical independence remains totally prevalent. We’ve tried to focus more on abilities and a different definition of independence but…

Sophie, who acts as a liaison between a rehabilitation centre and community care agencies, felt deeply disillusioned about how admission decisions were made:

I mean our organization is supposed to be client directed – but most clients can’t get in, there are so many exclusion criteria. I don’t see any client centeredness there. If you happen to have a duel diagnosis I don’t know where you’d go anymore. They don’t fit any program so they simply end up not being admitted to any.
Her comment highlights the participants’ view that certain kinds of clients were being excluded from rehabilitation – those with mental and physical disabilities, the elderly, the ‘walking wounded’ whose problems are primarily cognitive and behavioural, and those who are physically dependent on others. As Veronica said “I don’t think anyone in the system sees the patient’s life in quite the same way as the rehab therapists, the family and caregivers do …” and yet these individuals were rarely, if ever, involved in making admission decisions. These decisions were seen as being influenced by ‘nursing and staffing preferences,’ uninformed assumptions about clients’ potential for change and recovery, and beliefs about physical independence as the primary rehabilitation goal held by decision-makers. Kate reflected the participants’ views when she said:

These decisions effectively cut out those people who need time to reach their potential, those who have cognitive rather than physical impairments, and those who will never be ‘independent’ in a physical sense. The system fails them and somehow you feel as if you’ve also failed them.

On the other hand, Janine, who worked in a rehabilitation centre, questioned the appropriateness of the admission of two clients whose condition rapidly deteriorated during their six weeks stay as in-patients. She resented the collusion she saw occurring between the acute care surgeon involved and the admitting physiatrist, both in terms of facilitating the admission and in not telling the clients the truth about their condition. As she said:

I felt it put me in a very difficult position. I felt as if my expertise was being questioned somehow. My experience in rehab is to get people’s condition stabilized at the very least but usually they progress and improve. In these cases, the clients were getting two different messages. The physician telling them that they would get better and what I’m having to tell them is that their condition is worsening.

In her role as physical therapist she shouldered the responsibility of addressing with the clients the physical worsening she was observing and to coordinating ‘realistic’ discharge plans with the team. She felt compelled to be truthful with the clients even though that put her at odds with the physicians involved. However, she felt that she, and the team, in rehabilitation were ill prepared
to assist these clients in a caring and knowledgeable way and that a palliative care environment might have been more appropriate. In the end, she felt that the centre staff just wanted the clients discharged as quickly as possible. In one case, the client developed a number of complications and died before discharge could be arranged, and in the other, the 50-year old client was discharged to an extended care facility. As she said:

Rehab’s not set up for this sort of situation – when the patient’s condition keeps changing. In rehab it’s a completely different approach and philosophy particularly in physiotherapy, we’re so goal and achievement oriented.

Janine felt that the organization, including herself, had failed these clients and their families in not being honest with them in the first place, and in raising unrealistic expectations by admitting them to a rehabilitation setting when rehabilitation had little to offer them. As she said:

It raises issues for me about the inconsistency of the admission decisions that are made, how dehumanizing the system can be, our personal involvement with clients, and the difficulty when clients are not told the truth in a humane way. I mean the neurosurgeon has been following the client’s condition so, of course, what he has to say is going to have a lot more credibility. I guess it makes you think about your life, I mean I would want to be treated in a certain way but who knows what would happen to you – makes you realize how vulnerable you are.

The moral distress experienced by the participants in these situations arose from a perceived inability to bring to bear their professional expertise in influencing the decisions being made, and a perception that the decisions being made were unfair to clients. The continued existence of a hierarchy within the institution and a lack of accountability on the part of the decision-makers were identified as situational constraints. Decisions to admit clients into rehabilitation programs were difficult to challenge, as no formal mechanisms appeared to exist for review of these decisions at any stage in the rehabilitation process. Different professional groups appeared to have different concepts of optimal rehabilitation outcomes or client potential. The participants considered that clients in rehabilitation presented complex problems few of which were conducive to a strictly medical approach.
Discharge Decisions

Many of the same underlying issues related to discharge decisions. Kate and Janine identified that the discharge decision-making process began as soon as clients were admitted. Clients’ involvement in rehabilitation programs is relatively short and, for those individuals for whom independence, in the traditional physical sense, is not an achievable goal, parents or spouses have to assume primary caregiver responsibilities. The participants identified one of their roles as physical therapists as preparing families for these responsibilities, but they felt disturbed and constrained by the perceived “rush to discharge many of these clients.” As Kate explained:

My practice, as compared with ten years ago, is far more concerned with the people important to the individual client, they are like 80% of the puzzle. We are also demanding more and more from this primary network to assume responsibilities that the system can no longer take on. We try to make sure that these responsibilities are presented as a choice, that they don't have to take on full care of their family member when they are discharged, but how do we really do that when we know, in most cases, there’s nothing out there for them?

Janine related this to one client’s situation. The client was a young man who had sustained a severe head injury affecting his cognitive more than his physical functioning. His wife and he had both been working full-time at the time of the accident, and his mother provided day care for their baby. As Janine said:

There’s this push to get him out of the door, like there’s nothing more we can do for him. When you're trying to work within a time frame of 6 - 8 weeks to get someone home it's very hard to take the time to sit down and talk about the issues or for the family to adapt to what’s happened. My thinking is that this poor man is not going to last long at home. I just don’t know how they will manage.

Barbara was very concerned for a client who was paraplegic and who had, in the course of his hospitalization, both in the acute and rehabilitation settings, developed a serious pressure area. Despite this he was discharged to Northern British Columbia. As Barbara said:
I mean when he was discharged he wasn’t even six months post injury and he was on his own essentially dealing with being home with a disability and a nasty pressure area, which in my experience, was not going to get better under those circumstances. I think that a lot of empathy and the human approach has kind of gone out the window.

Barbara’s concerns focused on the lack of care available for him in his community, his relatively recent injury and lack of experience with the resulting consequences of disability, and the fact that the equipment ordered for him would not be in place when he arrived home. In addition, because his diagnosis was paraplegia the third party payer refused to fund attendant care to assist him while the pressure area healed. The client was discharged against Barbara’s judgement as, in her opinion, a result of a combination of team disagreement and lack of experience, the physician’s decision, and adherence to admission length of time policies for different levels of spinal cord injury. As she said “I went to bat for him.” She got the nurse clinician to look at his pressure area and she agreed that it would be preferable if the client could either stay in rehabilitation or be admitted to acute care until it healed but this did not prove possible. Barbara contacted the insurance adjuster to negotiate attendant care on a temporary basis and expressed her concerns to the physician; however, her efforts were to no avail. Despite gaining the support of other team members Barbara was unable to effect the discharge decision or put in place support for the client at home. This decision, in Barbara’s opinion, merely deferred the problem. She felt that the client’s condition would worsen, that he would require further extensive hospitalization and that his quality of life and ability to independently function in the long term would be severely compromised.

These complex and difficult decisions about who will be treated and for how long in rehabilitation were compounded, for the participants, by a lack of transparency in the decision-making process. Their own ability to influence these decisions tended to be situational and dependent on being in the right place at the right time or on the relationship they had established with those professionals who had decision-making authority. The participants’ in this study were acutely conscious that many clients who needed their services were denied them, and even for
those clients who were admitted, length of stay was so short that they were ill prepared to cope with the consequences of disability after discharge.

**Undermining the Relationship of Trust Between Clients and Health Professionals**

The problematic situations described in this section involve other health professionals' interactions with clients. They focus on the participants' perceptions that the clients' dignity was compromised and that inappropriate care was provided. In effect the participants' were concerned that the relationship of trust established between health care professionals and clients was being undermined to the detriment of the client. Beauchamp and Childress (1994) define trust as "a confident belief in and reliance upon the ability and moral character of another person. Trust entails a confidence that another will act with the right motives in accord with moral norms" (p. 469). The idea of trust goes beyond adherence to professional rules and regulations, it requires a personal commitment on the part of professionals to honour the client's dignity and to treat them and their wishes, choices and preferences with respect, that is, to be trustworthy in morally ambiguous situations. Beauchamp and Childress (1994) consider that the centrality of trust in the professional client relationship has declined. Among the contributing causes of the erosion of trust, they suggest, are the loss of intimate contact with clients over time, the increased use of a diversity of specialists, conflicts of interests in referrals and treatment decisions, and the growth of large, impersonal, and bureaucratic medical institutions. In rehabilitation, where clients' needs and goals can only be effectively met by the collaboration of an interdisciplinary team, the idea of trust extends beyond the individual professional and client relationship to include the inter-professional relationships as well. These will be discussed in more detail in Chapter Eight.

I have chosen two scenarios, described by Dawn and Ruth, as examples of situations described by the participants where these relationships of trust were undermined. Dawn was a member of a team of therapists (physical therapy, occupational therapy and speech language pathology) who provided rehabilitation care for clients with strokes throughout one large acute hospital. The occupational therapist asked her advice about the condition of a client who had
been transported from the ward that morning to the rehabilitation treatment area. The client had a history of circulatory problems. During the night she had been complaining of leg and chest pain, and when Dawn saw her she was “sweating, breathless, distressed and her leg was blue and mottled.” From experience Dawn knew that, given the client’s history, these signs were very serious and probably indicative of deep vein thrombosis and/or pulmonary embolus. She went on to explain:

There was no recognition of these problems on the part of the nursing staff or they would never have sent her down to O.T. We immediately put her on a stretcher, gave her oxygen, and took her back to the ward. I talked with the ward nurse who frankly did not understand the implications – that it was an emergency. She said she’d ‘deal with it’ but she clearly wasn’t going to call the physician. I know I’m not a diagnostician but I think I knew what was happening and it was an emergency. We’re talking by the patient’s bed so I decide we should discuss it elsewhere. She didn’t want to go out of the room saying she wanted to have witnesses. I was nice to her but insisted that we not discuss it in the patient’s room or in the corridor. So we went into the office and I explained my concerns to her. In the end I phoned the family doctor which was really something that should have been done earlier in the morning. Anyway the long and short of it was that the patient had a mass of tests all day. She was terrified because the nurses had turned off the call bell, they weren’t listening to her, awful punitive stuff going on, awful stuff. The tests all came back and the nurse’s comment was that they couldn’t get hold of the family doctor. So I suggested that as the vascular surgeon had been involved with this client that we should call him. She didn’t want to go behind the family doctor’s back etc. etc. I mean that’s just not the way to handle this. The patient died that night. I knew that was going to be the end result. I’d spoken with her family physician and the vascular surgeon. I’ve been around, I knew it was likely to happen; she was a sitting duck with her history. It wasn’t her death so much that distressed me but I am desperately distressed with the way this patient’s last 12 hours was managed and how terrified she was. You know she was a nurse, worked in hospital, knew what was happening. I felt so awful for her.

The second example involved a client who developed an incomplete spinal cord injury and was admitted with a diagnosis of spinal tumour requiring a series of radiation treatments. There was some uncertainty about whether the client, whose first language was Hindi, understood English sufficiently well to grasp the complexities of her condition and the proposed treatments. The neurologist involved made the decision, at the request of the client’s family, not
to inform her of the diagnosis or the rationale for the treatments. The radiologist providing the
treatments agreed to uphold the decision unless the client asked direct questions about her
diagnosis. Ruth, as the client’s physical therapist, had no input into these decisions. As Ruth
explained:

The consent for the treatments must have come from the family but she [the
client] was all there mentally so they could have brought in an interpreter if that
would have helped but the physician had agreed not to do that behind the family’s
back. I mean she was basically having treatments for something she didn’t know
she had!

Ruth enlisted the nurse clinician’s support but in the end the physician refused to discuss his
decision with them. The arguments Ruth marshalled included:

I felt adamant that if somebody has something it’s not fair for the family to
withhold the information from them. I understand it might be a cultural difference
but at the same time I don’t understand that. I know we need to be sensitive to
cultural differences but it felt a bit like an excuse. Basically it’s not fair for her to
be kept in the dark about her diagnosis. I think she would have figured it out if she
had wanted to know but in the mean time I think it would cause her a lot anxiety.
I was worried that one of us would let something slip or she would ask us and we
wouldn’t know how to respond to her.

This case raises many fundamental ethical issues, such as, respect for a patient’s
autonomy, informed consent, and truth-telling. It raises questions about the degree to which a
family’s wishes and opinions can take precedence over those of a patient. It points to the poorly
understood assumptions and values held by people engaging in cross-cultural communication in
health care, and the need for negotiated action involving the client, family and more than one
health care discipline. The issues raised in this case are not new and have been widely discussed
in more appropriate forums than this thesis. Ruth’s primary concern was that of sustaining a
relationship based on trust with the client. She identified many of the ethical issues raised and
reflected on how her own values and beliefs influenced her own analysis of the case. Ruth felt
that she knew what should be done, felt a moral obligation towards the client but found herself
unable to act. The resulting moral distress she experienced can be traced through her articulation
of the anxiety and powerlessness she felt as a result of the client’s situation. As she said:

No one was telling her anything. It felt horrid, I dreaded going in to treat her
because of all the stuff I knew that she didn’t. I felt worried she might overhear
something. I wanted to tell her but …

Ruth, in this situation, did not feel that she had either the knowledge or authority necessary to act
autonomously or to influence significantly the decisions being made by the physicians and
family members.

The participants all had considerable experience with the complexities of rehabilitation
delivery of service. This experience, while often enabling them to act more effectively on behalf
of their clients also seemed to compound the anxiety and stress associated with the situations
they described. It was as though, in acquiring their experience, reoccurring situations had a
cumulative effect, and for two participants – Dawn and Margaret – these situations were taking a
personal toll. There was apparently a fine line between feeling sufficiently empowered within the
institutional setting to enable them to feel as if they were acting effectively on behalf of clients,
and feeling defeated by the perceived constraints and neglect of clients. Dawn and Margaret,
who worked in very different environments were clearly feeling burnt out. As Dawn said:

During the last two years of my ups and downs in health care I have definitely
come to a decision that there are two things I cannot tolerate: patients being
mistreated and people – either patients or members of staff – being bullied. These
things upset me totally. I’ve had it with this place, it’s not the patients, it’s all the
other stuff.

Their experiences, and those of the other participants, reinforce the suggestion I made
earlier that there is a need to explore the moral underpinnings of the ‘realities’ of practice and to
better prepare practitioners to engage in moral reasoning and debate. Learning these ‘realities’ by
practical example has been the primary means of acquiring skills and competencies in physical
therapy but concerns have been raised that the development of clinical and moral reasoning has
been serendipitous and largely neglected in the academic settings. As one participant said “you
have to pick your battles” when faced with the ambiguities of clinical practice that is based on multiple relationships and commitments, on negotiated goals and outcomes, and practical and procedural limitations. Introducing concepts such as moral distress to students and practitioners may assist them to analyze the impact of their own beliefs and values on their practice. It opens up the possibility that distress is derived from unrealistic expectations of oneself and the practice environment. The impact of the practice environment and the, often implicit, ideologies that are inherent in the provision of health care services are rarely made explicit and need to be understood and analyzed by health care professionals (Smith, 1990; Townsend, 1998).

**Institutional Constraints**

Some situations, described by the participants as dilemmas, arose from a lack of congruence between the organization’s espoused values and the enactment of those values in the organization’s daily operations. During the interviews with participants I heard an undercurrent of scepticism about the organizations in which they were employed. They were all aware of the public documents, for example, patient orientation booklets, mission statements, goals and objectives, produced by the organizations emphasizing client-centred care and quality of service. What the organizations espoused, however, appeared to be understood differently by the participants providing direct client care. The participants felt that this lack of congruence undermined the core values focused on client care that guided their professional practice. I agree with Ray, Goodstein and Garland’s (1999) opinion that “clinicians caught in this maelstrom of competing values have sought refuge in the individually focused bioethical foundations of clinical practice to provide the patient care they consider appropriate” (p. 216). However, this approach does not take into account the context of clinical practice or acknowledge the importance of organizational structures and processes.

Boelman and Deal (1991) describe the ‘organization’ from the perspective of culture, that is, a combination of myths and symbols which constitute the daily life of an organization. In their words, myths and symbols "explain, legitimize, maintain solidarity and cohesion, communicate unconscious wishes and conflicts, and provide a narrative which anchors the present to the past"
They suggest that examples of such myths might be: the assumed superiority of the 'true professions' of medicine and law; the idea that there is one best way of doing things; or faith in the objective neutral expert. These myths are frequently played out in the form of procedures and processes and persist despite the fact that they may have outlived their utility. Such procedures and processes were described by all the participants: for example, clients being subjected to complex and labour intensive admission procedures; committees that met routinely but that produced few discernible outcomes; or physicians holding weekly rounds which required that the clients sat by their beds until seen. These ritual activities, in my opinion, serve the purpose of maintaining a sense of security and order in the organization but are frequently antithetical to client – centred care. Professionals, and physical therapists are no exception, frequently fail to recognize the extent to which these activities shape professional practice and interdisciplinary relationships, dampen initiative, sustain hierarchies, and consume time and resources.

All the participants in this study identified situations in which the values they espoused were at odds with administrative decisions or policies. However, none of the participants appeared to feel that they had a direct role in influencing the institutional structure. Kate, as a senior physical therapist, was involved in planning the renovations of a ward to accommodate neurological rehabilitation patients. She became frustrated that decisions were being made by “the gods” (as she called the administration), against the advice of the rehabilitation team that “reflected a total lack of appreciation of people’s needs – both clients and staff – in rehabilitation.” One of the examples she gave related to the renovation of an existing ward to create a rehabilitation unit. These renovations did not include making the bathrooms accessible for clients using wheelchairs. This decision, while seemingly a simple one, has significant detrimental consequences affecting the clients’ potential self-care function and staff workload. Dawn also spoke of the energy she and her colleagues expended in proposing and, when funding was allotted, planning an acute rehabilitation unit for clients with stroke, only to have the funding withdrawn when the administration personnel changed. In both these examples the
organization's decisions had a negative impact on client care and on the provision of rehabilitation services.

Veronica described a situation where her client, who had become quadriplegic as a result of a work related injury, had developed an intractable bladder infection requiring intravenous (IV) antibiotics. He was eight weeks post-injury and an inpatient at the rehabilitation centre. There appeared to be a policy, although it was unclear where the policy originated, that nursing staff at the rehabilitation centre did not administer medications intravenously (IV). As a result, in order to receive the treatment he needed, the client was transferred to an acute hospital medical ward. As Veronica explained:

We don't do IV antibiotics at the centre (laughs ironically). It's a huge issue, a policy or nursing union thing which is frustrating. It doesn't make any sense because, of course, we could continue his rehab with an IV in place. I guess having been in the system a good while I challenge people more. So I tackled the medical director on this. He said his hands were totally tied, he agreed it's a ridiculous issue. You see what I was worried about was the standard of care the patient would get on a medical ward. We had another patient go over with something similar and he came back with really bad pressure sore.

The client was transferred so the rehabilitation therapists made a plan to support him while he was there. The plan included education of the staff on the ward about his specialized power wheelchair, positioning in bed to prevent skin complications, and providing basic treatments, such as checking wrist splints and maintaining joint range of movement. They were informed, however, that the policies were such that they were not legally allowed to treat him even though the institutions had recently amalgamated into one large organization. As Veronica said:

We realised that we could try to educate the staff there but they were basically too busy to manage rehab needs. So our patient pretty well stayed in bed for the whole time he was there. He was good, tried to take care of himself but it was sort of hopeless...We did manage to keep in touch with him. We figured that if we visited - were around more- then the staff would pay him more attention and there was a chance that he'd get better treatment. Squeaky wheel! We did it as a team. We kept phoning asking how he was doing, do you have any questions, oh we
forgot these splints we’ll bring them over etc. The social worker was able to legitimately go to talk to him and she did. He survived but no thanks to the rehab centre or the medical ward!

Veronica’s core concern was that “at this early stage, the likelihood of this patient suffering ill effects at the hands of the medical system was relatively high.” This situation is an example of rehabilitation staff collaborating to ‘get around the system’ to make it work for their client. In many of these situations the participants, although feeling disempowered, also found ways to subvert or circumvent policies and decisions and I will discuss these strategies later in this chapter.

The issue of client access to rehabilitation programs, discussed earlier in this chapter was also raised in the larger context of appropriate utilization of rehabilitation programs, program development and implementation. Janine, Sophie and Jill all spoke of their perception that, since amalgamation of a number of acute and rehabilitation facilities, they have increasingly felt the pressure on the rehabilitation institution to alleviate the constant shortage of beds in the acute facilities. Janine likened it to being “a clearing house for the hospital” but questioned what message that sent about the value of rehabilitation services and the clients being served. As Jill said:

I appreciate that decisions are made within the constraints of the larger health system and that we’re under fiscal constraints. We hear it all the time. Right now the hospital’s in critical, it’s always in critical. That means they are trying to move patients as fast and wherever they can. Patients get diverted down to the States and to other provinces, the Emergency beds are full and we end up being pressured to clear beds and accept patients who increasingly aren’t rehab candidates. It’s hopeless for everyone.

Participants also identified the lack of efficient service delivery for certain client populations needing rehabilitation. This was felt to be particularly true in the larger acute hospitals. These contained within them specialist programs or units delivering care to specific groups of rehabilitation clients, for example, brain injury, neurological, spinal cord injury, and arthritis. However, certain kinds of clients, for example, those diagnosed with stroke, were not
treated as a unified group but admitted throughout the hospital on to medical and family practice wards. The participants all viewed these clients as rehabilitation candidates but because of the lack of specialist care these clients were often not referred to the rehabilitation services within the hospital or to rehabilitation programs in other institutions. These clients are generally older and the participants perceived them as not being valued by the staff or the institution. Dawn explained the problem as she saw it:

The resources are managed inefficiently. There is a sort of class system with regards to where you are admitted as a patient. Your location in the hospital and the physician you’re admitted under will influence your access to care. It’s anyone’s guess where patients will be referred. Some family practitioners are used to referring patients to one rehab facility and don’t consider any other. Some rarely refer to rehabilitation and their patients always end up in a long-term care facility never having any rehab. In some cases, patients could go to the rehab service in this hospital, as an interim stage, instead of waiting for six weeks on a medical ward where the staff are not set up for managing stroke. It is all so fragmented, such poor communication.

Interestingly, the rehabilitation services – occupational and physical therapy and speech language pathology - were organized to provide some consistent approach in the form of a team who attempted to assess, treat and influence discharge decisions for all clients with a diagnosis of stroke admitted to all areas of the acute hospital. As Dawn explained:

We see the problems [related to the care of these clients] because we’re a unified group of therapists – OT, PT and SLP – and all the stroke patients admitted to the hospital are treated by us. We created that deliberately so that we know what happens to the stroke patients in the hospital and can at least start rehabilitation early. I can tell you their care will be different just from where they are located.

The creation of this service within the larger institutional setting indicates a reciprocity of values held by the rehabilitation therapies in relation to this group of clients that is at odds with those of the organization. However, despite their efforts these clients were still perceived as essentially being barred from rehabilitation programs and discriminated against in the institutional system. As Kate said:
They are a heavy population of patients to work with, physically heavy and demanding of time. They often have a number of other associated problems and there is the emotional aspect as well. They're not a 'nice' kind of patient to look after but if they're on a rehabilitation unit at least you've got people interested in working with this population.

These concerns about discrimination or exclusion of clients from essential rehabilitation services echo the concerns articulated by a number of authors about the allocation of services in rehabilitation (Banja, 1992; Callahan, 1993; Caplan, Callahan & Haas, 1987; Kuczewski & Fiedler, 2001; Roy, Williams & Dickens, 1994). In many institutions, decisions about which services to provide are often made by physicians ‘at the bedside,’ or on a basis of their fund-raising potential or the institution's reputation, rather than on an overall assessment of client need (Roy, Williams & Dickens, 1994). “Certain groups of patients (for example, the chronically ill or elderly) may receive a minimum of nursing and rehabilitative care, in comparison to patients who can be restored to good health, such as cardiac patients” (p. 350).

The participants' accounts of dilemma situations were replete with descriptions of their efforts to communicate with other professionals, expedite appropriate referrals, and coordinate services on behalf of their clients. Underscoring these efforts was their sense of feeling overwhelmed by the fragmentation of rehabilitation services. Ruth provided a compelling illustration that involved a complex mixture of some of these factors. She told me about an older client who had a history of rheumatoid arthritis and who had sustained a spinal cord injury four weeks earlier. The client needed further rehabilitation and had requested that it be closer to her home in Victoria. After considerable work on the part of various team members including the resident physician, the client was accepted on a rehabilitation unit in Victoria as soon as a bed became available. A week later the decision was rescinded with no explanation given. The charge nurse, working with the client’s family practitioner and a rheumatologist, managed to arrange transfer to an arthritis program in Victoria. The client waited two weeks for a bed to become available. Her husband had been staying in a hotel in Vancouver since her accident. The
day of her discharge, the ambulance was due, her husband had left to catch the ferry to Vancouver Island planning to meet his wife in Victoria, when the rehabilitation unit phoned refusing to take the client. The charge nurse finally persuaded the original rehabilitation program in Victoria to admit the client and she left several hours later than expected. As Ruth said:

On the day we were getting the run around they [the client and her husband] knew what was happening because every time it changed they were told. None of us realised that the information was going to change an hour later. The poor lady was so distressed, losing faith in the system rapidly and feeling like no one wanted her. It was all so disrespectful and unnecessary.

The team members could not understand why she had been refused at the last minute after the arrangements had been confirmed two weeks earlier. A few days later the team discovered that the physiatrist, who regularly assessed patients for admission to the rehabilitation centre in Vancouver, had informed the Victoria program that the client was not a rehabilitation candidate. He had not actually assessed or even seen the client himself (the resident physician had been involved), had not consulted with the team, had not recorded his actions or informed the charge nurse. Ruth explained how the team members felt:

It made us so mad after all the work we had done in getting ready for the transfer. His [the physiatrist] actions were frankly incomprehensible to us. So unfair for the patient. He really didn’t have the authority or the right to do it. We wanted to challenge him on it but in the end it was his word against ours. There’s no accountability. I mean how do we hold physicians accountable for things like this?

Ruth described how the team planned to address the problems inherent in this situation but admitted that “even though everyone was behind trying to deal with it – write a letter, talk with the administration – nothing actually happened in the end.”

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8 A physician specializing in the diagnosis and treatment of rheumatic diseases e.g. rheumatoid arthritis or fibromyalgia
These situations experienced as dilemmas by the participants raise a number of issues related to institutional practice that are beginning to be addressed in the rehabilitation literature. Townsend (1998) suggested that medical values and authority structure become internalized in the way professionals' view themselves and their ability to treat and interact with clients. Mattingly & Fleming (1994) found that this internalization was evident in the concerns of occupational therapists who participated in their research. These concerns focused on how a particular treatment activity might appear to other staff members, on whether a treatment will cross into the practice territory of another professional, on whether they can divulge information to clients about their condition, curtail treatment or discharge a client.

The influence exerted by the institutional context of health care on professionals is essentially covert and contributes to the tension that is experienced by therapists between their desire to provide client-centred practice and the requirement to work within the constraints of the organization setting (Townsend, 1998). Smith (1987, 1990) argues that the coordination of institutional processes is mediated ideologically. She defines such ideology as "the ideas, images and symbols by which experience is given form" and which are taken for granted as the normative reality. These institutional ideologies are acquired by members as a result of professional training which teaches people how to "recycle the actualities of their experience into forms in which it is recognizable within the institutional discourse" (1987, p. 160). Health professionals occupying positions in institutions get caught up in the overlapping circles of procedures, rules, policies, documentation and discourse which are seen as essential to getting the work done. It is only when divergence, as in problematic situations, occurs between the normative and actual practice that these ideologies are questioned (Smith, 1987; Townsend, 1998). Schon (1987) suggested, "the predicament of practitioners subject to constrictions on freedom of action in their organizational settings should be brought into the professional curriculum" (p. 321). However, little has been written in the physical therapy literature about how practitioners come to understand complex practice issues or the organizational environment in which their practice takes place. It is my opinion that, by acknowledging and analyzing the
experience of moral distress, physical therapists may begin to recognize how organizational 
structures and processes influence practice and operate for the good of the client; and how they 
cause harm.

**Fragmentation and Lack of Rehabilitation Services**

Rehabilitation clients managing the long-term consequences of disability and chronic conditions require access to services at many points of their lives. These clients, as a result of recent advances in medical technology and medications, are living an almost normal life span (Eastwood et al, 1999). The recognition that the current provision of rehabilitation services is woefully inadequate both in terms of the allocation of available resources, the lack of resources and the fragmentation of services has been well documented most recently in a

Vancouver/Richmond Health Region Discussion Paper (2000). These authors identified that clients wait at every stage of the health continuum for access to appropriate rehabilitation services:

- in costly acute care beds while awaiting acute rehabilitation;
- in acute rehabilitation beds while awaiting community-based services; and
- in the community, where inadequate services mean costly care admissions for preventable secondary complications and loss of function (p. 5).

The participants believed, based on their experiences, that the inability of rehabilitation clients to access appropriate services caused preventable medical complications and poor health outcomes. In their view, such complications both adversely affected clients’ quality of life and created an additional financial burden on the health care system. As Kate said:

> Just consider the trauma and loss of self worth these people have experienced. It’s a whole new identity, they can’t fulfil their old roles in life, they are a different person, they are trying to work out where and how they fit in. Yet they are being given the message by the system that you’re not worth the time, you’re not worth giving the opportunity to maximize your abilities. No resources are being put into you, we don’t believe you have that potential.
Concern for the client’s future ability to re-access essential services and receive follow up rehabilitation care ran like a thread through their accounts of the dilemmas they experienced. As Michael said:

What we need is a more creative approach to how and when people access rehabilitation. These decisions are still driven by the ‘cure’ idea but rehabilitation is about way more than the physical. At the moment a person has to access the system immediately, straight after acute care or there’s nothing for them – they’ve lost their chance.

All the participants felt pressured to prioritize their interventions in order that the clients would be capable of managing the ‘survival issues’ related to their disability or condition. In their opinion, this was a minimalist approach to client care that they found difficult to reconcile with their definition of rehabilitation. Their concerns focused particularly on young clients with brain injury, older clients with strokes or clients with high lesion spinal cord injuries, clients from impoverished environments, such as the Down Town Eastside of Vancouver, and minority groups, such as First Nations clients. Kate captured the problem when she said:

Decisions for these patients are being made really early now and the system is like a one – lane highway and if you get off you can’t get back on again.

Kate’s analogy of a ‘one-lane highway’ reflects the participants’ comments that the provision of rehabilitation services within the larger health care system was ‘linear’, ‘exclusionary’ and ‘discriminatory.’ Sophie, who frequently worked with younger clients in the community, was constantly aware of how the lack of appropriate services adversely affected her clients’ quality of life and their potential to be active participants in society. In her opinion, these clients ‘had been forgotten by society’ and in the absence of adequate services, follow up programs or financial resources, she felt, as a health care professional, that she had relatively little to offer them. As she explained:

Services are either not available within the community, or if they are, have shaky funding or aren’t very efficient. Particularly for the population I work with
[severe brain injury]. It's appalling! You know when you're sending 16 year olds off to old people's homes because there is no where else for them to go, that's pretty harsh to live with.

The participants felt that these disparities in allocation of resources placed a tremendous burden on the clients and their families and that the decisions represented a discrimination against people with disability and chronic conditions that reflected the attitudes of society at large. As Margaret explained:

Really the issue is what does society view as important to fund? Is it only the individual who can go back to work or live independently that is seen as worthy? I don't think the underlying motivations for these decisions about programs and services are being overtly discussed. It's quietly happening, decisions are being made, without the public really understanding.

I have interpreted the participants' concerns for the inequities associated with allocation of resources for rehabilitation clients, who they perceive as particularly vulnerable in the community, as a source of moral distress. The broader ethical discussion pertaining to the distribution of health care resources using criteria based on such concepts as, for example, justice, equality and equity, or the degree of client harm or benefit that might result from such decisions, are beyond the scope of this study.

This interpretation, however, does raise some questions about the extent to which health care professionals should be expected, or prepared in their education programs, to assume an advocacy role within an organization or the larger health care system. For example, to what extent should moral distress experienced by health care professional groups influence institutional reform? And, to what extent is the expression of these concerns about fair access to rehabilitation services part of a physical therapist's domain and responsibility? In my experience, individual professions are, in reality, collectively concerned with the specific interests, scope of practice and continuation of that profession. These do not automatically reflect the concerns of clients who need to access health care services nor are they congruent with the concerns of organizational leadership. Physical therapists have not, in any consistent way, assumed decision-
making responsibilities in the different levels of health care administration (Piper, 1991). In planning services and organizational change many different stakeholder values, including those related to cost-control and efficiency, need to be taken into account. Health professionals, like physical therapists, have the opportunity to mediate on behalf of clients within institutional settings, however, they are rarely prepared by their education to analyze the economic or political values that impact cost containment policies or resource allocation decisions within health care organizations. As Ray, Goodstein and Garland (1999) suggest “what the organization espouses may be understood differently by clinicians who provide patient care” (p. 216). Physical therapists, better prepared to engage in dialogue on the moral and ethical components of their practice, may subsequently be able to articulate these disparities between their professional values and those espoused by the rehabilitation organization, and to more effectively contribute to service planning and policy development.

Rodney (1997) suggested that institutional ethics committees could play a leadership role in shaping the ethical life of health organizations. Authors studying the role of health care ethics consultants and committees (Coughlin & Watts 1993; Hoffman 1991; Miedema 1993; Scheirton 1992) discussed the advantages of members of these committees having a background knowledge of health care ethics. They also identified the imbalance of individual discipline participation on committees. Physicians and nurses were found by all these authors to dominate the committees. Other professionals (lawyers, occupational therapists, patient advocates, clergy, social workers, bioethicists and hospital administrators) were on occasion involved, however, physical therapy was not mentioned. It is a rare circumstance, according to Triezenberg & Davis (2000), to have a physical therapist servicing on a hospital ethics committee. Ethics committees offer an opportunity for members to engage in interprofessional debate regarding the moral implications of health care policy and to potentially influence policy. Physical therapists have not, to date, been adequately prepared for such debate or involvement (Triezenberg & Davis, 2000).

My sense is that, by analyzing the sources of moral distress, therapists will begin to selectively identify situations where they can make a valuable contribution by participating in
informed public discussion of issues related to the provision of rehabilitation services. Such analysis could be facilitated in education programs by using 'real' practice issues involving other health professions as the basis for an ethics curriculum. The experience of moral distress draws attention to the moral component of the professional role and the need to more effectively prepare physical therapists for this role. Such implications for physical therapy education will be discussed in Chapter Nine.

**Enacting the Role of Moral Agent in Professional Practice**

Authors in nursing (Redman & Fry, 2000; Rodney, 1997; Rodney & Starzomski, 1993) suggest that professionals, by drawing upon personal experience and the high standards of behaviour demanded by specialized knowledge and skills, can enact their role as moral agents. Rodney (1997) views moral agency “as inclusive of objective characteristics (rationality, autonomy, and self-interest), and as a process that emerges and is enacted in dialogue with others” (p. 65). Perhaps more simply stated a moral agent is someone who is capable of thinking, deciding and acting in accordance with personal and professional moral standards and rules. Implicit in the idea of agency is the ability to reflect on, and assume responsibility for, the outcome of an action. I have suggested that the participants in this study faced situations that caused them moral distress because, while they perceived certain courses of action would be right, situational constraints prevented them influencing decisions or taking what they perceived to be effective action.

Rarely did the participants characterize the difficult clinical situations they described or their attempts to ameliorate them as ethical or moral in nature. Warren (1989) contrasts these everyday experiences of clinical problems with the “crisis issues that are the bread and butter of contemporary moral philosophy” (p.37). She chooses to calls them “housekeeping issues” in which “the personal is professional.” Conceptualizing the participants' dilemmas in this way suggests that these problematic situations are ongoing, and that the decisions made and actions taken needed to be congruent with each complex client situation and context. The participants clearly did act in these situations to overcome institutional constraints on behalf of their clients.
In discussing their dilemmas, they offered a number of examples of creative strategies, some of which were described earlier in this chapter, that they used to circumvent situational barriers.

Kate, for example, described how the rehabilitation team earmarked those clients, who were unlikely to be referred after discharge to further services, for a maximum team effort while in rehabilitation. Dawn related how she and a nurse colleague ‘pulled a few strings’ and had managed to get a client, who had sustained a profound stroke but who, in their view, was making definite progress assessed and accepted by a rehabilitation facility. Their action contravened the original plan, made primarily by the physiatrist, to discharge her straight home to the care of her family. Sophie described how she and her colleagues quietly made decisions to involve clients, who did not strictly fit the established criteria for inclusion, in rehabilitation programs offered at the centre. As she said about one client:

Because he had a mental illness as well as a physical disability they didn’t know what program he should go into so he simply ended up not being admitted to any. So we sneaked him into my group.

Another way the participants attempted to influence these decisions was by ‘networking’ on behalf of clients with their colleagues in different facilities. As Dawn said “physiotherapy is a small world and those of us working in rehabilitation know each other and think along the same lines.’ Within the same institution, participants shared their concerns about individual clients and negotiated support for a discharge plan with other team members.

The participants clearly perceived the situations discussed in this chapter, while troubling and frustrating, to be a ‘fact of life’ of their day-to-day practice and the many strategies they used to ‘get round the system’ were largely taken-for-granted. What was not clear from the participants’ accounts was the moral reasoning process that they brought to bear in implementing these strategies. They were clearly motivated by respect for client autonomy and welfare and the resulting plan was frequently negotiated with other health care professionals. There is a danger, however, that despite their good intentions these types of activities could have negative as well as positive consequences. They could, for example, result in inconsistencies or inequities of
client care, disempowerment of the client, neglect of the client's wishes and desires, and
disrespect for the roles and responsibilities of other health care professionals and administrators.
The participants gave me the impression that they considered that these strategies fell short of the
action that they would take in ideal conditions, that they recognized them as a compromise.

Wong (1992) considers compromise to be an important component of the moral value of
accommodation. He argues that realizing the value of accommodation requires the virtues of
resourcefulness and creativity. These virtues, according to Wong, "are necessary for the ability to
act on one's own moral position while minimizing damage to one's relationship with those in
opposition, for the ability to find concessions acceptable to oneself and others, and for the ability
to incorporate elements from ethical systems conflicting with one's own" (p. 783). The
participants in this study clearly used their practice knowledge and experience in creative and
resourceful ways. Their experiences of moral distress would, however, perhaps be lessened if
these intentional actions and the virtues underlying them were better understood.

Conclusion

In this chapter I have explored a series of dilemmas experienced by the participants
which I interpreted as causing them moral distress. I perceived these dilemmas as being related
to situational constraints that prevented the participants from fully exercising their professional
knowledge and expertise on behalf of their clients. These dilemmas are interrelated but for the
purpose of discussing them, I created three groups of dilemma situations. In the first group,
participants found that individual admission and discharge decisions lacked fairness and
consistency. These decisions were perceived as discriminating against clients who did not
conform to an emphasis on independence in activities of daily living and physical functioning.
The participants felt 'impotent,' unable to effect change, and in many cases, act effectively on
behalf of their clients in terms of making appropriate referrals or facilitating the optimal
discharge plans needed to support the clients' quality of life. The participants, as employees of
rehabilitation institutions or programs, which they saw as failing their clients, were placed in
morally ambiguous positions. They were convinced that the appropriate rehabilitation services
would enhance a client’s quality of life, but many ‘potential’ clients would not be accepted into rehabilitation programs. As professionals they envisioned a rehabilitation process that they knew could not achieve its professed goals in the relatively short time allotted. Other situations placed their definition of treating clients with respect in conflict with the actions of other professionals.

In the second grouping, the participants described situations in which their trust in the integrity of other health professionals and the institutions in which they worked was undermined. A conflict existed between the professional values they enacted and those publicly espoused by the organization. The participants identified issues of inter-agency conflict and misuse of rehabilitation resources in order to alleviate ‘crises’ of bed shortages in the acute care system. The participants perceived decisions being made on behalf of the client as being unduly influenced by professional priorities, beliefs about the value of physical independence over other capabilities, and administrative pressures. They expressed a concern that certain clients were discriminated against as being in some way ‘unworthy’ or ‘difficult’ when decisions about access to rehabilitation resources were made.

The third group of dilemma situations involved the fragmentation of services and lack of appropriate resources in the community needed to support vulnerable clients over the long term. At the root of these dilemmas was the perception that rehabilitation clients continued to be ‘forgotten,’ ‘overlooked,’ ‘denied the infrastructure in the community they needed,’ and ‘devalued in the system.’ They felt that the health care system reflected the stigmatization by society of people with disabilities. They knew that the majority of clients – particularly those without third party payer coverage – would not have access to rehabilitation, follow up programs, or adequate attendant care in the community.

I chose to interpret the participants’ perceptions of these dilemma situations as moral distress. The participants did not use the concept of moral distress to frame the experiences they described related to these situational constraints. This is not surprising since moral distress is not a concept that has been discussed by the physical therapy profession. Moral distress occurred as a result of a dissonance between their interpretation of their clients’ potential quality of life and
the perceived reality, and their perceived inability to bring to bear their knowledge and expertise effectively on behalf of these clients.

The participants gave examples of strategies by which they attempted, often in collaboration with other members of the health care team, to circumvent decisions and policies that they perceived as disadvantageous to their clients. These strategies clearly reflected the participants' implicit process of moral reflection and reasoning. However, in many of the situations described, their ability to act ideally or to advocate effectively for their client was either not feasible or beyond their scope of practice. By exploring the concept of moral distress, physical therapists may learn to cope with moral conflict and ambiguity in clinical practice and to recognize compromise and the value of accommodation as important components of moral agency.

The centrality of interdisciplinary team relations was pervasive throughout the participants' accounts of the situations I have grouped in the theme related to the experience of moral distress. As Schon (1987) suggested professional practice consists of both the scientific and the artistic aspects of a discipline's knowledge base. The scientific aspects are dependent on the technical knowledge and skills of a discipline; whereas, the artistic aspects are those related to the ability to grapple with the 'grey areas' of professional practice where moral ambiguity, value conflicts, and ethical dilemmas are characteristic of practice (Naylor, 1995). Working cooperatively with other professions on the interdisciplinary team is characteristic of these 'grey areas' of practice and is the focus of the next chapter.
In this chapter I will discuss the final broad theme of interdisciplinary collaboration in rehabilitation which emerged from the participants' accounts of their dilemma experiences. This theme arises from the interaction with other professionals in everyday practice and speaks to the centrality of interdisciplinary teamwork in rehabilitation provision of care. In Chapter Five I discussed the participants' perceptions of physical therapy practice in rehabilitation settings. The practice they described represents the service physical therapists can provide for clients in rehabilitation who are faced with the reality of chronic conditions and disability. The umbrella of rehabilitation is large and encompasses many disciplines each of which has specialized in a specific aspect of client care. The participants described themselves as contributing specialist knowledge, but they consistently acknowledged that addressing the multidimensional needs of clients in rehabilitation required close collaboration with a diversity of other disciplines. Working with other disciplines was viewed, by the participants, as central to achieving the goals of rehabilitation. It was simultaneously a valued component of practice and a source of dilemma experiences. Inter-professional relationships between the participants and other disciplines were influenced by the organizational structure and by the different approaches to practice held by the disciplines involved in client care in rehabilitation. The participants' reflections on their relationships with other disciplines were underscored by a genuine desire to collaborate more effectively. They expressed concerns about their own communication skills and ability to negotiate conflict and their lack of understanding of the value orientations which shape their own and other health care providers' approaches to practice. In this chapter, I will discuss these concerns and relate them to the theoretical development of physical therapy as a discipline and the provision of education for health professionals.

The Nature of the Interdisciplinary Team

There has been an increased demand for rehabilitation services as a result of several factors. Medical advances and perinatal care have increased the survival of adults following
traumatic injury and of children with disabilities, and increased age brings a concomitant increase in the potential for disease or injury (Sutherland & Fulton, 1994; The Economist, 1994). At the same time rehabilitation services have undergone significant restructuring in most provinces in Canada with the goal of downsizing institutional resources and devolving care to the community. However, the ‘closer to home’ trend has not, to date, been supported by an adequate community infrastructure or services (Vancouver / Richmond Health Board, 2000). For rehabilitation professionals, these changes have meant depleted resources and less time to ‘rehabilitate’ their clients. The participants in this study identified some aspects of this restructuring as sources of dilemma experiences. I interpreted these dilemmas as causing moral distress and discussed them in Chapter Seven. Given the increased demand for rehabilitation services and the need to effectively and efficiently address the complex needs of rehabilitation clients, an interdisciplinary orientation to service delivery has become imperative (Drinka & Clark, 2000).

Rehabilitation has traditionally, been characterized by a multidisciplinary approach to service delivery (Caplan, Callahan & Haas, 1987; Caplan & Reidy, 1996; Diller, 1990; Heruti & Ohry, 1995; Keith, 1991; Kumar, 2000; Purtilo & Meier, 1993). The team approach in rehabilitation arose from the need to involve a variety of professionals in comprehensively addressing the needs of individuals with disabilities and chronic conditions. The terms multidisciplinary and interdisciplinary are most commonly used to describe team functioning in rehabilitation (Kumar, 2000). The term multidisciplinary, according to Capilouto (2000), refers to teams of health professionals operating within a traditional medical model in which the physician acts as the care team leader. In my experience, this model involves team members sharing their information and respective goals with each other; however, this dialogue does not significantly impact the respective approaches to practice. Interdisciplinary team members also share their respective goals for the client. However, there is an expectation that the achievement of these goals will be supported by all team members throughout the daily interactions with the client (Capilouto, 2000). An example of such cooperation would be the expectation that once a speech language
pathologist, working with a client following a stroke, had determined a safe and effective method of swallowing, that the nurses, occupational therapists would reinforce the same procedure. Interdisciplinary teams differ from multidisciplinary teams in that all members are considered equal in their contributions to client care (Capilouto, 2000). Miller, Freeman and Ross (2001) described this type of team, where most members of the team displayed a high degree of collaboration, as ‘integrated.’ The participants clearly perceived the interdisciplinary team concept to be the ideal mechanism for provision of service in rehabilitation; however, while Barbara and Margaret discussed this ideal it seemed, from their perspective, to be largely unrealistic. Interdisciplinary teamwork, for the other participants, was a source of both rewards and dilemmas but was consistently conceptualized as an integral component of rehabilitation practice.

All the participants spoke at length about the influence their involvement with other disciplines exerted on their everyday practice. When asked who the team members were, the participants produced a formidable list of disciplines including, dietary sciences, medicine, nursing, occupational therapy, pastoral care, psychology, social work, speech language pathology, recreational therapy, and vocational rehabilitation. The involvement of these disciplines varied from core member to consultant or resource person, depending on the nature of the client’s problems and their goals.

**The Value of Working as a Team**

Seven participants identified working collaboratively with other professionals as a major advantage of practice in rehabilitation as opposed to acute care settings, this despite the dilemmas associated with these relationships. Michael, who treated clients with neurological conditions in an outpatient clinic, felt isolated and missed the team interaction he had enjoyed when working on an inpatient service. The participants identified a number of benefits to be gained from working on a team (Table 8.1). These included increased productivity, work quality, accountability and job satisfaction. They felt that professionals working cooperatively and efficiently together benefited the clients and their families.

The participants spoke of the personal pleasure and professional benefit of ‘getting to
Benefits of Working on Teams: Summary of Participants' Comments.

- Learn a lot from each other
- Not necessary to always agree with each other - debate stimulating / challenging
- Makes me justify my professional position - good for me
- Working together results in the best benefit for the client
- Complex clinical issues and social context need more heads
- Facilitates joint treatment sessions
- Decreases overlap and duplication between professions
- Informal communication enhances team work
- No direct management or leadership needed if team is cohesive
- Decreases territoriality about professional roles
- When we work well together it's a great feeling
- Increases knowledge and understanding of other professions' roles

know other team members' and consistently identified the support they derived from their team colleagues, particularly in occupational therapy and speech language pathology. As Sophie said:

"they [team members] are a great resource, we're always bouncing ideas off each other and discussing problems. It helps when the team is stable, you really get to know each other well."

The relationships the participants established with other team members were perceived as facilitating understanding and respect for each other's roles. Rodney (1997) proposed the concept of a relational matrix to capture the nature of "the connectedness and interdependence of individuals working in relationship with each other in an organizational context" (p. 143). She suggested that who is in the matrix is not a given but, rather, "is determined by the nature of the relationships that emerge in the particular practice context" (p. 153). The matrix may or may not be supportive of practitioners' efforts to enact their role as moral agent, according to Rodney, although it seems that the nature of the relationships between individuals in the matrix makes a significant difference. The participants identified a number of strategies (Table 8.2) that in their
view promoted effective team functioning. These reflect both the relationships conceptualized by Rodney and also foreshadow the participants’ dilemma experiences.

Table 8.2

Strategies that Promote Effective Team Functioning

- Stability of team membership – need to work together consistently over time
- Individual members are approachable, receptive to questions.
- Team members supportive of each other
- Demonstrate respect for other members’ opinions
- Need to understand each other’s roles thoroughly
- Located in close proximity facilitates informal liaison
- Clear communication styles
- Clear identification of who is doing what
- Team members are reliable and can be trusted to pull their weight
- Shared enthusiasm for clients and rehabilitation practice
- Understand conflict resolution strategies
- Issues need to be resolved within the team
- Negotiate leadership model

Two participants – Margaret and Barbara – who had graduated respectively in 1968 and 1973 were less enamoured with interdisciplinary team functioning. As Margaret said: “a well-matched and functioning team is fantastic but it is rare in my experience.” Their concerns focused on their perceptions that other team members were much younger and lacked experience, that immediate client problems were addressed but that discharge planning did not take into account the implications of living with a disability over the long term. Barbara frequently found the formal team meetings “a waste of time,” preferring to liaise with other team members on a one-to one basis, as needed. Both of them felt that their experience carried little weight with the other team members, and that the team “is hard work and a drain on your resources.”
Research on Interdisciplinary Team Functioning in Rehabilitation

Although the team concept is considered central to rehabilitation, there is little consensus and few empirical studies on this inherently complex topic (Kumar, 2000). Drinka and Miller (1996) attempted to uncover similarities and differences in perceptions of health care teams by the professionals who work in them and are affected by them. They examined the metaphors applied by professionals to health care team functioning. The metaphors used represented a reality of multidisciplinary functioning in which there was one defined leader, and there was evidence to suggest that these metaphors became more complex and varied with increasing clinician experience. McClelland & Sands (1993) investigated how interdisciplinary teams adapted when one discipline was not present at team meetings. Their findings demonstrated that team members brought differing knowledge and observational perspectives to the team process, and that team deliberations and goal setting appeared to be a function of who was present and what was negotiated by those present. Strasser, Falconer and Martino – Saltzmann (1994) conducted a study involving three rehabilitation teams to explore perceptions of team environment and inter-professional relations. The perceptions of inter-professional difficulties were found in general to be independent of which team the respondent belonged to, their experience in rehabilitation and their professional discipline.

Interestingly, these researchers found that physical therapists, when contrasted with other disciplines, proved to be the exception. A majority of the physical therapists perceived that their professional judgement caused other team members to be defensive. The researchers, in discussing their findings, speculated that “perhaps physical therapists perceived themselves as more important and somehow less dependent on team process issues, and that the [defensiveness they perceived on the part of other team members] may reflect less appreciation of, or tolerance for, the usual give-and-take of team process issues” (p.180). These findings are reflected in Margaret and Barbara’s more disillusioned attitude towards the interdisciplinary team as compared with the other participants in this study. The fact that they were ‘trained’ at a time when the profession and the delivery of rehabilitation services were more firmly aligned with the
medical model may be contributing factors. It is perhaps surprising, given the value attributed to interdisciplinary team functioning in rehabilitation, that health care professionals are, in general, inadequately prepared for the team membership role (Drinka & Clark, 2000; Kumar, 2000; Strasser, Falconer & Martino-Saltzmann, 1994). Diller’s (1990) comment that rehabilitation professionals “have not developed an adequate theory of teams and the logic under which they operate” (p. 277) would appear to be still relevant.

The Role of the Rehabilitation Client as Team Member

Shared goal setting and the avoidance of duplication of services, according to Latella (2000), are at the core of successful interdisciplinary team functioning. Teams are involved in problem solving beyond the scope of their own discipline, and once the goals are set, each discipline works toward goal attainment within their own discipline. Most noticeably the literature on health care teams does not address the role of the client and their family in establishing the goals of rehabilitation and in decision-making (Law, 1998). In writing about her family’s rehabilitation experiences, Martone (2001) poignantly articulates their sense of exclusion from the decisions made on behalf of her daughter by the ‘health care team.’

Rehabilitation institutions now espouse a client-centred approach to practice, although, as has been discussed in Chapters Two and Seven, this espoused value may not be translated, in any concrete manner, into the realities of service provision.

The participants consistently described their practice as focused on the client as a person. They all alluded to, and appeared to endorse, the concept of client – centred practice; however, their discussions of team functioning focused primarily on those disciplines with whom they collaborated. Their client-oriented sentiments were expressed almost solely in relation to their individual therapist– client therapeutic interactions. They rarely addressed the role of the client in interdisciplinary team decision-making. Only two participants spoke about the client as part of the team decision-making process: Kate when prompted and Barbara to express her ambivalence about the client – centred focus in rehabilitation. Typically, the participants described clients as not being involved in team meetings and gave clients’ lack of understanding of medical
terminology, team conflicts, and the risk of overwhelming the client as reasons for their exclusion. Rounds and discharge meetings were usually the settings in which client and family involvement was encouraged.

The 'rhetoric' supporting both interdisciplinary practice and client-centred care is firmly in place; however, in my opinion these concepts have not been effectively reconciled or implemented in rehabilitation. This is not really surprising given the diversity of interpretations of both these concepts in the health literature (Gage, 1995). In contrast to physical therapy, there has been a proliferation of occupational therapy and nursing articles dealing with the implementation of client-centred care. This concept has been a component of the occupational therapy philosophy since the early 1980s (Law & Mills, 1998). In the nursing literature the ethic of caring has been identified as the theoretical focus of nursing practice (Carse & Nelson, 1996). From this perspective the lived world, the life story, and the goals of the patient become the essence of caring for and about the patient. Each discipline on the team comes to the rehabilitation process with a different interpretation of the meaning of illness and disability, and with values and assumptions about priorities of client care. These examples of different interpretations of client-centred practice, in my opinion, draw attention to a source of conflict within interdisciplinary teams.

There are a number of assumptions, according to McColl, Gerien and Valentine (1997, p. 512), associated with the client-centered approach that may assist in differentiating it from other models. The first assumption is that clients know what they need to attain their goals of care or therapy; and thus, the client establishes the agenda for care. The second assumption is that the only relevant viewpoint or frame of reference is that of the client. A third assumption is that the dominance of professionals in the therapeutic process is in fact counter-therapeutic. Professional control of the therapeutic process creates dependency, disempowerment and contributes to institutionalization (Albrecht & Devlieger, 1999; Trieschmann, 1988; McColl, Gerien & Valentine, 1997). A final assumption is that health professionals cannot actually promote change or new learning on the part of a client; they can only create an environment that facilitates
change by providing information, ideas, suggestions, resources and establishing a relationship of trust with clients. Individual professionals may strive to be client-centered but the concept has not been consistently defined, and fairly significant structural changes in the organization of health care and professional education are needed to accommodate this shift in ideology from the biomedical approach (McColl, Gerien & Valentine, 1997; Townsend, 1998). Geddes, Finch and Larin (1999) suggest that deliberately staying client-centred rather than competency centred, and fostering a climate that encourages the understanding of differing views, may protect client autonomy.

In rehabilitation, client autonomy represents a more complicated process in which the client (or surrogate decision-maker) is assisted over time to assimilate the consequences of their disability or chronic condition into their lifestyle and social context. This is a lengthy process requiring a gradual transformation of how they perceive themselves and is one of the factors differentiating rehabilitation from acute care (Banja, 1992; Caplan, Callahan & Haas, 1987; Jennings, 1993). According to Martone (2001) "because a patient’s own health and value systems are at stake when making health care decisions, the patient should have ‘moral authority’ superior to that of the health care professionals. Otherwise the patient’s dignity is not respected" (p. 37). Martone’s experience mirrors that articulated by individuals who have experienced rehabilitation first hand (for example, Klein, 1997; Reeve, 1998). In reality, professionals find it hard to visualize their expertise as only a small part of the whole picture, and that their services are ‘negotiable’ in the context of the client’s lifestyle, behaviours and values (Banja, 1992; Jennings, 1993).

Increasing client participation and control in the rehabilitation process has been linked to favourable outcomes (Albrecht & Devlieger, 1999; Trieschmann, 1988). Macleod and Macleod (1996) found that following spinal cord injury, clients who assumed an active role were more likely to be independent after discharge from the institution and less likely to be readmitted with medical complications. However, there is still very little literature on developing frameworks or models for client-driven interdisciplinary care planning, by which clients can be empowered to
be fully involved in team decisions, develop relevant goals and play an active part in evaluating their rehabilitation process (Gage, 1994; Macleod & MacLeod, 1996).

**The Importance of Communication**

All the participants considered communication skills critical to their clinical practice in developing rapport and trust with clients and their families, in clearly articulating elements of their professional role and resolving conflict effectively with clients and other health professionals. However, with the exception of Barbara, all the participants considered themselves ill prepared to meet the communication challenges they face in their everyday practice. I consistently got the impression that they considered their personal communication skills to be inadequate to meet the exigencies of the dilemma situations they were recounting. As Jill said:

> It's all about communication. But you only realise that once you're graduated and out in the real world. It's been an ongoing process for me. As a profession I don't think we value communication and counselling skills but they are so important in what we do in rehab.

The participants most commonly identified geographical proximity, that is sharing a common space either office or treatment area, as one of the major factors facilitating informal communication, rapport and trust between professional groups. As Dawn explained:

> The stroke team mostly work in the gym which is separate geographically from the wards. It means that the nurses can't just pop in and see how their patient is doing or for that matter what we do with the patients. Communication is better on those units where the treatment area is on the same floor.

This proximity was generally achieved with the other rehabilitation therapies and social workers whereas they experienced nursing as being located separately. Janine valued the opportunity to interact with other disciplines both formally and informally:

> We [team members] catch each other throughout the day, even though we have rounds together it seems that a lot of the time we're just catching each other when we're on our way to something else or as situations arise. OT's and PT's share an office and the social worker's office is just across the hall so she quite often
comes over to fill us in on some information or to leave post-it notes on our desks. People are good at sharing information and trying to check with each other.

As a result the disciplines of occupational therapy and speech language pathology and, to a lesser degree, social work appeared, for the participants, to constitute the core members of the interdisciplinary team. It is these professions that were, for the participants, authentically present and with whom they developed a mutual trust and respect.

In contrast, the participants found communication with the nursing staff to be problematic. Kate attributed the problem to the nurses scheduling:

The nurses aren't consistent because they are on shift work. There has been some effort to have the nurses work in a smaller orbit so they get to know a group of patients better. The doctor, social work, OT, PT and speech don't rotate so there's an opportunity for us to get to know each other's personalities. It really helps communication.

As Janine explained, in the rehabilitation centre, primary nurses were assigned to individual clients but, while they did work consistent shifts, these were frequently the afternoon shift meaning that they overlapped with the rest of the team members by only 1-2 hours. Communication was generally conducted by a series of notes. Attempts were made to schedule meetings during the time available but this strategy had limited success and the nurses were unable to capitalize on the valued informal communication that occurred between the other disciplines during the day.

Communication with physicians was related to difficulties in connecting with them given their often irregular and unannounced visits to clients and treatment areas. In this way, physicians were also viewed as being peripheral to the core interdisciplinary team. The intensity with which the participants spoke of their relationships (or lack of them) with nurses is indicative, in my opinion, of the significant impact that nursing practice has on both the client's well being and on physical therapy practice in rehabilitation. As Kate said:

The role of the nursing staff is absolutely vital and I have a lot of respect for what
they do and their knowledge base. We are very dependent on them to inform us about the patient’s status, and to reinforce the things we instigate for the benefit of the patient – both short and long term effects.

Several of the participants had the opportunity to work with a clinical nurse specialist, an individual who assumes the role of practice leader reminiscent of the ‘head nurse’ position. This individual worked consistently on the weekdays and was able to act effectively as a bridge between nursing staff and other disciplines, to participate fully in the interdisciplinary team and to maintain continuity of client care. As a result of having a consistent presence this individual played an integral role in arranging client discharge and advocating for clients, particularly with physicians. The older participants recalled the past when they were able to get to know and “even socialize with nursing colleagues” who chose to work on specific units or programs. This collegiality with nurses had also been my experience and we spoke of the wealth of expertise that these individuals shared with us in the early stages of our own careers.

**Impact of Structural Barriers on Team Work**

Structural disincentives such as scheduling and allocation of nursing resources, from the participants’ perspectives, not only impeded communication between nurses and other disciplines, but also constrained standards of nursing practice and isolated nurses from interdisciplinary team involvement. Ruth empathized with the nurses when she said:

> It must be so hard to take on the patient’s illness or problem, take on the responsibility for that person’s whole care when they rarely see them for more than one shift. It must be so unrewarding for them.

Margaret captured the essence of the participants’ observations when she said:

> I think nurses are being encouraged to perceive themselves as managers - as case manager for the patients - but as long as the nurses are working different shifts and rotating between different units it doesn’t work. It’s not their fault but they haven’t a hope of staying on top of things because they don’t stay consistently on one team.

The participants recognized the considerable blurring of roles and overlap of
responsibilities between health care professionals on the rehabilitation team. Examples of such overlaps exist between nursing and social work which share a focus on the psychosocial dimension of care, and between occupational and physical therapy which share assessment of client equipment needs, such as, wheelchairs. These ‘grey areas’ can contribute to interdisciplinary communication and functioning, making it easier to reinforce different disciplines’ interventions. However, these overlapping roles have received little attention in the literature and are not addressed in a constructive manner in education programs. Consequently, they can become a source of misunderstanding and conflict. The participants viewed this merging of aspects of different disciplines’ roles as advantageous for the clients as long as “someone was prepared and able to keep the whole picture in mind.”

Maintaining the ‘whole picture’ was seen as the unique contribution of nursing. However, the lack of continuity and the use of ‘casual’ or ‘float’ nurses, meant that the nurses were perceived as not being able to acquire the expertise they needed to develop this role or to provide effective care for specific rehabilitation client populations. Dawn’s frustration on behalf of her clients is evident in this comment:

The stroke team has been trying to push for better care for stroke patients, not nursing care in general just that related to strokes, specifically on the family practice units. It’s been a bit frustrating because we spend time educating one group of nurses and then they don’t carry it over to the next and they don’t seem to generalize the information from one patient to another.

Identifying, and following up on specific aspects, of a client’s care was seen as a nursing responsibility, but participants found themselves becoming involved in these liaison and coordinating roles because they, in contrast to the nurses, consistently saw the same clients five days a week until they were discharged. As a result, they acknowledged that they frequently circumvented nursing or assumed responsibilities that technically fell into the nursing domain. As Ruth explained:

A lot of medical issues – pain management, getting X-rays done, organizing referrals - are being followed up with the medics by therapy staff. I can
understand why the nurses could see that as undermining their role. We’re the consistent ones, we know the day to day issues in a way that the nurses don’t because of the way they are scheduled. But it is bypassing the nurses and undermining their professional role.

These structural barriers to team involvement and standards of nursing care are reflected in the nursing literature. Authors (for example, Armstrong & Armstrong, 1996; Growe 1991) suggest that the casualization of nurses and workload measurement systems in nursing fit comfortably with a reductionist medical model of the patient. However, they do not fit well with either nursing models of care or with the experiences of clients or nurses. The opportunity to establish rapport with the clients over time was valued by the participants but they felt that the same opportunity was not afforded the nurses. They saw it as contributing to their expertise and were concerned that because of the lack of continuity in nursing care there was a potential for important signs of distress, complications or problems experienced by the clients to be missed.

The participants valued working with nurses who had expertise and an interest in rehabilitation practice. As Janine said:

Certainly when I worked on the acute side those nurses who had worked on rehab in the past could see the problems that might be anticipated down the road and approached care differently. It made such a difference to the overall care of the patient.

They recognised that management strategies of ‘floating’ nurses to different areas of the institution, and the use of part-time nurses, discouraged nurses from gaining expertise in one area. The situation is different in physical therapy. Physical therapists elect to work in rehabilitation settings and as a result acquire expertise and knowledge working with particular client populations. They become recognized over time as clinical specialists. The participants felt that specialization in nursing – the development of knowledge and skills valued by the institution and the nursing profession - was related to the high-tech, high-cost acute areas, such as intensive care units, renal dialysis or neo-natal nurseries. There is an inherent assumption in the manner in which health institutions are organized that the nursing role is generic and that nurses can,
therefore, be transferred without detriment from one area to another and from one client population to another (J. Ericksen, personal communication, January 3, 2002). Rodney (1997) draws attention to the significant status difference in the terminology used to describe different areas of nursing practice, for example, ‘from the floor’ or ‘from the unit’ (p. 230). She questions why areas, such as general medical – surgical areas and long term care, are not given recognition as specialties in nursing. Armstrong and Armstrong (1996) suggest such areas of practice are low-tech and best practice here relies almost entirely on a professional approach of caring for the whole person. Too often, they suggest, caring for the basic needs of clients are defined as non-medical and therefore reducible to a quick physical activity or eliminated entirely from workload assignments. These organizational assumptions devalue the important contribution expert nurses make in caring for rehabilitation clients.

From the participants’ perspectives, rehabilitation clients have complex problems and considerable expert knowledge and skills are required to treat and care for them effectively. In addition, they felt that these clients were frequently labelled as ‘heavy,’ ‘dependent,’ and ‘not viewed as nice’ by nurses who were frequently short staffed and unable to attend to the clients’ basic care needs, such as, hygiene, feeding, transferring out of bed and dressing. According to the participants in this study, the budgeting of nurses, that is the methods used to determine the number and mix of nursing personnel required to meet the needs of the clients, did not take into account the care demands characteristic of the rehabilitation client population. Ruth observed that the “the way nurses are employed in the hospital has really changed since I first came to Canada – for the worst, I may add.” Her observation corresponds to the period of time that Storch & Meilicke (1994) identify as “a climate for change in the organization and management of health services that transcends anything since the foundation for the current system was completed in 1968” (p. 32).

The participants clearly recognized the contribution that the nursing profession makes in everyday management of the complex clinical situations that are characteristic of rehabilitation care. In these situations the knowledge and expertise of nursing and physical therapy is both
overlapping and complementary. The participants all appreciated the opportunity to work closely and effectively with nurses on behalf of the clients, and deeply regretted it when organizational structure disincentives, and their own inability to communicate effectively interfered with that professional relationship.

**Understanding Unique Approaches to Practice**

These issues, while frustrating for all involved, represented only one aspect of the participants’ reflections on interdisciplinary team functioning. The participants identified a number of dilemma experiences that caused them to reflect on their own orientation to practice and those of other professions. These included how professions acquired particular values over the course of their education and subsequent clinical experience. They frequently used ‘philosophy of practice’ as synonymous with ‘approach to practice’. They appeared to be referring to aspects of practice such as attitudes towards clients, the values that guided practice, and how professionals prioritized their everyday interaction with clients, rather than the techniques and skills associated with individual disciplines. This is a topic I will return to later in this chapter.

The participants’ concerns focused on the perceived clash between nursing and physical therapy approaches to client care in rehabilitation. They used phrases like “no common language,” ‘different philosophies,” “different approaches to patient care,” and “we’re on different wavelengths” to describe the problem. Dawn explained it more comprehensively:

I think nurses see themselves as patient specialists rather than nursing specialists as part of a team. When you communicate you have to have the same language and you have to understand where each professional group is coming from and is going, what each is trying to achieve.

The participants felt that by reflecting on, and openly discussing, perceptions of each other’s philosophies of practice, nurses and physical therapists would “be better able to treat each other with respect, recognize where we excel and capitalize on each other’s expertise.” Ruth encapsulated both the problem and the desire when she said:
It would really help communication if we all understood the fundamentals of what each of us has to offer in patient care. The main frustration is that we always seem at odds, or one group gets cut out of the decision-making rather than focusing on the unique philosophy we each bring to patient care.

The most fundamental difference between the two professions’ approaches to care is captured in Veronica’s brief but telling statement “the nurses deal in the here and now, day to day care, whereas we are concerned with the long-term.” Nurses were perceived as working intensely with individual clients throughout an 8 – 12 hour shift. Physical therapists, on the other hand, saw individual clients for 45 – 60 minutes a day over the course of their stay on the unit, ward or program. As Kate said:

Just the vision nurses’ see as important and what therapists’ see is very different. We don’t see all day, we see a snapshot of perhaps an hour a day and it sometimes depends what time of day we see the patients as to how they are functioning. But we do see the patient over weeks – months. It’s a very different perspective.

Participants spoke of the limitations of only seeing clients at a specified time each day and recognized that they were often unaware of the client’s twenty-four hour context. They all relied on getting this important information about clients from the nurses. As Janine said:

They [the nurses] know because they have seen the client during most of the day but on the other hand ‘rehab’ seems to happen somewhere else, and the information we can provide about the client’s gains and capabilities don’t seem to have any relevance to them.

I have schematized these two perspectives, as conceptualized by the participants, as two intersecting lines (Figure 2). The vertical line represents the nurses’ intense and detailed in-depth view of the client’s circumstances and the horizontal line represents the therapists’ broader long-term view of the client’s capabilities. The intersection of these lines is where the two professions interact in providing service and care for the client in rehabilitation. It is at this intersection that these discrepant day-to-day care priorities appeared to come into conflict as Kate explains:
Figure 2. Participant's perceptions of nursing and physical therapy priorities of care
The highest nursing priority is that the patients get medically stable and well and we have to merge our priorities with theirs. They are much more task oriented than us. The problem is some of the things we see as priorities, like casting or splinting to prevent contractures or facilitate function later, aren't seen as belonging in the nursing domain. They become just one more task they have to do and consequently they end up low on the list of priorities for the day. An example - the OT and I spent hours trying to prevent this patient from developing knee and hip contractures - range of movement, expensive cast to be worn 24 hours if possible. He got a bladder infection and the nurses put the IV in the leg so the cast can't go on. It took us three days to persuade them to change it. They just didn't understand the consequences of the patient not wearing the cast for his future.

The participants consistently described nurses as being 'task oriented.' This designation fails to capture the complexity of nurses' decision-making in the clinical setting and is certainly indicative of the participants' acknowledged lack of in-depth understanding of the nurses' role. Interactions between nurses and physical therapists about day-to-day priorities and goals of care seemed fraught with misunderstandings as the example given by Ruth illustrates:

The nurses' role is vital, they are oriented to the immediate needs of the patient. Are the neurology vital signs within appropriate range, are the correct diagnostic tests being done, have the doctor's orders been followed up, is basic care being addressed? We - the rehab therapists - look at patient care from a totally different perspective. We want to get them moving, help them do things themselves, prevent complications. The nurses turn a patient so they don't get pressure - skin - problems. We turn a patient for the purposes of - positioning and stuff - the long term effects on joint range, spasticity, prevention of contractures those sort of things. The reality is they don't have the time for things like that. It's a whole different philosophy. We're very conscious that there are these differences in philosophies and it does influence how we liaise with the nursing staff and ask for things to be done, and what we demand of them. But we are very dependent on them to maintain the things we instigate for the benefit of the patient - both short and long term effects. The perception - if we're not careful - could very easily become one of you do, do, do - put these casts on, take them off, get the patient up etc., and then I - as the physiotherapist - am just going to come along at my set time and do my thing and then walk away.

Both professions claim the centrality of the client and family in determining and implementing selected interventions (Boblin-Cummings, Baumann & Deber, 1999; Jensen et al, 1999).
However, the participants described their relationship with the client as being different from that established by nurses.

The participants characterized nurses as caring both for and about their clients, and as establishing a different kind of rapport with clients based on the intimate nature of many of the tasks that define their day-to-day practice. As Jill said:

Their relationship is no better or worse than the one we have with clients - just different. Theirs is based on what they can do for the patient, ours - I mean OT, PT and SLP - is focused more on 'we want to teach you how to do it - look after - yourself.' It makes team communication difficult. Different professions have very different goals related to the same client. We need to be on the same page if we are going to serve the clients well.

In contrast, they characterized themselves, as physical therapists, as focused primarily on caring about clients. This focus is evident in Janine's comment 'we want to teach you [as a client] how to do it - look after - yourself.' The participants' consistently made the claim that the purpose of physical therapy interventions, in collaboration with other interdisciplinary health care members, was maximizing client and family responsibility and autonomy, including giving them moral authority over matters concerning their own health. These claims are reflected in other disciplines' characterizations of their practice. The term client-centred has many different meanings in health care and a different model of care is associated with each meaning, making it quite difficult to gather evaluation information on any one client-centred model of practice (Gage, 1995).

Participants speculated that differences in philosophies originate in the various professional education programs. As Jill explained:

It can happen in any area of rehab I think - this lack of discussion and different viewpoints on management - I think it also has something to do with different professions’ different perception of disability and living with a disability. I think the training / education of rehab therapists, and I include OT and SLP in that, is fundamentally different from nursing, and I wish I could better understand that
difference then I could do something about it. It's so difficult to engage in an open and non-defensive discussion of these differences.

Dawn shared a disturbing experience with me that triggered her awareness of the two professions' different educational backgrounds. The rehabilitation therapy team, consisting of herself and her occupational therapy (OT) and speech language pathology (SPL) colleagues were asked to provide an orientation session to nurses newly assigned to the family practice and medical wards. Given the constraints of time the rehabilitation therapists decided to "pick out two things per profession we wanted them to take home from the session." They decided to make the learning experiential and asked for volunteers to act as patient models. Dawn, as the physical therapist chose to teach safe and comfortable positioning of clients in bed and walking with a walker. The occupational therapist chose establishing optimal sitting posture. Since many of the clients on these wards were diapered (a practice the therapists were trying to decrease) they asked the patient model to wear a diaper over her trousers. The therapists were concerned about the practice of diapering patients who had difficulty moving independently because of the increased skin problems and the negative effects on sitting posture, bladder and bowel re-training and self-esteem associated with the use of diapers. They felt that by having a volunteer describe the sensation of wearing a diaper, while trying to perform tasks like shift position in the wheelchair or stand and walk, that these problems would be more clearly illustrated. For the same reason, the speech language pathologist, who focused on optimizing swallowing through positioning in sitting, asked volunteers to try swallowing thick liquids in slumped positions. Although the volunteer nurses actively participated in the sessions without complaint, the following day the clinical nurse specialist told the rehabilitation therapists that these sessions were inappropriate and 'degrading' for the nurses participating. The rehabilitation therapists, according to Dawn, came to the following conclusions:

We were all so used to learning like that, doing things to each other but we suspect that the nurses don't do that sort of thing. We become so comfortable with the physical stuff. I think they have a very different background. I think we take for granted that physical comfort level. We're taught on each other's bodies, I
suspect they’re taught on paper. I question whether they have actually felt being turned over in a bed and how uncomfortable being left in a poor position when you can’t move yourself. To us learning like that isn’t degrading or unprofessional, we wouldn’t have planned it that way if we had thought that. It’s imperative that we understand their professional education if we are to cross the boundaries between therapists and nurses.

Dawn’s discussion of this incident also indicates the commonality of approaches shared by the rehabilitation therapies. Consistently throughout this study, the participants, with the exception of Barbara and Michael, spoke of their close working alliances with the other rehabilitation therapies – occupational therapy and speech language pathology. The participants talked of ‘discussing problems,’ ‘making plans,’ ‘consulting’ and ‘sharing treatment sessions’ with their therapy colleagues. These interactions were valued as learning opportunities, as challenging, supportive and collegial and as ultimately benefiting the clients. Veronica described the nature of these interactions as:

There are so many areas where we overlap. We’re always communicating like ‘I’m concentrating on this today with so-and-so,’ and how does that work with the problems they are encountering or the aspects of care they are focusing on? I might say to the SLP ‘the patient needs supervising walking can you do that coming back from speech to the cafeteria?’ or she might ask me to ensure certain postural positioning to enhance swallowing. We’re on the same wavelength, same goals, same philosophy. It doesn’t mean we always agree mind you! (laughs).

Alliances between the rehabilitation therapies were supported by similar scheduling and staffing patterns and shared working space and appeared to be grounded in fundamental practice commonalities and a desire to accommodate their different approaches to each others’ practice. In contrast, in relation to the day-to-day functioning of the interdisciplinary team and interaction with clients, physicians were conspicuously absent from the participants’ descriptions of dilemmas of practice related to interdisciplinary functioning.

The Physician’s Role on the Interdisciplinary Team

In Chapter Seven I discussed the dilemma experiences identified by the participants that involved physiatrists as ‘gate-keepers,’ particularly related to admission and discharge decisions
affecting individual clients’ access to rehabilitation services. I interpreted these situations as causing the participants moral distress. The participants’ accounts indicated that other members of the team, specifically nurses and occupational therapists, shared their concern about the lack of fairness and appropriateness of these decisions. The participants observed that neither they nor the interdisciplinary team were able substantively to influence or change the decisions, even though they experienced them as being detrimental to the clients’ well being. The evaluation of clients for admission and discharge purposes, like the prescription of medications, has been a traditional component of a physician’s scope of practice that has not been seriously challenged by other health care professionals. In these situations, physicians have the authority within the organization and, historically, over the allied health professions, such as physical therapists, occupational therapists and nurses. In these situations, the participants experienced feelings of impotence in the face of the physician’s authority. Admission and discharge decisions required, in their view, a comprehensive assessment of the client and a thorough understanding of the various contributions team members might make to the client’s rehabilitation process. The participants expressed concern that no single discipline was prepared by their education to make these complex decisions and that a collaborative approach to admission and discharge decision making would be more appropriate.

In everyday practice, however, the interaction between physicians and physical therapists appeared to be relatively unproblematic. This coincides with my own experience working in rehabilitation settings. The participants were concerned about “maintaining a good working relationship” with neurosurgeons and physiatrists and were aware, in a general sense, of their influence on client care. As Kate said “it’s them that make the final decision about what opportunities the patient may have. It can have such an impact on their future, and that’s where the potential conflict exists.” Compared to the collegiality, which the participants valued between them and other rehabilitation disciplines, and the importance they accorded the nurses’ role, physicians were perceived as peripheral to the day-to-day decisions and provision of client care.

In some of the participants’ accounts of the interdisciplinary team the physicians acted as
leaders of the team with varying degrees of success depending on their experience and personal style. As Jill said:

I think in acute care areas the multidisciplinary model – dictatorship style with the doctor taking the lead – works fine, you need someone directing it, to get the patient out the door as soon as possible. But when you're looking at the more complex client in rehabilitation there are a lot of directions this can go in, it's long term, rehab has to have a different approach.

Sophie was involved with an interdisciplinary team that she defined as 'self-directed.' She identified the role of the physician as follows:

I do enjoy being on a self-directed team because it has no designated leader. When we do work well together it's such a great feeling. We use the doctors as consultants. We don't really need a doctor (laughs) although we don't tell them that. I think this is the type of team you're going to see more and more in the future.

The participants' interactions with physicians primarily focused on clarifying and providing information; for example, consulting about a client's diagnosis or prognosis, clarifying a client's status or orders following surgery or diagnostic procedure, and providing information about a client's progress in physical therapy. They described being irritated, particularly in the acute rehabilitation settings, about the considerable time and energy they expended in contacting physicians when they needed to communicate with them about a client. In the main, however, these interactions had a positive outcome and were considered amicable. The nature of the relationships between physical therapists and physicians had a distant quality to them, and had significantly less impact on the participants' everyday practice and their perception of 'good' client care than their relationships with the nursing staff.

This difference may be attributable to two factors: the close alignment historically of physical therapy with the medical model, and the degree of professional autonomy physical therapists enjoy within the institutional setting and within health care in general. Miles-Tapping (1985) suggested that the profession of physical therapy, like dentistry and optometry, closely aligned itself with the medical model and settled for a limitation of their scope of practice. By
accepting the limitation of their scope of practice, which Miles-Tapping identified as a form of domination, these professions avoided having to develop a separate theory of disease. As a result, the medical model has dominated what counts as legitimate and 'scientific' knowledge in the profession. An aspect of this control mechanism is the adoption of a similar language. Physical therapists, for example, have been taught to consider the client's symptoms as subjective and to make bio-mechanical diagnoses. As discussed in Chapter Six, the profession is committed to the concept of evidence-based practice developed in medicine whereby treatment approaches are confirmed by valid and reliable research and objective measurable outcomes. Physical therapy authors (for example, Bithell, 2000; Parry, 1995; Richardson, 1999b; Roskell, Hewison & Wildman, 1998) contend that our professional education is still linked in a theoretical and epistemological sense to medicine (Chapter Two). While these commonalties of theory, knowledge and language have contributed to participants' dilemmas of practice, related to the uncritical adoption of the concept of evidence-based practice discussed in Chapter Six, I contend that they also promote the day-to-day relationship between physical therapy and medicine.

In rehabilitation settings, physical therapists perform assessments and make decisions about treatment independent of physicians. This was not always so. Until the early 1990's, physical therapists required physician orders to treat clients both in the private and public sectors. Recent changes in the Health Authorities Act – the document that initiated the transition to regional boards – quietly dissolved legislative obstacles, making the benefits of direct access to physical therapy available within institutions and agencies (Melcombe, 1999). In the past physical therapists working in rehabilitation settings were covered to practice by what was called a 'blanket referral' but this is no longer required. Physician orders are sought only when the physical therapy activity is directly related to surgery or when the medical stability of the client is in question. In contrast, the nurses' experiences with physicians in day-to-day practice
are frequently conceptualized in terms of the power dynamics\(^8\) inherent in the nurse-physician relationship (Benner, Tanner & Chesla, 1996; Hugman, 1991; Rodney, 1997; Street, 2001). This relationship is frequently depicted "as far from ideally collaborative and that issues of status inequity, gender bias, and power imbalance are commonplace" (Benner, Tanner & Chesla, 1996, p. 218). The nurse – physician relationship has also been explored from the perspective of the different values and assumptions held by the two professions (for example, Grundstein-Amado, 1993; Rodney, 1997; Uden et al, 1992).

**Understanding Different Philosophies of Practice**

The participants in this study analyzed the interdisciplinary conflict situations they experienced from both a structural and a theoretical standpoint. They reflected on what they called the different philosophies and priorities of practice, how these influence the ways in which different disciplines define and address clinical problems, how quality of life is conceptualized, and how patterns of communication among health professionals are affected in the rehabilitation setting. I was impressed by their deliberations given the dearth of theoretical analysis in the physical therapy literature. Nursing and occupational therapy have historically been closely linked with physical therapy but these professions have responded differently in terms of the development of the discipline. These professions have been exposed to the same changing organizational and professional climates in Canada and both disciplines have actively explored theory – practice issues, whereas physical therapy has not.

Jensen et al’s (2000) theoretical model of expert physical therapy practice, introduced in Chapter Five, represents an attempt to make explicit the profession’s conception of practice.

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\(^8\) I fully acknowledge that issues of power are pervasive in health care, however, I have intentionally chosen not to discuss those issues in this thesis. The reason for this is twofold; (1) the participants accounts did not identify conflicts related to power, other than the gate-keeping role of physicians as dilemma experiences and; (2) given the complexity of the issues I felt it was beyond the scope of this thesis.
The underlying assumption of this model is that expert therapists share a relatively common understanding of their role as physical therapists, regardless of clinical specialty area. The core of the model – the philosophy of physical therapy - is conceptualized by Jensen et al (2000) as the integration of the four dimensions of practice – knowledge, clinical reasoning, movement and virtues. This philosophy represents “a therapist’s vision of practice – that is, what it means to practice physical therapy, including the therapist’s beliefs about the purpose of physical therapy” (Jensen et al, 1999, p. 181).

The philosophy of a discipline, according to Meleis (1997), focuses on providing the framework for asking both ontological and epistemological questions about the values, assumptions, concepts, propositions, and actions of that discipline. Baum and Christiansen (1997) consider the values, beliefs and principles of a discipline, collectively described as its philosophy, to have a major influence on its identity and development. Particular values and overall value orientations are instilled in the process of acquiring an identity as a nurse, physical therapist, or physician – including those related to such concepts as respect for autonomy and quality of life. Some disciplines, and I will use nursing and occupational therapy as examples, have well developed literature outlining the profession’s theoretical and clinical bases (for example, Meleis, 1997; Christiansen & Baum, 1997; Law, 1998). Although it is important to avoid stereotyping each profession, this literature does reveal striking patterns that do seem to characterize the unique ways in which these different disciplines define their practice knowledge and approach to the client.

The participants in this study identified a need to understand their own professions’ philosophy of practice better as a first step to promoting interdisciplinary understanding. This, in my opinion, is a legitimate need given that the philosophical and historical roots which shape the practice, and the values and priorities held by physical therapy today, are rarely articulated in the literature or taught in the academic programs (Richardson, 1999a). The acquisition of knowledge, skills, values, roles and attitudes associated with the practice of a particular profession occurs through a process of professional socialization. This process of socialization
begins during the period of formal education and continues through interaction with others in a diversity of clinical settings. Professional socialization may be seen as the development of a unique voice and professional view of the world (Drinka & Clark, 2000). However, articulation of a profession’s core values and assumptions must begin with a comprehensive exploration of the profession’s theoretical and philosophical foundations, core concepts and guiding principles (Baum & Christiansen, 1997).

The ability to reflect on the important differences, as well as the similarities, among health professions is an increasingly important characteristic of effective teamwork and collaboration for the future of the health professions (Drinka & Clark, 2000). The participants’ in this study felt that understanding and appreciating the value and validity of each profession’s perspective or way of ‘being in the clinical world’ would enhance collaboration and communication between disciplines. However, in reality, this important learning all too often occurs serendipitously in the clinical setting and is dependent on individual clinicians’ reflective skills and motivation. The goal of interdisciplinary collaboration is limited by the ways in which health care disciplines are currently educated in isolation from each other. It is becoming imperative that opportunities be developed, in both the academic and clinical settings, through which students can study and practice with a diversity of other health professions (Drinka & Clark, 2000). Perhaps most importantly, if clients and their families are to assume greater responsibility for decision-making and care, efforts should be made to develop a unifying definition of client-centred care in rehabilitation that could then form the core guiding principle for interdisciplinary learning and subsequent practice.

**Conclusion**

In this chapter I have discussed the insights which the participants shared with me about working with a diversity of disciplines in interdisciplinary teams and about the nature of barriers to effective team functioning. The participants recognized that as a result of the complex nature of rehabilitation practice there was considerable overlap between disciplines of competencies and responsibilities in relation to client care. In their relationships with other rehabilitation
therapies – particularly occupational therapy and speech language pathology – this overlap appeared to be successively negotiated. The participants valued and relied upon their interactions with these professionals and obviously considered them to be core team members.

They clearly articulated the essential role that nurses potentially play on the interdisciplinary team and the benefits to the client of an effective working relationship between nurses and physical therapists in rehabilitation. In their view, this relationship was constrained by structural barriers and a lack of mutual understanding of the two professions' philosophies or approaches to practice. The participants identified structural barriers, such as, inconsistent work schedules, the casualization of nurses, lack of continuity with clients, inadequate staffing and lack of proximity to other professions, as preventing nurses from fully participating in team functioning and decision-making. The participants' analysis of the intersection of nursing and physical therapy approaches to practice in caring for the client (Figure 2) draws attention to the different priorities of care held by the two professions. The participants' perceived nurses and physical therapists as holding different values and beliefs about effective client care, or perhaps holding the same values but operationalizing them differently in practice.

In the previous chapter I discussed the participants' dilemma experiences related to admission and discharge decisions which involved physicians in the role of gatekeeper. These decisions were frequently made in isolation and were reflective of the hierarchy that continues to be a feature of institutional structure and policies. In this chapter, the focus of which has been interdisciplinary team functioning, I have discussed the participants' perceptions of their day-to-day interactions with physicians as causing irritation rather than being experienced as dilemmas. The participants perceived the role of physicians as mostly peripheral to the core interdisciplinary team functioning and more distant from everyday practice and interactions with the client. Irritations arising from their relationship with physicians related primarily to difficulties in accessing them when needed, negotiating their role as team leader and communicating information. I have hypothesized that the more benign relationship between physicians and physical therapy may be the result of the traditional theoretical and
epistemological alignment of physical therapy with medicine and the degree of professional autonomy physical therapy has in everyday practice in the institutional setting.

The client's voice appeared to be missing from the participants' accounts of interdisciplinary team function. Ensuring that the centrality of the client in goal setting and decision-making within the rehabilitation team has proved difficult (Macleod & MacLeod, 1996; Martone, 2001; Gage, 1994). Initially in the rehabilitation process clients lack the knowledge they need to manage the disabilities they have acquired. They are faced with a diversity of health care professionals who possess expertise in components of their care. The locus of power and authority initially resides with the professionals, who acting in the clients' best interest, may find it difficult or impossible to shift that power to them or their families.

The interdisciplinary health care team is considered the key approach to addressing the complex health issues and needs of clients with disability and chronic conditions. All the participants, regardless of whether their own experience as a team member was positive or negative, considered the interdisciplinary team to be an important and unique feature of rehabilitation practice. Effective team functioning requires that professions clearly articulate their philosophies of practice, understand the impact that organizational structure and the health system context inevitably have on practice, and develop a more coherent approach to the role of the client on the interdisciplinary team.
CHAPTER NINE: CONCLUSIONS

This study evolved from my interests in exploring the realities of rehabilitation service provision both from the perspective of the client (Carpenter, 1994) and the health care professional. My own experience had alerted me to the neglected discussion of the 'particularities' of everyday practice in institutional rehabilitation settings, and this study represents my desire to contribute to the growing dialogue about health care practice in rehabilitation. Some fundamental characteristics differentiate provision of rehabilitation care from acute care services (Albrecht & Devliger, 1999; Banja, 1992; Caplan, Callahan & Haas, 1987; Caplan & Reidy, 1996; Jennings, 1993; Purtilo & Meier, 1993; Trieschmann, 1988). These characteristics, which were discussed in Chapter Two, relate to the complex and long-term consequences of living with chronic conditions and disability, and the multifaceted approach required in assisting individuals to assimilate disability into the continuum of their lives. It was in this rehabilitation context that I chose to situate this exploration of dilemmas of practice as experienced by physical therapists.

For the purposes of the research I employed a broad definition of 'dilemma' in the hope that the participants would not censor the situations they chose to share with me. The in-depth nature and diversity of the participants' discussions of the dilemmas they were experiencing in their practice appeared to affirm this decision. My interest in exploring dilemmas of practice in rehabilitation and the meanings practitioners attribute to them is congruent with an interpretivist theoretical approach to inquiry (Chapter Three). At the core of the interpretivist approach is an interest in understanding the complex world of lived experience, and a respect for the perspective of those individuals who live and interact within that world. A qualitative research approach, specifically ethnography, was chosen as the most appropriate to address the complexity of the topic and to provide a detailed view of the therapists' perspectives.

This study represents the perspectives and interpretations of dilemma experiences shared with me by ten physical therapists practicing in a number of rehabilitation centres and programs in the Vancouver area. Their descriptions of physical therapy practice in rehabilitation settings,
while not unfamiliar to me, provided me with valuable contextual information and new insights about the realities of clinical practice in a changing health care system. In order to define and share their interpretations of dilemma experiences the participants engaged in an individual process of reflection. They all spoke of how they valued the opportunity that their involvement in the study gave them to reflect on their everyday practice. I was gratified by the participants’ commitment to this research. They were willing to be interviewed four times over a period of six months. One participant reviewed the interview transcripts, and five participants reviewed the initial data analysis and provided feedback. I have since met several of the participants in a professional capacity and their enthusiasm for, and interest in, the study has been evident. The participants’ commitment to their practice and to the clients in rehabilitation permeated their interview discussions and responses to my questions.

In Chapter Five I introduced a theoretical model of expert practice in physical therapy developed by Jensen et al (1999, 2000). This model introduces the first theoretical representation in physical therapy of the knowledge valued by therapists practicing in clinical settings. The development of this model was timely in so far as it provides an appropriate organizational framework by which I could represent the participant’s practice in rehabilitation (Chapter Five). Eraut (1994) defined the key characteristics of expertise as the ability to bring one’s judgements and practice knowledge under critical control, involving self-regulation, self-evaluation and a disposition to learn from colleagues. While the participants did not, at any time during the research process, claim the designation of ‘expert’, they were all committed to rehabilitation as a specialty area of practice and spoke of how they utilized their experience and expertise in their day-to-day practice. I identified Eraut’s (1994) key characteristics of the expert practitioner in the approaches to practice that the participants described. The understanding of the particularities of rehabilitation practice, the commitment to reflecting on and developing their ‘practice’ knowledge, and the desire to facilitate learning for peers and students that they articulated clearly defined the participants as experts in their chosen field of practice.

In Chapter Six I argued that ‘practice’ knowledge, as described by the participants in
rehabilitation, is largely tacit and difficult to articulate, and is developed in specific contexts and associated with experience. Jensen et al (2000) identified four dimensions of expert practice in physical therapy – knowledge, clinical reasoning, movement and virtues. These dimensions, according to the participants in this study, included a sound knowledge base and clinical reasoning skills, to which they added attributes such as professional judgement, technical skills, communication and other interpersonal skills which enabled them to include client and family perspectives in decision-making.

Three major themes of dilemma experiences, presented in Chapters 6 through 8, emerged from the data. A number of epistemological issues related to professional accountability and the justification and the nature of physical therapy ‘practice’ knowledge were raised in relation to these themes. The participants questioned the ‘authority’ of the concept of evidence-based practice as it is currently conceived and promoted within the profession. They identified a need to develop rigorous alternative sources of ‘evidence’ to support their current ‘practice’ knowledge that are more congruent with the client-centred and interdisciplinary values espoused by rehabilitation service providers. A second theme explored the situations causing moral distress in which the participants found themselves prevented from acting on behalf of the clients owing to constraints resulting from clashes with other health professionals or to organizational policies or influences. The third theme related to their involvement with the interdisciplinary team. The participants viewed interdisciplinary team functioning as an integral and valued characteristic of rehabilitation but disagreements with other health professions about the quality of client care, and a lack of understanding of different philosophies of practice were perceived as constraining their professional practice.

In this final chapter I will provide a review of my research in terms of methodological and theoretical considerations, and discuss these themes in relation to the physical therapy professional culture and rehabilitation service delivery context. In reviewing my own research, I suggest that this work can make a number of potential contributions to physical therapy practice and education. First, by profiling ‘practice’ knowledge and the need to develop alternative ways
of generating ‘evidence’ to support ‘best’ practice I hope to promote a broad concept of ‘evidence’ that would better reflect the complexity of practice realities. Second, by contributing to an analysis of physical therapy practice in rehabilitation I hope to illuminate the need for the traditions of physical therapy practice to be made more explicit. By traditions of practice I mean the culture of the profession, with its historical roots, and associated values and norms. It is my belief that reflection and debate about the philosophical values and beliefs inherent in practice, and the relationship of practice to the dominant models – biomedical and client-centred – of service provision for persons with disabling conditions will contribute to a more thorough articulation of the domain of physical therapy. I contend that this understanding will assist physical therapists to recognize and appreciate the ‘different voices’ of other professionals with whom they work. Third, I hope to highlight the need to define client-centred practice as the core essence guiding interdisciplinary collaboration and to reflect the interdisciplinarity of health care provision in professional curricula and education programs.

Methodological Considerations

I chose an ethnographic methodology for this study because it lends itself to the investigation of individual and shared experiences in specific contexts (Chapter Three). The term ethnography has diffused widely to other contexts of inquiry, for example, nursing and other health professions, from its original intellectual source (Morse, 1994). However, as in this study, ethnography as methodology and ethnographic methods focus on gaining understanding of a group of people who share similar social and cultural characteristics. Multiple interviews with each participant were used in this study as the primary source of data. By interacting with each participant over a prolonged period of time I was able to immerse myself in the data collection and ongoing analysis process. I was able to develop an intimate familiarity with the study findings and to capitalize on my professional knowledge and experience of the rehabilitation context and practice as a result of this ‘prolonged engagement’ (Lincoln & Guba, 1985). It also allowed me to build an in-depth profile of the participants grounded in the rehabilitation context in which they practiced (Chapter Five) and facilitated an ongoing discussion of their dilemma.
Estimating the actual number of participants required in a qualitative study is difficult (Morse, 2000). It depends on a number of factors, for example, the quality of the data, the scope of the study, the nature of the topic, the number of interviews per participant, and the qualitative method and study design used (Morse, 2000). In this exploratory study the questions asked were intentionally broad and there was a potential for the dilemma experiences to occur over time rather than to be experienced as finite. By interviewing each participant several times over a six-month period we were able to explore the phenomenon of interest - dilemmas of practice - over a prolonged period of time. The participants were encouraged to reflect between interviews on issues arising in their practice and bring them up for discussion in subsequent interviews. On several occasions a dilemma experience was ongoing and discussed during more than one interview. There is a tendency for research informants to make response choices in accordance with what they think the researcher desires or prefers (Morse, 1994). By establishing a broad definition of the phenomenon of interest, and by conducting multiple interviews with each participant I believe this tendency was minimized in this study.

Throughout this time I was engaged in reading and re-reading interview transcripts, writing field notes and reflective memos and, in general, making sense of the data. It was during this continual data analysis process that I could have made the decision to involve additional participants if, by doing so, I felt that the information I was acquiring would have been strengthened. However, it became clear to both the participants and myself that we had nearly exhausted the topic after the third or fourth interview, and I felt that enough data had been collected to ensure the desired depth of information about their dilemma experiences. One participant Michael, in fact, declined to be involved in a fourth interview feeling that he had little left at that time to contribute to the discussion of dilemmas of practice.

The choice of a qualitative research design enabled me to capitalize on the experiences of professionals who are expert physical therapists, and who have an intimate knowledge of the rehabilitation context and the unique client population who require specialist rehabilitation experiences.
services. The participants were selected purposively for the contribution they could make to the theoretical insights I anticipated would emerge from the study findings. I actively sought participants who had experience in the topic of interest—physical therapy practice in rehabilitation—and who were willing to share and reflect upon their experiences with me. According to Morse (2000) "it is this selecting that ensures that the [emerging] theory is comprehensive, complete, saturated, and accounts for negative cases" (p. 5).

Much more than participant selection, however, is entailed in ensuring the analytic integrity of qualitative research. In planning and implementing this study I was mindful that a qualitative study has integrity when, as Sandelowski (1986) observed:

> It presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own (p. 30).

To that end I incorporated strategies, discussed in Chapter Four, designed to enhance the rigour of the research process and I tried to authentically represent dilemmas of practice shared with me by the participants. The ethnographic ethic, according to Altheide and Johnson (1995), calls for the researcher to substantiate their interpretations and findings with a reflexive account of themselves and the processes of their research. The researcher, in this way, is central to the qualitative research process. "The gendered, multiculturally situated researcher," according to Denzin and Lincoln (2000), "approaches the world with a set of ideas and values, a framework (theory, ontology) that specifies a set of questions (epistemology) that he or she then examines in specific ways (methodology, analysis)" (p. 18). A thorough and ongoing assessment of the researcher's approach and background, a strategy called 'reflexivity' (Hammersley & Atkinson, 1995), is an essential component of the qualitative research process.

With the concept of reflexivity in mind, I located myself as the researcher in this study by thoroughly articulating my theoretical influences, and the assumptions, beliefs, and knowledge about the physical therapy culture and practice and the context of rehabilitation that I brought to the research process (Chapter Three). My position as an 'insider' to the physical therapy
profession and practice played an indisputable role in shaping this study. The participants commented, and I observed, that my extensive clinical experience in rehabilitation, our common language and understanding of the rehabilitation institutional context, and the physical therapy culture which we shared, contributed in a positive way to their level of comfort and willingness to share their experiences with me. My rehabilitation experience and theoretical understandings contributed to my ability to ask probing questions during the interviews and to the interpretive decisions I made in analyzing the data. Paradoxically, the close relationships developed between participants and researcher in qualitative research can also threaten the credibility of the research. During the research process I spent considerable time with the participants over a period of six months. The researcher can become so enmeshed with the participants that separating their respective experiences can become difficult and adversely affect interpretive decisions (Krefting, 1991). In this study I was both a doctoral student in educational studies and a physical therapist with considerable experience working in rehabilitation settings. To ensure that this type of over-involvement did not occur I endeavoured, throughout the study, to be aware of and reflect on the influence of these two roles and of the common professional interests I shared with the participants. As a doctoral student I was concerned about ensuring the ‘quality’ of the research design and implementation and, in particular, being attentive to the participants’ perceptions of dilemmas in rehabilitation. As a physical therapist, I was aware that I held decided views about rehabilitation practice derived from my own clinical experience. While I made every effort to keep these views and assumptions as transparent as possible (Chapter Three) I was frequently conscious of the need to maintain a balance between these two roles during the research process.

The individuals who volunteered to participate in the study shared my understanding and commitment to the profession of physical therapy as practiced in rehabilitation settings. Our collective assumption (and hope) was that the research findings would contribute to the physical therapy body of knowledge and to the provision of service in rehabilitation settings. This contribution depends on the credibility of the research. One way of judging the credibility of a
The question of generalizability of qualitative research findings is frequently raised. For some this is illusory because the purpose of qualitative research is to describe a particular phenomenon or experience, not to generalize to others (Sandelowski, 1986). However, it is my hope that this study will facilitate new ways of evaluating physical therapy practice not just in rehabilitation settings. As such I had to assume responsibility for incorporating a number of strategies into the research process that would contribute to the ‘transferability’ of the research. Lincoln and Guba (1985) referred to ‘transferability’ as the criterion by which the degree to which the findings can be applied to other contexts and settings or with other groups can be judged. Transferability is dependent on the representativeness of the informants for a particular group. The participants constituted an older and more experienced group than is commonly representative of physical therapists working in institutional settings. In Chapter Five I speculated that therapists with less experience in a particular specialty area of practice might be more focused on developing professional proficiency than their more experienced colleagues. In contrast, experts seem more interested in reflecting on their practice and the ‘larger picture’ within which that practice is situated (Daley, 1999). For this reason, transferability of the participants’ insights and perspectives, and the interpretations I made during the research process, may not resonate for some members of my profession.

It is also critical if transferability is an issue, according to Krefting (1991), “that researchers provide dense background information about the informants and the research context and setting to allow others to assess how transferable the findings are” (p. 220). I believe, as the
researcher, I fulfilled this responsibility by providing detailed information about the participants, and rehabilitation service delivery in British Columbia, and the participants' orientation to expert practice in rehabilitation in Chapters Two through Five. In this way, I believe I have supported the transferability of the study findings. As Lincoln and Guba (1985) noted, as long as the researcher has provided sufficient descriptive data to allow comparison, transferability becomes more the responsibility of those wanting to apply the findings to another situation or group than that of the researcher of the original study.

Theoretical Considerations

Physical therapy is a 'profession,' like other occupational groups, that claims a professional knowledge base distinctive to itself, that enables members to practice competently, autonomously and with accountability, and whose members contribute to the development of this body of knowledge. The dilemmas identified in this study present a challenge to physical therapy knowledge as it is currently characterized, generated and disseminated within the profession. They raise important epistemological issues to be considered in physical therapy. These issues are not unique to the profession of physical therapy. However, they do have a number of implications for research and education that I shall discuss later in this chapter.

The profession continues to struggle to develop unifying theories of physical therapy that resonate with the realities of professional practice (Roskell, Hewison & Wildman, 1998; Tammivara & Shepard, 1990). Traditionally, physical therapy like other allied health professions, for example, occupational therapy and nursing, has functioned within a biomedical rehabilitation model. This model is characterized by the assumption that the patient has an objective impairment that causes the disability (Engel, 1977). The need for rehabilitation services is indicated because the patient has some normative deviation in everyday functioning and the cause of the difficulty can be objectively detected and measured using bio-medical technology (Baum & Christiansen, 1997). Professionals in health care, as a result of their specialist education have information and skills that contribute to their understanding of illness and disability. However, within the biomedical model the assumption is that these give professionals
the advantage over the patient who is considered ill-equipped to make decisions about the nature and course of rehabilitation, because they lack this specialized expertise (McColl, Gerien & Valentine, 1997).

Problems associated with disability are primarily understood, from a biomedical perspective, by reducing them to their component parts associated with different body systems. This 'reductionism' is, according to Baum and Christiansen (1997) reflected in the language used in rehabilitation. They consider the word 'function' which when used in occupational therapy describes “a behaviour related to the performance of an activity, a task, or a role” (p. 29). In medicine, however, these authors suggest, the term 'function' is most often interpreted in its reductionistic sense with referral being made to the function of a diversity of human organs, for example, pulmonary function or liver function. The participants in this study appeared to have adopted the former definition of the word but the same cannot be said for some areas of physical therapy practice nor is it reflected in the physical therapy research literature. There is also an implicit assumption embedded in the biomedical model that the patient and support group will cooperate with the interdisciplinary team, as McColl, Gerien and Valentine (1997) suggest “primarily because of the recognized expertise of the team, and the implicit good sense of its recommendations” (p. 510).

While the biomedical model serves some recipients of health care services well it appears to be counterproductive to others. The disadvantages of this model in rehabilitation are being increasingly discussed in the literature (for example, Albrecht & Devlieger, 1999; Barnes & Mercer, 1996; Caplan, Callahan & Haas, 1987; Oliver, 1990; Trieschmann, 1988). These disadvantages pertain to the willingness of professionals to assume responsibility for decision-making which often serves to disempower and alienate individuals with disabilities who are capable of making their own decisions. Rehabilitation, as conceptualized within a biomedical model, is time limited. However, the emphasis on recovery, and the patterns established in the professional – patient relationship within the biomedical model, do not prepare the individual for living with a disability nor to resume their social role and obligations (McColl, Gereien &
Valentine, 1997). In response to some of the disadvantages of the biomedical model and to factors influencing current health care changes (Chapter Two) many health professions are seeking other models of service to guide their interactions with clients. The client-centred approach to rehabilitation is one such model and was discussed in Chapter Seven.

The occupational therapy and nursing literature, in particular, have developed theoretical approaches that have gone beyond the biomedical approach (Cant and Higgs, cited in Richardson, 2000). This has been achieved by developing theories of professional practice that are interpreted and elaborated in practice and through research and focused on the guiding principles of client-centred and holistic health care. These professions are developing an alternative approach to characterizing their professional knowledge bases by grounding and illuminating practice in an applied understanding of practice epistemology (Fry, 1989; Townsend & Reibero, 2001). By this I mean exploring the ways in which knowledge informs practice and is developed from practice. The same, in my opinion, cannot be said for the physical therapy profession. It is not that physical therapists do not use theory in their practice but rather that this use has not been made explicit and therefore is unavailable for discussion or development (Domholdt, 2000). There is very little literature in physical therapy representing a debate by the profession about the theoretical or conceptual approaches, including the biomedical model, which influence and guide physical therapy practice (see Chapter Two). This contrasts with, for example, occupational therapy where there is a proliferation of such literature (for example, Christiansen & Baum, 1997; Kielhofner, 1992; Law, 1998; McColl, 2000).

Attempts have been made to develop an overarching conceptual model or framework of physical therapy (for example Cott et al, 1995; Hislop, 1975) but these appear to have failed to provide an accurate description of physical therapy or to provide a framework for study of phenomena within physical therapy. Certainly none of these broad conceptualizations seem to have been adopted in any consistent manner by the profession. The usefulness of such overarching theories has been questioned. Stevens (1984), discussing the development of a 'grand theory' of nursing wrote:
The next obstacle to understanding and developing theory...is the great press for a universal, unitary nursing theory...Indeed, it is the conflict and diversity among the theories that account for much of the progress in any discipline. A search for conformity is an attempt to stultify the growth of a profession (pp xii-xiii).

I would contend that the development of a ‘grand theory’ of physical therapy would, of necessity, be vague and of limited congruence with the multifaceted nature of professional practice and research. However, physical therapists have been accused, according to Domholdt (2000) of being “beggars and borrowers of information and theories from anatomy, physiology, kinesiology, psychology and physical education, rather than being creators of own their body of knowledge” (p. 7). What has been missing in the development of the physical therapy profession has been the creation and evaluation of conceptual systems (consisting of models and frameworks) that organize applied knowledge in physical therapy (mechanisms for linking theory to practice). In contrast, in occupational therapy a number of theories, such as the Canadian Model of Occupational Performance, based on general system theory have been developed which describe the emerging work surrounding the core issues in occupational therapy practice of person, environment and occupation (Baum & Christiansen, 1997). These theories provide a general guide to an overall professional approach. They assist in organizing the complexities of practice and provide a focus for research and subsequent theory re-evaluation. This theory-practice gap in physical therapy has resulted, according to Roskell, Hewison & Wildman (1998), in the divergence of holistic and biomechanical approaches to therapy, perceived inconsistencies between professional education and clinical practice, and between research evidence and the clinical realities experienced by practitioners. These inconsistencies are reflected in the participants’ accounts of their dilemma experiences related to their ‘practice’ knowledge: justifying it, and negotiating the scope and application of it with others with whom they worked on behalf of the clients.

**Professional Accountability: Adhering to Evidence-Based Practice**

Professional accountability was, for the participants, inextricably bound to the concept of evidence-based practice but, in reality, their practice was shrouded in uncertainty that the ‘best’
available evidence did little to alleviate. Physical therapy has traditionally adopted the designation of an 'applied science' with all the inherent implications of applying 'scientific' knowledge to certain practical situations. The concept that knowledge is created through 'scientific' research has dominated the profession's thinking in such a way that it is passed on unquestioned by practitioners. The participants were clearly heavily influenced by these prevailing professional norms. This influence was a key factor in the dilemmas they described associated with the concept of evidence-based practice (Chapter Six).

The concept of evidence-based practice, as it is currently embraced by the physical therapy leadership (Cole et al, 1994; Harris, 1996; Jette, 1995; Klassen et al, 2001; Mitchell, 1992; Robertson, 1994), in my opinion, needs to be critically evaluated. It is unclear where the demand for evidence-based practice in the health care professions has been generated. There is little accountability built into the Canadian health system in contrast to the United States where practitioners are under enormous pressures related to third party payer funding to document effectiveness (Lyn Jongbloed, personal communication, October, 2001). It is my contention that in physical therapy the answer lies in the early attempts to establish professional credibility by aligning with medicine and embracing a positivist knowledge base. This resulted in greater value being placed upon propositional, scientific knowledge and a technical - rational approach, characteristic of the biomedical model, being adopted as the basis for practice. The values inherent in evidence-based practice, as it has been conceived and implemented to date, influence the type of research conducted by the profession and the outcome measures used to evaluate client progress, and consequently influence the physical therapy curriculum content. The research associated with physical therapy reinforces the image of the profession as primarily addressing disability and impairment. This image, as the participants have suggested, does not consistently represent the realities of physical therapy practice in different settings.

This congruity between physical therapy and medicine can be further illustrated by looking at the 'problem-solving' or 'clinical decision-making' models (Basmajian & Banerjee, 1996; American Physical Therapy Association, 2001) that continue to be used by the profession
as a means of framing physical therapy practice and teaching students. These models bear a striking resemblance both to the hypothetico-deductive model of medical inquiry (Elstein, 1995) and to the 'technical rationality' model of professional practice criticized by Schon (1983). Donaghy & Morss (2000) suggest that the value of such models lie in their “repeatability and suitability as a working paradigm for patient assessment and treatment” (p. 4). Such models focus on the role of the individual professional, and fail to address the uncertainties of clinical practice and do not reflect the complex ‘practice’ knowledge used by therapists in specific clinical situations (Donaghy & Morss, 2000; Mattingly & Fleming, 1994, Parry, 2001). The recommended steps (Sackett, 2000) used to teach evidence-based medicine reflect a similar linear approach to decision-making.

I would argue that, while the investigation of the efficacy of many physical therapy treatment interventions lends itself to the ‘scientific’ approach promoted by the concept of evidence-based practice as it is currently conceived, significant gaps exist between clinical practice and research in some specialty areas. The absence of conceptual models or frameworks linking research to the realities of physical therapy practice and the traditional alignment of the profession with the biomedical model has, in my view, limited critical debate about the concept of evidence-based practice.

Authors in both medicine (Maynard, 1997; Naylor, 1995; Pellegrino, 1999; Tonelli, 1998) and the rehabilitation therapies (Bithell, 2000; Hammell, 2001; Mead, 1998; Parry, 2001; Ritchie, 1999; Sumasion, 1997; Townsend & Reibero, 2001), have begun to question the relevance of evidence-based practice as it is currently conceptualized and to call for a broadening of the concept to reflect client and professional practice realities. These authors argue that establishing the efficacy of interventions or approaches to treatment has limited applicability to the reality of clinical practice. Evidence of efficacy is derived from well-designed studies that seek to administer the intervention in as ideal conditions as possible. Effectiveness, on the other hand, is about ensuring that clinical interventions are based on the best available evidence and about applying such interventions within real life conditions. These conditions,
include such factors as, organizational systems, the client’s preferences and goals, client health status and characteristics, and interdisciplinary involvement. Clinical effectiveness, therefore, is achieved by using interventions that are known to work, and embedding those within a service provision environment and system that are of the highest quality. Another way of describing clinical effectiveness was suggested by Graham (cited by Bury & Mead, 1998, p. 27) as the right person, doing the right thing, the right way, in the right place, at the right time, with the right result. If clinical effectiveness, that is, securing the greatest possible health gains from available resources, is to be considered the required outcome of health care services then a broader definition of ‘evidence’ is needed.

However, this six ‘R’s’ approach to clinical effectiveness continues to negate the role and preferences of the client. The question needs to be asked “whether the purpose of judging ‘successful’ outcomes by measuring specific [therapist identified] skills is simply a means to justify and validate current rehabilitation practice and interventions” (Hammell, 2001, p. 230). There is an increasing awareness that rehabilitation clients do not share the same priorities, preoccupations or perceptions of problems as health care professionals or researchers (Carpenter, 1994; Eisenberg & Saltz, 1991; Johnson, 1993; Weaver, 2001). Client – centred rehabilitation, which is discussed in more depth in Chapter Eight is, according to McColl, Gerien and Valentine (1997) “a therapeutic orientation whereby clients engage the assistance and support of a therapist to facilitate their problem solving and the achievement of their own goals” (p. 511). Part of the professional’s responsibility in their interactions with clients is to identify, to the best of their ability, the ‘best’ evidence relevant to the therapeutic approach and to the client’s condition or injury. This evidence then represents information by which clients can make decisions about their short and long-term care. However, few researchers have sought to explore the meaning of client-centred practice to clients (Hammell, 2001) or to ensure the evidence accumulated is congruent with client priorities. As Corring (1999, p. 8) observed:

Items such as the preferred approach to service delivery, priorities of treatment goals, and definitions of ‘rehabilitation’ and ‘getting better’ are but a few of the
examples of the discrepancies between the two groups [clients and practitioners].

Participants in this study spoke of their efforts to make clinical decisions on behalf of their clients based on a broad definition of effectiveness in the rehabilitation context. These decisions were based on their 'practice' knowledge, not 'best' evidence. I suggest that it is this 'practice' knowledge that we need to be accountable for, not just the narrow definition of knowledge identified within the concept of evidence-based practice as it is currently defined and implemented in physical therapy. However, as the participants in this study identified, establishing the credibility of 'practice' knowledge is problematic and requires the development of alternative approaches to generating evidence to support both the efficacy and effectiveness of our interventions and models of service delivery. This has implications for physical therapy research and practice that I will address later in this chapter.

Professional Accountability: Moral Deliberation in Practice

Professional accountability is usually presented in physical therapy in terms of upholding professional competencies and standards of behaviour. The underlying assumption is that by meeting the clients' and society's expectations that physical therapists will, by virtue of their specialist knowledge and skill, provide the best quality of service. These professional and moral obligations are upheld by a series of mechanisms that characterize self-regulating professions (Eraut, 1994). In physical therapy, for example, such mechanisms include, restrictive admission policies to education programs, a network of provincial regulatory organizations (for example, the College of Physical Therapists of British Columbia), a national qualifying examination (Canadian Physiotherapy Competency Examination) and a professional Code of Ethics/Rules of Conduct (Canadian Physiotherapy Association, 1989). The profession's public commitment to evidence-based practice can be seen as reinforcing this definition of professional accountability. This definition represents a rather narrow view of physical therapy practice and expertise. Professional accountability goes beyond regulation of practice and establishing competency. In order to fulfil the responsibilities to clients inherent in the professional role, and encompass the realities of practice, a broader definition of professional accountability needs to be considered.
Such a definition should encompass the psychosocial components of professional practice, such as, the relationship between therapist and client, between individual professionals and their colleagues in the workplace and the relationship with the organization in which they work. The participants consistently identified these components as essential to their everyday ‘expert’ practice and as the source of dilemma experiences (Chapters Seven and Eight). An alternative way to approach the concept of practice expertise, and expand the definition of professional accountability, is from the perspective of professional ethics and moral theory.

The participants did not articulate or frame their dilemma experiences or problematic situations using the language of moral theory or health care ethics. They did, however, discuss their perceptions of ‘good’ practice, what that entailed and how their ability to provide ‘good’ practice was constrained by other professionals, institutional structures or system barriers. This is not surprising given the narrow interpretation of professional ethics reflected in the limited physical therapy literature (see Chapter Two). In addition, while there is a growing interest in ethical issues arising from rehabilitation practice, when contrasted with those originating in acute care medicine, the literature base is also limited (see Chapter Two). The comparatively small emphasis on ethics in physical therapy education programs has been recognized within the profession (Barnitt & Roberts, 2000; Solomon & Geddes, 2000; Triezenberg, 1996; Triezenberg & Davis, 2000). “Research into successful strategies to teach clinical ethics has primarily focused on physicians in traditional learning environments” (Solomon & Geddes, 2000, p. 280) and little is known about the effectiveness of ethics education in physical therapy.

This ethics content has been significantly influenced by ‘biomedical ethics.’ Seedhouse (1991) attributed the development of bioethics to the experiences of physicians whose education and personal commitment was found inadequate to address the complex medical situations associated with abortion, euthanasia, organ transplantation, and life and death decisions involving technology. It is hardly surprising that bioethics education has primarily focused on a prescriptive approach to ethical decision - making in the form of ethical principles or principlism theory (Beauchamp & Childress, 1994). In this manner, the values associated with reductionist
scientific approaches, characteristic of the biomedical model, were reflected in this approach to ethical decision-making. This approach to ethics instruction in medicine was perceived by Seedhouse (1991) as of little help to students in addressing what he considered to be the central issue of ethics, "how best to conduct one's life in the presence of other lives" (p. 281).

Feminist authors (Little, 1996; Nodding, 1989; Sherwin, 1992; Tong, 1996; Warren, 1989) have pointed the way to a concept of health care ethics that is broad in orientation, that makes transparent issues of power, and focuses on relationships and holistic practice. A closer analysis of practice in health care, such as offered by the participants in this study, reveals the pluralistic nature of health care service delivery in terms of the diversity of different professional cultures and philosophies which contribute to the provision of health care. However, the same ontological diversity can, according to the participants in this study, militate against the development of shared goals, values, language and norms, and against the capacity to articulate one's practice to others and mutually agree about each other's role in client care. It is this complex environment that makes it increasingly imperative for health professions, like physical therapy, to include moral theory and the application of moral reasoning to the everyday practice of physical therapy in a diversity of clinical settings (Barnitt & Roberts, 2000; Brockett, 1996; Triezenberg & Davis, 2000).

It was clear that moral deliberation was an integral component of the participants' day-to-day practice, that they were, as Andre (1993) expressed it "thinking fruitfully about dilemmas" (p. 365). "Moral deliberation involves a constant interplay among specific judgements, general values and principles, and background beliefs about the world" (Benjamin, 2001, p. 24) brought into focus through the lens of 'practice' knowledge applied in specific communities of practice. Wallace (cited by Benjamin, 2001) characterizes morality as "a collection of disparate items of practical knowledge that have their origin and authority in the learned activities that are the substance of our lives" (p. 25). The participants described how they acquired expertise in rehabilitation through an ongoing process that involved learning from clients, peers, team members and professional education. However, no body of 'practice'
knowledge can be said to be complete, it is always evolving in response to the generation of new theories and knowledge, changing health imperatives and health care systems. Ozar (1993) made the argument for inclusion of ethics in professional education as a means of adapting in a flexible and meaningful way to these changes. He stated:

It is through ethics education, and perhaps through this means alone in these rapidly changing times, that professions and professionals will be able to re-establish the public’s confidence that they will properly use their specialized knowledge, skill, and power (p.150).

Little (2001) argues that such moral expertise requires a 'principled' understanding of morality, that is, “mastery of a relevant set of concepts – having a deep understanding of these concepts, not just surface competence, and the skill to navigate them when they tangle together in concrete situations” (p. 35). There is a growing awareness of the need to provide learning opportunities for students by which they can develop moral expertise and better prepare them for their professional role as moral agents (Barnitt & Roberts, 2000; Geddes, Finch & Larin, 1999; Solomon & Geddes, 2000; Triezenberg & Davis, 2000). The issues raised by the participants, for which they felt ill-prepared by their own education, reflect four moral dimensions or ‘concepts’ of practice, identified by Triezenberg & Davis (2000) as potentially forming the basis of a physical therapy ethics curriculum. The first, an in-depth analysis of the client – therapist relationship that would include understanding the client’s perspective, enacting client – centred care, and how interactions between team members can improve or detract from the client’s quality of life. The second, identifying how personal beliefs and values could influence our understanding of the opinions of others, different cultural or minority values and our attitude towards disability and chronic illness. The third, examining individual differences, which I interpret as developing a respect and understanding for the role and responsibilities of other professional groups, and being committed to facilitating and honouring client choices and decisions. The final dimension involves promoting awareness of ethical issues within physical therapy practice by systematically discussing everyday practice in terms of what constitutes
‘good’ practice through an analysis of ‘real’ situations.

In physical therapy the literature surrounding the teaching and incorporation of ethics into practice lags behind that of nursing and medicine (Barnitt & Roberts, 2000). While the physical therapy accreditation process requires that some form of instruction of professional ethics be included in the programs, the requirement is non-prescriptive and therefore, the extent and focus of this instruction can vary greatly from one program to another (Triezenberg & Davis, 2000). These ‘concepts’ are central to ‘practice’ knowledge, but their inclusion in education programs depends on the value and credibility given them by individual programs and often individual faculty members. In enacting their moral agency practitioners draw on their experience of the particularities of practice, on their ‘practice’ knowledge and expertise.

The internalized norms and values of a profession also play an important part in moral deliberation and reasoning. Some of the components of ‘practice’ knowledge valued by physical therapists, and discussed in Chapter Five, are shared by other health care professionals, and might be considered generic competencies. Other professions, for example, chiropractors, massage practitioners, occupational therapists and kinesiologists share some knowledge and skills with physical therapists. However, as Triezenberg and Davis (2000) point out we do not consider individuals who merely possess a similar knowledge base, and practice some of our skills, to be physical therapists. This knowledge base and these skills represent the physical therapy scope of practice but in order to make the transition to being a member of the profession more is needed. The values, beliefs and attitudes modeled by practicing clinicians and educators determine the substance of the ‘practice’ knowledge that students acquire and learn to value.

This socialization process in physical therapy has largely been taken for granted. Tensions and incongruities exist related to what is formally taught (explicit curriculum) and what is learnt in clinical settings (implicit curriculum), and to the values embodied in what is taught in different settings and modeled by clinicians and faculty. Decisions are also made, based on chronically overloaded curricula in physical therapy, faculty expertise and availability of resources, about what is consciously or unconsciously excluded from students’ education
These tensions and incongruities contribute, in my opinion, to the theory-practice gap identified in physical therapy (Roskell, Hewison & Wildman, 1998) and to the uncritical adoption of evidence-based practice as formulated in medicine. More discussion, in my opinion, between faculty, clinicians and students is necessary to explicate, and make explicit, the philosophical and ethical bases of physical therapy practice, curricular content and educational goals, and approaches to teaching. I contend that understanding the physical therapy philosophy of practice, and the values and beliefs inherent in professional practice (see Chapter Eight), would better prepare clinicians for the contradictions and uncertainties inherent in everyday practice. Incorporating moral theory in the curriculum and facilitating moral reasoning in clinical situations would assist clinicians to assume the professional role of moral agent (see Chapter Seven) and promote interdisciplinary communication and understanding.

**Sharing Accountability with Others**

Interdisciplinary team involvement has been identified as one of the characteristics of working with clients with disability and chronic conditions (Banja, 1992; Caplan, Callahan & Haas, 1987; Caplan & Reidy, 1996). The participants in this study perceived working in interdisciplinary teams as being characteristic of both the rehabilitation context and their everyday practice. Yet, as Eraut (1994) commented, “interprofessional relations are strangely absent from accounts of the ideology of professionalism” (p. 4)) and physical therapy, in my opinion, is no exception. The participants valued working with other disciplines because it enabled a diversity of expertise to be shared as different perspectives were brought to bear on specific clinical situations. It forced them to stop and reflect on their practice, to be challenged and it stimulated creativity in their practice. They spoke of the collaborative working relations they had with their peers and other rehabilitation therapists – occupational therapists and speech language pathologists – which they attributed to shared priorities and values in relation to promoting the client’s quality of life over the long term. For the participants, these individuals were authentically present in their everyday practice. This meant they had developed a
relationship of trust based on mutual respect and, I contend, on a degree of understanding of each profession’s philosophies of practice. They shared the uncertainties about their practice as well as the certainties, were able to be honest about their knowledge limitations, and respected each other’s opinions. They disagreed with each other but were prepared to compromise and negotiate with each other, seeing such disagreements as valued learning opportunities. They shared a recognition of the pitfalls and inadequacies of organizational structure and health care system and the impact on their ability collectively to provide client care. It was these individuals with whom the participants discussed the issues of ‘doing right,’ and ‘preventing harm’ that arose in their day-to-day practice, and who reinforced the decisions they made in specific situations. Conversely, while nurses were perceived as potentially playing a vital role on the team, the participant’s relationships with nurses were identified as a source of ‘difficulty,’ ‘misunderstanding,’ ‘miscommunication’ and ‘frustration,’ and these I interpreted as being a source of moral distress.

As moral agents individual professionals bring a particular set of personal values and principles to professional interactions and identify with a particular professional culture. These values and principles, in turn, give shape and meaning to professional lives and provide a basis for moral choices and judgements. As Benjamin (2001) suggests, though subject to revision in the light of new knowledge or experience, these values and principles and cultural viewpoints, “have a more or less definite, identity – conferring structure” (p. 28). The exigencies of practice require, however, that we accept the fact of reasonable moral pluralism (Benjamin, 2001). According to Benjamin (2001) moral pluralism requires that we take a detached or impersonal point of view in our interactions with others in order to share the power to shape and make decisions with those affected by them. This viewpoint is based on the understanding that plural and conflicting values and principles can be applied to specific problems, and different individuals will approach an issue with a different world view and set of experiences and take reasonable but different positions on that issue. By assuming an impersonal point of view
professionals can balance personal conviction with respect for the ‘reasonable’ opinions of others.

The pluralism of society and health care cultures makes it difficult for health care professionals, particularly if they are inadequately prepared by their education, to understand and respond adequately to the value conflicts and moral compromise inherent in clinical practice. This lack of ability on the part of health care professionals to engage in meaningful dialogue and decision-making is perceived by Murphy (2001) as resulting in increased suffering for both patients and staff. Health care professionals, in these circumstances, most often meet each other as moral strangers, not only when working together on behalf of the client but also in administrative meetings and even in healthcare ethics committees (Murphy, 2001). Murphy called for the need to ‘create a moral space’ in which team members could proactively identify problematic contextual features and solicit opinions from the stakeholders rather than relying on applying principles and rules of ethics to a situation which had already occurred. Moral agents, according to O’Neill (2001), usually bring multiple commitments and principles and multiple goals to any deliberative task, and the difficulty of making practical judgements lies in satisfying this plurality of requirements.

Benjamin (2001) considers that these situations call for compromise, which in these kinds of circumstances may prove “integrity preserving for both sides” (p. 29). Moral conflict can be mediated, according to Wong (1992) by engaging the skills of arbitration, negotiation, synthesis, and reconciliation. In emphasizing the importance of investigating and cultivating virtues such as, respect, resourcefulness and creativity he reinforces the position of those who advocate a more systematic moral education for professional groups like physical therapy (Barnitt & Roberts, 2000; Geddes, Finch and Larin, 1999; Triezenberg & Davis, 2000). These insights have implications for health care professional education and these will be addressed in the last section of this chapter. Wong (1992) sees attainment of such virtues as essential for “the ability to act on one’s own moral position while minimizing damage to one’s relationship with those in opposition, for the ability to make concessions acceptable to oneself and others, and the ability to
incorporate elements from ethical systems conflicting with one's own (p. 763).

It has been my experience in rehabilitation that professionals on a daily basis face moral problems where decisions need to be made and actions taken. For the participants in this study these were essentially taken-for-granted practical problems where the question was 'what should be done in a given situation.' These problems are rarely absolute, there are usually many variables that make them unclear, and solutions, usually negotiated with clients and other health care professionals, are relative. This moral and/or clinical reasoning process, at least in physical therapy, is rarely analyzed or made explicit. In contrast, the experience of problematic situations – those that caused moral distress and involved conflict with other team members – challenged the participants to question their normally taken-for-granted 'schemes of experience' and generally defied resolution. Exposing practice issues, and how expert practitioners address them, to conscious and deliberative thought will, in my opinion, lead to a fuller explication of 'practice' knowledge and professional accountability. In this way the gap between what is learnt and researched in academic settings, and what is considered relevant and useful in the clinical setting, will be diminished. The exploration of epistemological issues that this thesis represents has some important implications for physical therapy practice and education.

**Implications for Practice, Education and Research**

While listening to the participants during the interviews, and during subsequent data analysis, it became clear to me that the participants were best defined as experts. It was also evident that they considered the attainment of expertise as an ongoing process related to their immersion in a specific area of practice, for example, spinal cord injury or stroke rehabilitation. Interpretations of expertise are deeply embedded in the ways the profession of physical therapy is conceptualized, practiced and managed but are difficult to teach. Although experts clearly possess more knowledge, it is their ability to organize and apply that knowledge that is critical and which differentiates the practice of experts from that of novice practitioners. Expertise embodies 'practice' knowledge but it has been traditionally under-researched and poorly articulated. As physical therapy education in North America moves from a baccalaureate to a
professional Masters degree as the entry-to-practice qualification it will become more imperative that new graduates are equipped with the complex 'practice' knowledge and theoretical knowledge they will need as autonomous practitioners. By studying expert practice in a diversity of clinical settings 'practice' knowledge will gain recognition in the academic setting, be more effectively taught and role modelled within the profession and, therefore, more accessible for those developing professional competency.

The theoretical model of expert practice (Jensen et al, 2000) exemplifies the fundamental elements of expertise required by a physical therapist to meet the challenges and expectations of a dynamic health care system. The participants appeared to be engaged in a developmental process that involved continual personal growth, evaluation and learning in each of the dimensions that constitute Jensen et al’s (2000) model. The model also offers a framework upon which a rigorous debate might be based about how the profession defines and fosters expertise, about the nature of 'practice' knowledge used by experts in clinical practice, and how this knowledge might be more systematically evaluated and incorporated into theory development. Finally, it draws attention to the need to articulate the professional values, behaviours, and traditions, what the model calls the philosophy of physical therapy, that represent the essence of the profession.

This philosophy, which represents the 'gestalt' of physical therapy 'practice' knowledge, has not been debated in any systematic way by the profession. This lack of debate has resulted in an incomplete understanding of the knowledge gained from practice. Working within a positivist paradigm has, I contend, limited reflection within physical therapy on the nature of their practice, what knowledge is valued and the theoretical orientations to practice adopted by physical therapy. More research, building on Jensen et al’s (1999) study and model of expert practice is needed to evaluate the way 'practice' knowledge is utilized in physical therapy in response to 'real' problems in practice.

In physical therapy (Bithell, 2000; Ritchie, 1999), as in other professions, such as medicine (Green & Britten, 1998; Pellegrino, 1999; Tonelli, 1999) and occupational therapy
(Hammell, 2000; Law & Baum, 1998; Townsend & Rebeiro, 2001), there is a growing realization of the need to broaden the definition of what counts as ‘best’ evidence. Future approaches to the generation of evidence need to shift the focus from the need to demonstrate and document the worth of an individual profession’s knowledge base and interventions. Efforts need to be made to develop collaborative research partnerships that are more congruent with the realities of the interdisciplinary approach to addressing client’s problems and goals. Research needs to be directed at discovering the client’s perspective on the relevance and effectiveness of professional interventions and outcomes. Involvement of clients at all stages of the research process would lead to more accountable and relevant research (Barnes & Mercer, 1996). In physical therapy, the research agenda needs to be expanded. The uncritical adoption of a quantitative research paradigm, while entirely appropriate in some areas of physical practice, has limited the profession’s ability to investigate the realities of complex ‘practice’ knowledge, engage in research projects with other professional groups or understand the perspectives of clients.

Qualitative research methods, such as, narratives, action research, focus groups, and in-depth interviews, offer ways of exploring subjective experiences – both of clients and health care professionals - of the particularities of practice and of the broader health care context. Research, as expressed by the participants, is currently viewed by many clinicians as occurring in academia and having little relevance to their practice. The introduction of qualitative methods would, in my view, address some of the questions that arise from the realities of practice and encourage clinicians to see themselves as researchers. Currently, such alternative research methods are not consistently included in physical therapy undergraduate, graduate or continuing education courses. If they are to be incorporated in a meaningful and rigorous way into a broader definition of evidence – based practice this will have to change. It will require, in my opinion, significant reflection on, and debate about, the profession’s historical background, traditions, priorities, and what is valued in clinical practice.

Bury and Mead (1998) suggested that, by acknowledging the primacy of practice as a
starting point for research, additional sources of evidence could be developed. In their view, such strategies could capitalize on clinical expertise and experience with clients. The participants in this study suggested a number of ways in which they attempted to make their practice more explicit and rigorous. These included meticulously documenting the information shared with clients and the clients' assessment of how well it addressed their needs. Kate suggested that documenting her clinical reasoning processes, the evidence she used to substantiate her intervention decisions and the *real* outcomes reported by her clients would be a useful contribution if discussed with other therapists. This form of documentation, while time-consuming for the therapist, could contribute to the consensus exercises periodically conducted by the profession in particular areas of physical therapy practice, for example, management of shoulder problems experienced by clients following stroke, or interventions in chronic respiratory therapy. Clinicians need to be encouraged to analyze their practice rigorously on a case-by-case basis and disseminate this information in constructive ways, for example, through publication in professional association journals and special interest group meetings. In addition, if as a profession we are committed to a client-centred model of practice then the 'best' evidence must reflect the client's needs and self-defined outcomes. This requires an understanding and analysis of the client's context and lifestyle, and how clinical interactions and interventions affect the client's quality of life and experience of illness and disability. This understanding will be difficult to achieve if physical therapists have not been encouraged to explore their own attitudes and beliefs about living with a disability, and to acknowledge how these can impact practice (Hammell, 1992; Johnson, 1993). These strategies would assist the profession to unpack 'practice' knowledge making it more accessible and open to public scrutiny.

I have argued that 'practice' knowledge involves the integration of both personal and professional world views, and the acquisition of knowledge and skills through professional education and socialization. The theoretical model of expert practice in physical therapy (Jensen et al, 2000) has provided a framework by which the participants' orientations to their expert practice in rehabilitation could be explicated. The dilemma experiences identified by the
participants led me to explore the moral dimensions of their interactions with clients and other health care professions. This kind of knowledge is reflected in the virtues dimension of the model of expert practice. Jensen et al (2000) suggest that over time, and with experience, expert physical therapists become responsible for the moral dimensions of professional action, and virtuous behaviours are integrated into practice, enabling practitioners to effectively use themselves therapeutically. However, Triezenberg and Davis (2000) argue that the physical therapy profession “has never gone through a systematic look at its moral history, the actions and decisions that reveal certain meta-beliefs that have shaped the conscience of the profession as a moral agent in the health care arena” (p. 57). They argue, as I do, that this absence of critical discourse has contributed both to the atheoretical nature of the profession and an undervaluing of physical therapy ‘practice’ knowledge.

The four moral ‘concepts’ of practice proposed by Triezenberg and Davis (2000) as a basis for a physical therapy ethics curriculum, indicate a need to better define and evaluate the profession’s interactions with clients and other professionals in the practice setting. These concepts, and the rhetoric in rehabilitation, are based on the assumption that an interdisciplinary approach to service provision enhances client outcomes. This assumption is currently not substantiated by research and, in my view, it would be useful for practitioners to collaboratively address this issue in the future. Well-designed courses which assist health care professionals to explore their role as moral agent could provide an avenue by which the taken-for-granted components of ‘practice’ knowledge may be made more explicit (Donaghy & Morss, 2000; Hunt et. al, 1998; Triezenberg & Davis, 2000; Barnitt & Roberts, 2000). Earlier in this chapter I drew attention to the impact the implicit curriculum could have on the teaching of moral behaviour and attitudes. For ethics and moral theory to be incorporated effectively in physical therapy education programs it will be necessary for educators to be explicit in identifying moral issues and ethical concepts, and to role model the importance of incorporating ethical decision-making in practice (Solomon & Geddes, 2000). In addition, it will be important that this curricula content reflect the ‘real’ issues experienced by clinicians in practice.
As Kate, who participated in this study, said, "my practice is really the dilemma." The issues, identified by the participants as problematic, arose in their day-to-day clinical practice. These issues were not the headline or big-ticket issues often associated with biomedical ethics. Instead problematic situations occurred in the context of a client's interaction with the interdisciplinary team and individual health care professionals. Andre (1993) suggested that professionals need to understand the relationships developed in the practice setting and how best to interact and help others; to understand the structured social world and be able to evaluate how social structures and organizations can cause good and how they may be harmful to those operating within them; to think "fruitfully" about dilemmas and display moral reasoning; and to develop the individual moral strength, traits and skills to be able to act. Andre's suggestions support the need for a more systematic approach to moral education in physical therapy, and in turn, reflect the more implicit elements of 'practice' knowledge which have not, to date, been systematically included in physical therapy curricula.

This study draws attention to the need to develop and rigorously evaluate interdisciplinary education opportunities within the health sciences. Traditional teaching in the health sciences has isolated the various professions. This isolation does not serve the respective professions well in light of changing health care priorities (Browne et al., 1995). A College of Health Disciplines recently established at the University of British Columbia represents a challenge to these traditional academic approach to health and human services education. This unique initiative reflects the growing recognition that, in order for health practitioners to be proactive leaders in constantly changing national and international health systems, it is necessary to foster, enhance and sustain a culture of interprofessional and interdisciplinary education (Office of the Coordinator of Health Sciences, 2001). Initiatives such as this one will require individual academic programs to demonstrate their commitment to the concept of interprofessional education by incorporating interprofessional content into their curricula, by dedicating class time and committing resources to support learning opportunities.

However, to my knowledge few consistent interdisciplinary education initiatives
have been incorporated into physical therapy curricula in Canada and, I suspect, this reflects the curricula choices made by other health care professions. Currently, learning in interdisciplinary contexts is largely serendipitous being dependent on the availability of interdisciplinary courses at individual universities, the motivation and interest of individual faculty in promoting interprofessional learning opportunities or on student interactions with other disciplines in clinical settings. Physical therapists currently learn interprofessional collaboration through experience in specific practice settings, by modeling the behaviours of more expert practitioners and through working closely with other professions on interdisciplinary teams. It is perhaps in the discussion of ethical and moral issues arising from day-to-day practice that different disciplines providing client services could most effectively come together to explore their commonalties and gain an understanding of each other’s unique roles and responsibilities.

The themes that emerged from the participant’s accounts of dilemma experiences in rehabilitation have focused attention on professional accountability, collaborating with other health professionals and on the pluralistic nature of rehabilitation practice. This pluralism is a reality of health care and reflects the many ways expertise is recognised and the diversity of values and priorities that clients and health care professionals bring to their interactions in the clinical setting. In concluding, the final words of this thesis should, I think, refocus attention on the client. In my opinion, the most compelling influence on physical therapy practice in the future will be the collaborations we forge with clients. To reiterate what Benjamin (2001) said “awareness of a ‘certain blindness’ with regard to people different from ourselves, and other sources of fallibility, should incline us to share the power to shape and make decisions with those affected by them” (p. 29). Our professional efforts may prove meaningless unless our practice truly centres on respect for who the client is, their experience, their goals and preferences and the choices they make in the short and long term, and on facilitating their full participation in decision-making. The challenge lies in valuing and incorporating the concepts of client-centred care and interdiscipliary practice into the educational and clinical contexts where we educate health care professionals.
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APPENDIX 1: SAMPLE INTERVIEW QUESTIONS

The following are examples of some of the questions which could be asked during the first interview:

- Why do you choose to work in rehabilitation care?
- Can you describe work in rehabilitation?
- What is it about rehabilitation practice that interests and keeps you in it?
- In what way does your practice in rehabilitation differ from other areas in which you have practiced as a physical therapist?
- Can you cast your mind back and think of a situation while you were working in rehabilitation which you would describe as a dilemma. Could you describe it for me in detail? Explain what made it a dilemma for you?
- How was this dilemma resolved or was it to your satisfaction? If 'No' why wasn't it resolved satisfactorily?

Questions asked in the subsequent three interviews will be partly focused by the dilemmas described by the participants in their journals. Examples of broad questions could be:

- Were others involved in this dilemma? If so who and why?
- Have you experienced this type of dilemma in your practice before? If so how is this current dilemma, and the way you are dealing with it, similar or different?
- How did you resolve this dilemma?
- Was a resolution possible which was acceptable to you?
- What knowledge, input, resources did you use in resolving the dilemma?
- Has the nature of the dilemmas you are experiencing in rehabilitation practice changed over time?
- In an ideal world how could this dilemma have been resolved?
- What do you think contributed to this dilemma?
- Can you describe how you clarified the dilemma for yourself?
- What sort of dilemma is this? How would you characterize it?
- What is the core of this dilemma for you?

C. Carpenter April 1999
APPENDIX III: SUGGESTIONS FOR JOURNAL USE

Study: An investigation of dilemmas of practice in rehabilitation settings as experienced by physical therapists

Suggestions for using the journal in this study

I would like to read the journal entries and to copy the journals after the last interview. Please write about the dilemmas descriptively, providing the salient details, and in long hand.

Some things you might think about in journal writing are:

• For you, what makes this a dilemma
• what sort of dilemma is this
• who else is involved
• what are the contributing factors
• what resources have you used to try to resolve it
• how did you resolve it (if it is resolved). If not, what are the barriers to you resolving it

You may wish to use the note book provided to jot down memory cues during the work day and then write it up in more detail on the computer at home OR just use a computer. Some people think more clearly on the computer. That is definitely an option.

Definition of 'dilemma' used in this study

The concept of 'dilemma' is defined as a problem, tension or difficult complex practice situation which causes a therapist to question his / her professional capabilities, causes them to spend an unusual amount of time and mental energy pondering on it, or simply causes them undue personal anxiety or distress, or considerable frustration.
APPENDIX IV: SAMPLE FIELD NOTES

Janine - September 22, 1999
Interview #1

Interview conducted in my home. Janine and I have known each other professionally for many years and I am glad she is participating in the study. She is articulate, experienced, sensible and thoughtful. We chatted over tea and cake before starting the tape. I suspect she will be someone like K. that I should start the tape with as soon as they enter the door! She began to describe her current dilemma and I immediately thought I recognised it from another participant’s interview. I clearly can’t use the information I gain from other interviews but it might inform my questions. In fact it turned out that it was a different but very similar case. It raises the possibility that the situations the participants are describing could overlap, and involve more than one facility and more than one participant as clients are admitted and discharged as part of their rehabilitation process.

Janine described how she doubted her own capabilities particularly when the client moves on to be treated by another therapist. She has loads of experience as a PT in rehab, and is singularly looked up to by her colleagues. The doubts she expressed were so familiar and it was refreshing to her speak of them so openly. She has clearly reflected on this before.

She described the client’s case in considerable detail. I found myself very interested in the client and the practice ramifications and don’t think I probed the nature of the dilemma as Janine understood it particularly well. I must say I am finding it hard at times to actively listen, analyze what is being said sufficiently to ask useful probing or perceptive questions in these interviews and this was one of those times when I felt distracted by the details.

She is one of the first people who has used the journals as I hoped they would be used. She has written quite a lot of detail down and referred to her notes during the interview. I enjoyed this one, her interest and serious approach plus her ability to express herself are encouraging.
I have received a copy of this consent form for my own records.

I consent to participate in this study.

Participant Signature  Date

Signature of Witness  Date