The construction of physiotherapists’ identities through collective memory work

Ralph Hammond

A thesis submitted in partial fulfillment of the requirements of the University of Brighton for the degree of Doctor of Physiotherapy

April 2013

The University of Brighton
Abstract

This thesis examines the challenges for professional practice, socialisation, and identity in Physiotherapy. The government’s modernisation agenda and society’s increasing expectations of healthcare require physiotherapists to update their role, location, and identity. Physiotherapy has viewed identity as a fixed entity emphasizing coherence, continuity and distinctiveness. Socialisation has required the acquisition of a professional identity as one among several necessary ‘assets’ for novices. Yet how do physiotherapists come to be the physiotherapists they are?

I argue that professional identity is an ongoing and dynamic process; physiotherapists make sense and (re)interpret their professional self-concept based on ever-evolving attributes, beliefs, values, motives, and experiences. Physiotherapists co-construct the meaning of being a physiotherapist within intra-professional and inter-professional communities of practice. Clients inform this, mediated through an unfolding career by workplace and institutional discourses, boundaries and hierarchies, and the contingencies of a life story. I suggest this co-construction is done through ‘identity work’ and that this is something physiotherapists are doing consciously and unconsciously in the act of being a physiotherapist; that is, identity work involves a constant and ongoing act of becoming of identity rather than of having an identity.

The theoretical paradigm I adopted was pro-feminist social constructionism with a more specific theoretical lens of Critical Theory, based on Habermas’s theory of communicative rationality. A memory group of eight participants was established. It met for two hours, once a fortnight, for six months and once again six months later. Seventeen hours of group discussions were recorded and transcribed. Twenty one memory stories and seventeen ‘crafted dialogues’ were generated from the data. Using narrative analysis, I have interpreted the data as saying that there are issues of authenticity that strike at the heart of participants’ sense of being a physiotherapist; group members embodied this through personal and group reflection about how they addressed ethical dilemmas.

This thesis makes four major contributions to knowledge. First, it provides a modernised conceptualisation of professional identity for the physiotherapy profession. Second, it generates insights about feelings applicable for professional development. Third, it reports the successful testing of the feasibility and applicability of a method, collective memory work, for future research into the nature of identity in both physiotherapy and other professions. Fourth, it introduces crafted dialogue as an evocative data management technique to foreground the voices of participants in physiotherapy research. More empirical data is required to understand how physiotherapists negotiate the professional practice dilemmas they face, what resources they draw on, and how they enact the values the profession espouses.
Table of contents

LIST OF TABLES, PICTURES, DIAGRAM, BOXES AND FIGURES ...................................................... IX

ACKNOWLEDGEMENTS .................................................................................................................. XI

DECLARATION ................................................................................................................................ XV

ACRONYMS USED IN THIS THESIS .............................................................................................. XVII

CHAPTER 1 INTRODUCTION ............................................................................................................ 1

1.1 Background to the research .................................................................................................... 1
1.2 Identifying my disturbance ...................................................................................................... 4
  1.2.1 The initial disturbance ..................................................................................................... 4
  1.2.2 The second disturbance .................................................................................................. 6
1.3 Research purpose and overall aims ......................................................................................... 7

CHAPTER 2 CURRENT CONCEPTIONS OF PHYSIOTHERAPY .......................................................... 9

2.1 Introduction ................................................................................................................................ 9
2.2 The origins and growth of the profession in the United Kingdom ...................................... 10
  2.2.1 Current definitions of physiotherapy ............................................................................. 15
2.3 A portrait of the profession of physiotherapy ....................................................................... 22
  2.3.1 Scope of the profession of physiotherapy ..................................................................... 23
  2.3.2 Training and career structure ....................................................................................... 24
2.4 An organisational paradigm for physiotherapy .................................................................... 28
  2.4.1 The focus of interest for physiotherapy ......................................................................... 30
  2.4.2 What physiotherapists can do and know ...................................................................... 32
  2.4.3 The world-view of physiotherapy ................................................................................ 36
  2.4.4 The location of physiotherapy in the scientific world .................................................. 42
2.5 Summary .................................................................................................................................. 44

CHAPTER 3 PRESSURES TO REIMAGINE PHYSIOTHERAPY ............................................................ 47

3.1 Introduction ............................................................................................................................... 47
3.2 Changes in the social and political context for physiotherapy ........................................... 48
  3.2.1 Societal changes ............................................................................................................. 48
  3.2.1.1 Social demographics ............................................................................................... 49
  3.2.1.2 Personal identity ..................................................................................................... 52
  3.2.2 Modernisation of healthcare ......................................................................................... 54
  3.2.2.1 Clinical governance ................................................................................................. 56
  3.2.2.2 Professionalism ........................................................................................................ 58
3.3 Changing professional practice knowledge in physiotherapy ............................................ 59
3.4 Changing notions of professional and patient roles ............................................................. 63
  3.4.1 Client - Therapist relationships ...................................................................................... 64
  3.4.2 Professional roles ........................................................................................................... 64
9.5.1 Furthering a Conceptualisation of Physiotherapy Identity 227
9.5.2 The Feeling of Being a Physiotherapist 228
9.5.3 The Role and Place of Pictorial Semiotics in Physiotherapy Identity 229
9.5.4 Identity Conceptualisation in Other Health Professions 230

9.6 SUMMARY 230

Chapter 10 Conclusion 232

References 234

Appendices 252

Appendix 1 Definitions and Descriptions of Physiotherapy 252
A1.1 Fontana Dictionary of Modern Thought 252
A1.2 CSP Description of Physiotherapy 252
A1.3 HCPC Description of Physiotherapy 253
A1.4 WCPT Description of Physical Therapy 253

Appendix 2 A Reconceptualised Critical Theory 256

Appendix 3 Research Ethics and Governance Permissions 258
A3.1 University of Brighton Faculty of Health and Social Science Research Ethics and Governance Committee 258
A3.2 Local Research Ethics Committee 259

Appendix 4 Participant Governance 262
A4.1 Advertisement for Chartered Society of Physiotherapy (CSP) Website 262
A4.2 Participant Information Sheet 264
A4.3 Consent Form 268

Appendix 5 Collective Memory Work Meetings 269
A5.1 Meeting Schedule 269
A5.2 Collective Memory Work Meetings: Planning 270
A5.3 Ground Rules 271
A5.4 Meeting One: Introductions; Setting the Scene 272
A5.5 Meeting Two: Theme Board Technique 273
A5.6 Meeting Three: Discussion of Theme Boards Leading to Agreement of the First Trigger Topic: Persona 273
A5.7 Meeting Four: Reading of Persona Memory Stories and Discussion 274
A5.8 Meeting Five: Discussion and Analysis of the Trigger Topic Persona Memory Stories 274
A5.9 Meeting Six: Summarising Persona Memory Stories and Choosing New Trigger 274
A5.10 Meeting Seven: Reading Memory Stories for Trigger Topic Lifestyle 274
A5.11 Meeting Eight: Discussing and Analysing the Trigger Topic Lifestyle Memory Stories 274
A5.12 Meeting Nine: Discussing and Analysing the Trigger Topic Lifestyle Memory Stories 275
| A5.13 Meeting Ten: Reading Memory Stories for Trigger Topic Choices | 275 |
| A5.14 Meeting Eleven: Discussing and Analysing the Trigger Topic Choices Memory Stories | 275 |
| A5.15 Meeting Twelve: General Discussion to Round Up our Meetings | 275 |
| A5.16 Meeting Thirteen: Discussion and Agreement of Discussions | 275 |

**APPENDIX 6 TRANSCRIPTION CONVENTIONS**

**APPENDIX 7 EXAMPLE OF CREATING A CRAFTED DIALOGUE FROM THE RAW TRANSCRIPTION**

| A7.1 Transcript Relating to Persona Stories 1 and 2 | 277 |
| A7.2 Crafted Dialogue for Transcript Persona Stories 1 and 2 | 279 |
| A7.3 Transcription and Crafted Dialogue Side by Side for Comparison | 282 |

**APPENDIX 8 PROFORMA TO STRUCTURE THE ANALYSIS**

**APPENDIX 9 ITEMS INCLUDED ON THE COMPACT DISC**

291
List of tables, pictures, diagram, boxes and figures

<table>
<thead>
<tr>
<th>Table/Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Definitions of some health professions</td>
<td>16</td>
</tr>
<tr>
<td>Table 2</td>
<td>List of the CSP professional networks, 2012</td>
<td>25</td>
</tr>
<tr>
<td>Table 3</td>
<td>Number of physiotherapists registered to the HCPC</td>
<td>28</td>
</tr>
<tr>
<td>Table 4</td>
<td>Population estimates by Ethnic Group 2002 – 2009</td>
<td>50</td>
</tr>
<tr>
<td>Table 5</td>
<td>Assumptions that underpin collective memory work</td>
<td>88</td>
</tr>
<tr>
<td>Table 6</td>
<td>List of the ethical considerations addressed in the planning of data generation (Page 1 of 3)</td>
<td>103</td>
</tr>
<tr>
<td>Figure 1</td>
<td>Flowchart of Study Process</td>
<td>115</td>
</tr>
<tr>
<td>Table 7</td>
<td>Outline of each CMW study group meeting (Page 1 of 2)</td>
<td>119</td>
</tr>
<tr>
<td>Picture 1</td>
<td>Theme Board</td>
<td>128</td>
</tr>
<tr>
<td>Diagram 1</td>
<td>Participants’ mind map of themes emergent across the texts</td>
<td>131</td>
</tr>
<tr>
<td>Box 1</td>
<td>Relationship of the original transcription to the memory stories and crafted dialogues</td>
<td>139</td>
</tr>
<tr>
<td>Table 8</td>
<td>Summary of crafted dialogues (Page 1 of 2)</td>
<td>145</td>
</tr>
<tr>
<td>Table 9</td>
<td>To show the structure of the Labovian analysis</td>
<td>148</td>
</tr>
<tr>
<td>Table 10</td>
<td>Analytical structure of the form of the memory stories</td>
<td>149</td>
</tr>
<tr>
<td>Table 11</td>
<td>Analytical structure of the content of the memory stories and crafted dialogues</td>
<td>151</td>
</tr>
<tr>
<td>Table 12</td>
<td>Identity claims made by the study participants</td>
<td>156</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Initial specification for professional identity</td>
<td>171</td>
</tr>
<tr>
<td>Table 13</td>
<td>Underpinning ethics, values and concepts</td>
<td>189</td>
</tr>
<tr>
<td>Table 14</td>
<td>Three levels of moral development</td>
<td>191</td>
</tr>
<tr>
<td>Table 14 (continued)</td>
<td>Three levels of moral development (2 of 2)</td>
<td>192</td>
</tr>
<tr>
<td>Table 15</td>
<td>Alternative ethical frameworks</td>
<td>194</td>
</tr>
<tr>
<td>Table 16</td>
<td>Wenger’s matrix of identity dimensions</td>
<td>202</td>
</tr>
<tr>
<td>Figure 3</td>
<td>The constant and ongoing act of becoming of identity</td>
<td>205</td>
</tr>
<tr>
<td>Figure 4</td>
<td>Co-construction within intra-professional and inter-professional communities of practice</td>
<td>207</td>
</tr>
<tr>
<td>Table 17</td>
<td>Guidelines for the ethical consideration of research</td>
<td>216</td>
</tr>
</tbody>
</table>
Acknowledgements

I did not appreciate quite what I was embarking on. I have been fortunate to have many colleagues, friends and family to support me through what has been a highly self-indulgent process. Thank you for accepting the choices I have made, for showing an interest, and cajoling me when necessary.

At the Chartered Society of Physiotherapy, thank you to Dr Jill Higgins for the original suggestion. Dawn Wheeler, my then line manager, was immediately supportive: thank you very much. Sue Hayward-Giles and Ceri Sedgley have been wonderfully encouraging throughout, regularly checking on my wellbeing. Claire Strickland protected me at work to get through to completion and Helen Whittaker has picked up what I left behind. Thank you both for your forbearance.

The Chartered Society of Physiotherapy has been generous with funds and true to its commitment to lifelong learning. I have been very privileged. Maryam Boroumand, thank you for helping me with the original application and processing the funding applications each year. I was grateful to receive a grant from the CSP Educational Awards Panel and CSP South West Regional Training Fund. The PhysioFirst Educational Foundation contributed funds that supported the practical logistics of undertaking the data generation.
The 2006 professional doctorate cohort at the University of Brighton was a great group. Channine Clarke, Rob Kirkwood, and Carol McCudden have been splendid fellow students who challenged, cared, and kept it real.

Two clinical colleagues, Claire Farley and Lucy Paull, have been my inspiration for what is good about physiotherapy. Dr Carol McCrum, Consultant Physiotherapist at East Sussex Healthcare NHS Trust, very kindly commented on early chapters.

Marilia Vasquet-Whittome, Jayne Ingles and Tracey Harrison of the University of Brighton Clinical Research Centre and Doctoral College supported me through the bureaucracy. I would particularly like to thank Jayne for her help to meet tight committee deadlines. Her calmness, knowledge and efficiency saved the day on several occasions.

Two superb supervisors have advised me. Dr Vinette Cross and Professor Ann Moore of the University of Brighton have been extremely generous with their time, patient and challenging of my thinking, and caring for my welfare. Importantly they were accessible, diligent and responsive; I could not have hoped for better supervision.

I have in Chris Mercer and Colette Ridehalgh two magnificent friends who were more than generous with their professional curiosity, hospitality and tolerance of late night arrival times. Matthew and Victoria Haslett helped keep
the show on the road and even put up with my Habermasian thinking, astonishing! As always, thank you Michael and Jenny Hammond.

The participants struggled through snow, wind, and rain to contribute so generously. Thank you to Caroline, Diana, Emma, Helen, Louise, Sue, and Vicky for your interest, commitment, and resourcefulness.

Anna, thank you for your gracious and unwavering commitment to helping me find the emotional strength and intellectual space to pursue these studies, and your enthusiastic acceptance of what has come to be. To my dear Iris and Nancy, thank you for showering me with love and cuddles.
Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

[Signature]

Dated 16 April 2013
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMW</td>
<td>Collective Memory Work</td>
</tr>
<tr>
<td>CSP</td>
<td>Chartered Society of Physiotherapy</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>HCPC</td>
<td>Health and Care Professions Council</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>SSH</td>
<td>Secretary of State for Health</td>
</tr>
<tr>
<td>TBT</td>
<td>Theme Board Technique</td>
</tr>
<tr>
<td>WCPT</td>
<td>World Confederation for Physical Therapy</td>
</tr>
</tbody>
</table>
Chapter 1 Introduction

“Not only does the wind of chance events shake me about as it lists, but I also shake and disturb myself by the instability of my stance: anyone who turns his prime attention on to himself will hardly ever find himself in the same state twice. … I speak about myself in diverse ways: that is because I look at myself in diverse ways. …There is nothing I can say about myself as a whole simply and completely, without intermingling and admixture.”

Michel de Montaigne (1593) *On the inconstancy of our actions*

The search for self-definition in the professions and a need to understand the factors that shape professional identity has been a consistent focus of attention among social researchers throughout the past decade. This effort has introduced the notion of individuals' engaging in 'identity work' as they seek strategies to enact their professional identity in the workplace (Kram, et al., 2012); but this is no easy task. Montaigne’s words above illustrate some of the challenges to be faced when turning one’s ‘prime attention’ on professional practice, socialisation, and identity. This thesis examines these challenges in relation to Physiotherapy, the largest of what are termed the Allied Health Professions in the United Kingdom (UK).

1.1 Background to the research

Physiotherapy is a socially constructed occupation that emerged in the years surrounding the beginning of the 20th century (Nicholls & Cheek, 2006). This was in response to the medical profession claiming massage parlours were operating as brothels and the nefarious practices of the day were obscuring the potential for massage as a remedial intervention (Wicksteed, 1948).
Physiotherapy helps restore movement and function when someone is affected by injury, illness or disability (CSP, 2011a).

Physiotherapy now faces in two opposing directions (Parry, 1997). One direction is towards technology; physiotherapists learn, deliver and experience their practice as a highly technical activity, with independent statutory regulation, embedded in medical practices, and driven by financial accountability and resource-limited commissioning. Simultaneously, physiotherapy presents a vision of research-based patient-centredness and the delivery of healing and rehabilitation to participation in previous life activities (Richardson, 1999a). It is in this context that claims are made about what physiotherapy services are, what physiotherapy is, its relative effectiveness, and the supposed threats from other professions. In this thesis, I argue that physiotherapy builds its collective identity on an under-theorised understanding of local identity work. The profession has conceived socialisation as the acquisition of a professional identity as one among several required ‘assets’ for novices. Yet how do physiotherapists come to be the physiotherapists they are? What experiences shape their self-conceptions?

I am both a Chartered Physiotherapist and professional adviser at the national professional body for physiotherapists in the UK, the Chartered Society of Physiotherapy (CSP). My role at the CSP has focussed on the development and implementation of policy for how the profession engages with its stakeholders in interpretation of the evidence for the effectiveness of physiotherapy interventions. The Shorter Oxford English Dictionary [SOED]
defines Physiotherapy as “the treatment of disease, injury, or deformity by physical methods such as manipulation, massage, infrared heat treatment, and exercise, rather than by drugs” (Trumble & Stevenson, 2002, cited throughout as SOED, 2002). I was interested to consider how closely this and other definitions and descriptions of physiotherapy reflect the history and growth of the profession, its self-image, socialisation processes, and the self-conceptions of individual physiotherapists, and how these impact on the construction of physiotherapists’ professional identities. At the same time, wider external events (described in Chapters Two and Three), the ‘wind of chance’, and a collective compulsion to survive conspired to ‘shake and disturb’ me. Below I present the origins of my interest in the themes of this thesis by providing two vignettes from my working life that ‘disturbed’ me sufficiently to turn my prime attention to the issue of professional identity in physiotherapy, culminating in a statement of the research purpose and aims, at the end of the Chapter. This sets the scene for an appraisal of current conceptions of the profession, Chapter Two, a portrait of its origins and growth, its nature, curriculum and career structure. In Chapter Three I examine the wider literature to consider the external drivers for change faced by occupations, trades and professions in healthcare. I do this by taking three elements in turn: the socio-political forces for change; the current moment emerging from how professional knowledge is being conceived; and finally professional roles and client relationships. In drawing conclusions from this analysis and relating it back to my research purpose and aims, I formulate my research question. In Chapter Four I explain my theoretical assumptions and position and describe my chosen methodology, methods
and study design for addressing the research question. Chapter Five provides a detailed account of what was a complex data generation process involving intensive ‘identity work’ by the research participants using collective memory work. Chapter Six details the approach to data management and the subsequent data analysis. Chapter Seven explains how I have interpreted the data. Chapter Eight offers a critical discussion of this interpretation, developing the notion of how professional identity is conceived in physiotherapy. I connect this to theories of memory, the development of moral thinking and agency, and conclude with a final articulation of a modernized conception of professional identity. Chapter Nine considers the work’s contribution to professional identity construction within the profession of physiotherapy as well as its wider contribution to methodological diversity across professions and future interdisciplinary research into professional identity.

1.2 Identifying my disturbance

As mentioned above, two events, or critical incidents, served as catalysts to this research.

1.2.1 The initial disturbance

My initial disturbance concerned a description of physiotherapy supplied by a colleague to a member of a devolved parliament in the United Kingdom. I did not agree with the description provided. When discussing this with colleagues we found that while we agreed that the description provided was wrong, we
did not agree on an alternative. At a regular peer group meeting, we discussed this situation. It became apparent that we all had quite different ways of describing what physiotherapy is. These personal descriptions reflected how we conceived of the profession. It was apparent these conceptualisations were quite different, and that many of these did not reflect the descriptions frequently used.

My reflection on this incident led to a significant learning moment, namely, that definitions and descriptions are not fixed and stable for all time. It is not merely that changes only occur as more, and better, research is published into the relative effectiveness of physiotherapy interventions; it is that the underpinning values, beliefs and purpose remain under-theorised. I came to realise that this disturbance was more complicated than a mere disagreement over the wording of a description. It went to the heart of my self-conception of my working life, the profession I shared with my colleagues, and the scale, scope and perspective of its contribution to society. My concern was that current definitions and descriptions lacked a resonance with the profession and inadequately reflected real life. My concern was that, therefore, the profession lacked confidence to engage in society. By society I mean both the public sphere – public debates, discussions and consultations that take place in general society: on television, radio, in parliament, on the internet, and in pubs and parks – and the professional sphere – formal consultations, submissions, descriptions and communications that different ‘actors’ within the profession pursue on behalf of the profession.
This disturbance was problematic for me in my work role: through requests for evidence of effectiveness for new services, and considerations about the scope of practice and role of physiotherapy services. These requests arose to meet both the government’s modernisation agenda and society’s increasing expectations of healthcare (Secretary of State for Health [SSH], 2000), and more recently to support the profession in rising to the challenges of new models for the commissioning of services (SSH, 2010). Such changes influenced members of the CSP at an individual and a local level and related to the role, location, and scope of physiotherapy. They depended on ingenuity, opportunism, flexibility, and an ability to use research evidence (Higgs, Refshauge & Ellis, 2001). The profession was changing, and I wondered if this was progressive and contained, or reactive and directionless.

1.2.2 The second disturbance

The second pivotal instance occurred during a discussion with a physiotherapist who had contacted the CSP for professional advice. She sought evidence and support to prepare her argument to commissioners to develop the physiotherapy service in her area. This service development business case involved providing the service in a different location (primary care), and extending the treatment options that the service would offer (physiotherapy, including particular interventions that the commissioners were not recognising as usual physiotherapy - acupuncture, injection therapy, and health promotion advice). This experienced and senior member of the profession had no language to draw on to articulate the scope, purpose and
benefit of physiotherapy. Her reaction troubled me – partly because of its petulance, partly because I recognised this response in many other physiotherapists, and myself. I therefore came to see the identity of the profession and its members as problematic. I began to realise that not everyone understood the profession as I did, that there perhaps was not one ‘right’ definition of physiotherapy, and that the behaviour, values and practice of physiotherapists might be significant in this.

1.3 Research purpose and overall aims
These disturbances prompted me to consider whether a stronger integration of the profession into society, through the understanding of the profession by politicians, would be an important step for the profession to secure. I felt strongly at the time that the profile of physiotherapy in society was not as “high as it should be”. This fuelled feelings that I was not always sure how to handle. The second disturbance was to do with the ability of a physiotherapist to respond to the challenge of explaining and justifying her service. In addition, I began to think that the personal, formative, professional experiences of being a physiotherapist, the consequences for practitioners in their lives (both professional and personal) of being a physiotherapist, and how they constructed their physiotherapist identity, could generate insights into the nature of physiotherapy as it is today. Therefore, I developed research aims that would reveal how physiotherapists construct their professional identity.
The key aim of the thesis was to examine critically how physiotherapists come to be the physiotherapist they are, in order to understand better how physiotherapists construct their professional identities on a daily basis, in the reality of the lives they are living.

The objectives of this research were to

1. Instigate a reconstruction of the self-formative process of physiotherapists, through which to reveal insights applicable to the professional development of participants,

2. Understand how physiotherapists find real life solutions to problems of action coordination and social integration, for example, inter-professional working, client relationships, communication, as part of the professional identity construction process,

3. Understand the impact of the career life span on physiotherapists’ professional identity,

4. Evaluate the feasibility and applicability of a collective memory approach as a template for future research into the nature of identity in physiotherapy and other health professions.
Chapter 2 Current conceptions of physiotherapy

2.1 Introduction

The two vignettes presented in Chapter One are instances that exemplify the nature of my practice. I qualified as a physiotherapist in 1991 and have worked for ten years as a clinician in the National Health Service. After my graduation, I undertook the ‘traditional’ route for gaining experience, skills and knowledge of the profession through junior and more senior roles across the broad clinical specialty spectrum of the profession. I have been in my current post since 1998. During this time I have had to consider the evidence for the effectiveness of physiotherapy interventions, been party to situations where others external to the profession express their views of physiotherapy, and observed from within the professional body’s work to develop and promote the image, profile and presentation of the profession. These experiences have led me to question what is physiotherapy, how is it perceived, and what is its contribution to society.

In the following sections, I will demonstrate how and why these questions are significant and how they stimulated me to consider the issue of professional identity in physiotherapy. In order to consider the relevance of current definitions of physiotherapy and the ability of its members to justify their services, I have analyzed the published literature. I considered this literature relating to the changes occurring in healthcare in general and physiotherapy in particular in two discreet ways. In this chapter, I present a portrait of the profession of physiotherapy and review efforts of the profession towards self-knowledge. In doing so I wish to avoid implying a linear trajectory of the
profession that suggests a triumphant progression, forwards, ‘upwards’, and increasingly successful; rather I mean to reflect on key moments for the profession. In Chapter Three, I address the drivers for change, the internal and external forces challenging the profession to reimagine itself.

2.2 The origins and growth of the profession in the United Kingdom

For such a large healthcare profession there has been a surprising dearth of interest in its history. Wicksteed (1945) and Barclay (1994) published their books to meet important socio-historical events: the end of the Second World War and the place of physiotherapy in the post-war society, and the 90th anniversary of the creation of the CSP. Both books are of their time, reflect the purpose of publication, and consequently tend towards the triumphant. Wicksteed (1948) provides a useful though one-dimensional review of physiotherapy, recording the creation of the emergent profession during the late 1890’s as a series of meetings, lobbying, and hard work undertaken by driven and well-connected nurses and midwives. Barclay produced her book to coincide with the 90th anniversary of the creation of the CSP, and she traced the evolution of several occupations through to the emergence of one single profession and its subsequent growth (Barclay, 1994). Even as recently as 2006, Jones and Jenkins (2006) presented the development of the profession, its professionalisation, solely in terms of its structure and not its values, beliefs and behaviour (Jones & Jenkins, 2006). While Barclay, Wicksteed, and Jones and Jenkins recognised that the history of the profession is one of initial and ongoing dominance by the medical profession,
none critically explored what this has meant, what alternatives existed, what was not done, and thereby provided a constructive yet critical analysis.

The literature on the sociology of professions is extensive. The debate continues as to what constitutes both a profession and professionalisation. Jones and Jenkins (2006), writing about physiotherapy, used the developmental sequence of professionalisation proposed by Wilensky in 1964. He suggested the first step was “to start doing full-time the thing that needed doing”, setting up a new area of practice provided by members of the nascent profession recruited from other occupational groups (Wilensky, 1964, p.142). This would be followed by the establishment of training schools, which would lead directly to consideration of the standards of practice and recognition in the community (Wilensky, 1964). The practitioners pushing for prescribed training, and the first ones to go through it would combine to form a professional association (Wilensky, 1964).

The discourse in physiotherapy is to suggest the profession has followed such a path. In 1894 an organisation was established as the Society of Trained Masseuses by four nurses (Wicksteed, 1948). This organisation was the forerunner to the Chartered Society of Physiotherapy. In 1920, the Society was granted a Royal Charter. The Royal Charter established the Chartered Society to improve “the training and status of persons (both male and female) engaged in Massage, medical Gymnastics, Electrotherapy and Kindred subjects” (CSP, 2011c, p.10). Physiotherapy has tried to stabilize its role and position in society and move beyond its seedy origins (Nicholls &
Cheek, 2006). This strategy has had an enormous effect on how it has come to see itself, and how and why it has made decisions about its priorities, focus, and energies (Parry, 1995; Wicksteed, 1948). Throughout the 20th century the CSP amalgamated with other organisations; for example with the Institute of Massage and Remedial Gymnastics (1920), the Faculty of Physiotherapists (1968), the Physiotherapists Association Ltd (1970), the Society of Remedial Gymnastics and Recreational Therapy (1985) (Barclay, 1994). The Society adopted its present name in 1944 (Wicksteed, 1948).

Wilensky (1964) postulated that the next steps would be inter-occupational conflict between the new practitioners and older established occupations in the same sphere, the definition of core tasks, efforts to gain the support of law for areas of practice, and the prescription of an ethical code (Wilensky, 1964).

For physiotherapy Wilensky’s milestone of “inter-occupational conflict” between new and older established occupations has revolved around the relationship between physiotherapy (the new practitioners) and the medical professions (the older established occupations). Wiles and Barnard (2001) observed that the profession’s engagement with the medical profession to date has sought to “achieve status in the eyes of the medical profession” (Wiles & Barnard, 2001, section 1.7). They claimed this was in order that doctors would treat physiotherapists as “practitioners in their own right rather than as technicians who do doctors’ bidding” (Wiles & Barnard, 2001, section 1.7). One aspect of the dominance of the medical professions within the
health sector is the orientation, the gaze, they adopt towards their object of interest: illness and disease. The medical model constitutes the following beliefs (Wade & Halligan, 2004):

a. All illness arise[s] from an underlying abnormality within the body (a disease),
b. All diseases give rise to symptoms. Health is the absence of disease,
c. Mental phenomena are separate from, and unrelated to, other disturbances of bodily function,
d. The patient is a victim of circumstance with little or no responsibility for the presence or cause of the illness,
e. The patient is a passive recipient of treatment, although cooperation with treatment is expected (Wade & Halligan, 2004).

The medical model and medical profession has maintained a considerable influence over the physiotherapy profession (Øvretveit, 1985; Roberts, 1994). I return to the issue of the relationship between physiotherapy and the medical model in section 2.4 when I present an organisational framework for considering a possible paradigm for how the profession orients its goals and practice.

Miles-Tapping (1985) argued that a discourse existed suggesting that the dominance of medicine in the healthcare sector has meant all other health related occupations have faced a similar struggle for voice, recognition and
respect (Miles-Tapping, 1985). It may be that because of this, the practical tasks of gaining state respect, a public voice, and the government’s ear has been overly important for the self-respect of its practitioners. In 1968, the sociologist Robert K. Merton sounded a note of caution to his sociology colleagues that remains pertinent for the physiotherapy profession of today:

“The very uncertainty about whether the accumulated knowledge of sociology is adequate to meet the large demands now being made of it by … government … provokes an overly zealous and defensive conviction on the part of some sociologists that they must somehow be equal to these demands, however premature and extravagant they may be”

(Merton, 1968, p.49)

This advice to sociologists for prudence lay at the heart of my concerns for physiotherapists about identity and self-awareness in physiotherapy.

In 1977, an amendment to the relationship between the medical profession and the “remedial professions”¹ was mooted (Department of Health and Social Services, 1977). The Standing Medical Advisory committee published a discussion paper recommending, “therapists may decide upon the nature of the treatment if this has not been agreed with the doctors previously” (CSP, 1977, p.326). The subtlety recognised the ability of physiotherapists to “equat(e) the different forms of treatment to the pattern of patient response” (CSP, 1977, p.326). The Privy Council responded to this recommendation and enacted a key change to a bylaw of the Society’s statutes in 1978 supporting greater autonomy in practice (CSP, 1978).

¹ Occupational therapists, physiotherapists, remedial gymnasts
In 1976, the University of Ulster established the first degree course in physiotherapy (Barclay, 1994). By 1992, the profession had become an all-graduate entry profession. During the 2000’s, national governmental policy has encouraged direct access’ self-referral to physiotherapy, it has extended the scope of practice, and increased the numbers of qualifying physiotherapists (SSH, 2000).

2.2.1 Current definitions of physiotherapy

There are many definitions of physiotherapy\(^2\). The dictionary definition given earlier\(^3\) succinctly delineated physiotherapy from other interventions, implicitly considering physiotherapy as a collective noun for interventions, yet omitting any acknowledgement of the required reasoning process prior, during, and after the delivery of these treatments. This description also did not give any indication of accountability on the part of the physiotherapist for the treatment provided. It implied no standard of behaviour, or quality; it merely saw physiotherapy as an intervention; physiotherapist is the noun for “a person skilled or trained in physiotherapy” (SOED, 2002\(^4\)).

It is instructive to compare the definitions of other healthcare professions. Table 1, overleaf, lists some other health professions and the definitions provided by the Shorter Oxford English Dictionary. The Table lists the

\(^2\) For the purpose of this thesis I have considered definitions from the United Kingdom only; however there are others, notably the description of physical therapy provided by the World Confederation of Physical Therapy (WCPT, 1999), which I have included in Appendix 1.

\(^3\) See above, page 14; “the treatment of disease, injury, or deformity by physical methods such as manipulation, massage, infrared heat treatment, and exercise, rather than by drugs” (SOED, 2002).

definitions of the health professions of nursing, dentistry and medicine. It is worth noting that this is as *professions* that practice something.

**Table 1 Definitions of some health professions**

<table>
<thead>
<tr>
<th>Health Profession</th>
<th>Definition</th>
<th>Qualification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentistry is the</td>
<td>profession or practice of a dentist</td>
<td>A dentist is</td>
<td>&quot;whose profession is to diagnose and treat disease, injuries, and malformations of the teeth, jaws and mouth, extract teeth, insert artificial ones, etc&quot;</td>
</tr>
<tr>
<td>Medicine is the</td>
<td>science or practice of the diagnosis and treatment of illness of injury and the preservation of health</td>
<td>A physician is a person</td>
<td>&quot;who practices medicine&quot;</td>
</tr>
<tr>
<td>Nursing is the</td>
<td>practice or profession of providing healthcare as a nurse</td>
<td>A nurse is a person,</td>
<td>&quot;especially a woman, caring for the sick or infirm, specifically, one professionally trained for this purpose&quot;</td>
</tr>
<tr>
<td>Physiotherapy is</td>
<td>the treatment of disease, injury, or deformity by physical methods such as manipulation, massage, infrared heat treatment, and exercise, rather than by drugs</td>
<td>A physiotherapist is</td>
<td>a person skilled or trained in physiotherapy</td>
</tr>
</tbody>
</table>

[Taken from SOED (2002)]

The examples of treatment cited in the Shorter Oxford English Dictionary situate the profession in relation to medicine and the medical model, and so describe the treatment as done to a person (a patient, one who suffers). One response to this is to question the validity of the treatments cited and the
nature, purpose, composition, and diversity of interventions provided. Another response is to challenge the undermining of the professional nature of the “treatment”, given the status of physiotherapy as a profession (Secretary of State, 1960; SSH, 1999). Another, defensive, interpretation is to see this as a deliberate ploy by contributors to the dictionary to maintain physiotherapy as a treatment within certain bounds, the bounds of the profession of medicine. A fourth interpretation is that this is merely an oversight, and that appropriate representations to the Editor of the dictionary could lead to their correction.

The Fontana Dictionary of Modern Thought (Jones and Wood, 1999) provides a more detailed description of physiotherapy (see Appendix 1). This gives recognition to a wider scope of intervention and identifies a possible (though narrow) focus of interest. However it remains within the medical model and is one-dimensional, in that it only considers the alleviation of ‘disorders’ with no recognition that health is not “merely the absence of disease or infirmity” (WHO, 2006).

The definition provided by the statutory regulator of physiotherapy, the Health and Care Professions Council (HCPC), is succinct and contains the added dimension of wellness (see Appendix 1). The HCPC has a remit to consider, and discriminate, between physiotherapy and the other health and care professions it regulates. Its description of physiotherapy focused on the
physical dimension of the term, both the component of interest – the body, and its means of delivery – physical intervention\(^5\).

The professional body for the physiotherapy profession, the CSP, “proudly” connected its conceptualisation of physiotherapy to its Royal Charter (CSP, 1978, p.197). In the UK, one approach to conceptualizing physiotherapy has been to focus on three core elements: massage, exercise, and electrophysical modalities (CSP, 2002a). These “pillars” remain a central feature of the CSP curriculum framework description of physiotherapy and is the basis for its interpretation of the scope of practice of the profession (CSP, 2008). Williams (1986) reported that students “dislike the old-fashioned sound of it” and “it does not sound scientific” (p.67). A more recent definition of physiotherapy published by the CSP in its 2002 curriculum framework declared that “Physiotherapy is a health care profession concerned with human function and movement and maximising potential” [CSP, (2002a); see Appendix 1]. This more sophisticated definition clarifies the area of interest, competence, and intervention of the profession, though it does not cite what contribution the knowledge base of the profession has to make. It does not situate physiotherapy within society, at either an institutional or an individual level.

\(^5\) The SOED defines ‘physical’ as ‘pertaining to medicine’ as well as ‘suggestive of bodily activities or attributes’, and is derived from ‘physic’ meaning the ‘art or practice of healing’; ‘physiotherapy’ is created from ‘physio-‘ (‘nature’; ‘physiological’) and ‘therapy’ (the medical treatment of (physical or mental) illness’, from the Greek \textit{therapeia} (healing). All references from SHORTER OXFORD ENGLISH DICTIONARY, (2002) TRUMBLE, W. & STEVENSON, A. (Eds.) \textit{Shorter Oxford English Dictionary}. 5th Ed, Oxford, Oxford University Press. That the construction of the word physiotherapy is so embedded in medical derivations may explain its definitions, and reflects its origins in late Victorian society.
The CSP’s definition underpins the curriculum framework for physiotherapy undergraduate education (CSP, 2002a). This provides the areas of knowledge, the scope of interest and an orientation of the profession to focus the development of training courses for the reproduction of the profession. As such, the failure to situate the profession in society\textsuperscript{6} could indicate why the profession remains rooted in medicine, why it changes in reaction to events rather than anticipating them, and possibly, why its members lack a conception of a wider possible role.

What the CSP’s 2002 definition acknowledged that the Shorter Oxford English Dictionary did not was the awareness that physiotherapy is a practice and not merely a delivery of treatments; implicit in this idea of practice is the idea of a reasoning process. However, Rothstein and Scalzitti (1999) argued that physiotherapy should not be “defined by the listing of our procedures, nor is it advisable to suggest therapists have three main means of providing patient care (interventions)” (Rothstein & Scalzitti, 1999, p.10). To flourish in the working culture of the early twenty first century, when evidence of the effectiveness of interventions, services costing, and client satisfaction, are crucial, members of the profession need a language to articulate their role and the subsequent benefit to society in terms that stakeholders (commissioners, government agencies, and the public) recognise. O’Hearn (2002) believed the tendency for the profession to take a task-oriented approach to describing physiotherapy weakened its own cause. As I

\textsuperscript{6} By society I mean both the public sphere – public debates, discussions and consultations that take place in general society: on television, radio, in parliament, on the internet, and in pubs and parks – and the professional sphere – formal consultations, submissions, descriptions and communications that different ‘actors’ within the profession pursue on behalf of the profession.
understand him, one example of this could be the CSP’s Rules of Professional Conduct that said “While the debate about definition is sure to continue, the profession has at the same time always retained links to three core skills: massage and manipulation, electrotherapy, exercise and movement” (CSP, 2002b, p.7). This approach generates uncertainty as to what differentiates physiotherapy from other professions such as osteopathy or sports science (O’Hearn 2002). O’Hearn (2002) blames this on an approach to life through “actions and a self-definition through what we do and not by any overriding principle or purpose” (O’Hearn, 2002, p.5). However, it may have more to do with the prioritising of its traditional language, stories of its self-history, and with these, the idea that it has to be one profession, a straightforward, fixed, collective entity.

The CSP recently re-interpreted its original Royal Charter and produced a clarification of its interpretation of the scope of practice of the profession (CSP, 2008). This imaginative interpretation utilised a clause in the Royal Charter “pillars” to extend and expand the types of interventions available to the physiotherapy (CSP, 2008, p.30). However, by reading “other kindred treatments” as permission to take up new treatments, the CSP has not boldly re-imagined what the profession is, or could be. It also failed to address the criticism of Rothstein and Scalzitti (1999); that is, in an evidence-based world, a task-based definition makes the profession vulnerable should evidence be published that refutes the benefits of a specified task.
It appears that descriptions of physiotherapy were formulated using language and terms likely to appeal to a small, powerful audience, for historically valuable reasons. These definitions seem phrased to reflect a profession embedded in a medically dominated healthcare system (Roberts, 1994). It maintains the profession in a state of thrall to an external sovereign authority, rather than constructing a vision of the values, purpose, and possibilities the profession can offer society. What such definitions do not provide are an explication of the norms, values and facts that underpin and sustain the profession’s identity; what they do offer is a universal (within the profession) and absolute (unchanging) description that feels old-fashioned and no longer adequate. This inadequacy is to do with a greater awareness of the existence of multiple realities and the need for greater recognition of context, contingency and competing claims to truth. More useful would be a definition and description that articulates the thinking of the profession, its values, purpose and role. If the Royal Charter written and conferred on the profession in 1920 does not permit this, then a re-definition by the Privy Council might help to supply the necessary momentum for updating the collective professional identity.

Beeston and Simons (1996), in their study of the practice perspectives of neurological physiotherapists, commented that one shared value among their participants was the use of a “common set of concepts and language to facilitate communication between members of the sub-group” (physiotherapists working in neurological clinical practice). However, this shared value may also be a reason why the respondents “found it difficult to
explain their role to non-therapists” (Beeston & Simons, 1996, p.238). They suggested that physiotherapists know in their heads what physiotherapy is about; they cannot explain it succinctly to each other or to outsiders. This assumption may be correct. Their inability to articulate their practice might reflect the lack of a language, but it might also be that there is a lack of a common set of concepts, and a working practice that wrongly assumes shared collective thinking, or that the thinking (the concepts, values, beliefs) is taken for granted or even presumed.

2.3 A portrait of the profession of physiotherapy

Having considered some of the key events in the growth of the profession, I now sketch out a picture of the profession as it is in current times. The picture I hope to portray is one of a profession still evolving from its original form. I will describe the scope of the practice of the profession, how this scope is statutorily regulated, and the size, nature and form of its membership.

The CSP asserts that physiotherapy is a health care profession whose members are “autonomous professionals, able to act as first-contact practitioners” (CSP, 2002a, p.19). Noronen and Wikstrom-Grotell (1999) regarded physiotherapy as an “applied science, which possesses its own knowledge base, [with] its educational methods based on that knowledge, and a practical application that has an important task in society,” (Noronen & Wikstrom-Grotell, 1999, p.175). Freidson (1994) considered that descriptions of this nature mirror the style of other professions when describing themselves, in that they seek to situate the occupation on its own, containing
practitioners with special skills or knowledge, and able to make a ‘worthwhile’ contribution to society (Freidson, 1994).

2.3.1 Scope of the profession of physiotherapy

The origins of the profession lie in massage (Wicksteed, 1948). During the twentieth century and as medical technologies, practice and knowledge improved, the physiotherapy profession evolved its ways of working (for example, Barclay, 1994; Pratt, 1989; Wicksteed, 1948). In recent years, the scope of the profession has developed enormously (CSP, 2008). Extended scope practitioners led the way. These are clinical physiotherapy specialists working beyond the recognised scope of practice of the profession, for example, requesting investigations (blood tests, scans, nerve conduction studies), and using the results of investigations to assist clinical diagnosis and appropriate management of patients, listing for surgery, gaining limited prescribing rights\(^7\). In 2012 the UK government announced that it would

---

\(^7\) The Medicines Act 1968 and Prescription Only Medicines (Human Use) Order 1997 legislates for the sale, use and production of medicines. This includes prescribing rights. **Prescription only medicines** can only be sold and/or supplied with a prescription from an appropriate practitioner (e.g. a doctor, dentist, pharmacist and in certain circumstances, a nurse prescriber or **supplementary prescriber**). **Prescribing** There are two types of prescriber: An **independent prescriber** able to prescribe medicines on their own initiative from the British National Formulary (BNF), for example, Doctors, Extended Formulary Nurse Prescribers. A **supplementary prescriber** is able to prescribe medicines in accordance with a clinical management plan. The plan is agreed between the supplementary prescriber, a Doctor and the patient. Medicines can also be given by another professional with the instructions of an independent prescriber or via local arrangements. A **patient specific direction** is an instruction given by an independent prescriber to another professional to administer a medicine to a specific patient. A **patient group direction (PGD)** is a written instruction for the supply or administration of medicines to certain groups of patients. The instruction is agreed and signed by a senior doctor and pharmacist and includes the following information: The health professional who can supply or administer the medicine; The condition(s) included; A description of those patients who should not be treated under the direction; A description of circumstances where referral to another professional should be made; and The drugs included and method of administration. The legislation currently permits several professions to administer or supply medicines under a patient group direction including physiotherapists. **Supplementary prescribing - physiotherapists.**
prepare legislation to permit the conferral of full prescribing rights to suitably qualified physiotherapists (and podiatrists), with the intention that training courses would start in 2013 (DH, 2012).

The number of CSP professional networks demonstrates in part the degree of differentiation within the profession. A professional network is “the term given to a physiotherapy organisation that has been recognized by the CSP; ... self-governing bodies that are responsible for their own financial and organisational liabilities (CSP, 2012b). In 2012, there were 36 formally recognised professional networks, see Table 2, overleaf (CSP, 2012b).

### 2.3.2 Training and career structure

A physiotherapist in the United Kingdom can work as an employee of the country’s National Health Service, in private practice, or in private hospitals or for charities as part of the independent sector. They also work in schools, for sports associations, professional sport, residential homes, and hospices. Physiotherapists work in secondary care, that is, acute hospitals; they provide a service to cardiovascular services, intensive therapy units, gerontology wards, mental health and learning disability services musculoskeletal out-patients, paediatrics, rheumatology, surgical and medical wards (including specialist burns units), and to women’s health.

**HCPC** registered physiotherapists can become supplementary prescribers. The HCPC approves post-registration programmes that allow registrants to qualify as a supplementary prescriber; trained physiotherapists can then have their registration annotated to indicate that they are able to practise as a supplementary prescriber.
Table 2 List of the CSP professional networks, 2012

<table>
<thead>
<tr>
<th>Professional networks</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Medico-legal</td>
</tr>
<tr>
<td>Amputee rehabilitation</td>
<td>Mental health</td>
</tr>
<tr>
<td>Animal therapy</td>
<td>Neurology</td>
</tr>
<tr>
<td>Aquatic therapy</td>
<td>Neuromusculoskeletal</td>
</tr>
<tr>
<td>Bobath-based</td>
<td>Occupational health &amp; ergonomics</td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>Oncology &amp; palliative care</td>
</tr>
<tr>
<td>Continence</td>
<td>Older people</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Energy medicine</td>
<td>Orthopaedic medicine &amp; injection therapy</td>
</tr>
<tr>
<td>Electrotherapy</td>
<td>Pain</td>
</tr>
<tr>
<td>Extended scope</td>
<td>Paediatrics</td>
</tr>
<tr>
<td>Hand therapy</td>
<td>Private practice</td>
</tr>
<tr>
<td>Independent Healthcare</td>
<td>Research</td>
</tr>
<tr>
<td>International working</td>
<td>Respiratory care</td>
</tr>
<tr>
<td>Leaders and managers</td>
<td>Sports Medicine</td>
</tr>
<tr>
<td>Learning difficulties</td>
<td>Therapeutic riding</td>
</tr>
<tr>
<td>Massage &amp; soft tissue techniques</td>
<td>Vestibular rehabilitation</td>
</tr>
<tr>
<td>McKenzie</td>
<td>Women’s health</td>
</tr>
</tbody>
</table>

(Adapted from CSP, 2012b)

Government and trade unions negotiated a nationally agreed career banding within the NHS that came into force in 2004. This connects to a career framework and pay scales (DH, 2004b). This has enabled the development of NHS funded advanced practitioners with the creation of clinical specialist and consultant posts. Through greater retention of staff, advancement of career opportunity, and a higher degree of quality care, these roles aim to provide posts that are more senior for those wishing to remain in clinical practice and not find the only route to seniority and higher pay to be via management. As of 2011, there are 140 physiotherapy consultants on the CSP Consultants database (CSP, 2012a). There are thirty-five qualifying programmes from different providers throughout the UK (CSP, 2012c), which include alternative entry points (for example, Masters Degrees, accelerated courses). There is no centrally held list of physiotherapists who have become
professors, but a working list identified forty-five (CSP, personal communication, 2012).

In 1977 after a period of negotiation between the CSP and the Ministry of Health changes to the bylaws of the Royal Charter were approved: rather than the previous stipulation that all registering members had to undertake a declaration not to “undertake any case” unless it was “under the direction of a medical or dental practitioner”, now members could only treat those patients who had been “referred to him (sic) by a registered medical or dental practitioner … unless he has direct access to the patient’s doctor” (CSP, 1978, p.197). The important element of this bylaw change is the final clause, removing the absolute requirement for medical referral. The subtle change may have been strategic in enabling progressive medical doctors to agree to a more autonomous role for such physiotherapists willing and able to accept such responsibility but without overly upsetting the most cautious of the medical profession. The original government paper, published by the Department of Health and Social Services in 1977 was a *discussion document* (CSP, 1977, p.326) recommending, “therapists may decide upon the nature of the treatment…” (Recommendation 1) and that the “therapist should discontinue the therapy and discuss with the doctor the needs of the patient in the light of altered circumstances” (recommendation 3) (CSP, 1977, p.326). In 1980, Mercer published a report entitled ‘Aspects of professionalisation in physiotherapy’ (Mercer, 1980). This focussed on what Freidson distinguished between the structural element of professional status and that concerned with values, attitudes and behaviour - `professionalism'.

26
He investigated the claim that “professional occupations are non-routine, allowing scope for autonomy” (Elliott 1972, cited in Mercer, 1980, p.180). This refers to the substance of professional behaviour rather than its form.

The profession was originally regulated by the professional body as part of what has traditionally been known as self-regulation. The CSP published Rules of Professional Conduct throughout its history. In 1960, the UK government established the Council for Professions Supplementary to Medicine, through the Professions Supplementary to Medicine Act 1960. This statutory body regulated the profession until 2003 (SSH 1999). Since then statutory regulation of the profession has been strengthened and re-imagined, and is undertaken by the Health and Care Professions Council (SSH 1999). The role of the HCPC is to protect the public. The statutory regulator publishes Standards of Conduct, Performance and Ethics (HCPC, 2008), Standards of Proficiency (HCPC, 2007), and Standards for Continuing Professional Development (HCPC, 2011). The Health Professions Order 2001 also provided statutory protection of title; only those registered with the state regulator may use the terms physiotherapist and physical therapist. There are 46,699 physiotherapists registered with the Health and Care Professions Council (HCPC); see Table 3.

---

8 In 2011, the CSP published a Code of Professional Values (CSP, 2011b). As this was published after the study design and data generation, I will leave discussion of this valuable document until Chapter 8.
9 The Health Professions Council changed its name in August 2012 to the Health and Care Professions Council (HCPC)
10 Health Professions Council Statistics – historic; downloaded 8/3/2012: http://tinyurl.com/44jriqi
**Table 3 Number of physiotherapists registered to the HCPC**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapists registered to the HCPC</td>
<td>5,981</td>
<td>9,171</td>
<td>15,510</td>
<td>22,020</td>
<td>30,602</td>
<td>44,695</td>
<td>46,699</td>
</tr>
</tbody>
</table>

### 2.4 An organisational paradigm for physiotherapy

Authors have taken diverse approaches to considering what physiotherapy is. Some have looked for a core component (for example, Dean, 1985; Hislop, 1975), one has investigated a philosophy of physiotherapy (Pratt, 1989) and others a model for physiotherapy (for example, Roberts, 1994). In order to make sense of this literature, I have chosen to assemble my analysis within an organisational framework, and to view earlier work within a provisional paradigm of physiotherapy.

Kuhn (1996) defined paradigm as the “universally recognized scientific achievements that, for a time, provide model problems and solutions for a community of researchers” (p.x). A paradigm is built upon the principle that, for a certain period of time, a community poses research problems and solutions using the same underlying model of analysis. Tyni–Lenné (1989) recommended the development of paradigms for physiotherapy. She argued, “each of us [physiotherapists], when describing what physiotherapy is, expresses different aspects of the physiotherapy paradigm depending on what we value and are conscious of in physiotherapy” (Tyni-Lenné, 1989, p.169). Tyni-Lenne argued that physiotherapy needed to create the notion of “physiotherapy science” (Tyni-Lenne, 1989, p.170); this could be something

---

<sup>11</sup> Most recent data available: 29/02/12
akin to occupational science which explores the idea of occupation as the basis of occupational therapy and that this has grown within occupational therapy discourses over the last twenty years (Yerxa, 1993). This does not mean the search for an essential element. A key concept, or essential element, is the prime “attribute, constituent, that something must have for it not to be something else and that serves to characterise it” (SOED, 2002). Tyni-Lenne (1989) recommended the creation of an explicit attempt to orient research towards the goals and practice of physiotherapy. This might stimulate the articulation of a tentative notion of what those goals and that practice might be, and to use both as a heuristic to support the development of a clearer sense of the self-image of the profession and its members.

In 1999, Noronen and Wikstrom-Grotell proposed a provisional professional paradigm for physiotherapy. They argued for the need to investigate identity by making the “assumptions behind the field’s professional knowledge ... explicit” (Noronen & Wikstrom-Grotell, 1999, p.176). A professional paradigm can be a “conscious internal model” to guide physiotherapists in their practice (Noronen & Wikstrom-Grötell, 1999, p.180).

The Finnish philosopher Törnebohm (1987, cited in Noronen & Wikstrom-Grötell, 1999) proposed that a paradigm exists in all practices where social and cultural changes occur. The members of a social group possess this paradigm and different paradigms specific to each individual. Törnebohm distinguished between paradigms of life and professions. Venkula (cited in

---

12 Cited references are in Finnish, hence my use of secondary material
Noronen & Wikstrom-Grötell, 1999 has proposed that there exist macro-paradigms and micro-paradigms. Science would be a macro-paradigm within which would fit theoretical perspectives (for example, positivism, interpretivism). The other macro-paradigms proposed are religion, art, and the human mind (Venkula, cited in Noronen & Wikstrom-Grötell, 1999). Noronen and Wikstrom-Grötell (1999) outlined components of a professional paradigm, as presented by Törnebohm (cited in Noronen & Wikstrom-Grötell, 1999). This constituted four elements: one, the component of interest (the focus of the profession); two, the component of competence (what members of the profession can do and know); three, the worldview (how the field of practice is understood); and, four, the view of science (how the field is viewed by others). I use this framework to organise my thinking in relation to the identity of physiotherapy.

### 2.4.1 The focus of interest for physiotherapy

The first component of interest is the focus of the profession. Historically this has broadly been a contribution (“supplementary”) to medical care of medically ill patients under the medical model of care within hospitals (secondary care). When defining physiotherapy many writers have used the medical model and couched practice in medical language; for example, Peat (1981) predicted the physiotherapist of the future would be a “health scientist … a full and equal partner in the delivery of healthcare” (p.175). In 1989, Pratt offered four concepts that underlie the practice of physiotherapy: science, the medical model of illness, a holistic view of the patient, and an

---

13 Cited references are in Finnish, hence my use of secondary material
empirical attitude to physiotherapy practice. His philosophy of physiotherapy concluded:

“.. from a well defined process of training and practice in which the scientific attitude plays a prominent part, there nevertheless emerges a wide variety of activities in hospital and community, using high technology and bare hands to alleviate problems as diverse as those arising from physical trauma and psychiatric disturbance...thereby implying attitudes in the physiotherapists which may be single-mindedly scientific on some occasions and comprehensively person-centred on others”

(Pratt, 1989, p.119)

Carr and Shepard (1987) have called physiotherapy an “applied movement science” (Carr & Shepard, 1987, p.3). Recognising the inadequacies for current practice of these tendencies, Roberts (1994) called for further examination of the model that physiotherapy uses to underpin its thinking and practice. She appreciated the attractiveness of alternative models, however she cautioned against rejecting the medical model and taking up the social, holistic or any other physiotherapy model without more careful analysis of the profession’s fundamental beliefs (Roberts, 1994).

Historical accounts of the profession report a gradual evolution of a profession predominantly located in the secondary healthcare sector (Barclay, 1994). Physiotherapy has evolved from an orientation towards disease, impairments, and symptoms of the patients, to health, functional activity and participation of the patient in their particular life situation (Noronen & Wikstrom-Grotell, 1999). Recent attempts to gain a more patient-centred approach to healthcare (for example, DH, 2004a) have stimulated calls for greater use of reflective practice as a means for generating new knowledge in physiotherapy (for example, Donaghy & Morris, 2000; Higgs et al., 2004).
There has been a gradual move towards recognition of the complexity of ongoing needs of people with longer-term conditions (Department of Health [DH], 2005). The profession has had to review and refashion the way it delivers illness prevention and longer-term management services (DH, 2005). However, the profession remains embedded in the medical model even if its practice has moved towards a more holistic and client-centred approach (Kell & Owen, 2008).

In recent times, external drivers have seen a move to more primary care involvement (Higgs, et al., 2001) and towards health promotion (Davis & Chesbro, 2003) and wellness (Carpenter, 1996). Parry (1997) noted “a conflict between physiotherapy as a biomedical science or as a caring profession” (p.431). Stenmar and Nordholm (1994) found, in their study of 187 Swedish physiotherapists that the view of the profession as a caring profession prevailed. This literature is showing a gradual move towards a greater sophistication of focus; gradual because physiotherapy is not letting go of old certainties gained through medical patronage, sophisticated because it is searching for a more profound understanding of where, and how, best to locate its focus.

2.4.2 What physiotherapists can do and know

The second component of interest in my organisational framework is the nature of the knowledge that the profession has and how it uses this in its field of operation. Higgs and Titchen have differentiated types of knowledge
as propositional, craft and personal\textsuperscript{14} (Higgs and Titchen, 1995) while Habermas (1978) suggested technical, personal and emancipatory\textsuperscript{15}. These two schemas recognise that different types of knowledge exist and that such knowledge serves different purposes. There has been some discussion about the nature and type of knowledge that can be of value to the profession (for example, Herbert et al., 2001; Higgs & Titchen, 1995; 1998; Higgs et al., 2004; Robertson, 1996; 1997).

The historical connection of physiotherapy with medicine has led to a tendency to focus on post-positivist perspectives and the discovery of facts. A governmental agenda in the United Kingdom to modernise the mastery of technical skills of NHS employees to deliver more transparently evidenced interventions has driven this (for example, SSH, 2000; DH, 2000; 2007; 2008; 2012). The focus of modernising governments has been on propositional or technical knowledge – the acquisition, circulation and comprehensive implementation of facts about the world that support ‘best practice’. This has been the case with, for example, the work undertaken by the National Institute for Health and Clinical Excellence (Sim & Richardson, 2004). The implementation of clinical governance furthers this instrumental rationality: chief executives of healthcare providers are held personally accountable for having systems in place for constantly evaluating and improving the quality of care (SSH, 2000).

\textsuperscript{14} Propositional is formal and explicit, craft tacit and embedded in practice, and personal knowledge is the collective knowledge held by the community, including an individual’s life experiences HIGGS, J. & TITCHEN, A. (1995). “The nature, generation and verification of knowledge” Physiotherapy, 81, 521-30

\textsuperscript{15} Emancipatory knowledge is that which empowers people through self-reflection HABERMAS, J. (1978). Knowledge and Human Interests, London, Heinemann.
This instrumental approach and prioritising and valuing research that generates propositional knowledge, Higgs et al., (2004) have argued, is too often at the expense of research into, and the valuing of, craft knowledge and the empirical skills, knowledge and practices of health practitioners (Higgs et al., 2004). While there may be an internal logic to the necessity of each policy, the application of this thinking has undermined the complementary rhetoric of the importance of craft and personal knowledge (Higgs, Richardson, & Dahlgren, 2004). This consequently leads to a greater need for Habermas’s emancipatory knowledge (Habermas, 1978). Trede (2006) argued that, given this situation, the need for emancipatory practices (in education, research, and clinical practice) has become more necessary. This emancipatory moment is the need for individuals and institutions to adopt a critically engaged, constructively attuned attitude to the prevailing situation in healthcare and healthcare education (for example, Edwards & Richardson, 2008; Higgs et al., 2004; Trede, 2012). It requires a self-awareness of one’s practices, external image, and identity.

Noronen and Wikstrom (1999) claimed the areas of competence included “therapy skills, communication and cooperation skills, the ability to acquire and process information, internationalization of the profession, and understanding of the professional culture” (Noronen & Wikstrom, 1999, p.177). Thomquist (1994) focussed on the ability of physiotherapists to “operate between unintegrated worlds of knowledge and the relationship between general and particular knowledge … between the ‘scientific’ context-free attitude and every-day contextualized knowledge” in order to relate to
their patients as embodied subjects (Thornquist, 1994, p.701). Parry (1997) has called for different methods of inquiry into propositional and technical knowledge in physiotherapy. She suggested that physiotherapy had evolved from the domination of the medical profession and needed to develop a broader use of ways of knowing to survive (Parry, 1997). She claimed that the traditional theoretical perspectives used included an unresolved conflict between positivism and interpretivism, and as such, the profession “wavers on an uneasy balance between scientific reductionism and holism” (Parry, 1997, p.435).

These views reflect a growing recognition of my experience: of being made to adopt a scientific gaze, medical language, and an objective world-view, with patients and the profession, that never felt comfortable or representative of what I was seeing, feeling and doing in my practice. The profession appears to confuse itself with its conflicting worlds of positivistic objectivism and its hermeneutic constructionism. If physiotherapists adopt different research paradigms to inform their approach to clinical reasoning, and if they differ in what they subsequently know and value, if they work in quite different situations and use different techniques to achieve different outcomes, do they have the same identity across the profession?

Higgs et al., (2001) have noted that physiotherapists are responding to opportunities to develop their role and scope of practice. In the UK, this has led to the development of advanced practitioner grades (clinical specialists and consultants) and individuals incorporating skills from outside the usual
scope of practice into their role (extended scope practitioners) (DH, 2000). This has been seen to be a beneficial development for the profession (for example, CSP, 1978; 2008), however, O’Hearn (2002) worried that increased specialisation was leading to unnecessary fragmentation of the profession:
“there is little professional discourse on what unites us..., only on what tasks separate us” (O’Hearn, 2002, p.4). O’Hearn’s concern was that fragmentation of the profession through greater specialisation could lead to a loss of control over the identity of the profession and challenge the professionalisation of physiotherapy (O’Hearn, 2002).

2.4.3 The world-view of physiotherapy

The third element of my organisational framework for considering a paradigm of physiotherapy (as outlined on p.42 and originally described by Noronen and Wikstrom-Grotell, 1999) is the world-view of physiotherapy. This is an explication of how the field of practice is understood. Krebs and Harris (1988) observed that the physiotherapy profession\(^\text{16}\) has not generated much theory to describe how it views its world. Törnebohm, a professor of philosophy in Finland claimed the practice-oriented aspects of research cannot be established unless the paradigms of the practitioners are subject to articulation and critical assessment, and modified if necessary (cited in Tyni-Lenne, 1989, p.170\(^\text{17}\)).

---

\(^{16}\) The profession of physiotherapy is called physical therapy in some parts of the world; the two are synonymous. I have used physiotherapy for consistency.

\(^{17}\) Cited references are in Finnish, hence my use of secondary material

The debate is whether it is possible to realise a “set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations among variables,” (Kerlinger, cited in Domholdt, 1993, p.15) sufficiently broad (grand) to encompass all it views, while making it sufficiently rigorous to explain and predict phenomena. What little theory has been published has been broadly focussed on aspects, or conceptualisations, of touch and movement, and include pathokinesiology (Hislop, 1975), handling (Williams, 1986), and movement (Cott et al., 1995; Sahrmann, 1998).

Hislop (1975) argued in terms of pathokinesiology being the science and model for physiotherapy (Hislop, 1975). Hislop (1975) proposed pathokinesiology as the essential element, the distinguishing clinical science for physiotherapy; she defined it as “the study of anatomy and physiology as they relate to abnormal human movement” (Hislop, 1975, p.1071). She expanded this notion to develop a model for practice. Dean (1985) also embedded pathokinesiology within a model of psychobiology, and attempted to incorporate psychosocial factors within the profession’s realm in order to
overcome the deficiencies in Hislop’s model (Dean, 1985). This proposal developed thinking for physiotherapy beyond that of expressing it in terms of tasks or interventions.

Williams (1986) based her conception of physiotherapy on the medical model and on the definition provided in the Chartered Society of Physiotherapy’s original Royal Charter (Williams, 1986). She considered that “massage is our core” (Williams, 1986, p.67) arguing that the profession uses its hands “for palpation... to feel pressure, to feel tension, we have a healing sensory touch that expresses care and human contact” (Williams, 1986, p.67). Her case weakened as she enlarged this core to include the legacy of medical gymnastics in physiotherapy leading the profession to expertise in abnormal and normal human movement, and “medical electricity and kindred treatments”, without adequately explaining how and why the latter two should be included. It could be that she was implicitly recognising a “set of interrelated constructs” (Kerlinger, cited in Domholdt, 1993, p.15). However, Rothstein and Scalzitti (1999) argued against such an approach, suggesting, “Physiotherapy should be more than the sum of our techniques” (Rothstein & Scalzitti, 1999, p.10).

Cott et al. (1995) felt pathokinesiology to be one-dimensional and unreflective of the diversity and location of (then) current practice. Despite recognising the evolving complexity of the theories its practitioners were using, it failed to reflect the diversity of the profession. Cott et al. (1995) placed movement at the heart of physiotherapy in their proposal for a grand theory of
physiotherapy. When Cott and her colleagues developed the movement continuum theory they intended it to be “broad enough to apply to all aspects of physiotherapy” (Cott et al., 1995, p.88), with the aim of movement as the key concept for the profession. Movement is a taken for granted notion in physiotherapy; Jensen and colleagues (1999) admitted that because the practice of experts was ‘so obvious to us’ as physiotherapists, ‘we forgot to address ... movement in our study’ (Jensen et al., 1999, p.73), this was “later added” to their final conceptual model (p.73).

Cott et al. (1995) suggested that physiotherapists conceived of movement at the core of their work. Cott et al. (1995) based the Movement Continuum Theory (MCT) on the principle that movement is essential for human life, taking place on “a continuum from the microscopic level to the level of the individual interaction in society” (Cott et al., 1995, p.89):

- Physiotherapy interventions can take place at one or several places along this continuum
- Each individual is viewed as having a maximum achievable movement potential (MAMP), a preferred movement capability (PMC), and a current movement capability (CMC)
- Pathologies or developmental limitations have the potential to change the MAMP and to create a differential between the CMC and the PMC
- Physiotherapy intervention seeks to assist the individual to either achieve their MAMP or reduce the difference between the PMC and the CMC (taken from Cott et al., 1995).
While this concept is intuitively attractive and does attempt to reflect how physiotherapists conceive of their profession, it lacked empirical evidence to support the case that it included the knowledge and values of practitioners. Beeston and Simons (1996) claimed it is vital that frames of reference are depicted from the practitioner’s perspective as well as from a basis of theory and research. They add that the context of practice is vital to understanding the “meaning that practitioners and researchers contribute to practice” (Beeston & Simons, 1996, p.235). However, they did find from their study of neurological physiotherapists, that “above all the respondents saw themselves as ‘managing human movement’ (Beeston & Simons, 1996, p.236). It would be interesting to investigate whether physiotherapy specialisms self-identified similarly.

Others have advocated developing the concept of movement as the core for physiotherapy (for example, Sahrmann, 1998). The World Confederation of Physical Therapy cited the Movement Continuum Theory in its Description of Physical Therapy (WCPT, 1999). Stenmar and Nordham (1994) report Tyni-Lenne’s view that physiotherapists may have two different approaches to intervention. One approach is to focus on the movement problem and the impaired organ; the other is to focus on the patient-therapist relationship as a basis for a learning process whereby the patient achieves health as the goal (Tyni-Lenne, cited in Stenmar & Nordham, 1994). This may explain why Noronen and Wikstrom-Grotell (1999) claim that there remains a lack of

consensus on the definition of what constitutes physiotherapy and its unique contribution to the healthcare field though they do not cite their evidence, or reasoning, for this.

Broberg et al. (2003) developed a more nuanced notion of physiotherapy and began to view the profession in a more mature way. Their conceptual framework for a curriculum framework established movement as the most fundamental aspect cutting across the profession (Broberg et al., 2003). One aspect of their framework is the content of the subject of physiotherapy, which contains core concepts: body, movement and interaction (Broberg et al., 2003). This views the body as the “locus of the zest for life” (p.163), movement as both an “aim and a means” (p.164) and interaction as the “reciprocal relationship between the patient and the physiotherapist” (Broberg et al., 2003, p.164). This extension of the MCT has the potential for supporting the profession’s move towards a more health-oriented world-view rather than its historically embedded disease-oriented medical model.

This literature suggests that the profession is accepting movement as pre-eminent. Though some authors have reported a lack of consensus on the essential element, or core, of the profession, this seems to be more a failure to seek consensus, than an inability to gain it. Habermas took the view that gaining consensus may be possible through a democratic discourse which arises through the ‘non-coercively unifying consensus-building force of a discourse in which participants overcome their, at first, subjectively biased views in favour of a rationally motivated agreement’ (cited in Sikka, 2006,
What is uncertain is whether the profession is ready to engage in rigorous debate about the theoretical foundations of physiotherapy. A question also remains as to whether it is desirable to gain such “rationally motivated agreement” to a single pivotal “essential element”.

It could be that a search for conformity can stultify the growth of a profession (Stevens, cited in Domholdt, 1993, p.22). In a comment for nursing that applies equally to physiotherapy, Stevens concluded, “it is the conflict and diversity among theories that account for much of the progress in any discipline” (Stevens, cited in Domholdt, 1993, p.22). This literature demonstrates a profession seeking greater self-awareness in order to solidify its position and project a stronger self-image. I argue that greater self-awareness is necessary if developments are to be sustainable and not short-term reactions to external demands.

2.4.4 The location of physiotherapy in the scientific world

Several researchers have explored how specific sections of the profession and others identify the profession. Belanger (1998) lamented that “even two neighbouring North American associations [Canadian and American] cannot agree on what constitutes physical therapy” (Belanger, 1998, p.246). However, there is nothing intrinsically wrong with two professional bodies taking a different approach to describing physiotherapy; they could have had local reasons and different audiences in mind, and possibly different political agendas.

---

19 Cited reference is in German, hence my use of secondary material
Brown and Greenwood (1999), two occupational therapists, drew on physiotherapy literature to exemplify their belief, in a consideration of the similarities of and differences between physiotherapy and occupational therapy, that the two professions are different, because physiotherapy “remains focussed on the treatment of the immediate physical consequences of disease” while occupational therapy does not (Brown & Greenwood, 1999, p.166). Dalley and Sim (2001) found that nurses perceived the role of physiotherapists on a stroke unit as being concerned with mobility and movement, and valued the knowledge and skills on these areas. This limited evidence seems to suggest that when members of two professions are working close together they can forge a mutual understanding of each other’s roles, but that historical role clashes and stereotypes persist (Brown & Greenwood, 1999; Dalley & Sim, 2001).

As physiotherapy seeks to develop its identity, it requires far greater understanding of its current identity and the image it portrays to both healthcare professionals (colleagues) and the external world. If the report of Parker and Chan is generalisable, that occupational therapists view physiotherapists as “overbearing and overrated”, then there is much to do (Parker & Chan, 1986, p. 671).

The ideas here reflect the earlier observation of Freidson that, for a profession to defend itself from external challenges, it needs to consider threats to its monopoly, autonomy, self-determination, standing in society, and livelihood (Freidson, 1994). He reviewed attempts to explicate the nature
of professions and proposed the key attributes to be a commitment to the occupation, fellow workers, and to work, by people who are paid (ibid). He has suggested that past notions of altruism, such as ‘serving people’, were an ideology “advanced to protect an interest” [the self-interest of the profession] (ibid, p.125). If Freidson (ibid) was right that successful professions have been ones that can determine their own work, then it might be seen that the changes the profession has been able to effect, protection of title, development of advanced practitioner roles, extension of scope of practice, and evolution of the location of its presence, position the profession well for the future. The challenge for members of the profession might be to maintain control not just of how they secure contracts of work, but also what this work actually is.

2.5 Summary

This chapter has provided a broad outline of the reasons for my interest in the identity of physiotherapy. It has sketched out some of the challenges the profession faces and why this is a topic worthy of investigation. I have painted a picture of the structure, nature and scope of the profession of physiotherapy in broad strokes.

For many years descriptions, definitions and possibly practitioners’ personal conceptions have considered physiotherapy as fixed, stable, and a-historical, that is, there is one sort of physiotherapy, all physiotherapists are the same, and that these do not change. If this was ever true, I have argued that the role, location and character of physiotherapy (as a profession, an
intervention, and its practitioners) have now changed. In Chapter Three, I shall trace and comment on the pressures that exist to reimagine what physiotherapy is and how it can be delivered.
Chapter 3 Pressures to reimagine physiotherapy

3.1 Introduction

“Physiotherapy practice exists in a climate of constant change. These changes relate predominantly to three factors: changes in the physical, social, political information and technology contexts; changes in professional practice knowledge, and changes in professional and patient roles.”


With these comments Trede (2006) summarises the healthcare world that physiotherapy practitioners face. One aspect of my original disturbance as explained in Chapter 1 (pages 4-5) was an emerging interest in the relationship between definitions of physiotherapy and current practice. Given this state of “constant change” I was also troubled and intrigued by how physiotherapists had responded. I was beginning to see that if the definition of physiotherapy is not fixed for all time, then perhaps how we are as physiotherapists, the stories we tell ourselves about who we are and what we can do, might be more complex. In this chapter I use this concern to focus my consideration on what is currently understood to be physiotherapy. I describe the changing socio-political climate, the possible external drivers for change, and the pressures the profession faces. Next, I consider the nature of professional and personal identity in this context, and this allows me to move to a consideration of the changing nature of professional and client roles. I then explain how this appraisal of the literature has helped me develop lines of thinking as I formulated my research question.
3.2 Changes in the social and political context for physiotherapy

In this section the impact of broad social changes and subsequent Government policy for healthcare, the health professions in general and physiotherapy in particular are considered. This illustrates some of the external drivers on the self-identity of the profession, and physiotherapists, and exemplifies some of the conflicting challenges the profession faces.

3.2.1 Societal changes

Modernity is a period of historical time that “rupture(s) with the past” (Frosh, 1991, p.7). This post-traditional period is characterised by Berman (1982) as a “maelstrom of perpetual disintegration and renewal, struggle and contradiction, ambiguity and anguish” (Berman, 1982, p.15). Frosh (1991) has characterised modernity as “uncertainty, rapidity of change and kaleidoscopic juxtapositions of objects, people and events” (Frosh, 1991, p.7). Previous assumptions and traditions are challenged, and accepted ideas and types of relationships between people are undermined: “all that is solid melts into air” (Marx & Engels, 1998, p.7).

Cultures create discourses through which members can reassure themselves of their “wholeness, coherence, and rootedness” (Yngvesson & Mahoney, 2000, p.77). However the central feature of the self in modern society is its reflexivity, what Craib (1998) calls a “constant questioning and reconstruction of the self as a lifetime project” (Craib, 1998, p.2). Bendle (2002) has suggested the current age suffers a crisis of identity. He usefully identified four elements to how this has occurred:
1. Problematising self-knowledge
2. Valorising human potential
3. Breakdown of hierarchies with a rise in social mobility
4. Flexibility of self-definition

(Bendle, 2002, p.6)

Bendle (2002) explained the first element, problematising knowledge, as arising because in “pre-modern” times the self was regarded as transparent and unproblematic. The 20th century saw the self become a “vast inner continent, to be explored only with considerable difficulty” (p.6). Bendle (2002) explained the third element as arising because the breakdown of traditional hierarchies in society permitted the prioritisation of self-realisation in this world, rather than waiting for the next. With such a rise in individualism and a decline in predictable and constant social structures and processes, came a requirement for greater fluidity in identity; hence the identity crisis (Bendle, 2002).

3.2.1.1 Social demographics

While members of UK society have a different and evolving, non-traditional self-conception, they are also different numerically, in both numerical size and diversity. Over the next 20 years, the UK population is expected to grow by “between 2 million and 8 million” and the proportion of people aged over 85 will rise by “between 37 per cent and 94 per cent” (Wanless, 2001, p.1). The population of the UK was 62.3 million in mid-2010, up 470,000 (0.8 per cent) on the previous year; the highest annual growth rate since mid-1962 (ONS, 2011). Since 2001, the population has increased by an average of 0.6 per cent per year (ONS, 2011). This compares with 0.3 per cent per year
between 1991 and 2001, and 0.2 per cent per year between 1981 and 1991 (ONS, 2011). The UK population continues to “age gradually” (ONS, 2011). The number of people aged 85 and over was more than 1.4 million in mid-2010, accounting for nearly 2.3 per cent of the total population (ONS, 2011). In 1981 this age group had 0.6 million people in it (1.1 per cent of the population) (ONS, 2010, p.2).

New population estimates by ethnic group for England and Wales indicate that the majority White British group has stayed constant in size between 2001 and 2009 while the population belonging to other groups has risen by around 2.5 million to 9.1 million over the period – about one in six of the population (ONS, 2011). Table 4 shows the national population estimates by ethnic group and the average annual growth rates for the period 2001–2009. Table 4 demonstrates that the population of the UK is diversifying. This poses challenges. The Commission on the Future of Multi-Ethnic Britain (Parekh, 2000) noted that its brief was to analyse the current state of multi-ethnic Britain and propose ways of countering racial discrimination and disadvantage and making Britain a confident and vibrant multicultural society at ease with its rich diversity (Parekh, 2000).

Table 4 Population Estimates by Ethnic Group 2002 – 2009

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>87.9%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Mixed</td>
<td>1.8%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>5.9%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>2.8%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.8%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>0.8%</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

(ONS, 2011, p.5)
Sixty-eight percent of students qualifying from Physiotherapy education were female\textsuperscript{20} (CSP, 2012c). Until 2007, the overall number of male students studying Physiotherapy had been increasing at a rate of 1\% per year reaching a peak at 28\% (CSP, 2012c). In 2010/2011, 2\% more male students were studying physiotherapy but values are “still in line with an average rise of 1\% per year since the first annual quality review” (CSP, 2012c, unnumbered). Eighty-eight percent of the students studying on qualifying physiotherapy programmes had self-identified as white [British, Irish, other] (CSP, 2012c). The CSP acknowledged “Physiotherapy programmes remain significantly below the UK average for recruiting students from ethnic minorities” (CSP, 2012c, unnumbered).

A UK government-commissioned independent review of the long-term resource requirements for the NHS drew interim conclusions that the UK must “expect to devote a significantly larger share of its national income to health care over the next 20 years” (Wanless, 2002, p.119). It projected the likely costs of reversing the “significant cumulative underinvestment” of recent past decades, to “catch up with the standards of care seen in other countries” so as to deliver a “wide-ranging, high quality service for the public and individual patients” (Wanless, 2002, p.119). Significantly, it deemed success ultimately dependent on “how effectively the health service uses its resources. They must be used more effectively than has typically been the case in the past” (Wanless, 2002, p.119). The final Wanless Report (2004) observed that “patients want more choice and higher quality services;

\textsuperscript{20} Most recent data is for 2010/11
demographic change is not the main factor driving up health care costs; improving the use of information and communication technology is key to improving quality and productivity (Wanless, 2004, p.6).

The 2008 government-commissioned Marmot Review identified that “focusing solely on the most disadvantaged will not reduce health inequalities sufficiently” (Marmot, 2010, p.15), that reducing health inequalities “is a matter of fairness and social justice” (p.16). Marmot (2010) claimed that inequality in illness accounted for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year, and additional NHS healthcare costs associated with inequality in excess of £5.5 billion per year (Marmot, 2010). Coining the phrase "proportionate universalism", the Marmot Review recommended, “to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage” (Marmot, 2010, p.15). Addressing health inequalities was deemed to benefit society in many ways, for example, economic benefits in reducing losses from illness associated with health inequalities which currently account for “productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs” (Marmot, 2010, p.15).

3.2.1.2 Personal identity

Identity has been regarded as an entity that is rational, measurable, stable and predictable, founded on childhood experience and internal processes. The Shorter Oxford English Dictionary defines identity as “the condition or
fact of a person or thing being that specified unique person or thing, especially as a continuous unchanging property throughout existence …” (SOED, 2002). The field of identity theory is huge and I do not intend to provide an overview of the entire field. Recent conceptions of identity have recognised that change can occur over time. Craib (1998) described how a person's life unfolds over time, observing that identity is expressed through a series of changing thoughts, feelings, and actions.

The differentiation and modernisation of the profession has occurred as society has increasingly fragmented; this leads to the possibility of a transformation of identity for both the profession and the individual member. So it is interesting to note calls for the development of the profession's identity come at a time when more and more identities are being lived, and considered, as flexible, fluid and situated. I suggest the tendency of the profession has been to desire a single identity in a culture that Featherstone (1991) has called “integrated, bounded and distinct” (Featherstone, 1991, p.142). It remains to be seen whether socialisation processes that provide what Yngvesson and Mahoney (2000) called a “rootedness” and “coherence” and feed the emergent professional with a sense of “wholeness”, also equips the same professional with a sufficiently fluid self-identity to cope with the uncertainty and rapidity of change, that face the modern healthcare professional (Yngvesson & Mahoney, 2000, p.78).
3.2.2 Modernisation of healthcare

Recent UK Secretaries of State for Health have claimed the government to be committed to modernising provision of healthcare in the UK (for example, SSH, 2000; 2010). This reflects international processes, whereby “the practices of health and health care are changing dramatically” (Higgs et al., 2001, p.79). Changes, often at an individual or a local level, reflect the ability of individual practitioners to be flexible, to seize opportunities and to use research evidence (ibid, 2001).

The impact of the reforms on physiotherapy were outlined in "Meeting the Challenge: A Strategy for the Allied Health Professions" (DH, 2000), a national strategy setting out the role for the allied health professions in England. As a strategy, "Meeting the Challenge" provided a broad overview of the direction for change (DH, 2000). The strategy reinforces health policy as set out in the Health Act (SSH, 1999), the NHS Plan (SSH, 1999). The themes of "Meeting the Challenge" and the "modernisation" of the NHS are essentially modernising care, modernising the workforce, and modernising education and training. This period saw the revival of the internal market within the NHS, with an expanded role for the private sector with the aim of increasing capacity and cutting waiting lists, and the introduction of a national tariff for patient services. These areas have been progressed with a greater engagement of clinicians in defining quality of care and outcome measurements (DH, 2008).
The most recent government white paper, Liberating the NHS (SSH, 2010), requires further development of how healthcare is organised, provided for, and aims to underpin the role and purpose of state provided healthcare with a modern emphasis: giving patients greater choice (SSH, 2010) This focus on personal care that reflects “individuals’ health and care needs”, requires shared decision making, greater choice and easier access to information (SSH, 2010). Rehabilitation and reablement are included as core elements of allied health professional practice, working with patients, carers and clients to support them to manage their own care and live full productive lives. One challenge explicitly posed is for providers of services to demonstrate an ability to deliver services against nationally agreed, evidence-based, quality standards. Accordingly those commissioning such services will also be challenged to demonstrate the ability to commission against externally published criteria. A statutory external auditor, Monitor, has been established to evaluate both elements (SSH, 2010).

With these Acts of Parliament and plans for ‘modernisation’, the UK national government claims to have been rationalising healthcare interventions to save money, maximise efficiency, and achieve greater healthcare outcomes (SSH, 2010). With the complementary policies to increase preventative measures to reduce the need for healthcare consumption they are seeking greater clarity and tighter control of their budgets (SSH, 2010). The publication of government policy that sought to intentionally blur the boundaries of healthcare professionals’ historical roles in order to improve
clinical efficiency and government policy that demanded greater accountability and regulation has made this modernisation and ‘bureaucratization’ more explicit (SSH, 2000). All healthcare professions are changing to reflect the different ways their services are being purchased, “commissioned”, delivered and evaluated, physiotherapy included. In doing so, physiotherapy has recognised itself as having an identity crisis (Hislop, 1975; Paris, 2006; Rothstein, 2002). To flourish, members of the profession need evidence to support the effectiveness of their service and a language to articulate their role and the subsequent benefit to society in terms that stakeholders (commissioners, government agencies, and the public) can recognise (DH, 2007; SSH, 2000). What it means to be a physiotherapist has changed; physiotherapists are encouraged to delegate tasks to more junior and differently qualified staff not regulated by a statutory regulator, to work more overtly within healthcare teams and across sectors, and to amend their philosophy for the provision of care. Traditional working practices and boundaries have been challenged (SSH, 2000); previously well understood contents, terms and conditions of their work have changed (DH, 2004b); and the self-understandings of clinicians has required re-evaluation (DH, 2000; 2007; 2008).

3.2.2.1 Clinical governance

Healthcare is being modernised and rationalised: this reflects modern life, and is part of what Relman (1988) has termed the “third revolution” in
healthcare: “assessment and accountability”21 (Relman, 1988, p.1222). With the success of hospitals and medical technologies, the healthcare sector has expanded and with this the cost to the country and for government. National governments of advanced, capitalist, Western states are rationalising healthcare interventions to save money, maximise efficiency, and achieve greater healthcare outcomes. With this modernisation and rationalisation of healthcare has come the notion of clinical effectiveness underpinned by evidence-based practice (SSH, 1998; 2000). The emphasis on accountability has required that people who make budget decisions make explicit the evidence they used to support these decisions (SSH, 2010). The intention is that this enables clarity and transparency in the choices made on how and what to commission.

Clinical governance emerged in the latter years of the 20th century (SSH, 1998). Clinical governance requires NHS organisations to be “accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish” (Scally & Donaldson, 1998, p.61). This was in response to an increasing realisation of both the public and government that previous

21 Relman (1988) suggested the first era was of expansion, with the rapid growth and success of hospital facilities, development in science and technology, and extension of insurance coverage. The second era was the “revolt of the payers” or the era of cost containment and required government and insurance companies to reign in their expenses and more carefully manage resources (p.1221). This laid the foundation for the third, current era, of assessment and accountability, where providers are required to demonstrate evidence for the effectiveness of the interventions they propose, and efficiency in their ability to deliver them (RELMAN, A.S. (1988), “Assessment and accountability: the third revolution in medical care” New England Journal of Medicine, 319, 18, 1220 – 1222).
systems of quality control were breaking down. Self-regulation of the professions, the increasing complexity of medical technology and healthcare interventions, and higher expectations of the consumer society were overburdening the existing controls (SSH, 1999).

Quality Accounts are the latest manifestation of how the NHS accounts for its spending and delivery (DH, 2010). These are annual reports to the taxpayer from providers of NHS healthcare about the quality of services they deliver. The primary purpose of Quality Accounts is to “encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer” (DH, 2010, p.8). They are proposed by the Department of Health (2010) as a means for managers and governors to “demonstrate their commitment to continuous, evidence-based quality improvement, and to explain their progress to the public” (DH, 2010, p.8).

3.2.2.2 Professionalism

The CSP (2001) identified that becoming a professional requires an “acceptance, often implied, of certain responsibilities, in return for certain privileges” (CSP, 2001). These responsibilities required behaviours and attitudes of individuals in whom professional trust is placed. The Allied Health Professions Project (2003) identified that professionalism requires a motivation to deliver service to others, adherence to a moral and ethical code of practice, a striving for excellence through maintaining an awareness of limitations and scope of practice, and the empowerment of others.
Professional competence is closely related to the concept of professionalism. The Allied Health Professions’ Project [AHP Project] (2003) defined it as “the complex synthesis of knowledge, skills, values, behaviours and attributes that enable individuals to work safely, effectively and legally within their particular scope of practice” (AHP Project, 2003, p.103). The underpinning thinking of the model recognised that professional competence is “complex, varied and evolving; that it cannot be defined simply or prescriptively; and that it requires the use, development and maintenance of a wide range of knowledge, skills and attributes” (ibid, p.103). The model connected competence to the adherence to the code of conduct for a profession. It also understood it to evolve during a career, be personal and particular in its scope of practice, and be greater than technical, clinical skills (AHP Project, 2003).

3.3 Changing professional practice knowledge in physiotherapy

The previous section considered the external drivers for change. The literature has organised these drivers into two themes: social and cultural pressures, including evolving social demographics, citizens as consumers, and new conceptions of personal identity; and the modernisation of healthcare, driven by clinical governance, a modernised conception of professionalism, and new media. These have challenged all professions to review and articulate its knowledge for practice. What counts as evidence has become more significant, and what is considered as knowledge to

---

22 The Model acknowledges, “while their competence develops and deepens in some areas, it naturally diminishes in others” (AHP Project, 2003).
underpin that evidence, hotly debated (see for example, Herbert et al., 2001; Higgs et al., 2004).

The socio-cultural changes identified in section 3.1 and the information technology revolution has led to a greater need for closer examination of the merits of specific interventions. This is contained in Relman’s notion of the ‘age of accountability’ (Relman, 1988)\(^{23}\). This is the requirement for health care professionals to be able to account for the cost and clinical effectiveness of proposed interventions and treatments, and for those paying for such care to understand what they are paying for, the likely benefits and the possible detrimental consequences. In the case of NHS physiotherapy, a central strategy has been to prove the efficacy of practice through scientific evidence (Wiles & Barnard, 2000).

This clinical accountability led to the development of the concept of evidence-based medicine (for example, Sackett et al., 1996). One early definition of evidence-based medicine stated that it was the “conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients” (ibid, 1996, p.71). The physiotherapy profession adopted evidence-based medicine during the 1990’s (for example, Bury, 1994; Donaghy & Morris, 2000; Herbert et al., 2001). This adoption merely substituted the word practice for medicine to create evidence-based practice

\(^{23}\) See above, p.68, n.18
Wiles and Barnard (2001) observed that while

“EBP may be seen by the knowledge and managerial elite within the profession as the most appropriate way forward for safeguarding the future of the profession and contesting challenges from other health ‘tribes’, the rank and file who are expected to put such strategies into action in their day-to-day work frequently have a different view.”

(Wiles & Barnard, 2001, 1.13)

However, Turner (2001) found evidence amongst “rank and file” physiotherapists of “positive attitudes, enthusiasm, and (an) awareness of EBP that could be maximised to positively influence future practice to ensure physiotherapists become evidence users” (Turner, 2001, p.116-7). Though she did acknowledge that the physiotherapy profession was “somewhat deficient in research readership, research utilisation, and use of scientific method” (Turner, 2001, p.116).

There are several key criticisms of evidence-based practice. Goldenberg (2006) argued that conclusions of the relative effectiveness of interventions wrongly assumed the evaluative standards of EBP to be transparent, neutral, objective, and universal and “obscured the subjective elements that inescapably” enter the social context of [healthcare] practice” (Goldenberg, 2006, p.2630-1). Miles et al. (2008) suggested the major flaw to be the failure of EBP proponents to have developed a “detailed theoretical structure with explanatory power and substantial empirical corroboration” (p.622). Miles et al. (2008), in a detailed opening commentary to a special issue on the

---

24 Given the variety of definitions published for the phrases evidence-based medicine, evidence-based physiotherapy, evidence-based practice, for the purposes of this thesis, I shall adopt the generic phrase, evidence-based practice.
theoretical foundations and practical applications of evidence-based practice, also criticised the lack of evidence that [EBP] improves clinical outcomes.

A more recent definition of evidence-based practice drew on criticisms of the initial definition of evidence-based medicine, saying that evidence-based practice requires that decisions about health care be

“Based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources”

(Dawes et al, 2005, p.4)

To flourish in the culture of evidence-based practice and commissioning, members of the physiotherapy profession need evidence to support the effectiveness of their service and a language to articulate their role and the subsequent benefit to society in terms that stakeholders (commissioners, government agencies, and the public) can recognise.

Evidence-based practice aims at greater explication of the evidence of effectiveness for specific interventions. Much craft knowledge is to do with models, theories, approaches and styles that are picked up and put down as practitioners develop their clinical reasoning skills and according to patient preference (for example, Edwards et al., 2004; Higgs et al., 2004; Jensen et al., 1999; Jones, 1997). In the twenty years since the emergence of the evidence based practice model an industry has grown to support its implementation. This industry has led to debate about its underpinning philosophy (for example, Bury & Mead, 1998; Dawes et al., 2005; Goldenberg, 2006; Miles et al., 2008; Sackett et al., 1996). Organisations
have emerged to systematise the appraisal and categorisation of reviews of the evidence: for example the Cochrane Collaboration (Hill, 2000), the National Institute for Health and Clinical Excellence (SSH, 2000). Researchers have investigated the reaction of clinical practitioners in physiotherapy (for example, Iles & Davidson, 2006; Swinkels et al., 2002; Turner 2001; Wiles & Barnard, 2001). Statutory support of this model (HCPC, 2008) combined with clinical governance (SSH, 2000) have been reinforced by government’s requirement for commissioners to commission services against evidence-based “quality standards” (SSH, 2010).

The healthcare arena has changed, physiotherapy needs to keep up, and how the profession presents itself needs strengthening. The two aspects of a changing healthcare world, the socio-political climate and the growing self-awareness within the profession, have led to a realisation and acceptance of the need to develop theory and philosophy for physiotherapy (for example, Bithell, 2005; Parry, 1997; Peat, 1981; Pratt, 1989; Roberts, 1994). With this has come a greater understanding of a need to develop thinking for what counts as physiotherapy knowledge (for example, Herbert et al., 2001; Tammivaara & Sheppard, 1990).

### 3.4 Changing notions of professional and patient roles

The previous sections have considered how social, cultural and political forces and changing professional practice knowledge are challenging traditional conceptions of what healthcare is, how and what is provided and who provides it. This has required the traditional healthcare professions
(medicine, nursing, dentistry, midwifery and the allied health professions) to reflect on their own professional identity. The concept of identity will be explored in order to better understand its relationship with professional socialisation, the healthcare professions and the identity of physiotherapy.

3.4.1 Client - Therapist relationships

Over the past decade the profession has been exposed to many external demands for change:

“Radical changes are needed in the way staff work to reduce waiting times and deliver modern, patient-centred services. This is not a question of staff working harder. It is about working smarter to make maximum use of the talents of all the NHS workforce”

(SSH, 2000, p.82)

Communication and the relationship of physiotherapists with their clients and the general population are changing as government policies take hold. Patients have increasing access to information to help them make choices about their care. They have increased control over their own care records (SSH, 2000). The government has promoted the idea of shared decision-making under the rubric “nothing about me without me” (SSH, 2010, p.13). The nature and type of service provision has changed as information, communication technologies come on stream, and populations adapt to such (for example, CSP, 2012d).

3.4.2 Professional roles

One consequence of modernization in health and social care services is a move towards multiprofessional team working (Nancarrow & Borthwick,
Effective team working between professionals improves client care (DH, 2005). For effective team working, traditional professional demarcations and scope of practice have been challenged and collaborative working explored. This has required that professionals be more flexible and develop a greater understanding of each other:

“In some community clinics teams made up of occupational therapists, district nurses, physiotherapists and social care staff, working flexibly together across traditional boundaries have halved the length of stay for orthopaedic patients and enabled more frail people to stay at home”.

(SSH, 2000, p.83)

NHS employers have been required to empower appropriately qualified nurses, midwives and therapists to undertake a wider range of clinical tasks including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs (SSH, 2000, p.83). Physiotherapy seized these opportunities for new roles by extending its scope, developing technical skills and successfully advocating for further “rights” (for example, CSP, 2011b; DH, 2012).

### 3.4.3 Physiotherapy’s identity

The profession has faced many external demands for change over the past decade. The modernisation of healthcare, the rise of accountability and public expectations, communication technology, and population changes, all require the profession to be quite different from the past (SSH, 2000). In response, the profession of physiotherapy is changing. This is both in its practice, as new roles and interventions are adopted, and in its theory, as evidence-based accountability takes hold. Descriptions and definitions of the
profession are being recast. In this environment individuals make decisions about how they practice on a day-to-day basis based on conceptions of who they are, which are often ad hoc, context-specific, or determined by personal notions of their professional role, contribution or identity. These views could be generated in response to long held conceptions of what the profession is, half-formed views about what it means to be a professional in a specific context (for example hospital ward), and the need to have a workplace image or identity.

Endeavours for greater self-knowledge and security are neither new nor particular to physiotherapy. Many related health professions and professions from other sectors are scrutinising themselves and their place and role in society. Occupational therapists, journalists, exercise scientists, charity workers, nurses, physicians; psychologists, general practitioners, and lawyers have all been investigating their identity (for example, Aldridge & Evetts, 2003; Booth & Hewison, 2002; Jones & Green, 2006; Kirpal, 2004; Lingard, et al., 2003; Mackey, 2007; Parsons, 2004; Perrotta, 2006; Sigurdsson, 2001; Sommerlad, 2007).

This requirement to assert an identity is current because economic pressures within the UK National Health Service are requiring commissioners of services to question how its money is spent and to challenge historical roles (SSH, 2000). This poses a challenge to physiotherapy’s sense of professional self-identity, self-worth, and public profile. This recognition has stimulated a desire to further the professionalisation of the physiotherapy
profession (that is, to enhance the institutions within the profession that underpin a developing profession, such as its democratic processes, its career pathway, its role models and senior leaders, its subgroups, its connections with wider society). Richardson (1999a; 1999b) has also identified the need to develop the professionalism of its members, and the corresponding need for a better understanding of socialisation processes into and within the profession (Richardson, 1999a; 1999b).

Through the intervening years numerous physiotherapists have called for discussion and investigation into “a clear professional identity” (Belanger, 1998, p.245); for example Carpenter, 1996; O’Hearn, 2002; Richardson, 1999a. In 2007, there was debate within the United Kingdom about the role of extended scope practitioners and the urgent economic restraints being fostered upon the National Health Service. This led one physiotherapist to implore the profession to ‘have more confidence in the unique perspective that physiotherapists have to offer’ (Bairstow, 2007, p28), though he failed to say what he thinks this “unique perspective” is. There is agreement that investigation is required into what physiotherapy is (for example, Cott et al., 1995). Several reasons have been given for why a clear identity is necessary. The temptation to focus on what makes physiotherapy different from other healthcare professions could strategically be the wrong tactic – perhaps commissioners of services prefer services able to demonstrate similarity with nationally endorsed service delivery models and practices and are less interested in which professions provides them. This also challenges
the ideology of identity: that of “not being split, about being complete” (Yngvesson & Mahoney, 2000, p.87).

A sense of urgency has been expressed over a long period that physiotherapy should define its own theoretical basis and, hence identity. Hislop (1975) argued that the profession faced a “crisis of identity”, was still “in search of an identity” and was in an “age of survival (which is not assured)” (Hislop, 1975, p.1070). Nearly thirty years later, the Editor of the American Journal of Physical Therapy claimed that “Physical therapy is still in the midst of an identity crisis” and that “we know and understand what we do, but we do not know who we are” (Rothstein, 2002, p. 365). Paris, in his 2006 Mary McMillan lecture to the American physical therapy profession, said:

“We must do something desperate to establish an identity for this profession. Most of us struggle to define to others what physical therapy is. Think of the medical profession, and you think of illness, disease, and medications. Think of dentists, and you think of teeth. Think of veterinarians, and you think of animals. Think of athletic trainers, and you think of sports. Think of physical therapy, and it’s ... what? Where is that association, where is that brief statement that can gain public recognition?”

(Paris, 2006, p.1550)

With this quest for self-knowledge, self-determination and identity, lies the presence of the profession in society. In common with most professions (Freidson, 1994) physiotherapy has striven for a greater public profile and increased visibility, see, for example, CSP (2005).

---

25 By society I mean both the public sphere – public debates, discussions and consultations that take place in general society: on television, radio, in parliament, on the internet, and in pubs and parks – and the professional sphere – formal consultations, submissions, descriptions and communications that different actors within the profession pursue on behalf of the profession.

26 This has been observed within occupational therapy as part of the ‘folklore’ of the profession WILDING, C. & WHITEFORD, G. (2007). “Occupation and occupational therapy:
This chapter has considered attempts in the literature to define more precisely both what physiotherapy is, based on theories of what an ‘essential element’ could be, and through which, to more closely understand the profession’s identity. These efforts have not solved the challenge. A more robust approach might be to adopt a pluralistic approach to professional identity and to strive to enable physiotherapists to construct identities through personal and collective self-reflections on experiences, situations and intentions.

Professional identity develops over time and involves gaining insight into professional practices and the development of the talents and the values of the profession (Adams et al., 2006). Professional identity is “one’s professional self-concept based on attributes, beliefs, values, motives, and experiences” (Slay & Smith, 2011, p.85). It relates to the professional role undertaken by the individual, and thus is a matter of the “subjective self-conceptualization associated with the work role adopted” (Adams et al., 2006, p.56).

3.5 Research question

Chapters two and three have illustrated that over the past decade the profession has been exposed to many external demands for change. The modernization of healthcare, the rise of accountability and public expectations, communication technology, and population changes, all require

Knowledge paradigms and everyday practice” Australian Occupational Therapy Journal, 54, 185-193.
the profession to be quite different (SSH, 2000). In response, the profession of physiotherapy is changing. This is both in its practice, as new roles and interventions are adopted, and in its theory, as evidence-based accountability takes hold. Descriptions and definitions of the profession are being recast. In this environment individuals make decisions about how they practice on a day-to-day basis based on ad hoc and context-specific conceptions of who they are, and determined by personal notions of their professional identity. These views could be generated in response to long held conceptions of what the profession is, half formed views about their professional or work identity, fuelled by their personal and workplace self esteem, and reaction to how they are recompensed for the work they do (either in monetary or societal terms).

There is agreement that investigation is required into what physiotherapy is, and a variety of reasons have been cited for why a clear identity is necessary (for example, Edwards, 2006; Hislop, 1975; Rothstein, 2002; Trede, 2006). To date no formal studies have been published to specifically consider the identity of the profession as a whole. What this review of studies into the identity of physiotherapy has constructed is an argument for the need for an investigation not into the profile of physiotherapy, or what is physiotherapy, or what do physiotherapists do and how do they act; but rather an investigation into their self-concept.

The research question underpinning this thesis was:
What does it mean to be a physiotherapist?

The key aim of the thesis was to consider how physiotherapists come to be the physiotherapist they are. How do physiotherapists construct their professional identities on a daily basis, in the reality of the lives they are living?

3.6 Summary

In this chapter I have sketched out the challenges on the profession to reimagine itself and flourish in a changing environment. I have structured this around three aspects of change in the modern world: the changing socio-political context, changing notions of what is deemed professional practice knowledge in healthcare, and changing professional and patient roles. This context has stimulated an “identity crisis” for the profession as it has had to reimagine what services it provides, to whom, and how, what standards of professional knowledge and practice delivery are acceptable.

There are few existing theories of physiotherapy as a whole (Cott et al., 1995). Those that do fail to consider personal experiences. Explorations of what physiotherapy is, and could be, that have been published in the literature, have tended to be opinion pieces and have not included personal experience in a rigorous manner (for example, Paris, 2006; Williams, 1986). I have used this analysis to develop an argument for the need for an investigation not into the profile of physiotherapy, or what is physiotherapy, or what do physiotherapists do and how do they act; but rather an investigation
into their self-concept. I finish the chapter by presenting my research question that underpins this thesis and the key aim of the thesis.
Chapter 4 Methodological approach and methods

In this chapter, I describe the theoretical position I constructed as an approach to the research question, and how I planned to address my research question. I provide a critique of my methodological options, describe in detail my chosen methodology, and explain the methods I used to generate my data. I begin by explaining how my thinking evolved from my initial disturbance about a proposed description of physiotherapy to a consideration of what it means to be a physiotherapist.

My first disturbance involved how the profession of physiotherapy communicates with significant stakeholders, in this case a member of a devolved parliament. I was concerned with the description of the profession. It seemed to me that the description the CSP was providing did not reflect a current picture of the profession and its contribution to society in a sufficiently convincing and influential manner. The second disturbance concerned how physiotherapists respond to challenges to the profession’s contribution to healthcare: when questioned about the truth of what the profession’s role, are physiotherapists able to marshal a defence and justification that is persuasive; can we redeem the claims we make about our effectiveness?

With the wealth of external requirements for change and emerging ideas about what physiotherapy can be in this new world, I was interested in how physiotherapists act: how do they personally construct their professional identity in the workplace and in their personal lives? In asking
physiotherapists what it means to be a physiotherapist I wanted to provide an opportunity for them to move beyond their immediate ability to phrase their thinking in words, and open up a space whereby they could reflect on their experiences as they are today. I was interested to know about the stories they told themselves about being a physiotherapist and how this fed into their identity. To inform my selection of an appropriate methodology I considered what my own views on the nature of reality are and what my conceptions of knowledge are.

4.1 Epistemology: Social constructionism

I took the decision to locate this thesis within a social constructionist epistemology. This assumed the existence of multiple realities and that knowledge and understanding is co-created and contextually shaped by the people participating in the research and their historically situated backgrounds. Crotty (2003) described constructionism as the view that “all knowledge, and therefore all meaningful reality, is contingent upon human practices being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context” (Crotty, 2003, p.42). He added that social constructionism also recognises that the institutions through which we make meaning precede us and that we are already embedded in them. Social constructionism then was the broad epistemological position taken for this study. The intention was to encourage physiotherapists to open up a space for thinking, speaking and talking in new ways. Given this, I chose to give this epistemological position a Critical Theory perspective in general and a Habermasian one in particular.
(Crotty, 2003). With this twist it was intended to provide a perspective that could challenge the institutions, the means, and the normative forces in which the participants operated.

4.2 Theoretical perspective: Habermasian communicative rationality

Critical Theory originated from what is now known as the Frankfurt School in the 1930s. This interdisciplinary collaboration rejected the traditional idea of theory that “corresponds to the activity of the scholar which takes place alongside all the other activities of a society but in no immediately clear connection with them. … it conveys not what theory means in human life but only what it means in the isolated place in which…it comes into existence” (Horkheimer, 1972, p.197). Geuss (1981) defined it as “a reflective theory, which gives agents a kind of knowledge inherently productive of enlightenment and emancipation” (ibid, p.2). This is achieved through its “criticism of ideology” (ibid, p.3). Their ideology prevents agents from “correctly perceiving their true situation and real interest” (ibid, p.3): if they are to free themselves from social repression, the agents must rid themselves of ideological illusion (Geuss, 1981). Critical theory has evolved from these conceptions. Kincheloe and McLaren (2000) reconceptualised critical theory within ten domains (see Appendix 2). They suggested that critical theory is a map or guide to the social sphere, and that for research it does not help us see the world, rather it “helps us devise questions and strategies for exploring it” (Kincheloe & McLaren, 2000, p.281). I used these two sets of thinking about critical theory to approach the work and theories of the German philosopher and social theorist Jurgen Habermas (1929 to date).
Habermas developed a critical theory that was post metaphysical, yet non-defeatist (Cooke, 1994). He was post metaphysical in recognising that the move of societies from traditional to modern ways of life has brought about systems differentiation so that the values, norms, and actions of individuals can no longer be conceived in one unified manner (Habermas, 1991). He was non-defeatist because he stressed the value of rationality and the use of reason embedded in the values and beliefs drawn from the period now known as ‘The Enlightenment’ (Cooke, 1994). Habermas did not see the progress of society since the late eighteenth century as negative, and wished to avoid the relativism that might emerge from radical critiques of reason. Habermas believed that through communicative rationality the benefits of greater self-reflection and the use of reason in a society of mixed values and opinions could be harnessed (Habermas, 1984, 1987a, 1987b).

Habermas’s central theory was that of communicative rationality: the potential for rationality that is implicit in the everyday linguistic practices of modern societies (Habermas, 1984, 1987a). This is the giving and accepting of reasons for an utterance that informs understanding and agreement in communication (Habermas, 1984, 1987a). Three underpinning and interconnected sets of theories support this central idea:

a. Theory of communicative action: this is the idea that two people can talk about something in the world and in doing so mutually orient themselves to understanding each other, as opposed to achieving a goal (which would be called strategic action) (Habermas, 1984, 1987a).
b. Formal pragmatics: the competent communicator *intuitively* raises three types of validity claim in any given speech act, to the truth, to truthfulness and to normative rightfulness (Habermas, 1999).

c. Pragmatic theory of meaning: to understand an utterance is to understand the claim that it raises (Cooke, 1994). Habermas claimed that language co-ordinates action in a cooperative way rather than through force or manipulation (Habermas, 1984, 1987a). This assumes a distinction between consensual agreement and compliance, which Habermas used in his idea of the pre-theoretical knowledge of competent speakers and actors (Habermas, 1984, 1987a).

Habermas's theoretical system supported the possibility of reason, emancipation, and rational though critical, communication (Bohman & Rehg, 2007). He has developed critical theory through an ontological critique of historical materialism that assumed a ‘mediating position between the extremes of subjectivism and objectivism’ (Mill et al., 2001, p.113). Habermas proposed a “pragmatic epistemological realism” (Habermas, 2003, p.7). If a statement for which a speaker claims truth is indeed true, this is because it “accurately refers to or represents existing objects, or actual states of affairs” though recognising that these descriptions depend on our “linguistic resources” (Bohman & Rehg, 2007, unnumbered). These insights were useful for my intentions with this study: to consider what stories physiotherapists tell themselves and others about how they have come to be the kind of physiotherapist they are.
Habermas assumed a plurality of forms of knowledge, acknowledging the value of three different knowledge interests: technical control, understanding, and emancipation (Habermas, 1978). As such, knowledge is created not discovered. Dialogical and negotiated agreement means it is always potentially wrong and liable to change as modes of thinking evolve, and so is ‘fallibilistic’ (Habermas, 1999). Habermas believed that the pragmatic rationality of a theory lies in its potential effectiveness in solving problems (Habermas, 1999). He rejected the foundationalist attempt to confirm or falsify theory through grounding knowledge in a-historical, _a priori_ certainties (Mill et al., 2001, p.114).

Habermas viewed empirical claims about the nature of reality as ‘situated, contingent and potentially fallible’ (Mill et al., 2001, p.113) and saw a virtual reality shaped by social, political, cultural, economic, ethnic and gender values that are formed over time. The theory of communicative action provides a mechanism through which many of these features can be analysed and why this might be (Habermas, 1984). He based this thinking on an “emancipatory form of knowledge through universal pragmatics” (Ashenden & Owen, 1999, p.3). Universal pragmatics tries to identify and reconstruct the “universal conditions of possible mutual understanding” (Habermas, 1999, p.21). Habermas argued, “We understand a speech act when we know the kinds of reasons that a speaker could provide in order to convince a hearer that he is entitled in the given circumstances to claim validity for his utterance … when we know what makes it acceptable” (Habermas, 1999, p.232). With this Habermas linked the meaning of speech
acts to the practice of ‘reason giving’: claims are open to criticism and justification (Habermas, 1999). A speech act is successful when the hearer presumes that the claims in the speech act could be supported by good reasons. If a hearer challenges the speaker then the communication changes from ordinary speech to “discourse”—a process of discussion in which the claims are tested for their rational justifiability as true, correct or authentic (Habermas, 1984).

4.2.1 Developing a pro-feminist attitude

In Chapter 1, I described my physiotherapy background and the context in which I work. As a man studying a professional group that contains predominantly women, I was concerned to consider the potential ramifications of gender dynamics. Pro-feminism is an emergent term that does not yet have a consistent use, understanding or meaning. For my purpose, I have used some of the broad principles of pro-feminism to focus my theoretical stance. So, pro-feminism is support ‘of the cause of feminism’ (for example, Educating Gender Diversity, undated; Flood, 2009; Pease, 2000). The term is used about men who are “actively supportive of feminism and of efforts to bring about gender equality” (Wikipedia, 2011\(^{27}\)). Corbett, Francis, and Chapman (2007) identified that the different kinds of feminism share a position. This is that women face “some form of oppression and exploitation” (Corbett et al, 2007, p.84). Recognising that these oppressions and exploitations are experienced differently (depending on race, class, 

\(^{27}\) I recognise that using Wikipedia is academically unusual. I argue that in this case it is reasonable: the term pro-feminism is emergent and lacks an agreed definition. As such, the very collaborative nature of Wikipedia encourages discussion to better articulate a consensus.
culture, religion, sexual preference, age, physical abilities and nationality) all feminisms have a commitment to uncover and understand the forces that cause and sustain oppression. Corbett et al. (2007) concluded that feminisms work to obtain, individually and collectively, a commitment to end all forms of oppression (p.84).

In adopting a pro-feminist attitude, I sought to recognise that women experience inequalities and injustices in society, while men receive various forms of power and privilege. The current, dominant model of manhood or masculinity is oppressive to women, as well as limiting for men themselves, and so men must take responsibility for their own behaviours and attitudes (Pease, 2000). For this study, I adopted the background position of a heightened awareness of these assumptions during the recruitment of participants, their preparation for involvement, engagement, and later during the final analysis in how I have used their stories, reflections, discussions and opinions.

4.3 Methodology: Collective Memory Work
The Habermasian critical theory I adopted sought to adopt a mediating position between objectivity and subjectivity and realism and idealism. It took the view that knowledge generation needs to recognise power relations and historical artefacts that are always already present in any social situation. However, it was most particularly about transformation, about seeking to enlighten those in the field and through this, work towards emancipation. I aimed to listen to what physiotherapists said were their personal, formative,
professional experiences of being a physiotherapist and through this come to a greater understanding of how they constructed their professional identity.

Given this research aim, a strategy could have been to seek consensus and adopt Delphi or nominal group methods. The value of this could have been to generate agreement on views across a larger range of the profession, both in terms of numbers and geographical spread. The profession could have been purposively sampled according to pre-determined domains, for example, age, rank, occupational setting. This would enable the development of themes upon which the individuals and the group as a whole could agree. The limitation of this approach is that it cannot get beyond the superficial and the general. Local views or views contingent upon specific circumstances could have been lost amidst the many. It could have required the particular to become generalised too soon in the research process. I considered Delphi or nominal group consensus-generating methods would be limited in their ability to generate the profound self-reflections I was after. This was because the power relations of such techniques, whereby the participants are subjects researched upon by researchers who retain an authority and control over the content, direction, and analysis of data, might only have allowed for a superficial engagement and too readily a satisfaction with the existing. What I mean by this is that such consensus-generating techniques do not necessarily engage participants in an ownership of the research process. Potentially the approach also leaves the participants with nowhere to go; if participants have views that differ from other participants there is not necessarily an opportunity for discussion and the sharing of thinking to allow
for a changed opinion. Methodologically this approach would have had to remain at the superficial level because any in depth reconstruction of past events would require closer researcher engagement and, with large groups and a geographical spread, this would not be possible.

Physiotherapy is a socially constructed occupation; therefore, the methodology ought not to conform to, or adopt, the logic of the natural sciences. As Warnke says in her introduction to Apel (1984) beliefs and practices, norms and values, roles and institutions are “inherently meaningful” by standing in “some relation to both subjective intentions and cultural traditions” (Apel, 1984, p.vii). The intention was not simply to explicate some unvarying law of human behaviour, but to make this behaviour intelligible, to “illuminate its rationality in terms of cultural assumptions and subjective intentions” (ibid, p.vii). Through interpretation, I intended to explore the complexity of meanings that are inherent in the actions and practices of the profession. Nor was it the intention to generate a theory of physiotherapy, rather to generate insights into how physiotherapists construct their professional identities on a daily basis, in the reality of the lives they are living.

With the research process I aimed to facilitate the participants to feel able to share their professional identity, give themselves permission to change, to reflect on this and consider any change or no change within the support structure of a group all undertaking similar reflections. This was therefore a
form of phenomenology. Phenomenology emerged from Husserl’s investigations into hermeneutic studies and attempts to understand the experience of people (Habermas, 1984). I wanted to go further in seeing experience as a constant management of the power relations that might exist in a situation, and identity as something created in real life practice. As such, another possible methodology could have been ethnography. The benefits of this methodology are that the research process could have focussed on one or two physiotherapists and explored their lived experiences of being a physiotherapist. This could have provided detailed insights delving deeply into formative experiences. However my concern was that it might provide a linear, causal explanation of their identity construction, perhaps even as ‘inevitable products of their own experience’ (Stephenson, 2005, p.34), and possibly omit the social processes necessary for the formation of identity.

An alternative ethnomethodological approach might have been to observe one practice in depth over a period. I could have immersed myself in a physiotherapy outpatient department and observed practice. While, again, this would have yielded useful information for revealing more about what physiotherapy is, as it is practised, it would not have provided sufficient insight into the meaning behind the actions; it would always have required my interpretation, as an outsider, of events and meaning rather than the insider practitioners’ interpretations. Given epistemological commitment to the co-production of identity and “collective strategies for intervention”, I wanted to avoid this (Stephenson, 2005, p.43).
In outlining my philosophical position, I took the view that any analysis of a profession needed to consider the issue of power (Freidson, 1994). To adopt a Foucauldian genealogical approach would have been a useful mechanism for exploring the issue of power relations and knowledge in physiotherapy. The power relations through which physiotherapists operate exert real influence on the profession (Roberts, 1994). To explore the profession and the power relations could expose important insights about the identity of physiotherapy. However, I chose to reject genealogy. My aim was not to trace the history of the profession in order to understand it, nor to reveal previously unexposed power restrictions that pervade the profession. Recognising that power relations exist, the aim was to gain insights into how individuals construct their own professional identities.

I took the view that local and contingent environments influence the construction of knowledge while also perpetuating universal behaviours both of the powerful and the powerless. I wanted to understand what this meant for physiotherapists and physiotherapy, to help specific individuals come to see this for themselves, and to provide a forum for them to develop collective strategies for intervention. My concern to select a methodology that would engage participants in the process and provide an opportunity for self-reflection and if necessary change, stemmed from my practice role of implementing national clinical effectiveness initiatives for the physiotherapy profession. The implementation of nationally developed ideas is problematic in different domains, be it clinical guidelines, outcome measurements, clinical audit, or making a business case to commissioners (DH, 2008). This left me
feeling that the process of creating research can too often be separate from those who are then tasked with using or “implementing” it. The intention therefore was to adopt a methodology that would bring the two together: the generation of knowledge and its implementation in physiotherapy practice.

It was decided to conduct this investigation through one type of narrative research strategy that incorporates features of participatory action research (Kemmis & McTaggart, 2000) called Collective Memory Work (Haug et al., 1987). Narratives have been claimed as the key scheme by which human beings make their experiences meaningful (Lapointe, 2010). Collective Memory Work (CMW) requires the collation of written memories according to certain rules as its method of data generation. CMW was chosen because of the wish to use the writing of a memory, the creation of a text, the discussion of it, its reappraisal and collective theorising of the group, and subsequent actions, to “facilitate an understanding of the hidden structures and tacit cultural dynamics that insidiously inscribe social meanings and values” (Kincheloe & McLaren, 2000, p.288).

There are few existing theories of physiotherapy as a whole. Krebs and Harris (1998) claimed they knew of none, though Cott et al., (1995), Dean (1985) and Hislop (1975) have published theories of physiotherapy. Those that do exist have failed to consider sufficiently personal experiences in

---

28 By physiotherapy practice I include the workplace practice of physiotherapists, whether they be clinicians, manangers of clinical physiotherapy service, academics, educators, researchers, advisers

29 Haug et al. (1987), the originators, do not call collective memory work (CMW) participatory action research. Working in a German-speaking feminist paradigm, they explicitly aimed to avoid patriarchal language and preferred to use their own language to articulate their thinking, assumptions and principles. As such CMW is not merely a method but also a methodology.
asserting their value. The opinions of what physiotherapy is, and could be, published in the physiotherapy literature, have not introduced personal experience in a rigorous manner; rather it has been used as a gloss or an example (for example, Paris, 2006; Williams, 1986). Rather than survey or speak to physiotherapists (and/or others) about what they think physiotherapy is, and run the risk of developing a traditional theory of physiotherapy, I felt it preferable to work closely with one small group of physiotherapists. I would invite this group to reflect on their formative experiences of physiotherapy, how they constructed their professional identity, and to consider the implications of these. This would open up the opportunity of an appraisal of what the collective identity of physiotherapy might be, through individual identities. I would do this by adopting a Habermasian mediating position between a realist or materialist notion that there is a unified, fixed truth to what physiotherapy is, and a relativist conception that there are as many constructions of physiotherapy as practitioners. The intention was to create the possibility, through communicative rationality, of an individual and collective identity based on self-reflection, personal development, and enlightenment to the self-perpetuating delusions that limit individual action. The interest in the use of memory as narrative and not merely as recollection was because, as Crawford et al. (1992) concluded, “meanings are constituted in action and action in meanings” (Crawford et al., 1992, p.38).

Haug et al. (1987) developed CMW with the intention of better understanding the potential for women’s liberation from the prevailing patriarchal orthodoxy,
“to counter heteronomy with autonomy, unhappiness with a struggle for the capacity to be happy” (Haug et al., 1987, p.33). Since then it has been used for wider purposes; Small (1999) adapted CMW for her doctoral studies that sought to uncover themes in women’s and girls’ tourist experiences; Pease (2000) used CMW in his investigations of masculinity; Stephenson (2005) used CMW in her research into HIV subjectification. I assumed the perspective, in developing a research study, that overbearing power and domination mark our experience of everyday life and yet it is possible to retain the potential for transformation beyond such constraints. If we are to understand the structures underneath our experience, we must make this potential visible. Rather than develop a portrait of physiotherapy in a broad and general sense, I chose to investigate how individuals become physiotherapists, how they create and are created as physiotherapists. I was interested in how individual people with their personal identities come to be the physiotherapist they are within the profession of physiotherapy; that is, how they forge their professional identity.

4.3.1 Assumptions of Collective Memory Work

CMW investigates how “persons become selves and the part persons play in that construction” (Crawford et al., 1992, p.36). The underlying theory is that subjectively significant events, and the way they are remembered and constructed, play an important part in the construction of the self (Crawford et al., 1992). Haug et al. (1987) described that we ‘learn how to accept, incorporate and become part of existing structures and so how we become part of society’ (p.39). CMW aims to be productive in that it provides new
ways of looking at how language is used in socialisation, and the uses we make of language, for example with metaphor or cliché. Haug commented

“In asking how experience is reproduced in memory, we find out where we compromised without realising it…. Re-discovering the responsibilities we regain new chances and different possibilities to act in the present and in the future.”

(Haug et al., 1987, p.42)

The research process sought to confront this tacit knowledge and the “taken-for-grantedness” (Haug et al., 1987, p.36) of everyday professional life and examine the specific and unexamined theories that underlie it. Table 5, below, outlines the assumptions of CMW.

Table 5 Assumptions that underpin collective memory work

| 1. | The personality narrates to itself stories selected from its history and past. |
| 2. | Memories are not pictures of people’s experience. |
| 3. | CMW interrogates the process of selectively choosing, arranging and presenting experiences, asking why we recall and relive the events we do. |
| 4. | People recall and reconstruct their memories so they can live alongside them with the minimum of contradiction and inconsistency. This determines how they act and respond to the situations in which they find themselves. |
| 5. | Memories mark those options in the past for the expansion and liberation of the self. CMW challenges this assumption of early experience as a prison of the self. |
| 6. | Anything a person remembers constitutes a relevant trace in his or her construction of self. |
| 7. | Memories are not direct quotations from experience, but are continually reprocessed in the formulation of identity, a process in which certain events from the past acquire subjective significance. |
| 8. | What is significant about memories is not their surface validity as true records, but their active role in the construction of identity - the task for memory work is to reveal the processes by which we construct our sense of self by uncovering successive layers of significance in personal accounts. |

(Adapted from Schratz & Walker, 1995)

For the reasons alluded to above, I positioned myself within the memory-work group. I wanted the researched to become the researchers, and to
eliminate as much as I could the hierarchies that might exist between ‘the researched’ and me. The idea of CMW is to close the gap between theory and experience in ways intended to change the nature of experience, not simply to accept it. The methodology therefore has a political and social motive (Crawford et al., 1992; Haug et al., 1987; Schratz & Walker, 1995).

4.4 Methods: theme board technique and collective memory work

I selected two research methods for data generation. The facilitated creation of personal theme boards is a potentially useful method of introducing the participants to the research topic, to stimulate their creative thinking, and to support the development of the group dynamic. Lloyd and Papas (1999) have identified the value of art as being a means of communication that allows individuals to use images “as a bridge” (Lloyd & Papas, 1999, p.32). It is this bridge that supports the “expression of personal meaning” (Lloyd & Papas, 1999, p.32). The second and prime data generation method was collective memory work.

4.4.1 Theme board technique

The value of this technique is its ‘lack of threat’ for those participants who may feel they lack artistic ability and would otherwise be reluctant to contribute with other art forms through embarrassment at what they might produce. Williams (2002) proposed that because the pictures are already created and the individual has simply to select those images seen to be relevant and then assemble them as one collective picture collage helps to
remove this anxiety (Williams, 2002). The technique used followed that of Williams (2002):

1. Participants flick through magazines and cut or tear out pictures and slogans that they feel can be used to represent issues for discussion, based on the prompting question

2. Use a range of easily obtainable glossy ‘waiting room’–type magazines with the exclusion of specific health–related publications. This was to generate the use of symbolic images rather than actual pictures of the issues being explored.

3. Each participant assembles the images on a flip chart page.

4. When all participants had produced their theme board they are facilitated to explain to the group how they have represented their ideas through the selected symbols.

5. Other members of the group question the presentation offering their own interpretations and considering the contributions of others in the group. This open expression of ideas through a pictorial representation allows a whole range of attitudes, beliefs and feelings to emerge and be explored, thus generating greater understanding of others’ perceptions of the same situation

(Williams, 2002)

4.4.2 Collective memory work

The assumptions of CMW have been listed previously in Table 5, page 88. The process of undertaking CMW is described below in five stages.
Stage One

Participants meet to talk about the topic, to ‘bridge the gap between the subjects and the objects of research (Schratz & Walker, 1995, p.40). Participants are invited to consider how to approach writing the memory of a particular experience. Haug et al. (1987) agreed to write memories according to a set of rules:

1. Write a memory
2. of a particular episode, action or event
3. in the third person
4. in as much detail as is possible, including even inconsequential or trivial detail and what you were thinking at the time and what happened
5. but without importing interpretation, explanation or biography

Stage Two

Choosing a trigger topic

The group collectively chooses a “trigger” topic. This is an important criterion in the formation of the group and ownership of the work (Crawford et al., 1992). Crawford et al. (1992) advised that the choice of the trigger “cannot be over-emphasized” (Crawford et al., 1992, p.46), and caution against starting with the most obvious trigger, as these are likely to produce ‘obvious and somewhat over-rehearsed responses’ (Crawford et al., 1992, p.45). Ready-made questions are likely to be ‘firmly rooted in popular prejudice’ and ‘their meanings in general glib’ (Haug et al., 1987, p.53). The meeting
finishes on the agreement that each participant goes away and, for 'homework', writes a memory on this trigger in time for the next meeting.

Stage Three

Writing a memory story

Participants write a description of a particular event or episode rather than an account. This avoids justification and explanation. Participants are asked to write in the third person to establish each author as both object and subject of the research. The requirement for detailed description, including apparently inconsequential details, aims to avoid evaluation; Crawford et al. (1992) have suggested that what may appear irrelevant can point to the "hidden moral and normative aspects of our actions" (Crawford et al., 1992, p.46).

Stage Four

Discussing the memory stories within the group

The memory group reassembles and discusses each memory text. Schratz and Walker (1995) have made two key suggestions to assist this phase:

1. Participants ask questions of the text that must be answered with the words or phrases contained within the text, about the activities, feelings, interests and wishes of the author; feelings and interests of the others, language, blind spots, gaps, connections and contradictions.

2. Participants ask questions about the text concerning its construction.

In light of these discussions the participants go away and amend their
text. They meet again and try to draw out themes from their discussions of these memories (Schratz & Walker, 1995).

Stage Five

*Group analysis of the discussions*

After the first reading of the texts one is selected by the group as a starting point and the first impressions of the group are discussed (asking for instance, “What does the author say her problem is? Which theories does she seem to have?”). These impressions are written down so at the end they can be compared to the final understanding the group achieved. Crawford et al. (1992) established some rules to support this phase:

a. Each participant expresses opinions and ideas about each memory in turn, and

b. looks for similarities and differences between the memories and looks for continuous elements among memories whose relation to each other is not immediately apparent. Each participant should question particularly those aspects of the events that do not appear amenable to comparison. She or he should not however resort to autobiography.

c. Each participant identifies clichés, generalisations, contradictions, cultural imperatives, metaphor … and

d. discusses theories, popular conceptions, sayings and images about the topic.

e. Each participant examines what is not written in the memories (but what might be expected to be), and
f. re-visits, re-examines, and rewrites his/her own memory text in light of the discussion (adapted from Crawford et al., 1992, pp. 43–52).

This collective reflection aims to reveal the processes involved in the making of the common understandings of the actions in the memory. Crawford et al. (1992) claimed the knowledge of processes of construction generated by CMW comes from two sources: first each participant's self-reflective activities and second, how participants talk to each other about their own and others' actions and experiences. The focus of CMW is the process of construction of the meanings in the events of the memories.

The group meets and considers whether any themes are emerging from its discussions. If so, the group discusses any theories related to these themes, and if necessary, agrees whether there are any general conclusions the group can agree on, or not. Depending on the number of times, nature of the group, and interest of the participants, related literature, ideas, formal and informal theories and other materials may be introduced to these discussions by participants as a means for theorising the themes and drawing conclusions from their discussions. The benefit of this is to permit involvement as a participant and so over time works to create a more genuine 'co-researcher' ethos; ownership of the study aims and outcomes may be improved with strengthened quality and direction of the group, and as discussions become more profound so the possibility of greater theorisation of the discussions. The end result was envisaged as a set of themes that had emerged from the group, through discussion (involving self-
group—reflection of specific memories) on the broad topic of what it means to be a physiotherapist.

4.5    Designing the study

In this section I describe the planning of the study. The intention to create the opportunity for participants to discuss and reflect together posed some challenges for the number of participants to recruit and for the form in which they would operate. One immediate decision was how to structure the study: should there be one or several groups; how many in each group. The implication for this was how to form the group(s), how to give direction, and what the process would be for recording the group work for data analysis purposes. Another issue for consideration was whether to have physiotherapy specialities in a group and what, if any, range of participants to try to recruit. Connected to these two matters were how frequently to meet, for how long to meet, and what exactly I ask the participants to do.

4.5.1    Number of participants to recruit

In planning the study the recruitment process sought to take account of the challenge the methodology posed on the significant time commitment required of participants. It was anticipated that ten physiotherapists would be required to form a working group. I required enough participants to encourage and stimulate debate and reflection but not too many to prevent constructive and sustainable group dynamics, nor to stifle each participants’
voice. Care was taken to get this number right: it was intended that all participants should have sufficient time to express their ideas, opinions, and thoughts, and to feel able to talk about their experiences with the group. A concern was that having too many co-participants might overwhelm some participants and encourage only the more vocal to share their thoughts. The number selected was also intended to ensure there were sufficient participants to maintain a working group should some withdraw at a later date, while not having too many to prevent the fledgling group from forming as a group and enabling participants to get to know each other. The intended level of detail that would emerge from the methods used meant that a sample of six or seven people should be sufficient. I therefore aimed to recruit ten participants to allow for several participants dropping out.

4.5.2 Engagement of participants

The natural timeframe for CMW, that is, the chronological time that would elapse during delivery of the different stages required for undertaking CMW, took into account the following issues:

a. It was considered necessary to have at least two meetings to engage the participants. This would be necessary to introduce participants to each other, for the group to form itself, and to take them through the process of theme board technique.

b. Choosing a trigger topic for the first ‘cycle’ of CMW and then reading and discussing the first memory stories would take two or three meetings.
c. It was envisaged that three or four ‘cycles’ might be necessary to generate sufficient data.

d. This totaled eleven or twelve possible meetings.

Given this, consideration was given as to how frequently these might need to be held. There existed a tension between holding meetings sufficiently frequently to generate momentum, to encourage the participants and maintain their engagement, while providing enough time to lapse in between meetings for participants to reflect on the meetings.

Two key risks were identified:

1. Establishment, formation and ongoing engagement of the group and participant withdrawal

It was considered vital to establish the participants as a group. It was considered important to seek to create sufficient commitment to the group to support and sustain itself through mutual interest and self-benefits. Therefore the plan was to nurture a participatory ethos that would encourage participants to feel a sense of engagement with the project; to feel empowered to pursue the analysis and reflections that emerged, as they emerged, and to want to develop conclusions from this analysis. A specific example of how this intention was implemented was for the participants to be asked to agree between them the trigger topics that would initiate the personal memories of professional experiences and so the direction of the data generation process.
On a more practical level, the intention was to ask participants to meet as a group for about eight months. To lessen the potential travelling commitment for participants, physiotherapists were sought who were based in or around the Bristol region of south west England or prepared and able to travel to Bristol to participate in the discussion group meetings. It was intended that the venue of future meetings would be agreed between participants at the first meeting.

2. Ability of participants to engage with the principles of the methodology / relinquishing of a dominant role by me, the researcher

To manage this potential issue I sought to clarify the methods during the informed consent process, and repeat this both prior to the first meeting and at the first meeting.

4.5.3 Participant inclusion / exclusion criteria

Recruitment aimed to identify a variety of people with a range of experience; specific inclusion criteria required that participants:

1. Must be a physiotherapist trained in the UK
2. If a currently practicing clinician / manager then they must have had at least one years’ post-graduation clinical experience
3. If a currently practicing lecturer the they must have had at least one year’s experience as a physiotherapy lecturer and one year’s clinical experience

4. Must be prepared to engage with the data generation methods

5. Must be willing and able to attend the meetings

The inclusion criteria ruled out other potential participants. This was justified given the intention for the knowledge I hoped to produce; generative knowledge of individual and collective experiences of socialisation within the profession.

Crawford et al. (1992) found successful those groups in which the individual members were ‘reasonably homogenous on some criterion which, a priori, we regarded as relevant’ (Crawford et al., 1992, p.42). Central to this success is mutual trust; this is seen to be essential if the groups are to meet for the necessary time (Crawford et al., 1992; Haug et al., 1987; Schratz & Walker, 1995). As a consequence, I excluded non-physiotherapists and those physiotherapists who did not train in the United Kingdom.

4.5.4 Participant recruitment strategy

The aim was to include in this group a range of physiotherapists with different roles. This would include academics / lecturers, clinicians, and retired physiotherapists. Potential participants were targeted from a higher education institute, a National Health Service department of physiotherapy, and a special interest group for retired physiotherapists, the Retired
Physiotherapists Association. This convenience sampling aimed to increase the range of possible experiences that would be included in the group of participants by increasing the potential for a wide distribution of personal memories across time, workplace location, and work role.

It was anticipated that people with an interest in the topic and methods, and a preparedness to invest the time and energy with the project would be recruited. It was acknowledged that this would rule out many other potential participants and potential experiences. This was deemed acceptable on the basis that the research study design required participants who would need to be people willing to commit to the project’s aims and objectives, the project itself, and to invest intellectually in self-reflection and memory work. While recruitment aimed to identify a variety of people with a range of experience, the recruitment methods would focus on identifying people prepared to invest this time and commit to the work and discussions required of the methodology.

The inclusion of retired physiotherapists aimed to add depth and richness to the data generation and analysis: for example, would the construction of identity develop or evolve over time across groups or generations? The idea was that retired physiotherapists might introduce elements of the role of history, professional evolution, and experience to the group. While the profession consists of different areas of expertise emergent from the clinical setting, patient population, occupational setting, the preliminary nature of this
exploratory study and the methods used required a convenience method to improve access to potential participants.

I planned that I, a physiotherapist, would position myself within this group. This sought to overcome some of the power dynamics that could exist were I to be an observer or facilitator of the group. While the principles of study participation were participatory, inclusive and empowering, I did need to steer the group through the study plan to ensure data generation was methodical, justifiable, understandable and repeatable as befits a doctoral study.

The intention was to recruit participants from one geographical area of England. The city of Bristol was identified because it has a school of physiotherapy, large teaching hospital, large independent practice population, all within close proximity of each other, and significant numbers of members of the Retired Physiotherapists Association, and is relatively close to my workplace.

A letter was sent to the head of department / chair of association requesting permission to recruit staff / members. With this permission I gained agreement to attend a departmental / Association southwest regional meeting to present the study protocol and to invite volunteers to participate. An advertisement was also placed on the professional body's online discussion forum: InteractiveCSP³⁰ (see appendix 4). The intention of this additional recruitment strategy was to increase the chances of successful

³⁰ Any member of the professional body (CSP) can join this web site, register to specific networks of the site, and post items of content (for example, research recruitment advertising): www.interactivecsp.org.uk.
recruitment by providing another format where potential participants could see the proposed study, and possibly engage with it.

A pragmatic and convenience sampling procedure was used until sufficient recruits were found. The deciding factor for eligibility was motivation and dedication to the study. The level of detail in the data generated suggested that six or seven people would be sufficient. It was decided to recruit ten to allow for several participants dropping out. This number was also based on a need for enough participants to encourage and stimulate debate and reflection but not so many to prevent constructive and sustainable group dynamics, nor to stifle each participant’s voice.

4.5.5 Ethical considerations

The study was designed to establish the participants as a group and to seek to create sufficient commitment to the group to support and sustain itself through mutual interest and self-benefits. This meant that further care was required to consider the welfare of the participants. Table 6 describes the ethical considerations addressed in the planning of research data generation.
<table>
<thead>
<tr>
<th>Ethical consideration</th>
<th>How this was addressed</th>
</tr>
</thead>
</table>
| 1. How to respect participants’ anonymity, confidentiality and ongoing informed consent | • The material collected from individuals through CMW was only used in ways authorised by participants during the initial consenting process, as described in the Participant Information Sheet, and during discussions during data generation meetings.  
• The only person with access to the study data was me. This aimed to limit any vulnerability to exposure of person-identifiable data.  
• My doctoral supervisors would only access anonymised raw data. |
Table 6 (continued) List of the ethical considerations addressed in the planning of data generation (page 2 of 3)

<table>
<thead>
<tr>
<th>Ethical consideration</th>
<th>How this was addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Respecting the intellectual property of participants</td>
<td>Agreement was gained with the group regarding the interpretation and ownership of data, authorship and the dissemination of learning; that I, as a doctoral student, would author the final research report.</td>
</tr>
<tr>
<td>6. Ensuring professional and legal probity</td>
<td>Participants were advised that should strong evidence of malpractice arise during the course of the discussions, I would report this to the appropriate authorities; that is, the profession’s statutory regulator, the Health and Care Professions Council.</td>
</tr>
<tr>
<td>7. A risk to participants was the intrusion of the study into their professional identity.</td>
<td>To overcome this, I spoke with each participant before each meeting and with the group as a whole at the start of each meeting and suggested that if the personal reflections and groups discussions were too intense and intrusive, that the participants could choose to withdraw at any time, without giving a reason.</td>
</tr>
<tr>
<td>8. A burden for participants was the inconvenience of the frequency of meetings and the work of writing a memory text in between meetings. Participants may have ended up writing up to three texts, depending on how the discussions progress and whether the participants choose to do so.</td>
<td>I spoke with each participant during the course of the study and suggested that if the workload for participation became too much of a burden, then they could choose to withdraw at any time, without giving a reason.</td>
</tr>
<tr>
<td>9. The consequence for the study should participants have withdrawn was that the group dynamics would alter and adversely affect the progress of group discussion.</td>
<td>To overcome this, I aimed to recruit ten participants. If any participants withdraw during the course of data generation, all participants will be invited to discuss, negotiate and agree whether the two groups rejoin as one.</td>
</tr>
<tr>
<td>Ethical consideration</td>
<td>How this was addressed</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>10. It was possible, in the writing of a memory text, or during the group discussions, that a participant might reveal a situation, encounter or action that was unprofessional, illegal or distressing.</td>
<td>I am a professional adviser at the professional body for the profession of all participants. I have ten year’s experience in dealing with conversations with members of the profession who contact the professional body concerning sensitive, embarrassing and upsetting situations. As such I would refer to the professional body’s professional advice service, which can treat the matter in confidence, should the need arise.</td>
</tr>
<tr>
<td>11. The participants were asked to write a memory of an experience. They were advised to consider with some care which experience / memory they choose. They were asked to personalise their part in the text and to anonymise all other participants and locations in the text. As such the memory of real situations was remembered and so context-specific information shared.</td>
<td>The study offered the opportunity to reflect on their professional identity, how they present themselves at work. It was considered that to do this both on their own and in a supported group with others doing the same, may have given participants the chance to change how they behave, communicate, or respond to specific professional encounters. This may have meant they are better able to handle specific patient encounters or to handle professional dilemmas or problem situations. It may have provided participants with the mental space to reflect on workplace habits and professional attitudes they had come to adopt.</td>
</tr>
<tr>
<td>12. The nature of the study methods required participants to reveal in their written texts specific details about a memory.</td>
<td>The personal data of participants (for example, contact details) were stored on my work computer. This computer had a private drive to which only I (and potentially information technology staff) had access. All participants were asked to write their text in the third person, and to anonymise the names and locations of identifiable people and sites in the writing of their texts.</td>
</tr>
</tbody>
</table>
4.5.6 Research ethics and governance

Research ethics and governance permission from the University of Brighton Faculty of Health and Social Science Research Ethics and Governance Committee was gained on 23/01/09 (see Appendix 3). This permitted submission of the research study application to the online Integrated Research Application Service (IRAS). Local Research Ethics Committee approval was given on 17/09/09 (see Appendix 3). This approval was subject to agreement from the local NHS Research and Development Department to recruit NHS staff and use NHS facilities. Agreement from University Hospitals Bristol NHS Foundation Trust Research and Development Department to recruit NHS staff and use NHS facilities was received on 10/8/09. Permission from the University of West of England Research Ethics committee was given on 29/12/09\textsuperscript{31}.

4.6 Summary

This chapter has described the theoretical perspective adopted for the study. This perspective was one based on social constructionism. However a more sophisticated perspective was taken using the ideas of Critical Theory, based particularly on the work of the German social theorist, Jurgen Habermas. As I was a man researching a population of predominantly women, consideration was given to how to address the possible ramifications. A pro-feminist attitude

\textsuperscript{31} The slight discrepancy in dates reflects the difference between the date of meetings and the date I received letters / emails confirming decisions.
was adopted which sought to surmount some of the possible issues that could arise from this gender imbalance.

The research methodology of collective memory work was selected as a means of overcoming the subject-object divide that can exist in research. The nature of the research questions and the type of knowledge aimed at required close and careful communication with the participants. This chapter has described what other techniques might have been used and why CMW was selected. The two methods of theme board technique and CMW aimed to establish the participants as a group understanding and engaged with the study aims and objectives.

With this study I undertook an exploratory investigation of the personal experiences of physiotherapists of being a physiotherapist. The next chapter, Chapter 5, describes the research process, including who was recruited, the generation of data, and how this data has been analysed.
Chapter 5 Research process and data generation

5.1 Research process

I was interested to explore the nature of how members of a specific profession in the United Kingdom in the early years of the 21st century construct their professional identity. The challenge in devising the study was to remain true to the theoretical perspective and ideals as outlined in Chapter 4. The challenge in formulating a recruitment strategy was to attract interest from potential participants and then engage their commitment. Once recruited, participants engaged in a process of self-reflection. This permitted the opportunity for discussions of such reflections with others in an ongoing pursuit of more profound collective reflection and consideration of the processes and experiences the participants could recognise in their own reflections. In this chapter I explain how the participants worked together to address the research question. I also describe what data we generated and how I recorded, stored, and transcribed this, in preparation for analysis.

5.1.1 Recruitment

Participants were approached from the:

1. Local university - with the intention of recruiting academics and lecturers,

2. National retirement association for physiotherapists - with the intention of recruiting local physiotherapists who have retired from working life.

3. Local NHS hospital - with the intention of recruiting local clinicians.
4. Online national physiotherapy discussion website - with the intention of recruiting local participants not found through the previous routes:
InteractiveCSP – www.interactivecsp.org.uk.

5.1.2 Gaining informed consent

I replied to any inquiries from the web-based advert either by telephone or email, depending on what information the potential participant provided, to arrange a meeting. I contacted each potential participant individually by telephone to explain the study question, aims, and methods and to answer any questions potential participants had. Anyone expressing interest was given a verbal description of the study proposal and emailed a Participant Information Sheet, Informed Consent Form and a stamped, addressed envelope (see Appendix 4). All participants completed the Informed Consent Form and returned it by post to me or by hand at the first meeting.

Potential participants were assured their employment status would not be affected by their decision to participate. It was intended that this assurance could be established with their manager prior to the recruitment process. In the event, this assurance was not required, because the timing of meetings was outside of their employed time, and so had no effect on their employed situation.

Informed consent was secured from the participants after discussing the purpose of the research, its procedures, the possible risks and benefits, so they
understood and could make a voluntary decision whether to participate. Recognition of the potential for minor distress or embarrassment and potential changes to work practices following self and peer-reflection was included in this. I contacted each potential recruit between 24 hours and five days after they initially agreed to participate. They were asked again to confirm their wish to participate and offered the chance to withdraw.

I recruited seven physiotherapists to form a working group. The study participants were physiotherapists, five of whom were registered with the profession’s statutory regulator, the Health and Care Professions Council (HCPC), two were retired and had removed their name from the HCPC register. Including me, also registered with the HCPC, the data generation process had eight participants.

5.1.3 The participants

All participant names have been changed to a pseudonym as one means to protect their anonymity. Participants were aware of their pseudonym because these were used throughout the data generation process. I am included in the following list of participants.

1. Caroline was a retired female physiotherapist who specialised in obstetric and gynaecological physiotherapy
2. Chris was a 35 - 49 year old male physiotherapist working in community rehabilitation
3. Diana was a 35 - 49 year old female physiotherapist who has specialised in musculoskeletal outpatients
4. Emma was a 20 - 34 year old female physiotherapist undertaking band 6 rotations in an NHS secondary care provider
5. Helen was a retired female physiotherapist who worked in a wide range of general inpatient services
6. Louise was a 20 – 34 year old female physiotherapist working as a NHS research studies portfolio holder
7. Sue was a 35 - 49 year old female physiotherapist working in community rehabilitation
8. Vicky was a 50 – 64 year old female physiotherapist who works in a musculoskeletal outpatient clinic and also in private practice

5.1.4 Setting up the first meeting

Once informed consent had been gained, I negotiated with each participant on a convenient venue. An initial date was mooted and once all had agreed to this date the venue was booked. This was a private room at a local Quaker’s Friends Meeting House. A neutral venue was chosen (as opposed to one participant’s workplace) to reduce any difficulty a participant might have with someone else’s workplace, and to reduce any implicit hierarchies which might have invaded the group dynamic and formation.
The venue had easy car parking, good access for wheelchair users, tea and coffee-making facilities, toilets, and was secluded – to minimise the chance the meeting might be interrupted. The room was set up so that there were eight chairs, one for each participant, around a central table. As this was a public venue the furniture was of a type to withstand multiple uses, so a table cloth was thrown over the table, and plates of biscuits and fruit were available on the table. The intended effect was for the room and atmosphere to be welcoming and not intimidating, to help create a space where the participants would feel able to share their thoughts, experiences and ideas about physiotherapy.

5.1.5 The memory work meetings

The meetings were held fortnightly between January and June 2010 starting at 5pm, and generally lasting until 7pm. I proposed to the group that we agree how frequently we would meet, and suggested as a start, ten times. I thought this number would be sufficient for us to generate the data I envisaged needing. We discussed this, and decided that we would “see how things went”; anticipating that three cycles of the memory work (which might be nine meetings) was acceptable at this early point. See Figure 1, Flowchart of Study Process, overleaf.
Figure 1 Flowchart of Study Process

Department of physiotherapy

Recruitment of physiotherapists to study

Higher Education Institute

Retired Physiotherapist Association

TOPIC 1
1st cycle
1st mtg
Agree topic
2nd mtg
Discuss stories
3rd mtg
Analysis
Agree 2nd topic

TOPIC 2
2nd cycle
4th mtg
Discuss stories
5th mtg
Analysis
6th mtg
Emerging themes
Agree 3rd topic

TOPIC 3
3rd cycle
7th mtg
Discuss stories
8th mtg
Analysis
9th mtg
Emergent themes and conclusions
The content of each meeting is described in Appendix 5.2: Collective memory work meetings. Below I briefly outline the process the group took to generate the data.

Introductory exercise: creating theme boards

1. The participants were asked a question (‘how have you come to be the physiotherapist you are today?’)

2. Participants were asked to flick through magazines and cut or tear out pictures and slogans that they feel can be used to represent issues for discussion.

3. Each participant assembled the images on a flip chart page.

4. When all participants had produced their theme board I facilitated each participant to explain to the group how they had represented their ideas through the selected symbols. The seven theme boards are contained in the compact disc appended to the inside back cover of this thesis

5. Other members of the group questioned the points made, offered their own interpretations and considered the contributions of others in the group. This open expression of ideas through a pictorial representation was intended to allow a whole range of attitudes, beliefs and feelings to emerge and be explored, thus generating greater understanding of others’ perceptions of the same situation.

6. The theme boards were digitally photographed and used as part of the data for the study.

32 See Appendix 9 for a list of all the items included on the compact disc
7. The discussions about each theme board were recorded and transcribed, to form further study data.

Once this introductory ‘exercise’ of creating theme boards was completed, I led the group into the central method of data generation to be used for the study: collective memory work. The protocol for capturing and working with their memories, as described in Chapter 4, page 92-93, was explained. I then facilitated the group to take our previous discussion of the theme boards as a starting point for this part of the process and agree on what topic, or trigger / cueing theme, to write a memory.

We agreed our first trigger topic, Persona, and finished the meeting. In between this meeting and the next, we wrote our stories. When we next met, we read them out to each other, and then discussed them. I kept each memory text, and each discussion group meeting was recorded and transcribed. The transcriptions of each meeting were presented to all participants at each subsequent meeting and participants were asked to read and discuss these as a means for stimulating group reflections on the memory stories. The timeframe was important to facilitate vibrant group dynamics and so greater ownership, possible theorising, and self-reflection.

The participants needed reminding of the proposed process several times during the first few meetings. It was also negotiated at their first meeting that the participants would agree some ‘ground rules’ at their second meeting; one of
which included agreement permitting me to help keep the group discussions focused to the research question, see Appendix 5.3, p.274.

In light of these discussions the participants went away and returned a fortnight later. We met again and tried to draw out themes from our discussions of these memories. After the first reading of the texts the group mutually agreed on one as a starting point and the first impressions of the group were taken (asking for instance, “what does the author say their problem is? Which theories do they seem to have?”).

The exact timings of each meeting are detailed in Table 7, overleaf. A more detailed description of each meeting is attached in Appendix 5.2.
### Table 7 Outline of each CMW study group meeting (page 1 of 2)

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Attendees</th>
<th>Length of recording</th>
<th>Length of transcript (sides / words)</th>
<th>Topic of discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Caroline, Chris, Diana, Emma, Helen, Louise, Sue, Vicky</td>
<td>File 1* 36m 28s</td>
<td>6 sides / 3,730</td>
<td>Introductions; setting the scene</td>
</tr>
<tr>
<td>Two</td>
<td>Chris, Diana, Emma, Helen, Louise, Sue, Vicky</td>
<td>No recording</td>
<td></td>
<td>Theme board technique</td>
</tr>
<tr>
<td>Three</td>
<td>Caroline, Chris, Diana, Emma, Helen, Louise, Sue, Vicky</td>
<td>File 4 1hr 26m 59s</td>
<td>28 sides / 15,864</td>
<td>Discussion of theme boards leading to agreement of first trigger topic: <strong>Persona</strong></td>
</tr>
<tr>
<td>Four</td>
<td>Caroline, Chris, Diana, Emma, Helen, Louise, Sue, Vicky</td>
<td>File 5 1hr 48m 25s</td>
<td>36 sides / 19,300</td>
<td>Reading of Persona memory stories and discussion</td>
</tr>
<tr>
<td>Five</td>
<td>Caroline, Chris, Diana, Emma, Helen, Louise, Sue,</td>
<td>File 6 1hr 47m 38s</td>
<td>33 sides / 17,130</td>
<td>Discussion and analysis of the trigger topic Persona memory stories</td>
</tr>
<tr>
<td>Six</td>
<td>Caroline, Chris, Diana, Emma, Helen, Louise, Sue</td>
<td>File 7 2hr 6m 25s</td>
<td>33 sides / 15,420</td>
<td>Summarising Persona memory stories and choosing new trigger</td>
</tr>
</tbody>
</table>

* = the transcript only records part of the meeting. The first hour was not recorded because I wanted the participants to settle down, introduce themselves and get to know each other and me before recording them talking. I thought this would be off putting and might slow down the process of group formation.
<table>
<thead>
<tr>
<th>Meeting</th>
<th>Attendees</th>
<th>Length of recording</th>
<th>Length of transcript (pages / words)</th>
<th>Topic of discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seven</td>
<td>Caroline, Chris, Diana, Emma, Helen, Louise, Sue</td>
<td>File 8 1hr 48m 30s</td>
<td>26 sides / 13,644</td>
<td>Reading memory stories for trigger topic <strong>Lifestyle</strong></td>
</tr>
<tr>
<td>Eight</td>
<td>Caroline, Chris, Diana, Emma, Louise, Sue</td>
<td>File 9 11m 41s File 10 1hr 31m 54s</td>
<td>3 sides** / 1,528 21 sides / 9,859</td>
<td>Discussing and analysing the trigger topic Lifestyle memory stories</td>
</tr>
<tr>
<td>Nine</td>
<td>Caroline, Chris, Diana, Emma, Louise, Sue</td>
<td>File 11 35m 14s File 12 1hr 07m 59s</td>
<td>8 sides** / 3,803 4 sides / 2,186</td>
<td>Discussing and analysing the trigger topic Lifestyle memory stories</td>
</tr>
<tr>
<td>Ten</td>
<td>Caroline, Chris, Diana, Helen, Louise, Sue</td>
<td>File 13 1hr 45m 37s</td>
<td>27 sides / 14,575</td>
<td>Reading memory stories for trigger topic <strong>Career Choices</strong></td>
</tr>
<tr>
<td>Eleven</td>
<td>Caroline, Chris, Diana, Helen, Louise</td>
<td>File 14 1hr 47m 32s</td>
<td>28 sides / 15,392</td>
<td>Discussing and analysing the trigger topic Choices memory stories</td>
</tr>
<tr>
<td>Twelve</td>
<td>Caroline, Chris, Diana, Emma, Helen, Louise</td>
<td>File 15 1hr 35 20s</td>
<td>24 sides / 12,745</td>
<td>General discussion to round up meetings</td>
</tr>
<tr>
<td>Thirteen</td>
<td>Caroline, Chris, Diana, Emma, Helen, Louise, Sue</td>
<td>File 16 1hr 39 19s</td>
<td>Not transcribed</td>
<td>Discussion of conclusions and reflections on involvement in study</td>
</tr>
</tbody>
</table>

** = there are two files for this evening’s meeting. The tape recorder batteries ran out and had to be replaced. In doing so, I created a new file – no data was lost.
5.2 Transcription

5.2.1 Transcription process

Each meeting was recorded using a digital voice recorder\textsuperscript{33}. After each meeting this recording was transcribed using a word processing package on a personal computer. I undertook this process, to develop my familiarity with my data and to initiate my secondary analysis. The transcription process followed the transcription conventions described in Appendix 6. Each participant was given a pseudonym. Each meeting was transcribed onto a separate word document. Each line was numbered.

5.2.2 Transcription dilemmas

I listened to each recording several times during the process of making the transcription to check for accuracy and to try to clarify indistinct sounds / speech. I typed the words as they were spoken, that is, syntactical errors, poor grammar, moments of hesitation and the repetition of words were not corrected. I anonymised identifying features during transcription. This posed three dilemmas: about anonymity, about the symbolisation of oral language, and the management of my rights to anonymity.

\textsuperscript{33} Olympus® WS-320M Digital voice recorder
5.2.2.1 Anonymity

Deciding what to transcribe when a participant said the name of a specific hospital, city location or named physiotherapist arose as a matter to be decided. When participants have referred to specific hospitals, organisation, or individuals I have anonymised these.

On two occasions, I have kept the names of physiotherapists in the transcription. This is because I felt their inclusion did not abuse their right to privacy, that both held public positions and their inclusion in the informal story related by the participant was not pejorative, and that their inclusion added to the verisimilitude of the story.

5.2.2.2 Symbolising oral language in written form

The transcript was produced verbatim, with discourse markers, false starts, group responses (for example, [group laughter], [group chatter]), nonlexical utterances (for example, ‘mmm’, ‘erm’), and pauses included. In doing so I had to make decisions about how to present these and when and how to be consistent; here are two examples to illustrate how I did this:

1. On occasion a participant would say a short ‘mm’, at other times the nonverbal agreement would be elongated, ‘mmmmmmmm’; I decided that for the

---

purpose of this study I needed to record that agreement was made, and so I symbolised this with a consistent ‘mmm’.

2. Frequently more than one person would laugh. Often I was not able to distinguish the voice of the participants laughing. For the purpose of this study, I decided that I needed to record that a laughter response occurred and to symbolise this, so I have symbolised the act of this as [group laughter]. When one person laughed and I could distinguish who the participant was I have identified them, [named participant laughs].

In describing this detail to the process of transcription I have aimed to be transparent about the nature of the transcription process, to admit to the subjectivity of the transcription process, and thereby exemplify my epistemological position of social constructionism; another person could transcribe the same recordings, make different decisions about the transcription conventions, and produce a different transcription document.

5.2.2.3 Addressing my rights to anonymity as a participant

As I was the only man in the group, the use of the male pronoun identifies me. I have given myself a gender-neutral pseudonym.

On occasion, the discussion turned to my work and my employer. I decided that when this detail was included as a matter of course I would anonymise the organisation, and so protect its right to confidentiality. However, when it was
included in the discussion as any group of physiotherapists might refer to the national organisation, I have kept it in.

5.2.2.4 Creating the full transcription

The transcription of each meeting was copied to a second file. This created one full transcription.

5.3 Summary

This chapter has described the processes of participant recruitment and data generation according to the theoretical perspective, ideals and study design outlined in Chapter 4. Eight physiotherapists formed a collective memory group in order to engage in a process of self and group reflection. They met twelve times over a six month period and a thirteenth time six months after the final data generation meeting. I have described how the participants worked together to address the research question, what data was generated using collective memory work, and how this data was recorded, stored, and transcribed, in preparation for analysis.
Chapter 6 Data analysis

“Telling stories helps people to think about, and understand, their personal or another individual’s, thinking, actions, and reactions”

(Ollerenshaw & Creswell, 2002, p.329)

“To speak is one thing, to be heard is another, to be confirmed as being heard is yet another.”

(Martin, 1998, p.9)

6.1 Introduction

Data analysis proceeded in two phases. **Phase One** involved two stages. In Stage 1 participants responded to each memory story after it was recounted and discussed what it evoked for them. Stage 2 involved the group’s summative thematic analysis of all the stories told across the sessions. **Phase Two** took the form of secondary analysis, undertaken alone by the researcher after Phase One was complete. Phase Two comprised two stages. In **Stage 1** (described in this chapter) the raw data of the memory group meetings’ transcriptions were read, reflected upon, and a systematic structure for analysis determined, that was coherent with the study aims, and that would enable an interpretation consistent with my philosophy for the study. Following this, in **Stage 2**, detailed interpretive analysis was carried out. This process is described in Chapter 7.
The data consisted of personal theme boards and private memories that the participants were facilitated to create, the transcriptions of recorded group discussions, and any notes the participants and researcher generated during the process of discussing and analysing the theme boards and memories:

1. Transcription of the 13 collective memory meetings
2. 7 personal theme boards
3. 21 personal memory stories

The seven personal theme boards are contained on the compact disc (CD) which is included in the inside folder at the back of this thesis. Construction of the theme boards was an introductory exercise designed to engage the participants in the study, to help ‘break the ice’, and to facilitate their initial reflections on their professional identity. Overleaf, page 127, is one of the theme boards, provided as an example of what one participant created. The 21 personal memory stories are contained within the full transcription, and listed in a separate Word file included on the CD, called Memory Stories.
Picture 1 Theme board

35

Original in colour
6.2 Phase One: Stage 1 - Participants’ discussion of each memory story

The methodology encouraged analysis to occur within the participant group as we collected data, indeed it was part of the same process. At each session, individuals read their own memory story aloud; this memory then provided the focus for subsequent discussion, which aimed to de-emphasize the author by using their memory to draw out “popular conceptions, commonalities, shared experiences, and differences” (Crawford et al., 1992, p.49). However, drawing conclusions or summarising our collective thinking proved difficult. The group shied away from drawing conclusions and from explicitly making meaning from what had been discussed. There was a tendency to sum up discussions in terms of what is a physiotherapist rather than what it is like to be a physiotherapist, or what stories we have been telling ourselves about being a physiotherapist. We found that Stephenson’s (2005) description of the memory-work groups in which she had been a participant researcher could apply equally to this research: “We are a diverse group of people who exercise agency and resistance in different ways, who find commonalities as well as differences between us” (Stephenson, 2005). As such the group struggled to move from concrete examples of practice experiences to what this means or meant and what we might conclude from them. We also found that the natural tendency of the participants was to ask the participant who had just read their story more questions about their story: what else happened, why, what were they thinking?
6.3 Phase One: Stage 2 - Participants’ summative analysis

The written memories as defined in Chapter 4, page 92-93, comprised the main data. These provided the basis for the group’s summative theorising and analysis. However other stories were generated during the memory-work process, which were different in form to the memories. They were spoken in the first person as opposed to written in the third person, they did not have the uncensored detail of the written memories, and they were sometimes accompanied by justification, description and explanation. This telling of stories during the analysis of the written memories occurred because the research process evolved in such a way that permitted this to happen. Telling stories is a way in which people attempt to make sense of their lives, and understand the self in relation to others and wider social structures (Riessman & Quinney, 2005). Stories told in response to a previous comment show how people were explaining and understanding their experiences and the discussion.

Discussion stopped when the group decided that they had explored all avenues of the wider social issues as represented across the texts, including comparison of the similarities and differences between the stories prompted by a particular trigger. After the participants had worked through three cycles of collective memory work it attempted to summarise its group conclusions. One participant, Diana, wrote out a draft mind map and the group commented on this and amended it. Diagram 1, overleaf, is the mind map.
Diagram 1 Participants’ mind map of themes emergent across the texts

- "Can do"
- Boundaries
- Opportunities
- "9-5" Term time
- Personality type
- Post qualification career choice
- Lifestyle
- Joiners
- Confidences
- Common sense
- Gut feeling vs. experience
- Determination and fight
- Influential people
- Overseas
- Communication skills
- Buzz
- Push - Pull
- Feeling appreciated

The original was drawn in pencil and didn't scan clearly, so this is a representation.
6.4 Phase Two: Stage 1 – Finding an analytic structure

The group theorised at what Haug (1987) called the “first level of analysis”. This is selecting the memory, choosing the words for the memory story, and then discussing the story with the group (Haug et al., 1992, p.22). The originators and early adopters of the methodology were in a position as academics to spend several years undertaking the method of data generation and analysis. These originators and early adopters appeared to be comfortable with the inclusion of theory into discussions of their memories and had a professional investment to drawing out meaningful conclusions (for example, Crawford et al., 1992; Haug et al., 1987). The experience of the CMW group I had assembled was similar to Ingleton (2007) in that the group was interested in the sharing and understanding of experiences, and less prepared for theorising at an abstract level (Ingleton, 2007). We also did not share the same academic goals of thesis writing or publication (Ingleton, 2007).

In order to develop a thesis which is my own I had to move beyond the limited collective conclusions we drew and undertake further analysis of the dataset. This demanded a more systematic analysis that the group was able to undertake, an analytical approach that sought to “preserve the spirit of the collective work” (Oinas, 1999, p.268). Therefore, the group was not involved in this second level of theorising. Interpretation in qualitative research should be believable, made so, in part, by systematic procedures, transparency and openness. The focus of this chapter and the next is to provide transparency to the systematic handling of the data, its analysis, and finally interpretation.
Various measures were taken to ensure the robustness and relevance of the data generated, and these are described here.

I started with thematic analysis, as planned, according to the process described by Braun and Clarke (2006). I collated the transcription of each meeting into one computer file and printed this. This was 294 pages of text. I read the transcription of each meeting, correcting typing errors while listening to the tape simultaneously. This meant I attended the meeting, spent roughly 30 hours transcribing each meeting, read and re-read each transcript several times during the process of generating the transcript. I then started my more formal analysis with several close readings of the transcripts. Using different colour highlighter pens, I tried to highlight passages, attempting to identify possible codes, categories and phrases that struck me as likely to be “significant”. While doing this, I noted and highlighted other topics that were apparent throughout most of the stories. I became aware of a creeping anxiety that cutting and pasting words and phrases was too arbitrary and reductionist. I then realised I was making judgments about the participants, which topics I should highlight, and which I should ignore. I became concerned that I would exclude some important passages because of physical limitations in handling the stories or my personal preferences of choices, too soon in the process.

These prolonged attempts at looking for data units of meaning, ‘finding’ codes, categories and then eventually themes, left me feeling that the voice of the participants was becoming lost. Other doctoral researchers using this
methodology have tended to limit the collective analysis early on and then undertake thematic analysis; to code, group, categorise, thematise and check. However, I became concerned that this approach was in danger of burying the voice of the participants beneath my analysis and thereby reverting to a subject / object divide, which I had explicitly sought to overcome.

The heart of the conversations, how participants worked to make meaning from the stories they had personally remembered and written up, was becoming lost. The value and purpose of collective memory work, the collectivism, the combined personal and group reflections, was in danger of becoming invisible or forgotten. I therefore sought an alternative means of data management as a means to help me engage with the data generated. This might also help me make sense of it.

I undertook the thematic analysis between the twelfth and thirteenth meetings. This was a gap of six months. However, I felt both prior to this thirteenth meeting and afterwards, that I had not satisfactorily reflected the collective discussions, or progressed sufficiently with the analysis. I felt I had an ethical responsibility to present the stories of my participants in an engaging way. I had initially tried thematic analysis. I have therefore chosen to re-present the stories in poetic form, as a more evocative data management process and then undertake a narrative analysis.
6.4.1 Data management: poetic re-presentation and crafted dialogue

Poetic re-presentation is a method of presenting research data, especially participants’ stories, to answer research questions (Butler-Kisber, 2002). The method involved crafting the transcripts in a caring and relational manner. This maintained the voices of the participants; retained the nature of their discussions, and created an evocative text. It also permitted me to focus on the meaning the participants made of their experiences.

Traditional reports of qualitative data can produce a “detached, categorical account” of a phenomenon (Carroll et al., 2011, p.628). The result of this can be to prioritise the researcher’s point of view and values rather than study participants. Consequently, participants might end up disenfranchised as the context, personal meanings, and feelings of their narratives become lost. Brady (2004, p.622) argued for a combination in research of “humanistic and scientific design”, for “artful-science” (Brady, 2004, p.622). Such arts-based techniques utilise a humanistic framework focussing on individual narratives, emotional experiences, and values, privileging the integrity of participants (Carroll et al., 2011). Clarke et al. (2005) suggested that combining structured analysis with representations of study participants in a series of prose poems is “artful science,” offering “a different window into the lives of the study participants” (Clarke et al., 2005, p.913). Richardson (1994) has used the metaphor of a crystal to explain the value of this approach. A crystal, which, with its many faces and angles, is multi-dimensional and multi-directional, and reflects and refracts light depending on ‘our angle of repose’ (Richardson, 1994, p.522).
Increasingly researchers have used poetic representation as the sole means of presenting research data (for example, Furman, 2006; Furman et al., 2006; Richardson, 1997). Poetic representations have been referred to as poetic transcription (Glesne, 1997), poetics (Brady, 2004), prose poems (Clarke et al., 2005). Such researchers have used this technique to present data that remains faithful to the text, experience, or phenomena. Using this technique has enabled me to present the data I generated in an accessible way, that I found engaging, and to do this ethically, pragmatically and transparently. This is ‘found poetry’ or crafted dialogue. I crafted the poems out of the transcripts, where their memory stories initiate the discussion.

6.4.2 Procedure for organising the data

The transcripts from all the collective memory work meetings were added together to form one long transcript of 294 pages. I cleansed this of typographical errors, inconsistencies of spelling, font, and style. I then extracted the text from this whole as follows:

1. I extracted each memory story and the discussion about it into a new Word document.

2. If the participants read several stories sequentially, I extracted these together as well as the discussion that followed.

3. I searched the whole transcript for any further references to a particular memory story or any further reflections about the previous discussion. I also transposed this text to the new Word document.

4. I repeated Steps 1-3 for all the other stories evoked by the trigger story. For the first trigger topic, Persona, there were eight stories; for
the second, Lifestyle, there were seven stories; for the third, Career Choice, there were six stories. See Box 1, page 138.

5. This enabled the creation of a single text that contained one memory story and all discussions that related to it.

6. I then re-presented in poetic form the newly created text:

   a. The prose (from the transcript) was arranged into simple poetic form

   b. Believing that in poetry every word counts, decisions were taken as to whether to leave or omit words when they added or detracted from the poetic flow; for example, conjunctions such as ‘and’, ‘that’, ‘but’ were removed; as were redundant phrases, for example, ‘kind of’, ‘sort of’, ‘I think’; responses such as ‘yeah, ‘yes’, ‘no’ (in agreement), when they do not add to the flow of the discussion or the crafted dialogue

   c. Other words or phrases were deleted: ums, stammered words, words begun and not continued, transcription comments [for example, (laughs); (pause); (group laughter); (group nods)]

   d. No words were added

   e. Some personal linguistic styles were retained as these reflected individual participants’ natural speech and added to the verisimilitude of the poetic form

   f. I have tried to be guided by breath points and spoken rhythm

   g. I added full stops and capital letters (at the start of each line) to enhance meaning, and quotation marks to highlight quoted speech.
h. I created a title for each poetic representation / crafted dialogue.

Either this title was a direct quotation from the discussion or I coined what was for me a memorable phrase.

In this way, I retained the primacy of the voice of the participants over me. I also maintained the tenor of the discussion and the work of speech acts as participants sought to make meaning in the discussions. Box 1, overleaf, shows the relationship of the crafted dialogues to the original transcription.

With this data management technique, I established a dataset over which I had tighter control. I also felt that I was remaining true to the epistemological position I had adopted.
Box 1 Relationship of the original transcription to the memory stories and crafted dialogues

<table>
<thead>
<tr>
<th>Narrator</th>
<th>Crafted dialogue</th>
<th>Narrator</th>
<th>Crafted dialogue</th>
<th>Narrator</th>
<th>Crafted dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen</td>
<td>The dying man</td>
<td>Emma</td>
<td>The wandering woman</td>
<td>Emma</td>
<td>No crafted dialogue generated</td>
</tr>
<tr>
<td>Sue</td>
<td>Scary Sue</td>
<td>Helen</td>
<td>No crafted dialogue generated</td>
<td>Diana</td>
<td>Finding my niche in outpatients</td>
</tr>
<tr>
<td>Vicky</td>
<td>That doubt phase in your third year</td>
<td>Sue</td>
<td>No crafted dialogue generated</td>
<td>Louise</td>
<td>The job interview</td>
</tr>
<tr>
<td>Diana</td>
<td>Weekend working goes wrong</td>
<td>Louise</td>
<td>My mother, my family and me</td>
<td>Caroline</td>
<td>The transformed spare bedroom</td>
</tr>
<tr>
<td>Louise</td>
<td>This intimidating patient</td>
<td>Diana</td>
<td>No crafted dialogue generated</td>
<td>Sue</td>
<td>What makes me tick</td>
</tr>
<tr>
<td>Emma</td>
<td>The Christmas show</td>
<td>Caroline</td>
<td>War torn Africa</td>
<td>Chris</td>
<td>The patient and the pizza</td>
</tr>
<tr>
<td>Caroline</td>
<td>On call apple</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chris</td>
<td>Wanting to give a good impression of the profession</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I created seventeen crafted dialogues. Below I present one of the memory stories with its accompanying crafted dialogue. This is to maintain the voice of the participants ahead of me, and provide an insight into what the memory stories and the crafted dialogues looked like.

6.4.2 Example of a memory story: 2 – 1: Emma

“Emma and her physio flat mates had had a hard week at work. They had all recently rotated and subsequently been reading up on various topics to get them through the day. It was always interesting to rotate into new teams – different dynamics and working styles. Sometimes a good thing but always exhausting until you’d found your feet. They’d chat about the day by the lockers making sure the people they were talking about were out of ear shot or save it for the lift home. The usual smell of socks and a set of scrubs bundled in the corner. Often the conversation spilled over into after work tea and biscuits in the kitchen. Tonight, the juniors were meeting up for drinks and a boogie, so the post work analysis was cut short to make way for early dinner and a glass of wine. The three headed out of the flat at about seven, it was almost dark. The meeting place wasn’t too far away and their heels weren’t too challenging so they decided to walk. Heading down the main road, an old lady came up to Emma and asked her the way to the outpatient clinic – handing her a clinic letter. The letter was for an appointment the following week in the morning. The lady was anxious and confused. The three calmly explained where she was and that it was a Friday evening. The clinic letter revealed that the lady only lived around the corner, so they walked the lady back to her flat. Having dropped her off, Emma couldn’t stop worrying about the lady – the scenario and the best course of action was indeed a topic discussed over drinks. She had noted the GP and clinic from the letter and didn’t feel completely happy until she’d contacted them to explain what had happened. When speaking to the surgery, they chuckled – “arh... Mrs. X... yes, she’s done that quite a few times – not to worry dear”. Emma was relieved, but still voiced concern. Emma hasn’t seen the lady since.”

6.4.3 Example of the accompanying crafted dialogue: The wandering woman

<table>
<thead>
<tr>
<th>Emma</th>
<th>Work hard; play hard, but never switching off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sue</td>
<td>Not sure if that’s a good thing or a bad thing</td>
</tr>
<tr>
<td>Helen</td>
<td>You learn to switch off</td>
</tr>
<tr>
<td></td>
<td>To a certain extent</td>
</tr>
<tr>
<td>Sue</td>
<td>Some people just push your buttons for some reason</td>
</tr>
<tr>
<td>Chris</td>
<td>What you were saying there is</td>
</tr>
</tbody>
</table>
You'd done your moral duty - to take her somewhere safe
Were you still worrying about it?

Emma
All night
We understood the implications:
Hit by a car
Panicking; wandering the road on a Friday night
Asking people when her clinic appointment was.
---

Sue
I wonder whether most of society would notice
Someone in need
Because of our knowledge and training
Perhaps we could recognise that a little old lady,
Why she might be confused,
Other people might think she’s drunk or batty
Might dismiss it from that point of view
You thought "oh, I wonder why..."
That set you off on a train of thought

Emma
You’re used to dealing with confused ladies
Know how to deal with them,
Someone might want to intervene but not be sure how to

Louise
You know the knock on effects,
You can see the potential things that might happen to her.
You don’t just think “mad old lady, wandering around”
You can see all the extra things that might happen to her.

Caroline
And you know the system too,
You know the system and how to get help to her.
---

Chris
The reason you as a group continued to talk about it
Was because it wasn’t quite resolved?
We deal with this often with our patients
If you had been able to take her home,
See her into the house, check the gas was turned off

Emma
We did take her home

Chris
Why were you continuing to talk about it?

Emma
It’s just clarifying that you’ve done the right thing,
It’s just clarification and confirmation that you've done the right thing
by everybody else
That they were physio's as well makes it easier

Diana
The humanity which means anybody could have seen there was a need
You wouldn’t have had to be medically trained
All you had to be was a good person
With a degree of humanity
To see this lady was in the wrong place
Needed to be taken home
The second thing was that you took it a step further
You made the extra effort to contact the surgery
Perhaps someone non-medical, non-trained
There was two extra miles
Which you did as part of your professional training
Which perhaps you might not have done
If you had not had the training or any medical training
That's the way I look at it

Sue
Would you have done the same if you had been with other friends
Who weren't physio's?
Emma: It wouldn’t have been so easy
Sue: Would you have worried about it?
Emma: Probably would have been worrying about it more
I wouldn’t have been able to offload
It wouldn’t have changed my actions
Chris: “Worrying whether I’d done the right thing”?
Caroline: It was obvious to me you’d done the right thing
Emma: Yeah, I suppose so.
Sue: What do you think might not have been right about it?
Emma: I did do the right thing,
But you always worry:
She’s gonna get back out again
Should you go to the family to make sure she’s all right?
She’s not going to go back out again
But that’s overstepping the mark
I’m not going to go in and cook her dinner,
She was quite happy for us to come in and have a coffee
She opened her bag and took her keys out
“I don’t know where I am”,
We tried to re-orientate her: “please stay in”
Louise: Is there a vulnerable adult-type obligation?
Emma: Yes, which is why I rang the GP surgery
They were so blasé
“Oh, it happens all the time,
Don’t worry about it”
Louise: So she opens her house to someone she doesn’t know?
Emma: Yeah, “so she’s a crazy lady don’t worry”,
Yeah, that didn’t exactly put my mind at rest!
I don’t know anything about her
So it’s not really my place to start arguing with the GP
Diana: It’s opened your eyes to something
Not in your control and you are in their world
That can be scary
You see what can be done or what needs to be done
But you are powerless to do anything about it
There’s a lot of stuff out there that is actually very horrible
Sue: Welcome to the life of the community physio
Diana: If you thought hard about a lot of the stuff you see
You wouldn’t sleep at night!
Sue: Oh I know!
I might have taken her home but
Not have worried about it quite as much,
Possibly
Emma: I was a junior with a lot of fairly newly qualified physio’s too
Chris: The story is professionalism, straight honesty
Things like that, respect for an older person in society
A vulnerable person in society,
Anybody can be that but not everybody is
That was missing from the story when you expressed it
I think that’s important
She really was quite vulnerable
You had had quite an insight into that vulnerability
When she was at home she opened the door
You could have walked in
Sue: Or you could have been three not-so-scrupulous people
Who biffed her over the head
Stole her money and, burgled her flat,
You didn’t, obviously!

Chris
This story is something I recognise
In a world where there are opportunities
You have to be honest
One of the things is honesty, scrupulous respect for others,
Perhaps it’s so obvious

Emma
You need to know when to switch off
Cope with anxious thoughts
When I was working on intensive care I couldn’t switch off
I just found it so overwhelming
There were people my age on ventilators and in horrendous conditions
I still don’t like it
Although I have to
I’m on call
There are people who can do that day in day out
Not think about it
Not worry about it
It is about coping with your boundaries
What does go on in your head

Louise
I used to leave intensive care thinking
Did I remember to say that to the nurse?
Did I remember to say that to the patient?

Emma
I think the nurses are so good
It didn’t really matter in terms of environment
I probably worry more about this
I tend to think about it too much,
It upsets me I suppose,
That’s what it is,
I can’t get my head around it.

Sue
When you are as young as you are
It’s your mortality in your face,
It’s “there but for the grace of god”
Circumstances, it could be you,
That’s horrible, I think,
Maybe that’s the first time you’ve come up against it, I don’t know,

Emma
Yeah, I’ve never done intensive care as a student,
So yeah, my first rotation,
To suddenly have this burns patient
Inflicting horrendous amounts of pain,
“What are we doing?”
We shouldn’t be playing God in this situation,
The patient died,
There were a couple of really heavy burns
I couldn’t get my head around that

Caroline
I used to find ITU horrific because I was looking upon it
From the point of a mother

Sue
Yes!

Caroline
“What are the parents feeling?”

Sue
We’ve talked about empathy
That’s empathy, isn’t it?
I find myself thinking the people about my age
Could be me
People with MS,
Those are the ones that push your buttons

Caroline
That's perhaps where we differ
We go in there with a job to do,
Bagging or whatever it might be
Its empathy not sympathy
For the layperson, it will be pure sympathy
Wouldn’t it,
You feel so helpless
At least we have a specific job
And we can do it well

Louise
We’re confronting human tragedy
Experiencing what could happen
We have to inwardly digest and
Deal with that and
Come out the other end as a normal human being

Emma
You said for you it was completely draining

Chris
For physio’s at times we are very much central to the situation
In a very controlled environment, so burns, ITU, where we feel more
peripheral, marginalised.
At times so what we do / don’t do becomes
Less vital, perhaps
And other situations where it’s uncontrolled
Where we feel very responsible
How much one can cope in different situations
We have to accommodate -
At time we can and at times, we can’t

Emma
People who work in acute love the adrenalin rush
The stress
I would go “Oh, no thank you – I would rather be in a nice rehab
situation”
What it means for me to be happy in my job
And the levels of boundaries and empathy
Would be different to someone else

Louise
It’s also about being adaptable in terms of where our role sits
Like you were talking about
The central, key thing
But also at times the more marginal
For the patient, the client,
Even in one particular specialism physio can be
Very marginal or very key
For you as an individual
Being the individual
You have to be able to adapt and understand your role,
Your priority within each different client’s experience
It’s very different; it’s quite an emotional skill
To be the key person,
Pressure’s on you
Your comments are really vital
The next patient your comments are irrelevant
Often as physio’s we’re still involved
Just in a smaller way.
Table 8, below, provides the name of the narrator of the memory story, the number I have ascribed to it, the title of the crafted dialogue generated out of the ensuing discussions, and a brief summary.

Table 8 Summary of crafted dialogues (page 1 of 2)

<table>
<thead>
<tr>
<th>Memory story</th>
<th>Title of crafted dialogue</th>
<th>Summary of the memory story and nature of the crafted dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Persona</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Helen</td>
<td>The dying man</td>
<td>Conveys a sense of anxiety about autonomy; about how we communicate with colleagues, and how we can be the authors of our own anxieties</td>
</tr>
<tr>
<td>1.2 Sue</td>
<td>Scary Sue</td>
<td>Represents how we use everyday conversation to challenge the myths and misperceptions of the profession to either collude in or overcome our own sense of misrecognition</td>
</tr>
<tr>
<td>1.3 Vicky</td>
<td>That doubt phase in your third year</td>
<td>Vicky’s student story of how the approach of a practicing clinician and patient inspired her</td>
</tr>
<tr>
<td>1.4 Diana</td>
<td>Weekend working goes wrong</td>
<td>The ambiguity between personal competence and confidence and working as part of a team with less experienced colleagues; how do we help staff strike the balance between the two, and secure a moral grounding for ongoing practice</td>
</tr>
<tr>
<td>1.5 Louise</td>
<td>This intimidating patient</td>
<td>Illustrates some difficulties of being a novice coping when an expert patient challenges one’s sense of professional knowledge and skill: how patient-centred are we?</td>
</tr>
<tr>
<td>1.6 Emma</td>
<td>The Christmas show</td>
<td>A sense of freedom to try different ways of engaging and being in a rehabilitation unit: her professional sense of delivering ‘traditional’ patient – therapist interventions and the show which engaged the patient in a different way</td>
</tr>
<tr>
<td>1.7 Caroline</td>
<td>On call apple</td>
<td>Demonstrates how Caroline uses her sense of professionalism to cope in an unusual and stressful situation; the group discuss the ethics of accepting call-in’s and this goes to the heart of how the profession or a service markets itself to other professionals</td>
</tr>
<tr>
<td>1.8 Chris</td>
<td>Wanting to give a good impression of the profession</td>
<td>Represents Chris’s anxiety about being himself in the workplace and having a voice and being permitted to voice his opinions</td>
</tr>
<tr>
<td></td>
<td>Memory story</td>
<td>Title of crafted dialogue</td>
</tr>
<tr>
<td>---</td>
<td>--------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>Lifestyle</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Emma</td>
<td>The wandering woman</td>
</tr>
<tr>
<td>2.4</td>
<td>Louise</td>
<td>My mother, my family and me</td>
</tr>
<tr>
<td>2.6</td>
<td>Caroline</td>
<td>War torn Africa</td>
</tr>
<tr>
<td>2.7</td>
<td>Chris</td>
<td>Postgraduate training</td>
</tr>
<tr>
<td><strong>Career choice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2</td>
<td>Diana</td>
<td>Finding my niche in outpatients</td>
</tr>
<tr>
<td>3.3</td>
<td>Louise</td>
<td>The job interview</td>
</tr>
<tr>
<td>3.4</td>
<td>Caroline</td>
<td>The transformed spare bedroom</td>
</tr>
<tr>
<td>3.5</td>
<td>Sue</td>
<td>What makes me tick</td>
</tr>
<tr>
<td>3.6</td>
<td>Chris</td>
<td>The patient and the pizza</td>
</tr>
</tbody>
</table>
6.4.4 Analysis of the structure of the memory stories

Mishler (1999) influenced the analytic approach I used. I have examined the structure, form and interaction of the memory stories and their accompanying crafted dialogues with the understanding that they link inextricably (Mishler, 1999).

I identified the structural properties for each memory story according to the structure described by Labov and Waletzky (1966). Labov and Waletzky (1966) argued that in telling a narrative, the narrator is setting forth a viewpoint via an oral account of an experience, with the personal meaning of the events made explicit in the evaluation (Labov & Waletzky, 1966). Riessman and Quinney (2005) noted that the “temporal ordering of a plot is most familiar” and responds to “a Western listener’s preoccupation with forward marching time” (Riessman & Quinney, 2005, p.394). I shared this familiarity; though I appreciate this would not be a universal response. By identifying the parts of the narrative according to the Labovian structure, I focused my attention on the Evaluation.

In each narrative, I identified and marked the structural parts, as outlined in Table 9, overleaf. See Appendix 8 for an example of how this was undertaken.
Table 9 to show the structure of the Labovian analysis

<table>
<thead>
<tr>
<th>Structure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation</td>
<td>This introduces the audience to the necessary background for the narrative. Characters, time, physical and social settings are mentioned or more fully described.</td>
</tr>
<tr>
<td>Complication</td>
<td>After the orientation, (usually) the narrator introduces a complication, which may be small, such as an occurrence of interest or it may be more significant, such as a problem, a crisis or a turning point.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>The evaluation conveys the meaning of the narrative to the listener. The evaluation will also reveal the attitude of the narrator towards the narrative.</td>
</tr>
<tr>
<td>Resolution</td>
<td>The resolution of the complication normally follows the evaluation, according to Labov and Waletzky. Here the narrator reveals the outcome of the events.</td>
</tr>
<tr>
<td>Coda</td>
<td>The narrator may signify the end of the narrative by adding something that brings the narrative and the audience back to the present moment.</td>
</tr>
</tbody>
</table>

(Based on Taylor, 2008)

6.4.5 Analysis of the form of the memory stories

The connection between the memory stories which portray accounts of experiences, their meanings, and the construction of identity, was developed by considering the crafted dialogues as “interactive and dramatic” (Taylor, 2008, p.84). I did this by creating a list of questions based on the work of Taylor (2008). Table 10, overleaf, lists the questions used to structure this stage of the data analysis. See Appendix 8 for an example of how I have undertaken this.
Table 10 Analytical structure of the form of the memory stories

<table>
<thead>
<tr>
<th>Form</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>Where does it take place?</td>
</tr>
<tr>
<td>Time</td>
<td>When did it take place?</td>
</tr>
<tr>
<td>Actors: Protagonist and Others</td>
<td>Who are the actors?</td>
</tr>
<tr>
<td>Sequence of events</td>
<td>Are they told in chronological order?</td>
</tr>
<tr>
<td>Action / Plot</td>
<td>What is the plot?</td>
</tr>
<tr>
<td>Consequence</td>
<td>Is there a moral point; has there been a transformation? For what is the story a vehicle? Why did the protagonists do what they did?</td>
</tr>
</tbody>
</table>
(Based on Taylor, 2008)

6.4.6 Analysis of the content of the memory stories and crafted dialogues

Mishler centred his analytical techniques on the idea of narrative as praxis (Mishler, 1999). This is that personal narratives as socially situated actions, identity performances and fusions of form and content (Mishler, 1999). Habermas (1984, 1987a) and Mishler (1999) suggest the interactive processes between speaker and listener can convey meaning. The coherence of the narrative helps the analyst to see “how the participant has constructed the story” through attention to contradiction, themes, patterns of speech, and metaphors.

Cousin (2009) has provided some concrete focus to this approach: Contrastive rhetoric in which a speaker “counter-poses” a statement with a binary opposition. This can illustrate “how people structure their experiences, views and choices” (Cousin, 2009, p.47). Opposition talk in which people contrast themselves with others (Cousin, 2009) in order to, as Savin-Baden (2004) suggests “define themselves in terms of what they are not” (Savin-
Baden, 2004, p.372) or set up an opinion or stance by “defining themselves in opposition to others and their stance” (Savin-Baden, 2004, p.372). Analysis of the use of **membership categorization** permits consideration of the “characteristics speakers have assigned to people (Cousin, 2009, p.47).

**Stake inoculation** is the use of a phrase to “manage the contentiousness of a statement” (Cousin, 2009, p.48); for example, “I dunno” permits a speakers to say both what they want to say and to secure themselves from being tied to this position (Cousin, 2009). **Metonymy** is a figure of speech in which a concept is not called by its own name, but is invoked by connecting it to something that is closely associated with it; for example, ‘Westminster’ is used to denote the UK parliament. **Respondent generated metaphors** are figures of speech used by participants that provide clues as to how they “see things” (Cousin, 2009, p.48); a metaphor is used when a word or phrase is applied to an object or action to which it is not literally applicable.

Based on the work of Cousin (2009) and Taylor (2008) I constructed Table 11, overleaf, to guide a systematic scrutiny of each memory story and accompanying crafted dialogue. I attended to both the content and the discussion between the participants. Appendix 8 provides an example of how this was undertaken.
Table 11 Analytical structure of the content of the memory stories and crafted dialogues

<table>
<thead>
<tr>
<th>Content</th>
<th>Why is this included?</th>
<th>Do we see elaboration, contrast, explanation, consequence?</th>
<th>Any metaphors?</th>
<th>Do we see repetition of words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coherence / lack of coherence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a link between the narrative and the crafted dialogue?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims to identity?</td>
<td>Direct claims: I am...</td>
<td>Indirect claims: they're not like me... (contrastive rhetoric, opposition talk, membership categorisation?)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What values / beliefs does the speaker express explicitly or implicitly?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do these values / beliefs relate to the values of the prevailing culture and cultural metanarratives?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Am I using my own knowledge/understanding of our shared culture to help elicit meaning?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the impact of the meeting as context for what the participants are doing?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What does this tell me about what it means to be a physiotherapist?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6.5 Summary

This chapter has described the processes undertaken for data generation and analysis. Data analysis proceeded in two phases. **Phase One** involved two stages. In Stage 1 participants responded to each memory story after it was recounted and discussed what it evoked for them. Stage 2 involved the group’s summative thematic analysis of all the stories told across the sessions.

The data consisted of the transcriptions of recorded group discussions and any notes the participants and researcher generated during the process of discussing and analysing the theme boards and memories. **Phase Two** took the form of secondary analysis, undertaken alone by the researcher after Phase One was complete. Phase Two comprised two stages. In **Stage 1** (described in this chapter) the raw data of the memory group meetings transcripts were read, reflected upon, and a systematic structure for analysis determined that was coherent with my study aims, and that would enable interpretation consistent with the philosophy of the study. Following this, in **Stage 2**, detailed interpretive analysis was carried out. This process is described in Chapter 7.
Chapter 7 Constructing meaning from these stories

Having found a way to interrogate the data through analysis of three aspects of it: structure, form and content I then asked what is this all saying? What are the participants doing when we talk like this? Hence, this chapter describes Phase Two: Stage 2 of the analytic process in which I attempt a detailed interpretation of the memories in the context of my research question, what does it mean to be a physiotherapist?

7.1 Phase Two: Stage 2 – interpretation

The memory stories present a convincing range of individual experiences that shed light on the professional experiences of participants, physiotherapists. The crafted dialogues offer insight into the discussions and are, in and of themselves, valuable. Reading the data set in different ways promotes different responses. When read one after the other, the memory stories are clearly comparable in some aspects but very different in other ways. However, when each is read and then followed by the crafted dialogue, the reader gains a sense of the flow of conversation and attempts at understanding, meaning making and interpretation the group made.

The response to my questions posed above is to surmise that we were sharing ethical dilemmas and through these showing / demonstrating our professionalism and commitment to the profession.
7.2 Identity claims embodied through ethical dilemmas

“Identity is commonly construed in terms of subjective experience. Hence we may speak of a ‘sense’ of being a particular person, or a ‘sense’ of belonging to a particular community. Our focus here is not identity as something experienced so much as identity as something performed or enacted. Rather than focussing on who people say they are or what they say they feel, it asks what people do in order to be someone”

(Jordens & Little, 2004, p.1643)

Story 2.1 and its accompanying crafted dialogue, The wandering woman, contain an important discussion about the presence of ethical dilemmas in being a physiotherapist. The wandering woman illustrates an unresolved anxiety about the limits of personal agency in social ethical dilemmas, the need for intersubjective discussion about acceptability, and for the profession, creating space to air and share these issues.

7.2.1 Identity claims

Identity consists of “individual dispositions, such as attributes, beliefs, values, motives, and experiences” (Lapointe, 2010). My analysis unearthed identity claims made as the participants addressed themselves to these ethical dilemmas. These were claims made by the participants to support a position or belief. In Table 12, overleaf, I list a few of these. This list shows some examples of the range of identity claims that participants made, illustrating the range of techniques the participants used to make these claims.
<table>
<thead>
<tr>
<th>Story / CD</th>
<th>Identity claim</th>
<th>Analytical technique</th>
<th>Contribution to identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The patient and the pizza</td>
<td>“He felt this was meaningful rehabilitation”</td>
<td>Oppositional talk: as opposed to what the ‘rehabilitation staff’ thought, presumably that such was not meaningful; said with some frustration</td>
<td>Personal belief</td>
</tr>
<tr>
<td>2. That doubt phase in your third year</td>
<td>“magic hands” and was “going to go curing people”</td>
<td>Feelings: A period during our training of doubt; doubt about whether the course is a good one, doubt about whether the profession we were training for continues to be something we want for ourselves; doubt about its meaning and purpose.</td>
<td>Personal motivation</td>
</tr>
<tr>
<td>3. The Dying Man</td>
<td>“Helen contacted the GP to request a visit fully expecting that Harry would have been readmitted to hospital later that day”</td>
<td>The speaker casts herself as an innocent bystander as events occur around her; appears disempowered, disillusioned?</td>
<td>Personal attitude</td>
</tr>
<tr>
<td>4. The Transformed Spare Bedroom</td>
<td>“At the end of the lecture he said, “So, who can tell me the aims of antenatal care?” The whole set held their breath as he looked straight at her (sitting in the front row naturally) and said “You”. So she told him and after a pause he said…. “ABSOLUTE RUBBISH!”</td>
<td>Oppositional talk: the phys med consultant had these old-fashioned ideas and she had more modern ideas; some righteous anger with this reaction</td>
<td>Personal value</td>
</tr>
<tr>
<td>5. My mum, my family and me</td>
<td>“the youngest sibling”; “irritated by her brothers’ lack of understanding of what she did”; “she was the only girl”; “they at last had some respect”;</td>
<td>Member categorisation: Relationship with older brothers / father; expresses irritation, Feelings: of being patronised</td>
<td>Gender</td>
</tr>
</tbody>
</table>
Table 12 (continued) Identity claims made by the study participants (page 2 of 2)

<table>
<thead>
<tr>
<th>Story / CD</th>
<th>Identity claim</th>
<th>Analytical technique</th>
<th>Contribution to identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. The wandering woman</td>
<td>Emma says “it’s not really my place to start arguing with the GP”:</td>
<td>Participant Generated Metaphor “my place” conveys a positioning of herself in relation to the GP: this suggest an incoherence or dissonance – I am worried about this woman but not so worried that I will challenge the authority of the GP yet I will subsequently end up worrying “all night” (line 16). Feelings: Anxiety about whether she has done enough / “the right thing”</td>
<td>Professional belief</td>
</tr>
<tr>
<td>7. This patient is a bit intimidating</td>
<td>“set up camp”</td>
<td>Participant Generated metaphor: establish an area of the gym as if it were his own: feeling challenged and her sense of place as one of being in charge is threatened – patient-centred care / paternalism and gender issues</td>
<td>Professional belief</td>
</tr>
<tr>
<td>8. This patient is a bit intimidating</td>
<td>“did everything at 100 miles an hour”</td>
<td>Participant Generated metaphor: very fast; too fast for her feelings of being in control</td>
<td>Workplace experience</td>
</tr>
<tr>
<td>9. Wanting to give a good impression</td>
<td>“on top of things”</td>
<td>Contrastive rhetoric – conveying sense of an obstacle to climb / to surmount; Feelings: of confidence and optimism</td>
<td>Workplace experience</td>
</tr>
<tr>
<td>10. Scary Sally</td>
<td>“I don’t think of myself as scary”</td>
<td>Member categorisation – some colleagues do, and delight in this; Feeling: bewilderment</td>
<td>Inter-professional experience</td>
</tr>
<tr>
<td>11. The Wandering woman</td>
<td>“We’re confronting human tragedy”</td>
<td>Member Categorisation - Other non-health workers do not</td>
<td>Career experience</td>
</tr>
<tr>
<td>12. War Torn Africa</td>
<td>“The Club”</td>
<td>Metonym for exclusive, white’s-only, ex-pat world</td>
<td>Gender</td>
</tr>
</tbody>
</table>
I began to appreciate that the participants were describing that they negotiate such conflicts of identities. I came to realise that it is not possible to consider how a professional’s identity is constructed or co-constructed without recognising the work involved interweaving their personal values, beliefs and experiences with their socialised professional values, and their workplace ways of working. In the following subsections, I use my data to exemplify this interpretation for personal, workplace, career and professional identity.

7.2.2 Personal identity

Three memory stories were about participants constructing their sense of their professional self through personal experiences. *My mother, my family and me* has Louise gaining respect from her brothers and her father. This is through observation of her subtle and soft skills and knowledge she gained as a physiotherapist, which they had not previously really understood or valued. *When weekend working goes wrong* is a situation that resonated with the participants because of its ambiguity between competence and confidence; how do we help staff strike the balance between the two, and secure a moral grounding to their ongoing practice. *The transformed spare bedroom* is a transformative story through which Caroline works out the physiotherapist she wants to be; and that this fits with her personal passions and lifelong interests. Below, I cite an excerpt from *The Christmas Show*, in which the participants construct some meaning from the notion that personal beliefs can collide with professional situations and vice versa.

*The Christmas show*
Chris Your story really struck a chord with me
When I worked in a rehab setting in the 1990’s
It was a tertiary centre, neurosurgery
We put on a Christmas show and all the staff did things
A load of the physio’s dressed up and did a routine
I didn’t
It was because I didn’t think it was professional.

Louise Did it affect your respect?
Chris I didn’t feel confident to go up and be silly - I felt like the next day I would have had to treat them
Emma They were so much better ‘cos I had done that
Louise Knowing you as a person
Sue I had an experience along those lines.
We took clients away for a two-day break; we cooked together;
We did activities together.
I had one of my most seminal moments as a physiotherapist.
We did rock climbing: I got stuck
I just froze
All I needed to do was let go
I was on a rope but no, I’m hanging on
The instructor came along beside me
It was like hearing myself:
He said very calmly “take one hand and move it”
And gave me confidence; he encouraged me.
I climbed to the top of the wall.

Louise Someone panics half way round a transfer
Sue It was quite earth shattering,
I’d been qualified about eleven years
Never really realised it
Chris They thought I was a bit of a wet blanket not joining in, not game for a laugh
When I left, what they would do is get whoever was leaving and put you in a wheelchair,
        Put a silly hat on,
        Put funny clothes on
        Wheel you around:

    I absolutely hated that

Caroline Unprofessional
Chris That was unprofessional
Helen Do you think being serious with being professional
Diana You should take your job seriously but not yourself
That is the definition of being professional
Sue Doesn’t that show how difficult it is to work out where the boundaries are?
Your boundary didn’t involve dressing up
That was ok for you
You did and that was right for you

7.2.3 Workplace identity

Scary Sue represents an opportunity for individuals to exercise their communicative rationality: how we use everyday conversation to challenge
the myths and misperceptions of the profession to either collude in or overcome our own sense of misrecognition. However, it is also a story of how she compromised her self-opinion in order for her new work colleagues to accept her in the new workplace.

**Scary Sue**

Louise Was that the first time you’d had to stick your neck out and be that strong?
Sue No
Louise Just wondering why that one stuck
Sue Because when I went back
The carer referred to me as ‘Scary Sue’
My colleagues then jumped on
And the joke is now “send in Scary Sue”
Vicky I was struck by that as well
The nice thing is they wanted to tell you
At the end of that little episode
They wanted you to know you were Scary Sue
Not in a threatening way
In an endearment way
How often have we been called things that reflect our characters?
You know physio-terrorists,
The-rapists
All the other things that they call us
They never mean it in an aggressive and malicious way
They like us to know
They like the rapport
If they’d been truly scared they wouldn’t have been able to tell you.

It may be that the story is important to Sue because it represents the time when she realised she was part of the new team, accepted into a new community of practice. Different participants reacted differently to the notion of being scary:

Helen An assistant I worked with
We were known as the gruesome twosome
(...)
Helen In a funny way it’s an affectionate term
Rather than being malicious
(...)
Chris What’s your reaction to the physio terrorist, ‘Scary Sue’ label?
Emma It’s a bit tongue in cheek,
It’s seen as a joke.
I don’t see it as an insult to me
I just see it as a bit of a laugh.
Chris
I've never liked it.
I've always reacted against it.

Sue
I don't like it.
I don't see myself as scary
I would say I am very much the opposite of scary

Helen
I worked for a doctor who was a lovely chap
But he was an absolutely useless doctor
One occupational therapist said to me one day,
“He’s scared of you”
“I don’t think I’m scary”
“It’s the way you look over the top of your glasses”
If I asked him to do anything
He did it
If other people asked him
He didn’t

Louise
Was it respect for your knowledge?

Helen
I don’t know.

...  

Chris
Some physio colleagues have revelled in
The idea of being the physio terrorist,
Of being the scary one,
They’ve enjoyed going onto the ward
Or outpatients
They’ve enjoyed this sense of

Helen
Power

Chris
Perhaps it is power
It was their presence,
Their persona;
I don’t like the connection with what I do for a living
Being something that people find
Scary or
Domineering or
Dominating over the people I work with.
We’ve talked a lot about empathy
And a certain altruism in what we do
I suppose humanistic caring
So to be labelled something like that
It doesn’t sit with me,

(From Scary Sue)

_The dying man_ conveys a sense of anxiety about autonomy, about how we
communicate with colleagues and how we can be the authors of our own
anxieties. _On call apple_ demonstrates how Caroline uses her sense of
professionalism to cope in an unusual and stressful situation; the group
discuss the ethics of accepting ‘call-in’s’ and this goes to the heart of how the
profession or a service markets itself to other professionals. _When weekend
working goes wrong_ is a situation that resonates with physiotherapists
because of its ambiguity between competence and confidence; how do we help staff strike the balance between the two, and secure a moral grounding to their ongoing practice

**When weekend working goes wrong**

Diana  
I did feel that I knew what I was doing  
So it wasn’t that I didn’t have the skills to do it  
I wouldn’t say I felt comfortable  
I wouldn’t say I was anxious  
I’d walked onto this unit many times  
I’d treated all the kids when I worked there.  
There is a security that comes with familiarity  
Familiarity means that the nurses come running to you  
Or the child who you’ve seen before,  
You know the changes  
You know they’re going off,  
You know when they’re improving  
Or whether they’re staying the same  
You walk on to the unit which you haven’t been on for a while  
On my own  
You could allow yourself to be anxious  
But you had to keep reassuring yourself that you knew what you were doing  
You’ve done it before  
You had the skills  
You wouldn’t be happy unless the nurse was there.

### 7.2.4 Career identity

The participants construct their identities recognising that these are not linear, but that they are responses to events, personal history, decisions. *The job interview* is Louise demonstrating her agency in moving her working life forwards to suit her changing needs. The two stories and discussions *What makes me tick* and *Finding my niche in outpatients* are simpler. Diana conveys a sense of relief that her change of profession is working out. She identifies with the investigative work of the musculoskeletal physiotherapist. In *Scary Sue*, Sue overcomes both a poor personal working relationship and her anxieties about a certain clientele to find a role and post that is
professionally meaningful and fits her personal life priorities. The participants discuss their reaction to the moniker and eventually their approach to patients:

**Scary Sue**
- Sue: If you work in the community you learn to step back a little bit
- Emma: It’s quite different if you work in community
- Sue: It’s very different
- Emma: Working in community versus the wards, I had to change the way I worked when I came into the community; the seniors were saying “The way you were approaching things”
  - I had no idea
  - On reflection
  - On certain patients
  - I was coming across bossy
  - I was just so used to being on a ward and being in charge

**Chris**
- Can you give us an example of that?

**Emma**
- There was a lady, who’d broken her arm,
- I was telling her the things that she shouldn’t have done
- She should have done this,
- I wasn’t accepting in her setting
- The goals that were important to her
- Meaningful for her in the house
- In her house
- It really took me aback when someone said
  - I was so used to people saying “you’re good at communicating - you build a good rapport with patients”
  - Suddenly
  - For someone to say to me
  - “You came across quite bossy then”
  - “Oh gosh, I did”,
- When I thought about it, I had
- I just completely changed the way that I came into people’s homes
- The way I set goals with patients
- The way I gave instructions

**Louise**
- What’s it been like taking that back in hospital?

**Emma**
- I’m definitely less bossy!

### 7.2.5 Professional identity

*I heard every word you said about me* illustrates anxieties about professionalism and the moral dilemmas within the norms of clinical practice. *The patient and the pizza* is Chris conveying his need to act the ideals of rehabilitation rather than to process the instrumental reason of the rhetoric
that exists both in books and how the technical performance he witnesses at
work. Below I provide an excerpt from *On call apple* in which the participants
discuss the matter of constructing their professional identity, or being
professional, in front of parents, when they are feeling unconfident.

*On call apple*

Chris When the staff nurse left what were you thinking?
Caroline I wouldn’t have expected her to stay.
Louise I wouldn’t have expected a nurse to stay with her
I would have done exactly what you did
Making sure the parents were happy with you to stay
Chris Can you remember the parents’ reaction when the nurse left?
Caroline “Thank god, here’s the physio, come to save her.
What’s she going to do?”
They were terrified
Chris They were terrified?
Caroline I don’t think they wanted to see what I was going to do
In case I did something nasty
Helen If you were able to calm the child down
How much of the child’s distress was being transmitted from the
parents?
Caroline Probably a huge amount
Vicky It’s always the parents you’re treating isn’t it?
Louise May be better when they left?
Caroline You never know do you?
Louise Were you more comfortable with the idea of them
leaving?
Caroline No, I always used to try and encourage parents
To stay
That’s something that used to happen on the neonatal unit
They’d say the physio’s here, wait outside
I used to say “No you can stay”
Parents are terrified you’re going to do something awful:
Stick needles or hit them or I don’t know
Louise It increases the parents’ understanding of what’s going on
Caroline We had a child who was in permanently
She died when she was about four and a half
The parents were in constantly
A lot of the younger physio’s were intimidated by them
They knew more about her condition than the physio’s did
They’d make them wait outside.
I can still remember now her father used to stay and help me
He helped me
Helen That’s about confidence as well isn’t it
Caroline That was my confidence yes
I was that bit older
Louise Recognising what different skills you bring to it
From the skills the parents had
Because of their knowledge
7.3 Authenticity

Connected to the lens of ethical and moral dilemma is the notion of coherence. I began to see that we, the participants, were telling how we continued to construct a professional identity over time and that, while we utilise personal, workplace, colleague and career beliefs, values and experiences in doing so, this led to both conscious and unconscious tensions between each identity. I have summed this up with the word authenticity: how do I manage the tension when a belief or value from one identity world conflicts with a belief, value, or situation from another? In the next two subsections, I explain how I understand this idea using the concepts coherence and non-coherence.

7.3.1 Faithfulness to particular values: Coherence

Caroline’s story War torn Africa is about being true to one’s knowledge and training and an ethical desire to want to work rather than be a kept person (woman) in colonial Africa. The discussion contained in the subsequent crafted dialogue picks up the importance to the participants of their love for the profession. My mother, my family and me has Louise gaining respect from her brothers and her father for the subtle and soft skills and knowledge she has gained as a physiotherapist, which they had not previously really understood or valued. Postgraduate training represents Chris’s ownership of his continuing personal development, rather than for it to be passive receipt of workplace learning and marketing of work. In the excerpt from The dying man below, the participants support the narrator in her actions: her actions remain faithful to values the group say they hold.
The dying man: 1 – 1: Helen

Vicky I was impressed
Go in, help, tidy up the patient:
I mean - faeces, urine; make the bed, and get him comfortable;
That's beyond the call of duty.
That was good.
Helen I couldn't leave him.
Vicky Absolutely,
That's going the extra mile, that's what physio's do.
It's not measures, it's not reported, it's the human element of the job.
Helen Yes.
Louise You can't write a business plan for that.
Helen I couldn't have walked away.

... He was distressed
Because of what had happened;
His wife was distressed
Because she hadn’t been able to prevent it happening
I had a duty to make him comfortable.
I do meet his wife out and about
Even now, she says how grateful she was.

7.3.2 Separating roles: non-coherence

Wanting to give a good impression of the profession represents Chris’s anxiety about being himself in the workplace and having a voice and being “permitted” to voice his opinions. This represents a consistent inconsistency: he is aware that in his personal life he would expect to be “allowed” to voice his opinions, but is prepared, in this work situation, to give way to the dominant voice of the medical consultant. This is an example of the participants justifying the compromises they make: why and how they act in specific work situations and how they justify to themselves their behaviour.

7.4 Summary

I have interpreted the data generated, the memory stories and crafted dialogues, as saying that there are issues of authenticity that strike at the
heart of participants’ sense of being a physiotherapist; the participants embodied this through talking about how they have addressed ethical dilemmas. At the beginning of Chapter One, I quoted Michel de Montaigne (1593) saying that he speaks about himself “in diverse ways ... because I look at myself in diverse ways”. My interpretation reflects this insight: I have tried to interpret what the participants were doing with their narratives as well as what they were saying during the data generation meetings. The adoption of a performative attitude by the participants mirrors Montaigne’s “intermingling and admixture”. This holistic interpretation responds to the original aims for this study, to appreciate better how physiotherapists come to be the physiotherapists they are.
Chapter 8 Discussion

“In asking how experience is reproduced in memory, we find out where we compromised without realising it…. Re-discovering the responsibilities we regain new chances and different possibilities to act in the present and in the future.”

(Haug et al., 1987, p.42)

Chapter Seven provided an explanation of what meaning I have generated from the data. I have explained how I have assessed the data holistically and derived a central understanding. This was that throughout the data generation meetings issues of authenticity struck at the heart of participants’ sense of being a physiotherapist, embodied through talking about how they have addressed ethical and moral dilemmas. Haug’s words above suggest that “new chances and different possibilities to act in the present” might exist. In this chapter, I take up this thought and explore the “different possibilities to act”. Through a developing consideration of identity in physiotherapy, I arrive at a more sophisticated conceptualisation of how the profession might understand professional identity. Section one (8.1) takes as its starting point the traditional notion of identity acquired as a fixed entity by novices in their early training. The study data suggested that individuals continue to develop their thinking about their identity over the course of their career, and feed this with their evolving personal (ego) identity, the workplace mores, and contingencies of working life and career. They do this through identity claims and I consider some of the claims the participants made. Section two (8.2) develops a theme of moral and ethical reasoning in identity construction by considering recent trends of thinking about professional identity development.

37 Except for use in connection with formal research governance procedures, when ethics is always used, the terms ‘ethical’ and ‘moral’ are used interchangeably within this thesis.
Section three (8.3) discusses how this more sophisticated understanding of moral and ethical reasoning strengthens self-determining and emancipatory practices. This permits me to return in Section Four (8.4) to professional identity in physiotherapy and present a further conceptualisation of how this might be re-imagined when placed within the exigencies of modern times.

8.1 On the construction of identity by physiotherapists: an initial consideration

The traditional notion of identity is of something acquired as a fixed entity by novices in their early training. The concept of identity is taken for granted, has not been clearly defined, and has been used to cover a range of ideas, for example, role, image, ethics. When I started these doctoral studies I too shared a taken for granted impression of what identity and professional identity means. I designed, planned and undertook the data generation study with the expectation of generating quite different results. I imagined that the collective memory group would generate experiences or occasions that resonated across the group. This would be an initial contribution to a developing bank of such situations that educationalists would problematise and help physiotherapists address. For example, I used “the death of a patient” as one such ‘experience’ when recruiting potential participants to the study. During data generation, another possible topic I saw was “working with an incompetent colleague”. I had in mind that physiotherapists would then share coping strategies for such a bank of situations. It remains possible that there is a range of such experiences that emerge after registration. Possibly, it is only practicing physiotherapists who can properly address them.
Certainly, the participants did embody such ethical dilemmas; however, there were insufficient data to reinforce any specific ‘experiences’ as being universal. Nor did the participants pursue the discussions in that direction; to my discomfort, in establishing a group as I had done, I discovered that the group took its own route in the topic and focus of the discussions.

What I have concluded from the data generated is that these sorts of experiences are common, that some physiotherapists use them to help develop their own professional identity, and that some continue to develop their thinking about their professional identity over the course of their career; but without necessarily recognising that they are doing so. Importantly, I have also interpreted the data to suggest that an evolving personal (ego) identity, workplace mores, and the contingencies of a working life or career informs this. I am not claiming this for every physiotherapist. I place at the centre of this conceptualisation the notion of authenticity: coherence between personal and professional / workplace values, attitudes and beliefs. In doing so I suggest it is possible for both self aware and unconscious non-coherence. The former means an individual is aware of a difference between their personal values or beliefs and their professional or workplace actions; the latter is connected to institutionalisation in which engaged thoughtfulness is superseded, or sublimated by the discourse and practices, the culture, of a specific workplace. This interpretation of the data develops a conceptualisation of professional identity for physiotherapy that reflects recent professional identity literature. It recognises the central role that feelings play in such identity work. The challenge, I suggest, is for individuals
to negotiate these, and adopt a self-aware and self-regulating practice within their communities of practice.

Figure 2, below, shows how I have combined the different types of identity claim that physiotherapists drew on in constructing their professional identity. I suggest personal identity is at the centre of this and that feelings, conscious and unconscious emotions connected to experiences, drive this construction. Physiotherapists are socialised into a profession with its own attitudes, beliefs, motivations and values. Their work nurtured this nascent identity: the institutional attitudes, beliefs, motivations and values, the discourses, hierarchies, and practices and how they respond to these. Their evolving career feeds this – by the stories they tell themselves or others about their working life.

Figure 2 Initial specification for professional identity
Figure 2 recognises that the physiotherapist might adopt a certain attitude to their identity, for example victim, agent, observer. The following extract from The Job Interview shows how one participant interpreted her pride in her profession and how she felt she had to fight to make it be what her expectations of it suggested it could be.

Louise
I am proud of being a physio
I enjoy every aspect of it
I want to keep the doors open

Caroline
You are still a physio.
We’re still physio’s, aren’t we?

Helen
Of course we are, yes. I still keep a watch; I look at how people are walking

Chris
Why are you proud to be a physio?

Louise
This afternoon I had a physio and a nurse working for me
We have a computer system that does all the pathology stuff,
I found out today that in the Trust
Physio’s don’t have access for blood results and things
The physio that works with me fought for a long time to get access,
So she could check Hb’s before she got someone out of bed
Without having to ask a nurse,
And all the rest of it,
She has admin and clerical access to this computer system
Which means she can’t print off a label to send a sputum sample off
Or send an MRSA swab off or whatever,
When I phoned to try to get her access changed
They looked at her previous profile
Went back to what profile I was asking them to give her
“She’s not a nurse”,
“No”,
We ended up debating it
I said “fine, I’ll go to my line manager”,
I was writing the message, the email,
To explain to them that they were going to get an email
It just got me off on one of my rants!
How people don’t understand the scope of what we know
And of what we do,
It just seemed that someone who is leading all of this has
Absolutely no knowledge of what we do
And a viewpoint,
A girl who works with me found it hysterical:
‘Oh, look, Louise’s going off on one of her rants again’,
I’m proud of it because I think we have got so much to give
I think we bring in so many different aspects,
So many different bits of knowledge
This important, integral part of the patient’s pathway

38 Caroline and Helen are retired
I think we are very capable
We are very good at moving things on;
We are a good cog in that flow process in many different ways
Little things like other people not understanding what we do
Not understanding what we can give
Making daft decisions because of it

The Job Interview Louise

Emotion drives this personal agency; anger, frustration, some disillusionment, yet shining through is possibility, the “different possibilities” for change, of how things could be. The challenge then becomes one of whether the individual wants to make a difference, make the change happen or gives in to how things are. This is an example of how individuals constantly strive to shape their personal identities within the “discursive forces” of organizations (Sveningsson & Alvesson, 2003, p.1165). Louise was reflecting on how she was struggling with the constructions of the professional identities made by others in a complex and hierarchical organization – an NHS hospital. Sveningsson & Alvesson (2003) suggest the elements of change, contradiction and fragmentations create reactions such as curiosity, anxiety and a search for ways of actively dealing with identity (Sveningsson & Alvesson, 2003, p.1167). This example illustrates what Lapointe (2010) observes, that narratives, as the site for identity construction, are not freestanding, self-contained units but are “always embedded in the local conditions and emerge as a result of interaction” (Lapointe, 2010, p.3).

8.1.1 Personal identity claims

Caroline’s story captured in The Transformed Spare Bedroom exemplifies how she came to appreciate her unfolding need to be true to her passion for obstetric care. Despite, or because of, having a grandfather and father who
specialised in obstetric medicine, she trained in physiotherapy. As she lived her personal life, she came to realise that what she cherished was antenatal and postnatal care. She was able to bring her physiotherapy skills, knowledge and experience to this passion, and forged a career in obstetric physiotherapy. She crystallised this in the story she recounts.

In *Post-graduate Training* Sue finds part time and flexible working permits her to feel an engaged mother while simultaneously maintaining working; this is not unproblematic: Caroline and Diana dispute working part time for “pin money”: for some it suits while others (full timers) resent the indifference to what they value so highly.

### 8.1.2 Career identity claims

In developing this idea of professional identity, I am making a connection to both a work identity and an evolving career identity. This interpretation of the data suggests that the participants were discussing and constructing the idea of themselves as physiotherapists as having changed during the course of their working life. Lapointe (2010) defined career identity as a “practice of articulating, performing and negotiating identity positions in narrating career experiences” (Lapointe, 2010, p.4). Christiansen (1999) suggested that “over time, our evolving identities and our actions are woven together to provide a coherent life story” (Christiansen, 1999, p.555). The stories individuals tell about their career are not tied to a particular role or place but derive their meaning from “sequences of work-related experiences” constructed through “discursive resources” (for example discourses, master narratives, biographic
particulars) derived from given local, socio-cultural and historic, contexts (Lapointe, 2010, p.4).

Career narratives can also draw on professional discourses or other social discourses with associated identity positions and categorizations such as gender, family relations, and special interests. All of these discourses offer particular subject positions that determine the rights, obligations and possibilities for action (Lapointe, 2010).

8.1.3 Diversity in physiotherapy

My interpretation of the dataset concludes that the participants embodied ethical dilemmas in the stories theytell about themselves and how they have come to be the physiotherapists they are. One matter that was embodied is gender. One explicit account of this was in “My mother, my family and me”. Here Louise told the story of how her role in the family changed during her mother’s final illness:

Louise

It has totally changed the dynamics
Of the relationships with my brothers:
Respect
I was the girl
I do one of those jobs that girls do,
I came from a patriarchal family type set up,
I had a Dad who was a surgeon and a Mum who was a nursery nurse
Being a physio - it wasn’t nursing
But you know it was never going to earn lots of money
It was “if you ever want to borrow money”
Patronising
Lack of respect
That scenario completely changed

My mother, my family and me (Louise: 2 – 4)
The participants discussed the implications of their gender throughout the dataset. The story Caroline recounted called *War torn Africa* stimulated membership categorisations in which the participants saw physiotherapists as people who want to work as opposed to wives of “ex-pat” men who were happy to “Play tennis, drink gin”. Caroline established herself as an agent who wanted to practice her profession. The discussion between participants moved on to the flexibility of the profession: the ability to find part time work in physiotherapy, for employers to appoint women who wanted part time and flexible hours to enable them to also provide child care. This encompassed debate about the relative merits of full time and part-time physiotherapists and their motivations: “pin money” or a career:

Caroline  
A lot of white women didn’t work at all

Sue  
Not only did you want to work
You wanted to do physio and not teaching

Louise  
Getting stuck in
Getting involved

Sue  
Adapting to the not quite so perfect

Caroline  
Predicting situations

Sue  
The sense that you were making some kind of difference

Emma  
And you saw it as a challenge

Chris  
You were rejecting the not working in order to work

Caroline  
Exactly: I had a vocation

Emma  
Why do you think you had such a strong drive?

Diana  
I can understand the drive:
You’ve only just qualified

Caroline  
I have lots of personas, I’m the children’s mother to some, I’m a dog walker, I’m a physiotherapist
I was incredibly depressed
What was I going to do?

Sue  
Play tennis, drink gin

Diana  
I’m off work at the moment
It’s very seductive

Chris  
I’m wondering whether there was an issue with earning some money.

Caroline  
When I first came back to this country
All my salary went into the girl’s post office accounts

Diana  
I work with a colleague who referred to income as pin money
I found that very insulting

Sue  
It depends on your situation

Diana  
I know it does
She was perceiving herself to be earning pin money
I was doing many more hours than she was
Having to do a lot of CPD
I was driven to keep up to date
I did resent that very much
Her view of her work was different
Was very different
To how I viewed
Louise I wouldn’t resent it but I would be envious
War torn Africa (Caroline: 2:6)

The participants did not address the issue as a matter of gender and a woman’s right to work, to secure an independent means of living. This seems to suggest that there was a limited feminist consciousness within the group. This reflects my observations of the profession, that there is little published or articulated gendered (feminist / masculinity) discourse. An alternative theory is that the patriarchal objectivist stance pervades the profession and prevents members feeling able to express their femininity in public. This seems to reflect something observed by Mercer in 1980. He identified ideal-types of professional physiotherapists along a continuum from a therapist with “low clinical autonomy” because of clinical inexperience (defined as a “newly qualified therapist - working”), choice, or attitude of therapist / doctor (exemplified as a “middle aged married returner”), to the therapist with “high clinical autonomy” due to specialty, experience, seniority, attitude of therapist / doctor (Mercer, 1980, p.181-2). He concluded that the nature of the specialty was dominant in determining what scope existed for the development of clinical autonomy and set this against the relative relationship that could be developed with the doctor (Mercer, 1980, p.184).

I have not interpreted the data as providing any evidence of matters relating to ethnicity. I suggest that this absence is remarkable and important. In a
country and during times when culture, ethnic background, religious belief, and matters of enculturation, assimilation, and integration are so challenging (Marmot, 2008; ONS, 2011; Parekh, 2000) it is striking that the participants did not bring this up for discussion. There is some limited literature in physiotherapy regarding aspects of socio-cultural diversity. For example, Lee (2006) addressed physiotherapists’ perceptions of clients from culturally diverse backgrounds and Hunt (2007) considered physiotherapists “taking culture seriously”. In two recent papers, Yeowell (2010) investigated the perceived needs of Pakistani women in the north west of England in relation to physiotherapy, and the extent that physiotherapists met these and Croot (2012) reflected on the physiotherapy needs of Pakistani families caring for children with disabilities. The CSP and the HCPC included ethnic diversity statements throughout their codes and standards (CSP, 2011b; HCPC, 2008). Another strand of socio-cultural diversity is the matter of class and the impact that self-conceptions of class have on identity construction and the attitudes and motivations towards work, career, and personal and professional identity. There has been little examination of the place and impact of socio-cultural diversity on the attitudes, beliefs, values and motivations that exist within the profession.

8.1.4 Role strain and resilience

Contained within the data I generated was much emotion. Within the context of this thesis, I interpret these emotions in how they connect to professional identity and how physiotherapists come to be the physiotherapists they are. The first is in role strain, as I understand it the negative pressures imposed
on someone within the role they have. This was both explicit and implicit.

Louise’s “rant” about the computer access permissions (The Job Interview: 3-3: Louise) was an example of frustration about the institutional limitations imposed on her and her colleagues that indirectly impacted her role - her exasperation was the beginning of the possibility for her to make a change, to realise herself differently. Louise has several options: to leave the situation as it is and inwardly fulminate, second to share her feelings, but not do anything more to overcome the computer access permissions, and third, to act to try to get the permissions changed. This exemplifies the central theoretical assumption of this thesis: Habermasian communicative rationality. Louise has it within her to act for change. The self-identity and the self-efficacy they have may determine whether she or others in similar positions do so. They could adopt a position of difference and rage against the Other that (in this example) nurses have the computer permissions. She can challenge the reasons for the decision (the truth) and argue for change. Whatever she chooses to do, she currently carries the emotion that provoked the “rant” with her.

Louise    That's why we are so passionate
           I've ranted over the past couple of months while we're doing this,
           We wouldn't be bothered if we didn't think we have something to give
           That is why we should be included.
           There is a reason that we are that bothered
           We don't get recognition
           There is a real lack of understanding of what a physiotherapy role is.

Chris    Until we actually assert ourselves with what we can do
           We have the skills
           We make a fuss

Louise    There’s countless examples that I could name since I qualified
           Common and accepted practice,
           Oxygen prescription
           Giving and managing oxygen therapy
           In very few trusts is it recognised that's its physio role,
           And physio’s are allowed to do it
           Yet in most hospitals physio’s lead it,
I interpret Helen in The Dying Man as expressing some unacknowledged frustrations with her role, as she understands it: she tells the story as one of triumph in which she demonstrates her caring values while simultaneously establishing herself as a passive bystander watching the doctor fail to do as she wishes. I wonder whether this leaves her with unconscious or unacknowledged feelings of disempowerment; she does not see her role as the physiotherapist to challenge the doctor, which might exacerbate her feelings of disempowerment.

The data contain many expressions of emotions, of feelings: worry, anxiety, frustration, pride, confusion, confidence. Many of these were unacknowledged by the participants during our discussions; they did not discuss feelings. Recent government policy is putting increasing pressures on staff to deliver (SSH, 2010) This role strain requires resilience to cope, and clarity of identity as to whom one is, what one’s role and purpose is, and what values underpin one’s thinking, in order to make constructive and prudent decisions. Physiotherapists have the potential to use their

---

In suggesting weaning,
If you look at strict guidelines oxygen is meant to be a prescription,
It’s meant to be on drug charts,
You have to be willing to stick our heads above the parapet,
Be prepared to defend it

Diana
It’s challenging the status quo
The status quo has often been there for ten, twenty, thirty years,
When physio were just remedial gymnasts,
Came on the wards
Did a few exercises, pumped their chests and went home,
As a profession we’ve moved on

Louise
Sometimes we are happy to complain that things haven’t moved on,
Yet there is not a real clarity about it

Diana
The people who make those decisions don’t know

Chris
Is that because we don’t assert ourselves?
I want to challenge how it is currently being done

The Job Interview (Louise: 3.3)
experiences to cope. This might be to withdraw, to establish “defence systems”, (Menzies, 1970), to use clinical reasoning processes, or to cope in meeting new professional demands, such as service changes, role / title definitions, different places of location. This poses the question as to whether physiotherapy names or values the concept of being brave. Bravery is the courage to stand up for personal beliefs or professional values or to implement workplace initiatives when being a physiotherapist. The professional codes of ethics and standards of behaviour are virtuous and normative; to implement them is expected and to err leads to potential sanction. I explain in section 8.2.3 (p. 197 – 200) how this drives the “conventional” moral thinking person and undermines attempts to move professionalism towards a “post-conventional” moral identity. It also buries bravery and hides courage.

8.2 On professional identity

I have developed this connection between memory and moral thinking as part of the identity work that occurs for an identity to cope with evolving circumstances. Identity work requires the activities of “forming, repairing, maintaining, strengthening and revising the constructions that are productive of a sense of coherence and distinctiveness” (Sveningsson & Alvesson, 2003, p.1165). In Chapter Three, I have argued that physiotherapy is changing, there are pressures to reimagine physiotherapy, and that this imposes challenges for its professional identity. Professional identity is a widely used phrase and possibly generally well understood concept, though
there has been little theorisation of what it means in physiotherapy, and how it is used.

Many studies of identity emphasize coherence, continuity and distinctiveness. Many of these assume a stable self-definition and/or a stable definition of the organization as well as of the link/overlap between these (for example, working in different institutions within the National Health Service). Bucholtz and Hall (2005) argued that “identity is the social positioning of self and other” (p.586). Bucholtz and Hall (2005) have constructed a useful framework for the analysis of identity as produced in linguistic interaction, based on the following principles:

1. Identity is the product rather than the source of linguistic practices and therefore is a social and cultural phenomenon,
2. Identities encompass macro-level demographic categories, temporary and contingent stances and roles, and local, cultural positions,
3. Identities may be guided through the use of labels, linguistic styles, structures and systems,
4. Identities are relationally constructed through several, often overlapping, aspects of the relationship between self and other, including similarity/difference, sincerity/artifice, authority/obedience,
5. Identity may be in part intentional, in part habitual and less than fully conscious, in part an outcome of negotiation, in part a construct of others’ perceptions and representations, and in part an outcome of larger ideological processes and structures.

(Adapted from Bucholtz & Hall, 2005)

Few studies have looked at the process by which physiotherapists come to develop their professional identity. I came to the view that the framework of Bucholtz and Hall neatly summarised what I experienced during the data generation process. As I tried to make sense of the data, I began to
recognise the subtleties of identity work that the participants were undertaking.

The profession has tended to consider socialisation into the profession as part of how an individual acquires a professional identity. For example, Ohman et al. (2001) defined a view of professional socialization that

“starts at the beginning of the educational programme and is a continuous, life-long process of learning formal knowledge, skills and rules, as well as informal and tacit knowledge, norms, values and loyalties within the profession. The process gradually leads to a professional identity” (ibid, p.16).

While this acknowledges socialisation as a continuous “lifelong” process, it perpetuates thinking about identity that is arrived at, possessed. As Thomas & Beauchamp (2011) say the development of a professional identity is as “an ongoing and dynamic process” (p.762) requiring the “making sense and (re)interpretation of one’s own values and experiences” (Thomas & Beauchamp, 2011, p.762). I suggest a fixed notion of identity in which individuals absorb norms misses the possibility of conceiving of professional identity as this “ongoing and dynamic process” through a person’s working life (and beyond). I have moved away from this idea, considering identity solely from a perspective of the acquisition of assets – values, beliefs and attributes as unnecessarily objective. My concern is that it fails to do sufficient justice to how someone conceives of himself or herself. It also omits the relational aspect of identity that Bucholtz and Hall identified (Bucholtz & Hall, 2005).
8.2.1 Socialisation

Greenwood (1957) described a profession’s values as the “basic and fundamental beliefs, the unquestioned premises upon which [a profession’s] very existence rests” (Greenwood, 1957, p.50). Professional socialisation instils a profession’s values. An individual acquires the knowledge, skills, behaviours, attitudes and values of a particular profession and constructs an initial professional identity through the process of professional socialisation. Aguilar et al. (2012) observed that the values of a profession are “influenced and shaped by the surrounding societal, institutional, cultural and political environments” (Aguilar et al., 2012, p.3). Socialisation into the professional community provides a sense of stability, belonging, and values, and it reduces ambiguity (Hotho, 2008, p.729). Hotho (2008) suggested the profession as an institution provides “the scripts on which individual professionals draw in their daily practice” (ibid, p.729). These scripts form “the practical knowledge that informs their action and the basis of evaluation” (ibid, p.729). What one profession considers a value within an environment, another may consider irrelevant. Socialisation into the profession has been considered for undergraduates and pre-registration curriculum in physiotherapy (for example, Broberg et al., 2003; Ohman et al., 2002; Richardson, 1999a). While the idea of socialisation as a lifelong enterprise is frequently evoked, there is little published literature on post graduation socialisation in physiotherapy. Part of socialization into a profession could meaningfully include individuals developing an understanding of what it means to be a professional and challenging or questioning the idealized version that has been presented to them. A recent example of this has come
from the UK government’s Chief Health Professions Officer, who challenged
the Allied Healthcare Professions to “have the conversation” (about the issue
of professionalism and professional behaviour) (Middleton, 2012). Aguilar et
al. (2012) suggested that consideration of professionalism can be viewed
from a values or a behavioural perspective, the demonstration of desired
professional behaviours or the upholding and applying of the values of a
profession (Aguilar et al., 2012).

Often the professional group is claimed to be the most significant in an
individual’s life (Adams et al., 2006). I wonder if this is always true. This
assumes similar motivations to work. Those who are parents of young,
school aged children may have other priorities and for a time in their life at
least, reduce their commitment and motivations to work. Those new to the
profession may have high motivation as they seek to secure their ‘place’
within it. Caroline’s need to work when out in Africa reflected her self-identify
as a newly graduated physiotherapist, this was important to her sense of
identity, her personal identity, and the identity work she had to do involved
and required her to pursue a job in physiotherapy. This continued to be a
story she told herself because being a physiotherapist, despite now being
retired, was an important aspect of her personal identity. The understanding
of specific processes and situations of identity construction in and around
work and organizations in physiotherapy as it relates to motivation and
attitude is somewhat limited. As many authors have pointed out, there is a
lack of in-depth studies of specific acts, events and processes (for example,
Chris’s story *Postgraduate Training* was problematic for him because it exemplified a loss of coherence between his professional and workplace values. Therefore, his identity was compromised. Sharing this experience within the group stimulated discussion about attitudes, and the extent of commitment, to continuing professional development. Each participant expressed motivations that reflected their beliefs and commitments to both their career and their other ongoing personal identity. Was it acceptable to have to pay for one’s own postgraduate training, how much of this should be in one’s own time. What were the motivations for undertaking continuing professional development? It could be a quest for knowledge, for craft or propositional knowledge, or the need to justify one’s registration to the statutory regulator. The group concluded that each physiotherapist and the different professions they work with hold a range of attitudes and motivations towards this.

8.2.2 **Social integration**

By social integration, I mean the integration of the profession into society. Society as a whole and its institutions in particular shape how professional identities of physiotherapists are constructed. Their various backgrounds and life histories also shape these; thus, there is the potential for a constant becoming. This can be a fluid and evolving process, with identities transforming because of experiences, and continuing throughout their careers.
The physiotherapy profession often uses the word identity synonymously with image (for example, Belanger, 1998) and the hunt for a strong brand (for example, Paris, 2006). The profession has considered identity from the perspective of what image it does have, in order for a collective image to be adopted and used to market the profession (for example, WCPT, 1999). It may be useful to separate out these concepts. A strong image, brand and narrative are important to communicate, position, and market the profession, or the services the profession can provide. However, for an emergent, relatively young profession more effort is required to reflect and theorise its values, beliefs and knowledge in order to do so. In the UK, the profession has taken a big step forwards in publishing a code of values and ethics (CSP, 2011). More empirical data are required to understand what core ethical knowledge in required in physiotherapy, how physiotherapists negotiate the ethical dilemmas they face in practice, what resources they use, and how they interpret and implement the values the profession has chosen to espouse. In doing so, the profession might better be able to strengthen its collective self-concept. A better articulated self-concept may enable more members of the profession to feel confident and able to engage in the public domain.

8.2.3 Moral thinking

Professional identity is to do with the values, attitudes and beliefs that people have. I suggest it is co-constructed between two people, and is partly based on, or stimulated and enriched by, memories of experiences and the stories told of experiences. This thesis is based on the idea of memory informing
and integrating moral reasoning into our personal and professional life. This section considers what sort of moral thinking physiotherapists may be required to do.

Habermas has described how people make meaning of their actions by participating in the ‘communicative context’. This is, as I understand it, the thrust of Habermas’s conception of communicative rationality: the potential for all competent speakers to challenge each other and come to an understanding. Moral meanings are constructed in and through the words and forms of discourse that are encountered in dialogical and narrative exchanges. The participants’ stories reflected larger discourses and narratives that live within the culture of physiotherapy. As moral people, in principle, we must be able to give an account of our own actions:

“One reason we tell stories is [as] a sort of self-examination by self-exposure. Often we find out what we think by listening to what we say. Telling stories helps us to find out who we are”

(Tirrell, 1990, p.117)

The CSP’s Rules of Professional Conduct, which have been in place since 1920, and its Code of Professional Values and Behaviour (CSP, 2011), form the starting point for articulating the values, beliefs and motivations of the profession. This latter is a major step forwards in articulating the nature of professional and ethical thinking required of physiotherapists in current times. The CSP based its Code of Values and Behaviour (CSP, 2011b) on the prime ethical framework used in healthcare ethics: principlism. Table 13 lists the CSP’s stated ethical position against the four principles of principlism.
<table>
<thead>
<tr>
<th><strong>Principlism</strong></th>
<th><strong>CSP Underpinning ethics (CSP, 2011b)</strong></th>
<th><strong>CSP Underpinning values (CSP, 2011b)</strong></th>
<th><strong>CSP Core professional concepts (CSP, 2011b)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respect for autonomy - free-will or agency</td>
<td>Respect for individual autonomy</td>
<td>Altruism, in terms of giving priority to the interests of individuals</td>
<td>Competence</td>
</tr>
<tr>
<td>2. Beneficence - to do good</td>
<td>Promoting what is best for the individual</td>
<td>Advocacy</td>
<td>Person-centred practice</td>
</tr>
<tr>
<td>3. Non-maleficence - not to harm</td>
<td>Avoiding harm</td>
<td>Honesty and integrity</td>
<td>Professional autonomy</td>
</tr>
<tr>
<td>4. Justice -- social distribution of benefits and burdens</td>
<td>Fairness in how services are delivered</td>
<td>Compassion and caring</td>
<td>Professionalism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accountability for decision-making and actions</td>
<td>Scope of practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fulfilment of care and social responsibility</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commitment to excellence</td>
<td></td>
</tr>
</tbody>
</table>
In my role as professional adviser at the CSP, and in my clinical practice, I have to make use of these two documents. With societal changes, as outlined in Chapter Two, and the increasing expectations for transparency required through clinical governance, comes a greater responsibility for physiotherapists. This is to articulate their thinking and record their actions. The increasing ability of healthcare to maintain life poses increasingly complex moral dilemmas.

Kohlberg's stages of moral development holds that moral reasoning, the basis for ethical behavior, has six identifiable developmental stages, each more adequate at responding to moral dilemmas than its predecessor (Rest et al., 1999). Kohlberg determined that the process of moral development was principally concerned with justice, and that it continued throughout the individual's lifetime. Kohlberg's six stages can be more generally grouped into three levels of two stages each: pre-conventional, conventional and post-conventional (Habermas, 1991). Table 14 outlines these three levels of moral development and briefly describes the six sub-levels.
### Table 14 Three levels of moral development

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Pre-Conventional</th>
<th>Judges the morality of an action by direct consequences; solely concerned with self. Not yet adopted society's conventions for what is right or wrong, instead focuses on external consequences that certain actions may bring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Obedience and punishment orientation</td>
<td>Lacks recognition that others' points of view are different from one's own (How can I avoid punishment?)</td>
</tr>
<tr>
<td>2.</td>
<td>Self-interest orientation</td>
<td>Limited interest in needs of others, but only where it might further the individual's own interests (What's in it for me?)</td>
</tr>
<tr>
<td>Level 2</td>
<td>Conventional</td>
<td>Typical of adolescents and adults; Judgment of morality of actions against society's views and expectations. Obeys rules and follows society's norms even when no consequences for obedience / disobedience. Adherence to rules somewhat rigid and a rule's appropriateness or fairness seldom questioned</td>
</tr>
<tr>
<td>3.</td>
<td>Interpersonal accord and conformity</td>
<td>Enters society by filling social roles. Receptive to approval or disapproval from others as it reflects society's accordance with the perceived role: &quot;good boy&quot; or &quot;good girl&quot; to live up to these expectations, having learned that there is inherent value in doing so. Desire to maintain rules and authority exists only to further support these social roles. The intentions of actions play a more significant role in reasoning at this stage: &quot;they mean well&quot;. (Social norms)</td>
</tr>
<tr>
<td>1.</td>
<td>Authority and social-order maintaining orientation</td>
<td>Obeys laws, dictums and social conventions because of their importance in maintaining a functioning society: society must learn to transcend individual needs. A central ideal or ideals often prescribe what is right and wrong, such as in the case of fundamentalism. If one person violates a law, perhaps everyone would—thus there is an obligation and a duty to uphold laws and rules. Culpability is thus a significant factor in this stage as it separates the bad domains from the good ones. Most active members of society remain at stage four. (The good boy/good girl attitude)</td>
</tr>
</tbody>
</table>
### Level 3

**Post-Conventional**

<table>
<thead>
<tr>
<th>2. Social contract orientation</th>
<th>Growing realization that individuals are separate entities from society, and individual’s own perspective may take precedence over society’s view; they may disobey rules inconsistent with their own principles. These people live by their own abstract principles about right and wrong—principles that typically include such basic human rights as life, liberty, and justice. People who exhibit post-conventional morality view rules as useful but changeable mechanisms—rules can maintain the general social order and protect human rights. Rules are not absolute dictates.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. Universal ethical principles</th>
<th>Moral reasoning based on abstract reasoning using universal ethical principles. Laws valid only insofar as they are grounded in justice, and a commitment to justice carries with it an obligation to disobey unjust laws. Decisions are not reached hypothetically in a conditional way but rather categorically in an absolute way: an individual imagines what they would do in another’s shoes if they believed what that other person imagines to be true. The resulting consensus is the action taken. In this way action is never a means but always an end in itself; the individual acts because it is right, and not because it is instrumental, expected, legal, or previously agreed upon.</th>
</tr>
</thead>
</table>

(Based on Habermas, 1991)
The point I want to make with the various theories outlined in Tables 13 and 14, and in Table 15 below is that the theory and practice of moral and ethical judgement has progressed in recent times and that the frameworks and practices of physiotherapists changed too. Principlism has dominated thinking about healthcare ethics (Carpenter & Richardson, 2008; Purtilo, 2005). The CSP, in publishing a set of rules (1920 – 2010) has followed a societal norm for professions. In publishing the Code of Professional Values and Behaviour (CSP, 2011b) it is adopting a new position, more reflective of Kohlberg’s level three, post-conventional moral thinking. However, as I illustrated in Table 13, this code continues to use the ethical framework of principlism.

What the CSP Code of Professional Values and Behaviour provides is a modernised articulation of the background thinking and underpinning ethical stance for the profession regarding an attitude towards role, behaviour and standards of practice. Principlism has been widely adopted in medical ethics and education and by other health professions (Carpenter & Richardson, 2008; Purtilo, 2005). However, recent thinking on ethical reasoning in healthcare has led to the development and recognition that there are different ways for individuals to reason. Practitioners have started to apply alternative theories in practice (Carpenter & Richardson, 2008). In Table 15, I describe some of these alternatives.
<table>
<thead>
<tr>
<th>Ethical framework</th>
<th>Brief description of ethical framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casuistry or case-based ethics</td>
<td>Emphasises the importance of looking closely at the facts and values in context and uses exemplar cases, rather than ‘principles’ or ‘rules’</td>
</tr>
<tr>
<td>Ethics of care</td>
<td>Influenced by feminist theory, understands autonomy differently: self-governance has different meanings for people and people define the “self” in different ways. Professionals urged to adopt a respectful, compassionate concern for each unique individual’s welfare in the context of their life, relationships and value system</td>
</tr>
<tr>
<td>Narrative ethics</td>
<td>Focuses on developing a shared understanding of the meaning of the illness experience and the patient’s story within the patient–health professional relationship that enhances the healing potential of the encounter</td>
</tr>
<tr>
<td>Virtue-based ethics</td>
<td>Emphasis on the kind of person you should strive to be: ‘moral character’ who ‘demonstrates a predictable disposition to choose the good whenever confronted with a choice’; able to find a caring response</td>
</tr>
</tbody>
</table>

There is a need to develop thinking about how we enable different ethical philosophies to sit within the profession. There are different levels of abstraction within the field of moral thinking. The moral domain is broad and moral judgement is only one aspect (Rest et al., 1999). The profession is emerging from a history of having rules that perpetuate a conventional mode of thinking. This led to individuals obediently following or adhering to a set of rules. This has the potential to limit reflection and reflexivity in practitioners’ thinking about the values, beliefs and ethics of their practice. One challenge for the profession is to connect the broad, high-level abstract principles of moral reasoning (for example, Kohlberg’s model) with more concrete ethical principles that can inform and guide everyday situations (Rest et al., 1999). Carpenter and Richardson (2008) and Swisher (2002) have reviewed the
literature in physiotherapy and ethics and identified that interest in ethical concerns of professional physiotherapy practice is increasing, and that gaps remain. The idea of moral agency is being promoted within physiotherapy (for example, Carpenter, 2010; Purtilo, 2000; Swisher, 2002). This mirrors the third stage of moral development, post-conventional moral thinking (Rest et al., 1999).

The CSP’s ROPC and Code of Professional Values and Behaviour, the HCPC standards, and the requirements of clinical governance in healthcare institutions have led to a greater degree of explicit moral and ethical reasoning. This has occurred simultaneously with a rise in the theorisation of clinical reasoning (for example, Edwards, 2004, 2005; Jensen, 1999; Jones, 1997). I suggest, in line with others (for example, Carpenter & Richardson, 2008), that there is a need for more discussion considering the types of ethical and moral dilemmas that physiotherapists face, how they deal with them, and what is successful in order to develop the profession’s national articulation of its ethics and values. For example, what does ‘altruism’ mean for physiotherapy? How do physiotherapists enact this? What challenges do physiotherapists face when enacting an altruistic attitude? Does altruism mean the same thing within one specialty (for example for physiotherapists working in state-sponsored musculoskeletal outpatients and in private practice musculoskeletal outpatients)? Does altruism mean different things across the profession (for example when working in burns rehabilitation and for learning disability services)? What does autonomy mean for physiotherapists who work in intensive care and for primary care...
physiotherapists who inject prescribed medicines? What tensions exist for physiotherapists in their attempts to “promote what is best for the individual” in mental health, in women’s health, paediatrics?

It is natural for a relatively young profession to need to develop a stronger and clearer understanding and articulation of its ethics. How physiotherapists enact their values can support a better appreciation of this. Recent work on clinical reasoning has focussed on the contribution of ethics to the relationship between practitioner and client rather than that between the physiotherapist and colleagues, recognising post-conventional moral thinking in a post-metaphysical world where there are not necessarily rights and wrongs but collectively agreed upon decisions.

I suggest more work is required in physiotherapy to understand and articulate the values of physiotherapists. They remain taken for granted, and essentially virtuous rather than realistic (i.e. grounded in real life practice). Aguilar et al. (2012) considered the professional values of physiotherapists in Australia (Aguilar et al., 2012). Aguilar et al. (2012) classified the physiotherapists’ values and compared them against those published in the United States of America. This helps to understand how physiotherapists think about themselves, but the list remains a list of worthy but ill-defined virtues. The profession would benefit from better understanding how successful its members are in enacting such values (for example, Mansbach et al., 2011). Personal beliefs can be in conflict with workplace or colleagues’ beliefs. It would be useful to examine further how physiotherapists manage
such conflicts: how they are left feeling, and what do they do with these resultant feelings. One such value is the patient – therapist relationship, of late challenged by the idea of client-centred practice. This model of practice places the patient centrally in the professional relationship and supports the notion that an understanding of the patient’s perspective should underpin good practice in an equal therapeutic relationship (CSP, 2011b; DH, 2004a; 2005). An example of how physiotherapists really enact the principles of the value of an equal relationship is how successfully practitioners secure informed consent, the challenges of which for physiotherapists are beginning to be explored (for example, Delaney & Frawley, 2012).

8.3 Emancipatory knowledge in physiotherapy

D’Entreves (1996) suggests that one way for contrasting the difference between Habermas and a postmodernist perspective is to consider their “sense of responsibility”: Habermas privileges a responsibility to “act in the world in a normatively justified way”, while “the postmodernists “celebrate the responsibility to otherness” (D’Entreves, 1996, p.2)39. D’Entreves (1996) suggests that these two senses of responsibility open up a perspective on the function of language. Habermas sees in language its capacity to coordinate action, while postmodernists to disclose the world (D’Entreves, 1996, p.2). These perspectives are not mutually exclusive but more a matter of who considers which the first among equals (D’Entreves, 1996, p.2). Those who are developing skills in ethical reasoning and are becoming used

---

39 When referring to postmodernists, D’Entreves appears to have in mind Derrida and Foucault and others who have followed their work (D’Entreves, 1996, p.1-2).
to discussing ethical and moral reasoning in their workplace and as a professional develop a stronger sense of what they believe, value and know. Habermas claims that emancipatory knowledge is related to the development of self-knowledge. This supports the gaining of power over the forces that control one’s life, understanding why a situation has come about based upon human actions and what the future could be. It is this set of thinking that informs his notion of communicative rationality upon which this thesis sits.

Trede (2006; 2012) has proposed that the profession adopt a critical social science of physiotherapy. The thrust of this suggestion is to embed ideas of enlightenment, empowerment and emancipation within a professional physiotherapy discourse and praxis:

“Professionals should not, as is too often the case, be sent out into the world of practice with a set of stock answers, or worse, unanalysed prejudices. Moreover, in their dealings with patients, they should be encouraged to make their values explicit, while recognising the rights of their patients. Therein lies the opportunity for real engagement between patient and professional.”

(Kennedy, 2009, p.118)

I have asked how physiotherapists construct their identity as a means for helping to understand what physiotherapy is today. In doing so I have argued that if physiotherapy can better examine itself and create more widespread articulation of its own norms of thought, discourse and practice, then it opens up a space for dissent, critique and action. This could be by challenging the inherent contradiction between the instrumental rationality the profession has embraced and its desire to enable autonomous agency. A profession that does this might find it can better serve an emancipatory interest in health and in society.
8.4 On the construction of identity by physiotherapists: concluding remarks

I have proposed that my interpretation of the data suggests that identity is no longer satisfactorily understood as a fixed asset. I have also proposed that professional identity in physiotherapy is a more complex notion, recognising that identity is fluid across time and place. However, I want to take this thinking further and suggest that the concept of identity is not only fluid but that it is co-constructed between people; that is, on their own, an individual does not create it. This additional aspect to the concept of identity was evident in the study data. The participants considered how their personal values and motives influenced their professional identity, that is, their professional attitudes, values, beliefs, and motivations. They provided examples of how they talked through such values with others, at times physiotherapy colleagues (for example, The Wandering Woman), non-physiotherapy colleagues (for example, What Makes Me Tick), or friends (for example, My Mother, My Family and Me).

Poole (2008) argued that memories that are not “supported and confirmed by my friends, family members, colleagues and the like tend to lapse” (Poole, 2008, p.152). Physiotherapy is not an isolated profession and operates within what Wenger called “communities of practice” (Wenger, 1998). I see professional identity incorporating group interactions in the workplace; how people compare, and differentiate themselves, from other professional groups. Wenger (1998) identified three modes of belonging to social learning systems, namely engagement, imagination and alignment. Later Wenger
(2002, pp. 78–79) added the following statements in his descriptions of these three modes:

**Engagement** is “doing things together, talking, producing artifacts (for example, helping a colleague with a problem)”;

**Imagination** is “constructing an image of ourselves, of our communities and of the world in order to orient ourselves, to reflect on our situation, and to explore possibilities”;

**Alignment** is “making sure that our local activities are sufficiently aligned with other processes that they can be effective beyond our own engagement”.

*The Wandering Woman* is a crafted dialogue in which the participants recognized a need to do things together. Emma and her physiotherapy friends talked through their experience to “check they had done the right thing”. She aligned herself and her community of practice with the GP practice. However the response they received from the GP practice undermined this alignment, the reassurance they wanted, and may be why this story, this experience, is memorable for her.

Wenger’s definition of imagination included the phrase “constructing an image of ourselves” and this is related to our perceptions of the role we play in a given context. As Wenger (2002) pointed out: “our identities are not necessarily strong or healthy. Sometimes they are even self-defeating”.

200
Wenger (2002, p.92) proposed the following three qualities: connectedness, expansiveness and effectiveness. Wenger’s (2002) descriptions of these qualities included the following:

**Connectedness** A strong identity involves deep connections with others through shared histories and experiences, reciprocity, affection, and mutual commitments.

**Expansiveness** A healthy identity will not be exclusively locally defined. It will involve multi-membership and cross multiple boundaries.

**Effectiveness** Identity is a vehicle for participating in the social world, but it can also lead to non-participation. A healthy identity is socially empowering rather than marginalizing.

Table 16, overleaf, combines these qualities into a matrix structure with the three modes of belonging (engagement, imagination and alignment discussed earlier) connected to the three qualities (connectedness, expansiveness and effectiveness) listed above.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How does one’s engagement within a COP contribute to the forming of deep connections among members?</td>
<td>How does one’s engagement within a COP contribute to interactions with other COPs?</td>
<td>How does one’s engagement within a COP contribute to effective action within the COP?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A2: Imagination</td>
<td>How does one’s image of self and community help towards forming deep connections among members of a COP?</td>
<td>How does one’s image of self and community help towards creating interactions with other COPs?</td>
<td>How does one’s image of self and community contribute to effective action within the COP?</td>
<td></td>
</tr>
<tr>
<td>A3: Alignment</td>
<td>How do established alignments contribute to the forming of deep connections within a COP?</td>
<td>How do established alignments help towards creating interactions with other COPs?</td>
<td>How do established alignments contribute to effective action within a COP?</td>
<td></td>
</tr>
</tbody>
</table>

COP = Community of Practice

Based on Wenger (2000) p. 240
Wenger’s model reflected Habermas’s idea of “individuation through socialisation” (Habermas, 1995 p.149). This was the theory that an individual has to be socialised into the thinking, beliefs, values and knowledge and accepted into a group or culture before they can then devise their own version of these same beliefs, values and knowledge and remain accepted (Habermas, 1995). The crucial twist is that while they may not agree with an individual, they recognise the individual’s right to have an opinion, because the individual is part of what is recognised as the same as the group (Habermas, 1995). This, Habermas argued, is performed through discursive and reflective processes (Habermas, 1995). This chimes with recent conceptions of identity as a process, a becoming, instead of as a thing or substance or a being (Sveningsson & Alvesson, 2003; Wenger 1998).

I am interested in how this plays out for physiotherapists in full time clinical practice. In the crafted dialogue (Postgraduate Training), the discussion hones in on the attitudes the participants have towards full time and part time clinicians. One participant used full time work as a member categorisation technique to categorise herself as full time, committed and motivated to work, against part time workers who work for “pin money”. Others in the group challenge this. This might mirror Wenger’s ideas of expansiveness, connectedness and effectiveness: do full time clinical physiotherapists lack the connectedness that part time physiotherapists are able to achieve through other relationships and within other communities of practice? Is the model of working full time on a ward or in a department unhealthy for identity construction? The possibility of individual agency, choice and change is
made possible by what Lapointe (2010) identifies as the “multiple and contradictory positions in a given situation and the reflexive capability of the person as an embodied being to adopt alternative positions — to imagine otherwise” (Lapointe, 2010, pp.3-4). The participants did this on several occasions, for example Caroline with The Transformed Bedroom story, Chris in The Pizza and the Patient, Louise with Postgraduate Training. This thinking repeats Haug’s observation that in “re-discovering the responsibilities we regain new chances and different possibilities to act in the present and in the future” (Haug et al., 1987, p.42).

My thesis suggests that the co-construction of identity is done through ‘identity work’ and that this is something physiotherapists are doing consciously or unconsciously in the act of being a physiotherapist; that is, identity work involves a constant and ongoing act of becoming of identity rather than having an identity.

Professional identity is one of the multiple social identities an individual holds. Figure 3 represents this thinking. It illustrates the central role of personal identity in professional identity construction. The personal attitudes, beliefs, values, motives and experiences that an individual holds and enacts feed the ongoing professional identity. This identity work is enhanced by workplace identities and builds on career identity constructions. This is included in Diagram 3. Some physiotherapists have more than one job or have had more than one career and bring these identities to their physiotherapy professional identity. The emotions that a physiotherapist consciously or unconsciously
feels influences, and possibly drives, this identity work, and leads to the possibility of agency, choice and change for how one thinks, speaks and behaves.

**Figure 3 The constant and ongoing act of becoming of identity**

Figure 4, p.216, further develops this model and represents the key messages for this conceptualisation of how physiotherapists construct their professional identities:

1. The co-construction of identity is done through ‘identity work’. Identity work involves a constant and ongoing act of becoming of identity rather than having an identity.
2. Physiotherapists undertake identity work consciously or unconsciously in the act of being a physiotherapist; of making sense and
(re)interpreting one’s attributes, beliefs, values, motives, and experiences.

3. It involves the possibility of individual agency, choice and change, made possible by adoptable positions in a given situation and the reflexive capability of the person as an embodied being to assume alternative positions — to imagine otherwise.

4. Emotion drives this personal agency; anger, frustration, some disillusionment, yet shining through is possibility, the “different possibilities” for change, of how things could be. The challenge then becomes one of whether the individual wants to make a difference, make the change happen or gives in to how things are.

5. Physiotherapists co-construct their professional identities within intra-professional and inter-professional communities of practice, clients inform this, and this is mediated through an unfolding career by workplace and institutional discourses, boundaries and hierarchies, and the contingencies of their life story.

Figure 4 shows the connections between this identity construction and time. It also shows the connections between identity construction and both local (micro) contextual factors (for example, a workplace situation) and larger (macro) contextual factors, (for example, a national discourse). Figure 4 also adds the dialogical, intersubjective element of co-construction of identity, for example, colleague and clients, family and friends.
This construction of identity is fed by the individual’s feelings; of making sense and (re)interpreting one’s attributes, beliefs, values, motives, and experiences, one’s professional self-concept constitutes professional identity. Professional identity is related to the professional role and socially situated; it is not tied to a particular post or place. For example, a band 5 physiotherapist on a respiratory rotation can construct a professional identity with the staff, patients and carers during their time on that rotation. When they leave the post another band 5 physiotherapist constructs a different professional
identity in that workplace: it is therefore a local accomplishment. The construction of professional identity involves the possibility of individual agency, choice and change, made possible by positions in a given situation and the reflexive capability of the person as an embodied being to adopt alternative positions — to imagine otherwise.

8.5 Summary

This discussion has reflected on the interpretation of the data generated and has discussed and developed the concept of professional identity in physiotherapy as an ongoing and dynamic process; of making sense and (re)interpreting one’s professional self-concept based on ever-evolving attributes, beliefs, values, motives, and experiences. Physiotherapists co-construct their identity within intra-professional and inter-professional communities of practice, informed by clients, and mediated through an unfolding career by workplace and institutional discourses, boundaries and hierarchies, and the contingencies of a life story. I have suggested this co-construction is done through ‘identity work’ and that this is something physiotherapists are doing consciously and unconsciously in the act of being a physiotherapist; that is, identity work involves a constant and ongoing act of becoming of identity rather than of having an identity.
Chapter 9 Critical reflections of the research study

9.1 Reflections on the research process

Collective memory work was a useful source of data generation for research in physiotherapy. The value of the methodology was that it had clear principles and guidance for implementing the method. There is sufficient scope to refine the technique to suit the proposed study question and the practicalities of engagement of the participants. This encouraged me to think that future research with different cohorts of participants could use the CMW technique but with variations to suit their particular needs.

9.1.1 Returning to the original study aim

The original research aim, listed in Chapter 1, was to examine critically how physiotherapists come to be the physiotherapist they are, in order to understand better how physiotherapists construct their professional identities on a daily basis, in the reality of the lives they are living. Within a context of changing healthcare requirements and institutional expectations, I was interested to know how do physiotherapists come to be the physiotherapists they are. Therefore, the research question posed was “What does it mean to be a physiotherapist?”

The aim of the study has been addressed in that I have generated a way of thinking about what it means to be a physiotherapist. I have done this by concluding that physiotherapists come to be the physiotherapists they are through an on-going and dynamic process of ‘identity work’. This involved
individuals making sense and (re)interpreting their professional self-concept based on ever-evolving attributes, beliefs, values, motives, and experiences. Making meaning of being a physiotherapist was something physiotherapists were doing consciously and unconsciously in the act of being a physiotherapist all the time; that is, identity work involves a constant and ongoing act of becoming of identity rather than of having an identity.

9.1.2 Researcher as participant
The process of undertaking ‘insider’ research has proved challenging. I held initial concerns about the preparedness of participants to share their experiences and responses honestly: how much they would be ‘on show’. I also had some fears that they would not engage with the initial icebreaker theme boards or the main data generation method, collective memory work: would they write up the story of a memory, would they continue to attend each meeting, would they have the stamina to endure 12 meetings? These fears proved unfounded, as the participants held their interest and maintained the commitment. The reactions of the participants to the first task, the theme boards were positive and this technique was successful, valuable. During the last meeting, meeting 13, six months after the final data generation meeting, the participants were reflecting on their involvement in the research study and came to talk about the theme boards: “I loved it”; “I quite enjoyed it” (agreeing); “Very good way of breaking the ice”. Only one participant withdrew.
One tension I tried to balance was how frequently the group ought to meet in order to generate and sustain momentum to the data generation. This needed to be weighed against the real possibility of overwhelming the participants or expecting too much of their generosity in participating. We discussed the frequency of the meetings and agreed on two not three weeks. However, I came to find my capacity to transcribe the recording of each meeting in two weeks (i.e. before the next meeting) and prepare for the next meeting was tested. The reality of completing this procedural and preparatory work for each meeting was more of a burden than I had anticipated.

By situating myself within the group, I had to try to relinquish control of meetings yet also felt a compulsion to want to drive the study through. This tension did not recede. I was constantly anxious about when and how to intervene during the meetings, when to let the flow of the discussion continue, even when we wandered off topic, how much to leave this to be and when and how to try to bring the discussion back to the focus of the meeting. I worried about their response: would they see this as an intervention by me as the researcher – so that I retained a control over them that I had hoped to cede, or would they see this intervention as an acceptable contribution by another participant to help keep the meeting ‘on track’.

This balancing act was also present in my delivery of the day-to-day logistics of the meetings. In Table 5, Chapter Four I described the intention to respect the participants’ welfare during the course of the data generation meetings; in
delivering this I once again found myself ‘in charge’. Providing refreshments (tea, coffee, biscuits, fruit), ensuring a warm and welcoming venue (for example, by checking the heating was on, setting the room out, laying a tablecloth, tidying away afterwards), and being the first to arrive and the last to leave, promoted me as the lead or facilitator and upset my role as participant. For future research of this type, I would look to engage the participants in taking responsibility for some of these tasks. In making these observations I recognise that my role was twofold: I was the researcher with most invested in the study, and I wanted to be a participant. It was my responsibility to looking into the welfare of the participants, to send emails before and after the meetings, to keep in touch since data generation finished.

9.1.3 Engagement of participants

What I was able to do successfully was to recruit physiotherapists to the study, to engage them in the topic, research questions and methods, and maintain their interest over the course of the study. The participants attended twelve meetings, once a fortnight for six months, and a final meeting six months later. I found that physiotherapists were prepared to participate in an arts-based activity (the theme boards); they were able to reflect on their experiences, to write these down, and to present them back to a group. This overcame the suspicion that physiotherapists would not engage in such “non-traditional” research techniques. I found they enjoyed the process: the discussions of these memories within the group and the critical discussion about what the stories means to them individually and collectively.
During the final, thirteenth, meeting, the participants discussed their recruitment. They shared their immediate responses to the original advertisement posted to the web forum (interactiveCSP). Several participants (one in an academic post, the other two retired) admitted they had initially been interested in the topic of the study but had assumed that the target audience was clinical physiotherapists. They had therefore not responded to the original advertisement, but did to the second. For future research recruitment, I would strengthen the focus of the advertisement to the target groups, possibly by creating several different advertisements. This could be achieved by highlighting ‘retired’ physiotherapists or ‘academic / research’ physiotherapists, in the text.

9.1.4 Matters of analysis

I found the analysis a challenge. This challenge was to work with the stories in a way that met the needs of my degree while also respecting the theoretical perspective I had taken. On embarking upon the themed analysis, I slowly became concerned that I was reverting to the realist orientation that I had actively sought to reject. I was concerned that this prioritized and privileged me over the participants (i.e. my choice of words were selected not theirs). I was also anxious about making too many decisions too soon, before I felt ready to do so. I had so much data I also felt overwhelmed and gradually had to admit to myself that I found it hard to read and engage with the transcriptions.
I realised that the wholeness of the data, the experience of the participants, and the discussions we had required a different type of analysis. This requirement was new to me and unexpected. I came to see that I needed to maintain the intersubjective, dialogical nature of the method, the ‘to-ing’ and ‘fro-ing’ of utterance and response, the telling of anecdotes, the use of supportive gestures, and the agreement and disagreement that occurred. I came to see that storytelling is at the heart of this thesis in several ways: using theme board stories were the initiation for participants into the method of collective memory work. We shared written stories we had written privately, we shared personal stories as we discussed and analysed the memory stories. Mattingley (1998) has observed how storytelling is part of clinical life: handover stories, patient episodes of care stories, patients’ experiences stories, episodes of clinical practice life, stories of success, of failure, of embarrassment, of anxiety, of getting it right and of getting it wrong (Mattingley, 1998). I have come to see the stories as a tool for the interpretation of the data generated: the crafted dialogue is a form of ‘storying’ the discussion, and one that helped me maintain and preserve the voice of the participants. I propose that crafted dialogue, an arts-based technique is useful for data interpretation because it can convey the meaning of my research data without claiming to have captured “reality”.

215
9.1.5 Rigour and quality

I have used the framework of Khanlou and Peter (2005)\(^{40}\) to reflect on the ethical basis of this study. See Table 17.

Table 17 Guidelines for the ethical consideration of research

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Social / scientific value</td>
</tr>
<tr>
<td>2.</td>
<td>Scientific validity</td>
</tr>
<tr>
<td>3.</td>
<td>Fair subject / participant selection</td>
</tr>
<tr>
<td>4.</td>
<td>Favourable risk–benefit ratio</td>
</tr>
<tr>
<td>5.</td>
<td>Independent review</td>
</tr>
<tr>
<td>6.</td>
<td>Informed consent</td>
</tr>
<tr>
<td>7.</td>
<td>Respect for potential and enrolled participants</td>
</tr>
</tbody>
</table>

(Taken from Khanlou & Peter, 2005)

1. Social / scientific value

One study objective was to have effects on, and for, the participants and their practice. To be successful this would generate insights pertinent to the individuation of each, and themes that resonated for the socialisation of the wider profession. I aimed to generate knowledge focused ‘upon action, not understanding alone’ (Khanlou & Peter, 2005, p.597); that is, for the participants, through self- and group-reflection, to ‘recover, and release themselves, from the constraints of irrational, unproductive, unjust, and unsatisfying social structures that limit their self-development and self-determination’ (Kemmis & McTaggart, 2000, p.597).

2. *Scientific validity*

The research process challenges more traditional realist forms of validity, through which ‘findings’ can be objectively and independently verified. The philosophical perspective outlined argues that a pluralist and pragmatic partnership between text as fact and participant as interpreter can generate knowledge. My interpretation of the text has added depth to the interpretive act and a broader perspective: I have emerged from the depth of the data and generated a more holistic interpretation for a wider audience. Other readers may interpret the same dataset differently. What gives the study validity, or pertinence and resonance, is the transparency I have tried to achieve in describing the process of participant selection, data generation, and data analysis, and my interpretation.

3. *Fair subject / participant selection*

Interested parties were recruited, that is, people with an interest in the method, methodology, and or the topic AND a preparedness to invest the time and energy with the project. This ruled out many other potential participants and potential experiences. This was justified given the intention for the knowledge interest the study has generated; that is critical, emancipatory knowledge for participants, having reflected individually and in a group on their own and each other’s professional experiences. I reassured potential participants that their decision whether to participate would not affect their employment status. If required I intended to establish this with their manager. However, this was not needed: all data generation meetings took place outside of participant employed / working hours.
4. Favourable risk–benefit ratio

The prime risks were outlined in Chapter Four. These were related to surrounding decisions made when the establishing and forming the group, participant withdrawal, and the ability of participants to engage with the principles of the methodology. The challenge was to find language that attracted the interest of the line manager and their staff. I needed to persuade potential participants of the sincerity of the methodological principles. I tried to demonstrate this through the process of recruitment and the negotiations in setting up and organising the group meetings. One of the principles of CMW was that the participants identified between themselves the trigger topics, the questions they asked each other, and therefore the specific direction of the study. Once the broad topic had been agreed, I, with, probably, the most invested in the success of the project, attempted to nurture a participatory ethos that encouraged the participants to ‘own’ the project; that is to feel empowered to pursue the analysis and reflections that emerged, as they emerged, and to develop conclusions from this analysis. When set against the benefits of knowledge generation, the risks outlined were outweighed.

5. Independent review

The relinquishing of a dominant role by me to the participants was liberating and purist, and created vulnerability: data generation was at risk if the participants had been unable to deliver what was required of them. The conclusions the participants drew from their self- and group-reflections exposed the thesis. I built an ‘induction’ element into the first meeting. This
aimed to establish agreements for how the group would operate, ‘ground rules’. For example, respect for each other, respect for confidentiality, commitment to engage constructively. The participants were encouraged to submit papers to peer-reviewed journals, as one means for demonstrating ownership of the process and conclusions, and to submit the process and analysis to consideration within the profession. While we did discuss this at the final meeting, meeting thirteen, and two participants agreed to draft some text, this did not happen and the idea was not progressed.

6. Informed consent

This was secured as part of the recruitment process, as described in Chapter 5, Section 5.1.2.

7. Respect for potential and enrolled participants

I attempted to respect participant autonomy and welfare through the protection of their confidentiality and privacy, assurance to participants that they could withdraw from the research without being challenged, and the provision of research results to participants. The processes for these were described in Chapter Four.

The deliberate blurring of the roles of the participants required particular attention to ensure ongoing respect for the participants, as research participants, and that the group worked together. Through this, I tried to enable the group to attend to the research question and study aims, and to engender ownership for the project.
9.2 Limitations of the study

This thesis has considered how physiotherapists construct their professional identity. It has focused on the discursive nature of identity work. This thesis has not considered image within the profession of physiotherapy, either the image of physiotherapy or the image of physiotherapists. This is a limitation to thinking about professional identity. Identity and image are intimately connected; I take image to be the signs, pictures, representations, held about a concept, in this case, the profession. There is some literature about the perceptions held of physiotherapy and of physiotherapists (for example, Dalley & Sim, 2001; Swinkels et al., 2002; Whitfield et al., 1996), but very little analysis of what may be considered the ‘pictorial semiotics’ of the profession. This is the analysis of the meanings of signs used within and about the profession. I consider image, branding and marketing as another aspect of professional identity. Further study could usefully ask what are the impacts and relationship of image, branding and marketing on professional identity within physiotherapy.

The ideas of image and external identity perceptions connect to the analytical distinction between people’s ‘internal’ self-identities and the ‘external’ social-identities to which they relate (Watson, 2008, p.123). This requires consideration of the idea of the self as an ideal, an actuality, and an expected phenomenon. This means firstly reflection on the self that one might strive toward, secondly on the self that actually exists, and thirdly on the self as a construction of society (Thomas & Beauchamp, 2011, p.763). This thesis has not considered this aspect of identity. A more sophisticated appreciation of
the role of self could enhance the individual physiotherapist's self-awareness. It might also contribute to external expectations about the profession and the role and motivations for how physiotherapists come to be. Another element of external expectations is the other in physiotherapy: for example, patients, users, families, work colleagues, managers. What is their role and identity and how do they construct themselves in relation to physiotherapists?

The diversity of the cohort of participants and the geographical limit to recruitment meant that the interpretation of the data generated and the subsequent conclusions may not be transferable to the wider profession. It could be that other physiotherapists with other ethnic or physiotherapy backgrounds undertake identity work in different ways. It is not possible to understand the impact of me as a man within the group. It is likely that a female physiotherapist leading such a group or a man leading a group of male physiotherapist participants would generate quite different data. Such studies would be valuable.

9.3 Location of this study in the wider context

This thesis addresses several aspects of being a physiotherapist in current times. These include ideas about what it is to be a professional, how to be a physiotherapist in the changing UK healthcare world, and how the profession might support its members to generate greater self-awareness, through more honest discussion of the feelings experienced and evoked in the act of being a physiotherapist. I address these three aspects below.
9.3.1 Evolving sense of professionalism

The published literature on professionalism is vast. In this thesis, I have connected the becoming of identity, a physiotherapist, with this sense of professionalism. This is central to how I interpreted the dataset. Participants did not refer to national documents when thinking and talking about professionalism, about moral dilemmas and ethical positions. Having undergone socialisation processes they took the ethical perspective of the profession for granted. As society’s ideas of professionalism have evolved over the past twenty or so years, so the processes of socialisation and professionalisation have risen to the surface. The statutory regulator of the profession of physiotherapy, the Health and Care Professions Council, has published its conclusions from a recent research study investigating healthcare professionals’ sense of professionalism (HCPC, 2011). While physiotherapists were not included in the population sample, the authors and commissioners intended the conclusions to be relevant for all its registrants (HCPC, 2011). The recent challenge from the UK government’s Chief Health Professions Officer to the Allied Healthcare Professions to “have the conversation” about the issue of professionalism and professional behaviour supports a recognition that previously taken for granted ideas about professionalism are being challenged (Middleton, 2012). What this thesis does is contribute to this discussion; the values, beliefs and attitudes that physiotherapists and healthcare professions hold are not static or fixed: they are constructed.
9.3.2 Contribution to socialisation processes within the profession

I have suggested that socialisation is not simply an acquisition of assets as an individual moves from novice to expert. The reality of practice is that individuals have to undertake work on their identity as an on-going process. They do this within the particular communities of practice they experience, which are both intra-professional and inter-professional, and contain discourses, hierarchies and ways of being that can both constrain and propel.

One of the central cultural reproduction processes in the profession is those that the professional networks provide. The professional networks are an important resource for the reproduction of physiotherapy cultural values, attitudes and beliefs. This might be performed through the attitude to learning styles and the teaching of propositional and craft knowledge. Role modelling can be an influence: how do senior members of the specific professional network conduct themselves, what roles do they adopt, and what positions and posts do they achieve and acquire during their career.

9.3.3 Promoting greater self-awareness

Professional networks also offer a place to share feelings evoked through specialty–specific experiences. However, I wonder whether the expression and sharing of emotions is encouraged, welcomed and respected or denied, hidden and seen as weakness. One challenge for the profession is to continue to nurture the professional networks. This is because they provide a place to offer the opportunity to affirm the conscious self-awareness of one’s feelings as a positive attribute of the maturing physiotherapist.
9.4 Contribution of this study to knowledge

This thesis makes four contributions to knowledge. First, it provides a modernised conception of professional identity for the profession. It has articulated what has previously been a taken for granted notion. In doing so, I hope to stimulate more discussion about this aspect of the profession. Second, it has generated insights applicable for professional development. These centre on the feelings of being a physiotherapist. The emotions that individuals carry with them feed the identity work they do. This thesis opens up a set of thinking directed towards a need for greater theorisation of self within the profession. Greater use of the wider literature could support this, for example theories of self-esteem, helpfulness, positioning. This challenges the dominant paternalist discourse within the profession, a focus on the client as patient, as one who suffers, as object. This has meant neglect of the idea of personal development, of self-determination and self-realisation. It has also sublimated the emotional aspect of one’s self, and hidden this from the ‘client-therapist’ relationship. Third, it has successfully tested the feasibility and applicability of a collective memory approach. Researchers using this method can ask many questions with a variety of cohorts of participants. This could be beneficial for future research into the nature of identity in both physiotherapy and across disciplines. Fourth, it has introduced crafted dialogue as an evocative data management technique to foreground the voices of participants in physiotherapy research.
9.4.1 Plans to share my learning from this study

I plan to share my work in various ways and through different means. Given the emphasis I placed on prioritising the participants over the researcher, and the nature of my topic and my interpretation of the data, I propose that interactive workshop-style events may be a useful means of helping clinicians engage with my data, conclusions, and key messages. Rather than put forward my argument as a finished accomplishment, I will breathe life into it by facilitation of reflective discussion or by attending events where my key messages can be debated, discussed, reflected upon and challenged. I therefore plan to submit abstracts to physiotherapy-specific conferences whose nature and style will allow for this.

I would also like to facilitate events at a local, regional and national level. This will be through feedback to my doctoral sponsors, the CSP South West Regional Physiotherapy Network and the PhysioFirst Educational Fund. The CSP South East Coastal Regional Physiotherapy Network has invited me to deliver a session at its conference on Professional Identity and Professionalism (2013). I will upload items of discussion to the CSP’s website discussion forum and try to stimulate debate about how physiotherapists address ethical dilemmas in their day-to-day practice. This intention has been given added weight, impetus, and momentum by the publication of the Francis Report (Francis, 2013) and the subsequent media, government, and healthcare industry discourse (for example, Cunnane & Warwick, 2013; Cameron, 2013; Dixon et al., 2013). I will submit an abstract to the CSP Physiotherapy UK Conference.
I plan to write papers for submission to peer reviewed journals. Given its wide circulation within the UK physiotherapy population, I will submit to *Physiotherapy* journal a paper describing the main thrust of my argument on physiotherapy professional identity construction and models. I want to submit a paper to *Physiotherapy Research International* describing my data management techniques. This paper will explain how crafted dialogue and narrative analysis facilitated my engagement with the data and enabled me to construct my interpretation. I want to submit this to a physiotherapy–specific journal as a means of raising this thinking and these techniques with the academic physiotherapy community. I propose to submit a paper to *Qualitative Inquiry* journal on collective memory work, crafted dialogue and narrative analysis as it pertained to my study into physiotherapy professional identity. This is to engage a wider group of qualitative researchers with my key messages of fluid identity construction and raise their awareness to the interest in this thinking in the physiotherapy profession. This might also set an agenda for a discourse community able to debate these issues.

I will use my learning to contribute to policy development and implement at my workplace, most particularly to contribute to discussions about the CSP response to the Francis Report. I will contribute to committee work on regulation, education, and professional practice development. My role provides the opportunity within the CSP to contribute to national policy as it relates to CSP work on professionalism, regulation, continuing professional development and both education and practice development. I will submit agenda items to several member-led standing committees, the AHP
Education Leads forum, to the CSP Education Sub-committee, Student Executive Committee, Physiotherapy Associates Board, Professional Practice and Service Development Sub-Committee. Internally, I aim to share my learning with CSP staff who work for the Professional Advice Service and those organising the CSP Physiotherapy UK conference.

9.5 Recommendations for future research

The interpretation of the data, some of the identified limitations to the study, and the implications arising out of these provide fertile ground for future research.

9.5.1 Furthering a conceptualisation of physiotherapy identity

First, I suggest that more empirical data be generated to understand the real attitudes, genuine motives, and enacted values and beliefs of physiotherapists across the breadth of the profession and in different locations and sectors. By placing an emphasis on real, genuine and action, I mean to stress the practical rather than the idealised application of these. I have suggested that the profession might conceptualise professional identity in a more sophisticated way. There is scope, therefore, to investigate the extent to which physiotherapy practice might benefit from such a conceptualisation. Physiotherapists who work in private practice might have different motivations to those physiotherapists working in the charitable sector: how do these play out? Physiotherapists who remain in clinical practice throughout their career may develop different self-conceptions to
those who move into academic or managerial posts: what does this mean for their self-identities?

Another avenue of inquiry might be to examine what are the idealised versions of physiotherapy and of physiotherapists that are presented to new entrants to undergraduate training courses, postgraduates, and then to connect these idealisations to the reality.

9.5.2 The feeling of being a physiotherapist

The second broad theme I suggest for further research is emotion, the feelings that physiotherapists experience in being a physiotherapist. This study contributes to this area, and other work is emerging. I suggest there is much more for the profession to learn about itself. This thesis attempts to generate some understanding of the emotions evoked in being a physiotherapist and their impact on the individuals involved. Further research could examine the metaphors used by physiotherapists and the profession to represent their beliefs about and/or experiences with practice, clients and various subject areas, to symbolize their professional thinking, to learn more about their conceptions of practice, health, illness, and the delivery / provision of physiotherapy. It would be intriguing to see the data generated from repeated use of CMW. More selective sampling could be useful, for example, a cohort of male physiotherapists; a group of clients with long-term conditions who have experienced physiotherapy from many different physiotherapists over the course of their life; a set of physiotherapists who work in one specialty.
This is the first time that research into the physiotherapy profession has used CMW. Further use of this method might help to hone the technique. It could be that more directive group discussions would have focussed the collective group analysis and better facilitated its conclusions. It might be possible to establish a group that met for longer. This could be with the aim of helping it to move beyond the initial power relationships and to have a stronger sense of itself with a shared vision for the group reflections. CMW is not the only means for enabling an articulation of the emotions within the profession.

9.5.3 The role and place of pictorial semiotics in physiotherapy identity

The third theme for future research is the role and place of the art, signs, and pictures of physiotherapy: what can we learn about what they say and do. This thesis has not addressed the role of image, branding and marketing on identity construction in physiotherapy. It would be useful to consider what are the images, the pictures, signs, representations used in physiotherapy to portray what physiotherapy is about, and how this reflects idealisations of physiotherapists and the reality. Connected to this line of thinking is the role and success of branding techniques and marketing of the profession. This might be across the breadth of the profession, for example in recruitment to under-graduate and other pre-registration courses; the locations of physiotherapy service delivery (hospitals, clinics, schools, homes); commissioners and purchasers of specific services (for example statutory healthcare commissioners; private, individualised purchasers, corporate insurance-based brokers).
9.5.4 Identity conceptualisation in other health professions

My fourth suggested theme for research is to consider how physiotherapists co-construct their identity with other health professionals. The use of theme boards as a method for facilitating AHPs to self-reflect, to talk, and to share thinking might open up new sources of thinking about their experiences. Recognising that self-identity is one element of a profession’s identity, more work to capture current image, internal and external perceptions and patient’s views.

9.6 Summary

In this chapter I have reflected upon my study of one aspect of being a physiotherapist, that of professional identity construction. I have identified some limitations to the approach I have taken. It has not addressed the role that image, branding and marketing have on the self conceptions of physiotherapists, nor has it considered in detail external perceptions of being a physiotherapist and how this might contribute to being a physiotherapist professional identity. I have outlined the contributions to knowledge of this thesis. I have suggested these are to modernise the concept of professional identity in physiotherapy, to promote the valuing of the feelings that physiotherapists’ experience, to introduce collective memory work as a physiotherapy research technique, and to exemplify crafted dialogue as an evocative data management technique. I have also suggested three themes for research in this topic area, centred on furthering the conceptualisation of physiotherapy identity, investigating the feelings evoked when being a
physiotherapist, and analysing the use of pictures and images of physiotherapy and physiotherapists.
Chapter 10 Conclusion

This thesis has examined the challenges for professional practice, socialisation, and identity in Physiotherapy. The government’s modernisation agenda and society’s increasing expectations of healthcare require physiotherapists to update their role, location, and character. Physiotherapy has viewed identity as a fixed entity emphasizing coherence, continuity and distinctiveness. Socialisation has required the acquisition of a professional identity as one among several necessary ‘assets’ for novices. The study specifically focussed on how physiotherapy defined itself; how members of the profession use their self-descriptions formulated through personal formative experiences in the various professional and social platforms they encounter. Therefore, this thesis has addressed the issue of how physiotherapists come to be the physiotherapists they are.

The theoretical paradigm I adopted was broadly social constructionism with a more specific theoretical lens of critical theory, based on Habermas’s theory of communicative rationality. I also adopted a pro-feminist attitude. I recruited eight participants to a memory group. They met for two hours, once a fortnight, for six months and once again six months later. Seventeen hours of group discussions were recorded and transcribed. Twenty one memory stories and seventeen ‘crafted dialogues’ were generated from the data. Using narrative analysis, I have interpreted the data generated as saying that there are issues of authenticity that strike at the heart of participants’ sense of being a physiotherapist; group members embodied this through personal and group reflection about how they have addressed moral dilemmas. I
argue that physiotherapists’ professional identity is fluid across time and place; that they co-construct it *between* people, through ‘identity work’. Physiotherapists work on their identity as an ongoing process of becoming, doing so within intra-professional and inter-professional communities of practice, informed by clients, and mediated through an unfolding career by workplace and institutional discourses, boundaries and hierarchies, and the contingencies of their life story.

In this study I sought to help participants move beyond their immediate ability to phrase their thinking in words, and to open up a space where they could look again at their experiences as they are today. The profession continues to evolve rapidly, with further specialisation, more variety in the service location, patient populations and interventions, and greater imagination in its practice. This diversity might lead to fragmentation and break-up of the profession. To this extent, the ‘wind of chance events’ continues to ‘shake and disturb’ and the profession should look at and speak about itself ‘in diverse ways’ as the future unfolds. This thesis has provided a framework and perspective within which the profession can turn its ‘prime attention on itself’ in order to understand not only how physiotherapy continues to change, but also in what important ways it remains the same.
References


ALLIED HEALTH PROFESSIONS PROJECT (2003). Demonstrating Competence Through Continuing Professional Development London; CSP.


CHARTERED SOCIETY OF PHYSIOTHERAPY (2012a). Consultants’ 
database. Unpublished database. London; Chartered Society of 
Physiotherapy.

CHARTERED SOCIETY OF PHYSIOTHERAPY (2012b). Professional 
Networks. www.csp.org.uk [Accessed 1/7/12].

CHARTERED SOCIETY OF PHYSIOTHERAPY (2012c). Annual Quality 
Chartered Society of Physiotherapy.

CHARTERED SOCIETY OF PHYSIOTHERAPY (2012d). Integrated 
Musculoskeletal Services. London; Chartered Society of 
Physiotherapy.

essay on competence, coherence, and the creation of meaning” 
Eleanor Clarke Slagle Lecture American Journal of Occupational 
Therapy, 53, 547 – 558.

“Poetry and prose: Telling the stories of formerly homeless mentally ill 
people” Qualitative Inquiry, 11, 913-932.


participatory action research: A methodology of choice for examining 
critical nursing issues” International Journal of Nursing Practice, 13, 

COTT, C. A., FINCH, E., GASNER, D., YOSHIDA, K., THOMAS, S. G. & 
Physical Therapy” Physiotherapy Canada, 47, 87–95.

introduction to contemporary methods and approaches. Oxford; 
Routledge. ISBN 041 599 165 X.


CROOT, E.J. (2012). “The care needs of Pakistani families caring for 
disabled children: how relevant is cultural competence?” 


HAUG, F., ANDRESEN, A., BUNZ-ELFFERDING, A., HAUSER, K., LANG, U., LAUDON, M., LUDEMANN, M., MEIR, U., NEMITZ, B., NIEHOFF,


JORDENS, C.F.C. & LITTLE, M. (2004). “‘In this scenario, I do this, for these reasons’: narrative, genre and ethical reasoning in the clinic” Social Science & Medicine, 58, 1635–1645.


Appendices

Appendix 1 Definitions and descriptions of physiotherapy

A1.1 Fontana Dictionary of Modern Thought

Physiotherapy
A systematic method of assessing musculoskeletal and neurological disorders of function, including pain and those of psychosomatic origin, and dealing with or preventing these problems by natural methods based essentially on movement, manual therapy, and physical agencies.

Physiotherapy is involved with all problems of function and the ability and mobility of the population from birth to death; from antenatal preparation, through childhood disability, physical and mental handicap, accidents and illness to dealing with the problems of elderly people.

(Jones and Wood, 1999)

A1.2 CSP Description of physiotherapy

Physiotherapy is a health care profession concerned with human function and movement and maximising potential. It uses physical approaches to promote, maintain and restore physical, psychological and social well-being, taking account of variations in health status. It is science-based, committed to extending, applying, evaluating and reviewing the evidence that underpins and informs its practice and delivery. The exercise of clinical judgement and informed interpretation is at its core.

Physiotherapists are autonomous professionals, able to act as first-contact practitioners, as well as accepting referrals from other health care professionals. Through partnership and negotiation, physiotherapists work with people to optimise their functional ability and potential. In this way, they address problems of impairment, activity and participation and manage recovering, stable and deteriorating conditions. They treat a wide range of physical conditions (particularly those associated with the neuro-muscular, musculo-skeletal, cardiovascular and respiratory systems), across the life span (from neonate to old age) and those presenting with varying health status (both relating to physical and mental health).

Physiotherapists play a broad role in health promotion, health education and self-care. This can extend to advising and teaching patients’ and clients’ carers, other health care professionals and support workers in order to provide a coherent approach to maximising individuals’ independence and well-being.

Physiotherapists use manual therapy, therapeutic exercise and the application of electro-physical modalities. Through problem-solving,
clinical reasoning, goal-setting, evaluation and review, they apply these approaches in response to individual need, working with patients/clients and their carers. Physiotherapists’ assessment and evaluation of need – and potential need – includes the consideration of psychological, cultural, social and environmental factors and the impact these have on individuals’ functional ability and the needs of their carers.

Physiotherapists practise in evolving and increasingly diverse environments and are committed to working collaboratively with other professions. The profession is receptive to change and welcomes the increasing focus on rehabilitation within the modernisation of healthcare. It encourages innovation in ways that assure the safety, effectiveness and quality of the care it delivers and that are in keeping with its commitment to evidence-based practice.


**A1.3 HCPC Description of physiotherapy**

Physiotherapists deal with human function and movement and help people to achieve their full physical potential. They use physical approaches to promote, maintain and restore wellbeing.


**A1.4 WCPT Description of physical therapy**

**The nature of Physical Therapy**

Physical Therapy is providing services to people and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan. Physical therapy includes the provision of services in circumstances where movement and function are threatened by the process of ageing or that of injury or disease. Full and functional movement are at the heart of what it means to be healthy.

Physical therapy is concerned with identifying and maximising movement potential, within the spheres of promotion, prevention, treatment and rehabilitation. Physical therapy involves the interaction between physical therapist, patients or clients, families and caregivers, in a process of assessing movement potential and in establishing agreed upon goals and objectives using knowledge and skills unique to physical therapists.

The physical therapists’ distinctive view of the body and its movement needs and potential is central to determining a diagnosis and an intervention strategy and is consistent whatever the setting in which practice is
undertaken. These settings will vary in relation to whether physical therapy is concerned with health promotion, prevention, treatment or rehabilitation.

**What Characterises Physical Therapy?**

**Assumptions underlying the knowledge and practice of physical therapy**
The following assumptions are embedded in this description and reflect the central issues of physical therapy.

**Movement**
The capacity to move is an essential element of health and wellbeing.
Movement is dependent upon the integrated, coordinated function of the human body at a number of different levels.

Movement is purposeful and is affected by internal and external factors.

**Physical therapy is directed towards the movement needs and potential of the individual.**

**Individuals**
Individuals have the capacity to change as a result of their responses to physical, psychological, social and environmental factors.

Body, mind and spirit contribute to individuals’ views of themselves and enable them to develop an awareness of their own movement needs and goals.

**Ethical principles require the physical therapist to recognise the autonomy of the patient or legal guardian in seeking his or her services.**

**Interaction**
Interaction aims to achieve a mutual understanding between the physical therapist and the patient/client/family or care giver and forms an integral part of physical therapy.

Interaction is a prerequisite for a positive change in body awareness and movement behaviours that may promote health and wellbeing.

Interaction often involves partnership within interdisciplinary teams, in determining the needs and formulating goals for physical therapy intervention and recognises the patient/client/family and care givers as being active participants in this process.

**Professional Autonomy**
Professional education prepares physical therapists to be autonomous practitioners.
Professional autonomy is possible for individual physical therapists as they practice with patients/clients/family and care givers to reach a diagnosis which will direct their physical therapy interventions.

Diagnosis
Diagnosis within physical therapy is the result of a process of clinical reasoning which results in the identification of existing or potential impairments, functional limitations and abilities/disabilities.

The purpose of the diagnosis is to guide physical therapists in determining the prognosis and identifying the most appropriate intervention strategies for patients/clients and in sharing information with them.

In carrying out the diagnostic process, physical therapists may need to obtain additional information from other professionals. If the diagnostic process reveals findings that are not within the scope of the physical therapist’s knowledge, experience or expertise, the physical therapist will refer the patient/client to another appropriate practitioner.

Appendix 2 A reconceptualised critical theory

The following outlines a reconceptualised critical theory given by Kincheloe and McLaren (2000). All pages numbers are to this work.

Critical enlightenment
This is the analysis of ‘competing power interests’ (p.281) that exist between individuals and groups within a particular society – on this analysis critical theory research can seek to uncover who gains in particular social arrangements and the processes by which such power operates

Critical emancipation
This considers those who seek to control their own lives in solidarity with a ‘justice-oriented community’ (p.282). Critical research attempts to expose the forces that prevent individuals and groups from shaping the decisions that affect their lives, and through this achieve greater autonomy and agency.

Rejection of economic determinism
A reconceptualised critical theory rejects the orthodox Marxist notion that ‘base’ determines ‘superstructure’ – that is, that economic factors dictate all other aspects of human existence (p.282). Critical theorists consider that there exist multiple forms of power, including economics.

Critique of instrumental (or technical) rationality
They see instrumental (technical) rationality as ‘one of the most oppressive features of contemporary society’ (p.282), obsessing with means over ends. Researchers deliberating over technique, procedure or method should therefore reject this tendency in favour of maintaining a focus on the humanistic element of the research endeavour.

The impact of desire
Critical theory should value post-structuralist psychoanalysis as a resource in emancipatory research; a means to ‘discern the unconscious processes that create resistance and induce self-destructive behaviour’ (p.282). A post-structuralist position allows the researcher to accept that individuals are not always rational and autonomous, and adopt a greater sensitivity towards how desire can be socially constructed through ‘power, identity, libido, rationality, and emotion.’

Hegemony
Critical theorists recognise that power is a ‘basic constituent of human existence’ that shapes the oppressive and productive nature of the human condition (p.283). The notion of hegemony, that sees dominant power exercised not just through physical force but also through the social psychology exerted by social institutions. Hegemony requires consent through an ‘inequitable power matrix’ (p.283) – social relations ‘legitimated by their depiction as natural and inevitable’.

Ideology
Critical theorists view hegemony and ideology are inseparable; hegemony being the effort of the powerful to win over their subordinates and ideology the cultural forms, meanings, rituals and representations that produce consent to the status quo and participation within it (p.283). A reconceptualised critical theory adopts a recognition that subtle, ambiguous and situationally-specific forms of domination shape a vision of reality through covert coercion.

Linguistic / discursive power
Kinzeloe and McLaren understand that language is ‘not a mirror of society’, a neutral description of the real world, but an ‘unstable social practice with shifting context-specific meanings that serves to construct the world (p.284). On that analysis language and discourses can serve as forms of ‘regulation and domination’ (p.284)

Focus on relationship between culture, power, domination
Critical researchers view culture as a domain of struggle where the ‘production and transmission of knowledge is always a contested process’. The blurring effect produced by the hyper reality of TV, video games, computers, music (and the rest) can challenge traditional notions of time, history, community, self (p.284). This proliferation of signs, images, zeitgeist, functions as a means for control.

Role of critical pedagogy
Cultural productions, as a form of education, can generate knowledge, shape values, construct identity and this can be seen as a cultural pedagogy; that is, cultural agents can produce specific ways of seeing. Critical theorists seek to expose such practices.
Appendix 3 Research Ethics and Governance Permissions

A3.1 University of Brighton Faculty of Health and Social Science Research Ethics and Governance Committee

Dear Sir/Madam

University of Brighton research sponsorship

I am writing to confirm that the University of Brighton will act as research sponsor as required under the Department of Health’s Research Governance Framework for the project entitled ‘What it means to be a physiotherapist’ to be carried out by Ralph Hammond.

If there are any general questions about the University’s approach to research governance, please contact Hilary Ougham, Academic Research Officer.

Yours sincerely,

Chair of Faculty of Health Research Ethics & Governance Committee
Dear Mr Hammond

Study Title: What it means to be a physiotherapist
REC reference number: 09/H0106/58
Protocol number: 1

Thank you for your letter of 28 July 2009, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information was considered by a sub-committee of the REC at a meeting held on 16 September 2009. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research (“R&D approval”) should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.
Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flow chart</td>
<td>1</td>
<td>01 June 2009</td>
</tr>
<tr>
<td>Academic Supervisor CV</td>
<td></td>
<td>01 June 2009</td>
</tr>
<tr>
<td>Advertisement</td>
<td>1</td>
<td>01 June 2009</td>
</tr>
<tr>
<td>Compensation Arrangements</td>
<td>Letter from Brighton University.</td>
<td></td>
</tr>
<tr>
<td>Peer Review</td>
<td>Letter from Prof. A Moore</td>
<td>24 October 2008</td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td>Letter from Prof. J Scholes</td>
<td>01 June 2009</td>
</tr>
<tr>
<td>Covering Letter</td>
<td></td>
<td>01 June 2009</td>
</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>01 June 2009</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td>01 June 2009</td>
</tr>
<tr>
<td>REC application</td>
<td>2.2</td>
<td>01 June 2009</td>
</tr>
<tr>
<td>Employer approach</td>
<td>1</td>
<td>01 June 2009</td>
</tr>
<tr>
<td>RPA approach letter</td>
<td>1</td>
<td>01 June 2009</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>2</td>
<td>27 July 2009</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
<td>letter</td>
<td>28 July 2009</td>
</tr>
</tbody>
</table>

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review
Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

Notifying substantial amendments
Adding new sites and investigators
Progress and safety reports
Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0106/58 Please quote this number on all correspondence

Yours sincerely

[Signature removed]

Chair

Enclosures: “After ethical review – guidance for researchers”

R&D office for UH Bristol

North Somerset & South Bristol Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 16 September 2009

Committee Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Present</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr [removed]</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mrs [removed]</td>
<td>Lay Member</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4 Participant governance

A4.1 Advertisement for Chartered Society of Physiotherapy (CSP) website

Recruitment content for online interactive CSP web site

Title **What is physiotherapy? Research study**
[study title altered to reflect style of medium and increase impact, and so increase chance of successful recruitment]

Summary
To date no formal studies have been published that consider the identity of the profession as a whole. Rather than try to define physiotherapy, this new proposed study will investigate the lived experience of physiotherapists and so generate insights into the nature of physiotherapy as it is practiced today.

Content
Physiotherapy is a socially constructed occupation that emerged early in the 20th century in response to claims that massage parlours were operating as brothels. The potential for massage as a remedial intervention was becoming obscured by the nefarious practices of the day.

In recent years the modernisation of healthcare, the rise of accountability and public expectations, communication technology, and population changes require physiotherapy to be quite different. In this context, claims are made about what physiotherapy is, and its relative effectiveness.

To date no formal studies have been published that consider the identity of the profession as a whole. Rather than try to define physiotherapy, a new proposed study will investigate the lived experience of physiotherapists and so generate insights into the nature of physiotherapy as it is today. The study asks ‘What does it mean to be a physiotherapist?’

Are you interested in participating?

- Do you live / work in Bristol?
- Are you a physiotherapist trained in the UK, either currently in practice or retired?
- If you are a currently practicing clinician / manager: do you have at least one year’s post-graduation clinical experience?
- If you are a currently practicing lecturer: do you have at least one year’s experience as a physiotherapy lecturer and one year's clinical experience?
- Are you able and prepared to write and reflect on your formative years as a physiotherapist?
- Are you able to attend regular meetings after work?

Participants will undertake a technique called collective memory work. Starting with a facilitated group discussion, this technique involves agreeing a
topic related to the research questions, which then serves to trigger a memory of an experience for each individual. You will then write a short, detailed description of this memory. The group will analyze each text together according to a set of ‘ground rules’ and draw out themes from your discussions. This cycle is repeated several times with different topics over several months to be agreed by the group. The group agrees its conclusions based on its analyses.

If you are interested in finding out more about this important new research project, please contact Ralph Hammond MCSP, professional doctorate (physiotherapy) student, University of Brighton [contact details removed].
A4.2 Participant Information Sheet

You are invited to take part in a research study into the lived experience of physiotherapists, the Collective Memory Study. The main aim of the study is to determine what does it mean to be a physiotherapist?

The study aims to investigate the lived experience of physiotherapists in order to reveal:
1. Insights applicable to the personal professional development of participants, through
   a. an articulation of the way the physiotherapy world is: how reality constrains practices in tangible ways
   b. memories of how the culture of an organisation, its geographical setting, the professional culture in a particular geographical area, lead to the formation of personal professional identities
   c. a heightened level of personal self-consciousness and greater self-understanding
2. Themes that resonate for the socialisation of the wider profession through
   a. a reconstruction of the self formative process of the profession, with a view to its successful continuation
   b. real life solutions to problems of action coordination and social integration, for example, inter-professional working, client relationships, communication
3. A template for future research into the nature of other professions
4. Themes to challenge existing recruitment strategies into, and career choices within, the profession
5. Insights applicable to the global profession through the international dimension that the globalization of healthcare brings

A doctoral student researcher (Ralph Hammond) from the Clinical Research Centre for Health Professions at the University of Brighton in Eastbourne is conducting the study.

You have expressed an interest in this study following a preliminary conversation with Ralph Hammond. Now you will need to choose if you wish to participate. The following paragraphs describe what participation would involve.

Procedures
If you participate in this study you will be asked to attend a meeting with eight or nine other participants. All participants will be physiotherapists who trained and work in the United Kingdom.

You should only choose to participate in the study if you are prepared to attend these meetings approximately once every two or three weeks for about 10 meetings. The exact number, frequency and timings will be something you and the rest of the group would discuss and negotiate.

At the first group meeting, you will be asked a question (“what does it mean to you to be a physiotherapist?”) and invited to engage in magazine photograph collage, or ‘theme board technique’. The purpose of this
The technique is to introduce you to the research topic, to stimulate your creative thinking, and to support the development of group dynamics.

The theme boards will be digitally photographed and used as part of the data for the study. The discussions about each theme board will be recorded and transcribed, to form further study data.

Next, following a facilitated discussion, you will be asked agree with the other participants a topic to prompt the memory of an experience from your professional career.

After this first meeting you will be asked to write a short (1-2 sides of A4) story of a personal memory of a physiotherapy experience, on the topic agreed at the meeting.

Over the course of your involvement in the study you will be asked to write a maximum of three such stories.

It is important for the success of the study that participants attend most meetings and engage in the discussions and write memory descriptions in between. If you feel you will not be inclined or able to enter into either writing memories or discussing them in a group setting please do not agree to enter the study.

What if something goes wrong – Possible risks, discomfort or distress from participation in the study

Thinking back and reflecting on memories of your formative experiences may provoke powerful emotions, bad feelings, or possibly sadness.

Members of the group will be encouraged to be supportive, encouraging and helpful of each other. It is not intended to deliberately look for bad feelings or sadness, but there is a chance these may arise, for example, should a group member discuss the death of a patient and their response to this.

The study is not intended as a form of therapy nor treatment, for such feelings. Ralph Hammond will aim to nurture a supportive environment.

If you do not wish to raise such feelings in the group, or wish for support elsewhere, please raise this with the chief investigator, and he will organize for you to speak to someone, a trained counselor, away from the study.

Confidentiality
Ralph Hammond will keep personal information from you strictly confidential. The nature of the study is to share personal experiences and the feelings and emotions that come with them. All participants will be asked to recognise and respect confidentiality in the sharing of these experiences.
One aspect of the study is to share ideas during the discussions about the experiences the group recount, to consider these individually and as a group, and to summarize the group’s conclusions of these discussions.

You will be provided with copies of each other’s written stories and transcriptions of the group discussions, if you wish. You will also be given typed copies of draft summaries of the conclusions of the group during the course of the study.

Results of this study may be used in future research and may be published, but your personal details and any sensitive personal data you reveal in the course of the study will not be revealed.

Where and when the study will take place
The study will require attendance at group meetings, approximately once every two or three weeks for possibly twelve weeks. Each meeting will last approximately two hours. They will take place at a mutually convenient time and location, decided between the group members.

The duration of the study will be determined and agreed by the group. This means that the group decides how many stories it wants to write and discuss and for how long to keep going. The group will also decide collectively how frequently to meet (for example, it may decide to meet once a fortnight, or once a month), and so the duration of participation will depend on this.

Reimbursement
You will not be reimbursed for any expenses you incur as part of your participation in the study. The group will agree on a mutually convenient location.

All participants will be recruited from the Bristol area and their work location will be within approximately three miles of each other.

Potential benefits of participating
It is hoped that the study will offer you the opportunity to reflect on experiences in your formative years as a physiotherapist, leading up to the present, the words you use to describe them, and the way they have shaped how you are as a physiotherapist today.

Participation in and withdrawal from the study
Participation in this study is entirely voluntary. You are not obliged to participate and you can withdraw from the study at any time without giving a reason.

Please keep this information sheet for your future reference. If you have any questions regarding this research, feel free to ask Ralph Hammond:

[Contact details removed]
Any person with concerns or complaints about the conduct of the research study can contact:

Professor Ann Moore PhD, FCSP
Clinical Research Centre for Health Professions
University of Brighton
Aldro Building, 49 Darley Road
Eastbourne
East Sussex, BN20 7UR
Appendix 10

UNIVERSITY OF BRIGHTON
Clinical Research Centre For Health Professions
Adro Building
49 Dacre Road
Eastbourne BN20 7UJ
Telephone 01273 643647
Fax 01273 643944
www.brighton.ac.uk/wip/researchV

Participant Informed Consent Form

What does it mean to be a physiotherapist?

- I agree to take part in this research which is to investigate the lived experience of physiotherapists in an attempt to generate insights into the nature of physiotherapy as it is today

- The chief investigator, Ralph Hammond, has explained to my satisfaction the purpose of the study and the possible risks involved

- I have had the principles and procedures explained to me and I have also read the Participant Information Sheet. I understand the principles and procedures fully

- I am aware that I will be required to participate in a group of other physiotherapists; that, in-between meetings, I will write a short (maximum two sides of A4) story relating to an experience I have had on a topic agreed with the rest of the group, to listen to and to make more precise the words I use in this story in light of subsequent group discussions; and to participate in a group discussion regarding my own, and each other's, stories; and to repeat this process on several occasions (possibly for three times)

- I understand that any confidential information will only be seen by the chief investigator, Ralph Hammond, and will not be seen by anyone else

- I understand that I am free to withdraw from the investigation at any time.

Name (please print) ...........................................................................................................

Signed ...............................................................................................................................

Date .................................................................................................................................
# Appendix 5 Collective memory work meetings

## A5.1 Meeting Schedule

<table>
<thead>
<tr>
<th>Month</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10, 11 &amp; 12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post advert to website</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement recruitment plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet target managers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree 1st meeting date &amp; venue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>By 19th</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st meeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd meeting</td>
<td>Theme boards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st cycle</td>
<td>3rd meeting</td>
<td>Discussion &amp; trigger</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4th meeting</td>
<td>Memory stories</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5th meeting</td>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6th meeting</td>
<td>Discussion &amp; trigger</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd cycle</td>
<td>7th meeting</td>
<td>Memory stories</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th meeting</td>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9th meeting</td>
<td>Discussion &amp; trigger</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd cycle</td>
<td>10th meeting</td>
<td>Memory stories</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11th meeting</td>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12th meeting</td>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analyse collective analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circulate findings to collective</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13th meeting</td>
<td>Rounding up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A5.2 Collective memory work meetings: planning

Session plan First meeting

Pre-meeting actions

- Create folder
- Overview of what I’m trying to achieve – max 2 sides
- Potted history of CMW: taken from IRAS form
- Blank paper for ground rules
- Aide memoire for how to write a story
- Ralph’s contact details
- Paper for dates of future meetings
- Map
- UoB contact details
- Participant information sheet
- Pen
- Ring participants on Friday as reminder
- Read ethics to check I’ve done all I said I would
- Draft some ground rules
- Draft aide memoire on how to write the story
- Test recorder and get spare batteries
- Buy refreshments
- Ring venue on Friday to confirm arrangements

1. Aim of the first meeting:
   - To establish the participants as a group
   - To begin process of sharing hopes and fears

2. By the end of the session all participants to be clear about:
   - Each other’s names
   - Their role in the research process
   - The nature of how the meetings are intended to be run
   - Dates for future meetings

<table>
<thead>
<tr>
<th>Introductions</th>
<th>5pm – 5.15pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise: Postcards</td>
<td>5.15 – 5.30</td>
</tr>
<tr>
<td>Aim of research exercise: what do you understand you’re here to do</td>
<td>5.30 – 5.45</td>
</tr>
<tr>
<td>Break for drinks</td>
<td>5.35 – 5.45</td>
</tr>
<tr>
<td>Method: collective memory work</td>
<td>5.45 – 5.55</td>
</tr>
<tr>
<td>Style, manner of group: ground rules</td>
<td>5.55 – 6.05</td>
</tr>
<tr>
<td>Folders</td>
<td>6.05 – 6.10</td>
</tr>
<tr>
<td>What we will do next time</td>
<td>6.10 – 6.20</td>
</tr>
<tr>
<td>Meeting dates, venue</td>
<td>6.20 – 6.30</td>
</tr>
</tbody>
</table>
A5.3 Ground Rules

“Hi All

Here are the ground rules as I understood them from yesterday.

* Privacy - all to respect everyone's right to privacy when discussing collective memory study outside of the group

* Respect - all to respect each others (sic) opinions (which may differ) during the course of the meetings

* Open Forum - there will be the chance for a brief open forum at the beginning of each meeting to discuss issues that may have arisen for us.

Hope these are ok and as everyone understood them!”
A5.4 Meeting one: Introductions; setting the scene

Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue, Vicky

Aim of the first meeting: To establish the participants as a group; to begin process of sharing hopes and fears. By the end of the session all participants to be clear about: Each other’s names, Their role in the research process, The nature of how the meetings are intended to be run, Dates for future meetings

Respect participant autonomy and welfare through the protection of confidentiality and privacy, the acknowledgement of participants’ rights to withdraw from the research, the maintenance of participants’ welfare, and the provision of research results to participants. The purpose for the research was explained and discussed with participants. Ground rules agreed between all participants to:

- Respect each other’s responsibility to engage in the research process and reveal professional experiences with each other,
- While respecting their right to confidentiality of shared memories and experiences
- Agree a rule permitting me to help keep the group discussions focused to the research question.

Participants reminded of their choice to withdraw at any time without giving a reason. I was the only person with access to the study data, limiting any vulnerability to exposure of person–identifiable data

The principal investigator and secondary doctoral supervisor will only access raw data after it has been anonymised.

Should strong evidence of malpractice arise during the course of the discussions, it was explicitly acknowledged that I or any other participant could report this to the appropriate authorities; that is, the profession’s statutory regulator, the Health and Care Professions Council.

To facilitate and support the development of the group as a group some ethical statements will be discussed, negotiated and agreed on:

- This will include the need for group support, the role of me in nurturing this, related to action and self-reflection on part of the participants.

Agreement will need to be gained with the group regarding the interpretation and ownership of data, authorship and the dissemination of learning.

Person–identifiable information from transcripts, theme boards, and any other materials was anonymised.

This will include issues to do with confidentiality: all reports on the research will maintain confidentiality.

The material collected from individuals through Collective Memory Work (CMW) will not be used in any way not authorised by participants.

The written memory text from each participant will be held by me and stored in a locked cupboard for the duration of the study.

It was also thought possible, though unlikely, for CMW to result in some emotional distress (perhaps related to beliefs, painful or sad reflections or traumatic events) for participants. The group was briefed to ensure participants understood, accepted, and agreed that the CMW group was not
intended to be therapy, treatment or to lead to pejorative discussions where one individual could be criticised for their memory or past actions or for their ability to implement any planned / agreed changes.

The ground rules agreed were written up by one of the participants and shared after this first meeting to everyone by email, see Appendix A5.4 (p.274).

A date was agreed for the next meeting.

**A5.5 Meeting two: Theme board technique**  
*Attendees: Chris, Diana, Emma, Helen, Louise, Sue, Vicky*

1. Re-introductions.
2. Discuss and agree ground rules – ask some time to type these up, Data Protection Act and confidentiality, recordings, transcriptions, your names and contact details, photos, respect for other’s private feelings, stories, group confidentiality, however also open to sharing with colleagues, as long as anonymised, any others.
3. Undertake the theme board technique, “Depict your journey to becoming the physiotherapist you are today” and invited to engage in magazine photograph collage, or ‘theme board technique’.
4. This took the rest of the session.
5. I took photographs of each theme board, and kept each one, see compact disc.
6. Agree on dates of next meetings.

**A5.6 Meeting three: Discussion of theme boards leading to agreement of the first trigger topic: Persona**  
*Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue, Vicky*

1. I facilitated each participant in explaining to the group how they had represented their ideas through the selected symbols.
2. Other members of the group questioned the points made, offer their own interpretations and consider the contributions of others in the group. This open expression of ideas through a pictorial representation allows a whole range of attitudes, beliefs and feelings to emerge and be explored, thus generating greater understanding of others’ perceptions of the same situation.
3. Once the introductory ‘exercise’ of theme board technique was completed, I led the group into the central method of data collection to be used for the study, collective memory work. The group was invited to consider how to approach writing the memory of a particular physiotherapy-related experience. I facilitated the group to take the previous discussion from the theme board technique as a starting point for this discussion and agree what topic, or trigger / cueing theme, to use to write a memory on. Members of the group then chose the trigger.
4. The intention was that participants write a description of a particular event or episode rather than an account. It was agreed texts would be
written in the third person to establish each author as both the object and subject of the research. The group discussed how to choose an experience/memory. They were asked to personalise their part in the text and to anonymise all other participants and locations in the text.

5. The theme boards will be digitally photographed and used as part of the data for the study. The discussions about each theme board will be recorded and transcribed, to form further study data.

6. Discussion of the theme boards, leading into agreement of first trigger theme: Persona.

A5.7 Meeting four: Reading of Persona memory stories and discussion
Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue, Vicky

1. The group met again and discussed how to proceed.
2. After some deliberation it was agreed that two participants would read their stories out, and then the group would discuss the two stories.
3. This would be repeated with the next two people, and gradually all the stories would be both read out and then discussed.

A5.8 Meeting five: Discussion and analysis of the trigger topic Persona memory stories
Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue

1. Discussing and analysing the trigger topic Persona memory stories

A5.9 Meeting six: Summarising Persona memory stories and choosing new trigger
Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue

1. Summarising Persona memory stories and choosing new trigger.
2. Trying to engage and involve the participants and so over time work to create a more genuine ‘co-researcher’ ethos; ownership of the study may be improved with strengthened quality and direction of the group, and as discussions become more profound so the possibility of greater theorisation of the discussions.
3. Negotiating the next trigger topic: Lifestyle

A5.10 Meeting seven: Reading memory stories for trigger topic Lifestyle
Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue

1. Reading memory stories for trigger topic Lifestyle: Memory stories read out by Emma (2-1), Helen (2-2), Louise (2-3), Sue (2-4), Diana (2-5), Caroline (2-6), Chris (2-7).
2. Immediate reactions and initial discussions of the stories

A5.11 Meeting eight: Discussing and analysing the trigger topic Lifestyle memory stories
Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue

1. Discussing and analysing the trigger topic Lifestyle memory stories
A5.12 Meeting nine: Discussing and analysing the trigger topic Lifestyle memory stories
Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue

1. Discussing and analysing the trigger topic Lifestyle memory stories.
2. Trying to draw out themes from the discussion
3. Negotiating and agreeing the next trigger topic: Choice

A5.13 Meeting ten: Reading memory stories for trigger topic Choices
Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue

1. Reading memory stories for trigger topic Choices;
2. Memory stories read out by Emma (3-1), Diana (3-2), Louise (3-3), Caroline (3-4), Sue (3-5), Chris (3-6).
3. Immediate reactions and initial discussions of the stories

A5.14 Meeting eleven: Discussing and analysing the trigger topic Choices memory stories
Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue

1. Discussing and analysing the trigger topic Choices memory stories

A5.15 Meeting twelve: General discussion to round up our meetings
Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue

1. General discussion to round up our meetings;
2. Drawing out themes from the discussion

A5.16 Meeting thirteen: Discussion and agreement of discussions
Attendees: Caroline, Chris, Diana, Emma, Helen, Louise, Sue

1. Discussion and agreement of initial collective analysis
2. Impressions of the first draft of the secondary analysis
3. Reflections on the theme boards and collective memory work methods
4. Reflections on the whole process / the meetings: what we have enjoyed, what might we have done differently
5. Reflecting on how we were recruited: our expectations
### Appendix 6 Transcription conventions

| .       | Falling intonation | That was foolish. |
| ,       | Rising utterance   | I took bread, butter, and jam |
| ?       | Rising intonation  | What was that? |
| !       | Animated tone      | Look! |
| *italics* | Uttered with laughter in voice | And there he was *behind the door* |
| Speaker | Italicised speaker name = uncertain attribution | *Emma* |
| **CAPS** | Louder than surrounding talk | There were TWO OF THEM |
| -       | Sound cut off      | All over the pl- the floor |
| :      | Sound stretching   | We waited for a lo::::::ng time |
| (xxx)   | Unable to transcribe | We'll just (xxxxxxxxxxx) today |
| (word)  | Unsure transcription | And then he (jugged) it |
| []      | Other details      | Leave it alone [moves book] |
Appendix 7 Example of creating a crafted dialogue from the raw transcription

The following extracts are presented to show the process of data reduction and poetic re-presentation. The first extract is the text in its original format, that of transcription. The second is that same transcript re-presented in poetic form.

A7.1 Transcript relating to Persona stories 1 and 2

Helen has read her story; then Sue reads hers. Her story ends with these two sentences:

Sue  ... They did however admit that Sue’s visit had put the ‘wind up’ them and that they had christened her ‘Scary Sue!’ Sue fed this back to her colleagues and since then her office nickname is ‘Scary Sue’.

20m 55s
Group  (laughter)
(Cough)
(Pause)
Chris  Great, thank you very much. Has anyone got any comments or questions?
Emma  I think they’re both about difficult situations and dealing with conflict and strengths with your decision-making really, and I think you did that pretty well, and conflicts with other professionals, and standing our ground.
Helen  I’m happy to admit I was angry with the GP.
Vicky  We could tell!
Helen  He should have been readmitted the previous day.
Sue  I was probably quite angry as well.
Vicky  I was impressed by your, um, your ability go in help tidy up the patient, I mean faeces, urine, make the bed, and get him comfortable; that’s beyond the call of duty. I thought that was really good.
Helen  I just felt I couldn’t leave him
Vicky  Absolutely that’s, that’s, that’s, going the extra mile that I think that’s what physio’s do often do and it’s not measures and it’s not reported and it’s the human element of the job really
Helen  Yes
Louise  And you can’t write a business plan for that really
You’re story and I couldn’t really have walked away
Chris  why did you feel you that you had to do that?
Helen  Because he was distressed because of had happened his wife was distressed because she hadn’t been able to prevent it happening (pause) and I just felt I had a duty to make him comfortable
Caroline  Mm
Emma: I guess you had a relationship with his parents as well because he was a lovely chap.
Helen: Yes, yes I mean they were a lovely couple.
Emma: Mm
Helen: and I do occasionally still meet his wife out and about and she just even now this is a good few years ago she still says how grateful she was.
Emma: mm
Diana: how do you think his wife what does she what does she what qualities does she see in you for having done what you did? Because that’s really what we’re after, isn’t it?
Helen: mm
Diana: What did she what did she see if someone asked her what qualities does
Helen: possess to have done what she did that day or over that period of time what do you think she would say
Helen: Oh that’s a difficult one (laughs) um,
Caroline: What a kind lady!
Vicky: And what a nice memory for his death to be honest someone there right at the end caring and fighting for him I think that’s just super (laughs)
Caroline: I’m interested in your relationship with the GP ‘cos I’ve had with GPs and sometimes they feel very intimidated when the physio tells them things that they ought to know
Vicky: And the subsequent action was exactly that wasn’t it? That GP went in, thought, closed the book and then the ambulance arrived?
Diana: His wife may have seen you as a person she could trust and perhaps a person who she could fully open up to and tell it as it really was because you had an insight into
Helen: Well, I mean, the GP should have known that the District Nurses don’t go in and do washing and dressing
Diana: But didn’t know
Helen: But didn’t know because she had contacted the district nurses to go in and get him up and dressed. So, I thought it was just appalling on the GPs part
Diana: On the GP as well
Helen: Well hopefully
Louise: Well it sounds, from your story it sounded more than that. You were really aware of the deterioration and your knowledge of the patient from the previous week or whatever the time gap was. It was more than just, you, the way your story came across it sounded like you had more concerns which is why you thought you he needed to be in hospital.

Helen: Because we couldn’t get him out of bed so he was without anyone going in to help he was just going to be lying in bed and getting pressures sores.

Diana: So you saw the consequences of what potentially would and should happen that perhaps other pro other people say the GP could not have seen or perhaps chose not to see, erm, and so you were if you like you were seeing the passage of time and what absolutely needed to be done for that person maybe taking on roles in the flat over and above what you are supposedly professionally should do.

Helen: That’s right.

Diana: You did them because you saw it needed to be done and because of qualities such as integrity, and warmth and caring you saw what needed to be done right there and then was that.

Sue: I think that probably it’s a bit a bit about being you were there whereas probably maybe the GP hadn’t seen this person for a long long time and didn’t.

Helen: I can’t I can’t remember what the condition was which is why I didn’t put it in but I know it was associated with um, a skin condition that’s what he went into hospital with first but it wasn’t um, is it scleroderma it wasn’t anything like that it was something I hadn’t heard of before or since, um. And it was going to be he was going to deteriorate which maybe the GP wasn’t aware of, I don’t know.

Vicky: That was generous of you!

(Laughter)

A7.2 Crafted dialogue for transcript Persona stories 1 and 2

1: 1 and 1:2

Sue: ...They did however admit that Sue's visit had put the ‘wind up’ them and that they had christened her ‘Scary Sue!’ Sue fed this back to her colleagues and since then her office nickname is ‘Scary Sue’.

Emma: They’re both about difficult situations,
Dealing with conflict, conflicts with professionals,
Strengths with decision-making and standing our ground
You did pretty well.

Helen: I was angry with the GP.

Sheila: We could tell.
Helen  He should have been readmitted the previous day.
Vicky   I was impressed;
         Go in, help, tidy up the patient:
         I mean - faeces, urine; make the bed, and get him comfortable;
         That's beyond the call of duty.
         That was good.
Helen   I couldn't leave him.
Vicky   Absolutely,
         That's going the extra mile, that's what physio's do.
         It's not measures, it's not reported, it's the human element of the
         job.
Helen   Yes.
Louise  You can't write a business plan for that.
Helen   I couldn't have walked away.
         He was distressed
         Because of what had happened;
         His wife was distressed
         Because she hadn't been able to prevent it happening
         I had a duty to make him comfortable.
         I do meet his wife out and about
         Even now she says how grateful she was.
Diana   What qualities does she see in you for having done what you did?
Helen   That's a difficult one, um,
Caroline “What a kind lady”
Vicky   What a nice memory for his death:
         Someone there right at the end,
         Caring and fighting;
         Just super
Caroline GPs sometimes feel intimidated
         When the physio tells them things they ought to know.
Vicky   The subsequent action was exactly that,
         Wasn't it?
         GP went in,
         Thought,
         Closed the book,
         Ambulance arrived
Helen   I'm not given to telling doctors what to do:
         “This man needs to be in hospital”
Louise  There was a massive difference between your conversation with
         them as a couple
         And the GP’s
         There's a massive difference with what you read into the situation
         To the GP
         Is that a professional difference or is that personal?
Diana   His wife may have seen you as a person she could trust, fully open
         up to, and tell it as it was
Helen: The GP should have known the District Nurses don’t go in and do washing and dressing.

Diana: But didn’t know.

Helen: But didn’t know.

It was appalling.

Louise: It sounded more than that.

You were really aware of the deterioration.

Your knowledge of the patient from the previous week.

It sounded like you had more concerns.

He needed to be in hospital.

Helen: Because we couldn’t get him out of bed.

He was without anyone going in to help.

He was going to be lying in bed.

Getting pressures sores.

Diana: You saw the consequences of what potentially would happen.

Other people could not have seen.

Or perhaps chose not to see.

You were seeing the passage of time.

What needed to be done.

Taking on roles over and above what you should do.

Helen: That’s right.

Diana: You saw it needed to be done.

Because of qualities such as integrity and warmth and caring.

You saw what needed to be done.

Right there and then.

Sue: It’s a bit about being there.

The GP hadn’t seen this person for a long, long time.

Helen: I can’t remember what the condition was, it was going to deteriorate.

Maybe the GP wasn’t aware.

Vicky: That was generous of you.
A7.3 Transcription and crafted dialogue side by side for comparison

<table>
<thead>
<tr>
<th>Transcription</th>
<th>Crafted dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sue</strong>... They did however admit that Sue’s visit had put the ‘wind up’ them and that they had christened her ‘Scary Sue!’ Sue fed this back to her colleagues and since then her office nickname is ‘Scary Sue’.</td>
<td><strong>Sue</strong>... They did however admit that Sue’s visit had put the ‘wind up’ them and that they had christened her ‘Scary Sue!’ Sue fed this back to her colleagues and since then her office nickname is ‘Scary Sue’.”</td>
</tr>
</tbody>
</table>
| **20m 55s** Group (laughter) (Cough) (Pause) Chris Great, thank you very much. Has anyone got any comments or questions? Emma I think they’re both about difficult situations and dealing with conflict and strengths with your decision-making really, and I think you did that pretty well, and conflicts with other professionals, and standing our ground. Helen I’m happy to admit I was angry with the GP. Vicky We could tell! Helen He should have been readmitted the previous day. Sue I was probably quite angry as well. Vicky I was impressed by your, um, your ability go in help tidy up the patient, I mean faeces, urine; make the bed, and get him comfortable; that’s beyond the call of duty. I thought that was really good. Helen I just felt I couldn’t leave him. Vicky Absolutely that’s, that’s, going the extra mile that I think that’s what physio’s do often do and it’s not measures and it’s not reported and it’s the human element of the job really. Helen I couldn’t leave him. Vicky Absolutely, that’s going the extra mile, that’s what physio’s do. Helen I couldn’t have walked away. Vicky It’s not measures, it’s not reported, it’s the human element of the job. Helen He was distressed. Vicky Because of what had happened; Helen Yes. Louise You can’t write a business plan for that.
<table>
<thead>
<tr>
<th>Helen</th>
<th>Yes</th>
<th>His wife was distressed because she hadn’t been able to prevent it happening.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louise</td>
<td>And you can’t write a business plan for that really.</td>
<td>I had a duty to make him comfortable.</td>
</tr>
<tr>
<td></td>
<td>You’re story and I couldn’t really have walked away.</td>
<td>I do meet his wife out and about.</td>
</tr>
<tr>
<td>Chris</td>
<td>why did you feel you that you had to do that?</td>
<td>Even now she says how grateful she was.</td>
</tr>
<tr>
<td>Helen</td>
<td>Because he was distressed because of had happened his wife was distressed because she hadn’t been able to prevent it happening (pause) and I just felt I had a duty to make him comfortable.</td>
<td>Diana What qualities does she see in you for having done what you did?</td>
</tr>
<tr>
<td>Caroline</td>
<td>Mm</td>
<td>Helen That’s a difficult one, um,</td>
</tr>
<tr>
<td>Emma</td>
<td>I guess you had a relationship with his parents as well because he was a lovely chap.</td>
<td>Caroline “What a kind lady”</td>
</tr>
<tr>
<td>Helen</td>
<td>Yes, yes I mean they were a lovely couple</td>
<td>Vicky What a nice memory for his death:</td>
</tr>
<tr>
<td>Emma</td>
<td>Mm</td>
<td>Caroline GP’s sometimes feel intimidated</td>
</tr>
<tr>
<td>Helen</td>
<td>and I do occasionally still meet his wife out and about and she just even now this is a good few years ago she still says how grateful she was mm</td>
<td>Vicky The subsequent action was exactly that, Wasn’t it?</td>
</tr>
<tr>
<td>Diana</td>
<td>how do you think his wife what does she what does she what qualities does she see in you for having done what you did? Because that’s really what we’re after, isn’t it?</td>
<td>Caroline When the physio tells them things they ought to know.</td>
</tr>
<tr>
<td>Helen</td>
<td>mm</td>
<td>Vicky GP went in,</td>
</tr>
<tr>
<td>Diana</td>
<td>What did she what did she see if someone asked her what qualities does possess to have done what she did that day or over that period of time what do you think she would say</td>
<td>Thought, Closed the book,</td>
</tr>
<tr>
<td>Helen</td>
<td>mm</td>
<td>Amen</td>
</tr>
<tr>
<td>Louise</td>
<td>Oh that’s a difficult one (laughs) um,</td>
<td>Helen I’m not given to telling doctors what to do: “This man needs to be in hospital”</td>
</tr>
<tr>
<td>Caroline</td>
<td>What a kind lady!</td>
<td>Louise There was a massive difference between your conversation with them as a couple And the GP’s</td>
</tr>
<tr>
<td>Vicky</td>
<td>And what a nice memory for his death to be honest someone there right at the end caring and fighting for him I think that’s just super</td>
<td>Diana His wife may have seen you as a person she could trust, fully open up to, and tell it as it was</td>
</tr>
<tr>
<td>Caroline</td>
<td>I’m interested in your relationship with the GP 'cos</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Vicky</strong></td>
<td>I’ve had with GPs and sometimes they feel very intimidated when the physio tells them things that they ought to know. And the subsequent action was exactly that wasn’t it? That GP went in, thought, closed the book and then the ambulance arrived.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Helen</strong></td>
<td>It was appalling.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Louise</strong></td>
<td>But didn’t know.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diana</strong></td>
<td>It sounded more than that.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Helen</strong></td>
<td>You were really aware of the deterioration. Your knowledge of the patient from the previous week. It sounded like you had more concerns, He needed to be in hospital.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Helen</strong></td>
<td>Because we couldn’t get him out of bed, He was going to be lying in bed. Getting pressures sores.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diana</strong></td>
<td>You saw the consequences of what potentially would happen, Other people could not have seen, Or perhaps chose not to see. You were seeing the passage of time, What needed to be done, Taking on roles over and above what you should do.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Helen</strong></td>
<td>That’s right.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diana</strong></td>
<td>You saw it needed to be done, Because of qualities such as integrity and warmth and caring, You saw what needed to be done, Right there and then.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sue</strong></td>
<td>It’s a bit about being there, The GP hadn’t seen this person for a long, long time.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Helen</strong></td>
<td>I can’t remember the condition; it was going to deteriorate, Maybe the GP wasn’t aware.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Louise</strong></td>
<td>Well it sounds, from your story it sounded more than that. You were really aware of the...</td>
<td></td>
</tr>
<tr>
<td>Helen</td>
<td>deterioration and your knowledge of the patient from the previous week or whatever the time gap was. It was more than just, you, the way your story came across it sounded like for you it was more than just the ability to get him out of bed the next day it sounded like you had more concerns which is why you thought you he needed to be in hospital. Because we couldn’t get him out of bed so he was without anyone going in to help he was just going to be lying in bed and getting pressures sores.</td>
<td></td>
</tr>
<tr>
<td>Diana</td>
<td>So you saw the consequences of what potentially would and should happen that perhaps other people say the GP could not have seen or perhaps chose not to see, erm, and so you were if you like you were seeing the passage of time and what absolutely needed to be done for that person maybe taking on roles in the flat over and above what you are supposedly professionally should do.</td>
<td></td>
</tr>
<tr>
<td>Helen</td>
<td>That’s right.</td>
<td></td>
</tr>
<tr>
<td>Diana</td>
<td>You did them because you saw it needed to be done and because of qualities such as integrity, and warmth and caring you saw what needed to be done right there and then was that.</td>
<td></td>
</tr>
<tr>
<td>Sue</td>
<td>I think that probably it’s a bit a bit about being you were there whereas probably maybe the GP hadn’t seen this person for a long, long time and didn’t.</td>
<td></td>
</tr>
<tr>
<td>Helen</td>
<td>I can’t remember what the condition was which is why I didn’t put it in but I know it was associated with um, a skin condition that’s what he went into hospital with first but it wasn’t um, is it scleroderma it wasn’t anything like that it was something I hadn’t heard of before or since, um. And it was going to be he was going to deteriorate which maybe the GP wasn't aware of, I don't know.</td>
<td></td>
</tr>
<tr>
<td>Vicky</td>
<td>That was generous of you.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 8 Proforma to structure the analysis

(Described in sections 6.3.3; 6.3.4; 6.3.5)

#### 1.1 Helen the Dying Man

<table>
<thead>
<tr>
<th>Structure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orientation</strong></td>
<td>Harry had been home from hospital for a day or two the first time Helen called on him and his wife. He had been referred to the reablement team and as the problem was mainly one of mobility, Helen as the physiotherapist for the team did the initial assessment. Harry had been in hospital for several weeks whilst his condition was diagnosed. During that time his mobility had deteriorated. The diagnosis was made of quite a rare condition and there was little hope of improvement. He and his wife, Jane, lived on the second floor of a block of flats which did not have a lift.</td>
</tr>
<tr>
<td><strong>Complication</strong></td>
<td>On this first visit Harry was able to move around with the help of a Zimmer frame but was struggling to get out of the chair. As the Occupational Therapist and Helen worked very closely together, Helen was able to fit chair raisers to enable Harry to rise from sitting more easily. As Harry and his wife had not wanted carers in to help out and they seemed to be coping quite well at that time a further visit was not deemed necessary for several days. <strong>When Helen returned for the next visit the situation had changed. Harry’s mobility was much more limited and he and Jane were struggling.</strong> Consequently Helen contacted the GP to request a visit fully expecting that Harry would have been readmitted to hospital later that day. In the light of this a follow up visit was not arranged but Helen arranged to phone Jane the following morning to check whether Harry had been readmitted. When Helen phoned first thing the following morning, Jane was in quite a state as she had not been able to get Harry out of bed. Fortunately Helen had a student on placement with her at the time so they both dropped everything and went round to see Harry. Harry had been unable to get out of bed all night and had consequently wetted and soiled the bed and by herself Jane had been unable to clean him or change the bedclothes. Even with the assistance of Helen and the student, Harry was unable to stand. The only thing that Helen felt able to do was with the help of the student and Jane to clean Harry up, change the bedclothes and make Harry as comfortable as possible. This they did. When they had...</td>
</tr>
</tbody>
</table>
done this Helen contacted the GP again who was quite defensive. She stated that she had arranged for the district nurses to go in that morning to get Harry up and dressed. Helen knew this would not happen but that the district nurses would just refer to social services for an assessment to be made. In view of Harry’s total dependency social service carers would not get him out of bed without appropriate equipment. Helen’s comment to the GP was that Harry needed to be in hospital because he was at risk of developing pressure sores. The GP’s response was that there was nothing more she could do. Helen was not herself able to get a patient admitted to hospital as it all had to through the GP. Helen and the student stayed with Jane and had a cup of tea whilst deciding what to do.

**Resolution**
Harry died in hospital a few weeks later.

**Evaluation**
However before they left the GP phoned Jane to say that she was sending an ambulance to take Harry back into hospital. Helen was not herself able to get a patient admitted to hospital as it all had to through the GP.

**Form**

<table>
<thead>
<tr>
<th>Setting</th>
<th>Harry’s home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>In the past</td>
</tr>
<tr>
<td>Actors</td>
<td>Protagonist: Helen</td>
</tr>
<tr>
<td></td>
<td>Others: Harry; Jane, his wife, Helen’s student; the GP</td>
</tr>
<tr>
<td>Sequence of events</td>
<td>Helen calls on Harry; they seem to be coping; Helen visits a couple of days later – the situation has changed and they are no longer coping; Helen rings GP expecting Harry to be readmitted; Helen rings next day and finds things worse; she and student go around to find him in a soiled bed, unable to move. They make him comfortable. Helen rings GP – they talk. GP admits Harry. Harry later dies</td>
</tr>
<tr>
<td>Action / Plot</td>
<td>Deterioration of a patient; discussion with GP about whether to admit him; too late the GP does</td>
</tr>
<tr>
<td>Consequence</td>
<td>The patient dies a few weeks later</td>
</tr>
</tbody>
</table>

**Content**

<table>
<thead>
<tr>
<th>Why was the narrative chosen?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Told as triumphant story of how PT’s know better than GPs – “here is one example where I knew the patient needed to be admitted but when I told the GP to do so she didn’t and the patient subsequently died”.</td>
</tr>
<tr>
<td>• Story told as vehicle for showing how Helen was committed to her patients and advocated for them</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coherence / lack of</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Interested in the student – what is she as an actor in this story? Why is she necessary? I wonder if</td>
</tr>
</tbody>
</table>
| coherence | the fact of her presence changed Helen’s practice – was she showing off, distracted, embarrassed by what she could / couldn’t do. Why did they have to ‘drop everything’? This is melodramatic language  
• Lack of coherence: “Consequently Helen contacted the GP to request a visit fully expecting that Harry would have been readmitted to hospital later that day.” What did she actually ask the GP to do – did she explain the situation at home; did she say her advice was that he needed to be readmitted? |
|---|---|
| Is there a link between the narrative and the crafted dialogue | • We discuss our reactions to this story first by commenting on what they are about: “difficult situations, dealing with conflict, conflicts with professionals” (1-2), and what this says about physiotherapists: “Strengths with decision-making and standing our ground” (3).  
• The story is validated by us: “You did pretty well” (4), “I was impressed” (8).  
• The storyteller admits to the emotions she remembers feeling: “I was angry with the GP” (5) because “He should have been readmitted the previous day” (7).  
• We consider the implications of this story; how as physiotherapists we often feel we are placed in difficult situations where we have to “go beyond the call of duty” (11). These can arise because of the personal situation the patient and family are in: “I couldn’t have walked away” (19) expresses a moral stance.  
• We move on to talk about how as physiotherapists we are good communicators and are able to see into the situation and to act decisively to intervene. |
| Claims to identity? | • “As the problem was mainly one of mobility Helen as the physiotherapist for the team did the initial assessment”: As a physiotherapist I deal with problems of mobility  
• “Helen contacted the GP to request a visit fully expecting that Harry would have been readmitted to hospital later that day”: As a physiotherapist I can ask the GP to do things and expect them to be done  
• The speaker casts herself as an innocent bystander as events occur around her. |
<p>| What values / beliefs does the speaker express explicitly or implicitly? | • As the Occupational Therapist and Helen worked very closely together Helen was able to fit chair raisers to enable Harry to rise from sitting more easily: it is important for both professionals to work closely |</p>
<table>
<thead>
<tr>
<th><strong>How do these values / beliefs relate to the values of the prevailing culture and cultural metanarratives?</strong></th>
<th>• The interpretation of the story by us is that here is an example of a physiotherapist facing a challenging situation is able to both roll her sleeves up and undertake nursing tasks to deal with the situation in hand and then to ring and assert her assessment of the situation with the general practitioner. This is a triumphant picture we paint of the physiotherapist, the embattled frontline worker, doggedly working with ignorant and absent doctors. This is a physiotherapist as victim heroically “caring and fighting” in the face of an “appalling” situation.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Am I using my knowledge / understanding of our shared culture to help elicit meaning?</strong></td>
<td>• “Fortunately Helen had a student on placement with her at the time so they both dropped everything and went round to see Harry.” I understand the fortunately to mean that because of this she had booked out time from seeing patients in her diary to deal with this ‘crisis’.</td>
</tr>
</tbody>
</table>
| **What do I infer about what it means to be a physiotherapist?** | • The story can also be read as one of the PT as a disempowered professional, unable to admit the patient to hospital and therefore dependent on requesting medical doctor to do so. This led to strategic action, that is goal oriented conversation whereby the PT was wanting the GP to admit the patient, but the communication was distorted, “Helen contacted the GP to request a visit”, rather than advising on what she had found what her concerns were, and what action she would request the GP take. It is therefore an example of a failure in communication. GP didn’t necessarily understand or agree with the need for admission. The experience is remembered because the patient ended up dying and blame is apportioned (?unresolved guilt).  
• I wonder if leaving a message with the GP and expecting the GP to understand the situation is a passive aggressive form of behaviour; one that commits to a self-fulfilling fallacy – that GPs don’t know what they are doing, and if I don’t give sufficient information I’m not surprised when they don’t do what I’m wanting them to do. I wonder whether there isn’t a different interpretation, one that provides emancipatory potential. That the patient died two weeks later makes me question the events as they are told. I recognise the events that occurred in the story, and I recognise the interpretation the group told ourselves about what happened, why and what we are to make of it. I also suspect that such events are not uncommon. I wonder whether there is another way of interpreting what happened and this second version perhaps explains why the experience has been remembered and perhaps why it was problematic. I wonder whether the problem was that all care
had to go through the general practitioner. It may be that the physiotherapist could have rung and requested an urgent social services assessment and the provision of carer support to enable the patient to be helped to be washed, cleaned and for a 24-hour management plan of at risk his pressure areas to be implemented.

- However the physiotherapist didn’t asset her professional authority to do this, but hid behind the role and authority of the general practitioner and required the GP to make all the decisions. This led to the patient being readmitted to hospital. The challenge of working with other people is communication; in healthcare this includes the patients, carers, family and other healthcare professionals and at times other service providers, for example social services. In constructing our professional identity we have the opportunity to choose to be a victim and to actively collaborate / contrive in this, whereas we could raise up above the victim status and assert our clinical reasoning, experience and knowledge and to take responsibility for sorting out a situation and the management of a patient. This requires self-confidence, knowledge of who to ring, how to make a referral, confidence that this is the necessary thing to do, and a preparedness to follow up whether this happens. It is much easier to ring and leave a message with the GP or their secretary and in so doing hand over responsibility to someone else. If we do this we can’t then be surprised if the GP or anyone else begins to believe we are not able / prepared to handle such situations.
Appendix 9 Items included on the compact disc

Disc included in pocket in back inside cover of thesis

1. The memory stories and crafted dialogues
2. Chris’s theme board
3. Diana’s theme board
4. Emma’s theme board
5. Helen’s theme board
6. Louise’s theme board
7. Sue’s theme board
8. Vicky’s theme board