Experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients

Bernadette Henderson

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

August 2011

The University of Brighton
ABSTRACT

Experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients.

The physiotherapist-patient interaction is the medium through which physiotherapy is practiced. However, to date little physiotherapy research literature reports on physiotherapists’ interactive behaviours in clinical practice. The objectives of this study were to explore, interpret and describe experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours when treating chronically breathless patients and to make recommendations for practice.

The study is located in the interpretive research paradigm. It has adopted a hermeneutic phenomenological approach underpinned by a relativist ontological stance and Gadamerian philosophy (1975/2004).

Five experienced cardiorespiratory physiotherapists’ were video recorded in a natural treatment setting with a chronically breathless patient. Data were generated through a video-cued recall and reflection, and a follow-up interview with each physiotherapist. Three themes were derived from the physiotherapists’ accounts: ‘Creating a facilitative space’, ‘Accessing and attending to your world’ and ‘Sharing my world’. These were considered to be key dimensions of physiotherapists’ understandings of their interactive behaviours. The concept of ‘Merging Worlds - facilitating the journey to a shared understanding and purpose, and safe achievement of purpose’ draws together these key dimensions and represents the nature of the interactional behaviours of experienced physiotherapists when managing chronically breathless patients.

The challenge of explicating tacit practice knowledge was observed during the process of data generation. This issue was considered alongside the thematic interpretation and the concept of ‘Merging Worlds’ to inform the development of a new model of physiotherapy practice: Mindful, Reciprocal Interaction. A series of questions to facilitate explication of, and critical reflection on interactive behaviours were developed for use by physiotherapists to enhance their interactive behaviours during encounters with patients.

The findings of this study provide new knowledge for physiotherapy practice.
# TABLE OF CONTENTS

**ABSTRACT** .................................................................................................................. 2

**TABLE OF CONTENTS** ................................................................................................. 3

**LIST OF FIGURES** ........................................................................................................ 6

**LIST OF BOXES** .......................................................................................................... 7

**LIST OF TABLES** ......................................................................................................... 8

**DECLARATION** ............................................................................................................. 9

**ACKNOWLEDGEMENTS** .............................................................................................. 10

**CHAPTER 1: INTRODUCTION** ..................................................................................... 11

1.1 Introduction ................................................................................................................. 11

1.2 How the study arose .................................................................................................. 11

1.3 Research question .................................................................................................... 19

1.4 The aim of the study ............................................................................................... 19

1.5 Significance of the study ....................................................................................... 19

1.6 Structure of the Thesis ......................................................................................... 20

**CHAPTER 2: BACKGROUND** ..................................................................................... 22

2.1 Introduction ................................................................................................................. 22

2.2 Professional Practice Knowledge ............................................................................ 23

2.3 Physiotherapists’ interactive behaviours - pedagogic influences ......................... 26

2.4 Physiotherapists’ interactive behaviours – practice perspective ......................... 33

2.5 Patient and relationship centred care .................................................................... 44

2.6 Patient and relationship-centred care in practice ................................................. 52

2.7 Summary .................................................................................................................. 54

**CHAPTER 3: METHODOLOGY** .................................................................................... 57

3.1 Introduction ................................................................................................................ 57

3.2 Philosophical Underpinnings ................................................................................... 57

3.3 Hermeneutic Phenomenology .................................................................................. 61

3.4 Research Methodology ............................................................................................. 67

3.5 Methodological Structure ....................................................................................... 68
3.6 Summary ........................................................................................................ 73

CHAPTER 4: METHOD ........................................................................................ 74
4.1 Introduction ..................................................................................................... 74
4.2 Overview of study process .............................................................................. 74
4.3 Ethical Considerations .................................................................................... 75
4.4 Selecting and recruiting the participants ......................................................... 81
4.5 Data Generation: Investigating the experience in the participants’ world ...... 84
4.6 Management and organisation of the data ...................................................... 93
4.7 Data Analysis .................................................................................................. 94
4.8 Summary ........................................................................................................ 95

CHAPTER 5: FINDING MEANING ..................................................................... 97
5.1 Introduction ..................................................................................................... 97
5.2 Mining for meaning in the participants’ accounts ............................................ 98
5.3 Summary ...................................................................................................... 113

CHAPTER 6: THEMATIC INTERPRETATION .................................................. 115
6.1 Introduction ................................................................................................... 115
6.2 Creating a facilitative space .......................................................................... 116
6.3 Accessing and attending to your world ......................................................... 126
6.4 Sharing my world .......................................................................................... 142
6.5 Summary ...................................................................................................... 154

CHAPTER 7: MERGING WORLDS ................................................................... 155
7.1 Introduction ................................................................................................... 155
7.2 Merging Worlds: Facilitating the journey to a shared understanding and purpose, and safe achievement of purpose .................................................... 155
7.3 Summary ...................................................................................................... 172

CHAPTER 8: MINDFUL, RECIPROCAL INTERACTION ................................. 173
8.1 Introduction ................................................................................................... 173
8.2 Process of knowledge explication .................................................................. 173
8.3 Mindful, Reciprocal Interaction; Synthesis and application ........................... 180
CHAPTER 9: SUMMARY AND CONCLUSIONS

9.1 Introduction

9.2 Achieving the aims and objectives of the study

9.3 Rigour and reflexivity, limitations and reflections

9.4 Contributions to knowledge

9.5 Recommendations

9.6 Concluding thoughts

REFERENCES

APPENDICES

Appendix 1: Causes of Chronic Breathlessness

Appendix 2: Knowledge Types Used in Practice

Appendix 3: Professional Practice Models in Health

Appendix 4: Table of studies on physiotherapist-patient interaction

Appendix 5: Participants Research Journey

Appendix 6: Letter of NHS Research Ethics Committee Approval

Appendix 7: NHS Trust Department of Clinical Governance and Risk Approval

Appendix 8: Participant’s Study Information Sheet

Appendix 9: Patient’s Study Information Sheet

Appendix 10: Participant’s Consent Form

Appendix 11: Patient’s Consent Form - Part 1

Appendix 12: Patient’s Consent Form - Part 2

Appendix 13: Patient’s Medical Consultants Study Information Sheet

Appendix 14: Video-cued Recall and Reflection Interview Guide

Appendix 15: Follow-up Interview Guide Sample

Appendix 16: Video-cued recall and reflection - Sample Transcript

Appendix 17: Follow-up Interview - Sample Transcript

Appendix 18: Video-cued recall and reflection - Sample Transcript
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Communication cycle</td>
<td>49</td>
</tr>
<tr>
<td>2</td>
<td>Simultaneous internal and external dialogue between two individuals</td>
<td>50</td>
</tr>
<tr>
<td>3</td>
<td>Philosophical perspective informing the research study</td>
<td>73</td>
</tr>
<tr>
<td>4</td>
<td>Data generation process</td>
<td>75</td>
</tr>
<tr>
<td>5</td>
<td>Collapsing down codes</td>
<td>95</td>
</tr>
<tr>
<td>6</td>
<td>Analytical process</td>
<td>97</td>
</tr>
<tr>
<td>7</td>
<td>Environment mind map</td>
<td>107</td>
</tr>
<tr>
<td>8</td>
<td>Creating a facilitative space theme</td>
<td>110</td>
</tr>
<tr>
<td>9</td>
<td>Accessing and attending your world theme</td>
<td>111</td>
</tr>
<tr>
<td>10</td>
<td>Sharing my world theme</td>
<td>112</td>
</tr>
<tr>
<td>11</td>
<td>Summary of the themes and sub-themes</td>
<td>113</td>
</tr>
<tr>
<td>12</td>
<td>Merging Worlds</td>
<td>157</td>
</tr>
<tr>
<td>13</td>
<td>Mindful, Reciprocal Interaction</td>
<td>181</td>
</tr>
</tbody>
</table>
LIST OF BOXES

Box 1: Definition of clinical reasoning .................................................................30
Box 2: Video recorded patients and context .........................................................84
Box 3: Extract from the preliminary code list .....................................................101
Box 4: Example of a concept descriptive memo ..............................................104
LIST OF TABLES

Table 1: Moving from text to meaning units and codes ........................................ 100
Table 2: Moving from meaning units and codes to concepts .............................. 103
Table 3: Moving from core concepts to sub-themes and themes......................... 108
Table 4: Physiotherapist-patient interactions: A framework for critical reflection 182
DECLARATION

I declare that the research contained within 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

Dated
ACKNOWLEDGEMENTS

My grateful thanks go to my family, John, Juanita, Ian, Michael, Eileen, Paul, Lou, Emily, Lucy, Claire, Callum, Patrick, Tom, Kathleen and Johnny MacKenzie and Jean Furbank for their love and never ending emotional and practical support.

Special thanks go to my daughter Cat (and Rob), my sister Coggie and my mother Maureen who throughout this journey have given me strength, and been a calm port in many a storm.

To my dear friends Maureen, Dominic, Theresa and Charles you were steadfast shining stars lighting my way.

To Irene, Heather, Laura, Adina, Kathy and Peter thank you for your friendship, humour and encouragement.

To Vikki Butler and Carol McCrum whose support, insightful comments and gentle criticism kept me on the right path.

To my supervisors Val Hall and Angela Glynn, thank you for abiding with me and providing a never ending source of expertise and support.

To the NHS Trust where I work, Jude Monteath and all the Staff in the Therapies and Dietetics Department for giving me the time and assistance to complete this Thesis.

To Karen Osgood, always available and eager to help whenever I needed, you lighten the load considerably.

To Guy Robinson and Sue Sellens, you are librarians extraordinaire. Many thanks for always finding those elusive papers and books.

In particular, I would like to thank the participants who willingly observed, discussed and reflected on their own interactive behaviours, and the patients who allowed their physiotherapy treatment session to be video recorded.

Lastly, I dedicate this thesis to my father Patrick Joseph Quigley and to all breathless patients and those that care for them.
CHAPTER 1: INTRODUCTION

1.1 Introduction

This thesis reports a qualitative research study designed to investigate cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients. This chapter presents the origins of the research interest, which arose from a disturbance in my practice. It describes how the study arose in terms of my personal professional background, work context, motivation and pre-understandings. Also included are the purpose of the study, the research question, the significance of the thesis and an overview of the thesis chapters.

1.2 How the study arose

Traditionally, physiotherapy practice has been viewed as a physical therapy. Along with other health care professions, physiotherapy has afforded high status to scientific knowledge and technical competence. As a result, physiotherapy training, research and literature have been dominated by empirico-analytical understandings of knowledge and the biomedical model. Technical skills, physiological and anatomical measurement, quantifiable outcomes and efficiency have been valued. Less interest and importance appear to have been directed towards ways of knowing that value care, attentiveness, relationships and practical knowledge. As a result, there is a tendency to reduce physiotherapy to the study of, and debate about technique. Unsurprisingly, at the start of my professional doctorate journey I was strongly orientated to using a positivist approach to investigate a specific physiotherapy technique. As I explored my understandings of reality and how I believe I come to know that reality, I realised that my fundamental beliefs about the lived experience of being a physiotherapist went far beyond knowledge of evidence based techniques and appropriate application of those techniques.

I have practiced as a cardiorespiratory physiotherapist in acute hospital settings for nearly thirty years. As a senior clinician, I have observed, supervised and examined many physiotherapy practitioners treating respiratory patients. One particular group of patients who have consistently stimulated reflection on my own
and others’ interactive behaviours are patients with chronic or acute breathlessness. Cardiorespiratory physiotherapists spend a great deal of their time treating patients with breathlessness. This group of patients are vulnerable, often feel powerless and can be extremely anxious. Chronic breathlessness is a common symptom of many respiratory, cardiac and other pathological conditions (Appendix 1). It can occur acutely in conditions such as pneumonia or pulmonary oedema or become chronic in conditions such as chronic obstructive pulmonary disease (COPD) and heart failure, or may relate to underlying psychological conditions that result in dysfunctional breathing syndrome.


Similarly, physiotherapy literature places emphasis on the technical and procedural approaches to managing breathlessness. Current physiotherapy management of breathlessness focuses on education regarding the underlying pathophysiology and symptoms, and physical techniques. Positioning, controlled breathing strategies, exercise training and activity pacing are advocated (Thomas et al. 2010, Pryor and Prasad 2002, Hough 2001, Morgan and Singh 1997). These techniques aim to manage or reduce the work of breathing, the symptom of breathlessness and improve function. It is generally accepted that breathlessness management techniques influence physiological factors such as respiratory rate,
static and dynamic lung volumes and energy conservation during rest and activity (Thomas et al. 2010, Pryor and Prasad 2002, Hough 2001, Morgan and Singh 1997). These recognised key sources of cardiorespiratory physiotherapy literature provide descriptions of techniques and theoretical knowledge to guide clinical practice, and reasoning concerning the use of appropriate techniques. However, they do not attend to interactive behaviours in cardiorespiratory physiotherapy practice or which behaviours are suitable and effective.

During my clinical practice I became increasingly aware that in addition to physical interventions, helping patients was enhanced by the ability of physiotherapists to gain an understanding of each patient’s life, beliefs and context. It appeared that the way physiotherapists interacted and behaved during treatment sessions influenced how well they could access individual patient’s beliefs and wishes, and the way patients interacted and behaved with the physiotherapist. Experienced cardiorespiratory physiotherapy practice seemed to involve competence in both technical performance and human interaction. The lack of cardiorespiratory physiotherapy literature offering any insight into how to interact with patients was a personal concern. My perception was that in addition to the traditionally taught physical techniques, cardiorespiratory physiotherapists were using knowledge and behaviours which appeared to directly foster positive interactions with patients. Additionally, I thought the persistent and frightening nature of chronic breathlessness had prompted physiotherapists to develop ways of interacting that aimed to reduce the patient’s anxiety. Cardiorespiratory physiotherapists seemed to realise that patients sought and required more than physical techniques and a distant relationship with their physiotherapist. Furthermore, cardiorespiratory physiotherapists’ interactive behaviours seemed to play a much more significant role in determining the success of the relationship and outcome of treatment than has been given recognition in the current literature. These insights led me to speculate that the ability to interact effectively with patients may be a core requirement of cardiorespiratory physiotherapy practice. If this is so, then the way cardiorespiratory physiotherapists deliver care is as important as the care itself. Consequently, the source of my disturbance was that little attention had been paid to what I perceived to be a fundamental and essential component of cardiorespiratory physiotherapy practice.
As a result of these conjectures I believed there was a need to identify and understand the ill-defined and yet to be described behaviours inherent in physiotherapists’ interactions with chronically breathless patients. My intention was to explore if there was a means of expressing, exposing and giving a description of experienced physiotherapists’ understandings of their interactive behaviours with breathless patients. If so, interactive behaviours could be made explicit, permitting analysis, description and dissemination. This practical wisdom could then be introduced into the formal knowledge base of cardiorespiratory physiotherapy and be conceived of and taught as purposeful behaviours.

A number of other underlying issues also influenced my thinking. Firstly, it is a central expectation of all professions to make the epistemology of their practice explicit including the nature of profession specific knowledge and the processes involved in creating that knowledge (Higgs et al. 2004). This did not appear to be the case regarding physiotherapists’ interactive behaviours. Secondly, expert physiotherapists are perceived to practice better because they know how to do the right thing at the right time and thus provide better care for their patients (Jensen et al. 2000, Rothstein 1999). There is a need to understand experts’ wisdom, skills and decision making, and to use the knowledge learnt through study of expert physiotherapists to improve physiotherapy education and patient care. Thirdly, there is an increasing imperative to be able to defend and articulate therapists’ practice in the current outcome driven United Kingdom health care market. Explaining and generating practice knowledge has implications for the capacity of therapists to retain, justify and strengthen their unique role in caring for patients and to be recognised as essential members of the health care team. Therefore, it is crucial that physiotherapy enters into dialogue about all of its practices particularly those that remain undefined (Larsen et al. 2008).

Additionally, owing to the increasing demand for evidence based practice and public accountability it is vital to make physiotherapy practice more explicit (Higgs and Titchen 2000).

Thus, the focus of this study was cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients. As the researcher, my pre-understandings, personal beliefs, knowledge and
experience were brought to the inquiry. The following section explicates these pre-understandings so that their influence on the study can be transparent.

1.2.1 The personal turn

I began my training as a physiotherapist over thirty years ago. At that time the physiotherapist’s role was primarily technical. Propositional knowledge was valued and the clinician tended to hold the power in the therapeutic relationship. During my training and as a newly qualified physiotherapist, I recognised that particular physiotherapists seemed to be more effective and successful during encounters with patients. I thought these physiotherapists were effective for a number of reasons. They appeared to treat patients as individuals, behaved towards them in a natural, calm, honest and respectful way. They listened, were compassionate and concerned with nourishing relationships and fostering independence in their patients. These behaviours appeared to be naturally more developed in some physiotherapists. I strove to emulate their behaviours.

Additionally, my role as an educator and supervisor of other physiotherapists has allowed me to observe the interactive behaviours of hundreds of student, junior and experienced physiotherapists. I have reflected extensively on which approaches and behaviours seem to develop and nurture more productive relationships with patients. However, it was not clear to me whether the behaviours I perceived were innate to the individual practitioner, developed through training and experience, or whether practitioners spontaneously adopted certain behaviours. The more I reflected on my own and others’ practice, the more I felt convinced that physiotherapists took account of the patient’s physiological, emotional and cognitive states and used their own behaviours in an attempt to influence these states. I suspected that the persistent and frightening nature of chronic breathlessness had prompted physiotherapists to develop particular strategies. There appeared to be an intuitive recognition that more than standard physical physiotherapy techniques were required. It seemed that practice had developed beyond a technical approach in an attempt to improve the care of breathless patients. I had also observed experienced physiotherapists in other specialties and perceived they were using similar interactive behaviours with their anxious patients.
Participation in a number of cognitive behavioural therapy, motivational interviewing and leadership courses orientated me even more strongly towards understanding the significance of behaviours during human interactions. I endeavour to continuously be aware of how I am when I am with a patient; how I am feeling, how I am responding. I am ever mindful of their life and health care experience thus far and how they might be feeling, and how they are responding to me.

1.2.2 The hypnotic turn

An early point on this research journey involved my personal experience of hypnotic induced relaxation. Being a reasonably sceptical person, I was astonished at how efficient and effective the technique was for bringing about mind and body relaxation. I felt that hypnotic induced relaxation could be used beneficially with patients in three ways. Firstly, the physiotherapist’s voice, speed and tone could promote a state of relaxation in the patient. Secondly, the patient experiences a deep form of relaxation, and thirdly, in a relaxed state people become more receptive to suggestion. However, the use of embedding suggestions during deep relaxation reaches into the realm of hypnotherapy and requires extensive training (Wengell and Gabriel 2008). I believed that incorporating some of the elements of hypnotic induced relaxation into the management of anxious, breathless patients would be highly appropriate and had the potential to be useful in any clinical situation where patients were anxious.

Following training in hypnotic induced relaxation, I introduced some elements of this technique into my practice and felt that my management of breathless patients improved. At that time I was also conscious that many of the specific behaviours applied in hypnotic induced relaxation were ones that I and other physiotherapists were using intuitively. These behaviours had developed over years of treating patients with breathlessness and dysfunctional breathing and included mirroring, leading and the use of voice including speed and tone. These behaviours appeared to produce observable positive physiological, emotional and psychological responses in breathless patients. These could be seen as a reduction in respiratory rate, normalising of respiratory pattern, reduction in muscle tone and patients appeared to become calmer. This insight supported my belief
that in addition to traditional physical techniques, other knowledge and behaviours were in use during interactions with breathless patients.

1.2.3 The focused turn

At this time it appeared to me that with experience cardiorespiratory physiotherapists had developed behaviours that assisted their assessment and management of the patient’s biopsychosocial state in order to achieve a helpful outcome for the patient. Whilst there is no special reference to interactive behaviours in the cardiorespiratory physiotherapy texts, communication and relationship skills are addressed in undergraduate physiotherapy training and some physiotherapy literature. However, the current lack of explicit knowledge regarding physiotherapists’ interactive behaviours in practice means there is no recognised physiotherapy framework or model through which interactive actions and attitudes can be discussed, reflected upon or evaluated. As it appeared that physiotherapists’ interactive behaviours complemented and enhanced biomedical assessment and management it seemed appropriate that more emphasis be placed on the significance of the physiotherapist-patient interaction and its influence on the relationship, the patients’ experience and the outcomes of therapy.

At this point, I assumed that cardiorespiratory physiotherapists, with experience and wisdom as practitioners, had developed a practical knowledge beyond the taught curriculum. The difficulty was how to go about describing and deciphering these seemingly taken for granted interactive behaviours. My aim was to explore, understand and make explicit the subtle interactive behaviours that I believed were inherent in experienced physiotherapists’ practice during encounters with breathless patients.

Originally, I had made two assumptions, that these behaviours were being used and that physiotherapists were consciously applying them. Initially, I felt I needed to explore other physiotherapists’ understandings of their practice; what, if any, interactive behaviours did physiotherapists think were at play? Were they using purposeful interactive behaviours or was this phenomenon purely my perception? My question was about complex, dynamic clinical practice from the perspective of individual physiotherapists. This interest could not be studied from an objective,
quantitative stance. As a ‘way in’ to physiotherapists’ understandings I came to recognize that an interpretive research approach would provide a way to explore what I believed to be partial, complicated or hidden understandings in physiotherapy practice.

With a keen desire to make sense of this phenomenon at stage one of my journey towards a Professional Doctorate, I conducted a small-scale research project asking:

What are novice and expert cardiorespiratory physiotherapists’ understandings of their interpersonal and interactive behaviour with breathless patients?

I wanted to gain an understanding of the phenomenon I had perceived from other perspectives as well as my own and intended to explore understandings of novice and experienced physiotherapists. Phenomenology was used as the methodology and retrospective interviewing as the method of data generation. However, key difficulties emerged. Retrospective interviewing highlighted the problems of whether verbal reports after an event reflect and represent behaviour. There is a complicated relationship between what people say they do, what they think they do and what they actually do (Punch 2005). The small-scale research project gave me a better understanding of what the participant physiotherapists said they did. However, the findings revealed that the physiotherapists predominantly spoke about the technical aspects of their practice; only a limited number of interactive behaviours were described. They did not articulate the array of complex behaviours that I perceived they used when I had observed them. I was unsure if this was because they were unaware of them or were unable to verbalise them.

Consequently, gaining in-depth knowledge of what physiotherapists thought they did during interactions with patients required extending my methods. I felt it was important that physiotherapists observe themselves and be brought face to face with their interactive behaviours. This would help to prompt recall of the detail of the interactions and facilitate rich description of personal understandings of interactive behaviours. Additionally, because the behaviours I was interested in
appeared to be more developed in experienced physiotherapists I decided not to include novice participants in the study which developed from the pilot project. As a result, the research question was refined.

1.3 Research question

What are experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours when treating chronically breathless patients?

1.4 The aim of the study

The overall aim of this research study was to gain an understanding of experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours when treating chronically breathless patients. A hermeneutic phenomenological approach was taken to explore these understandings.

Research objectives
1. To explore cardiorespiratory physiotherapists' understandings of their interactive behaviours when treating chronically breathless patients.
2. To express the physiotherapists’ understandings through thematic interpretation.
3. To use insights from the findings to make recommendations for practice.

1.5 Significance of the study

Cardiorespiratory physiotherapy practice primarily involves face-to-face encounters with patients. Whilst there is plenty of theoretical and technical knowledge informing the physiotherapy care of breathless patients there appears to be a significant gap in the physiotherapy knowledge base that describes and conceptualises experienced cardiorespiratory physiotherapists’ personal understandings of their interactive behaviours when treating patients with chronic breathlessness. This research study expands current physiotherapy practice knowledge by providing a thematic description and conceptualisation of experienced cardiorespiratory physiotherapists' understandings of their interactive behaviours. In addition, a new model of physiotherapist-patient interaction is introduced through which cardiorespiratory physiotherapists can explicate and
critically reflect on their interactive behaviours when treating chronically breathless patients.

1.6 Structure of the Thesis

The thesis is presented in eight chapters. This first chapter has set the scene for the thesis with a description of how the study arose in terms of my personal context, motivation and pre-understandings. An outline of the subsequent chapters is now provided as a guide to the thesis.

Chapter Two – Background

This chapter considers and summarises the literature that informed the study. It sets the study in the context of both the immediate and wider field and demonstrates a gap in cardiorespiratory physiotherapy practice knowledge. The chapter provides justification of the research question.

Chapter Three – Methodology

Chapter three describes and discusses the methodology that has informed the design of the research. Its purpose is to provide an account of the philosophical understandings that underpinned the development of the study and how these understandings guided the inquiry process. The chapter makes a case for the chosen theoretical perspective and methodology.

Chapter Four – Method

Chapter four details the procedural plan and the steps taken to generate data and demonstrates that the research methods chosen support the objectives of the study. It includes information on participants, recruitment, ethical issues, study setting, methods of data generation and an introduction to the data analysis techniques.

Chapter Five – Finding Meaning

Chapter five provides a detailed account of the steps and processes that were used to find meaning in the transcripts of the participants’ accounts.

Throughout chapters four and five issues of reflexivity and rigour are addressed and discussed. They offer a transparent account for the evaluation of the study.
Chapter Six – Thematic Interpretation
This chapter offers an interpretation of the physiotherapists’ understandings of their interactive behaviours through three thematic descriptions. The descriptions are grounded in the participants’ words entwined with my interpretation of their understandings.

Chapter Seven – Merging Worlds
Chapter seven presents a conceptualisation of experienced cardiorespiratory physiotherapists’ interactive behaviours that encapsulates the physiotherapists’ understandings. The concept is described and positioned within the relevant body of literature.

Chapter Eight – Mindful, Reciprocal Interaction
Chapter eight discusses the challenge of explicating practice knowledge. It describes how this issue together with the concept of ‘Merging Worlds’ informed the development of a model of physiotherapist-patient interactions; Mindful, Reciprocal Interaction. In addition, a series of questions are offered as a framework to facilitate physiotherapists’ explication of and critical reflection on their interactive behaviours.

Chapter Nine – Summary and Conclusions
Chapter nine relates the findings of the study to its original aims. It summarises issues of reflexivity and rigour, and limitations of the study. It describes plans for implementation and dissemination of the findings, and suggests directions for future research. A summary of the key contributions to knowledge and implications for practice is provided. The chapter makes explicit how the study provides an original contribution to physiotherapy practice knowledge.
CHAPTER 2: BACKGROUND

2.1 Introduction

The aim of this study is to develop knowledge about experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours whilst treating chronically breathless patients. This chapter considers and summarises the literature which has informed the study. Initially, literature that focused on what was currently known about physiotherapists’ interactive behaviours was sought. This was limited, fragmented and buried within other bodies of physiotherapy knowledge. Consequently, relevant literature from other disciplines was also drawn on to inform the study. Uncovering pertinent and applicable knowledge has been an ongoing and iterative process throughout this research.

As health care professionals, physiotherapists provide a ‘need’ service. People in need of health care are inherently under stress, due to a combination of illness, pain, anxiety and fear (Bendapudi et al. 2006). Receiving health care is an intensely personal experience, requiring patients to expose themselves physically and emotionally to the gaze of the health care professional (Pellegrino 2001, Foucault 1973). Physiotherapy care aims to help people understand and manage physical impairment, and to facilitate improvement within realistic parameters (Davis 1998). Primarily, this involves face-to-face encounters with patients. Therefore, the physiotherapist-patient interaction is the medium through which physiotherapy is practiced (Davis 1998). It is argued that every patient’s experience of and outcome from health care is individual and reflects the quality of the interaction with a health care professional (Goodrich and Cornwell 2008). Consequently, achieving the aims of physiotherapy will depend on the physiotherapist’s interactive behaviours and skills along with their technical knowledge and skills.

Social behaviour and skills used by ‘interpersonal professionals’, those whose jobs involve spending most of their working day interacting face-to-face with others, are acknowledged as central to professional practice (Hargie 2006:1). In the medical and nursing fields, and to a lesser extent the therapy field, the nature and function of behaviours and skills used during health care encounters are increasingly
understood to be essential to effective patient care (Tallman et al. 2007, Bendapudi et al. 2006, Klakovich and dela Cruz 2006, Rider and Keefer 2006, Di Blasi et al. 2001). However, the term interactive behaviour is vague and imprecise and can be interpreted in multiple ways. Various synonyms are used in the literature, for example, ‘social skills’, ‘interpersonal skills’, and ‘communication skills’ (Hargie 2011:5). The use and benefit of interpersonal and communication skills has been extensively researched and described (Hargie 2011, Hargie 2006). However, these terms conceptualise and limit interactive behaviours to an idea of a skill set, for example; set induction and closure skills, questioning skills, listening skills and non-verbal body language. Whilst knowledge and careful application of these skills is important my disturbance, which prompted this study, encompassed more than an understanding of skills. As a result, the scope of the following discussion is wide-ranging.

The literature reviewed is presented in the following order. To begin with literature on different types of practice knowledge is explored to clarify the type and nature of the knowledge that the study sought. I then turn to the possible pedagogic influences underlying physiotherapists’ interactive behaviours, namely physiotherapy pre-registration training, models of practice and clinical reasoning processes. Following on, I focus on physiotherapy practice based studies that directly and indirectly provide the current understanding of physiotherapists’ interactive behaviours with patients. The penultimate section explores patient and relationship-centred care, including the underlying conceptual frameworks, theories and outcomes of these forms of care. Finally, an overview of what is currently known about how these approaches are enacted in medical practice is provided.

2.2 Professional Practice Knowledge

Since this study intends to identify physiotherapy practice knowledge I had to be clear about the nature of the knowledge I was seeking. Thus, the departure point was an exploration of the literature to consider the possible sources of knowledge that might underpin experienced cardiorespiratory physiotherapists’ interactive behaviours. Philosophers and scholars have endeavoured to unpick and classify the different types of knowledge used in practice generally (Eraut 2000, Schon 1987, Polanyi 1958, Ryle 1949, Aristotle 1985) and pertinent to this study, in
health care practice (Fish and De Cossart 2007, Higgs and Titchen 1995). Various typologies, maps and accounts are offered which depict the multifaceted nature of practice knowledge and how theoretical, practical and personal knowledge are inextricably linked. A summary of the types of knowledge proposed by successive scholars is provided in Appendix 2.

**2.2.1 Types of knowledge used by health care professionals**

Three types of knowledge are considered to be in play during physiotherapy practice; propositional knowledge, professional craft knowledge and personal knowledge (Higgs and Titchen 2000). The first type, propositional knowledge, is also referred to as codified knowledge (Eraut 2007). This knowledge is public, research based and theoretical, and available in academic publications, books, journals, policy documents and guidelines. Acceptance of this knowledge is controlled by editors, peer review and debate using criteria of truth, originality, reliability, credibility and argument (Eraut 2007). Propositional or codified knowledge clearly reflect Ryle’s (1949) ‘knowing that’ and Schon’s (1987) ‘technical-rationality’ way of knowing. Thus, propositional knowledge is explicit knowledge in that it can be fully and clearly expressed or demonstrated. As will be discussed later in this chapter, there is little propositional knowledge regarding physiotherapists’ interactive behaviour with patients.

The second type, professional craft knowledge, is the practical and technical expertise gained from professional experience and tacit knowledge of the profession (Higgs and Titchen 2000). It concerns the practical everyday way of knowing and closely corresponds to Ryle’s (1949) ‘knowing how’, and Schon’s (1987) ‘knowing-in action’. Professional craft knowledge consists of both propositional (codified) and non-propositional (uncodified) knowledge (Higgs and Titchen 2000). It is argued that the uncodified knowledge of a professional community plays a crucial role in most work-based practices and activities and the potential for it to be made explicit and codified has been overstated (Eraut 2000). Consequently, not all professional craft knowledge has been made explicit.

The third type, personal knowledge, is thought to derive from an individual’s personal experiences and reflections on experiences (Higgs and Titchen 2000). Personal knowledge has been defined as:
'what individual persons bring to situations that enables them to think, interact and perform'.

Eraut (2007:406)

It is argued that personal knowledge incorporates and is shaped by each individual’s unique frame of reference and knowledge of self (Higgs and Titchen 2000). Within the frame of reference, propositional and professional craft knowledge are transformed into decisions, actions and behaviours influenced by individual's personal views and judgements (Higgs and Titchen 2000). As a result, personal knowledge may be either explicit or tacit.

The relationship between the three types of knowledge, propositional, professional craft and personal is understood to be dynamic and all types of knowledge are accessed and used flexibly in practice (Higgs and Jones 2000). This concurs with Polanyi’s (1958) view that in practice different types of knowledge cooperate; tacit with explicit, personal with formal. Support for these views is provided by Eraut (2000). In a series of studies investigating the practice knowledge of different professions Eraut (2000) reported that practice knowledge and capability are an integration of personalised codified knowledge, procedural knowledge in the form of skills and practices, understanding of people and situations, memories of cases and episodic events, practical wisdom, self-knowledge, attitudes, values and emotions. Furthermore, Eraut (2000) proposed that much of the knowledge underpinning expert practice is implicitly learnt.

A similar assimilation of multiple types of knowledge has been described in medical practice (Fish and De Cossart 2007, Fish and De Cossart 2006, De Cossart and Fish 2006, De Cossart and Fish 2005). Fourteen key components of doctors' knowledge have been identified, many of these components were found to require integration of both propositional and procedural knowledge. These authors have drawn attention to invisible elements of medical practice such as personal qualities, professional judgements, complex decision-making, values and attitudes that are not immediately visible to an observer. In addition, the authors suggested that these invisibles of practice were implicitly learnt forms of
knowledge that lie just beneath the surface of practice, procedures, processes, and organisations. De Cossart and Fish (2005) argue that some of the invisibles of practice can be uncovered with effort, with the potential to make some of them explicit. However, it has also been proposed that a proportion of tacit knowledge cannot be articulated, it is ineffable (de Cossart and Fish 2005, Schon 1987).

The findings of these studies suggest that the knowledge types informing physiotherapists’ interactive behaviours are likely to be predominantly uncodified personal and professional craft knowledge. Thus, it was surmised that the knowledge sought could be explicit, tacit or a combination of both. Additionally, one could speculate that the extent to which physiotherapists’ knowledge of their interactive behaviours is tacit is likely to vary between individuals. However, it has been argued that with a mutually agreed language, through doing and reflecting (Johns 2009), and sustained engagement with critical companions (Titchen 2001) or with a researcher (Clandinin and Connelly 1994), tacit knowledge can be articulated and made explicit by experts. This implied that even if experienced physiotherapists’ knowledge of their interactive behaviours was tacit there was potential to make it explicit. These insights also suggested that enquiry into aspects of physiotherapists’ practice that are potentially tacit would require selecting a methodological approach that could elicit and allow exploration of tacit understandings.

In addition to the literature on practice knowledge, other sources of physiotherapy literature describe and explore physiotherapists’ interactive behaviours and offer ways in which these behaviours may be influenced as a consequence. These sources include the pre-registration curriculum, standards of practice, learnt models of practice and clinical reasoning strategies. The next section discusses these pedagogic factors and the considerations arising for this study.

2.3 Physiotherapists’ interactive behaviours - pedagogic influences

It is highly possible that the physiotherapy pre-registration curriculum has an influence on physiotherapists’ interactive behaviours in practice. Current curriculum frameworks and standards of practice for the physiotherapy profession
stipulate a patient-centred, task and skill orientated approach to practice (Chartered Society of Physiotherapy 2002, Chartered Society of Physiotherapy 2008). Communication and interpersonal skills are specifically identified. These skills are also specified as necessary requirements for competent health professionals’ practice (Health Professions Council 2007). However, the curriculum and professional practice standards fail to provide a description of ‘how’ to achieve patient-centredness through communication or interpersonal behaviours. A recent survey of approaches to teaching physiotherapy students communication skills found that the majority of United Kingdom physiotherapy programmes included modules with either a primary or secondary focus on communication (Parry and Brown 2009). However, most modules concentrated on theoretical knowledge about communication, less than half of the programmes included any practical application or development and demonstration of communication skills. Assessment and outcome of students’ communication practices primarily focused on their skill in describing and reflecting on practices rather than their practical ability.

A systematic review of direct and indirect evidence for the effectiveness of health care professionals’ communication skills training (physiotherapists, occupational therapists, speech and language therapists, nurses and doctors) reported that it is possible to positively influence health professionals’ behaviours, quality of care and patient outcomes if the training interventions are specific, founded on effective practice evidence and delivered using practice modalities (Parry 2008). However, the review highlighted that this evidence only related to qualified practitioners. The author did not find any robust evidence for the effectiveness of delivering communication skills training to student health professionals or how it influenced wider aspects of patient care. Thus, the current research into physiotherapists and other health care professionals’ pre-registration communication and interpersonal skills training does not offer evidence that this type of training informs the interactive behaviours of experienced physiotherapists but it can influence practice if delivered post qualification.

This study seeks to develop knowledge beyond what is currently known about physiotherapists or other health care professionals’ communication and
interpersonal skills. Since it is suggested that uncodified personal and cultural knowledge play a crucial role in work-based practices and activities (Eraut 2007) the discussion now explores models of physiotherapy practice and their potential to influence interactive behaviours.

2.3.1 Models of practice

Models of practice are abstract frameworks, guiding theories and concepts which consist of ideas, beliefs and knowledge on which practice is based (Trede and Higgs 2008a). As such, a health care professional’s model of practice is likely to strongly influence their practice behaviours. A variety of implicit models of practice have been found to be encompassed within physiotherapy practice (Trede 2006). No single model has been universally proposed for physiotherapy practice. This means that each physiotherapist would be expected to have an individually constructed model of practice that informs their behaviours and actions.

Two key catalysts have influenced models of practice within physiotherapy; biopsychosocial theory (Engle 1980) and the evidence-based health care movement (Sackett et al. 2000). Historically, physiotherapy education, practice and research have been influenced by the discipline of medicine and the biomedical model that primarily assume an empirico-analytical philosophy. The biomedical model views illness and injury as biological problems with biomedical solutions. The person is secondary to the disease. More recently, biopsychosocial theory, which adopts a more interpretive philosophy, has been integrated into physiotherapy practice. The biopsychosocial approach reasons that to understand and respond appropriately to patients’ distress, and to give patients a sense of being understood, biological, psychological and socio-cultural components should be taken into account and addressed simultaneously (Engle 1980).

Evidence-based physiotherapy practice evolved from the evidence-based medicine movement in the early 1990’s. Evidence-based medicine is described as:

‘the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of
However, there appears to be a clear omission in the definition offered by Sackett et al. (2000) concerning how an integration of research evidence, clinical expertise and patient values is achieved. I suggest that effective health care professional-patient interaction is the way these three elements of evidence-based medicine are merged in clinical practice.

Trede (2006) offers three models of health care practice; the illness model, the wellness model and the capacity model. These models are based on Habermas’ (1972) theory of human knowledge and human interest. Habermas’ (1972) proposed that there are three types of human interest; technical, practical and critical. Using descriptive, critical and action-learning research strategies Trede (2006) found that these interests underpin a physiotherapist’s model of practice and determine his or her behaviours in clinical practice. Trede (2006) argues that physiotherapists’ underlying interests influence how they see their role as clinicians, how they see the patient’s role, how they believe clinical decisions should be made, and how they justify their professional roles and actions (see Appendix 3). Additionally, Trede (2006) found that physiotherapists unknowingly adopted their model of practice and were often unclear about their particular model, and the values that underpinned their practice. However, there appeared to be a preference for the illness, biomedical model.

This insight into physiotherapists’ models of practice has important implications for this study. Namely, that a physiotherapist’s interactive behaviours when treating a patient are likely to be influenced by a unique, personally constructed model of practice and that there may be lack of awareness of the model of practice being used.

2.3.2 Clinical reasoning

Whether there is a personal awareness or not, a model of practice will underlie and influence physiotherapists’ clinical reasoning and decision making processes. In practice, physiotherapists continually make decisions relating to diagnosis,
intervention, evaluation and interaction (Smith et al. 2008a, Smith et al. 2008b). An increasing body of research demonstrates that physiotherapists’ clinical reasoning is a complex, multidimensional, integrated, task and a context dependent process (Smith et al. 2008a, Smith et al. 2008b, Edwards et al. 2004). A recent definition of clinical reasoning is provided in Box 2.1.

‘Clinical reasoning (or practice decision making) is a context-dependent way of thinking and decision making in professional practice to guide practice actions. It involves the construction of narratives to make sense of the multiple factors and interests pertaining to the current reasoning task. It occurs within a set of problem spaces informed by the practitioner’s unique frames of reference, workplace context and practice models, as well as the patient’s or client’s contexts. It utilises core dimensions of practice knowledge, reasoning and metacognition and draws on these capacities in others. Decision making within clinical reasoning occurs at micro, macro and meta levels and may be individually or collaboratively conducted. It involves metaskills of critical conversations, knowledge generation, practice model authenticity and reflexivity.’

(Higgs et al. 2008a:4)

Box 1: Definition of clinical reasoning

It is proposed that physiotherapists’ clinical reasoning is an ongoing and iterative process throughout therapeutic encounters which requires cognitive, metacognitive, emotional, reflexive and social capabilities (Higgs et al. 2008a, Jensen et al. 2008).

Early models of clinical reasoning in physiotherapy and other health care professions were influenced by the empirico-analytical paradigm, cognitive science and the biomedical perspective (Higgs et al. 2008b). Research concentrated on hypothetico-deductive reasoning and the organisation and accessibility of knowledge (Jones 1992, Fleming 1991, Rothstein and Echternach 1986, Payton 1985). Cognitive models depict diagnostic reasoning and the processes involved. Later interpretive and critical research approaches offer distinctly different models

The clinical reasoning of six expert physical therapists in orthopaedic, neurological and domiciliary care settings was investigated using a multiple case study approach guided by grounded theory (Edwards et al. 2004). The findings suggested that physiotherapists use different reasoning strategies to either diagnose or manage patients. To make a diagnosis, the physiotherapists used diagnostic reasoning and narrative reasoning, this included understanding each patient’s personal perspective. To manage patients, the physiotherapists used procedural reasoning, interactive reasoning (purposeful establishment and ongoing management of the therapist-patient rapport), collaborative reasoning, reasoning about teaching, predictive reasoning and ethical reasoning.

The authors reported that these multiple clinical reasoning strategies were used in varying combinations, often tacitly, according to the particular clinical situation. As a result, Edwards et al. (2004) proposed a model of ‘dialectical reasoning’, where reasoning moves between hypothetico-deductive reasoning and the reasoning required to understand the patient’s experience. Dialectical reasoning is described as a complex interplay between the two fundamentally different reasoning processes, one being the empirico-analytical reasoning paradigm, which supports the physiotherapists’ assessment and analysis of physical impairment; the other being the interpretive reasoning paradigm, which supports the physiotherapists’ understanding of the patients’ lived experience. Edwards et al. (2004) suggested that dialectical reasoning involves critical reflection by the therapist on the assumptions underlying both modes of reasoning. Additionally, they proposed that the therapist attempts to understand the assumptions underpinning patients’
beliefs and decisions, and the therapist communicates their own assumptions to the patient.

It appears that only one study has explored cardiorespiratory physiotherapists' decision making in acute care settings. Smith et al. (2008a, study reported in greater detail in 2008b) observed and interviewed fourteen cardiorespiratory physiotherapists. Hermeneutic research strategies were used to identify the nature and processes of the participants' decision making. The authors suggested that three core factors influence cardiorespiratory physiotherapists’ decision making. These include factors related to the nature of the decision, factors related to the context in which the decision occurred and factors related to the physiotherapists. Smith et al. (2008a, 2008b) proposed that optimal decision making in cardiorespiratory physiotherapy practice is an interwoven process of managing these three factors in combination. These findings concur with Edwards et al. (2004) study of clinical reasoning in other physiotherapy specialities which showed that reasoning strategies do not operate in isolation, but are applied flexibly and simultaneously in practice.

Within the nature of the decision, Smith et al. (2008a, 2008b) describe four types of decisions; decisions about patients’ problems, decisions about interventions, decisions about how to interact with patients and decisions about evaluating the outcome of previous decisions. Within the contextual factors related to the circumstances in which the decision occurred (physical, organisational and socio-professional factors) they report that physiotherapists made decisions and adjusted their interactions to each patient’s situation, forming personalised therapeutic relationships. Decisions were made about each patient’s capacity to interact and actively engage in interventions. Factors unique to each patient and their context were considered when involving patients in decision making, choosing interventions, using interaction during interventions, and as a basis for forming effective relationships. The factors relating to the physiotherapists themselves consisted of their decision making capability, their level of experience and their unique frame of reference.
Additionally, Smith et al. (2008a, 2008b) identified four types of decision making capabilities: cognitive, social, emotional and metacognitive/reflexive. Social and emotional capabilities were concerned with understanding and relating to people and included self awareness, self-regulation, self motivation, social awareness and social skills. Decisions were informed by the physiotherapists’ frame of reference. This is consistent with Edwards et al. (2004) findings that physiotherapy clinical reasoning involves a complex set of reasoning processes related to a particular patient’s needs and their context.

Edwards et al. (2004) and Smith et al. (2008a, 2008b) have highlighted the flexibility of reasoning in physiotherapy clinical practice, during which multiple decisions and actions occur simultaneously. These studies suggest that some clinical reasoning processes include decision making about how to interact with patients and how to respond to patients’ interactive cues. Although providing valuable insights and resonating with my understanding of cardiorespiratory physiotherapists’ behaviours in practice, these studies do not provide detailed descriptions of physiotherapists’ personal knowledge of their interactive behaviours, attitudes and intentions and how they are enacted in practice.

Interpersonal interaction between physiotherapists and patients appears to have been taken for granted with the result that relatively few studies have been conducted on face-to-face interactions in real world physiotherapy settings (Reynolds 2005). Even fewer studies have explored the phenomenon from physiotherapists’ perspectives. I was unable to find any studies that have looked exclusively at cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients. The next section considers the current knowledge regarding physiotherapists’ interactive behaviours with patients more generally.

2.4 Physiotherapists’ interactive behaviours – practice perspective

As discussed in section 2.1, there is no clear definition of interactive behaviours and the term is often used synonymously with other terms. Consequently, studies that investigated both physiotherapist-patient interactions and physiotherapists’
communication skills were reviewed. A synopsis of the reviewed studies (Appendix 4) shows that to investigate physiotherapist-patient interactions researchers have employed a variety of methodologies ranging from qualitative interpretive and critical approaches to quantitative micro examination of verbal and non-verbal behaviours. The data generation methods employed included various combinations of direct observation, audio-recorded interviews and video recordings of physiotherapist-patient interactions. However, the video recordings were analysed and interpreted by the researchers. The studies examined a variety of physiotherapy specialities and settings and all involved small numbers of participants; this may well be a reflection of the methodological approaches and the volume and density of data generated. However, it appears that no studies have investigated cardiorespiratory physiotherapist-patient interactions or particularly pertinent to my research interest, cardiorespiratory physiotherapists’ personal understandings of their interactive behaviours with chronically breathless patients. This section discusses current knowledge regarding physiotherapists’ interactions with patients. By doing so, it demonstrates a gap in physiotherapy practice knowledge concerning cardiorespiratory physiotherapists’ interactive behaviours in practice.

2.4.1 Asymmetrical physiotherapist-patient interactions

A number of studies have reported physiotherapist-patient interactions as asymmetrical and are critical of the predominantly clinician-centred pattern of physiotherapist-patient interactions. These studies challenged my observation of and understandings about experienced cardiorespiratory physiotherapists’ interactive behaviours when treating chronically breathless patients.

Thornquist (1994) offered a detailed analysis of interactions between two outpatients and their musculo-skeletal physiotherapists. The physiotherapists’ encounters with patients were video-recorded, observed by the researcher and the physiotherapists were interviewed. This paper reports on two participants chosen because they most obviously illustrated a common pattern found in a larger study. The pattern was characterised by a discrepancy in the physiotherapist’s view of the patient’s body that became apparent in the physiotherapist’s practice. Thornquist (1994) reports that when communicating generally, the physiotherapists related to the patients as embodied subjects but during the
examination the physiotherapists treated the patients' bodies as a physical object, separate to the patients' personhood. The physiotherapists appeared to focus on the patients' physical symptoms and gave the patients limited opportunity to present their version of their lived experience. The information patients offered was adapted to the physiotherapists' frame of reference. Some of what the patient said about their lived experience was eventually followed up, but only after repeated cues from the patient. However, Thornquist (1994) proposed that the physiotherapists did convey interest in and recognition of their patients through physical orientation and eye contact. Additionally, Thornquist (1994) found that the physiotherapists did not appear to have a language to describe what happened outside the biomedical context and did not integrate the patients' physical data with impressions of the patient as a person. The physiotherapists perceived the patients' physical signs as a manifestation of pathophysiology. Thus, the physiotherapists' approach appeared to have been essentially biomedical. Thornquist (1994) concluded that these physiotherapists operated with unintegrated worlds of knowledge and that physiotherapist-patient relationships were asymmetrical, in that the physiotherapists' more powerful position allowed them to name the patients' problems, decide on treatment, and to control and define the encounters.

Similar findings were reported by Talvitie and Reunanen (2002) in an investigation into how physiotherapists and stroke patients constructed therapeutic interactions. Discourse analysis was used to study video recordings of ten physiotherapists during a therapy session. Talvitie and Reunanen (2002) found that the physiotherapists spoke most of the time, and the content of their communication was mainly verbal guidance and concerned therapy tasks. Additionally, the authors found that the patients only occasionally took the initiative during the interaction. Although the physiotherapists said their aim was to facilitate patients' goals and strategies, the patients' goals were not addressed. Talvitie and Reunanen (2002) suggest that the physiotherapists take a biomedical approach with no consideration of the psychosocial aspects of the patients' lives. Moreover, the physiotherapists were reported to be embarrassed by patients' emotional reactions. The findings of Thornquist (1994) and Talvitie and Reunanen (2002) were contrary to my perception that cardiorespiratory physiotherapist-patient
interactions were collaborative and that therapy goals and activities were mutually agreed.

A study by Wohlin Wottrich et al. (2004) further corroborated asymmetry in physiotherapist-patient interactions. Wohlin Wottrich et al. (2004) explored the characteristics and content of physiotherapy sessions in rehabilitation settings (neurological and geriatric) from both physiotherapists’ and patients’ perspectives using a qualitative descriptive and comparative approach. Ten physiotherapists and nine patients were observed and interviewed. The authors reported that although the physiotherapists claimed that they believed active patient participation was important, this was not supported in the way the physiotherapists interviewed patients or in their observed behaviour with patients. The physiotherapists took full control, and the patients assumed a subordinate role. Wohlin Wottrich et al. (2004) concluded that in order to empower patients to take more responsibility for their rehabilitation physiotherapists need to develop a conscious strategy to enable patients to share their personal experiences and knowledge. These findings highlighted that the physiotherapists’ espoused behaviours were in conflict with the behaviours they used in practice. Additionally, the behaviours that the authors reported they had observed did not correspond with my observations of cardiorespiratory physiotherapists’ interactive behaviours when treating breathless patients.

The final study reporting asymmetrical interactions was conducted by Parry (2004a). This study looked specifically at goal-setting during physiotherapy treatment sessions. Parry (2004a) identified only eight episodes of goal setting across seventy-four video recorded physiotherapy sessions, five of these episodes involved just one physiotherapist. Within the goal setting episodes patient’s participation and contribution appeared to be limited. Parry (2004a:677) reports that the physiotherapists ‘supplied’ the patient’s problems or abilities rather than eliciting the patient’s views. Parry (2004a) proposed that goal-setting, where patients’ views are elicited and incorporated into the therapy involves skill and effort and is influenced by powerful social constraints such as inequalities in knowledge, differences in expert and lay opinion, avoidance of discussing patients’ physical incompetence and limited therapy time. Parry (2004a) concluded that
goal-setting is a complex interactional activity and suggested a need to develop further knowledge in this area of physiotherapy practice.

The findings of these four studies portray physiotherapists as reductionist, biomedical, and controlling. The physiotherapists appear to have perpetuated power inequalities, the patient taking the role of a passive partner and the patients’ psychological and social concerns were to a large extent ignored. Whilst these insights are helpful in understanding the nature of physiotherapist-patient interactions, transferring these findings to a general understanding of physiotherapists’ interactive behaviours is limited due to the studies’ scopes, i.e. stroke and elderly rehabilitation and musculoskeletal outpatient settings. However, these studies are important because they indicate that a patient-centred and patient empowered approach although espoused are not necessarily used in practice. From the above, it can also be argued that physiotherapists do not view the interactive and relational aspects of physiotherapeutic encounters to be as valuable or as necessary as the biomedical and technical aspects.

An explanation for the asymmetry in patient-physiotherapist interactions has been offered. Parry et al. (2004b) observed and transcribed video-recordings of ten physiotherapists’ treatment sessions with stroke patients. Conversational analysis methods were used to analyse the data. The findings draw attention to interactional challenges that occurred during the treatment session. Interactional challenges were challenges that the patient’s physical impairment presented to both the patient and the therapist. The authors report that issues of the patient’s physical impairment were ‘kept off the interactional surface’ (Parry et al. 2004b:984). Parry et al. (2004b) report that some aspects of the therapists’ and patients’ conduct demonstrated asymmetry. At times the physiotherapists did not listen to or acknowledge the patients’ perceptions of their problems and were quick to disagree or propose alternative versions. Patients were compliant and often did not talk about their physical problems. However, the authors suggest that the patients’ and therapists’ ways of behaving were used to protect both parties and the therapy process from the potential negative implications of the patients’ physical impairment. The interactions between the physiotherapist and the patient appeared to avoid any recognition of failure of a patient’s efforts or lack of co-
operation with physiotherapy, and the physiotherapists seemed to positively construct the therapy as a collaborative and successful endeavour. Whilst confirming the asymmetrical nature of physiotherapist-patient interactions, this study indicates that the physiotherapists' behaviours were driven by a desire to protect patients’ feelings and that they were aware that they may be doing this. This study offers insight into why physiotherapists may interact in a particular way and that the physiotherapists made decisions about the way they interacted based on an empathic approach. However, the opinion that discussion about a patient's physical impairment is avoided during the interaction directly challenged my experience of how experienced cardiorespiratory physiotherapists handled chronically breathless patients’ physical impairment.

2.4.2 Symmetrical physiotherapist-patient interactions

In contrast to the asymmetric studies, the findings of Lundvik Gyllensten et al. (1999) and Oien et al. (2011) suggest that physiotherapist-patient interactions are not exclusively asymmetrical and that expert physiotherapists place importance on the interactive and relational aspects of encounters with patients. These findings echoed my observations of experienced cardiorespiratory physiotherapists’ interactions with patients.

Lundvik Gyllensten et al. (1999) explored primary care expert physiotherapists’ perspectives of the physiotherapist-patient interaction. Ten physiotherapists were interviewed to investigate what they perceived to be important factors that influenced the quality of the interaction during physiotherapy sessions. The important factors cited by the participants were divided by the authors into a ‘prerequisite dimension’ and an ‘interaction dimension’. Within the prerequisite dimension, the most dominant theme was ‘internal prerequisites of the physiotherapist’. The most frequently mentioned category within this theme was ‘practical professional skills and patient experience’. The interaction dimension included the themes of ‘establishing contact’, ‘ways of contact’, and ‘therapeutic process’. The authors suggested that these themes emphasise the importance of how interactions with patients were conducted and the participants’ concern for creating a positive affective climate in the practice setting. Lundvik Gyllensten et al. (1999) found that the physiotherapists focused on constructive dialogues with patients. The participants described empathy, respect, engagement, sensitivity
and the ability to listen as important tools that assisted in achieving the goals of therapy. Lundvik Gyllensten et al. (1999) proposed that expert physiotherapists’ skills in interacting enhanced patient resources and led to positive patient outcomes. However, patient outcomes were not measured.

The communication patterns of experienced musculoskeletal physiotherapists and patients during demanding out-patient physiotherapy sessions have been investigated using a multiple case study design (Oien et al. 2011). The main communicative pattern identified was ‘seeking for common ground – a demanding negotiating process’ (Oien et al. 2011:55). The authors found that this main pattern was interrupted by short episodes of two types of challenges; the pattern of ambivalence and uncertainty, and the pattern of impatience and disagreement. They reported that physiotherapist-patient communication appeared to be a demanding and complex process of negotiations during treatment processes. Oien et al. (2011) proposed that the physiotherapists' sensitivity and ability to negotiate the tasks, the emotions related to the tasks and the nature of the relationships seemed to facilitate change. The authors suggested that patients’ and physiotherapists’ capacity to bear and come through demanding situations creates new ways of interacting.

The findings of these two studies offered practice evidence in support of my pre-understandings of physiotherapists’ interactive behaviours. However, the methods of retrospective interviewing and researcher analysed video-recordings had not brought physiotherapists face to face with their interactive behaviours in authentic clinical situations. Consequently, the findings may only reflect participants’ espoused behaviours and researchers’ observations of physiotherapists’ interactive behaviours.

2.4.3 Physiotherapists’ verbal and non-verbal communication during interactions with patients

The actual verbal and non-verbal content of patient-physiotherapist interactions has been investigated. In a quantitative observational study Roberts and Bucksey (2007) measured the content and prevalence of verbal and non-verbal communications between seven physical therapists and twenty-one patients with low back pain. Video recordings of physical therapists-patient interactions were
observed by the researchers. Then, using a validated outcome measure, the Medical Communications Behaviour System, verbal behaviours were categorised for informational (content), relational (affective) and negative behaviours for both physical therapists and patients. In addition, the frequency of non-verbal behaviours, affirmative head nodding, smiling, eye gaze, forward leaning, and touch were recorded for both physiotherapist and patient. Analysis showed that verbal relational (affective) behaviours were less common than informational (content behaviours) and that the physiotherapists spent approximately twice as much time talking as patients. Additionally, the findings showed that the physiotherapists’ non-verbal behaviours, such as eye contact and head nodding, were used to facilitate rapport building. The highest proportion of non-verbal behaviour coded for the physical therapists was touch. However, due to a lack of sensitivity of the touch category, whether touch was therapeutic or affective to facilitate relationships with patients could not be determined. An additional finding was that the experienced physiotherapists demonstrated more affective behaviours than the novices. This study provides valuable knowledge about specific verbal and non-verbal behaviours used by experienced physiotherapists. However, the intentions of the behaviours or if the physiotherapists knowingly used the observed behaviours was not examined.

2.4.4 Differences between novice and expert physiotherapists’ practice

An alternative approach to understanding physiotherapy practice behaviours has been to look at the differences between novice and expert physiotherapists practice. Jensen et al. (1992) observed three master and three novice physiotherapists and their patients in an orthopaedic outpatient setting and then interviewed the physiotherapists. From this investigation, Jensen et al. (1992) produced a conceptual framework for understanding the physical therapy practice environment. The authors described five attribute dimensions that distinguish master from novice clinicians. These were an ability to control the environment; evaluation and use of data on patient illness and disease in evaluation; focused verbal and non-verbal connection with the patient; equal importance of teaching to hands-on care and confidence in predicting effective patient outcomes based on knowledge of pathology and experience with the course of healing. Jensen et al. (1992) characterised physical therapy intervention as a complex cognitive skill and an improvisational performance. Conceptualising expert physiotherapy practice as
improvisation suggested that physiotherapists adapt their behaviours moment-to-moment whilst interacting with patients. This conceptualisation was in accord with my experience and observation of physiotherapists’ interactive behaviours.

2.4.5 Female physiotherapists’ practice behaviours

Raz et al. (1991) examined the professional values and behaviours of ten female physiotherapists working in various clinical settings. The authors reported that female physical therapists saw caring as of primary value and this influenced their behaviours towards patients. The physiotherapists believed that the development and maintenance of trusting and reciprocal relationships with patients was central to clinical practice. They viewed their patients within the context of their homes, families and communities; this allowed the patient to be viewed as a person within a complex network of relationships and responsibilities. The authors reported that female physiotherapists’ interactions were characterized by interpersonal sensitivity, receptiveness and responsiveness. Raz et al. (1991) described how female physiotherapists sought ongoing input from patients about rehabilitation goals in order to negotiate mutually agreeable decisions. These findings describe a patient-centred approach, where the physiotherapists saw their relationships and interactions with patients as caring, symmetrical, mutual and reciprocal. As such, the findings supported my perceptions of cardiorespiratory physiotherapists’ interactions with chronically breathless patients at the outset of this study.

2.4.6 Physiotherapists’ interactive behaviours and patients outcomes

Three studies and one systematic review have investigated the relationship between physiotherapists’ interactive behaviours and patient outcomes. Ambady et al. (2002) demonstrated a link between physical therapists’ patterns of nonverbal communication and elderly patients’ therapeutic outcomes. Independent raters’ judgements of ‘thin slices’ of videotaped samples of therapists’ nonverbal behaviour were correlated with patients’ physical, cognitive and psychological functioning at admission, discharge and at three month follow-up. Therapists’ distancing behaviours were defined as not smiling and looking away from the patient. These distancing behaviours were found to strongly correlate with short and long term decreases in physical and cognitive function. In contrast, facial expressiveness such as smiling, nodding and frowning were found to be associated with short and long term improvements in functioning. This study
indicates that non-verbal behaviours can have measurable influences on patients’ outcomes irrespective of the type of treatment provided.

In the second study, Resnik and Jensen (2003) sought to define the attributes of physiotherapists whose patients achieved positive clinical outcomes. To identify patients with positive outcomes, a retrospective analysis of data from patients with lumbar spine disorders was performed using the ‘Focus on Therapeutic Outcomes Inc’ database (FOTO database, Knoxville, TN, USA). The patients’ physiotherapists were then interviewed. The authors reported that the physiotherapists whose patients had positive clinical outcomes had a patient-centred approach to care, were collaborative and promoted patient empowerment. These findings suggest that physiotherapists’ underlying model of practice influences the efficacy of physiotherapy.

The third study used critical ethnography to explore physiotherapists’ perspectives on how certain types of patient-therapist interactions influenced the achievement of patients’ goals on a pain management programme (Thomson 2008). Patient-therapist interactions were audio-taped, transcribed and analysed and then cross referenced with follow-up interviews with the therapists after each observation. Three types of interaction appeared to influence or contribute to the success or not of meeting the patients’ goals. These were interactions where the patient was resistant to the success of the programme; interactions that indicated an inability of the patient to synthesise insights gained on the programme; interactions that indicated that patients used the programme to improve and change their lives.

Thomson (2008) found that at the beginning of the programme the physiotherapists collaborated with their patients to formulate goals with the intention of individualising parts of the programme. The physiotherapists appeared to focus entirely on assisting the patient to identify a goal and in facilitating the patient to achieve the goal. The physiotherapists’ predominant aims were collaboration and empowering the patient to achieve their goal. When interacting with patients that were resistant to the programme, one strategy used by the physiotherapists was to articulate propositional knowledge. When interacting with patients that were unable to synthesise insights gained on the
programme, a common feature of the interactions was that the therapists appeared to be collaborative but were ‘benignly paternalistic’ (Thomson 2008:417). With patients that used the programme to improve and change their lives, the physiotherapist-patient interactions were characterised by mutually assertive conversations, negotiation and critical reflexive dialogues. Thomson (2008) argued that an interdependent relationship in which power is shared leads to positive outcomes. These findings support and expand on the work of Resnik and Jensen (2003) by providing detailed descriptions of various physiotherapist-patient interactions and how certain types of interactions influence the success of therapy. Successful therapy appears to entail patient-centredness, collaboration and physiotherapist-patient interdependence.

A systematic review to determine whether aspects of physiotherapists’ communication can influence patients’ pain experience highlighted that the therapeutic interaction had the potential to influence patients’ pain experiences (Jeffels and Foster 2003). This review is included in the discussion as chronic breathlessness can be viewed as comparable to chronic pain in that it is a subjectively experienced ongoing distressing sensation. From the reviewed studies, Jeffels and Foster (2003) identified influencing communication patterns as; reinforcement (verbal and visual), distraction, paying attention to the patient’s pain and analgesic suggestion (placebo). Jeffels and Foster (2003) suggest that negative comments and facial expressions may inadvertently increase or decrease the patients’ pain experience and concluded that physiotherapists need to be aware of the potential influence of their interaction on patients’ pain experience. However, seven of the eight reviewed studies were performed in laboratory settings. As such, extrapolating the findings to clinical settings and a different chronic symptom is limited. Nevertheless, this review supports the need to further explore physiotherapists’ interactive behaviours when treating patients with distressing chronic symptoms.

Although the focus of my study is on physiotherapists’ interactive behaviours rather than patients’ outcomes, these three studies and the systematic review indicate that physiotherapists’ underlying model/s of practice and interactive behaviours influence the patients experience and the efficacy of physiotherapy.
My research interest was supported by many of the authors cited in this section as they have suggested that physiotherapists need to be more reflective about their interactions with patients and recommend further development of knowledge in this area of physiotherapy practice (Oien et al. 2011, Parry 2004a, Wohlin Wottrich et al. 2004, Jeffels and Foster 2003, Lundvik Gyllensten et al. 1999).

The literature discussed in this section offers differing accounts of physiotherapists' interactions with patients. On the one hand, interactions are asymmetrical, practitioner centred, where the physiotherapist takes a biomedical approach and the patient is viewed as a passive partner. On the other hand, interactions are symmetrical, the physiotherapist focuses on the patient and the relationship, and the physiotherapist and patient co-create therapy. Additionally, there appears to be evidence of conflict between physiotherapists’ expressed models of practice and the actual model used in practice. Furthermore, expert physiotherapists appear to use more affective non-verbal behaviours than novices, to focus on verbal and non-verbal connection with patients and to form interdependent relationships with patients. Finally, it seems that patient-centredness, collaboration and certain patterns of interactive behaviours positively affect patients’ outcomes.

Consequently, it seemed appropriate to explore the health care philosophies that were informing the described diversity in physiotherapists' interactive behaviours in practice.

### 2.5 Patient and relationship centred care

The clinical philosophy underlying health care encounters has changed significantly over the last three decades, from practitioner-centred to patient-centred care, and more recently relationship-centred care. Due to the scarcity of research and discussion on clinical philosophies that underpin physiotherapy practice this section draws on literature from a medical context.

Practitioner-centred care takes a biomedical approach where the patient is understood only in terms of their disease and treated with technical and pharmacological interventions. Patient-centred care goes beyond the biomedical approach to include the patient’s experience and views. Although the term
‘patient-centred care’ emerged in the late sixties (Balint 1969), there is no clear definition of what it is. Patient-centred care has been described as both a key philosophy (Bower and Mead 2007) and a fuzzy concept (Bensing 2000). Stewart et al. (1995) and Pendleton et al. (1984) developed models of patient-centred care which incorporate either six components (Stewart et al. 1995) or seven tasks (Pendleton et al. 1984). By comparing and contrasting these two models, Illingworth (2010) found that some of the components and tasks matched, whereas others did not. However, Illingworth (2010) identified that the essential ingredient in both models was the influence of the doctor-patient relationship. Similarly, in a review of the patient-centred care literature, Mead and Bower (2000) identified five conceptual dimensions of patient-centredness. The dimensions include; taking a biopsychosocial perspective, seeing the patient as a person, sharing power and responsibility, developing a therapeutic alliance and awareness of the doctor as a person.

By examining the evolution of the phrase ‘patient-centred’, Illingworth (2010) proposed two defining strands. The first was ‘discovery’ of the patient’s perspective, where the patient is seen as a person with their own unique experience of their illness and related thoughts and feelings, and expectations of their doctor (Illingworth 2010:116). The second was ‘shared control’, where the doctor takes a mutual, participative and equal approach with the patient (Illingworth 2010:116). Drawing on Stewart et al. (1995), Illingworth (2010) distinguished three educational objectives for patient-centred medicine; process skills (e.g., open questioning, building relationships), content knowledge (knowledge elicited and shared by patient and doctor) and attitude (respect for the patient as an individual and acceptance of the value of the approach). This perspective of health care professional-patient interactions offered a useful lens to view physiotherapists’ interactive behaviours with patients and appeared to be highly relevant to my interest.

The Pew-Fetzer Task Force Report (Tresolini et al. 1994) conceptualisation of health care as relationship-centred care builds on patient-centred care so that health care is viewed as:

45
‘care in which all participants appreciate the importance of their relationships with one another’

(Beach and Inui 2006:S3)

Relationship-centred care explicitly focuses on:

‘the importance of interactions amongst people as the foundation of any therapeutic or healing activity’

(Tresolini et al. 1994:11)

Thus, relationship-centred care places great emphasis on the interaction and interdependence between the patient and health care professional. Relationship-centred care integrates the bio-psycho-social-spiritual dimensions of individuals with caring, healing and holism in health care. Although the health care professional-patient relationship is central to relationship-centred care, emphasis is also placed on the health care professional’s relationship with themselves, with other clinicians and with the wider health care system (Tresolini et al. 1994).

This re-orientation of health care highlights that the way health care is delivered is as important as the care itself. Relationship-centred care is a more comprehensive view of health care as it recognises the centrality of the health care professional-patient interaction and the importance of health care professionals’ interactive behaviours during encounters with patients. It could be argued that in certain health care scenarios e.g., medical emergencies, immediate medical treatment should take priority, and is more important than the health care professional-patient relationship. However, even in emergency situations the health care professional needs to pay attention to and nurture all the relationships that influence the patient’s care such as, the patient’s carers and other involved health care professionals.

Buber’s (1923/2004) thinking on the nature of human relationships provides another lens through which relationships and interactions in health care can be viewed. Buber (1923/2004) perceived human reality as relational and differentiated human relations into two types; I-It and I-Thou. Depending on the
relationship, the orientation of ‘I’, or self, changes. I-It has a subject-object relation; one of observation, measurement and examination. This means the ‘I’ experiences but does not participate in the relationship. I-Thou has a subject-subject relation; each individual perceives the other’s uniqueness and they share a sense of caring, respect, commitment and responsibility. The ‘I’ is turned outwards towards the other. During an I-Thou encounter, the ‘I’ enters completely into the relationship, to truly understand and ‘be there’ with the other person without pretence. It is characterised by spontaneity, subjectivity, mutuality, and appreciation and acceptance of the other. I-Thou relationships are achieved through dialogue. For Buber, dialogue is a form of interaction, either spoken or silent, that occurs between individuals. Both parties recognise the uniqueness of the other and want to turn towards the other with the intention of creating a mutual relationship (Buber 1923/2004).

This analysis can be applied to health care in which the I-It orientation corresponds to a biomedical, detached, practitioner-centred approach, where the patient’s body and person are regarded as separate entities. Contrastingly, the I-Thou orientation corresponds with a biopsychosocial, patient or relationship centred approach, where the health care professional sees each patient as a person, and the patient is encouraged to express their lived experience, feelings and ideas, and the health care professional provides support and empathy. Arguably, both practitioner-centred and patient-centred stances are necessary and valid, neither is right or wrong. By incorporating Buber’s views into an understanding of patient or relationship centred care, it can be seen as a clinical philosophy in which I-Thou relating is as valued as I-It relating.

If we presume that each individual considers their stance depending on the situation in which they find themselves, it follows that in clinical situations, both patients and health care professionals have a choice over their orientation to the relationship (Buber 1923/2004). If this is the case, one can speculate that a physiotherapist’s orientation would dictate the way they interact with a patient. Additionally, the question of whether physiotherapists’ knowingly or unknowingly choose their orientation comes to the surface. Therefore, to access and provide a description of cardiorespiratory physiotherapists’ understandings of their
interactive behaviours would necessitate a research approach that could explore both explicit and tacit aspects of physiotherapists’ practice knowledge.

2.5.1 Complex Responsive Processes of Relating

A way of making sense of interactive behaviours in health care encounters is provided by Suchman’s (2006) theory of human interaction, ‘Complex Responsive Processes of Relating’ (CRPR). This theory focuses on relational processes and the moment-to-moment spontaneous pattern making of every human interaction. It also offers a strong theoretical base for relationship-centred care.

Suchman (2006) argues that four well-established assumptions and perspectives underlie how health care interaction, communication and relationship behaviour are viewed and researched. Firstly, that all behaviour during an encounter is intentional and motivated. Secondly, that behaviour during the encounter has linear causality, i.e. every effect has a cause that can eventually be discovered. Thirdly, that communication is a straightforward process of information transfer, for example, the internal thoughts of a health care professional are encoded through words and gestures and the patient can internally decode that meaning and vice versa. Fourthly, that the analytical methods, commonly used to study health care encounters, correlate presumed static, independent variables e.g., doctors’ communication style, patients’ perceived health status, with presumed static outcome variables e.g., patients’ compliance with advice, patients’ satisfaction. These assumptions ignore the uniqueness of individuals, their personal understandings and ways of interacting, and the complexity of ongoing, dynamic clinical encounters.

The ‘Complex Responsive Processes of Relating’ theory was inspired by complexity theory, sociology and social constructionism. It theorises that patterns of meaning and relating continuously self-organise during human interactions. It describes a psychosocial relational process through which patients and health care professionals continually and reciprocally influence each other through self-organizing feedback loops. Suchman (2006) proposes that ongoing social interactions encompass patterns of meaning (e.g., vocabulary, concepts and knowledge) and patterns of relating (e.g., role structures, power relationships and behavioural norms), and that these patterns emerge from the relationship process.
Patterns of meaning and relating persist because they are continuously re-enacted or recreated moment-to-moment. Because of this moment-to-moment re-enacting and recreation, patterns of meaning and relating can be stable, or at times new patterns can occur spontaneously. Whether a pattern remains stable or a new one emerges in a given moment, is always a self-organizing process. For example, a patient's comment (e.g., “I only get breathless when I take my daughter horse riding”) brings about a new pattern of meaning for the health care professional (this could be asthma). Or, a patient's verbal and non-verbal expression of anxiety may result in a new pattern of relating (the health care professional becomes more compassionate). Self-organization requires the simultaneous presence of constraint and freedom. Constraint allows for patterns to form and take hold, freedom allows for spontaneous variation or change.

From this perspective, health care interactions can be seen as non-linear, characterised by unpredictable and emergent patterns that form spontaneously without either person’s intention or direction. This implies that although health care professionals may try to influence these patterns, the patterns are ultimately beyond the health care professional’s control. A gesture (verbal or non-verbal) and its response (verbal or non-verbal) form and are formed by each of the interacting individuals. During the communication cycle, each person’s response is also the next gesture, which in turn produces its own response (see Figure 1).

Simultaneous to the ongoing external dialogue, is a continuous internal dialogue within the brain (thoughts) and body (physical feelings, emotions) of each of the interacting individuals (see Figure 2).
If we accept that external and internal dialogues co-exist, then every word, phrase and non-verbal gesture introduced into the interaction by each individual will merge with memories, beliefs, judgements and emotions of the other. This means if observed from the outside the internal factors in the relationship process are undetectable.

Drawing on Suchman’s (2006) theory, it could be suggested that all interactions between health care professionals and patients are iterative and reciprocal, and self-organizing patterns of meaning and relating emerge moment-to-moment. If we take the view that the patient is the more vulnerable partner due to illness, symptoms, impairment and the context, then it is important that the health care professional is aware of and pays attention to their own psychosocial patterns of relating.

2.5.2 Complex biopsychosocial processes of relating

Alder (2007) expanded on Suchman’s (2006) theory by adding a biological dimension to the emergent, self-organizing psychosocial patterns of relating. He argues that psychosocial responses are inevitably biopsychosocial responses and that patients and health care professionals reciprocally regulate one another’s psychobiology. From this perspective, rather than viewing the patient-health care professional relationship as the context in which treatment is provided, the relationship itself becomes part of the treatment.
Studies of interpersonal physiology during psychiatric encounters have demonstrated correlations between psychotherapists’ and patients’ physiologic measures of autonomic activity (Waid 1984, DiMascio et al. 1957, Malmo et al. 1957, DiMascio et al. 1955). This suggests that health care interactions involve interpersonal physiological engagement, that takes place in real time and has ongoing, moment-to-moment, physiologic effects.

More recently, studies of the mirror neuronal system in humans have provided a neurophysiological explanation for interpersonal communication (Iacoboni 2005, Iacoboni et al. 2005, Iacoboni et al. 1999, Fadiga et al. 1995). The mirror neuronal system enables individuals to understand the meaning of others’ actions, the intentions of their actions, and their emotions, through activation of internal representations; an instantaneous motor coding of observed actions and emotions (Iacoboni 2005, Rizzolatti and Craighero 2004). When a motor action is performed by an individual, specific mirror neurons discharge in their brain, and when an individual observes another individual performing a motor action, mirror neurones in the observer’s brain also discharge but to a lesser degree (Fogassi et al. 2005). The mirror neuronal system in humans has been found to be linked to parts of the brain that are essential for detection of facial expressions and emotional behaviours (Carr et al. 2003, Bremmer et al. 2001). This suggests that observing emotions in another person e.g., a patient, can influence the emotional experience of the observer e.g., the health care professional, and vice versa. A number of researchers have argued that the mirror neuronal system may provide a neurobiological basis for interpersonal empathy (Iacoboni 2009, Leslie et al. 2004, Gallese 2003). This assertion is supported by positron emission tomography, which has demonstrated that empathy with distress in another person is correlated with activation of specific neural networks (Shamay-Tsoorya et al. 2005). These studies offer some insight into my observations that cardiorespiratory physiotherapists behave in certain ways during their interactions with chronically breathless patients. They may be exhibiting an interpersonal physiological response to the patient’s distress.
From the above, it could be argued that the theory of complex responsive processes of relating offers a theoretical basis for understanding physiotherapist-patient interactions in conflict with simplistic, mechanistic models of physiotherapist-patient interactions. Additionally, if the interaction is viewed as a biopsychosocial relational process, then the physiotherapist's physiology and empathic behaviours have the potential to directly affect the patient's psychobiology. Furthermore, the theory proposed by Suchman (2006) and the relational process offered by Alder (2007) suggest that important dimensions of physiotherapist-patient interactions are invisible to established approaches to investigating physiotherapist-patient encounters.

2.6 Patient and relationship-centred care in practice

The terms patient-centred and relationship-centred care are often used synonymously in the literature, most likely due to the common characteristics of their underlying clinical philosophies. Consequently, studies that allude to both these approaches were reviewed.

Health care experiences and outcomes associated with patient-centred care and doctors’ communication patterns have been extensively explored in medicine, using qualitative and quantitative research approaches. Research evidence has demonstrated that quality of care, patient experience and health outcomes are significantly influenced by the way doctors interact with patients (Garcia-Alamino 2010, Heritage and Maynard 2006, Brown et al. 2003). Interactive behaviours and communication styles during health care encounters have been shown to be influenced by both the doctor’s and the patient’s beliefs about control in the relationship, and each other’s behaviour. The relationship between doctors’ partnership building and how actively patients participate is one of mutual influence. Increases in one lead to increases in the other (Street et al. 2003, Street et al. 2005). If doctors explicitly encourage and show interest in patients’ views, passive and uninvolved patients become more participatory (Wissow et al. 1994, Street 1992, Street 1991, Cox 1989). In an observational study of patient-doctor interactions, Barry et al. (2001) found that doctors used a variety of communication patterns that varied between the ‘voice of medicine’ and the ‘voice of the lifeworld’. If doctors blocked or ignored chronically ill patients’ expressions of their lived experience, patients’ outcomes were worse (Barry et al. 2001).
Patient-centredness has also been associated with improved satisfaction (Little et al. 2001), fewer malpractice complaints (Levinson et al. 1997), increased adherence to treatment (Schneider et al. 2004) and improved perceptions of health status (Little et al. 2001, Stewart et al. 2000). There is strong evidence that patient-centred care improves patient satisfaction, patient adherence and health care outcomes (Griffin et al. 2004, Brown et al. 2003, Roter et al. 1997, Greenfield et al. 1985). However, most studies have investigated primary care interactions.

Few studies have described how to enact and achieve patient-centred care because it depends on many complex factors. These factors include the environment, health care professionals’ models of practice and communication patterns, individuals’ views of the health care professional-patient relationship, as well as patients’ desires, motivations, communication style and health related quality of life (Aita et al. 2005). Nevertheless, non-verbal behaviours such as eye contact, smiling and physical orientation towards the patient during the encounter have been shown to be ways in which health care professionals can enact patient-centred care (Roter and Hall 2006). Whilst exploring patients’ views of interactions with doctors, Bendapudi et al. (2006) found that how a doctor behaved was important to patients and easier to judge than their technical expertise. Patients could sense whether a doctor was rushed, preoccupied, tired, aloof, disinterested or alarmed, or if they were interested, compassionate, calm and confident. Bendapudi et al. (2006) identified seven ideal doctor behaviours: confident, empathetic, humane, personal, forthright, respectful, and thorough.

Patient-centeredness, the patient’s role as an active and expert partner in the clinical management of their condition and the healthcare relationship is increasingly emphasized by international and national policy makers (World Health Organisation 2002, World Health Organisation 2003, Department of Health 2010a). A collaborative approach to healthcare is not only seen as important for improving the quality of care for patients, it is also government policy. The recent white paper, Equity and excellence: Liberating the NHS (Department of Health 2010a) states that patients will be at the heart of everything it does, patients should have more choice and control, and the focus should be on things that really matter to patients. Shared decision making is highlighted as fundamental to this
process with the core principle that, there should be ‘no decision about me without me’ (Department of Health 2010a:3). An additional cited benefit of patient-centred care is significant reductions in health care costs achieved through patients taking more responsibility for their health and better patient concordance to treatment (Bunt and Harris 2009, Wanless 2002, Stewart et al. 2000).

However, international and national evidence indicates that progress towards patient-centred care in the National Health Service (NHS) is limited (Patient Opinion 2011, Richards and Coulter 2007). The NHS 2009-10 statistical data on written complaints reports that 12.2% were related to the attitude of staff (The NHS Information Centre 2010). A recent analysis of patient feedback on the NHS, the Patient Opinion Report (Patient Opinion 2011) identifies that the most common areas of concern raised by patients were related to the interaction between patients and staff. Particular problems cited were staff attitude (33%) and a lack of care and compassion (almost 30%). These reports raise serious concern as they indicate that patients are disenchanted with health care relationships. These concerns support the need for physiotherapists to confront, scrutinize, and understand the way in which they interact with patients.

2.7 Summary

The literature discussed in this chapter is diverse and was derived from a number of disciplines. The exploration of the different types of knowledge used in health care practice indicates that the knowledge informing physiotherapists’ interactive behaviours is likely to include personal and professional craft knowledge. This knowledge may be explicit, tacit or a combination of both. Some knowledge about physiotherapists’ interactive behaviours has been found in the models of practice and clinical reasoning literature, which strongly indicates that effective interpersonal interaction is viewed to be an essential component of physiotherapy practice.

Investigations that have looked at physiotherapists’ interactions with patients suggest that physiotherapists take either an asymmetrical, practitioner-centred biomedical approach or a symmetrical, collaborative and relationship centred approach. A modest amount of literature reports that expert physiotherapists use more affective non-verbal behaviours than novices, focus on verbal and non-
verbal connection with patients, and form interdependent relationships with patients. Additionally, there is some evidence that patients’ experiences and outcomes are positively affected if physiotherapists are patient-centred, collaborative and use certain patterns of interactive behaviours. Furthermore, it appears that some expert physiotherapists view the interactive and relational aspects of encounters with patients as important.

This chapter has also discussed literature relating to patient and relationship-centred care. Relationship-centred care seems to provide an appropriate clinical philosophy through which health care interactions can be considered and explored. Theories proposed by Suchman (2006) and Alder (2007) offer a theoretical basis for relationship-centred care. These theories also provide a way of viewing physiotherapist-patient interactions so that a better understanding of physiotherapists’ interactive behaviours during encounters with patients can be gained.

Although appropriate and effective interactive behaviours appear to be essential to patient and relationship-centred approaches, how these approaches are enacted in practice is not clearly described. Studies of medical encounters provide some indication of successful behaviours. These include behaviours that encourage the patient to express their unique experience of their illness, such as active listening and behaviours that promote participation, equality, collaboration and shared control with patients.

If we accept that the physiotherapist-patient interaction is the medium through which physiotherapy is practiced, it is surprising that there is relatively little knowledge about physiotherapists’ own understandings of their interactive behaviours. To date, physiotherapist-patient interaction during actual physiotherapy encounters has received relatively little research attention. Explicit descriptions of what interactive behaviours experienced physiotherapists use or think they use, and how they should be applied in practice are not available. Existing research investigating physiotherapist-patient interactions from physiotherapists’ perspectives is extremely limited and there is much that remains unknown. Current literature does not provide explicit rich descriptions of
physiotherapists’ personal understandings of their interactive behaviour in practice. Thus, there is a significant gap in the physiotherapy practice knowledge base. This study seeks to address this gap.

This study aims to explore physiotherapists’ understandings of their interactive behaviours when treating chronically breathless patients. It seeks to describe aspects of professional craft knowledge and personal knowledge that inform cardiorespiratory physiotherapists’ interactive behaviours, recognising that some of this knowledge may be tacit and difficult to reveal. The next chapter gives an account of the theoretical perspective and methodological approach taken to explore yet to be described physiotherapists’ understandings of their interactive behaviours.
CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter presents the theoretical perspective and methodology that have informed the design of the research project. Its purpose is to provide an account of the particular philosophical understandings that underpinned the development of the study and how these understandings guided the inquiry process. The choices I made regarding how to investigate the question are explained. The study is located in the interpretive research paradigm, informed by phenomenology and hermeneutics drawn from Heidegger (1962/2005) and Gadamer (1975/2004). A discussion of the philosophical foundations of phenomenology and hermeneutics is provided to explain and justify why hermeneutic phenomenology was chosen as the research methodology. Crucial to the overall design was van Manen’s (1990) hermeneutic phenomenological approach to researching lived experience which guided the research approach.

3.2 Philosophical Underpinnings

The aim of this study was to explore physiotherapists’ interactive behaviours when treating chronically breathless patients by drawing on experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours. To achieve this I had to firstly understand the philosophical assumptions that inform different research paradigms. Secondly, I had to examine my personal theoretical perspective and the research question in order to situate the study within an appropriate research paradigm. Following that, it was necessary to develop a methodology that was compatible with these philosophical underpinnings to guide the design and execution of the study (Rubin and Rubin 2005, Denzin and Lincoln 2000). Explaining my unique ontological, epistemological and methodological perspectives makes their influence on the choices made throughout the research journey transparent. Maintaining a consistent theoretical perspective throughout the research process allows evaluation of the arguments and knowledge claims being made. Prior to the study, exploring my theoretical perspective was illuminating and involved in-depth critical consideration.
3.2.1 Ontological position

An individual’s ontological perspective consists of the assumptions, beliefs and human values that form their view of existence and reality (Crotty 1998). Deciding on a methodology required meticulous and comprehensive reflection on my ontological position (Dyson and Brown 2006, Crotty 1998). The two main contrasting positions in ontology are the realist relationship of subject-object, the belief that there is an objective material world ‘out there’, and the idealist relationship of subject-subject, the belief in a subjective ‘world in here’ (Dyson and Brown 2006). These two possibilities can be regarded as representing the extreme positions on a continuum of ontological assumptions, between which intermediate stances related to specific situations can be constructed by individuals. Ontologically, I am located towards the ‘world in here’, the idealist position. Within an idealist position, the stance of relativism fits best with my understanding of social reality. Relativists view reality as constructed and co-created through each individual’s perceptions, understandings, meanings and motives which they use to make sense of their everyday world (Dyson and Brown 2006). Consistent with my belief that the social world is made up of multiple individual realities influenced by context, I assume that physiotherapists’ understandings of their interactive behaviour will depend on their personal view of reality, their knowledge of the world and the meanings that they ascribe to their actions.

3.2.2 Epistemological position

Taking either a purely objective or subjective stance would have been inappropriate for this study as the intention was to construct an interpretation of the lived understandings of cardiorespiratory physiotherapists. Other physiotherapists and I have our own unique understanding of the social world and our interactive behaviours in clinical practice. Gaining knowledge of other physiotherapists’ understandings of their behaviours in the context of an on-going encounter with a patient could not be realised by being an objective observer, viewing practice from the outside. It was appropriate to draw on physiotherapists’ understandings from inside the situation and to develop a sense of the phenomenon from within the framework of my lifeworld as a physiotherapist. The aim was to co-construct a description of the participant physiotherapists’ and my own understandings of their interactive behaviours with breathless patients.
Epistemology addresses assumptions underlying what can be known and how we understand and obtain knowledge (Krass 2005, Denzin & Lincoln 2000). In keeping with a relativist ontological stance, I have adopted the view that our knowledge of reality is shaped through our social construction of the world; the epistemological position of constructionism (Crotty 1998). Meaning is constructed as we engage with and interpret our world because we intentionally direct our consciousness towards objects, actions and events. In the social world, the other person is our partner in the generation of meaning (Schwandt 2000).

From a constructionist perspective it is assumed that physiotherapists interact with the world through their personal filter of culture, history, experience, emotions, beliefs, gender and language and as a result will construct meaning in different ways in relation to the phenomenon of interactive behaviour. Knowledge about the meanings an individual constructs can only be acquired through dialogue with that person. This study was exploratory and could not be determined and standardised in advance. It was anticipated that an interpretation of the participant physiotherapists’ descriptions of their understandings of their interactive behaviours would emerge during the process of investigation.

3.2.3 The Interpretive Research Paradigm

My ontological position assumes that people’s knowledge, understandings, interpretations, experiences and interactions are significant features of their social reality. To generate data in accordance with my ontological and epistemological beliefs I needed to interact with physiotherapists and establish a dialogue with them as a ‘way in’ to their perceptions and meaning making of the world.

Interpretivism represents a collection of research approaches that have a shared theoretical view in which reality is not to be merely observed, but interpreted (Corbetta 2003). It is characterised by a belief in a socially constructed, subjectively based reality that is influenced by culture and history. The process of interpretive understanding as a way to access the meanings of the ‘other’s’ experience is based on Wilhelm Dilthey (1833-1911) and Max Weber's (1864-1920) ‘Verstehen’. The notion of verstehen, in the context of this study, is that I, as the researcher facilitate and ask physiotherapists to describe their
understandings of the phenomenon of interactive behaviours when treating breathless patients.

Interpretivist research does not look for a specific truth, reality is assumed to be multiple and constructed rather than singular and tangible (Mertens 2005, Denzin and Lincoln 2000, Crotty 1998). This enquiry was not concerned with measured, described physical techniques but with subtle ‘yet to be described’ aspects of practice. The interactive behaviours I sought to describe were perceived to be complex and dynamic, and potentially included many strategies and intentions that could be tacit and that the physiotherapists were unaware of. To gain access to the essential and inherent characteristics of the phenomenon in question required exploration of multiple perspectives and interpretation of human action.

Since the intention was to describe useful, relevant and meaningful practice knowledge, it was important to investigate the phenomenon in its natural setting (Ajjawi and Higgs 2007). Physiotherapy practice is context bound, influenced by the individuals concerned, the environment and the prevailing cultural and health conditions. The interpretive paradigm allows investigation of the nature of interactive practice behaviour within a situated clinical context. Incorporating the complexity of the individuals and the context in the research endeavour may disclose knowledge about the nature of experienced interactive behaviour in practice.

As a physiotherapist investigating other physiotherapists’ understandings of physiotherapy practice I am not objective but bring with me my pre-understandings of the phenomenon. The intention was not to test my pre-existing ideas but to create new ideas and categories. An interpretive approach asks the researcher to examine and expose their pre-understandings of the phenomenon. The introductory and background chapters have presented an in-depth reflection of my pre-understandings. This reflection aimed to reduce the influence of my personal preconceptions, assumptions and habitual ways of thinking and helped focus my attention on the creation of a jointly negotiated understanding.
Interpretation of physiotherapists’ understandings of their interactive behaviours involves exploring their perceptions, attitudes, meanings and motives when making sense of their practice behaviour (Dyson and Brown 2006, Cresswell 2003, Schwandt 2000). I needed to grasp the meanings that constituted their actions (Schwandt 2000). The intention is to understand these meanings, rather than discover ‘truths’ that objectively describe reality (Laverty 2003). This involves entering into dialogue with physiotherapists to generate data. The dialogue then changes my understandings and the physiotherapists’ understandings. The knowledge generated is inevitably time and context dependent (Higgs et al. 2009).

The interpretivist research paradigm uses various qualitative methods to explore the meaning ascribed to actions and experiences (Mackenzie and Knipe 2006, Denzin and Lincoln 2000). Qualitative research aims to produce in-depth accounts of experience or knowledge. Language, description and imagery are the methods used to generate and represent data. Using qualitative research methods for this study was particularly appropriate as the purpose was to explore and describe the meanings of the participants’ interactive behaviours rather than to predict, control or measure their actions. The desired outcome of using qualitative methods has been to generate and present a co-constructed rich description from a number of physiotherapists’ perspectives; this is compatible with interpretivist intentions (Laverty 2003).

The study sought to provide a description of physiotherapists’ understandings of their interactive behaviours when treating chronically breathless patients. To be able to elicit physiotherapists’ personal understandings it was necessary to access their everyday inter-subjective worlds. The interpretive research paradigm, using hermeneutic phenomenology as the methodology, was selected as the most suitable theoretical framework to gain knowledge of, and provide credible accounts of physiotherapists’ understandings of their interactive behaviour.

**3.3 Hermeneutic Phenomenology**

Hermeneutic phenomenology is both a philosophical stance and a method of inquiry. Hermeneutic phenomenology was chosen as the theoretical perspective to inform the study because it is primarily motivated by the desire to understand and interpret human experience. The terms hermeneutics and phenomenology
are frequently used interchangeably as they share some essential principles (Moran 2000, Spiegelberg 1982). The principles include a desire to understand the phenomena from the 'inside', to investigate the lifeworld, to understand the meaning of everyday experiences and to provide credible insights of the social world. However, the philosophical perspectives underpinning hermeneutics and phenomenology are argued to differ.

3.3.1 Hermeneutics and Phenomenology

Hermeneutics is the art or science of interpretation of texts, human action, events and situations (Bullock and Trombley 2000, Crotty 1998, Gadamer 1975/2004). The hermeneutic approach provides a way of transforming and expanding understanding through interpretation. The principal method is to explore the subject of study from different perspectives. Three hermeneutic concepts underpin the process of interpretation; the act of dialogue, the hermeneutic circle and the fusion of horizons. Through dialogue and hermeneutic interpretation, other experienced cardiorespiratory physiotherapists’ perspectives could enhance my understanding and provide new insights into cardiorespiratory physiotherapists’ interactive behaviours when treating chronically breathless patients.

Phenomenology is a philosophical approach developed by Edmund Husserl (1859-1938), and extended upon by Martin Heidegger (1889-1976) and Hans-Georg Gadamer (1900-2002). Husserl viewed phenomenology as a science of the consciousness (Osborne 1994, Husserl 1965) and argued that it is possible to understand the subjective meaning of actions in an objective manner. To understand the original experience and obtain the unique ‘essences’ of a phenomenon, Husserl (1965) described two processes: ‘intentionality’ and phenomenological reduction or ‘bracketing’. Intentionality involves deliberately directing attention towards a phenomenon. Bracketing entails suspending one’s natural attitude, i.e., our existing understandings of the phenomenon. Husserl (1965) argued that bracketing allows the researcher to step outside their personal historical circumstances and to cast off preconceptions in order to clearly see the essences, and to avoid misinterpreting the original meaning of the phenomenon. Husserl (1965) argues that this unbiased appraisal can either validate and enhance current understandings, or discover potential new meanings. Thus, the researcher is required to bracket out existing understandings of the phenomenon,
and take the role of impartial observer to describe the phenomenon. As an experienced cardiorespiratory physiotherapist, I could not lay aside my assumptions and pre-conceptions and objectively interpret other physiotherapists’ actions. I am part of the particular culture I wanted to investigate and therefore could not take the role of objective observer to describe the phenomenon.

Heidegger’s (1962/2005) phenomenological approach focuses on the concept of ‘Dasein’, the situated meaning of a human ‘being-in-the-world’, particularly the way human beings act in or relate to the world (Heidegger 1962/2005). ‘Dasein’ regards the person and the world as co-constituted and integrated. Heidegger (1962/2005) argued that we make sense of and understand the world from within our existence, not standing apart from it. I could not describe or interpret other physiotherapists’ understandings without accessing their understandings. To explore physiotherapists’ understandings of their interactive behaviours I needed to be-in-the-world in a specific way. This involved intentionally attaching myself to their worlds and entering into dialogue with them (van Manen 1990).

Phenomenology becomes hermeneutical when it is interpretive rather than purely descriptive. Hermeneutic phenomenology is a circular process. Understanding occurs within the hermeneutic circle where there is interplay between understanding ourselves and our understanding of the world. This inquiry into physiotherapists’ interactive behaviour began from my pre-understandings. As I set about understanding a particular facet of other physiotherapists’ worlds, I had to expose and be mindful of my always present, tacit background of understanding. Every dialogical encounter would produce an interpretation influenced by my historically lived experience. There could be no escape from my background and culture because they provide the ontological framework for the way I understand the world (Heidegger 1962/2005). I could not comprehend or interpret physiotherapists’ descriptions without this pre-understanding. However, my basic understandings have to be disclosed as far as possible, to render what is tacit, explicit. With this reflection, I become more aware of my numerous pre-understandings and how they might influence the interpretation. Through dialogue with physiotherapists, knowledge of the essences of their understandings could be realised. By moving back and forth between other physiotherapists'
understandings and my own, and referring to literature to discover what else has been written about comparable experiences, I anticipated that my prior understandings could be revised and new understandings uncovered. This dialectical interplay of multiple experiences reflects the concept of hermeneutics.

Gadamer (1975/2004) argued that the task of understanding is not a procedure; it is the very condition of being human. He saw understanding not as an isolated activity but a basic structure of our experience of life.

In his seminal work ‘Truth and Method’ (1975/2004), Gadamer describes four concepts; prejudice, fusion of horizons, the hermeneutic circle and play. I incorporated these concepts into my sense-making activities.

**Prejudice**

Prejudice is our preconceived understandings of things that originate from our past experiences and traditions which significantly influence how we perceive and interpret the world (Gadamer 1975/2004). The findings reported in this study will be my interpretation because my sociohistorical prejudices, language and culture are always present conditioning my interpretations. However, as Gadamer (1975/2004) suggests, they are not detrimental or distorting, but need to be recognised if I am to authentically explore other physiotherapists’ understandings. An examination and reflection on my pre-understandings have been offered in the introductory and background chapters.

**Fusion of horizons**

Drawing on Heidegger, Gadamer (1975/2004:304) proposed the concept of ‘horizon’ to communicate the breadth of vision that a person must have when endeavouring to understand another. An individual’s horizon is their perspective on the world, acquired through language and tradition, which continually alters over time. Any thing or experience within the world we interpret has its own horizon of meaning to us as an individual. Understanding develops when our initial understanding is challenged by an encounter with the ‘other’, and our current horizon moves to a new horizon.
I envisaged that individual physiotherapist’s horizons would meet mine through dialogue, neither horizon being suppressed during the process of understanding. I could realise a deeper understanding through the merging of my past horizon with the new horizon, informed by the other physiotherapists’ understandings. I anticipated that each physiotherapist and I would enter and leave the dialogue with separate yet altered horizons and that a new, deeper understanding for each of us would emerge through our dialogue. As a result I expected that individually we would experience a personal fusion of horizons. However, as Gadamer states, any new horizon is transient:

‘the fusion of the horizons of interpretation is nothing that one ever reaches [because] the horizon of interpretation changes constantly just as our visual horizon also varies with every step that we take.’

(Gadamer cited in Lawn 2006)

Thus, Gadamer (1975/2004) argues that a horizon of interpretation is never static. This notion implied that at some point I would have to settle on an interpretation to present. However, at the same time recognising that it would not be a definitive interpretation because further dialogue would inevitably change my horizon of understanding.

The hermeneutic circle
Gadamer (1975/2004) saw the hermeneutic circle of understanding as the process through which horizons are fused. It depicts a circular, iterative process of sense-making where the whole is understood in terms of the detail and the detail in terms of the whole (Gadamer 1975/2004). By examining and making sense of the detail of another physiotherapist’s understandings, I simultaneously project meaning to interpret the whole of their understandings. Equally, capturing a sense of the whole of their understanding modifies how I understand the detail.

Understanding of what is unknown or not understood can only be produced through participative dialogue (Denzin and Lincoln 2000). The physiotherapists were to be equal partners in the dialogue and hermeneutic interpretive process. By entering into a dialogical encounter with experienced cardiorespiratory
physiotherapists I challenge my preconceptions of physiotherapists’ understandings of their interactive behaviours. Meaning can then be mutually negotiated through the act of dialogue and interpretation of physiotherapists’ descriptions of their interactive behaviours. By being genuinely open to the physiotherapists’ understandings my understanding will be deepened and transformed.

In addition to examining and synthesising understandings, Gadamer (1975/2004) identified the importance of the application of understandings. This view connected fundamentally with my aim of providing context-generated understanding so that the insights of the experienced physiotherapists could inform practice.

**Play**

Gadamer (1975/2004) links play with understanding. The hermeneutic process is inherently playful, a to-and-fro movement, not fixed to any purpose that will bring an ultimate conclusion. In reciprocal dialogue, by altering our perspectives and prejudices, we play the game of understanding.

In this study, the game was to interpret cardiorespiratory physiotherapists’ interactive behaviours; the players are myself and the participant physiotherapists. We put our horizons into play. As I enter into dialogue with the transcripts, I step into a game of understanding. I put myself at risk in searching for an understanding greater than my perceptions as a single player. My aim was to be transformed and enriched by other physiotherapists’ horizons. The spectators are the readers of the final text. My intention is to draw the readers into the game, towards the horizon of meaning I have constructed.

Gadamerian hermeneutic phenomenology offers a highly appropriate methodology for health care practice research, and this particular study for a number of reasons. The approach endeavours to understand human experience from the perspective of individuals’ lived experiences and explores the meanings individuals give to actions and events. The conventional rules of validity, reliability and objectivity can be set aside as ‘truth’ depends on a collective version of
understanding. The process of understanding is dialogical and interactive; pre-judgements and assumptions are given consideration, made transparent and challenged so that the meanings of a phenomenon in practice can be explored, interpreted and described. The co-constructed meanings can then inform practice knowledge, and when applied have the potential to improve practice.

By using hermeneutic phenomenology as a methodology my aim has been to create an interpretation that resonates with physiotherapists and other health care practitioners, one that illuminates and provides different insight into an aspect of clinical practice.

3.4 Research Methodology

Hermeneutic phenomenology was selected as the method of inquiry as well as the theoretical orientation because it seeks to provide an interpretation of the array of understandings that exist about a phenomenon. Furthermore, it aims to connect to a collective experience through the production of rich textual descriptions of the phenomenon in the lifeworld of individuals (Smith 1997).

During the search for an appropriate phenomenological method to interpret and represent physiotherapists’ practice understandings I discovered the writings of the educational theorist Max van Manen (1990). He describes a detailed hermeneutic phenomenological approach to human science, which provides descriptions of human experience in the first person. Incorporating and developing on the work of Husserl (1965), Heidegger (1962/2005) and Merleau-Ponty (1962/2002), van Manen couples phenomenology and hermeneutics. He sees the researcher as trying:

‘...to be attentive to both terms of its methodology: it is a descriptive (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is an interpretive (hermeneutic) methodology because it claims that there are no such things as uninterrupted phenomena.’

(van Manen 1990:180)
van Manen’s use of hermeneutic phenomenology to explore pedagogy had a personal resonance as he also had a shared professional background with his participants. Having a shared clinical background with participants is beneficial because I have ‘insider’ knowledge of the work context, practices and language. However, it also means maintaining hermeneutic alertness, this requires a vigilant awareness of the assumptions and pre-understandings that I bring to the phenomenon throughout the research process (van Manen 1990).

To explore physiotherapists’ understandings of their interactive behaviours and lifeworld in context, van Manen’s (1990) approach to hermeneutic phenomenology corresponded with my beliefs and attitude concerning this research inquiry and data analysis. When the physiotherapists described their understandings of their interactive behaviours I would accept that this was their construction of reality. I would incorporate my understandings as an experienced cardiorespiratory physiotherapist to co-construct an interpretation of cardiorespiratory physiotherapists’ interactive behaviours when treating breathless patients.

The methodological structure offered by van Manen (1990) was used to guide the study because it aims to co-construct meaning from the lifeworld, does not expect the researcher to bracket their pre-understandings and assumptions, and considers the whole and the parts. This reproduces the concept of the hermeneutic circle as described by Heidegger (1962/2005) and expanded on by Gadamer (1975/2004).

3.5 Methodological Structure

Six activities have been drawn on from van Manen (1990). Compatible with the flexible philosophy of hermeneutic phenomenology these are not rigid or fixed steps. The researcher works on different aspects intermittently or simultaneously, there is dynamic interplay between each activity. The six research activities are:

1. turning to the phenomenon of interest
2. investigating the experience as we live it
3. reflecting on the essential themes which characterise the phenomenon
4. describing the phenomenon through the art of writing and rewriting
5. maintaining a strong and orientated relation to the phenomenon
balancing the research context by considering the parts and the whole

(van Manen 1990:30-31)

3.5.1 Turning to the phenomenon

The first activity was turning to the phenomenon of interest; a thoughtful and committed call to explore and make sense of an aspect of physiotherapists’ experience. van Manen (1990) describes phenomenological research as being-given-over to a quest, a deep questioning of something. It does not exist in a disembodied fashion as it:

‘… is always a project of someone: a real person, who, in the context of a particular individual, social, and historical life circumstances, sets out to make sense of a certain aspect of human existence.’

(van Manen 1990:31)

Practically, this first step entailed formulation of the research question. My interest began from living the experience; I was already powerfully orientated to the phenomenon. van Manen (1990) suggests it is not a shortage, so much as an excess of knowledge that can impede phenomenological inquiry. We feel we know a lot about the topic already from existing scientific and other knowledge. This can hinder our openness to take in knowledge of the phenomenon and see it afresh.

To counteract this, my pre-understandings of this particular phenomenon were explored and made explicit. An account of the turn to and examination of underlying assumptions of the phenomenon are presented in Chapter One. Other ideas and reviewed literature that informed understandings prior to and during the course of the research are presented in Chapter Two. As a phenomenological researcher, I intended to remain mindful of the influence of my preconceptions whilst closely attending to the understandings of the participant physiotherapists. Additionally, exposing my beliefs provides contextual meaning for the reader.

3.5.2 Investigating the experience as we live it

The source of phenomenological research is the lifeworld, but the nature of the lifeworld is elusive. To investigate physiotherapists’ understandings of lived
experiences means learning to look at the world by re-awakening one’s basic experience of the world (Merleau-Ponty 1962/2002). To learn about the nature of cardiorespiratory physiotherapists’ interactive behaviours in practice, I had to explore the understandings of those who were living and understanding the experience. As van Manen indicates:

‘We gather other people’s experiences because they allow us to become more experienced ourselves. We are interested in the particular experiences of this [physiotherapist] since they allow us to become “informed”, shaped or enriched by this experience so as to be better able to render the full significance of its meaning.’

(van Manen 1990:62)

Video-cued recall and reflection and in-depth interviewing were chosen as the ‘way in’ to the understandings of experienced cardiorespiratory physiotherapists. The participant physiotherapists were regarded as experts. The intention was to generate deep knowledge of experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients. A detailed description of participant selection and data generation methods are described in Chapter Four.

3.5.3 Reflecting on essential themes

According to van Manen (1990), phenomenological themes are the structures of human experience. They are not objects or generalisations but,

‘more like knots in the webs of our experiences, around which certain lived experiences are spun and thus experienced as lived wholes. Themes are the stars that make up the universes of meaning we live through. It is by the light of these themes that we can navigate and explore such universes.’

(van Manen 1990:90)

This notion of themes resonates strongly with my beliefs about how we make meaning of our lived experience and understandings. A thematic approach to analysis was adopted to bring into focus behaviours that were unclear, and to be
able to capture and describe the essence of the physiotherapists’ understandings. How meaning was found in the participant physiotherapists’ accounts is described in Chapter Five.

### 3.5.4 Describing the phenomenon: the art of writing

Hermeneutic phenomenological research is essentially a writing activity, the act of applying thoughtfulness and language to a feature of lived experience (van Manen 1990). Language makes it possible to explore the horizons of ourselves and others and so share meanings in our lifeworlds (Gadamer 1975/2004). Through language, the physiotherapists shared their understandings, and through language and writing their described understandings are brought into symbolic form for the reader.

Five different ways to present and structure phenomenological writing are suggested by van Manen (1990). I chose to write thematically as it offers a way to coherently describe and illuminate a phenomenon. As themes surface during the data analysis, descriptive paragraphs are composed, bringing together language and thoughtfulness to create a linguistic transformation. This is the creative hermeneutic process (van Manen 1990). Through writing my interpretation of other physiotherapists’ understandings of their interactive behaviour and my personal understandings become a co-construction of our understandings. Findings are assembled around the themes that emerge. Each theme is treated systematically, detailing the essential aspects of the phenomenon. Chapter Six presents the thematic interpretation of the physiotherapists’ understandings. These were carefully composed linguistic descriptions that represent the co-created essential meanings of the experienced cardiorespiratory physiotherapists’ accounts of their interactive behaviours when treating chronically breathless patients.

My desire is that the findings will connect with others’ experiences of their interactive behaviours with patients in order to enhance their understanding of their practice behaviours.
3.5.5 Maintain a strong and orientated relation to the phenomenon

A stance of scientific disinterestedness cannot be held if the research aim is to create a deep relationship with a specific phenomenon (van Manen 1990). Phenomenological human science requires a strong orientation to the original question and avoidance of distractions, speculations, preconceptions, and self-indulgent preoccupations. To avoid superficial and contrived interpretations the interpretive act was approached with integrity, maintaining a passionate focus on the phenomenon (van Manen 1990).

Throughout the study, the intention was to repeatedly return to the transcripts to ensure the fundamental question was being addressed and that the interpretation was supported by what the physiotherapists had said. Additionally, by maintaining an ongoing record of my understandings, thoughts, beliefs and feelings throughout the study helped to separate my presuppositions from the physiotherapists’ views. By keeping a strong and orientated relation to the phenomenon I intended that my interpretation would resonate with, and have meaning for, other physiotherapists and health care professionals.

3.5.6 Balancing the research context

Balancing the research context involves stepping back from the parts to view and consider the whole and how the parts contribute to the whole. This requires closely focusing on whether the derived themes portray the essential aspects of the overall understanding, and how each individual's understanding contributes to the whole interpretation. This process corresponds with Gadamer’s (1975/2004) hermeneutic circle of understanding and is part of the analytic process (van Manen 1990).

My intention was to enter into a continual dialogue with the individual transcripts, considering meaningful words, phrases and concepts to explore what was being said. When concepts were developed from each text they would be reflected upon to distinguish firstly, if that particular perspective was shared or different from other perspectives, secondly, what it meant in relation to the phenomenon and thirdly, overall was the study grounded in a suitable examination of the question (van Manen 1990). I anticipated that I would travel this circular journey throughout the analysis, writing and rewriting to construct the final thematic interpretation.
3.6 Summary

This chapter has described the theoretical perspective underpinning the study. As a relativist I believe reality is multiple and subjective. As a constructionist I believe that knowledge of reality is shaped through our social construction of the world. The study sought to explore and interpret a practice phenomenon as understood by experienced cardiorespiratory physiotherapists. In order to gain knowledge of other physiotherapists’ individual realities it was appropriate to locate the research in the interpretivist paradigm. Hermeneutic phenomenology was chosen as a suitable theoretical framework because the research interest centred on exploring, interpreting and describing an array of different physiotherapists’ understandings. The hermeneutic phenomenology methodological structure suggested by van Manen (1990) was selected as a way of deriving and providing an interpretation of experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours through the creation of in-depth textual descriptions.

Central to my research endeavour is to connect to a collective understanding of physiotherapists’ interactive behaviours in practice and to enhance that understanding. A methodological approach informed by hermeneutic phenomenology offered an appropriate way to achieve this. The philosophical foundations underpinning the methodology are summarised in Figure 3.

![Philosophical perspective informing the research study](image)

**Figure 3: Philosophical perspective informing the research study**

The next chapter presents a detailed account of the methods used to generate data of experienced cardiorespiratory physiotherapists’ personal understandings of their interactive behaviours during encounters with chronically breathless patients.
CHAPTER 4: METHOD

4.1 Introduction
This chapter presents the methods used to investigate the participant cardiorespiratory physiotherapists’ experiences of their interactive behaviours as understood and described by them. It provides an account of the procedural plan and the steps taken to generate data. The research methods have been chosen to suit the objectives of the study. Information on participants, recruitment, ethical issues, study setting, methods of data generation and an introduction to the data analysis techniques are included. Additionally, strategies used to ensure methodological rigour are described and discussed throughout the chapter.

4.2 Overview of study process
This study involved generation of data from a purposive sample of experienced cardiorespiratory physiotherapists. The participants’ research journey is depicted in Appendix 5. Following consent, each physiotherapist selected a chronically breathless patient from their caseload. The patient then gave consent to be video recorded. Each participant physiotherapist was video recorded during a treatment session with a chronically breathless patient to create a video recording of the interaction. The video recordings were not data. They were used during an interview to prompt the participant to recall and reflect on their own interactive behaviours during the encounter with the patient. Once the transcript of the video-cued recall and reflection based interview had been analysed, a follow-up interview was conducted to explore the physiotherapists’ understandings more deeply. A flow chart of the data generation process is provided in Figure 4.
4.3 Ethical Considerations

From its conception, this study and the data generation methods chosen raised a number of significant ethical issues. The following section discusses these issues.

Current ethical standards informed the research planning and practice (Robson 2002, Denzin and Lincoln 2000). Ethical approval for the research was obtained from the local NHS Research Ethics Committee on 28.09.07 (Appendix 6) and from the participating Hospitals Department of Clinical Governance and Risk on 01.02.08 (Appendix 7). In this study, standard ethical considerations related to the participants’ and patients’ privacy and confidentiality and informed consent. The specific ethical considerations raised centred on avoidance of harm and assessing risk to the participants and patients. As the specific ethical considerations required meticulous reflection, these are discussed first.

4.3.1 Specific Considerations

No harm/assessing risk

I did not anticipate any harm, either psychological or physical, to participants or patients. However, key issues relating to the participant-researcher power relationship, the physiotherapist participants’ and patients’ vulnerability, the use of video recording and the extent of any consequences of taking part were considered in depth.
Participant-researcher power relationship
I am an Advanced Clinical Practitioner in cardiorespiratory physiotherapy and have worked at the participating Acute Hospitals Trust for nearly thirty years, I am known by the physiotherapy staff. To reduce potential coercion, the physiotherapy participants were initially approached by a physiotherapy assistant to invite their participation in the study. The participants were reassured that if they chose not to participate they could do so without explanation and without consequences or repercussions.

As a senior clinician known to all the participants, the issue of the potential inequality of power within our relationship was considered. The physiotherapist participants could have become anxious because they felt their practice was being scrutinized by a more experienced practitioner (Robson 2002). The participants may have been unwilling to report their thoughts honestly because of my position. I made it very clear from the onset that the core aim of the study was their understanding of their interactive practice and my intention was to describe practice not criticise it.

To capture the entire interaction required the use of a hand held video recorder. My presence had the potential of influencing the interaction. To avoid this, a physiotherapy assistant operated the video camera. The choice of using a physiotherapy assistant, who often practices alongside a physiotherapist, was to minimise the effect of her presence as the camera operator.

Physiotherapist participants’ and patients’ vulnerability
The physiotherapists’ and patients’ vulnerability were considered throughout the data generation processes. By observing their own practice and reflecting on their practice, participants may have seen and divulged aspects they had not intended to discuss or remembered things they didn’t want to remember. There was a potential to cause distress, embarrassment, undue worry or loss of self esteem (Minichiello et al. 2004). Participants were advised they could stop the interview at any point if they had any concerns. Additionally, using my experience of communicating and discussing clinical practice with physiotherapists, time was
spent, immediately after each interview, thanking and debriefing the participants. I checked if anything during the interviews had caused concern. If the participants had expressed negative emotions, the source of their distress would have been discussed and an attempt made to resolve it at the time. If this had not been possible, the participant would have been advised to either find an independent source of support or to contact their line manager or one of the research supervisors. If the issues raised still could not be resolved a referral to the Occupational Health department would have been recommended. None of the participants expressed any distress.

As previously described, breathless patients are vulnerable. They are often anxious and frightened. The additional anxiety of being video recorded may have made the patients more breathless. I spent time during the consent process to reassure the patients that the physiotherapist was the focus of the research not them. The physiotherapist participants were asked to choose a patient they had previously treated as it was felt these patients would be less anxious.

There was the possibility that the patient might become unwell during the session. If this happened the video recorder was to be stopped and the normal medical procedures for caring for unwell patients would have been followed. None of the patients became unwell during the video recorded treatment sessions. Immediately after the video recorded session, time was spent thanking and debriefing the patient, I checked if anything during the encounter had caused concern. If a patient had experienced any emotional distress as a result of being video recorded the source of the patient’s distress would have been discussed and resolved. If the patient’s distress could not be resolved, they would have been encouraged to find an independent source of support or with the patient's agreement would have been referred to the Therapy Manager or one of the research supervisors. In addition, the patients had access the Trust’s Patient Advisory Liaison Service. None of the patients displayed or reported any concerns.
Use of video recording

Physiotherapist participants and the patients may have felt vulnerable because they were being video recorded; reassurance of confidentiality was given. However, I could not promise absolute confidentiality to the participants because of my responsibility towards mandatory reporting of malpractice to the profession (Minichiello et al. 2004). In the very unlikely event that something was captured on the video recording that gave reason for professional concern, the physiotherapist participants were told that I would discuss it with them prior to discussing it with their manager. The participants were prepared for this possibility as the process by which I would deal with a professional concern was discussed with them and described in the participant information sheet (Appendix 8). The video recordings did not raise any professional concern.

It was emphasised to both participants and patients that the video recordings were not going to be used as data but as a prompt to generate data. The physiotherapist participants and patients were assured that they could ask for the video recording to be stopped at any time or refuse its subsequent use if they chose. All patients were informed that they could view the video recording if they wished prior to its use. None of the patients asked to view the video recording of their physiotherapy session.

The possibility that a patient’s family might want to view or obtain the video recording, particularly if the patient died, prior to the video recording being destroyed was considered. If the immediate family wanted to view the recording a mutually agreeable time would have been organised, however the video recording would remain the property of the Trust until it was destroyed at the end of the study. Patients were informed in the patient information sheet that the video recordings would be destroyed on completion of the study. No requests for access were made by family members.

Working time implications

The treatment session that was to be video recorded with each participant was part of the physiotherapists’ normal working day and required no additional time as a consequence of their participation in the study. Each participant’s video-cued
recall and reflection and follow-up interview took a maximum of two and a half hours. The time requirement for each participant was discussed with the potential participants’ managers and it was agreed that as the interviews involved in-depth reflection on clinical practice, the time could be included in the physiotherapists’ professional development time allocation. The time required for the physiotherapy assistant to initially approach physiotherapy participants and to perform the video recordings (a potential total maximum of ten hours) was viewed as a benefit for developing staff in the use of video recording. This was agreed with the Therapy manager.

4.3.2 General Considerations

Privacy and confidentiality

Privacy and confidentiality were protected and the welfare, dignity and autonomy of the participants and patients were maintained at all times. Confidentiality of data and anonymity of participants, events and locations were preserved at all stages. The video recordings were collected and stored in accordance with the Data Protection Act (Office of Public Sector Information 1998). Any identifying details were removed and a code name was attributed to each participant’s video recording. The video recordings were not used for any other purpose than as a cue during the data generation phase. They will be destroyed on completion of the study. Only I and the patients’ physiotherapists had access to the video recording.

All data (audio recordings, field notes and transcriptions and video recordings) generated were kept secure in a locked cupboard at my work place, and computer data was password protected in accordance with the Data Protection Act 1998. If a patient’s name was used by a participant the name was erased from the audio recording and not transcribed. Identifying details of participants, events and locations were removed from the data. The participant’s code name was attributed to the audio recordings and transcripts. Only I and the academic supervisors had access to the raw data. Participants’ code names were preserved throughout the study and used in meetings with the research supervisors and will also be used in any future presentations or publications. Quotations from the transcripts are used in this research report to illustrate and justify interpretations.
The audio recordings will be destroyed and all other data will be disposed of in a secure manner in accordance with academic research regulations.

The physiotherapist participants had access to their patients’ health records and personal information as part of their clinical role. I did not have access to the patients’ records but the physiotherapists did discuss their patients’ personal and clinical information during the interviews. The patients were informed of this possibility in the patient study information sheet (Appendix 9). All patient data was anonymised and the patients’ consent to use this anonymised data was sought.

Video recording at the patient’s bedside has the potential of picking up unauthorised visual and/or audio data on other patients and health care professionals. This risk was raised by the Ethics Committee. If the physiotherapy session was not taking place in a private room the treatment area was screened in advance, ensuring that other patients could not be seen or heard, and ward staff were alerted to minimise the risk. The video recorder operator was instructed to avoid capturing any unauthorised footage. If some had inadvertently been captured it would have been removed from the video recording. The microphone was not sensitive enough to pick up any extraneous sound. No unauthorised visual or audio data was captured.

Consent
In order to obtain valid, informed and voluntary consent from research participants it was crucial that information about the purpose and process of the study was understandable and there was no coercion during recruitment and consent (Minichiello et al. 2004). To avoid deception, research commitments were made transparent from the beginning by providing comprehensible, detailed verbal and written information to participants and patients.

Potential physiotherapy participants were initially approached by the physiotherapy assistant to invite their participation in the study. I then arranged to meet the willing participants to explain the purpose, requirements and consequences of the study including the nature of data to be generated and the approach to data analysis. A participant information sheet was provided (Appendix 8). The
participants were given a minimum of twenty four hours to decide if they wanted to participate. If they agreed, signed informed consent was obtained (Appendix 10). A copy of the informed consent form was given to the participant for future reference and information. At that stage as the precise nature of the phenomena was unknown only a partial account of the research purpose could be provided to the participants (McKenzie, Powell and Usher 1997). Participants were reassured that they were free to withdraw their consent at any stage without explanation and without consequences or repercussions.

The participant physiotherapists approached a chronically breathless patient from their current caseload and asked for their permission to have a normal, routine physiotherapy session video recorded. I then met with the willing patients and provided them with a verbal explanation of the purpose of the study and explained that the focus of the study was the physiotherapist. A study information sheet was provided (Appendix 9). The patients were given a minimum of twenty four hours to decide if they would agree to be video recorded during a physiotherapy session. A two-part signed consent process took place. Prior to the video recording phase, I obtained patients’ signed informed consent to be video recorded (see Appendix 11). Immediately after the video recorded observation, the patients’ signed informed consent was obtained for use of the video recording during their physiotherapists interview (Appendix 12). Copies of the informed consent forms were given to the patient for future reference and information. Patients were reassured that they were free to withdraw their consent at any stage without explanation and if they did it would have no consequences or repercussions. They were also informed that the video recording would be destroyed on completion of the study.

All patient participants’ medical consultants were provided with a research study information sheet (Appendix 13).

4.4 Selecting and recruiting the participants

Purposive sampling was used to recruit experienced cardiorespiratory physiotherapists to explore understandings of their interactive behaviour with breathless patients. Participants were selected because of their specific personal experience and practical knowledge of the phenomenon, and would be
information-rich cases for in-depth study (Laimputtong and Ezzy 2005, Patton 2002 and Denzin and Lincoln 2000). Purposive sampling is compatible with interpretive research (Llewellyn et al. 1999). The particular strategy used to purposively select participants was intensity sampling, i.e. cases that manifested the phenomena intensely but not extremely (Patton 2002). The participants selected were a cohort with very specific experience and understanding but were not exceptional examples of this cohort. Selection took place in the acute NHS Hospital Trust in which I work. This Trust has a well established cardiorespiratory physiotherapy team with a number of experienced cardiorespiratory physiotherapists, all of whom I know. Substantial effort was made to recruit participants from another acute NHS Trust. However, time and procedural and logistical constraints prevented this.

4.4.1 Selection

To select participants with a purpose the inclusion criteria specified that they be currently practicing cardiorespiratory physiotherapists with greater than five years of specific cardiorespiratory physiotherapy experience. Additional criteria guiding the process of sample selection were that the participants were willing to be video recorded whilst interacting with a chronically breathless patient and that they were willing to observe and discuss their own practice.

It was anticipated that a maximum of ten participants would generate sufficient in-depth data. In addition to the inclusion criteria I used my judgement as an experienced cardiorespiratory physiotherapist to ensure that the participants chosen represented the population to be investigated (Tashakkori and Teddlie 1998). The final selection of participants was based on their agreement to participate and that they met the inclusion criteria.

Patients were not participants but were selected by the participant physiotherapists from their current caseload using the patient inclusion criteria. Thus, the patients were chronically breathless, either outpatients or inpatients due for discharge, who currently required physiotherapy management and were able to give informed consent to be video recorded during a treatment session.
4.4.2 The recruited participants

The recruitment of participants and data collection was prolonged and more difficult than anticipated for two reasons. Firstly, one of the potential participants went on prolonged sick leave and secondly, once participants had been recruited data collection was delayed because on a number of occasions, patients who had agreed to consider participating had inadequate time to decide due to the increasingly short length of stay of in-patients in acute hospital.

A total of five physiotherapists participated in the study. One potential participant declined which reassured me that despite my position, potential participants did not feel obliged to participate. All five of the participants were female. Two of the participants had trained in the United Kingdom (UK), three had trained outside the UK. Their experience as qualified physiotherapists ranged from six years to twenty one years and their specific cardiorespiratory experience ranged from five years to nineteen years. The participants were at varying stages of professional development and career pathways ranging from senior in-patient physiotherapists to a clinical specialist cardiorespiratory physiotherapist. Each brought their individual life experiences, attitudes, beliefs and motivations to describing the phenomenon. This array of perspectives and range of experiences provided richness to the data generated, which is consistent with the ethos of interpretive research.

4.4.3 The patients and context of video recorded sessions

The patients were purposefully selected by the participants. The patients were not participants; however, a physiotherapy treatment aimed at managing the patients breathlessness was video recorded by a physiotherapy assistant. All of the patients who were videoed were chronically breathlessness and required physiotherapy. Every one of the patients approached agreed to be video recorded and subsequently, gave their permission for the recording to be used for the research study.

The video recorded physiotherapy sessions included patients in different settings, with a variety of conditions, varying severity of breathlessness, and involved a
range of physiotherapy treatments. The patients and the contexts are described in Box 2.

<table>
<thead>
<tr>
<th>Patient One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient one was an in-patient in a side room on an acute ward. She was a frail elderly lady with chronic obstructive pulmonary disease, moderately breathless, on oxygen via nasal cannulae. She was highly anxious and due for discharge the following day. Her son was in attendance throughout the session. The purpose of session was to improve her exercise confidence and tolerance by supervised mobilisation with a walking frame.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient two was an out-patient. The session took place in a private room, on the hospital stairs and the physiotherapy gym. He was an elderly gentleman with COPD and was moderately breathless. The purpose of session was to improve his exercise tolerance and to incorporate breathing control on stair climbing and treadmill walking.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient three was an in-patient on the intensive care unit. She was a middle-aged lady with a COPD and was moderately breathless. She had a tracheostomy and was on oxygen. She was due for imminent discharge to a rehabilitation unit. The purpose of session was to improve her exercise confidence and tolerance by supervised mobilisation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient four was an out-patient. She was an elderly lady with dysfunctional breathing. The purpose of session was to educate her about her condition and to teach her relaxation and breathing control techniques.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Five</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient five was an in-patient in a side bay on an acute ward. She was a frail elderly lady with COPD, was severely breathless and on oxygen via an oxygen mask. She was anxious. The purpose of session was to find positions to reduce her breathlessness and to teach her breathing control techniques.</td>
</tr>
</tbody>
</table>

Box 2: Video recorded patients and context

[Original in colour]

The diversity of the patients selected by participants added to the richness of the data generated from the video-cued recall and reflection.

4.5 Data Generation: Investigating the experience in the participants’ world

The rigorous study of real-world physiotherapy interactions presented significant methodological challenges. It called for methods of inquiry that could explore complex information encompassing the intricate relationships between the patient,
therapist and the intervention. As previously described, physiotherapy practice draws on many types of knowledge. In this study I was seeking to construct and make explicit uncodified, professional craft and personal knowledge. Observation of professional performance and communication with practitioners are two approaches through which personal practice knowledge can be described and understood (Eraut 2007).

The views and interpretations of physiotherapists were fundamental to my research question (Dunne, Pryor and Yates 2005). I was committed to achieving authentic participation and cooperation between the participants and myself in the generation of practice applicable data. In order to give an account of possible ‘yet to be described’ physiotherapists’ behaviour from their lived experience, I listened to physiotherapists’ thoughts and reflections about their interactive behaviour as they observed themselves engaged in practice. The purpose was to provide substantial information to enhance my knowledge of their understanding. To capture the participants’ understandings of their interactive behaviour, data was generated through an audio recorded video-cued recall and reflection and a follow-up semi structured interview with each of the physiotherapy participants.

4.5.1 Rationale for data generation methods

Current methodologies for generating data on cognitive processes and decision making in naturalistic complex settings include concurrent reporting procedures (in action commentaries) and retrospective interview procedures (after action reviews) (Young 2005). These are called verbal reports.

Concurrent verbal reporting

The think-aloud technique is thought to be particularly valuable in revealing new or emerging phenomena rather than testing or substantiating what is already known because analysis begins from a position where meanings are unknown, rather than to confirm or contrast with known entities (Chi 1997, Payne 1994). It is argued that think-aloud provides a way of investigating the underlying cognitive processes of complex tasks which cannot be studied in other ways (Ericsson and Simon 1993). The participant is instructed to verbalise their thoughts during completion of a task, with the aim of capturing what they are thinking when performing a task, the types of knowledge and cognitive processes used, and to
provide a source of understandings during the initial stages of investigating behaviour. However, concurrent think-aloud has a number of disadvantages linked to reactivity and accessing and verbalising thoughts. When an activity involves a high cognitive load, the intellectual effort required by the participant to provide think-aloud commentary, interrupts and influences the speed or the performance of the main task (Ericsson and Simon 1998).

In this study, I felt reactivity would adversely affect participants’ natural performance. To think-aloud during a patient treatment could have interfered with the ability to develop thought processes and to articulate them coherently. The act of drawing attention to their interactive behaviour could alter the participants’ behaviour and reports of their thinking. Interrupting normal decision making could have raised safety issues by distracting the participant from their main tasks. Additionally, the think-aloud process may have provoked more critical thinking about the activity than in non-research circumstances. Branch (2000) suggests that the cognitive load of problem solving and speaking may be too difficult for some subjects. This difficulty can be reduced by using retrospective data.

Two other factors influenced my decision not to use concurrent think-aloud commentary. Firstly, I was concerned that the very nature of what I wanted to explore, interactive behaviour, would be influenced and changed by the physiotherapist thinking aloud, the inevitable effect of the physiotherapist talking aloud during an activity when normally they would be in conversation with the patient. Secondly, although frequently in practice physiotherapists explain their decision making processes to the patient, I could not anticipate the content of their commentary and thus the possible harmful impact on the patient and their carers of hearing the think-aloud.

**Retrospective verbal reporting**

Retrospective verbal reporting techniques help resolve the problem of reactivity. These methods have less impact on cognitive processes and behaviour because the report is made after the experience (Omodei et al. 1997, Ericsson and Simon 1980). However a challenge that affects both concurrent and retrospective verbal reporting procedures is that people are only able to access and verbalise conscious thoughts. If behaviour is automatic and subconscious it cannot be
expressed (Ericsson and Simon 1980). So, the ability to provide comprehensive and accurate data on cognitive processes that prompt actions can be limited. Additionally, the completeness of any verbal report depends on the subject’s verbal ability, language skills and particularity of syntax. Furthermore, many thought processes depend on visual, auditory, or mathematical imagery which are hard to verbalize, particularly if emotions or biases are involved (Omodei et al. 1997). Since participants may have been unable to provide relevant retrospective verbal reports because their behaviour is automatic and difficult to verbalise, retrospective reporting alone was perceived to be inadequate to explore the phenomenon under study.

Other challenges to retrospective reporting include hindsight bias (Woods and Cook 1999). Some cognitive processes are more likely to be recalled than others resulting in limited understanding of the decision making process. Interpretation is thought to be filtered because preverbal states (perceptual, affective and motivational) are less likely to be remembered (Omodei et al. 1997, Omodei et al. 2002). It is argued that self-reports tend to impart an impression that is self-enhancing and self-consistent through the processes of distortion and censoring (Omodei et al. 2002, Swann et al. 1987).

To enhance conscious awareness of practice behaviours and minimise reactivity, memory limitations, and hindsight bias, I decided to use video recordings of participants in practice to prompt retrospective verbal reports of their interactive behaviour with breathless patients.

**Video-cued recall and reflection**

Prior to the data generation, the initial plan was to use retrospective think-aloud prompted by the video recording of the participant in action. The think-aloud method I intended to use was transformed from the outset. Because I encouraged the participants to provide introspective explanations of their interactive behaviour, as they observed their interaction rather than purely thinking-aloud they recalled and reflected on their behaviours. Video-cued recall (Miller 2004) and video-cued narrative reflection (Raingruber 2003) are described methods of collecting retrospective verbal data in the literature. The participants' adaptation and development of the initially planned think-aloud produced a hybrid of video-cued
think-aloud, video-cued recall and video-cued narrative reflection. For clarity I will refer to the technique that emerged as video-cued recall and reflection.

**Video recording**

The use of video recording as a research tool is becoming more common as it helps to accurately and comprehensively explore the nature of practice based phenomena (Parry 2010). It documents actual as opposed to espoused behaviour, overcomes issues of lack of reliability in self reporting and enables participants to express their own interpretation of their behaviour. A variety of techniques using video recordings have been used in both qualitative and quantitative research studies in health care settings including video-cued recall (Miller 2004), video-cued narrative reflection (Raingruber 2003) and video-based conversational analysis (Parry 2004b, Parry 2010). Video recording has been cited as being particularly valuable in providing insight into interactive behaviour such as body language (Mwanga 1998).

In this study, video recording allowed information to be obtained in a permanent format so it could be viewed by the participants to allow them to observe, describe, and reflect on their verbal and non verbal interaction. It is argued that video recording provides continuous multi-sensory information about participants' lived experience and the context, and helps them to re-experience what had happened (Raingruber 2003). In this study, the use of video recorded treatment sessions as a prompt to produce verbal reports of the experience was particularly suitable as participants could observe their social interaction and behaviour. For hermeneutic phenomenology research purposes, video recordings were used to help the participants re-engage in the experience and to focus their awareness on tacit understandings and what may have been taken for granted.

The participants' and the patients' reaction to the video camera and operator were considered. The presence of the video camera and operator had the potential to influence the participants and the patients. This effect could have been reduced by having the camera in a fixed place recording automatically; however, this would have only allowed events in the line of the camera to be recorded. As physiotherapy interventions normally involve movement around the treatment setting, a fixed camera would have limited the range of possible observations.
There were also considerations regarding the credibility of video data. How well could video data adequately represent behaviours normally used by physiotherapists’ in practice? Having observed physiotherapy interactions for many years, I feel confident that the video recordings produced during this study are highly representative of cardiorespiratory physiotherapists’ practice. Generating data through participants’ reports whilst observing themselves on video, engaged in a real activity, reduces the risk of memory failure inherent in generating verbal data retrospectively. Video recording is not more objective than other forms of observation; the participants’ personal interests and theoretical orientation would inevitably determine which parts of the action they perceived to be relevant and reliably reflected their understanding of their practice.

The study of naturalistic complex behaviour required methods that minimised reactivity and could generate comprehensive verbal reports. Observing video recorded practice and providing a video-cued recall and reflection on that practice allowed the participants to recall the detail of their experience and helped reduce the problem of reactivity.

**4.5.2 Interviewing**

Interviewing was the method of choice to further construct the understanding of, and meaning in, the participant physiotherapists’ interactive behaviours from their perspectives. Interviewing techniques were used during the video-cued recall and reflection and the follow-up discussion stage. The purpose of the interview, at both stages, was to explore and negotiate understanding and meaning of complex behaviour without imposing any a priori categorisation that could restrict the area of inquiry (Denzin and Lincoln 2000). I employed and developed a combined approach incorporating an informal conversational interviewing style supported by a general interview guide as the study progressed. An informal conversational interview style was the principal technique used during the video-cued recall and reflection stage. During the follow-up interviews, the general interview guide approach predominated, however, the extent to which each style was used varied between stages and participants.

The informal conversational interview is a flexible, unstructured approach allowing the interviewer to follow any direction that emerges and that is appropriate to the
situation, the participant and the inquiry (Patton 2002). During the video-cued recall and reflection, questions were only asked when the video-cued recall and reflection did not produce generous description. The interview guide for the video-cued recall and reflection consisted of open-ended, relatively unstructured questions to prompt additional report of participants’ understandings of their behaviours, feelings, experiences and perceptions (see Appendix 14). The follow-up interview (see Appendix 15) was employed to provide a further opportunity for dialogue with the participants in order to generate additional data with which to construct a rich and deep understanding of the phenomenon (van Manen 1990). A generic guide for the follow-up interview was developed after analysis of the video-cued recall and reflection transcripts and included the nascent themes that had developed. This generic guide was modified prior to each follow-up interview to incorporate any additional, specific topics identified by the participant.

The overall purpose was to conduct participant-centred interviews with an attempt to go beyond those things that were on the surface, to probe for detailed and rich data on individuals' behaviours, attitudes and motivations. The aim was to find out if the participants could say more that would allow a fuller grasp of their understandings. The follow-up interview followed a deliberate range of topics asked in a relatively consistent manner (Schutt 1996). However, the style used relied primarily on open-ended questions and the specific order, wording, content of questions and the time and attention allocated to each topic varied. I was alert to what the participant said that required further elaboration and incorporated ad hoc questions. Inappropriate questions were omitted and appropriate additional ones included as suggested by Robson (2002). This feature of flexibility was significant as the interview schedule was refined within and between interviews. The combined interviewing style strategy allowed for flexibility to probe the participants’ understandings, to explore certain topics in depth and to incorporate questions on new emerging topics (Patton 2002). However, I had not anticipated the extent to which I would have to prompt and question most of the participants during both the video-cued recall and reflection, and the follow-up interview to elicit in-depth descriptions of their understandings of their interactive behaviours.
4.5.3 Process of data generation

The research methods developed and employed during this study were informed by procedures described by Raingruber (2003), Omodei et al. (1998) and Ericsson and Simon (1993). Data generation involved three stages.

Stage one – Video recording the interaction with a chronically breathless patient.
A physiotherapy assistant was trained to operate the video camera and instructed to maintain a neutral demeanour and to preserve confidentiality of other patients and staff by lowering the camera if necessary. Prior to the video recorded session the treatment area was prepared and the equipment tested. The participant was then video recorded during a physiotherapy session with a patient. Following the session, the video recording equipment was collected and a mutually agreeable time arranged with the participant to conduct the video-cued recall and reflection.

Stage two – Audio recording the participants’ video-cued recall and reflection.
Prior to stage two, video data was saved to a DVD which permitted viewing on a lap top computer. The video-cued recall and reflection took place in a comfortable, quiet location in the participating hospital within four days of the video recorded episode. The explanation given to each participant, prior to their video-cued recall and reflection was:

*I am going to play the video recording we made of you and your patient during a physiotherapy session so you can re-immers[e] yourself in the experience. What I am really interested in, is how you think you interact with your patient. The technical physiotherapy treatments you used are not the focus.*

*Please can you describe, as fully as possible, your understanding about the way you interact with the patient during the encounter? I would like you to keep talking throughout the recording and describe what you were doing, thinking and feeling at the time. You can include any thoughts, decisions, emotions or physical responses that occur to you.*
Participants were also told they could pause the video at any point if they wanted to explain or elaborate on any particular or significant points. While the video recording was playing, verbal prompts included suggestions of ‘keep talking’ if the participant stopped commenting for an extended period of time. The purpose of using a neutral cue such as ‘keep talking’ was to encourage participants to think-aloud but not to influence their responses by adding external ideas to their internal thought processes. This is consistent with the approach of Ericsson and Simon (1993), which aims to obtain a verbal report that is as undirected and uninterrupted as possible.

If the technique was failing to produce rich data, concurrent probing incorporating a combination of informal conversational interview and if necessary, a general interview guide approach (Appendix 14) was used. The aim was not to probe outside the initial experience but to help the participant to recall and reflect on what had occurred during the course of the physiotherapy session. The data generated provided rich descriptions of cardiorespiratory physiotherapists’ understandings of their interactive behaviours whilst treating chronically breathless patients. However, most of the participants had to be frequently prompted to elicit their understandings. The participants’ verbalised thoughts were audio recorded for transcription and analysis. The video-cued recall and reflection sessions lasted between thirty five minutes and one and a quarter hours. The audio recordings were transcribed verbatim and analysed using a detailed reading approach drawn from van Manen (1990).

**Stage Three – Audio recording follow-up interviews with participants.**

From the analysis of the video-cued recall and reflection transcripts, an in-depth semi-structured interview guide was developed to explore and discuss the initial derived concepts and themes (Appendix 15). A mutually agreeable time was set with the participants to conduct the follow-up interviews. The follow-up interviews took place in a comfortable, quiet location where confidentiality could be assured. The venue was agreed in advance with individual participants. I explained to the participant that the aim of the session was to explore more deeply their understanding of their interactive behaviours in practice. The interviews were audio recorded and lasted between forty five minutes and one and a half hours.
The video recorded observation was available for further observation if desired. During the follow-up interview themes developed from the initial analysis were explored whilst keeping the study of the phenomenon open in order to construct further and deeper understandings (van Manen 1990). The audio tape recorder could be turned off at any time at the discretion of the participant. None of the participants requested the tape to be turned off. Similar to my observation during the video-cued recall and reflection most of the participants found it difficult to easily articulate and explain their understandings of their interactive behaviours unless direct questions were asked. In response to direct questions they openly shared their understandings and provided rich descriptions in an uncensored manner. The interviews were transcribed verbatim and analysed using a selective reading as described by van Manen (1990).

4.6 Management and organisation of the data

The research data generated was in the form of audio recordings and text. I kept complete, organised and accessible data to facilitate analysis and to maintain an audit trail.

The audio recordings were carefully labelled and catalogued. For confidentiality purposes data were not downloaded onto a hard drive. Participants’ code names were attributed to the audio recordings. All audio recordings were anonymised and hand delivered to and collected from an audio typist. The audio recordings were transcribed verbatim by an audio typist and yielded extensive texts. Transcriptions were emailed using the secure NHS email system.

Three separate types of field note files were kept: a personal log, an analytical log and a transcript file (Ajjawi and Higgs 2007, Minichiello et al. 1995). The personal log included descriptive accounts of the participants, their patients and the settings. Minimal field notes were kept during the video-cued recall and reflection and follow-up interviews. I felt that writing notes could be distracting and affect rapport during the interview process. In order to minimise memory inaccuracies, notes were made immediately after the interviews to record observations, reflections, interpretations and experiences of the interview and any methodological issues that arose. The analytical log contained notes on interview questions and ideas relevant to the inquiry that developed from the data as the
research progressed. Reflections and decisions that influenced the direction of the research and reflexive inquiry were included. A record of my thoughts, beliefs and feelings in the analytical log helped support a reflexive approach towards my assumptions, preconceptions and understandings from the participants' descriptions of their understandings. The transcript file contained the transcribed interviews from the participants’ audio recorded video-cued recall and reflection and the follow-up interviews (samples are provide in Appendix 16 and 17 respectively).

These three field note files constitute the research journal, which details the research process. They provide transparency to interpretations, a detailed pathway of the methodological decisions and analytic undertakings, and an audit trail of the research process. This strategy serves to increase the credibility of the findings and rigour of the research process (Johnson and Waterfield 2004).

4.7 Data Analysis

The goal of the analysis was to explore and make explicit participants’ understandings of their interactive behaviours with breathless patients. To achieve this, analysis was guided by a combination of Gadamer’s (1975/2004) ideas on the fusion of horizons and hermeneutic circle of understanding and van Manen’s (1990) approach to thematic analysis as described below.

4.7.1 Thematic analysis

Thematic analysis is an analytical process through which meanings inherent in textual data are identified through ‘careful reading and rereading of the data’ (Rice and Ezzy 1999:258). Patterns are sought within the data, and the themes derived become categories for analysis. To describe and interpret participants’ understandings of their interactive behaviours, patterns within the expressed understandings that formed the overall experience had to be constructed from the transcripts using creativity and discovery (van Manen 1990). The task of identifying themes concentrated my attention on the phenomenon and gave control and order to my analysis and writing (van Manen 1990).

To find meaning in the transcripts of the participants’ understandings, two approaches as described by van Manen (1990) were used to isolate thematic
aspects of the phenomenon of cardiorespiratory physiotherapists’ interactive behaviours. These were the selective or highlighting approach and the detailed or line by line approach. Participants’ descriptions produced meaning units which were coded and a descriptive memo developed. The codes generated concepts which were then classified under core concepts which in turn generated sub themes and themes. Figure 5 illustrates the process of theme development. A detailed account of how themes were derived is provided in the following chapter.

![Figure 5: Collapsing down codes](Original in colour)

### 4.8 Summary

This chapter has discussed the ethical issues raised by the research, the study setting, the recruitment strategies and the participants. In addition, it has described the methods of data generation and the rationale for using those methods. Chapter Five details the analytical process that was employed to find
meaning in the participants’ described understandings of their interactive behaviours with chronically breathless patients.
CHAPTER 5: FINDING MEANING

5.1 Introduction

This chapter provides an in-depth account of the steps and processes that were used to find meaning in the participants’ transcripts, guided by Gadamer’s (1975/2004) hermeneutic circle of understanding, and van Manen’s (1990) hermeneutic phenomenological methodological structure. Examples of participants’ words and samples of code lists, descriptive memos, tables and mind maps are included. These illustrate how meaning units, codes, concepts and core concepts were developed from the words and key phrases, and how sub-themes and themes were derived from the core concepts. Issues of rigour are discussed throughout the chapter. This detailed explanation will permit evaluation of the credibility and consistency of the decisions made during the analysis. Figure 6 provides an overview of the analytical process.

![Analytical process diagram]

(VCRR – video-cued recall and reflection)

**Figure 6: Analytical process**

All quotes are presented with the relevant participant’s number, interview number and transcript line reference. For example, P1:I1:66 will indicate the quote came from participant one, interview one, line sixty six. Verbal fillers have been removed and replaced with three dots.
5.2 Mining for meaning in the participants’ accounts

Initially, the audio recordings of each of the participants’ video-cued recall and reflection were listened to repeatedly until I felt I had an overall sense of their experience. I then immersed myself in each transcript and sought and captured in language used by the participant, what they described as important elements of their experience. From the outset, I focused on participants’ descriptions of their interactive behaviours, not descriptions of physiotherapy techniques. This was at times difficult because participants gave many reasons for their behaviours. They often did not separate their interactive behaviours from their therapy actions. I used my knowledge and experience as a cardiorespiratory physiotherapist to make decisions about what behaviours appeared to reflect human interaction rather than purely therapeutic actions.

5.2.1 Preliminary phase: searching for meaning units and codes.

Each video-cued recall and reflection transcript was viewed as a unique and original description and approached with a desire to be open to statements that appeared significant and essential to the participant’s understandings. Transcripts were imported into an Excel document so every sentence cluster could be assigned a line number. The detailed reading approach described by van Manen (1990) was used to analyse each video-cued recall and reflection transcript. To obtain a comprehensive sense of what the participants had talked about, each sentence or sentence cluster was read and re-read and asked “What does this sentence or sentence cluster reveal about the participant’s understanding of their interactive practice?” This meticulous process prompted the development of meaning units.

Numbering the sentence clusters helped to isolate individual words and phrases and encouraged scrutiny of the meaning each might have. Portions of the transcript that contained ideas, topics or stood out as distinct meaning units were selected. Decisions were made about exactly what the participants’ words expressed about their understanding, what it meant to them and what code should be assigned to each meaning unit. This process of coding allowed categorisation of the data.
Initially open coding was used to develop preliminary categories. Participants’ descriptions frequently explained the reasoning behind and intentions of specific behaviours. The meaning units were coded to include this information. For example, the following two sentence clusters, from the same participant, were recorded under the same code ‘use of voice’ but included detail of the intention behind the behaviour. For the sentence:

Trying to keep my tone upbeat and just to make her feel comfortable with me. (P1:I1:4)

the meaning unit derived was ‘use of tone of voice to engender comfort with the participant’ and for:

If I use my voice like that it helps me feel calm. (P1:I1:113)

the meaning unit derived was ‘use of voice to engender calm in the participant’. Recording the detail retained the complexity of the participants’ understandings of their behaviours and their intentions. This line by line approach facilitated focused reflection on the significance of each statement and prevented the formation of uncritical assumptions. Table 1 provides an illustration of how codes were developed from meaning units. It includes an extract from each participant.
<table>
<thead>
<tr>
<th>Transcripts</th>
<th>Key words and phrases</th>
<th>Meaning units</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P1:1:4</strong></td>
<td>Trying to keep my tone upbeat just to \nmake her feel comfortable with me. Part \nof building a rapport with her and I \nthought she looked very nervous about \nthe whole thing so this general \nconversation at the beginning was just to \nmake her feel a bit more comfortable \nand less formal.</td>
<td>1 Keep tone upbeat to make her feel \ncomfortable with me. 2 Part of building a rapport 3 She looked very nervous about the whole thing 4 General conversation at the beginning to make her feel a bit more comfortable and less formal.</td>
<td>1 Use of voice (volume, intonation) to engender comfort with participant 2 Building rapport 3 Reading body language cues about patient's emotional state 4 General conversation, intentionally providing comfort and reducing formality</td>
</tr>
<tr>
<td><strong>P2:1:9</strong></td>
<td>I am sitting sort of reasonably close but \nobviously not close enough to invade his personal space and again if I needed to \nwrite things then obviously my notes are there so it is easy to do it but I can still \nkeep, feel like I am writing but still actively listening to what he is saying.</td>
<td>1 Sitting close - not invading patients personal space 2 Need to write notes 3 Active listening</td>
<td>1 Aware of body proximity 2 Maintaining documentation 3 Listening</td>
</tr>
<tr>
<td><strong>P3:1:132</strong></td>
<td>I was just observing that she was working harder with the breathing so I just said that if you want to stop you can stop here and you can sit down here in the chair so that's all I am doing there to give her some time and you know give some rest before we start again.</td>
<td>1 I was observing she was working harder with the breathing 2 I said that if you want to stop you can stop here and you can sit down here in the chair 3 Give her some time and give some rest before we start again.</td>
<td>1 Observation of physical signs, 2/3 Giving patient choices, empower patient</td>
</tr>
<tr>
<td><strong>P4:1:340</strong></td>
<td>So again hand gestures are very precise at that point. Again, I am watching her all the time and while I am giving all the spiel out, she then you know, is altering her pattern.</td>
<td>1 Hand gestures are very precise. 2 I am watching her all the time 3 While I am giving all the spiel out 4 She then is altering her pattern.</td>
<td>1 Participants body language - precise hand gestures 2 Observation 3 Explanation/ education 4 Observation</td>
</tr>
<tr>
<td><strong>P5:1:189</strong></td>
<td>Again, just observing her and the distress the coughing is giving her, still remaining quite close, in close proximity.</td>
<td>1 Observing her and the distress the coughing is giving her 2 Still remaining quite close, in close proximity.</td>
<td>1 Observation of physical signs and awareness of patients emotional response, 2 Close proximity</td>
</tr>
</tbody>
</table>

Table 1: Moving from text to meaning units and codes [Original in colour]
Initially, the generated codes were listed alphabetically in a Microsoft Word document with the relevant participant’s number, and transcript line reference recorded against the code. A preliminary descriptive memo for each code was constructed to record the detail and complexity of the codes meaning. Box 3 provides an extract from the code list for the code ‘use of voice’.

<table>
<thead>
<tr>
<th>Code: Use of voice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong> Participants are aware their voices send messages. Non-verbal elements of voice such as volume, tone, tempo and pitch are thought to influence a patient’s physical and emotional state. They intentionally adjust their voice to create a relaxed environment and specifically adapt their voice to individual patients and their particular problems.</td>
</tr>
<tr>
<td>- to produce calm in participant (P1:I1:113)</td>
</tr>
<tr>
<td>- tone (P5:I1:98)</td>
</tr>
<tr>
<td>- pace/tempo (P4:I1:204)</td>
</tr>
<tr>
<td>- pitch (P4:I1:204)</td>
</tr>
</tbody>
</table>

**Box 3: Extract from the preliminary code list**

The process of finding meaning in each sentence and assigning it to a code gave a sense of the detail and complexity, the “parts” of each of the participants’ understandings but also the commonalities of their understandings. I repeatedly returned to the texts to consider the “whole” moving backwards and forwards in the hermeneutic circle trying to make sense of the participants’ expressed understandings.

As the analysis proceeded, sections of text with shared meaning units were brought together under the appropriate code. The generated codes were continuously reflected upon. Codes were added, modified and merged with others in continuous engagement with the transcripts and the code list. The descriptive memos allowed for cross checking of consistency of meaning within and across codes.
5.2.2 Intermediate phase: Developing concepts and core concepts from meaning units and codes

A significant number of codes were generated from the meaning units during analysis of the first two transcripts. The codes appeared to fall into three general categories:

- interactive behaviours and strategies that participants described
- the participants’ practice approach
- aspects of the physical and emotional environment that the participants were aware of and attempted to influence.

The three general categories were used as separate concept column headings and codes were logged under the most appropriate concept column. An example of the tabulated analysis from one of the participant’s spreadsheets is provided in Table 2.
<table>
<thead>
<tr>
<th></th>
<th>Transcript</th>
<th>Key words and phrases</th>
<th>Meaning units</th>
<th>Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1:I1:8</td>
<td>Again, just trying to remove a bit of clutter from around the area from around her as well so she doesn't feel cluttered which will, you know, may impact on her breathing.</td>
<td>1 remove clutter from around the area and her so she doesn't feel cluttered 2 which will, may impact on her breathing.</td>
<td>1 Attention to and reducing the impact of disordered environment on patient 2 Awareness of link between physical environment and patients physical response</td>
<td>Organises space Intuitive Creates an organised environment</td>
</tr>
<tr>
<td>P1:I1:12</td>
<td>I am sitting down in front of her so I am not towering over again to make her feel comfortable and calm, and just acknowledging that I know that she had had a bit of an upset morning, and again just trying to acknowledge anything she might be feeling.</td>
<td>1 sitting down in front of her so I am not towering over 2 make her feel comfortable and calm 3 acknowledging that I know that she had had a bit of an upset morning, 4/5 trying to acknowledge anything she might be feeling.</td>
<td>1 Awareness of powerful body position 2 Induce calm and comfort 3 Awareness of patient's lifeworld 4 Recognising and responding to patient's feelings 5 Demonstrating empathy</td>
<td>Non-verbal communication: Body position to encourage comfort and calm. Attending to patient's experience and emotions Empathic Creating a supportive environment. (patient's emotional comfort)</td>
</tr>
<tr>
<td>P1:I1:16</td>
<td>I am holding her hand (laughter) again trying to make her feel a bit more comfortable but trying not to be too far in her face but close enough to be developing that rapport.</td>
<td>1 I am holding her hand 2 trying to make her feel a bit more comfortable 3 trying not to be in her face, close enough to be developing that rapport.</td>
<td>1 /2 Touch to facilitate comfort 3 Body proximity to facilitate rapport</td>
<td>Non-verbal communication: touch to provide comfort Finely tuned physical proximity Develops rapport Empathic Creating a facilitative environment (patient emotional and physical comfort) non-threatening</td>
</tr>
</tbody>
</table>

**Table 2: Moving from meaning units and codes to concepts** [Original in colour]
As the analysis continued, particular codes within each of the concept columns in the tabulated analysis were interpreted as more dominant to the participant physiotherapists’ understandings, for example ‘close body proximity’. Being in close proximity had various purposes within and between participants. For example, in both the extracts below the participants describe cognitive awareness of, and concern about the effect of their proximity on the patient. However, in the second extract the participant describes the additional purposes of maintaining eye contact and observation of the patient’s facial expressions:

I am sitting sort of reasonably close but obviously not close enough to invade his personal space. (P2:I1:9)

Again I’m quite close, trying to maintain eye contact again and just keeping an eye on the patient’s facial expression, making sure she is comfortable and not stressing her any further. (P5:I1:241)

In addition to talking about their body proximity, participants also described modifying their body position in relation to the patient. These two codes were merged to become one concept ‘attends to body proximity and position’. The associated descriptive memo drew the codes together and included the various explanations participants gave as reasons that influenced their position and proximity. The descriptive memo for ‘attends to body proximity and position’ is provided in Box 4.

**Concept: Attends to body proximity and position**

**Description:** Body proximity and position are seen to influence the interaction. Judging how physically close to get to a patient and what position to adopt is at times automatic and at others consciously considered, it depends on the intention and the participant’s knowledge of the patient and the patient’s responses. A balance is found that allows for sufficient distance so that a sense of intrusion is minimised but permits close observation of the patient’s body language, facial expressions and monitoring equipment. Positions and postures adopted are chosen to reduce intimidation, permit eye contact, provide reassurance and support, encourage relaxation and minimise any undue physical strain on the patient.

**Box 4: Example of a concept descriptive memo**
As concepts emerged, coding was applied more systematically. The generated concepts and descriptive memos were reflected on, refined and adapted checking for consistency of meaning. Concepts that related to each other were grouped together under a core concept. For instance, the concept of ‘attends to body proximity and position’ was linked with the concept of ‘adapts paralinguistic behaviours’. This had been generated from the ‘use of voice’ code. Because both these concepts related to non-verbal behaviours they were classified under the core concept of ‘attends to non-verbal behaviours’. Initially, other non-verbal behaviours such as the participants’ ‘eye gaze’ and ‘facial expression’ were also included in this core concept. Some concepts linked with more than one core concept. For example, ‘attends to body proximity and position’ was associated with two core concepts; ‘attends to non-verbal behaviours’ and ‘attends to patients’ and own external environment’ depending on the participants’ described intention.

As the analysis progressed, each video-cued recall and reflection transcript informed the analysis of the next. Within individual transcripts and across all transcripts there was constant movement between meaning units, codes and concepts back and forth to find core concepts. I strived to stay open to the texts and to avoid crafting the interpretation to fit with my personal preconceptions and prejudices, or a theoretical explanation.

Once analysis of each participant’s video-cued recall and reflection was complete, a follow-up interview was conducted to explore more deeply into each of the participant’s understandings. The follow-up interview consisted of questions based on my initial interpretation of the developing core concepts and nascent themes. Inevitably, each subsequent video-cued recall and reflection and follow-up interview informed the next. The purpose of the follow-up interview was to provide an opportunity for further dialogue with the participants about the initial interpretations. This allowed them to explore more deeply, expand on, clarify and correct whether the interpreted core concepts and nascent themes described their understanding of their interactive behaviours.
Analysis of the follow-up interviews

I listened to the audio recordings repetitively to grasp the whole of the participants' understandings and then analysed the transcripts using van Manen’s (1990) selective reading approach. Each transcript was read and re-read to determine statements that appeared particularly relevant (informed by the analysis of the video-cued recall and reflection transcripts) in detecting the meaning and essence of the participant’s understandings. The selected statements were highlighted and coded. This phase of the analysis was more focused. Highlighted statements and line numbers were copied from the text and applied systematically to core concepts. The descriptive memos of the core concepts became increasingly definitive with continuous reflection and movement back and forth between the initial and follow-up interview transcripts.

At this point, to further manage and find meaning in the participants’ descriptions without losing the complexity and content, I created mind maps using the Cayra software package (http://downloads.cnet.co.uk/view/business/cayra). The maps were developed around core concepts that were perceived to be more dominant and shared between participants such as, environment and non-verbal communication. The maps offered another perspective from which to look for patterns, and to demonstrate links. The Cayra software also allowed for recording of description of concepts and participants’ transcript line numbers. The maps underwent frequent revisions. An example of the environment map is provided in Figure 7.
5.2.3 Final phase: Moving from core concepts to sub-themes and themes

Analysis of the follow-up interview transcripts led to adaptations and additions to the core concepts and involved rigorous cross checking. Once the core concepts had been decided on, to discern what might have been overlooked, I re-examined the tabulated analysis and mind maps. By comparing and reflecting on shared and unique core concepts, explicit and implicit themes were searched for, added, modified and merged with others in a continuous hermeneutic conversation to generate a list of shared themes. Core concepts developed into sub-themes and themes. Examples of tabulated analysis from two of the participants are provided in Table 3.
<table>
<thead>
<tr>
<th>Concept</th>
<th>Core concept</th>
<th>Sub-themes</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attends to own non-verbal behaviours (to encourage patient to describe their understandings)</td>
<td>Attends to own non-verbal and verbal behaviours</td>
<td>Authentic listening</td>
<td>Accessing and attending to your world</td>
</tr>
<tr>
<td>Articulates understandings about patients current state</td>
<td>Shares understandings with patient</td>
<td>Trustworthy and honest</td>
<td>Sharing my world</td>
</tr>
<tr>
<td>Attends to body proximity (to not invade patient’s personal space)</td>
<td>Attends to patients external environment</td>
<td>Attending to our external world to influence our inner worlds</td>
<td>Creating a facilitative space</td>
</tr>
<tr>
<td>Attends to non-verbal body language (to demonstrate listening)</td>
<td>Attends to own non-verbal behaviours</td>
<td>Authentic listening</td>
<td>Accessing and attending to your world</td>
</tr>
<tr>
<td>Attends to own non-verbal behaviours (to demonstrate listening)</td>
<td>Communicates expectations</td>
<td>Authentic listening</td>
<td>Accessing and attending to your world</td>
</tr>
<tr>
<td>Articulates expectations of patient</td>
<td>Shares understandings with patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation of patient's physical and emotional state</td>
<td>Attends to patient's non-verbal behaviours and physiology</td>
<td>Profound watchfulness</td>
<td>Accessing and attending to your world</td>
</tr>
<tr>
<td>Attends to own non-verbal behaviours (to demonstrate listening)</td>
<td>Attends to own non-verbal and verbal behaviours</td>
<td>Authentic listening</td>
<td>Accessing and attending to your world</td>
</tr>
</tbody>
</table>

Table 3: Moving from core concepts to sub-themes and themes [Original in colour]
Care was taken not to rush to creating final common themes. Provisional decisions were frequently changed or modified to create a more accurate depiction of a theme. All quotes relating to particular core concepts, sub-themes and themes were read and checked against the original transcripts to assure internal consistency. Eventually, following prolonged and persistent revisiting of the data I realised that the search for themes could continue indefinitely and I reached a point where I felt the derived themes represented what was in the data. Inevitably, my interpretation of the participants’ understandings guided the way sub-themes and themes were constructed and named. Ultimately, three themes were derived; ‘Creating a facilitative space’ ‘Accessing and attending to your world’ and ‘Sharing my world’. These themes appeared to be the dominant structures of the participants’ understanding of their interactive behaviours.

These themes remain as faithful, and as close as possible to what the participants said about their understanding. The following three flowcharts (Figures 8, 9 and 10) summarise each theme and demonstrate their development from the participants’ descriptions through to sub-themes and themes.
Figure 8: Creating a facilitative space theme

[Original in colour]
Figure 9: Accessing and attending to your world theme
Figure 10: Sharing my world theme

[Original in colour]
5.3 Summary

This chapter has described the process of finding meaning in the participants’ transcripts and presents how the themes were derived from the participants’ accounts of their understandings. Additionally, it describes the process in detail to enable others to follow what was done that relates to rigour. Using a hermeneutic phenomenological approach, I immersed myself in the data seeking to find what the participants understood of their interactive behaviours with chronically breathless patients. From the outset I was prepared to see the phenomenon afresh. I did not presume what the findings might reveal. I took, as best I could, the stance of a novice, ready to learn (Gadamer 1975/2004). Although presented as a linear, step by step process the analysis was iterative and reflexive. During the data generation stage, data generation and analysis inevitably took place simultaneously.

The search to find meaning from the participants’ descriptions resulted in the development of three themes, ‘Creating a facilitative space’, ‘Accessing and attending to your world’ and ‘Sharing my world’. Figure 11 presents a summary of the themes and sub-themes.

Figure 11: Summary of the themes and sub-themes
To illuminate and present the phenomenon, an in-depth thematic interpretation was composed. This is presented in Chapter Six. To remain true to the participants' understanding of the phenomenon, the thematic interpretation is richly exemplified with the participants’ own words. The thematic interpretation is a co-construction, ‘a fusion of horizons’ of the physiotherapists’ understandings and mine.
6.1 Introduction

This chapter presents the themes that interpret the participant physiotherapists’ understandings of their interactive behaviours when treating chronically breathless patients. By applying a hermeneutic phenomenological approach three themes were derived; ‘Creating a facilitative space’, ‘Accessing and attending to your world’, and ‘Sharing my world’. Within the theme of creating a facilitative space is the sub-theme ‘attending to our external world to influence our inner worlds’. Within the theme of accessing and attending to your world are the sub-themes of ‘authentic listening and attending’, ‘profound watchfulness’ and ‘empathic connection’. Within the theme of sharing my world are the sub-themes of ‘trustworthy and honest’ and ‘shared control - following, guiding and leading’ (see Figure 11). Together the themes form “an intricate unity” (van Manen 1990:105). No individual theme carries more importance; each contributes to a comprehensive picture that describes the phenomenon of the participant physiotherapists’ understandings of their interactive behaviours with breathless patients. For clarity, throughout this chapter the participants will be referred to as the ‘physiotherapists’.

The themes developed following intense reflective engagement with the transcripts and are my interpretation of what the physiotherapists told me about their understandings. Common behaviours and attitudes were described. However, the intentions guiding behaviours differed within and between the physiotherapists. Certain behaviours traverse all themes. The thematic descriptions illuminate the phenomenon. They are grounded in the participants’ understandings, which they expressed through words, entwined with what I perceived to be the essence of the phenomenon. Included alongside some of the participants quotes are extracts of relevant reflections, comments and interpretations from my research diary. The extracts, in comic sans font, are included to further illustrate how the thematic interpretation developed in a co-constructed way from the understandings provided by the physiotherapists and my personal interpretation of the data. The physiotherapists extracts have been edited for verbal fillers such as ‘umm’ and
‘ah’, repetitions and hesitations otherwise they are a verbatim account from the transcripts. Pseudonyms have been used throughout the descriptions.

6.2 Creating a facilitative space

The first theme that developed during the process of interpretation was ‘Creating a facilitative space’. This theme communicates the physiotherapists’ understanding that they intentionally shape the external interactional environment because it was perceived to have a significant effect on the patient, the relationship and the outcome of the encounter:

I definitely feel like we are creating an environment and how you create that environment makes a difference to your success or failure with the patient. (P4:I2:216)

Physiotherapy is a physical and emotional experience for the patient. Paying attention to the environment and nurturing an atmosphere of order, privacy, calm and safety is important because the environment has a profound effect on the patient’s feelings, behaviours and the outcome of the encounter. (Reflective notes 13.06.10)

Creating and sustaining a space that encouraged social interaction, a feeling of safety, and an effective physiotherapy session was understood to be complex, where many intentions merged so as to meet both the patient’s and the physiotherapist’s needs. The environment extended beyond the physical surroundings to include the subjective inner worlds of both the patient and physiotherapist. All the physiotherapists saw an interplay between the external environment and their and the patient’s physical and emotional experiences of the encounter. Various behaviours were used in combination to foster a space that the physiotherapists believed facilitated their relationship with the patient and the aims of therapy. At times, this understanding motivated the physiotherapists’ behaviours, where they intentionally constructed a facilitative space, at other times the physiotherapists were unaware of their behaviours. ‘Attending to our external world to influence our inner worlds’ is the single sub-theme of creating a facilitative space.
6.2.1 Attending to our external world to influence our inner worlds

The treatment sessions took place either on busy in-patient wards, where there was limited control over the external environment, or in the out-patient department where more control was possible as patients were seen in a private room. The physiotherapists aimed to create and maintain an ordered, undisturbed, unrushed, physically safe space. The behaviours described included preparing and organising the physical environment, reducing distractions and interruptions, taking time, attending to the patients’ physical safety, and modifying their body proximity, position and voice.

Prior to the interaction, the physiotherapists took as much control as possible of the surroundings. Specific attention was paid to giving an impression of order and calm, and was influenced by the physiotherapists’ preferred working environment. The following account from Claire is an example of the preparatory behaviours:

\[
\text{That’s part of how I work as a therapist .... In order to create a positive working environment and a calm working environment and to de-stress the working environment that physically I probably need the environment … I’d walk in the door and I’d clean everything up and then I start, that may just be me as a person. But also I think that for myself, that if I’m stressed or worried, that physical clutter around me is certainly highly contributive.}
\]

(P1:I2:124-128)

In busy in-patient settings, interruptions, noise and disturbance were understood to influence social interaction. As Lucy explained:

\[
\text{We don’t have that much control over the actual, whether it’s a quiet environment or it’s not, not that much control, but to some extent because there are buzzers going off in the background that would affect the patient interacting with you … and if there is too many people around.}
\]

(P5:I2:289)

The physiotherapists discussed deliberately modifying the physical surroundings on the ward to establish a private, comfortable space, free from distraction:
The curtain pulled aside is good for her privacy, but just to have a bit of quiet to let her catch her breath... it is to take away the distraction. (P1:I1:129-133).

External environmental factors e.g. noise, other people can be distracting and influence how the patient interacts with the physiotherapist. These factors cannot always be controlled. However, the physiotherapists use behaviours that attempt to avoid the patient being distracted by environmental factors. (Reflective notes 06.08.10)

A private room in the out-patient department provided more of a controlled environment which allowed for the development of a relationship. Catherine related:

*It feels like a very protected environment ... particularly because it’s a room with a door, with walls, not a cubicle. You do feel like you sort of enter another zone ... with that person with you.* (P4:I2:200)

Taking time and not appearing hurried were perceived to be important. The physiotherapists believed that if they appeared to be in a rush it would create a stressful situation and have a detrimental effect on patients’ emotions. As Claire put it:

*I suppose that sort of creating a really non-threatening environment by taking time because essentially if you were there an extra five minutes it doesn’t make any difference and I think that time is important. Just to allow them to prepare themselves for what you are going to ask them to do ... without making them incredibly scared. ...I think that being in a hurry will create a stressful environment.* (P1:I2:485-489)

The environment encompasses more than the external physical environment, it includes the subjective experience of the patient. The physiotherapists anticipate environmental stressors and take actions to modify them. This links with environmental psychology, i.e. the
relationship between environment and human thoughts, feelings and behaviours (Amedeo et al. 2009, Bell et al. 2001). (Reflective notes 13.06.10)

Additionally, it was thought that not having enough time with a patient reduced the opportunity of being able to listen to and converse with the patient. The in-patient setting was perceived to be more pressurised and thus provided less opportunity to take time. Emily gave the following account:

*Time, it’s pretty important. With a lot of new patients... we are lucky to have an hour [out-patient appointments], but even then that’s not often quite long enough, but it’s so that things don’t feel rushed. I think sometimes that can be quite difficult in an in-patient environment when there’s huge pressures or other factors coming, when sometimes things are shortened and you don’t feel that you have as much time to listen and talk as much as you would like to because of all the other pressures going on. (P2:I2:244)*

Treatments involved encouraging and assisting patients to use breathing control techniques, participate in challenging physical activities and/or to relax. To be able to do this, the physiotherapists believed the patient needed to feel safe. The physiotherapists created a space that enhanced the feeling of safety. Claire expressed this as:

*It’s about their physical safety, about creating and ensuring that they know that you’ve created a safe environment. (P1:I2:417)*

Patients should feel physically safe during therapy sessions. The physiotherapists aim to create a safe environment and communicate that intention to the patient. (Reflective notes 06.08.10)

The physiotherapists understood that by monitoring the patients’ physiology and providing feedback to the patient about their physiology, they were able to reassure the patient that they were safe. The following extract illustrates how
Emily was sensitive to the patient’s concerns and endeavoured to assure the patient of their physical safety during the exercise session:

_He was just talking about his heart rhythm problems and I was just reassuring him that I would keep an eye on that and that would be fine. I think it was at the back of his mind because he had mentioned it a few times. So you could honestly say that you had been monitoring that while he has been exercising._ (P2:I1:269-273)

Physiotherapy treatment usually requires being in close proximity with patients. The physiotherapists were aware that their proximity to the patient could impact on patient’s emotions. Their physical closeness to the patient was determined by the patients’ non-verbal responses, physical ability, and the physiotherapists’ own preferences. Judging proximity was recognized to be patient-specific, as Claire explained:

_The only thing you have to perceive is what you are doing at the time. I certainly know if someone was standing very close to me that would make me a lot more anxious. But again I guess that it’s something you should be able to judge when you look at a patient, and you look at their facial expressions. Some people like you to be a good foot away … talking to them and some people are happy for you to be up close and particularly this lady is fairly unsteady on her feet as well, and her son often supervises her walking so I think it is appropriate … that I was close._ (P1:I1:93)

The physiotherapists felt that being in close proximity provided reassurance to the patient and themselves that the patient was safe and supported during the therapeutic activity, and also fostered relaxation. Claire cited patient safety as the factor influencing her proximity to the patient:

_I get in close to somebody when I am mobilising them for safety… to help them feel safe._ (P1:I2:248)
Whereas Lucy perceived being close as a way of helping the patient to feel confident and calm, and to be able to provide assistance:

*I’m close and just trying to reassure her and support her through this technique and make her a bit more comfortable and more relaxed.*

(P5:I1:267)

Choice of proximity is individualised to each patient and the context. It depends on the physiotherapist’s

- understanding of the patients preferences for personal space (a response to the patients non-verbal cues)
- concern for the patients safety during an activity
- desire for the patient to feel physically safe and relaxed during a therapy activity. (Reflective notes 10.07.10)

By adapting their body position, the physiotherapists believed that they influenced the patients’ physical and emotional state. Positions were assumed to permit eye contact, reduce intimidation, encourage relaxation and minimise any undue physical strain on the patient. The physiotherapists intentionally positioned themselves to be at or below the patients’ level:

*I have got to a level where I can maintain a good eye contact with J… at this stage and it is very close and personal.* (P3:I1:220)

Claire described anticipating the patient’s anxiety and how she responded to this by deliberately modifying her position and proximity:

*I was quite aware of the fact that she was very anxious, she is an anxious lady and this is a probably slightly intimidating encounter for her. I thought … by coming down below her level just trying to lessen her perception of it being intimidating, and again, to help her feel relaxed, I certainly don’t think that if someone is breathless and anxious it helps if you stand over them and close to them.* (P1:I1:52)
At times, the physiotherapists’ choice of body position in relation to the patient was not consciously considered. Lucy reflected:

You don’t always think about it, you automatically just change your posture. (P5:11:150)

At other times, they thoughtfully checked and modified their position and proximity moment-to-moment throughout the encounter. This was determined by concern for how patients might feel about the physiotherapist’s physical presence. Their intention was to minimise patients’ feelings of powerlessness and for patients to get a sense of a shared and supportive relationship. The complexity of the physiotherapists’ decisions and actions is exemplified in the following account:

If I am moving them from a seated position to lying on a plinth I am always very conscious that … for them it is quite a vulnerable time where the power is definitely shifting from a one-to-one conversation at eye level with each other to me looking down over them and then lying vulnerable with me. So I’m always quite careful at that stage to try and back off a bit and say I’m sure this feels a bit strange and try and acknowledge the fact that I am aware that they might be feeling that shift. That having just got them comfortable in one setting you are shifting the power in terms of just physicality and then if they seem fairly comfortable with it I will pull up quite close to them because then I think that they feel that I am there with them and I am in it with them not that they are there on their own and I’m outside of them as such but that depends on how they seem to be. (P4:12:122)

There is sensitivity and awareness of, and attention paid to the physical power dynamics within the encounter. (Reflective notes 06.08.10)

Choice of body proximity, position and posture depended on the physiotherapists’ intentions and prior knowledge of the patient. A sufficient distance was maintained so that the patient’s sense of intrusion was minimised, but also to be close enough to allow observation of the patient’s facial expressions, body language and
monitoring equipment. The following extract, provided by Emily, illustrates the multiple intentions underlying the physiotherapists’ behaviours:

Not so close that they feel that their own personal space is being invaded, but … close enough so that you can ask questions, that they can hear because some of the patient’s obviously are a bit hard of hearing … that you can make good eye contact. In this particular instance..., I know the person and I know how they are going to react … and also you need to be able to … see objectively how they’re responding … especially when you are looking at oxygen levels and heart rates you need to be close so you can look at the monitor and they would have been prepared for that because that would have been put on and you would have said to them I am going to need to keep a close eye on that. (P2:I2:96-100)

The physiotherapists believed their demeanour influenced the patients’ experience. Lucy thought that being physically tense had a detrimental effect on the patient’s physical and emotional responses:

If I am quite tense I think that is going to influence her [the patient] as well and that might trigger her to be tense and more anxious. (P5:I2:209)

The physiotherapists were aware that their voices carried messages. Non-verbal aspects of voice such as volume, tone, tempo and pitch were thought to influence a patient’s physical and emotional state. As such, the physiotherapists deliberately adjusted their voices. The following description, provided by Lucy, explains the way non-verbal elements of voice were modified to create a relaxed environment and specifically adapted to individual patients and their particular problems:

I think just my tone, voice tone, … it wasn’t a very high tone, high pitched voice. So just maintaining that tone throughout the session. For me … that is important with that patient because I don’t want to … get them anxious. … I think voice is really important for me in that situation. So not
too low, sort of in-between. Not very fast, so slowed down quite a bit, just being patient and ... especially with an elderly patient whose got COPD and she is quite frail, ... I think she responds quite well to a slow pace of tone. I think just enough volume for her to be able to hear me quite clearly, not too loud either. (P5:I2:181-201)

Non-verbal aspects of voice were also consciously modified when talking to a relative or carer. Claire recounted:

Your voice becomes a little bit louder and a bit more direct and a bit more formal than when you were with the patient. (P1:I2:281)

Non-verbal elements of speech such as volume, tone, tempo, pitch are recognised to communicate attitude, convey emotion, or modify meaning. (Reflective notes 01.08.10)

Catherine adjusted the speed, volume and tone of her voice throughout the encounter depending on her purpose. She was unaware of the extent to which she did this. When reflecting, she commented:

That was so marked when I watched it back much, much more than I had realised I had done it at the time... I realised I had done it ... but not to that extent. So yes initially using voice, jolly conversation and here we are together again, off we go and just trying to use more conversationally tones. But then in the relaxation very much making it a slower, quieter, deeper pace to get that level of zone out, but then picking up the pace when you are coming towards the end of the session and then back up to a place of feeling ready to be back out on the bus. (P4:I2:200)

Emily was more aware of, and deliberately modified, her voice. She varied the volume and intonation because she believed it helped to motivate and encourage patients to accomplish the intended activity:

When you are actually doing some physical activity with them your voice is probably... your intonation is going up and down according to how much
motivation you think they need to achieve that because if you had a voice that’s sort of very low and monotonous it’s not going to enthuse them at all, whereas if you’ve got someone whose voice is maybe louder a bit more fun in it, motivating them, they can then achieve that. I think probably that’s a conscious decision of where you are with that particular person’s treatment whether it needs to go to quieter… as to what you are actually trying to get them to do. (P2:I2:116-120)

The non-verbal behaviours used to create and maintain an environment that facilitates an effective physiotherapy session appear to be highly complex. Various combinations of non-verbal behaviours are described. These behaviours are understood to provide an environment that supports the patient’s needs and preferences. Non-verbal behaviours include modification of the external physical setting by the physiotherapist’s use of position, body language and voice. These behaviours are thought to decrease the patient’s anxiety and to help the patient feel safe. (Reflective notes 20.06.10)

Claire was unique in recounting how she adapted her voice to manage her own emotions and to compose herself during the therapy session:

*If I use my voice like that it helps me feel calm it’s the sort of voice I take when I am angry or it’s the sort of voice I adopt if I am busy and you know that helps me in my mind to slow things down and if I feel like that I am nice and calm then that certainly helps when you are treating a patient.* (P1:I1:113)

Non-verbal behaviours are also intentionally modified to influence the physiotherapist’s thoughts and feelings. This links with environmental psychology, the physiotherapist’s preferred environment (Amedeo et al. 2009, Bell et al. 2001). (Reflective notes 13.06.10)

During the physiotherapy activities, participants intentionally adapted how much they said and what they said. Their aim was to keep the patient relaxed using a balance of direct instruction and a conversational style. Claire recounted:
I am trying not to talk too much, just ... trying to give short simple instructions, having that conversation, but making things nice and ordered just to try and help her feel calm. (P1:1:28)

The way the physiotherapists describe creating the environment resonates with how I perceive physiotherapists should manage the therapeutic ‘space’. The patient is the vulnerable partner (distressing symptoms, unfamiliar surroundings) and the physiotherapist endeavours to be aware of and modify features of the environment with the intention of improving the patient’s experience of the encounter. (Reflective notes 26.08.10)

6.3 Accessing and attending to your world

The ‘Accessing and attending to your world’ theme represents the various approaches taken by the physiotherapists to develop a holistic understanding of the patient’s world. Understanding the patient’s experience, their individual needs and circumstances was at the heart of the encounter. The physiotherapists endeavoured to gain in-depth knowledge about the unique aspects of the patient’s world through listening, watching and empathic behaviours. They believed that understanding the patient’s experience was crucial in order to provide appropriate and effective therapy.

Accessing and attending to the patient’s world involved intense focus on what the patient said and did. Moment-by-moment unwavering multi-sensory attending and responding aimed to understand and acknowledge the patient’s thoughts, emotions and physical state. Attention was given to the patient’s whole being. Understanding the patient’s experience was perceived to be central to the encounter, as Lucy explained:

It is the patient’s experience and they are saying to you what they are going through and what sort of symptoms they are experiencing, so that’s the most important bit of information. (P5:1:112)

The patients experience is the focus. Profound attention is paid to accessing the patients experience and understandings, as these are
seen to be significant. The physiotherapists do not assume they already understand the patient’s experience, emphasis is placed on eliciting the patient’s perspective. (Reflective notes 30.08.10)

As they listened and watched, the physiotherapists continuously tried to make meaning of the patients’ words and physical responses. To reach a deeper understanding of their patient the physiotherapists interpreted what the patient said and did, and sensed and focused on the patient’s emotions. The following extract, provided by Catherine, represents the multifaceted nature of how the physiotherapists access and attend to the patient’s world:

*It’s almost as if you can see into the person. … Somehow as they are talking and the gestures they are making and the bits of their breathing that they are doing, that they don’t even realise they are doing but you can see. … Then somehow how you are emotionally into where they are at, because you can suddenly see something about the way they are looking at you, you can see that they are starting to be upset and you can see that quite a while before it becomes… the emotion that is then there to be dealt with. But you can see it building and then you can see physiological things … if they look pale or red … or are about to fall on the floor because their blood pressure has just dropped.* (P4:I2:170-174)

Physiotherapists are trained in physiological and physical assessment. This requires keen observational skills. However, in addition the physiotherapists simultaneously pay attention to the patient’s body language and non-verbal elements of speech. They talk of a holistic moment-by-moment vigilance that goes far beyond the patient’s physiology and physical symptoms to include the patient’s thoughts, emotions and perceptions. This holistic attention concurs with how I practice, having a moment-by-moment awareness of and response to patients’ multiple verbal and non-verbal cues (conscious that these express both the patient’s physical and affective state). (Reflective notes 10.09.10)

This holistic understanding of the patient informed how the participants’ proceeded with the encounter. Claire related:
I would think of it as a bigger picture, I think the physical bit is such a small bit. Well, not necessarily the physical bit influencing what I’m going to do but … everything else influences the way I go about doing it. Yep, the patient’s emotional state, just the background they’re experiencing, their family, their expectations. (P1:I2:297-309)

The quest to understand the patient’s world and experience was a feature of the physiotherapists’ understandings of their interactive behaviours. The physiotherapists revealed a great awareness of being the receiver and interpreter of patients’ verbal and non-verbal behaviours, but recounted less awareness of transmitting messages through their own verbal and non-verbal behaviours.

‘Authentic listening’, ‘profound watchfulness’ and ‘empathic connection’ are the three sub-themes of ‘Accessing and attending to your world’. Listening and watching empathically to become immersed in the patient’s world were explicitly expressed and interpreted to be significant behaviours during interactions with breathless patients.

### 6.3.1 Authentic listening

The physiotherapists wanted to develop a genuine understanding of the problem the patient presented with and did so through active listening. Multiple, simultaneous verbal and non-verbal behaviours were used intentionally to communicate their attention and interest in the patient. The physiotherapists focused on what was said, were eager to listen to and understand the patient’s lived experience and were willing to give the time needed for the patient to fully express themselves. Patients were encouraged to describe their story and were attended to with empathic understanding and acceptance. The physiotherapists did not assume they already understood the patient’s experience. They put themselves in the place of the patient and tried to see the world through the patient’s eyes. Lucy describes this feature in the following extract:

If I am explaining what my problems are I would like someone to actually not just hear my problems but actually listen to what I have to say so ... they can fully understand what I’m going through... So just being supportive and listening to what the patient is saying, and for me that
would help me as well, because I can basically take the patient’s feelings into consideration and then plan from there and plan that in my treatment, what their main problems are. (P5:I2:229)

The physiotherapists believed that a key part of their professional role was to listen to the patient’s worries and difficulties and to demonstrate that they were listening. This aspect was explained by Emily:

What is important is that they feel that they are being listened to, that’s why they have actually come to you as a professional. That their … concerns and problems are being listened to and you show them that you are listening to them by how you are behaving, responding, and what you are saying to them. (P2:I2:20)

Listening was communicated through a variety of coordinated non-verbal behaviours such as; eye contact, posture, gesture and touch. Regular eye contact was perceived to demonstrate attention. The physiotherapists believed that without frequent eye contact, communication could be hindered, with the risk that the patient may not feel listened to. Catherine recounted how she deliberately used eye contact to convey interest and attention whilst simultaneously writing notes:

I am trying to make the initial notes as I am going along and am also trying not to be looking down all the time so that she feels that I am actively listening to her and I am actively interested in her. … So the combination of the two looking up, looking down, looking up, looking down. (P4:I1:14)

Emily also described being aware that writing notes could be perceived by the patient as disinterest. She intentionally prepared the patient to prevent this perception:

I mention to people I am just going to take notes because they might feel that maybe you are not listening to them but having … mentioned that you are going to be doing that they are aware that you will be … and that’s
just part of your practice. So don’t worry if I’m writing, I’m still listening. (P2:I2:272-276)

In addition to eye contact, Emily used her body position and posture to communicate interest:

“Yes, a lot of eye contact going on, leaning forward, hopefully … a lot of positive signs going on there.” (P2:I1:20)

Accurately timed gestures such as smiling and affirmative head nodding were considered to convey attention and engagement. Reflecting on her understanding of how she listened, Emily said:

My understanding of active listening is obviously the patient is conversing with you and by using things like eye contact, nodding, smiling to the patient, doing those things at the appropriate time, it shows … it would hopefully impart to them that you are listening to them and engaging in what they have to say. (P2:I2:40)

Non-verbal behaviours play a significant role during the interaction. Listening is purposefully communicated. Body language, posture, gestures, eye contact, touch and non-verbal elements of speech convey attention and support. (Reflective notes 21.10.10)

The physiotherapists displayed a tacit understanding that touch communicated compassion, that it conveyed support and showed concern for a patient’s distress. Claire described using touch instinctively to demonstrate care for her patient:

My hand normally goes there naturally I don’t know why. … the patient knows how to catch her breath but sometimes I think it is nice if you are there and you are acknowledging that they are short of breath, to just have some hands on even if it’s not really a therapeutic hands on. (P1:I1:129)
Emily’s compassionate touching was purposefully selective; before touching, she made an appraisal of how receptive she thought individual patients might be:

*When sometimes you ask a question and you get a reaction that you really are not expecting, hopefully by that time you’d have judged whether that person is someone who likes to have … a hand put on them just to say its ok to be like that, do you want anything?* (P2:i2:96)

The extent to which the physiotherapists were aware of their non-verbal behaviours varied, sometimes the physiotherapists used non-verbal behaviours purposely as previously described and at other times they used them intuitively. Claire observed:

*I don’t think you are aware of it all the time, obviously you consciously are sometimes, but no I don’t think you automatically think I’m working in a body posture, I’m working in a face.* (P1:i2:449)

*Gestures such as smiling and affirmative head nodding are frequently utilised to convey attention. However, these non-verbal behaviours are often unconscious actions.* (Reflective notes 09.10.10)

Whilst observing herself on video, Catherine became more aware that her non-verbal behaviour may disclose less supportive thoughts and emotions:

*I kind of take the big breath in and kind of pause, so I guess she realises that I am going to say something and then when I say it I kind of waggle my head and then I think I do pull a sort of mouth gesture that indicates that I am not kind of all that happy with it.* (P4:i1:34)

To understand the patient’s perception of their problem and associated emotions, the physiotherapists encouraged dialogue and communicated with an open and compassionate attitude to what was, or might be, disclosed by the patient. Catherine describes encouraging the patient to talk so she could:
sort of tune into her and where it is at in her head….. trying to explore there was anxiety. What anxiety there is behind this because I am reasonably convinced that her breathing problem is anxiety or trigger driven and up to this point she hasn't really bought into that idea at all. But in a way, by trying to get her to explain what it is about, what she has read and thought about what she has read, I am starting to get a bit more insight into her psychological state. (P4:1:116-120)

Similarly, Lucy explored the patient’s views and psychological state:

… looking at things like depression, whether she is quite low in mood … basically her thoughts on the disease and the disease process and how it has been affecting her. (P5:2:98-102)

Patients’ thoughts and feelings are explored. There is openness to developing an understanding of the patients’ affective state in addition to their physical state. Links with ‘receptivity’ (Moustakas 1995). (Reflective notes 09.10.10)

The physiotherapists encouraged patients to talk in order to gain a richer understanding of the patient’s problems, thoughts and feelings:

I think just talking to your patient you are picking up on lots of physical things happening with them, what is happening there and then in reality and by what they are saying they are giving you an idea of where they are from an emotional and a mental point of view. (P2:2:48)

Verbal behaviours involved asking questions, minimising interruptions, summarising and acknowledging what the patient said. Emily recounted asking questions at the beginning of an encounter to acquire greater understanding:

… some idea of who they are and what their knowledge is. … Initially some of it is not going straight into the nitty gritty, definitely. You’re just
trying to get an idea of ... what is their problem? What is their understanding of why they have come? (P2:12:44)

Claire commented that non-verbal gestures alone could prompt the patient to expand on their understandings:

Just by nodding you are inviting them to discuss, to talk a little bit more. (P1: 12:377)

The physiotherapists were also sensitive to what the patient might not be saying, and encouraged additional disclosure through direct, focussed questioning. Catherine explained how she elicited a better understanding of the patient’s symptoms:

I felt very conscious that she wasn’t going to tell me about all the detail of her cough and her sputum and was making very light of it all. So I was trying to dig a bit more into finding out about how bad she had really been and digging into the colour of the sputum and things because she is inclined to just say ‘oh it’s fine, it’s fine, I’m fine, I’m fine’. So I was trying to make her feel relaxed so that I could get a bit more information out of her and then going back over “well it’s alright now” but was it, and then finding out in fact it hadn’t been and just clarifying for myself that in fact she had actually been quite unwell. (P4:12:8)

At the same time the physiotherapists voiced awareness that the conversation was unfolding in the moment and what they said may have consequences on what the patient divulged. Catherine describes this in the following extract:

I was a bit conscious I might be leading her at that point. I was trying to lead her to talk to me but ... I didn’t want her to just tell me what she thought I was wanting her to say. (P4:11:20)

Care was taken not to interrupt or say too much. Participants listened to patients’ stories with discretion and carefully considered what they said and did to avoid
influencing the patients’ accounts. They allowed time for the patients to draw on their own cognitive resources:

I was trying to be careful here not to speak too much, I was trying to give her time to speak and to expand on what she was telling me, even though in a way it was bringing out some of the things she was doing, that I don’t want her to do. I was almost trying to let her demonstrate all of that and think a bit more deeply herself about what she was doing and why she was doing it, where I was conscious if I kept interjecting with my thoughts of where we were up to she wasn’t saying as much. (P4:I1:112)

Participants summarised what the patient said to confirm their understanding was correct. The intention was to allow the patient to correct any misinterpretations so as to acquire a mutual, comprehensive understanding of the patient’s experience and problem. Emily explained that:

By summarising you give them a chance to, if you haven’t quite picked up on exactly what they are saying … to say well, actually, no I meant this or I meant that. So between the two of you, you have a full understanding of what is going on at a particular point. (P2:I2:40)

The intention of listening attentively (using verbal and non-verbal behaviours) is to obtain as accurately as possible an understanding of the patient’s experience. (Reflective notes 09.10.10)

Having assimilated her understandings about the patient, and verbally summarising them, Catherine felt she supported and corroborated what the patient was expressing or trying to express:

Somehow you summarised something or brought a series of pieces of information together that they maybe don’t even realise until you say it, is significant for them. Sometimes they already know and it’s just the fact that you have said it validates it, sometimes it’s the fact that you even come up with the idea that then suddenly seems to fit that validates it, makes it sensible. (P4:I2:272)
6.3.2 Profound Watchfulness

The physiotherapists’ watchfulness was continuous, vigilant and wide-ranging. They monitored and observed to understand the patient’s physical and emotional world, and to detect any changes:

Obviously there is always some checking and making sure the patient is comfortable with what they are doing and obviously if at any point he had been distressed with anything you would be able to recognise that. (P2:I1:366)

The objective physical assessment and evaluation of the patient was frequently mentioned. A typical example was provided by Roberta:

I need to have a listen to her chest before I start so I am going to have a look and also check her oxygen levels. (P3:I1:48)

Observation and interpretation of the patients’ physical signs and body language occurred simultaneously:

Looking for any obvious signs of distress when her shoulders start going up and she starts breathing a bit harder … basically just looking at her. I look at her facial expressions as well, I am looking at when she is very comfortable, and you can see it when she starts working harder she is not looking anywhere she is very focused she just wants to continue and … has that look on her face. (P3:I1:190)

The physiotherapists paid attention to the patients’ non-verbal expressions of emotion. They were acutely aware that patients frequently experienced anxiety and they watched for it. Lucy gave the following account:

Looking at how tense she is and her body language, to tell me what her anxiety levels are, to give me an idea of what she is like, what type of person she is and also how the disease is affecting her. (P5:I2:94)
Physical assessment is central to physiotherapy practice. However, body language that expresses underlying emotion is also perceived and assessed. There is sensitivity to patient non-verbal cues. (Reflective notes 01.10.10)

Face to face contact was maintained to observe the patients’ facial expressions and responses:

*Trying to maintain eye contact and also just observing the patient’s facial expression and how she responds to the questions asked.* (P5:I1:162)

The physiotherapists were attentive to patients’ voices and were aware that nonverbal speech sounds could indicate disparity between what the patient said and what they were thinking or feeling. The following extract illustrates how Catherine’s attention focused on nonverbal aspects of speech as she simultaneously processed verbal information:

*I think she is making all the right noises but I don’t think they are genuine.*

“Oh yes dear … there, there. I’ll try and say what you want to hear me say”. … *The things I am picking up on is not so much what she is saying it is how she is saying it and the tone of her voice and things. The sort of intonation, even just the noises she is making are not convincing me, I guess it is quite a subtle thing to be interpreting.* (P4:I1:74)

*There is sensitivity to vocal cues and body language, which take into account the personal and social context of what is being communicated.* (Reflective notes 21.11.10)

The listening and watching behaviours appeared to be habitual unless confronted with an unexpected response from the patient. The physiotherapists quickly processed an unanticipated patient reaction and consciously tried to resolve the difficulty. Emily provided the following description:

*I think most of it is just automatic now, … there is the odd occasion when I think something does happen where maybe you are not expecting something, or a certain response or a reaction which does make you as a
practitioner sort of sit up or stand up for a better word and try to work out what’s going on there. … I suppose then you are actually really thinking very hard as to how do I cope with this? Which way am I going to go? There is obviously a reaction here I’ve not … wasn’t responding to. How do I respond to that, that still makes this person feel safe and confident and … happy to be here. I think most of it is definitely intuitive but obviously there has to be some sort of consciousness because then you react to it. (P2:I2:108-136)

Listening and responding to patients’ individual experiences is central to physiotherapy practice and success. To listen involves continued attention and response to a patient’s verbal and non-verbal communications during the interaction. This links with Suchman’s (2006) theory of complex responses patterns of relating. (Reflective notes 10.11.21)

6.3.3 Empathic connection

The physiotherapists intentionally established an empathic connection with their patients. They experienced and demonstrated empathic understanding of their patient’s unique perspective. The physiotherapists were receptive and open to patients’ physical and emotional experiences and offered validation. This empathic approach underpinned their listening and watching behaviours. The physiotherapists interwove an empathetic presence moment-by-moment in their practice. They believed that effective therapy depended on their empathic approach to the patients’ individual perceptions, problems and concerns:

The key thing is that a patient is coming to you with specific problems that they are feeling or physical problems that they have that are very real to them and therefore it is important that you listen to those problems because they are very real problems to them. Unless you … understand them and have empathy with them then I feel it is going to be … difficult to then get them onboard, to then try and move them on and address those problems. (P2:I2:36)
Listening and watching provides access to the patient’s world and engenders empathy. Authentic listening and profound watchfulness allow reflection in the moment on the patient’s thoughts and feelings. The understanding gained guides the physiotherapy intervention. Links with Moustakas (1995:80) relationship facilitating process, ‘attunement’. (Reflective notes 20.09.10)

Through sensitive and receptive listening and watching, the physiotherapists could access the patient’s world and respond to their emotions. An empathic approach was perceived to be necessary to truly understand the patient’s experience. Emily described empathy as:

Carthy (2009:178) describes empathetic listening as: 

*trying to have an understanding of their issues, their problems and ... how those problems and issues have arisen and trying to put yourself in their shoes as to what is going on, and feeling sometimes that it is just horrendous.* (P2:I2:168)

Not only are the patient’s emotions listened to and observed but the physiotherapist seems to have the ability to feel the patient’s emotions. (Reflective notes 03.10.10)

To gather appropriate and significant information from the patient, the physiotherapists endeavoured to be sensitive, non-judgemental and avoided criticism, as Catherine explained:

*Catherine (2009:176)* describes empathetic listening as: 

*I just try to really engage in an adult to adult style of conversation so I'm not being like a teacher that is talking to a child or I'm not telling them off for choices they might have made in their life ... if you ask about smoking and they guiltily admit it, I always pass some comment about ‘its very difficult basically I can completely understand’. I try and make sure that they don’t think I am judging them.* (P4:I2:36)

Being attuned to patients’ feelings was thought to facilitate the relationship and to have positive consequences on patients’ motivation and commitment. This understanding was expressed by Lucy:
We understand what they are going through, empathise with them, also ... we want them to trust us. Just trying to establish a relationship with the patient and I think that affects our management of the patient and how they respond to us ... and how much they work with us in treatment sessions. (P5:I2:56)

Empathy was conveyed through the type of questions asked as well as accurate reflection and summary of the patients' thoughts, feelings and concerns. Emily said:

You are acknowledging what they have suffered has been awful and by acknowledging that and ... through saying it and summarising ... by having done that they hopefully realise, they will understand that you realise what they have been through has been awful. But you are there to help them to the best of your ability. (P2:I2:176-180)

By accurately reflecting the patients experience and feelings the patient will perceive the physiotherapist is empathic. (Reflective notes 20.08.10)

Claire purposefully used non-verbal and verbal behaviours to convey her empathic understanding:

I am sitting down in front of her so I am not towering over, again to make her feel comfortable and calm, and just acknowledging that I know that she had had a bit of an upset morning, and trying to acknowledge anything she might be feeling. (P1:I1:12)

By using these behaviours Claire believed she could:

... get her [the patient] feeling that I am thinking about everything, and that I am feeling for her. (P1:I1:20)

The physiotherapists sensed patients’ emotional states, and recognised that emotions could be expressed verbally or non-verbally. They were aware of,
acknowledged and responded to patients’ emotional experiences. Patients were
given the opportunity to explore their feelings further, either immediately or at
another time. Emily recounted:

Some patients, when certain things are said that are obviously very
emotive, and sometimes you get reactions that you weren’t prepared for.
… You would obviously acknowledge that they are upset. Do they want to
talk about that further or do they want to leave it there? Or maybe it’s not
the right time at that meeting to discuss that but possibly in later sessions
it might well be. (P2:I2:48)

When dealing with patients’ emotions, the physiotherapists maintained an
empathic stance to be able to guide and support the patient to find answers and
make changes to overcome their problems. They endeavoured to prevent the
patient or themselves becoming overwhelmed by the patient’s feelings. Catherine
describes this in the following extract:

It’s trying to be in a position where you can understand them but you are
not so caught up being them that you can’t find a way forward. So you are
not so emotionally empathetic with them that you are sympathetic … to the
point of being distraught yourself to the level at which they are distraught
… but that you are suitably empathetic to think for them what’s their way
forward. (P4:I2:192)

The physiotherapists suggested that it was not always possible to understand
patients’ experiences and emotions but believed it was important to attempt to
understand and to reveal that understanding to the patient:

I think it’s important to be aware of your patients and show an awareness
of your patient’s feelings and … try to understand, but sometimes we can’t
understand. (P1:I2:212)
A lack of interpersonal skills and objectification of the patient were thought to have a negative impact on the patient, the assessment and their therapy. Lucy gave the following description of poor interactive behaviour she had observed:

Some of them [other HCP] have got an aggressive tone when they speak to patients and are quite impatient as well. ... If someone is really stressed out they might take it out on a patient and actually try and rush things but with some patients you need to slow things down. So I have seen that with some people, aggressive tone and also being quite distant with the patient. A lot of the patients I have seen don't appreciate that at all, treating the patient like an object more than an individual, than a person. Also not introducing themselves and just getting on with things. ... That would influence assessment, it would influence treatment and ultimately the patient's satisfaction. (P5:I2:366-370)

Poor interactive behaviours can have a detrimental influence on the therapy process and the patient's experience of therapy. (Reflective notes 25.10.10)

One of the physiotherapists, Roberta, was atypical in that she focused almost entirely on the patient's physical state and the medical equipment during the encounter. She attributed this to being unemotional. However, the interaction was in the intensive care setting which may have influenced what she attended to. However, having observed herself she thought that she used empathic behaviours unknowingly:

I think I'm quite an emotionless person (laughing). It's not surprising that I'm thinking about the physical, you know, the equipment, but I do subconsciously do some things which I'm not even aware of, but I don't think about them. (P3:I2:310)

Physiotherapists vary in how consciously aware they are of their interactive behaviours. (Reflective notes 20.09.10)

Throughout the treatment session the physiotherapists describe assimilating vast amounts of detail about the patient's beliefs, attitudes, physiology, physical signs
and, verbal and non-verbal behaviours. This multidimensional assessment and interpretation of the patient’s world informed how the physiotherapists went about merging their world with their patient’s. Catherine’s account illustrates this:

There is a lot of calibration going on about the level of what you are seeing as well as what you can see about what that is telling you. About where the person is at in that certain range of things emotionally, physically, knowledge, understanding, skills to be able to take themselves forward, specific things like that. In general, a lot of calibration going on that changes how you put your point across, or whatever you do to put your point across. (P4:I2:186)

6.4 Sharing my world

The ‘Sharing my world’ theme encompasses the behaviours the physiotherapists used to achieve a shared understanding and purpose with their patients. Each brought to the relationship their own world of knowledge and experience. The physiotherapists perceived that through engendering trust, displaying honesty, and sharing control with their patients, the two personal worlds combine. There was a sense of collaboration. The physiotherapists portrayed that they were on the patient’s side but at the same time offered their own understandings. Their interpersonal and technical knowledge, experience and skills were made available and shared. The physiotherapists sought to empower the patient. This was accomplished by merging the patients’ unique problems and choices with their own knowledge to reach agreement on the aim of therapy and the tasks required to achieve that aim. The physiotherapists’ desire was to create a mutual understanding through which therapy goals could be negotiated. Throughout the encounter the physiotherapists intentionally shared control to help the patient achieve effective performance of shared goals. The physiotherapists’ intention was to create and sustain a collaborative and productive relationship during interactions. They described the stance of an informed companion on a journey with the patient, and working collaboratively with the patient.

The theme ‘Sharing my world’ encompasses two sub-themes ‘trustworthy and honest’ and ‘shared control - following, guiding and leading’. These sub-themes were explicitly expressed by the physiotherapists and interpreted to be significant.
The physiotherapists used verbal interpersonal exchange and non-verbal behaviours to share their world with their patients’. Some of the behaviours appeared to have been implicitly learnt with experience, the physiotherapists only became aware of them when observing themselves on the video recording.

6.4.1 Trustworthy and honest

The physiotherapists intentionally communicated to the patient that they were trustworthy. During the treatment session they explicitly articulated their beliefs about the patient’s current state, future possibilities, and their expectations of the relationship. Establishing a trusting relationship was perceived to be crucial if the patients were to share personal concerns, participate in goal setting and therapeutic activities, and have positive expectations of the benefits of therapy.

Engendering trust was seen to support treatment by making the patient more willing to follow advice and form an alliance with the physiotherapist. Roberta commented:

I think collaboration comes from trust, so if J can trust me then I’ll be able to treat her, it’s all in her benefit and she is going to be safe with me, then she’s going to collaborate with the treatment if she knows it’s in her best interest to do it. (P3:I2:218)

Gaining the patients trust is central feature of a collaborative relationship and the therapy process. (Reflective notes 23.11.10)

Lucy echoed this whilst reflecting on why she felt being trustworthy was necessary:

It’s really important, trying to establish trust with the patient, establishing a relationship with the patient … If I were a patient and if I didn’t trust somebody I would never comply with what they told me. (P5:I2:265)

She went on to say she wanted the patient to feel:
You can trust me number one. That you can confide in me and you can share your problems, so you need to feel comfortable in sharing information with me and, just basically believing that we are trying our best to help the situation, ... supporting the patient to feel supported by me.” (P5:I2:277)

From the outset, the physiotherapists aimed to engender trust and used a variety of strategies to achieve this feature. With only limited time available, Emily felt her interpersonal skills were crucial in quickly developing a trusting relationship:

First obviously when you see a new patient, with a very short space of time, just the way you introduce yourself, you welcome them into the room, you’re getting that interaction with that patient, forming a relationship with that person, one of trust. (P2:I2:44)

Whereas Claire purposefully sourced patient information prior to the encounter and communicated that knowledge to the patient as an approach to engender trust:

Before I’ve seen them to get as good a background picture as you can, ... you don’t want to have to be asking them a lot of questions that you can otherwise find the information, ... it helps them feel like you have got some control and it helps with their trust in you that you have come armed with that, certain bits of knowledge. (P1:I2:501)

One of the physiotherapists was unique in how she demonstrated her trustworthiness. She intentionally provided the patient with a detailed explanation of her experience. Catherine recounted:

Initially, when I am first seeing them I want to send the message that I’m a professional and this is my background, these are my skills, this is how I think I might be able to help, ...and I want people to trust me quite quickly, which is why I try to be very professional ... but feel they are comfortable to be able to trust me with things that might be difficult and that they
wouldn't necessarily speak about with someone else but equally try and keep that professional sort of, not exactly a boundary, but a certain amount of distance. (P4:12:28)

She continued to verbally confirm her authenticity:

*She talks a bit about … what a good doctor he is and how much faith she has got in him and that how he told her that by coming to see me she would get better. So then I try and reaffirm that kind of positivity by saying how long I have worked with … [the consultant] … and where else I have worked with him and how many other people I have seen to try and give her insight into feeling she can trust in that we are doing the right thing.* (P4:11:356)

Additionally, Catherine recounted, in the words she had used, how she had communicated her specific expertise relevant to the patient:

*I've treated a lot of patients and … that in one year I saw several patients with the same problem so I've seen it a lot, I am very familiar with it. … my specialty is cardiorespiratory physiotherapy and I've got a number of years experience in this area etc.* (P4:12:36)

The physiotherapists' interactive behaviours are influenced by how they want to be perceived by the patient and the type of relationship they want to create. Trustworthiness is portrayed through communication of knowledge and experience. (Reflective notes 25.11.10)

Emily also described speaking of her experience to patients:

*You can say to patients, I have treated many patients with this particular problem.* (P2:12:248)

Non-verbal gestures and eye contact were understood to communicate trustworthiness but were not always used consciously. Claire thought her use of
these non-verbal behaviours was a result of her growing confidence and experience of being with patients:

*Sometimes I do it [nod] to emphasise my point, if I am nodding at them it’s like I am telling the truth. … It is … a means of reassurance I suppose. I think eye contact is important and I hope that I provide all the patients that I see with eye contact. I think it comes with being confident around the patient and comfortable around a patient … its all about, … getting your patients to trust you, getting your patients to feel confident in you, giving them eye contact. I was certainly not aware of doing the nodding.*  
(P1:I1:169)

Having accessed the patient’s world and established trust, the physiotherapists articulated their beliefs about the patient’s current physical state and future potential. Examples of the physiotherapists’ open and honest communication of their opinion of the patient’s current situation are provided in the following extracts from Claire and Emily:

*Reinforcing that this was her and her at the most she does.*  
(P1:I1:141)

*Again just clarifying exactly where he is and the implications of that.*  
(P2:I1:16)

*The physiotherapist wants to understand the patient’s experience but also offers and expresses their opinion of the patient’s illness and impairment.*  (Reflective notes 10.12.10)

Being realistic with patients was believed to be important. Claire felt her experience had taught her to be honest with patients about the severity of their condition, not to give them false hope and to express her expectations of the patient:

*I think that with more experience you realise the importance of not giving unrealistic expectations … or saying to someone that is sick you are going*
to get loads better, … it’s … ensuring that they are aware of your expectations as well … providing you are realistic. (P1:l2:393)

Emily described how she swiftly corrected any misapprehensions with an explanation; compatible with what she believed was the patient’s ability to understand:

*Having assessed them, and by what they are saying to you, that maybe what you are finding isn't quite what they think is the same thing as why they have come. It is then explaining that and explaining to them in terms that they understand.* (P2:l2:20)

The physiotherapists expressed that they appraised, summarised and clearly articulated their understanding of the patient’s situation:

*We say to patients this is where you are, this is where I think you are going to be, this is how we can get there, and that’s what you do in this situation. You are saying this is you, this is as good as its going to get and you are doing it really well.* (P1:l2:391)

Emily believed this approach developed with experience, she did not intentionally decide to do this:

*A few years ago I was probably making a lot of conscious decisions … but now the way I practice is very much, this is where we are, this is where you want to get to, this is probably what we are going to need to do for you to get there and get you onboard to do that.* (P2:l2:72)

One of the physiotherapists described a more direct approach than the others when explaining to the patient how she saw her role and her expectations of the patient. Catherine clearly articulated to the patient that she expected them to take responsibility and be an active partner in therapy. Catherine provided this account of how she unambiguously stated her expectations:
I explain very clearly ... that I am expecting them to take themselves through this journey, with my guidance, and it's them that's going to make themselves better. ... When I see them the next time if that's not where we are going I will very clearly restate that this is where we need to be going, if you can't commit to this then I am not going to be able to help you. (P4:i2:32)

The therapy process is a guided 'journey'. The physiotherapist articulates what steps they would like the patient to take. There is an honest explanation of responsibilities and expectations. (Reflective notes 10.12.10)

6.4.2 Shared control - following, guiding and leading

The physiotherapists shared power with their patient. They skilfully tailored control by following, guiding, and leading their patient moment-to-moment depending on their purpose. Predominantly, during goal setting, therapy planning and activities the physiotherapists purposefully followed the patient lead, and shared power. During therapy activities power fluctuated, the physiotherapists intentionally followed, guided or led the patient, depending on the severity of the patient’s condition and the physiotherapist’s concern for the patient’s safety.

Throughout goal setting and treatment planning, patients were empowered to make their own decisions. The physiotherapists entered into dialogue with the patient to establish mutual goals and plans. They invited the patients’ opinions, expected patients to make choices and to say what they wanted to achieve from the intervention. Lucy stated:

If we make decisions for patients, we don’t actually know what the patient’s main problem is and we formulate the problem in our own heads thinking this is the problem ... it’s almost like a dictatorship type relationship. I think the best way to go about it is getting a patient involved and asking them what is it like for you, and ... based on our assessments as well. Trying to form a relationship with the patient and making a plan from there, making a problem list and then going from there. What’s important to the patient as well is we need to respect their opinions,
respect their choices, asking them what they would like to get out of the treatment. (P5:I2:257)

An understanding of the patient's experience, the physiotherapist-patient relationship and fostering patient autonomy are features of a successful therapy process/journey. The encounter is viewed as patient and relationship centred. The physiotherapists recognise the importance of understanding and responding to the patient's views, opinions and perspective. Interactive behaviours aim to enhance the patient's ability to name their problems and the therapy relationship. (Reflective notes 06.01.11)

Generally, mutually acceptable, patient centred, realistic and achievable goals were sought. If the physiotherapists believed, based on their experience, that patients' aspirations were unrealistic, they openly discussed their concerns and endeavoured to help the patient develop more realisable goals. Emily said:

*I think all goals need to be realistic and achievable but with the view that is obviously where they want to get. … It’s having that discussion and trying to get them to understand that that is probably never going to be achievable and can they rethink what they actually do want to be achievable, on the back of obviously having seen lots of patients with possible similar things, what might be the more achievable.* (P2:I2:68-76)

However, the degree of autonomy was patient-specific. In-patients that were medically unwell appeared to be less empowered. Goal setting with in-patients primarily centred on enabling patients to become functionally independent for discharge. The physiotherapists initially secured a mutual purpose with the patient but during follow-up treatments goals were not necessarily made explicit. It was assumed that previously agreed plans still applied. Claire gave this account:

*Essentially with that lady from memory you were still thinking about discharging and what physically she needed to accomplish before she could. … Being able to walk a certain distance, which essentially we would have spoken about before. I think … at a very simple level making*
those goals together so that they can see that when you have done this you can go home. (P1:I2:465)

Collaborating on goals with in-patients that were unwell was perceived to be more difficult. To counteract this Claire intentionally explained what was happening and what she was doing with the patient:

... give them a good explanation as to what you are doing and why you are doing it and even if it's not appropriate to fully talk about all the goals with the patient because they are too sick to do that. (P1:I2:281)

The physiotherapists aim to negotiate mutual achievable therapy goals. However, a more bio-medical paternalistic approach appears to predominate during encounters with in-patients. With out-patients there seems to be greater opportunity to allow patient autonomy and choice during the therapy activities. (Reflective notes 20.12.10)

On another occasion, the patient was given small achievable goals each day and the overall plan less frequently. Roberta revealed her more practitioner directed approach when treating a long term patient in intensive care:

I think its very important to break it down, and give them like bite size goals for a few days, and then give them the big picture once a week or something, this is where we are heading, this is what you can achieve. (P3:I2:230)

In the out-patient setting, the physiotherapists encouraged patients to be active partners in therapy and to take responsibility for themselves. Goals and possible treatment plans were discussed, and time was given for the patient to reflect and make their own decisions about their treatment. This approach is illustrated in the following extract from Emily:

What you are doing is informing the patient ... of really where they are at the moment, ... what they want to be able to achieve, what goals there are, ... how they are going to bridge that, but it is making them aware, that
yes, if they want to do that, this is what they then have got to be able to do, … making them aware that to do that they are going to need to do x, y and z. By having talked things through they are then able to go away, have a think about it and come back and say yes I’m happy to prepare to put that work in or well no I’m actually not, so with that you have given them the choice of yes we can do this together but you have got to put the hard work in, or no I actually don’t want to do that and then you are not going to be wasting anyone’s time doing that. (P2:I2:144)

The physiotherapists strove to empower and enable patients with knowledge and ability so they could take an active role in the management of their illness:

I try and give them the opportunity to ask me anything they would like to ask me about themselves or where we are going with the treatment or what their expectations are. … I try and give them information verbally, written, other reading material so that they have got a variety of sources that they can draw on, it’s not just about me with them. … I’m hoping it’s empowering them to understand all about themselves and their condition, what’s been happening to them, how to get themselves forward from this point, its starting to give them some tools to make decisions and choices about what happens next with their health. (P4:I2:40-44)

Occasionally, the physiotherapists described giving patients less autonomy. Claire explained how she pre-planned treatments and used verbal and paralinguistic behaviours to take more control:

Sometimes you need to be the power person to be able to take charge of the situation, You know by being clear about what you want to do and the tone of your voice and to have pre-planned what you want to do before you go in to a certain extent. (P1:I2:144-148)

Throughout the encounter power was finely tuned, moving back and forth between the physiotherapist and the patient. Catherine described how she saw the power balance during an interaction with an out-patient:
Initially the control is definitely with me as the professional because they are coming to see me. So the initial set up is that they would definitely be expecting me to lead and take them through the process but I think fairly soon after we have met and started the process I try and make the control more even so that it’s a joint control, so that both parties have control. I would say pretty much all the way through it is a joint control and unless I feel that the treatment is becoming unsuccessful or that it is going in a detrimental direction for either myself or for them, if I feel I am getting out of my depth ... in which case ... I will up the control on my side and I’ll really dictate and be in control but if it’s going smoothly with joint control then I’ll let them really dictate the control and let them tell them me what they think they need from me. (P4:I2:48)

The extent to which the physiotherapists took control during treatments was influenced by the patient’s physical capability. The physiotherapists’ intention was to promote patients’ safe independent functioning. With more breathless and unwell patients the physiotherapists assumed greater control if they considered it to be in the patients’ best interests. They used instruction and prompting to direct what the patients did, but continuously modified their level of control to give the patient more autonomy. The following extracts are from Claire and Roberta:

Trying to ... keep some control to the exercise by giving her some commands but then letting her... stop and rest when she feels like she feels she needs to. (P1:I1:74)

Control is allowed to fluctuate between the physiotherapist and the patient during treatment activities. With more acutely ill patients, empowering patients is complex because the patient’s physical safety takes precedent. The physiotherapists endeavour to empower patients by offering choices and giving the patient some control of when to start and stop a therapeutic activity. (Reflective notes 12.12.10)

I am just asking her if she thinks she needs to stop again and she says she is alright for the minute and she wants to continue, that was all right,
and she wants to stop now and I am just asking if she wants to sit down but she says she is fine.  (P3:1:116)

Initially, the physiotherapists watched patients closely and took control during activities. If they felt the patient was safe and able to judge their own capabilities they relinquished control:

… monitoring objectively and if I feel they are safe then I kind of give them leeway if they can carry on taking the lead and trying to go a little bit further if they felt comfortable with that.” (P5:1:135)

There is a finely tuned flux of power that moves back and forth. Patient safety dictates the physiotherapists’ level of control (Reflective notes 12.12.10)

Lucy felt she was able to do this because she thought most patients could assess and make their own decisions about their ability:

… most patients will stop though when they need to. I mean a lot of them know their bodies really well so they would stop anyway … They are really good, especially patients with COPD. I think they know their limits … (P5:1:143-147)

To give the patient a sense of being able to be functionally independently, the physiotherapists gradually handed over control. Emily described:

Initially, you are guiding them through it because you want to enforce good practice make sure they are doing it correctly so that they feel confident, then they can obviously feel that what they are doing is ok, its not distressing, its not hurting them, they feel comfortable with it. Then obviously the … easing back is then giving them the tools. Yes, I am here, but I’m actually not doing anything so therefore hopefully they can then translate what they are doing with you when they are at home. (P2:1:80)
Experiential practical knowledge, both explicit and tacit, guided how power fluctuated during the session. If there was concern about a patient’s physical and/or emotional wellbeing or a perceived discrepancy in understanding between the patient and themselves, the physiotherapists regained control. When discussing control during a therapy session Catherine said:

*It’s almost … a feeling rather than a logical thought process. … There’s just something about how it feels on that day at that time in that room that makes it obvious whether to retake control or relinquish control. A lot of it depends on how the other person seems to be … how vulnerable they are, or how emotionally stable they seem to be. Then, how in tune they are with where you are at in your mind with where the treatment is going or how far they have understood their problems. I think when you suddenly connect that your take on what their issues are and where the way forward is and if their take on it aren't sufficient then suddenly the controlmanship. If they suddenly go out of the line or can't line up, I think that's when you should get back some control.* (P4:I2:52)

### 6.5 Summary

This chapter has offered a thematic interpretation of the experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients. It has presented the themes and sub-themes that were co-constructed through thematic analysis. The themes encapsulate the essence of what is in the data. The outcome of my search for the physiotherapists’ understandings and attempts to make sense of the findings resulted in the development of the three major themes illustrated in this chapter, ‘Creating a facilitative space’, ‘Accessing and attending to your world’, and ‘Sharing my world’. The next chapter will discuss the meaning and ramifications of these themes for physiotherapy practice.
CHAPTER 7: MERGING WORLDS

7.1 Introduction

This chapter presents the concept of ‘Merging Worlds - facilitating the journey to a shared understanding and purpose, and safe achievement of purpose’. This conceptualisation of experienced cardiorespiratory physiotherapists’ interactive behaviours was developed from the thematic interpretation. The concept and its underlying dimensions are discussed from a philosophical perspective, which has drawn on Gadamer (1975/2004), Buber (1923/2004) and Moustakas (1995). In accordance with a phenomenological research approach, literature that enlightens, supports and challenges the findings is introduced and discussed. Perspectives from environmental psychology, phenomenological psychology, humanistic psychology and relationship-centred care, together with the literature considered in Chapter Two, have been drawn on to inform the development of understandings of cardiorespiratory physiotherapists’ interactive behaviours. The concept provides an innovative way of seeing and understanding experienced cardiorespiratory physiotherapists’ interactive behaviours during encounters with chronically breathless patients.

7.2 Merging Worlds: Facilitating the journey to a shared understanding and purpose, and safe achievement of purpose

An overall conceptual representation of the physiotherapists’ understandings was interpreted as ‘Merging Worlds: facilitating the journey to a shared understanding and purpose, and safe achievement of purpose’. This is graphically illustrated in Figure 12. This pictorial image of the co-construction of the physiotherapists' understandings and my interpretation of those understandings is a hermeneutic composition through which the whole is understood in terms of the parts, and the parts are understood in terms of the whole (Gadamer 1975/2004). The concept of ‘Merging Worlds: facilitating the journey to a shared understanding and purpose, and safe achievement of purpose’ draws together the three dimensions of the physiotherapists’ perspectives within the interactive dyad into a single concept. ‘Merging Worlds’ represents the hermeneutic dialogical journey that the physiotherapists described taking with their patients during the therapy interactions.
The previous chapter offered three themes as an interpretation of the experienced physiotherapists’ understandings of their interactive behaviours when treating chronically breathless patients. These themes were:

- Creating a facilitative space
- Accessing and attending to your world
- Sharing my world

The thematic interpretation provided a detailed description of interactive behaviours as expressed by the physiotherapists. Many of the physiotherapists’ non-verbal and verbal actions and attitudes, both known and unknown, traversed the three themes. The themes were organised around the physiotherapists’ described intentions to replicate the way in which the physiotherapists constructed the meaning of their interactive behaviours. The themes encapsulate the essence of what was in the data and were seen to be key dimensions of the physiotherapists’ understandings. The dimensions portray the physiotherapists’ perspective within the physiotherapist-patient interactive dyad. Although the dimensions reflect the sense I made of the physiotherapists’ understandings, an artificial division is depicted. All three dimensions interrelate and occur simultaneously during experienced physiotherapists’ interactions with patients. One dimension always calls forth another.
Figure 12: Merging Worlds: Facilitating the journey to a shared understanding and purpose and safe achievement of purpose

‘Merging Worlds’ incorporates the merging of the physiotherapists’ and the patients’ understandings regarding the patients’ problems, the development of a shared purpose of the therapy encounter and safe achievement of the shared purpose. As illustrated in the previous chapter, the physiotherapists sought to create a space they believed facilitated the merging of theirs and the patients’ worlds. They used behaviours relating to ‘Accessing and attending’ to gain understanding of the patients’ worlds and sought to share their own understandings with the patients through behaviours related to ‘Sharing my world’ (see sections 6.3 and 6.4). The physiotherapists explained how they endeavoured to reach a mutual understanding of the patients’ problems and agreement on the purpose of the treatment session with the patients. There was a sense that the physiotherapists sought to create a common world with their patient. Together, the physiotherapist and patient formed an interactional dyad. The merging of the
physiotherapists’ and the patients’ worlds became explicit in the verbal and non-verbal dialogue. ‘Merging Worlds’ describes the process offered by the experienced physiotherapists’ behaviours that facilitated the shared understanding of the patients’ problems, a shared purpose and shared therapy activity.

Throughout the encounter the physiotherapists described endeavours to merge theirs and the patients’ worlds by interpreting and responding to the patient and the situation moment-to-moment. The physiotherapists felt that excessive or undesirable environmental stimulation could influence the patient’s and their own behaviours and mood and so created a space that they believed would facilitate the therapy journey. The physiotherapists engaged in reciprocal verbal dialogue with the patient to facilitate the merging of theirs and the patients’ worlds. A ‘to and fro’ questioning and answering process was encouraged to elicit the patients’ understandings, and to negotiate and collaborate with the patient. However, in addition to verbal dialogue, powerful ongoing non-verbal dialogue occurred. Although Gadamer (1975/2004) used the term ‘language’ as the medium for understanding, his concept of language goes beyond spoken language to encompass non-linguistic language such as gesture and silent consent (Gadamer and Grondin 2006). Similarly, Merleau-Ponty (1962/2002) emphasised that we perceive others through their behaviours as well as language. In the same way, the physiotherapists gained insight into the phenomenological world of the patient through spoken language and through perceiving and interpreting the patients’ physical behaviours. For example, the physiotherapist perceived a patient’s anxiety through the patient’s facial expressions, or distress in breathing through the patient’s posture. The physiotherapists consciously attended to, interpreted and responded to patients’ non-verbal behaviours and body language.

Additionally, through behaviours designed to share control with the patient during goal setting and the therapeutic activity, the physiotherapists offered the view that they and the patient were moving together towards achieving the shared purpose safely. Thus, the ‘Merging Worlds’ concept depicts what Johns (2009:40) describes as a ‘working with’ rather than a ‘doing for’ relationship. The merging of the physiotherapists’ and the patients’ worlds was portrayed as a reciprocal and iterative process that allowed both parties to develop new understandings and
knowledge. Gadamer (1975/2004) argued that hermeneutics is primarily a practice; it is the art of understanding and making something understood to someone else. As such, the physiotherapists’ accounts of their attempts to understand the patients’ worlds and to share their world with the patient correspond with a hermeneutic approach to interactions with patients.

According to Gadamer (1975/2004) and Merleau-Ponty (1962/2002), a total merging of subjective worlds is impossible. It can only ever be an aspiration as one cannot entirely eliminate the individuality of perspectives. Nevertheless, through their interactive behaviours the physiotherapists aspired to merge their world with the patient’s. The physiotherapists explicitly stated and appeared to tacitly know that effective therapeutic encounters required ongoing moment-to-moment interpretation of the patients’ non-verbal and verbal behaviours.

The ‘Merging Worlds’ concept represents the experienced physiotherapists’ perception that effective physiotherapist-patient interactions are reciprocal, iterative, collaborative, and symmetrical. This conceptualisation of physiotherapy practice is in conflict with previously described asymmetrical, biomedical physiotherapist-patient interactions (Thornquist 1994, Talvitie and Reunanen 2002, Wohlin Wotruch et al. 2004, Parry 2004b). Conversely, the ‘Merging Worlds’ concept corresponds with the caring, symmetrical, mutual and reciprocal interactions described by Raz et al. (1991), the mutually collaborative two-way exchanges portrayed by Edwards (2000) and the forming of interdependent relationships with patients as suggested by Thomson (2008). Furthermore, the concept of ‘Merging Worlds’ is supported by and challenges the findings of Oien et al. (2011). Oien et al. (2011) reported that during therapy sessions physiotherapists and patients contributed to and gradually found common ground. This resonates with the ‘Merging Worlds’ concept. Additionally, similar to the physiotherapists in this study, Oien et al. (2011) participants viewed the physiotherapist-patient interaction as a complex dialogical process. In contrast to Oien et al. (2011), the physiotherapists in this study did not perceive reaching a common purpose as a demanding process but rather as a collaborative, reciprocal, interactive process. Furthermore, the physiotherapists in this study portrayed the interaction between themselves and the patient as positive and
mutual. They did not refer to interactional challenges such as ambivalence, uncertainty, impatience and disagreement as described by Oien et al. (2011).

The ‘Merging Worlds’ concept expands on the findings of Raz et al. (1991), Edwards (2000), Thomson (2008) and Oien et al. (2011) by depicting experienced physiotherapists’ interactions with patients as a co-constructed, interdependent hermeneutic journey. The concept offers an alternative way of understanding physiotherapists’ interactive behaviours whilst treating patients than is currently described in the literature. The following sections discuss the three dimensions that underlie the ‘Merging Worlds’ concept within the context of existing research and theory.

7.2.1 Creating a facilitative space

The dimension of ‘Creating a facilitative space’ encapsulates the behaviours which the physiotherapists described being used to create and maintain an environment that they felt could best facilitate the merging of the patients and their worlds. The word ‘space’ suggested itself because space communicates more than only the external environment to include the inner subjective experiences of the interacting partners. A facilitative space was understood to be a key feature of the physiotherapy encounter. Furthermore, continuous modification was needed if the patient was to divulge information, problems and concerns, engage in the session, and for physiotherapeutic techniques to be effective and safe.

Space and environment are known to influence human activity and experience, and play an essential part in interpersonal exchanges (Amedeo et al. 2009). Environmental psychology provides a way of examining the interrelationship between environment and human thoughts, feelings and behaviours. It emphasises the importance of person-environment-behaviour relationships when researching human activities and experiences (Amedeo et al. 2009). Bell et al. (2001) offer an eclectic model of environment-behaviour relationships that centres on how an individual perceives the environment. This perception is influenced by objective physical conditions, differences in individuals and by situational, social and cultural factors. The individual perceives the environment as either within their optimal range of stimulation and a situation of homeostasis exists or outside
their optimal range of stimulation which results in arousal, stress, overload and/or reactance (Bell et al. 2001).

The environmental stress model considers many aspects of the environment to be stressful (Evans and Cohen 2004, Bell et al. 2001). Stress is experienced in response to a threat and induces interrelated physiological and psychological responses (Brannon and Feist 2009, Lazarus and Folkman 1984, Selye 1956). The threat can be real or imagined; it is the perception of the threat that triggers the stress response. Environmental stressors are stimuli in external surroundings that provoke a stress response in an individual. Exposure to stress produces adaptive physiological responses in the body’s regulatory systems such as, cardiovascular, immune, sympathetic nervous system and hypothalamic pituitary axis. Allostasis is the adaptive preservation of these regulatory systems through neuromodulation of motive states and behaviours which occurs in response to changing environmental circumstances (Nielsen et al. 2007). Allostatic load refers to the cumulative physiological risk (biological wear and tear) associated with exposure to excessive psychosocial stressors (Nielsen et al. 2007). In the context of this study, the term allostatic load means the level of environmental stressors the physiotherapists perceived to exist in the therapy setting.

Three elements of environmental psychology are of particular relevance to the findings of this study; attention, preferred environment, and environmental stress and coping (De Young 1999). These elements are reflected in the understandings of interactive behaviours offered by the physiotherapists in this study. During therapy encounters, the physiotherapists initially directed their attention towards the environment. Therapy settings were perceived to be potentially threatening for the patient, often unpredictable and difficult to control. The physiotherapists described how they assessed the setting on behalf of the patient and themselves, and made decisions about what could pose a threat. The physiotherapists expressed an awareness of likely psychosocial stressors already experienced by the patient such as frightening symptoms, unfamiliar surroundings and expectation of activity, and through their behaviours endeavoured to reduce the patients’ allostatic load. The physiotherapists described taking steps to minimise and prevent potentially distressing and distracting environmental stressors. There was
discussion of how they reduced interruptions and ensured the patients’ privacy and safety. Additionally, the physiotherapists also saw themselves as part of the environment whereby their behaviours and actions had the potential to directly affect the patients’ physiological and emotional state. The physiotherapists sought to both minimise the effect of their presence and to positively influence the patients’ physiology by modifying their proximity, position and voice (see section 6.2).

Overall, the physiotherapists understood that their behaviour and the patients’ behaviour, and what could and could not be achieved during a treatment session, were facilitated or restricted by the environment. Creation and maintenance of a preferred environment is known to increase a sense of well-being and behavioural effectiveness in humans (De Young 1999). The physiotherapists described orchestrating a preferred environment, one in which they believed both the patient and the physiotherapist could feel confident and competent. The physiotherapists acted to change and take control of the environmental conditions.

The behaviours associated with ‘Creating a facilitative space’ correspond with the relationship facilitating process of ‘bodying forth’ (Moustakas 1995:81). Moustakas (1995) argues that ‘bodying forth’ is one of three key processes that contribute to the development and maintenance of a relationship. Bodying forth is an advanced presence that supports relations with others. It is being present in the world of another. The body is ahead of itself, anticipating, perceiving, explaining and understanding the other. The physiotherapists described behaviours that reflect the concept of bodying forth both prior to and throughout encounters. They anticipated and attempted to positively influence the experiences of the patient. Their intention was for the patient to feel as comfortable and relaxed as possible. The physiotherapists purposely prepared and maintained the space to facilitate the merging of theirs and the patients’ worlds (see section 6.2).

As a dimension of experienced interactive behaviours, ‘Creating a facilitative space’ is supported by and expands on the work of Jensen et al. (1992). Jensen et al. (1992) investigated attributes that distinguished expert and novice orthopaedic physical therapists and offered a conceptual framework for
understanding the physical therapy practice environment. One of the four improvisational performance attributes Jensen et al. (1992:714) described was the ‘ability to control the environment’. Expert clinicians were found to set the stage for intense therapeutic interventions through their control of the clinical environment. Novice clinicians were more reactive to external stimuli and did not take steps to control their environment. The dimension of ‘Creating a facilitative space’ extends the understanding of this attribute. It offers a more detailed conceptualisation of the specific behaviours used by these physiotherapists to control the environment (see section 6.2). Additionally, the physiotherapists offered understandings that these behaviours enhanced the subjective experience of both the patient and themselves.

Despite a lack of research evidence, the environment in health care settings is generally perceived to be unchangeable and little attention is paid to its impact on the subjective world of the patient and health care professional (Johns 2009). The findings of this study indicate that this is not so. The physiotherapists in this study understood that the external world affected the patients and their internal, subjective worlds. The physiotherapists modified the external environment to reduce its allostatic load in order to provide an optimal space for the merging of their own and the patients’ worlds.

7.2.2 Accessing and attending to the patient’s world

The dimension of ‘Accessing and attending to the patient’s world’ encompasses the behaviours used by the physiotherapists to elicit the patients’ perspective within the interactive dyad in order to facilitate merging the patients’ world with their own. ‘Accessing and attending’ behaviours were described as an attempt to enter into and understand the patients’ phenomenological world. The physiotherapists appreciated that the patients’ experience of the world was different to theirs, and that each patient had a unique perception of the world. The physiotherapists believed that to provide effective therapy it was important to understand the patients’ lifeworld. Moment-to-moment, throughout the encounter they brought the patients’ understandings and knowledge into play through their authentic listening, profound watchfulness and empathic behaviours as shown in section 6.3. These experienced physiotherapists understood these behaviours to
be a key feature of the way they interacted with patients to achieve effective therapy.

The physiotherapists’ understandings of their ‘Accessing and attending’ behaviours concur with the notion of transposing one’s self (Gadamer 1975/2004). Gadamer (1975/2004) suggests that if we are to understand the significance of what the other has to say to us, then we have to transpose ourselves into their perspective, the historical horizon from which they speak. The physiotherapists sought to understand the patient not only by making sense of the patients’ verbal and non-verbal behaviours but by being open to and allowing the patients’ understandings of the world to be appreciated. The physiotherapists appeared to take nothing for granted and were prepared to be informed and influenced by the patients’ perspective. They did not intend to suppress the patients’ understandings. This echoes the perspective offered by Gadamer (1975/2004) that understanding can only occur through accommodation of the other.

The notions of transposing one’s self and accommodating the other resonate with an I-Thou style of human relating proposed by Buber (1923/2004) (see section 2.5). Inevitably, the I-It orientation underpinned the technical requirements of the physiotherapists’ clinical reasoning and practice. However, the physiotherapists seemed to take a predominantly I-Thou orientation to the interaction (see section 6.3). They used behaviours that prevented objectification of, or separation from, a patient’s unique phenomenological world. The physiotherapists chose this orientation both knowingly and unknowingly. Overall, the physiotherapists appeared to effortlessly combine the two orientations, embracing simultaneous I-It and I-Thou moments. At other times, they moved along the continuum between I-Thou and I-It orientations depending on their personally preferred orientation, the severity of the patient’s condition and concern that the therapy activity might become unsafe.

The physiotherapists described that they were receptive to the patient by being open and prepared to hear and acknowledge anything that the patient might disclose. They encouraged the patient to give their account in their own way, and accepted and validated the patients’ unfolding experiences and understandings.
This receptivity was achieved through authentic listening and profound
watchfulness behaviours (see sections 6.3.1 and 6.3.2). The physiotherapists
encouraged the patients to disclose personal understandings by minimising
interruptions, asking questions, and summarising the patients’ experience. The
physiotherapists’ view of their behaviours echoes a second relationship facilitating
process proposed by Moustakas (1995:79) of ‘receptivity’. Receptivity can be
viewed as the strength that the health care professional brings to the world of the
patient (Moustakas 1995). By being empathically receptive, the physiotherapists
felt they could discern and understand the patients’ mood, situation and
behaviours. They gave undivided attention to the patient and listened
compassionately. The physiotherapists perceived and responded to their patients’
emotions. It appeared that the physiotherapists understood that their receptivity
was an ongoing source of encouragement and care that facilitated the relationship
with their patient and the therapy journey.

The physiotherapists perceived that their behaviours were a means through which
an empathic connection could be established with the patient. This empathic
attitude underpinned their listening and watching behaviours. There was an
understanding offered that empathic connection was the way to gain a deep and
intimate perspective of the patients’ experience. Empathic connection
corresponds with the third relationship facilitating process, ‘attunement’ described
by Moustakas (1995:80). The physiotherapists attuned themselves to the patient
moment-to-moment and attunement was exercised through their verbal and non-
verbal behaviours and empathic attitude (see section 6.3).

In this study, empathic connection incorporated two features; understanding the
patient and demonstration of that understanding to the patient. The first feature of
understanding the patient involved an un-prejudicial entering into the patient’s
world so as to gain greatest understanding. The physiotherapists endeavoured to
empathically understand the patient by being sensitively aware of the interplay
between the patient’s words, voice, facial expressions and physical actions as
described in section 6.3. They attended to all the patient’s forms of expression to
generate the most comprehensive and accurate picture possible of the patient’s
world.
The second feature of empathic connection is demonstrating their understanding to the patient. This involved how understandings gained were displayed and communicated during encounters. The physiotherapists enacted their empathic understanding by reducing the allostatic load of the environment, using appropriate questioning, summarising what the patient had said and through the use of their body position, gestures, facial expressions and voice. These behaviours were utilised to make the patient aware that they were understood and to allow the patient to judge and correct the accuracy and extent of the physiotherapists’ understanding.

In the psychotherapy and counselling fields there is a large body of research and practice evidence that suggests that certain core conditions of therapy are more important for therapeutic outcomes than the type of theoretical approach used (Hazler and Barwick 2001). The empathic attitude described by the physiotherapists also corresponds with one of the core conditions of the humanistic psychological approach that is empathic understanding. Rogers (1980, 1957) proposed that to understand empathically means entering into the private perceptual world of another person and laying aside one’s own views and values. Rogers (1957, 1980) argued that empathy, positive regard, acceptance and congruence are key features of client centred therapy and are essential to the success of psychotherapy and counselling. Rogers (1980, 1957) suggested that by seeking to understand the patient’s personal experience of the world and being fully present during the interaction, the therapist makes their acceptance of and confidence in the patient explicit and obvious. Current understanding of empathy in clinical contexts has been considerably influenced by the views offered by Rogers (1980, 1957). More recently, Spiro (1992) advocated that empathy should underlie and frame the behaviours and skills of all professionals who care for patients. As a dimension of experienced interactive behaviours, ‘Accessing and attending to the patient’s world’ is supported by the insights offered by Rogers (1980, 1957) and Spiro (1992). Additionally, the ‘Accessing and attending to the patient’s world’ dimension conveys these experienced physiotherapists’ attitudes to caring for patients as humanistic and patient-centred. This approach to interactions with chronically breathless patients has not previously been described in the cardiorespiratory physiotherapy literature.
In order to understand the patient’s phenomenological world and in response to perceptions concerning the patient’s physical and emotional circumstances, the physiotherapists modified their accessing and attending actions and attitudes. Additionally, rather than purely accessing an objective, biomedical understanding of the patient, the physiotherapists described being authentically interested in what the patient said, did and felt moment-to-moment across the encounter (see section 6.3). During the interaction, the physiotherapists almost exclusively fixed a holistic, contextualised gaze on the patient. Contrary to a biomedical approach, the patient and their problem was not seen as separate from their social or historical context. The physiotherapists’ behaviours and therapy actions appeared to be informed by an iterative, holistic approach to their interpretation of the patient’s world.

On the occasions the physiotherapists described focusing on the patient’s disease and impairment, their behaviour was motivated by reasons of safety. However, they did not see the disease and impairment as separate from the patient’s lifeworld. The physiotherapists understood their role as helping the patient to find strategies to manage their breathlessness which were appropriate to and could be incorporated into the patient’s everyday life. To do this the physiotherapists believed they had to have a comprehensive understanding of the patient and their life. This is inconsistent with the conceptualisation and management of the patient and disease as purely a biological phenomenon. The physiotherapists appeared to skilfully and seamlessly combine their biomedical knowledge and knowledge of the patient’s lifeworld to construct a holistic understanding of the patient.

The finding of interactive behaviours encompassed in ‘Accessing and attending to the patient’s world’ challenges previous conceptualisations of physiotherapist-patient interactions as asymmetrical (Parry 2004b, Wohlin Wottrich et al. 2004, Talvitie and Reunanen 2002, Thornquist 1994). The physiotherapists in this study actively and intentionally sought out the patients’ understanding of the world. During the encounter, whilst the focus was on functional outcomes, the physiotherapists incorporated the patients’ whole being in the world into their approach to assessments and treatments. Participants in studies conducted by Wohlin Wottrich et al. (2004), Talvitie and Reunanen (2002) and Thornquist (1994)
were reported to focus on patients’ physical symptoms and gave patients’ limited opportunity to present their version of their lived experience. Furthermore, in contrast to the findings of Talvitie and Reunanen (2002) and Thornquist (1994), the physiotherapists in this study did not view the patient’s body as separate from the patient’s self and appeared to effortlessly combine a biomedical and a patient-centred approach. This finding may have been influenced by the particular patient group, chronically breathless patients, involved in this study.

The dimension of ‘Accessing and attending to the patient’s world’ echoes the ‘discovery’ strand of a patient-centred care approach as described by Illingworth (2010). In addition, the dimension is supported by the findings of Edwards (2000), Lundvik Gyllensten et al. (1999) and Raz et al. (1991). Raz et al. (1991) suggested that the interactions of female physiotherapists with patients were characterized by interpersonal sensitivity, receptiveness and responsiveness and the ability to listen, and that these behaviours assisted in achieving the goals of therapy. Similarly, Lundvik Gyllensten et al. (1999) emphasised the importance of how physiotherapist-patient interactions were conducted. The authors highlighted that the participants were concerned about creating a positive affective climate during physiotherapy sessions. Furthermore, Edwards (2000) proposed that when physiotherapists used a two-way communicative approach, patients contributed their understandings of their condition and this increased the physiotherapists’ understanding of the patient.

The ‘Accessing and attending’ dimension expands on the views offered by these studies by providing a rich description of the interactive behaviours that these experienced physiotherapists perceived they used to form a holistic understanding of the patient (see section 6.3). Furthermore, this dimension depicts physiotherapists as automatically combining biomedical and patient-centred approaches. Overall, the dimension of ‘Accessing and attending’ illustrates how the physiotherapists iteratively constructed a holistic understanding of the patient and that this was seen to facilitate the therapy journey to a shared purpose and achievement of that purpose.
7.2.3 Sharing my world

The dimension of ‘Sharing my world’ encapsulates the behaviours that the physiotherapists used to share their understandings within the interactive dyad to facilitate the merging of their world with the patient’s world. The physiotherapists portrayed that it was important that their phenomenological world connected directly with the patients’ world. Each physiotherapist brought their unique perspective on the world to the interaction. Inescapably, this was bound to their experience, practice knowledge, model of practice, clinical reasoning strategies, social relationships, habits and culture. In Gadamerian (1975/2004) terminology, the physiotherapists brought their historical consciousness, tradition and history. All the physiotherapists alluded to a patient-centred model of practice but did not appear to have conceived of, or consciously reflected on, their behaviours as being a particular model of practice or on its practical application within therapy encounters.

In addition, each physiotherapist described using both cognitive and interpretive reasoning processes. It is argued that cognitive clinical reasoning strategies engender a formal asymmetrical collaboration between therapists and patients in which the perspective of the physiotherapist as the expert dominates. In contrast, it is proposed that interpretive clinical reasoning strategies lead to mutual collaboration in which the patient and his/her unique experience inform the decision making process (Edwards et al. 2004). Consequently, it appeared that interpretive clinical reasoning strategies informed the interactive behaviours of the physiotherapists in this study.

Generally, the physiotherapists did not describe suppressing their own understandings of the patient and the world during the interaction. This follows another aspect of the views offered by Gadamer (1975/2004) that in the process of ‘transposing ourselves’ we do not discount our own self. On the contrary, if we are to understand the other we must ‘bring’ ourselves. To varying extents, the physiotherapists portrayed an intention to bring aspects of their own world into play with the patients’ world during the encounter. Some physiotherapists talked about purposely articulating their professional experience and trustworthiness to the patient while others did not. All the physiotherapists discussed the patient’s
physical problems with the patient and perceived that they displayed honesty by openly expressing their beliefs about the patient’s current state and future possibilities. These findings challenge Parry’s (2004b) suggestion that physiotherapists keep issues of patients’ physical impairment ‘off the interactional surface’ (Parry et al. 2004b:984). The findings of this study imply that the behaviours described by Parry (2004b) are not universally used. Rather, physiotherapists’ interactive behaviours in practice are likely to depend on the context, the therapist, the patient, and the nature and purpose of the therapeutic encounter.

All the physiotherapists conveyed an intention to empower the patient and did so by integrating their knowledge and experience of human interaction and therapy techniques with the patient’s unique problems and personal choices. This integration was not explicitly described but was implicit within the physiotherapists’ descriptions of their attitude and demonstrated in the way they behaved during patient encounters as illustrated in section 6.4. The experienced physiotherapists appeared to exquisitely balance who held control throughout each encounter and described giving the patient varying levels of responsibility for naming the purpose of the encounter and achieving the therapy purpose. The locus of control seemed to depend on the physiotherapist’s perception of the patient’s capability. As the physiotherapists listened and watched, their understanding of the purpose and how to achieve the purpose was modified moment-to-moment as new understandings about the patient, what the patient wanted and the situation emerged. During the therapy activity, the physiotherapists described how they continuously interpreted the patients’ experience of and ability to perform the activity. The physiotherapists adapted their level of control as they interpreted the ongoing situation. By either following or guiding or leading the patient, the physiotherapists allowed the locus of control to vary. By sharing control, the physiotherapists aimed to facilitate the patient to achieve the shared purpose. The physiotherapists understood that behaviours which shared control encouraged and facilitated the therapy journey, and by facilitating the therapy journey they helped the patient to cope with their impairment and move forward.
The ‘Sharing my world’ dimension is supported by previous studies that suggested that physiotherapists seek and negotiate mutually agreed rehabilitation goals (Raz et al. 1991). Physiotherapist-patient interactions are suggested to be mutually collaborative exchanges of knowledge and power (Edwards 2000). Additionally, Resnik and Jensen (2003) proposed that physiotherapists who were patient-centred and collaborative achieved better patient outcomes. This view is supported by Thomson (2008) who suggested that successful patient outcomes are achieved when an interdependent relationship is established between the physiotherapist and the patient, where neither had power over the other but each gave power to the other. Furthermore, the feature of ‘shared control – following, guiding and leading’ within the dimension of ‘sharing my world’ strongly resonates with the ‘shared control’ strand of a patient-centred care approach (Illingworth 2010). The dimension of ‘Sharing my world’ develops on these previous studies. It explicitly depicts physiotherapists as endeavouring to share knowledge, understandings and control with patients rather than imposing their knowledge and understandings on the patient, and exerting control.

Additionally, by providing a description of physiotherapists’ interactive behaviours from experienced cardiorespiratory physiotherapists’ perspectives (see section 6.4) the conceptualisation of physiotherapist-patient interactions ‘Merging Worlds’ and its underlying dimensions expands on previous quantitative observational studies of patient-physiotherapist interactions (Roberts and Bucksey 2007, Ambady et al. 2002)

Overall, the concept of ‘Merging Worlds - facilitating the journey to a shared understanding and purpose, and safe achievement of purpose’ and the underlying dimensions reflect the essence of the physiotherapists’ understandings. It can be seen that the physiotherapists’ interactive behaviours were multi-dimensional and multi-functional. They gained and offered understanding and knowledge whilst simultaneously managing aspects of the physiotherapist-patient interaction, relationship and therapy activity. The physiotherapists perceived that the forming of a mutual, collaborative physiotherapist-patient relationship was crucial if effective therapy was to occur and that their interactive behaviours were important in the development and maintenance of that relationship.
This way of viewing physiotherapist-patient interactions corresponds with the way in which the Pew-Fetzer Task Force conceptualise relationship-centred health care (Tresolini et al. 1994). Relationship-centred care places the health care professional-patient relationship at the heart of health care (Tresolini et al. 1994). It offers a more comprehensive conceptualisation of health care than patient-centred care. Emphasis is placed on the significance of the patient-clinician interaction and the interdependence between the patient and clinician (Tresolini et al. 1994). The core principles of relationship-centred care include the personhood of the participants (both health care professional and patient), the importance of affect and emotion in relationships, the reciprocal influence of health care relationships and the moral value of forming and maintaining a genuine relationship (Beach and Inui 2006). These underpinning principles were reflected in the physiotherapists’ understandings of the physiotherapist-patient relationship and the way they interacted with patients. Relationship-centred care supports the understandings offered by the physiotherapists in this study. It provides a perspective on health care encounters that recognises the significance of the health care professional-patient interactions and the importance of health care professionals’ interactive behaviours. From this perspective it can be argued that physiotherapists should view interactive behaviours to be as important as therapy techniques.

7.3 Summary

This chapter has discussed a conceptualisation of experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours when treating chronically breathless patients. The concept of ‘Merging Worlds - facilitating the journey to a shared understanding and purpose, and safe achievement of purpose’ draws together three underlying dimensions, ‘Creating a facilitative space’, ‘Accessing and attending to the patient’s world’ and ‘Sharing my world’. The dimensions represent the physiotherapists’ perspective within the physiotherapist-patient dyad. The next chapter discusses the issue of the physiotherapists’ ability to explicate and reflect on their interactive behaviours and presents a model of physiotherapist-patient interactions and a series of questions to support physiotherapists’ understanding, explication and development of effective interactive behaviours.
CHAPTER 8: MINDFUL, RECIPROCAL INTERACTION

8.1 Introduction

This chapter discusses a key issue highlighted by this study, the challenging process of explicating knowledge. It offers a way of making practice knowledge explicit. The chapter is presented in two sections. The first section describes observations made during the data generation process that relate to the tacit nature of the physiotherapists’ knowledge of their interactive behaviours. It also discusses the research observation of the experienced physiotherapists’ limited display of, and ability to, critically reflect on their interactive behaviours in practice. The second section discusses how these observations together with the conceptualisation of the physiotherapists’ understandings, ‘Merging Worlds’, led to the development of a new model of physiotherapy practice, Mindful, Reciprocal Interaction. The model incorporates recommendations from previous research on physiotherapist-patient interactions, draws on the concept of fusion of horizons (Gadamer 1975/2004) and the theories of complex responsive processes of relating (Suchman 2006) and biopsychosocial processes of relating (Alder 2007). In addition, a series of questions have been composed to facilitate the use of the model as a mechanism to enhance a critically reflective approach to interactive behaviours in practice. The model and questions are offered as a tool through which cardiorespiratory physiotherapists can make explicit and critically reflect on their interactive behaviours when treating chronically breathless patients.

8.2 Process of knowledge explication

During the data generation phase I had made a number of observations that related to the challenge of making knowledge used in practice explicit. The experienced physiotherapists in this study appeared to have difficulty in articulating their understandings of the interactive behaviours. This difficulty is a recognised problem when investigating knowledge use in practice (Eraut 2000). The physiotherapists frequently described the way in which they interacted as intuitive:

... the way I interacted just came on automatically, I didn't really think about that much, it wasn't a conscious decision I was basically behaving automatically. (P5:I2:32-40)
As previously discussed in Chapter Two, literature regarding cardiorespiratory physiotherapists’ interactive behaviours in practice is limited and physiotherapy teaching programmes have a tendency to focus on theoretical knowledge about communication rather than any practical application or development of interactive behaviours. Therefore, it seemed unlikely that the physiotherapists’ understandings of their interactive behaviours were purely the result of the conversion of existing theoretical knowledge into tacit experiential knowledge through repetition and routinisation (Eraut 2000). This was an important issue as it suggested that the physiotherapists’ knowledge of effective interactive behaviours during therapeutic encounters had been learnt through implicit means.

The video-cued recall and reflection and follow-up interview methods helped enable the physiotherapists to explicate this tacit aspect of experienced practice. The video-cued recall and reflection was the first time any of the physiotherapists had been brought face-to face with viewing the way they interacted with a patient or had considered their interactive behaviours in practice. As intended, the video-cued recall and reflection and follow-up interviews prompted the physiotherapists to consciously think about and to articulate tacit knowledge underlying their interactive behaviours. The extent to which the physiotherapists were able to describe their tacit understandings of their interactive behaviours during the video-cued recall and reflection and follow-up interview may have been a result of having time to think and reflect more deeply than is possible in the clinical setting.

Thus, the methods of video-cued recall and reflection and the follow-up interview helped to explicate tacit aspects of the physiotherapists’ ‘knowing-in-action’ (Schon 1987:22). These reflections on their interactive behaviours offered appraisals that were both positive and negative:

*I didn’t realise how much non-verbal, how much body language I use, which I imagine I do all the time actually looking at that, and even watching myself speaking now, I am doing it all the time, so it is obviously quite an important part of my communication style. I think I am listening to people, but I am surprised I look like I am listening so much, I am surprised it comes over, I am trying to, that is what I am doing inside, but I am*
surprised it is so obvious that that is what I am doing … I am doing a lot of it without consciously really planning it although some of it is conscious planning, not all of it is. I mean the conscious things are about slowing the voice down and definitely looking up at someone and making eye contact but there is a lot more in there that I am surprised about. (P4:I1:360)

It is very weird I have never seen myself in a video, it’s very interesting to see how I speak, my mannerisms, my accent because I don’t realise it when I speak. It’s just very interesting to listen, how it looks from another angle. Very interesting, and the body language, there are things that I think I can work on. (P3:I1:228)

Furthermore, in the follow-up interview some of the physiotherapists commented that the process of exploring their understandings of their interactive behaviours in the preceding video-cued recall and reflection had made them more aware of and thoughtful towards their behaviours during encounters with patients since undertaking that session:

I thought about it quite a lot … the whole experience has been more uplifting and positive than I had anticipated. I didn’t think it would be negative, I thought I would find it more anxiety inducing than I have, I don’t find it makes me anxious at all and just felt very encouraged by what I had seen and surprised at my own … ability I suppose and in that sense it’s a confidence boost, because you think wow actually I was doing something and I can do something and there are skills there that are worthy and then it’s trying to think … how am I with a patient and then how am I in other aspects of my job and trying to translate that as well. (P4:I2:24)

The physiotherapists varied in their ability to articulate their understandings of interactive actions and attitudes applied during patient encounters. Although all the physiotherapists were experienced, some were more expressive and could convey more about their understandings of their interactive behaviours than others. Additionally, some aspects of tacit knowledge appeared to be easier to communicate than other aspects. Generally, the physiotherapists appeared to be
more aware of and able to describe behaviours that were encompassed in the dimension of ‘Creating a facilitative space’ than the behaviours encompassed in the other two dimensions. This may have been due to the more specific, practical nature of the interactive behaviours within this dimension.

A further observation during this study related to the way the physiotherapists appeared to have implicitly learnt that their non-verbal behaviours influenced the interaction, their relationship with the patient and the outcomes of therapy. In contrast, in the descriptions offered, the physiotherapists did not show consideration as to how their non-verbal behaviours might be perceived by the patient. Practice research has shown that physiotherapists’ non-verbal behaviours facilitate rapport building (Roberts and Bucksey 2007) and have measurable influences on patients’ outcomes irrespective of the therapeutic treatment (Ambady et al. 2002). Consequently, I propose that there is a need for physiotherapists to reflect more deeply on their non-verbal behaviours during interactions with patients and how these behaviours influence the effectiveness of their therapeutic encounters with patients.

An additional observation was that these experienced physiotherapists described ‘knowing how’ to execute smooth sequences of interactive behaviours. The physiotherapists expressed the notion of ‘knowing-in-action’ as described by Schon (1987:22). Knowing-in-action is a dynamic process which is enacted through spontaneous skilful performance but is characteristically difficult to express explicitly. Knowing-in-action inevitably requires some level of moment-to-moment awareness, appreciation, detection, correction and adjustment of activity. However, despite describing ‘knowing-in-action’ these experienced physiotherapists did not describe reflecting on their interactive behaviours either in-action or after-action unless an encounter had been problematic. Schon (1987:26) argues that to become more aware of what one is thinking and doing in practice requires undertaking a reflection on one’s ‘reflection-in-action’. Therefore, I suggest that to make aspects of knowing-in-action explicit physiotherapists need to develop ways of reflecting on their reflection-in-action.
Eraut (2007) proposes that one of three modes of cognition are used during professional practice; either instant/reflex, rapid/intuitive or deliberative/analytical. The mode used will depend on how much thinking time is available. The instant/reflex mode describes behaviours that have become routine. The rapid/intuitive mode involves greater awareness of what one is doing and is characterised by rapid decision making within an episode of continuous, semi-routinised action. This mode occurs when there is a mismatch between previous similar situations and the current situation but there is little time to think or reflect. The deliberative/analytical mode is characterised by explicit thinking by an individual or in consultation with others. This mode entails conscious deliberation on the use of different types of prior knowledge and their application and can only occur when the professional has time to think and reflect in depth. Thus, it was not surprising that the physiotherapists showed the use of instant/reflex and rapid/intuitive modes of cognition during interactions with patients but used a deliberative/analytical mode when asked to observe themselves and given time to think and reflect on their behaviours during the video-cued recall and reflections and follow-up interviews.

This finding supports the view offered by Eraut (2007) that the ability to undertake reflection on reflection-in-action requires a deliberative/analytical mode of cognition. Importantly, it is suggested that critical reflection on practice can produce adjustments to and enhancement of practice (Schon 1987, Johns 2009). Johns (2009) argues that critical reflection brings intuitive processes to awareness so that tacit knowledge can be examined and developed. Therefore, critical reflection offers a way for physiotherapists to conceive of, to critically think about and to make explicit their interactive behaviours during encounters with patients. However, Johns (2009) has suggested that for reflections to become more critical there is a need for practitioners to challenge assumptions and beliefs that underpin knowing-in-action (Schon 1987) and the observations during this study support this view.

Critical reflection is closely related to the concept of reflexivity. Although generally associated with qualitative research, reflexivity is now acknowledged to be equally important in health care practice (Jensen 2005, Taylor and White 2000). To be
reflexive in clinical practice means the health care professional is aware of and pays attention to their stance, personal values, emotional reactions, practices and voice in the interaction (Delany et al. 2010). Attention is also given to how these factors impact on the patient’s reactions and choices, and the outcome. The findings of this study support Johns’ (2009:11) call for ‘reflection-within-the-moment’, which encourages health care professionals to be reflexive moment-to-moment whilst undertaking practice. Johns (2009) argues that it is only by continuously reflecting-on-experience that health care professionals develop the ability to reflect-within-the-moment during practice. However, although the methods used in this study have shown that experienced cardiorespiratory physiotherapists have the ability to offer insightful, informed reflections related to knowing-in-action, there was little evidence that these physiotherapists reflected-on-experience or reflected-within-the-moment on the interactive behaviours they used in everyday practice. This observation suggests a lack of critical reflection in this area of physiotherapy practice. Consequently, it is argued that the incorporation of critical reflection into the day to day undertaking of cardiorespiratory physiotherapy practice would serve to explicate practice behaviours.

Previous researchers have also argued the need for physiotherapists to develop ways of understanding, conceptualising and thinking about the process of their interactions with patients. Lundvik Gyllensten et al. (1999) proposed that more emphasis should be placed on factors that promote interactional skills in physiotherapy and recommended reflection as a tool to understand and learn about the effect of physiotherapist-patient interactions. Parry (2004a) has shown the complexity within goal-setting as an interactional activity and recommended continuing to develop more detailed knowledge of practices and constraints in order to improve professional practice, guidance and education. Additionally, Oien et al. (2011) proposed a need for creating more useful ways of understanding challenging physiotherapist-patient interactions.

A final observation suggested that despite appreciating that interactive behaviours were fundamental to facilitating an effective therapy journey the physiotherapists did not have a model and framework through which they could describe or critically
reflect on their behaviours. A possible factor contributing to this finding may relate
to the lack of explicit or codified theory, concepts and language in this area of
physiotherapy practice, as highlighted in Chapter Two. Gadamer (1975/2004)
argues that the process of understanding relies on not just the task of
interpretation but also on application within a particular setting. Drawing on this
perspective, it was felt that for the findings of this study to be fully understood and
be of value to practice then the new concept developed of ‘Merging Worlds’ had to
be made applicable in everyday practice.

The findings of this study have offered a description and conceptualisation of
experienced cardiorespiratory physiotherapists’ understandings of their interactive
behaviours with patients. Other studies have suggested that expert
physiotherapists’ patterns of interactive behaviours produce better patient
Therefore, I felt it was essential to utilise the understandings gained by this study,
of this important aspect of experienced cardiorespiratory physiotherapists’ practice
knowledge, in a tool that could be used to enhance cardiorespiratory
physiotherapy practice. This knowledge can then be used to help others explicate
and improve their interactive behaviours during encounters with patients. I also
wanted to offer a way of helping physiotherapists in other specialities and settings,
and other health care professionals to realise more mindful approaches to
interactions with patients.

The notion of ‘being mindful’ in practice has been seen as another way of
describing reflexivity in action (Johns 2009:11). In the context of this discussion
and the model presented in the next section, ‘mindful’ refers to the physiotherapist
having an ongoing awareness during the interaction of what they are doing, why
they are doing it and that what they are doing in that moment corresponds with
their intentions as opposed to other types of ‘mindfulness’ for example, from an
Eastern philosophical perspective.

The following section discusses the synthesis of the understandings developed of
experienced physiotherapists’ interactive behaviours and the issues observed
during the study to offer a way of applying this new knowledge in practice. The
‘Merging Worlds’ concept and the knowledge gained from the process of explicating the physiotherapists’ practice knowledge were considered alongside recommendations that have been made in previous studies of physiotherapist-patient interactions. This synthesis of insights led to prolonged deliberation on how the concept of ‘Merging Worlds - facilitating the journey to a shared understanding and purpose, and safe achievement of purpose’ could be used to enable physiotherapists to explicate and critically reflect on their interactive behaviours during encounters with patients. As a result of these deliberations, I felt it was important to develop a model of physiotherapist-patient interactions informed by the concept of ‘Merging Worlds’. The model is described in detail below.

8.3 Mindful, Reciprocal Interaction; Synthesis and application

The model of Mindful, Reciprocal Interaction (see Figure 13) has been constructed from the findings and observations made during this study The model also draws on existing literature and theory, including the concepts of fusion of horizons (Gadamer 1975/2004), ‘reflecting-on-experience’ and ‘reflection-within-the-moment’ (Johns 2009), the theory of complex responses processes of relating (Suchman 2006) and the theory of biopsychosocial processes of relating (Alder 2007). The model depicts the physiotherapist-patient interactive dyad and is designed to assist cardiorespiratory physiotherapists’ understandings of the complexity inherent in their interactions with chronically breathless patients. Additionally, a series of facilitating questions linked to the model provide a framework for physiotherapists to explicate, and critically reflect on the way they interact with patients (Table 4).
Figure 13: Mindful, Reciprocal Interaction: A model to assist explication and critical reflection on interactive behaviours used during encounters with patients

[Original in colour]
### Perspectives and patterns of relating

#### Exploring the physiotherapist’s past horizon
(relating to Figure 13: Box 1)
- What ideas, beliefs and knowledge guide the way I approach my relationship with the patient (model of practice)?
- What ideas, beliefs and knowledge guide the decisions I make (reasoning processes)?
- How do my model of practice and reasoning processes inform the way I interact with and relate to the patient?

#### Exploring the patient’s past horizon
(relating to Figure 13: Box 2)
- What knowledge and experience could be influencing the way the patient interacts with and relates to me?
- How might the patient’s illness influence their viewpoint?
- Do I explore the patient’s viewpoint?

#### The physiotherapist’s patterns of relating and patterns of meaning
(relating to Figure 13: Box 3)
- How do I relate to the patient? (e.g., am I clinician, patient or relationship-centred?)
- What understandings and views do I bring to the encounter, as an individual and as a physiotherapist? (e.g., my vocabulary, concepts and knowledge)
- How does the way I relate and what has meaning for me become apparent moment-to-moment during the encounter? (e.g., verbal and non-verbal behaviours)
- Am I empathic? How do I express this?
- How does the way I relate and what has meaning for me influence the patient’s responses? (e.g., physiological, psychological, emotional)
- What effect has this interaction had on me as a person and as a physiotherapist? (e.g., emotional responses)
- Do I encourage or inhibit new ways of relating or new understandings to develop? (e.g., am I adaptable to other ways of relating, open to seeing other peoples meanings and viewpoints)

#### The patient’s patterns of relating and patterns of meaning
(relating to Figure 13: Box 4)
- How does the patient relate to me? (e.g., passive, collaborative, challenging)
- What understandings and views does the patient bring to the encounter? (e.g., their vocabulary, concepts and knowledge)
- How does the patient’s way of relating and what is important to them become apparent moment-to-moment? (e.g., their verbal and non-verbal behaviours)
- How does the patient’s way of relating and what has meaning for them influence my responses? (e.g., my thoughts, emotions, physical responses)

#### Verbal and non-verbal behaviours
- What am I expressing verbally and non-verbally?
- What is the patient expressing verbally and non-verbally?
- How do the patient’s behaviours effect me?
- How do my behaviours effect the patient?
- Does the way I interact influence the outcome of the encounter?

---

**Table 4:** Physiotherapist-patient interactions: A framework for explication and critical reflection

[Original in colour]
8.3.1 Components of the model of Mindful, Reciprocal Interaction and means of facilitating reflection on them.

This section describes the components of the model of Mindful, Reciprocal Interaction and a means by which each component can be critically reflected upon using the questions identified in Table 4.

The physiotherapist's past horizon of understanding

During physiotherapist-patient interactions each of the partners in the dyad bring their knowledge, experience and intentions i.e. their past horizon of understanding to the encounter (Gadamer 1975/2004). Suggested factors that underlie the physiotherapist’s past horizon are portrayed in Figure 13: Box 1. The factors include models of practice, reasoning processes and previous knowledge and experience. Chapter Two, section 2.3.1, discusses how these aspects are unique to each physiotherapist (Trede 2006). Greater consideration of these factors will support interactive behaviours that are more mindful and consciously applied within physiotherapy practice.

The patient's past horizon of understanding

Suggested factors underlying the patient’s past horizon are shown in Figure 13: Box 2. These factors include the patient’s prior knowledge and experience, and the patient’s unique experience of their illness.

Physiotherapist’s and patient’s patterns of relating and meaning, and physiology

The physiotherapists and the patients will have their own unique patterns of relating and patterns of meaning (Suchman 2006). These will be informed by their individual past horizon of understanding (Gadamer 1975/2004). Both partners bring their unique patterns of relating, patterns of meaning and personal physiology to the interaction (Suchman 2006, Alder 2007) (see Figure 13: Box 3 and 4).

The physiotherapist-patient interactive dyad

The circle enclosing the physiotherapist-patient interactive dyad (Figure 13) indicates that an ongoing reciprocal interaction is the foundation for achieving a
shared understanding and purpose and safe achievement of purpose with a patient. The physiotherapist-patient interactive dyad depicts the patient and physiotherapist as being present to each other and involves moment-to-moment perceiving, interpreting and responding to each other’s verbal and non-verbal dialogue. The large blue arrows represent the continuous external gesture-response communication cycle (Suchman 2006). The large blue arrows illustrate how the physiotherapists’ behaviours inevitably influence the patient’s behaviours and vice versa.

Facilitating questions
The series of questions in Table 4 correspond with the different components of the Mindful, Reciprocal Interaction model. The questions encourage the physiotherapist to view the physiotherapist-patient interactive dyad as a reciprocal, biopsychosocial, relational process. The questions provide a framework for physiotherapists to explore, explicate and critically reflect on their own and the patient’s interactive behaviours and how these behaviours influence the merging of theirs’ and the patients’ worlds.

Physiotherapists’ and patients’ internal dialogue
Within the large circle encompassing the physiotherapist-patient interactive dyad, two smaller circles denote the physiotherapist and the patient. The small blue arrows within each of the physiotherapist’s and the patient’s respective circles represent each individual’s ongoing internal dialogue. These arrows aim to prompt the physiotherapist to critically reflect on their own ongoing internal dialogue and to be aware that the patient also has an ongoing internal dialogue. The patient’s internal dialogue may or may not be disclosed yet will be influential on the interaction and its outcome.

Professional practice development
The challenge of explicating tacit knowledge has been discussed in sections 4.5.1 and section 8.2. The use of the model and facilitating questions are an aid to enable physiotherapists to explicate and critically reflect on their tacit knowledge and understandings. The depth of reflection necessary to examine one’s past horizon of understanding is difficult in-the-moment in busy clinical practice. As
such, I suggest that physiotherapists critically reflect on these factors annually as part of their continuing professional development. This may enhance physiotherapists’ knowledge of their pre-understandings and any changes that have occurred over time.

I propose that structured critical reflection on the physiotherapist-patient interactive dyad, that is the foundation of every patient encounter, should be incorporated into physiotherapists’ professional development sessions more frequently. Physiotherapists could undertake critically reflection independently, with a peer or with a more experienced supervisor. It is recommended that selecting interactions with patients perceived to be particularly good or difficult are a valuable learning opportunity to explicate and critically reflect on personal practice. Furthermore, the video-cued recall and reflection method was particularly effective in helping make tacit knowledge and routines become explicit. As such, a video-recorded interaction could be considered for use in conjunction with the model and questions. It is also recognised that in busy clinical environments the regular use of video-recording may be impractical and ethically challenging.

8.4 Summary

The chapter has discussed how the research findings led to the development of the new model of physiotherapy practice, Mindful, Reciprocal Interaction. The model depicts the physiotherapist-patient dyad as an interactional encounter. Additionally, a series of questions have been offered to provide a framework to aid explication of and critical reflection on interactive behaviours. The model of Mindful, Reciprocal Interaction and the facilitating questions offer a way for physiotherapists to become more aware of their interactive behaviours whilst treating patients. The model and questions are offered to enable physiotherapists to pay attention to the way they think, feel and respond moment-to-moment during interactions with patients to encourage a sensitivity to the way they behave in practice. I have also made recommendations about how the model can be used to develop physiotherapists’ knowledge of their interactive behaviours during encounters with patients. I propose that the explication of experienced physiotherapists’ understandings of their interactive behaviours will make this important aspect of practice knowledge available to develop more effective physiotherapy practice.
CHAPTER 9: SUMMARY AND CONCLUSIONS

9.1 Introduction

This chapter confirms that the research question and the aims of the study have been addressed. It summarises issues of reflexivity and rigour, and limitations of the study. Plans for implementation and dissemination of the findings, and directions for future research are described. A summary of the key contributions to knowledge and implications for practice is provided. The chapter makes explicit how the study provides an original contribution to physiotherapy practice knowledge.

9.2 Achieving the aims and objectives of the study

The original aim of this research study was to gain a deeper understanding of experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours when treating chronically breathless patients. The research objectives were:

1. To explore cardiorespiratory physiotherapists' understandings of their interactive behaviours when treating chronically breathless patients.
2. To express the physiotherapists’ understandings through thematic description.
3. To use insights from the findings to make recommendations for practice.

Hermeneutic phenomenology was chosen as the methodological approach because it endeavours to understand human experience from the perspective of individuals' lived experience and explores the meanings individuals give to actions and events. ‘Truth’ depends on a collective version of understanding. Consequently, this study drew on five experienced cardiorespiratory physiotherapists’ personal understandings of their interactive behaviours when treating chronically breathless patients. In addition, my personal pre-judgements and assumptions as an experienced cardiorespiratory physiotherapist were drawn on and challenged to re-awaken my understanding of physiotherapists’ interactive behaviours when treating patients. Consistent with a hermeneutic phenomenological approach to the process of understanding, data were generated.
through dialogue with the physiotherapists. The understandings described by the experienced physiotherapists were accepted as their construction of reality. A hermeneutic phenomenological methodological approach (van Manen 1990) was taken to the analysis of the cardiorespiratory physiotherapists’ accounts of their understandings. This involved in-depth exploration, interpretation and description of the understandings offered. The interpretations reached also incorporated my own understandings and drew on observations made during the data generation process with regard to eliciting practice knowledge.

The methodological approach facilitated the development of a rich thematic interpretation and conceptualisation of the physiotherapists’ understandings. The conceptualisation of ‘Merging Worlds’, was accomplished through three key dimensions: ‘Creating a facilitative space’, ‘Accessing and attending to your world’ and ‘Sharing my world’. The thematic interpretation and conceptualisation offers a detailed and insightful understanding of cardiorespiratory physiotherapists’ interactive behaviours when treating chronically breathless patients.

In addition, the model of Mindful, Reciprocal Interaction was created to allow the thematic interpretation and conceptualisation to have application in practice. The consideration of multiple perspectives, the methods of data generation used, the analytical process and presentation of the findings have supported the commitment of this study to a hermeneutic phenomenological approach.

9.3 Rigour and reflexivity, limitations and reflections

Issues of rigour have been addressed throughout the thesis. This section discusses aspects of reflexivity, rigour, study limitations and personal reflections not previously addressed. The findings and the scope of the study need to be judged in the light of these potential limitations.

9.3.1 Reflexivity

Reflexivity involved engaging in critical appraisal of my research practice. Initially, reflexivity was introspective. The research originated from my personal understandings. These understandings informed the research question and were the basis for acquiring a more generalised understanding and interpretation. Over the course of the study, introspective thinking evolved into a more explicit
understanding of the relationship between my personal understandings, the personal understandings of the physiotherapists and my knowledge claims (Finlay and Gough 2003).

From the outset of the research process I engaged in ongoing reflection on my prejudices and assumptions concerning interactive behaviours when treating chronically breathless patients. I viewed the physiotherapists as integral to the development of the findings. The data co-generated with the participants underpins the findings. ‘Collaborative reflexivity’ provided the opportunity to hear and take into account multiple voices and conflicting positions (Finlay and Gough 2003:161). Additionally, supervisor discussion facilitated the exploration of my understandings and assumptions and ensured that developing themes were representative of the data. I remained aware of how my own knowledge might influence how I interpreted the transcripts to help prevent over emphasising my own understandings in the data reduction. Throughout the study and the thesis I have endeavoured to make the influence of my pre-understandings and beliefs visible. I have remained mindful of these pre-understandings within my interpretations of the data. I have offered an interpretation supported by quotes from the physiotherapists so the findings can be transparent for evaluation. Additionally, I have discussed understandings offered by the physiotherapists and literature that did not concur with my interpretations.

9.3.2 Rigour

Rigour within the qualitative research paradigm is concerned with credibility, transferability, dependability and confirmability (Lincoln and Guba 1985). Confirmability is argued to be accomplished when credibility, dependability, transferability are achieved (Gethin and Clune-Mulvaney 2009). This section addresses these features in relation to this study.

Credibility

I have provided a trustworthy and faithful description and conceptualisation of the physiotherapists’ understandings of their interactive behaviours with chronically breathless patients. Credibility has been supported in a number of ways. I examined and made my pre-understandings transparent in Chapters One and Two. The descriptions generated during the video-cued recall and reflections
were initiated by the physiotherapists. I encouraged the physiotherapists to describe their unique understandings and they spoke freely about their understandings (see Appendix 16). Originally, I had planned to limit my influence during the video-cued recall and reflection to occasional prompting if the physiotherapists stopped talking. In the event, some of the physiotherapists required frequent prompting to elicit descriptions of their interactive behaviours. To reduce my influence during the follow-up interview I described nascent core concepts and themes that had been developed during analysis of the transcripts of the video-cued recall and reflection process. The physiotherapists were then encouraged to comment and discuss any additional thoughts and ideas (see Appendix 17). Again, some of the physiotherapists required much more prompting and direct questioning than others. These strategies intended to be a counter to my influence on the physiotherapists’ accounts and allowed the physiotherapists to provide rich, detailed descriptions of their personal understandings.

Additionally, during analysis I strove to remain open to statements that appeared significant and essential to the physiotherapists’ understandings. Although only I coded and developed themes from the data, the academic supervisors were consulted regularly throughout the analytical process to discuss and challenge the analytical choices and findings being developed. This enhanced consistency in the analysis and supported more insightful and considered interpretations. The findings are my personal interpretation of the physiotherapists’ understandings along with my observations during analysis which influenced and shaped the findings.

**Transferability**

Physiotherapy practice is context-bound and will be influenced by the particular individuals concerned and the environment in which it is undertaken. These factors need to be taken into account when transferring the findings to other physiotherapist-patient interactions and other contexts or specialities. Data were generated through recall and reflection on a video recording of a real world physiotherapist-patient interaction. I have provided a rich description of the experienced physiotherapists’ and my understandings of the nature of the interactive behaviours undertaken in a situated context; an encounter with a
chronically breathless patient. The study adds to physiotherapy practice knowledge by providing insights into experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients.

The findings of this study are not intended to be generalisable to the wider population of physiotherapists as this is not an interpretivist’s claim for research findings. The study did not set out to predict and find cause and effect, but to extend knowledge on the nature of experienced cardiorespiratory physiotherapists’ interactive behaviours. The knowledge developed can be drawn on and applied with consideration to inform more effective interactive behaviours in practice. I believe that the concept of ‘Merging Worlds’, the three dimensions described and the model of Mindful, Reciprocal Interaction will be meaningful to and have application for physiotherapists in other physiotherapy circumstances regardless of the practice context. Additionally, I believe the findings will resonate with and have significance for other health care professionals that care for patients with chronic breathlessness as well as other contexts involving distressing or challenging personal health experiences.

**Dependability**
Throughout this thesis the aim has been to make the research methods and each step of the research process and interpretation explicit and transparent. An audit trail was maintained during data generation and analysis to underpin the dependability of the study (see Chapters Four and Five and Appendices 16 and 17). The audit trail has included the transcribed interviews, field notes, notes on decisions made and the data analysis files. A detailed description of the research methods and analysis provided in Chapter Four and Five has allowed the analytical process to be followed and demonstrated how the findings were developed.

**Confirmability**
The credibility, transferability and dependability of this study have been described. However, the study’s confirmability will only be established when the findings are
meaningful to other physiotherapists and incorporated into the physiotherapy knowledge base and practice.

9.3.3 Limitations

The volume and detail of the data generated and the depth and complexity of the findings demonstrates that the research approach has been effective in exploring physiotherapists’ understandings of their interactive behaviours in practice. This section considers the study’s potential limitations.

There is an assumption that the data generated is an accurate and complete account of the physiotherapists’ understandings of their interactive behaviours. However, the physiotherapists may have overlooked certain understandings or overemphasised others. Additionally, some of the physiotherapists provided much more detailed descriptions than others. This raises the possibility that the coding and themes derived may have been shaped by the more talkative, expressive and reflective participants. Throughout analysis I repetitively returned to each of the physiotherapists’ transcripts to ensure that the codes, core concepts and themes developed were representative of the breadth of understandings described by the physiotherapists.

The sample was drawn from a population of experienced cardiorespiratory physiotherapists practicing in the Acute Hospital Trust where I have worked for many years. I supervise, educate and lead on practice change in the Therapies and Dietetics department and advocate a patient-centred approach. Consequently, my influence on the physiotherapists, the culture and approach to professional practice within the department cannot be ignored.

All the participants in this study were female. It is argued that female health care providers tend to use more partnership statements than men and show a stronger orientation towards sharing control (Roter et al. 2002). Although I did not intend to investigate gender, gender may have influenced the physiotherapists’ behaviours during the interaction. Consequently, caution is advised when applying the findings to different settings or to male physiotherapists.
The patients whose treatment sessions were video recorded had to meet certain criteria. They were medically stable, fluent in English and were prepared to engage in the therapy and research process. As a result, there may be limitations to applying the findings to more complex physiotherapist-patient interactions such as interactions with medically unstable patients, less engaged patients and patients who cannot speak English.

Additionally, I am a novice researcher and the intention of the follow-up interview was to discuss the concepts and themes derived from the video-cued recall and reflection. In hindsight, I recognise that my interviewing technique during these interviews was, at times, leading (Appendix 17). However, the concepts and themes raised during the follow-up interview were grounded in transcripts from the video-cued recall and reflection. A review of the recall and reflection transcripts indicates that during the video-cued recall and reflection my prompting had been minimal (Appendix 16). Questions were only asked when the video-cued recall and reflection did not produce generous description of the physiotherapists’ understandings of their interactive behaviours and in these instances the questions were largely open-ended.

Lastly, I am aware that a hermeneutic phenomenological approach is only one position from which to make an interpretation, that of the researcher. Other interpretations are always possible. I recognise that at any time there is potential for complementary and richer descriptions of experienced physiotherapists’ interactive behaviours when treating patients.

9.3.4 Reflections

Writing as reflection and to explicate thinking

The shaping of this thesis has been a slow process. At times I felt it was an insurmountable task that would never reach completion. Writing my thoughts and understandings, and making them coherent has been both stimulating and challenging.

Initially, the act of writing about my research question, theoretical perspective, methodology and findings separated me from what I thought I knew. This separation led to long periods of uncertainty and doubt. Yet, reflecting, writing and
re-writing led to new insights. The study moved forward and uncertainty was transformed into confidence. My thinking and perspective evolved, I came to realise what I knew (van Manen 1990). However, I recognise that my current knowing is transient and the new practice knowledge developed through this study can be extended upon and is open to further development.

Early within the writing process I was focussing on other research and knowledge rather than my own ideas and findings. Eventually, through writing I found a way to make my original ideas and findings apparent whilst at the same time incorporating other sources of knowledge to support my arguments.

Writing about and making explicit my thoughts and findings brought me closer to understanding the detail, complexity and depth of the participants and my knowledge of cardiorespiratory physiotherapists’ interactive behaviours when treating chronically breathless patients. Conversely, writing also allowed me to distance myself from the participants and my personal understandings of cardiorespiratory physiotherapists’ interactive behaviours. This distancing provided the opportunity to reflect more widely on everyday understandings. Reflecting on and writing about the findings allowed my understandings of cardiorespiratory physiotherapists’ interactive behaviours to become abstract. Iterative writing and re-writing and ongoing reflection helped me to see and conceptualise the multiple understandings in the participants’ accounts. Through writing, a thematic interpretation and a conceptualisation of the participants’ accounts were composed to make cardiorespiratory physiotherapists’ understandings of their interactive behaviours explicit. Van Manen (1990) proposes that:

‘writing decontextualizes thought from practice and yet it returns thought to praxis’

(van Manen 1990:128)

From the study’s inception, my aim was that the findings be transferable into everyday physiotherapy practice. I wanted the knowledge gained to return to practice. Writing my thoughts prompted the development of a model of
physiotherapist-patient interaction and a series of facilitating questions to enable explication and critical reflection on physiotherapists’ interactive behaviours in clinical practice.

Developing as a researcher
During the process of conducting the research study and writing this thesis I have learnt a great deal about being a qualitative researcher. My intense deliberations at each stage of the research journey have led to a greater understanding of the nature of the qualitative research process and the central importance of reflexivity in both conducting a qualitative study, and in my ongoing development as a researcher. As described in the previous section, reflection and writing profoundly influenced my growth as a qualitative researcher. I have learnt to reflect deeply on my assumptions, thoughts, the phenomenon under study and my research behaviours. I have moved from an epistemological position that espoused objectivism in the search for knowledge truth to a position that champions an interpretive approach to the generation of knowledge and understanding. Having negotiated and accomplished the complex process of qualitative inquiry I now see myself as a researcher.

9.4 Contributions to knowledge
Previous research investigating physiotherapist-patient interactions has used either qualitative or quantitative observational approaches. This study has focused on experienced cardiorespiratory physiotherapists’ personal understandings as well as drawing on observations made during the research process. As a result, the findings contribute new knowledge for physiotherapy practice on the interactive behaviours of experienced cardiorespiratory physiotherapists that has not previously been described. The following aspects of the findings of this study make significant original contributions to cardiorespiratory physiotherapy knowledge and practice:

- A detailed thematic interpretation of experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours is provided through three themes: ‘Creating a facilitative space’, ‘Accessing and attending to your world’ and ‘Sharing my world’. The themes portray key dimensions of the experienced physiotherapists’ understandings.
The new concept of ‘Merging Worlds - facilitating the journey to a shared understanding and purpose, and safe achievement of purpose’ is offered. This concept draws together the key dimensions of the cardiorespiratory physiotherapists’ described understandings of their interactive behaviours with chronically breathless patients.

This research study indicated that some process for explicating tacit practice knowledge was required. A new model of physiotherapy practice, Mindful, Reciprocal Interaction and a series of questions to facilitate explication and critical reflection on interactive behaviours used during therapeutic encounters with patients is proposed. This model was developed from the thematic interpretation and conceptualisation of the cardiorespiratory physiotherapists’ described understandings of their behaviours. Previous research and current physiotherapy literature has not offered a model or framework for explicating or reflecting on interactive behaviours in practice. The model of Mindful, Reciprocal Interaction and the facilitating questions provide a resource to enable physiotherapists to make explicit and to critically reflect on their interactive behaviours during treatment sessions with chronically breathless patients.

These three contributions to physiotherapy practice knowledge draw attention away from biomedical, technical approaches to patient management towards a model of practice that emphasises the importance of the physiotherapist-patient interaction and relationship.

Video-cued recall and reflection on a video recorded physiotherapist-patient interaction provided a novel method for rendering physiotherapists’ tacit practice knowledge of interactive behaviours explicit and in eliciting critical reflection on interactive behaviours used during encounters with patients.

Video-cued recall and reflection on real world interactions provides a novel research method for explicating tacit knowledge.
The findings from this research study highlight that experienced cardiorespiratory physiotherapists view their interactive behaviours as fundamental to successful therapeutic encounters with patients. The findings have implications for physiotherapy and other health care professions undergraduate and postgraduate clinical practice education. The findings support the development of more insightful and mindful interactive behaviours. Experienced physiotherapists’ tacit knowledge of interactive behaviours needs to continue to be made explicit so that these important practice behaviours can be described in further detail and shared.

9.5 Recommendations

I want my research to have an influence on health care practice. Therefore, it is important that the findings are disseminated and the recommendations are acted on so that the new knowledge is used in practice. This section discusses the action to be undertaken in order for the findings of this study to be incorporated into the body of knowledge informing physiotherapy and other health care professionals’ practice. In addition, directions for further research are also discussed.

9.5.1 Dissemination

My strategy to disseminate the findings includes local implementation, presentations to physiotherapy educators and professional conferences, national and international publication, and presentations within my profession.

In my role as an educator and supervisor, I plan to incorporate the model of Mindful, Reciprocal Interaction into the professional development of physiotherapists in the acute hospital Trust where I work. I also plan to evaluate the influence of incorporating the model and facilitating questions into the development of physiotherapists’ interactive behaviours in practice. The evaluation will involve interviewing physiotherapists to explore the influence of critically reflecting on their interactive behaviours during treatment sessions with patients. This dissemination strategy has been discussed with the service managers and two of the research participants. This plan has been met with enthusiasm and support.
Additionally, I intend to meet with physiotherapy educators to present and discuss the incorporation of the video-cued recall and reflection technique, and the model of Mindful, Reciprocal Interaction and the facilitating questions into pre and postgraduate curriculum planning and education.

The following presentations have been delivered in the last year or have been arranged to be presented in the near future:

*Interactive behaviours with anxious patients.* Presentation given at On-Call Course for Physiotherapists November 2010, Barnet and Chase Farm Hospitals NHS Trust

*Cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients.* Presentation given at PhD and Professional Doctorate Annual Work in Progress Conference. July 2011 University of Brighton

*Putting the spotlight on physiotherapists’ interactive behaviours.* Presentation to be given to senior musculoskeletal physiotherapists in October 2011 Barnet and Chase Farm Hospitals

*Putting the spotlight on physiotherapists’ interactive behaviours.* Presentation to be given to senior cardiorespiratory physiotherapists in October 2011 Barnet and Chase Farm Hospitals NHS Trust

*Critically reflecting on health care professionals’ interactions with chronically breathless patients.* Presentation to be given to Respiratory Physicians in March 2012. Barnet and Chase Farm Hospitals NHS Trust

*Health care professionals’ interactions.* Presentation to be given to Paediatric Consultants. Date to be arranged. Barnet and Chase Farm Hospitals NHS Trust
Pathophysiology of breathlessness and management of the breathless patient. Presentation to be given to MSc Physiotherapy students in January 2012. University of Hertfordshire

Physiotherapy management of the breathless patient.
Presentation to be given to MSc Physiotherapy students in February 2012 University College London

I also intend to submit papers from the thesis to the following national and international peer-reviewed journals:

Proposed journal: Physiotherapy
Title: Merging Worlds: Facilitating the journey to a shared understanding and purpose, and safe achievement of purpose.

Proposed Journal: Physiotherapy Theory and Practice
Title: Mindful, Reciprocal Interaction: A model of physiotherapist-patient interactions.

Proposed Journal: Association of Cardiorespiratory Physiotherapists in Respiratory Care Journal
Title: Cardiorespiratory physiotherapists’ interactive behaviours when treating chronically breathless patients.

Proposed Journal: Thorax
Title: Health care professionals’ interactive behaviours with chronically breathless patients: Experienced cardiorespiratory physiotherapists’ understandings.

Proposed Journal: Qualitative Research
Title: Video-cued recall and reflection: A novel way of eliciting tacit knowledge about practice behaviours.
Furthermore, I aim to submit papers to and attend national and international conferences organised by the Association of Chartered Physiotherapists in Respiratory Care, The Chartered Society of Physiotherapy and The British Thoracic Society.

9.5.2 Directions for further research

The practice knowledge generated by this study provides an understanding of experienced cardiorespiratory physiotherapists’ interactive behaviours with chronically breathless patients. The study has also highlighted directions for further research. These include exploration of:

- the ability of the model Mindful, Reciprocal Interaction and the facilitating questions to influence the abilities of physiotherapists to critically reflect on their interactive behaviours.
- interactions between physiotherapists and medically unstable patients, less engaged patients and patients who cannot speak English.
- influences of gender on physiotherapists’ interactive behaviours with patients
- physiotherapists’ understandings of their interactive behaviours in other specialities and clinical settings.
- aspects of effective interactive behaviours from the perspectives of other health care professionals.
- aspects of effective interactive behaviours from the perspectives of patients.
- interactive behaviours that are perceived as effective in achieving successful therapeutic encounters from a perspective of physiotherapists, other health care professionals and patients.

These directions are important to the continuing improvement of health care services generally. It is essential to continue to extend knowledge of effective health care professionals’ interactive behaviours during health care encounters from the perspectives of both health care professionals and patients. As previously discussed, patients’ experiences of health care encounters and processes have a significant impact on how they view the quality of care, and their
health outcomes (see sections 2.4.6 and 2.6). Additionally, measures of quality and outcome of patient care are no longer focused on biomedical indicators. There is now increasing emphasis placed on patient experience and patient determined outcome measures (Department of Health 2010b). Thus, it is important to conduct research that takes both experienced health care professionals and patients’ knowledge and experience into account.

9.6 Concluding thoughts

‘... we must search for ways to return to what is fully human, to deepen our awareness. Often this awareness comes through focusing and through explicating the crux of what is happening’

(Moustakas 1995:88)

The knowledge base currently informing interactive behaviours in physiotherapy practice is limited. It lacks in any description of cardiorespiratory physiotherapists’ interactive behaviours or their influence on patients’ participation, experience and outcomes. Important knowledge on interactive behaviours used in physiotherapy practice has been provided by focusing on experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours and incorporating knowledge from other fields.

This study has shown that experienced cardiorespiratory physiotherapists’ interactive behaviours are inherently complex, reciprocal and empathic and that these behaviours are viewed as essential to successful therapy encounters. The findings support the need to draw attention to and make explicit experienced health care professionals’ understandings of interactive behaviours during encounters with patients so practice can be enhanced.

By drawing on the understandings of experienced physiotherapists, the findings of this study offer a way for physiotherapists and other health care professionals to understand, conceptualise and critically reflect on their interactive behaviours during encounters with patients. The centrality of interactive behaviours to successful health care practice needs to be recognised, further explicated and incorporated into professional learning so that health care professionals conduct mindful, reciprocal interactions with patients.
REFERENCES


Department of Health (2010a) *Equity and excellence: Liberating the NHS*. The United Kingdom. Stationery Office Limited


Edwards I (2000) *Clinical reasoning in three different fields of physiotherapy: A qualitative case study*. PhD thesis, School of Physiotherapy, Division of Health Sciences, University of South Australia, Adelaide, Australia


Gysels MH & Higginson IJ (2009) Caring for a person in advanced illness and suffering from breathlessness at home: threats and resources. *Palliative and Supportive Care* **7**:153-162


Health Professions Council (2007) *Standards of Proficiency: Physiotherapists*. Health Professions Council


Parry RH & Brown K (2009) Teaching and learning communication skills in physiotherapy: What is done and how should it be done. Physiotherapy 95:294-301


Rice P & Ezzy D (1999) *Qualitative research methods: A health focus*. Oxford University Press


Street RL (1991) Information-giving in medical consultations: the influence of patients' communicative styles and personal characteristics. *Social Science and Medicine* **32**:541–8


Appendix 1: Causes of Chronic Breathlessness

<table>
<thead>
<tr>
<th>Causes of Chronic Breathlessness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac causes:</strong></td>
</tr>
<tr>
<td>• Left ventricular disease</td>
</tr>
<tr>
<td>• Valvular disease (mitral and aortic stenosis)</td>
</tr>
<tr>
<td>• Arrhythmias</td>
</tr>
<tr>
<td>• Pericardial disease</td>
</tr>
<tr>
<td><strong>Pulmonary causes:</strong></td>
</tr>
<tr>
<td>• Asthma</td>
</tr>
<tr>
<td>• COPD</td>
</tr>
<tr>
<td>• Fibrotic lung disease</td>
</tr>
<tr>
<td>• Pleural effusion</td>
</tr>
<tr>
<td>• Emphysema</td>
</tr>
<tr>
<td>• Primary or secondary lung malignancy</td>
</tr>
<tr>
<td>• Bronchiectasis</td>
</tr>
<tr>
<td><strong>Other causes:</strong></td>
</tr>
<tr>
<td>• Severe anaemia</td>
</tr>
<tr>
<td>• Psychogenic e.g. anxiety</td>
</tr>
<tr>
<td>• Neuro-muscular causes e.g. myasthenia gravis, Guillain Barre syndrome</td>
</tr>
<tr>
<td>• Thromboembolic disease</td>
</tr>
<tr>
<td>• Thyroid disease</td>
</tr>
<tr>
<td>• Obesity</td>
</tr>
</tbody>
</table>

Karnani et al. (2005)
Appendix 2: Knowledge Types Used in Practice

<table>
<thead>
<tr>
<th></th>
<th>THEORY / SCIENCE</th>
<th>PRACTICE</th>
<th>PRODUCTION/CREATIVITY</th>
<th>PRACTICAL WISDOM/ETHICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aristotle (1985) 4th Century BC</td>
<td>Episteme Theoretical</td>
<td>Techne Production</td>
<td>Phronesis Practical wisdom Ethics</td>
<td></td>
</tr>
<tr>
<td>Ryle (1949)</td>
<td>Propositional Knowing that</td>
<td></td>
<td>Procedural Knowing how</td>
<td></td>
</tr>
<tr>
<td>Oakeshott (1962)</td>
<td>Technical knowledge</td>
<td></td>
<td>Practical knowledge</td>
<td></td>
</tr>
<tr>
<td>Polayni (1967)</td>
<td>Explicit</td>
<td>Explicit</td>
<td>Tacit</td>
<td></td>
</tr>
<tr>
<td>Habermas (1972)</td>
<td>Instrumental action</td>
<td></td>
<td>Communicative action Emancipatory</td>
<td></td>
</tr>
<tr>
<td>Argyris and Schon (1974)</td>
<td>Espoused theories</td>
<td></td>
<td>Theories in use</td>
<td></td>
</tr>
<tr>
<td>Higgs and Titchen (2000)</td>
<td>Propositional</td>
<td>Professional craft knowledge</td>
<td>Personal knowledge</td>
<td></td>
</tr>
<tr>
<td>Eraut (2007)</td>
<td></td>
<td>Codified</td>
<td>Uncodified</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cultural</td>
<td>Personal</td>
<td></td>
</tr>
</tbody>
</table>

[Original in colour]
### Appendix 3: Professional Practice Models in Health

<table>
<thead>
<tr>
<th>PRACTICE MODEL</th>
<th>Illness model</th>
<th>Wellness model</th>
<th>Capacity model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kind of interest</strong></td>
<td>Technical</td>
<td>Practical</td>
<td>Emancipatory</td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td>Clinician centred</td>
<td>Patient centred</td>
<td>Patient empowered</td>
</tr>
<tr>
<td><strong>Philosophical paradigm</strong></td>
<td>Empirico-analytical</td>
<td>Interpretive</td>
<td>Critical</td>
</tr>
<tr>
<td><strong>Health definition</strong></td>
<td>Reductionist</td>
<td>Holistic</td>
<td>Holistic</td>
</tr>
<tr>
<td><strong>Focus of health</strong></td>
<td>Technical</td>
<td>Practical</td>
<td>Political</td>
</tr>
<tr>
<td><strong>Clinician power</strong></td>
<td>Clinician has power</td>
<td>Clinician may share some power</td>
<td>Equal power sharing</td>
</tr>
<tr>
<td><strong>Patient power</strong></td>
<td>Disempowered</td>
<td>Empowered</td>
<td>Empowered in a way that can be sustained</td>
</tr>
<tr>
<td><strong>Practice knowledge</strong></td>
<td>Propositional/technical</td>
<td>Propositional/technical and experiential</td>
<td>Propositional/technical/experiential and political</td>
</tr>
<tr>
<td><strong>Role of patient</strong></td>
<td>Passive, obedient, not asked to think for self</td>
<td>Interactive, participative but obedient, encouraged to think a bit for self</td>
<td>Interactive, participative, contributing, self-determining, learn to think for self</td>
</tr>
<tr>
<td><strong>Role of clinician</strong></td>
<td>Teacher/provider</td>
<td>Listener</td>
<td>Facilitator</td>
</tr>
</tbody>
</table>

(adapted from Trede and Higgs (2008a:34) [Original in colour])
### Appendix 4: Table of studies on physiotherapist-patient interaction

<table>
<thead>
<tr>
<th>Author</th>
<th>Date</th>
<th>Purpose</th>
<th>Sample</th>
<th>Data generation</th>
<th>Analysis</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raz et al.</td>
<td>1991</td>
<td>To identify gender-related values, perceptions, and experiences of female physical therapists.</td>
<td>10 experienced physical therapists (all female).</td>
<td>In-depth interviews</td>
<td>Aggregation of data for thematic analysis.</td>
<td>Three major thematic categories: (1) values, with subcomponents of caring, relationship, empowerment, and context; (2) family role, with subcomponents of enhancements, limitations, and coping strategies; and (3) sexism, with subcomponents of leadership, money, and respect.</td>
</tr>
<tr>
<td>Jensen et al.</td>
<td>1992</td>
<td>To investigate the work of master and novice clinicians within the practice setting.</td>
<td>3 master and 3 novice physiotherapists.</td>
<td>Direct observation and audio-recording. Interviews with physiotherapists’ and patients’. Review of patient records.</td>
<td>Aggregation of data for thematic analysis.</td>
<td>Five attribute dimensions distinguished master from novice clinicians: Four related to improvisational performance: ability to control the environment; evaluation and use of patient illness and disease data; focused verbal and non-verbal communication with the patient; importance of teaching to hands-on care. One related to knowledge of pathology and experience with the course of healing; confidence in predicting effective patient outcomes.</td>
</tr>
<tr>
<td>Author</td>
<td>Date</td>
<td>Purpose</td>
<td>Sample</td>
<td>Data generation</td>
<td>Analysis</td>
<td>Findings</td>
</tr>
<tr>
<td>------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Thornquist</td>
<td>1994</td>
<td>To describe how physiotherapists relate to and examine patients.</td>
<td>2 experienced manual physiotherapists (1 male and 1 female) Selected due to their discrepancy in the view of the patient's body that manifested in the physiotherapists' practice. Setting: Musculoskeletal outpatients</td>
<td>Direct observation and video recording. Interviews.</td>
<td>Descriptive analysis.</td>
<td>Patient information adapted to physiotherapists' biomedical frame of reference. Physiotherapists operate with unintegrated worlds of knowledge.</td>
</tr>
<tr>
<td>Lundvik Gyllensten et al.</td>
<td>1999</td>
<td>To identify expert physiotherapists perceptions of the important factors influencing the quality of the interaction in physiotherapeutic treatment</td>
<td>10 experienced physiotherapists (all female). Known to be experts in interaction. Setting: Primary health care</td>
<td>Interview using a multiple sorting technique to identify important factors or events contributing to interaction. Written examplar (first person account of a critical incident). 2nd semi-structured interview with examplar.</td>
<td>Triangulation of data. Cross-case analysis. Aggregation of data for thematic analysis</td>
<td>Two dimensions: 'Prerequisite dimension' and 'interaction dimension'.</td>
</tr>
<tr>
<td>Author</td>
<td>Date</td>
<td>Purpose</td>
<td>Sample</td>
<td>Data generation</td>
<td>Analysis</td>
<td>Findings</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ambady et al.</td>
<td>2002</td>
<td>To determine the relationship between physical therapists communicative behaviours in actual interactions with elderly patients and the patients health care outcomes.</td>
<td>11 physical therapists (8 female and 3 male) 48 patients (28 female and 20 male)  Setting: Geriatric rehabilitation</td>
<td>Video-recording, evaluation of thin slices of the therapists behaviours (48 interactions). Patients' physical and cognitive measures at admission, discharge and three month follow up.</td>
<td>Statistical analysis non-verbal communication and patients' health care outcomes.</td>
<td>Physiotherapists' distancing behaviours strongly correlated with short and long-term decreases in patients' physical and cognitive function. Facial expressiveness was associated with short and long-term improvements in patients' functioning.</td>
</tr>
<tr>
<td>Talvitie and Reunanen</td>
<td>2002</td>
<td>To identify how physiotherapists and patients construct their treatment interaction in stroke rehabilitation through conversation.</td>
<td>10 experienced physiotherapists (2 male and 8 female)  Setting: Stroke rehabilitation</td>
<td>9 treatments video recorded and transcribed. Non-oral and physical activities were noted.</td>
<td>Discourse analysis.</td>
<td>Amount: the physiotherapists spoke most of the time, the patients only asked a few questions or made brief comments. Content: mainly oral guidance related to implementation of therapy.</td>
</tr>
<tr>
<td>Resnik and Jensen</td>
<td>2003</td>
<td>To describe the characteristics of physiotherapists whose patients had good clinical outcomes. To build on previous framework of physiotherapy expertise.</td>
<td>6 expert physiotherapists and 6 average physiotherapists, selected based on patients' outcomes. Setting: Outpatient, acute care, paediatric and geriatric</td>
<td>Semi-structured interview. Follow-up interview, telephone calls, letters or email.</td>
<td>Grounded theory. Saturation of categories.</td>
<td>Physiotherapists classified as expert used patient-centred approach (collaborative clinical reasoning and promotion of patient empowerment)</td>
</tr>
<tr>
<td>Author</td>
<td>Date</td>
<td>Purpose</td>
<td>Sample</td>
<td>Data generation</td>
<td>Analysis</td>
<td>Findings</td>
</tr>
<tr>
<td>-----------------</td>
<td>------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Edwards et al.  | 2004 | To examine the clinical reasoning of expert physical therapists in different fields. | 6 expert physical therapists (purposeful sample).  
6 physical therapists (convenience sample)  
Settings: orthopaedic, neurological and domiciliary care. | Direct observation and audio-recording and field notes (79 sessions observed).  
Semi-structured and unstructured interviews.  
Combining of reasoning strategies: dialectical reasoning |
| Australia       |      |                                                                          |                                                                        |                                                                                  |                                      |                                                                          |
| Parry           | 2004a| To identify how interpretations and interactional consequences of physical incompetence are dealt with during stroke physiotherapy. | 10 experienced physiotherapists.  
(9 female, 1 male)  
21 patients  
(male and female.)  
Setting: Stroke rehabilitation | Video recorded treatment sessions (77 sessions). | Conversation analysis. | Patients and therapists limit physical incompetence negative implications.  
Therapy constructed as co-operative and successful. |
<table>
<thead>
<tr>
<th>Author</th>
<th>Date</th>
<th>Purpose</th>
<th>Sample</th>
<th>Data generation</th>
<th>Analysis</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parry</td>
<td>2004b</td>
<td>To identify physiotherapists and patients communication practices during therapy goal setting.</td>
<td>10 experienced physiotherapists. (9 female. 1 male) 21 patients (male and female.) Setting: Stroke rehabilitation</td>
<td>Video recorded treatment sessions (74 sessions).</td>
<td>Conversational analysis.</td>
<td>Only 8 goal-setting episodes identified. In 7 the therapist supplied the problems or abilities for which the goals were set. Interactional difficulties, delays in eliciting patients views and goals</td>
</tr>
<tr>
<td>Wohlin, Wottrich et al.</td>
<td>2004</td>
<td>To describe and compare characteristics of physiotherapy sessions from the physiotherapists’ and patients’ perspectives in relation to observed behaviour.</td>
<td>10 physiotherapists with varying duration of experience. 9 patients (male and female) Setting: Stroke rehabilitation</td>
<td>Observation of physiotherapist-patient session (18 observed interactions). Field notes. Separate semi-structured interviews with physiotherapist and patient</td>
<td>Aggregation of data for thematic analysis.</td>
<td>Six themes identified. Differences in physiotherapists’ and patients’ descriptions of the characteristics of physiotherapy sessions</td>
</tr>
<tr>
<td>Roberts and Bucksey</td>
<td>2007</td>
<td>To measure the content and prevalence of verbal and nonverbal communications between physical therapists and patients.</td>
<td>7 physical therapists (all female) 17 patients (12 male and 5 female) Setting: Patients with back pain</td>
<td>Video recorded initial assessment. Semi-structured interviews to determine perceived influence of video camera.</td>
<td>Mixed methods. 1. Statistical analysis of verbal and nonverbal communication. 2. Thematic analysis of interviews.</td>
<td>Physiotherapists spent twice as much time talking as patients, content behaviours in talk = 52%. Most prevalent non-verbal behaviours, touch (54%) and eye gaze (84%)</td>
</tr>
<tr>
<td>Author</td>
<td>Date</td>
<td>Purpose</td>
<td>Sample</td>
<td>Data generation</td>
<td>Analysis</td>
<td>Findings</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------</td>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Thomson</td>
<td>2008</td>
<td>To describe physiotherapists' perspectives of how therapist-patient interactions influence success or contribute to meeting patients goals.</td>
<td>4 physiotherapists various duration of experience (all female)</td>
<td>Observation, audio-recording and field notes.</td>
<td>Aggregation of data for thematic analysis.</td>
<td>3 types of interactions. Patients who achieved positive outcomes entered into interactions that were typified by assertiveness, negotiation, and critical reflection.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td></td>
<td></td>
<td>12 patients</td>
<td>Follow-up unstructured interviews.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Setting: three week chronic pain management programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oien et al.</td>
<td>2011</td>
<td>To describe communicative patterns (verbal and nonverbal) in demanding physiotherapy treatment situations.</td>
<td>6 experienced physiotherapists (1 male, 5 female)</td>
<td>Video recorded treatment sessions (44 sessions).</td>
<td>Aggregation of findings across cases for thematic analysis</td>
<td>One main communicative pattern: seeking for common ground – demanding negotiating process. Two types of challenges: ambivalence and uncertainty; impatience and disagreement</td>
</tr>
<tr>
<td>Norway</td>
<td></td>
<td></td>
<td>12 patients (10 female and 2 male)</td>
<td>Field notes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Setting: Psychomotor outpatient: patients with chronic muscular neck or back pain.</td>
<td>Interviews (6 with physiotherapists, 11 with patients).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patients’ personal notes about experiences of communication (40 sets).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Focus group with all the physiotherapists.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5: Participants Research Journey

<table>
<thead>
<tr>
<th>Participants research journey</th>
<th>Research Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in research study requested by physiotherapy assistant</td>
<td>Recruitment</td>
</tr>
<tr>
<td>Meet with researcher face to face to hear about the purpose of the study,</td>
<td></td>
</tr>
<tr>
<td>receive information sheet</td>
<td></td>
</tr>
<tr>
<td>Make decision</td>
<td>Decision time</td>
</tr>
<tr>
<td>minimum 24 hours</td>
<td></td>
</tr>
<tr>
<td>Meet with researcher to ask questions and to sign consent, receive a copy of signed</td>
<td>Consent</td>
</tr>
<tr>
<td>consent form</td>
<td></td>
</tr>
<tr>
<td>Choose a breathless patient from my current caseload and ask if they would be willing to</td>
<td></td>
</tr>
<tr>
<td>be video recorded during a normal treatment session.</td>
<td></td>
</tr>
<tr>
<td>Provide researcher with details of an agreeable patient</td>
<td></td>
</tr>
<tr>
<td>Agree date and time of session to be video recorded with researcher</td>
<td>Stage One</td>
</tr>
<tr>
<td>Treatment session video recorded</td>
<td></td>
</tr>
<tr>
<td>Video cued recall and reflection with researcher</td>
<td>Stage Two</td>
</tr>
<tr>
<td>Follow up interview with researcher and debrief</td>
<td>Stage Three</td>
</tr>
</tbody>
</table>

[Original in colour]
Appendix 6: Letter of NHS Research Ethics Committee Approval

28 September 2007

Mrs Bernadette Henderson

Dear Mrs Henderson

Full title of study: Experienced cardiorespiratory physiotherapists understandings of their interactive behaviour with chronically breathless patients.

REC reference number: 07/H0723/76

The Research Ethics Committee reviewed the above application at the meeting held on 25 September 2007. Thank you for attending the meeting with your Supervisor.

Ethical opinion

In discussion, the Committee had no particular ethical issues but the following points were raised and discussed.

1. The committee suggested it may be difficult to maintain confidentiality if the video recording was carried out in a ward situation. You agreed that this could be a problem and would endeavour to use a side room or a more private location to carry out this task.

2. Concern was raised about the possibility of a participant becoming anxious during the course of the video recording. You agreed to take this into consideration and would draw up a plan to manage this.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.
Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. The favourable opinion for the study applies to all sites involved in the research.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>1</td>
<td>05 September 2007</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>05 September 2007</td>
</tr>
<tr>
<td>Covering Letter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td></td>
<td>05 September 2007</td>
</tr>
<tr>
<td>Peer Review</td>
<td></td>
<td>29 August 2007</td>
</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>1</td>
<td>03 September 2007</td>
</tr>
<tr>
<td>GP/Consultant Information Sheets</td>
<td>1</td>
<td>03 September 2007</td>
</tr>
<tr>
<td>Participant Information Sheet:</td>
<td>1</td>
<td>03 September 2007</td>
</tr>
<tr>
<td>Participant Consent Form:</td>
<td>1</td>
<td>03 September 2007</td>
</tr>
<tr>
<td>Study Flow Chart</td>
<td>1</td>
<td>03 September 2007</td>
</tr>
<tr>
<td>CV for Supervisor - Dr. A. Glynn</td>
<td></td>
<td>03 September 2007</td>
</tr>
</tbody>
</table>

R&D approval

You should arrange for the R&D office at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research at a NHS site must obtain final approval from the R&D office before commencing any research procedures.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.
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.

<table>
<thead>
<tr>
<th>07/H0723/76</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please quote this number on all correspondence</td>
</tr>
</tbody>
</table>

With the Committee’s best wishes for the success of this project

Yours sincerely

Chair

<table>
<thead>
<tr>
<th>Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard approval</td>
</tr>
</tbody>
</table>

Copy to: Professor Ann P Moore
Appendix 7: NHS Trust Department of Clinical Governance and Risk Approval

01/02/2008

Mrs Bernadette Henderson

Dear Mrs Henderson

Re: Experienced cardiorespiratory physiotherapists understandings of their interactive behaviour with chronically breathless patients

Thank you for your letter of application, requesting for this Trust's approval of the above mentioned research project.

As you have confirmed that you have gained ethical approval from LREC and MREC, I am pleased to confirm that on behalf of [blank] Trust I approve your research project to take place within our organisation.

If you have any further questions please do not hesitate in contacting [blank] our Research contact for [blank] Trust on:

Tel: [blank]
Email: [blank] or

[blank]

Yours sincerely

Associate Medical Director and Trust Lead for Research

[Original in colour]
Appendix 8: Participant’s Study Information Sheet

Headed paper - dated

Physiotherapist Participant Information Sheet

Study Title: Experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviour with chronically breathless patients.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Researcher’s background.
The researcher is a post-graduate student at the University of Brighton studying for a Professional Doctorate in Physiotherapy in addition to working as an Advanced Clinical Practitioner in Cardiorespiratory Physiotherapy at [Redacted] Hospitals NHS Trust.

What is the purpose of the study?
The purpose of the study is to explore experienced physiotherapists’ understanding of their interactive behaviour whilst treating chronically breathless patients. It is anticipated that the findings will provide the researcher with a detailed appreciation of the participants’ perspectives of their behaviour. The study will inform a Professional Doctorate thesis which will describe and explore experienced physiotherapists’ interactive management of breathless patients. The ultimate aim is to gain a greater understanding of the behaviours and skills utilized which may support further developmental work to enhance physiotherapy interventions with chronically breathless patients.

Why have I been chosen?
You have been chosen because you are a currently practicing qualified physiotherapist with greater than five years of specific cardiorespiratory experience and you work in one of the hospitals participating in the study. A maximum total of ten physiotherapists and ten patients will be taking part in the study.

Do I have to take part?
No. Your participation is voluntary. You may refuse to participate or withdraw from the research without giving a reason, at any time. There are absolutely no consequences if you decide to refuse or withdraw. If you decide to participate you will be given a copy of this information sheet and a copy of the consent form which you will be asked to sign.

What will happen to me if I take part?
If you agree to take part you will be asked to identify a chronically breathless patient from your current caseload, either an out-patient or an in-patient ready for discharge. You will be asked to approach a patient selected by you and ask them...
if they are willing to be contacted by the researcher so that their consent to be 
video recorded during a routine treatment session can be gained. If the patient 
agrees, the researcher will be responsible for gaining the signed informed consent.

The study consists of three stages. The first stage is the observation stage 
followed by two interview stages. The observation will involve you being video 
recorded during a normal physiotherapy session with a chronically breathless 
patient. The patient may have a friend or family member present if they wish. 
This will not be used as data; the video recording will only be used as a prompt 
during the first interview. You may ask for the video recording to be stopped at 
any point or refuse for it to be used if you wish. The first interview with the 
researcher will be arranged at a time and a location convenient to you. During the 
first interview you will view the video recording of your physiotherapy session and 
be asked to describe your interactive behaviour by thinking aloud while you watch 
the video recording. If you find it difficult to describe your experience, approach 
and feelings in relation to your interactive management the researcher will ask 
prompting questions. The interview will take approximately one hour and will be 
audio recorded. The researcher may take notes during the interview. The audio 
recording of the interview will be written down. The researcher will spend time 
analysing the text of your interview and other participants' interviews. It is 
anticipated that the second interview will take a maximum of one hour. During the 
second interview, again at a time and a location convenient to you, the researcher 
will ask you about the themes and topics that have arisen from the first interviews. 
During the interviews with the researcher, personal and clinical information may be 
discussed. Your confidentiality and anonymity and the patients will be preserved 
at all times. Any identifying details will be removed from the data. The transcripts 
will be analysed to compare and contrast different physiotherapists’ perspectives 
looking for common themes.

What are the possible disadvantages if I take part?
There is the potential that you may feel anxiety because your practice is being 
observed and discussed. I am not looking to question your practice, but purely to 
explore and describe it. However, in the very unlikely event that there is 
something captured on the video that gives cause for professional concern I will 
discuss it with you prior to discussing it with your manager. You may feel distress 
talking about your experiences with chronically breathless patients. The 
researcher is an Advanced Clinical Practitioner in cardiorespiratory physiotherapy 
with more than twenty years of professional clinical experience including 
communicating and discussing with physiotherapists about their clinical practice. 
If you experience any distress the researcher will discuss with you the source of 
your distress and try to resolve it. If this is not possible, with your agreement, the 
researcher will refer you to your line manager or the research supervisor. If the 
issues raised still cannot be resolved a referral to an Occupational Health 
counsellor will be recommended.

What are the possible advantages if I take part?
There is no obvious immediate benefit to you. It is hoped that this study will 
support further developmental work to enhance physiotherapy interventions with 
chronically breathless patients. However, in depth discussion about ones own 
experiences of clinical practice can give insight into desirable and effective 
practice. It will allow you to express your personal knowing, ideas and opinions.
Will the interviews take place during my working hours?
This is up to you. It has been agreed with the Therapy Manager that the two hours required for the interviews will be considered as and included in your professional development time. If you would rather not use your professional development time for this purpose then the interviews can be arranged outside your normal working hours.

Will my taking part in this study be kept confidential?
All information collected about you during the course of the research will be kept strictly confidential.

Video recording: The video recording will be collected and stored in accordance with the Data Protection Act 1998. The researcher will remove any identifying details from the video recording and a code name will be attributed to it. The video recording will be destroyed on completion of the study. Only you and the researcher will have access to the video recording.

Data generated from interviews: Only the researcher and academic supervisor will have access to this data. All data (audio recordings, written record, notes) will be collected and stored in accordance with the Data Protection Act 1998. The researcher will remove any identifying details from the data. Code names will be attributed to the audio recordings and initial transcript. The code name will be preserved throughout the study and used in any presentations or publications. The data collected during the course of the study may be used for subsequent research. The audio recordings will be destroyed and all other data will be disposed of in a secure manner in accordance with academic research regulations.

Will I be debriefed at the end of the research?
Yes. You will receive a copy of the study findings and any publications arising from your participation. You will not be identified in any of the study reports.

Research Approval.
This study is being conducted with the approval of the …………… Research Ethics Committee and under the supervision of the Clinical Research Centre for Health Professions, University of Brighton.

Research Funding.
This study is not funded. Any expenses incurred in travelling to the interview will be reimbursed.

Independent Information or Advice.
You may obtain independent information or advice about your rights as a research subject or about being involved in this research study from the hospitals Research and Development Department.

Telephone numbers for Research and Development Departments:
Contact for further information.
Researcher:
Bernadette Henderson
Woodlands Unit
Barnet Hospital
Tel: [redacted]

or

Research Supervisors:

Dr. Angela Glynn
School of Health Professions
Robert Dodd Building
University of Brighton
49 Darley Road
Eastbourne, BN20 7UR
Tel: 01273643660

Professor Valerie Hall
University of Brighton
Mayfield House,
Falmer
Brighton BN1 9PH
Tel: 01273644015

Thank you for taking the time to read this.
Appendix 9: Patient’s Study Information Sheet

Headed paper - dated

Patient Information Sheet

Study Title: Experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviour with chronically breathless patients.

You are being invited to help in a research study. Before you decide, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask the researcher if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Researcher’s background.
The researcher is a post-graduate student at the University of Brighton studying for a Professional Doctorate in Physiotherapy in addition to working as an Advanced Clinical Practitioner in Cardiorespiratory Physiotherapy at Barnet and Chase Farm Hospitals NHS Trust.

What is the purpose of the study?
The purpose of the study is to explore physiotherapists understanding of their interactive behaviour whilst treating patients with chronic breathlessness. It is anticipated that the findings will provide the researcher with more knowledge about physiotherapist’s interactive behaviour. The study will inform a Professional Doctorate thesis which will describe and explore experienced physiotherapist’s interactive management of chronically breathless patients. The ultimate aim is to gain a greater understanding of the behaviours and skills used which can support further work to improve physiotherapy interventions with chronically breathless patients.

Why have I been chosen?
You have been chosen because you are breathless and currently require physiotherapy management and you are a patient attending one of the participating hospitals.

A maximum total of ten physiotherapists and ten patients will be taking part in the study.

Who are the physiotherapy participants?
Currently practicing experienced cardiorespiratory physiotherapists with greater than five years of specific cardiorespiratory experience.

Do I have to take part?
No. Your participation is voluntary. You may choose not to participate or to withdraw from the research, without giving a reason, at any time. There are absolutely no consequences if you decide to refuse or withdraw. If you decide to participate you will be given a copy of this information sheet and a copy of the two
part consent form. You will be asked to consent twice, firstly to being video recorded during a normal treatment session with your usual physiotherapist and secondly to allow the video recording to be used during the interviews. You will be asked to sign both.

What will happen to me if I take part?
If you choose to participate one of your normal routine physiotherapy sessions will be video recorded. This is the only part of the study you will be involved in. The aim is to video record a natural physiotherapy session, nothing will be different from the treatment you would normally receive. The video recorded treatment session will take approximately one hour and will be arranged at a time convenient to you and take place where you would usually be treated. You may have a friend or relative present if you wish. You may ask for the recording to be stopped at any time during the treatment session or refuse for it to be used if you want. You will be given the opportunity to view the video recording and approve its use.

Your confidentiality and anonymity will be preserved at all times. During the interviews with the researcher and your physiotherapist some of your personal and clinical information may be discussed. Any identifying details about you will be removed from the audio recorded interviews with your physiotherapist. The written record from the interviews with the physiotherapists will be analysed to compare and contrast different physiotherapist’s perspectives looking for common themes.

What are the possible disadvantages if I take part?
There is the potential that you may feel anxiety because you are being video recorded and that the video recording will be discussed. You are not being studied, I am looking purely to explore and describe your physiotherapists’ interactive behaviour. If you become unwell during the recorded session the video recorder will be stopped and the normal medical procedures for caring for patients who become unwell will be followed. If you experience any emotional distress the researcher will discuss with you the source of your distress and try to resolve it. The researcher is an Advanced Clinical Practitioner in cardiorespiratory physiotherapy with more than twenty years of professional clinical experience. However, if it is not possible for the researcher to resolve your distress, with your agreement, the researcher will refer you to the Therapy Manager or the research supervisor.

What are the possible advantages if I take part?
There is no obvious immediate benefit to you. It is hoped that this study will support further developmental work to enhance physiotherapy interventions with chronically breathless patients like you.

Will my taking part in this study be kept confidential?
All information collected about you during the course of the research will be kept strictly confidential.

Video recording: The video recording will be collected and stored in accordance with the Data Protection Act 1998. The researcher will remove any identifying details from the video recording and a code name will be attributed to it. The video recording will be destroyed on completion of the study. Only the researcher and your physiotherapist will have access to the video recording.
Data generated from interviews: Only the researcher and academic supervisor will have access to this data. All data (audio recordings, written record, notes) will be collected and stored in accordance with the Data Protection Act 1998. The researcher will remove any identifying details from the data. Code names will be attributed to the audio recordings and initial transcript. The code name will be preserved throughout the study and used in any presentations or publications. The data collected during the course of the study may be used for subsequent research. The audio recordings will be destroyed and all other data will be disposed of in a secure manner in accordance with academic research regulations.

**Will I be debriefed at the end of the research?**
Yes. You will receive a copy of the study findings and any publications arising from your participation. You will not be identified in any of the study reports.

**Research Approval.**
This study is being conducted with the approval of the ...Research Ethics Committee and under the supervision of the Clinical Research Centre for Health Professions, University of Brighton.

**Research Funding.**
This study is not funded. Any expenses incurred in travelling to the session will be reimbursed.

**Independent Information or Advice.**
You may obtain independent information or advice about being involved in this research study from your hospitals Research and Development Departments.

**Telephone numbers for Research and Development Department.**

**Contact for further information.**
Researcher: Bernadette Henderson

Tel: 07792339347

or

Research Supervisors:
Dr. Angela Glynn
School of Health Professions
Robert Dodd Building
University of Brighton
49 Darley Road
Eastbourne, BN20 7UR
Tel: 01273643660

Professor Valerie Hall
University of Brighton
Mayfield House,
Falmer
Brighton BN1 9PH
Tel: 01273644015

Thank you for taking the time to read this.
Appendix 10: Participant’s Consent Form

Headed paper - dated

Physiotherapist Participant Consent Form

Study Title: Experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviour with chronically breathless patients.

Researcher: Bernadette Henderson

I confirm that I have read and understand the information sheet dated …….. for the above study. I have had the opportunity to ask questions and they have been answered to my satisfaction.

I am aware that I will be required to participate in one video recorded session of my treatment of a chronically breathless patient and two audio recorded interviews with the researcher.

I understand that I have the choice for the interviews to be conducted during my professional development time or in my own time.

I understand that confidential information will be seen only by the named researcher and will not be revealed to any one else.

I understand that my data will be anonymised before data analysis. I give permission for the research supervisor to have access to my anonymised data.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

I understand that I will receive a copy of the study report.

I understand that anonymised direct quotations will be used in the study report, publications and presentations.

I agree to take part in the above study.

Name (please print)…………………………………………………………………………………………………….
Signed………………………………………………………………………………………………………………….
Date……………………………………………………………………………………………………………………….
Researcher (please print)……………………………………………………………………………………………
Signature of researcher………………………………………………………………………………………………
Date…………………………………………………………………………………………………………………………

Completed copies to be given to the participant and the researcher.
Appendix 11: Patient’s Consent Form - Part 1

Headed paper

Patient Consent Form - Part 1

Study Title: Experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviour with chronically breathless patients.

Researcher: Bernadette Henderson

I confirm that I have read and understand the information sheet dated ……. for the above study. I have had the opportunity to ask questions and they have been answered to my satisfaction.

I am aware that I will be required to participate in one video recorded session of my physiotherapy treatment.

I understand that during the interviews with the researcher and my physiotherapist some of my personal and clinical information may be discussed.

I understand that confidential information will be seen only by the named researcher and will not be revealed to any one else.

I understand that only the researcher and my physiotherapist will have access to the video recording.

I understand that the video recording will only be used as a prompt during the interviews and that the written report of these interviews will be anonymised before any analysis.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

I understand that I will receive a copy of the study report.

I agree to have a physiotherapy treatment video recorded.

Name (please print)…………………………………………………………………………………………
Signed……………………………………………………………………………………………………
Date……………………………………………………………………………………………………
Researcher (please print)…………………………………………………………………………
Signature of researcher…………………………………………………………………………
Date……………………………………………………………………………………………………

Completed copies to be given to the patient and the researcher.
Appendix 12: Patient’s Consent Form - Part 2

Headed paper

Patient Consent Form - Part 2

Study Title: Experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviour with chronically breathless patients.

Researcher: Bernadette Henderson

I confirm that I have read and understand the information sheet dated ........ for the above study. I have had the opportunity to ask questions and they have been answered to my satisfaction.

I understand that during the interviews with the researcher and my physiotherapist some of my personal and clinical information may be discussed.

I understand that confidential information will be seen only by the named researcher and will not be revealed to any one else.

I understand that only the researcher and my physiotherapist will have access to the video recording.

I understand that the video recording will only be used as a prompt during the interviews and that the written report of these interviews will be anonymised before any analysis.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

I understand that I will receive a copy of the study report.

I agree that the video recording of my physiotherapy treatment session on ............. may be used in the above study.

Name (please print)........................................................................................................................................
Signed...........................................................................................................................................................
Date..............................................................................................................................................................

Researcher (please print)...........................................................................................................................
Signature of researcher.................................................................................................................................
Date..............................................................................................................................................................

Completed copies to be given to the patient and the researcher.
Appendix 13: Patient’s Medical Consultants Study Information Sheet

Headed Paper - dated

Study Information Sheet

Study Title: Experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients.

Researcher: Bernadette Henderson MSc SRP

Patient name:
Hospital number:

Your patient is being invited to assist in a research study. They will not be a research participant. This information sheet is to explain why the research is being done and what it will involve.

Please take time to read the following information.

If there is anything that is not clear or if you would like more information please ask my contact details are at the end of the information sheet.

Researcher’s background.
The researcher is a post-graduate student at the University of Brighton studying for a Professional Doctorate in Physiotherapy in addition to working as an Advanced Clinical Practitioner in Cardiorespiratory Physiotherapy at Barnet and Chase Farm Hospitals NHS Trust.

What is the purpose of the study?
The purpose of the study is to explore experienced physiotherapists understanding of their interactive behaviour whilst treating chronically breathless patients. It is anticipated that the findings will provide the researcher with a detailed appreciation of the participant’s perspectives of their interactive behaviour. The study will inform a Professional Doctorate thesis which will describe and explore experienced physiotherapist’s interactive management of breathless patients. The ultimate aim is to gain a greater understanding of the behaviours and skills utilized which can support further developmental work to enhance physiotherapy interventions with chronically breathless patients.

Who are the physiotherapy participants?
Currently practicing qualified physiotherapist with greater than five years of specific cardiorespiratory experience working at one of the participating hospitals.

Who are the patients?
Chronically breathless patients, either out-patients or in-patients ready for discharge who require physiotherapy management and are able to give consent to being video recorded. The patients will only assist in the observation stage of the
study. A maximum total of ten physiotherapist and ten patient participants will be taking part in the study.

**Do the patients have to take part?**
No, their participation is voluntary. They may refuse to participate or withdraw from being video recorded without giving a reason, at any time. There are absolutely no consequences if they decide to refuse or withdraw. If a patient decides to participate they will be given a study information sheet and signed informed consent to be video recorded during a physiotherapy treatment session will be obtained.

**What will happen to the patient if they take part?**
The study consists of three stages. The first stage is the observation stage followed by two interview stages. The observation stage is the only part the patient will be involved in. This observed session will take approximately one hour. It will entail the patient being video recorded during a physiotherapy session. This video recorded session will be arranged at a time convenient to the patient and will take place where the patient would normally be treated. The patient may have a friend or family member present if they wish. The patient will be given the opportunity to view the video recording and approve its use. The video recording is not data and will only be used as a prompt during the interviews.

The physiotherapist participant will then be interviewed by the researcher on two occasions using the video recording to help them describe their interactive behaviour. During the interviews some of the patient’s personal and clinical information may be discussed. The interviews will be audio recorded and then transcribed. Patient confidentiality and anonymity will be preserved at all times. Any identifying details will be removed from the data. The transcripts from the interviews with the physiotherapists will be analysed to compare and contrast different physiotherapist’s perspectives looking for common themes.

**What are the possible disadvantages if a patient takes part?**
There is the potential that the patient may feel anxiety because they are being video recorded and that the video recording will be discussed. It will be emphasised that it is not the patient being studied; the researcher is looking purely to explore and describe physiotherapist’s interactive behaviour. The researcher is an Advanced Clinical Practitioner in cardiorespiratory physiotherapy with more than twenty years of professional clinical experience. If the patient experiences any distress the researcher will reassure them and the research supervisor will be available if necessary.

**What are the possible advantages if a patient takes part?**
There is no obvious immediate benefit to the patient. It is hoped that this study will support further developmental work to enhance physiotherapy interventions with chronically breathless patients.

**Will taking part in this study be kept confidential?**
All information collected about the patient during the course of the research will be kept strictly confidential.
Video recording: The video recording will be collected and stored in accordance with the Data Protection Act 1998. The researcher will remove any identifying details from the video recording and a code name will be attributed to it. The video recording will be destroyed on completion of the study. Only the researcher and the patients’ physiotherapist will have access to the video recording.

Data generated from interviews: Only the researcher and academic supervisor will have access to this data. All data (audio recordings, written record, notes) will be collected and stored in accordance with the Data Protection Act 1998. The researcher will remove any identifying details from the data. Code names will be attributed to the audio recordings and initial transcript. The code name will be preserved throughout the study and used in any presentations or publications. The data collected during the course of the study may be used for subsequent research. The audio recordings will be destroyed and all other data will be disposed of in a secure manner in accordance with academic research regulations.

**Will I be debriefed at the end of the research?**
Yes. You will receive a copy of the study findings and any publications if requested. The patients and physiotherapy participants will not be identified in any of the study reports.

**Research Approval.**
This study is being conducted with the approval of the Research Ethics Committee and under the supervision of the Clinical Research Centre for Health Professions, University of Brighton.

**Research Funding.**
This study is not funded. Any expenses incurred in travelling to the interview will be reimbursed.

**Contact for further information.**
Researcher: Bernadette Henderson
Physiotherapist
Tel: 

or

Research Supervisors:
Dr. Angela Glynn
School of Health Professions
Robert Dodd Building
University of Brighton
49 Darley Road
Eastbourne, BN20 7UR
Tel:01273643660

Professor Valerie Hall
University of Brighton
Mayfield House,
Falmer
49 Darley Road
Brighton BN1 9PH
Tel:01273644015

Thank you for taking the time to read this.
Appendix 14: Video-cued Recall and Reflection Interview Guide

Interview Guide

Study Title: Experienced cardiorespiratory physiotherapists’ understandings of their interactive behaviours with chronically breathless patients.

Guide to be used if ‘think aloud’ technique generates minimal data.

Time of interview:
Date:
Location:
Interviewer:
Participant Identification Number:

Researcher to briefly describe the purpose of the interview.

Tell me about this video recorded encounter with a chronically breathless patient

• What did you do?
• How did you do it?
• Why did you do it?
• What were your thoughts, emotional and physical responses and decisions at this point (related to observed interactive behaviour).
• Were specific interactive behaviours successful?
• Why do you think that?
• Was it a reasonably typical experience of treating a chronically breathless patient for you? If not, why not?

Has any of this discussion caused concern?
Any other issues not discussed which you would like to raise.

Thank the interviewee for participating in the interview. Assure him or her of confidentiality of responses.
Appendix 15: Follow-up Interview Guide Sample

Study Title: Experienced cardiorespiratory physiotherapists' understandings of their interactive behaviours with chronically breathless patients.

Time of interview:
Date:
Location:
Interviewer:
Participant Identification Number:

Describe the purpose of the interview: To expand on the participant’s video-cued recall and reflection and to explore developing concepts, core concepts and themes.

Potential topics to be discussed

1. The video-cued recall and reflection process.
   Any effect during the video-recorded session? Any subsequent effects?
   e.g. Did seeing yourself on video and discussing your interactive behaviours have any subsequent effects?

2. Participants’ non-verbal behaviours
   General
   e.g. You mentioned non-verbal behaviours such as body language, eye contact and gestures. Could you go into a bit more detail about the non-verbal behaviours you think are important?

   Specific
   • Body position and posture
     e.g. Can you describe why you chose particular body positions in relation to the patient?
     e.g. How do you judge your proximity during the interaction?

   • Use of voice
     e.g. You talked about your use of voice, can you tell me a little more about that?

   • Use of touch
     e.g. You described your use of touch, can you expand on that?

   • Eye contact
     e.g. Can you tell me a bit more about your eye contact with the patient?

   • Gestures
     e.g. You mentioned that you used head and hand gestures a lot, could you say some more about that?
3. Creating the environment

e.g. You talked about creating the right environment, what factors do you think are important?

You mentioned that you prepared the therapy area and the patient for the physiotherapy session? Could you tell me a bit more about that?

You describe providing comfort to the patient, can you expand on what you mean?

4. Attending

e.g. You previously talked about closely observing the patient to assess their physical and emotional state. What were you observing specifically?

5. Listening

e.g. You mentioned that you were actively listening to the patient. How would you describe active listening?

e.g. You described getting the patient relaxed to get more information from them, can you expand on this?

6. Empathic approach

e.g. Previously you said that you felt empathic towards the patient. Do you think you demonstrate that empathy? How?

7. Sharing information, decisions and control

e.g. You described how you articulated to the patient’s your understanding of their current state and what you believed was possible for the patient to achieve? How do you do this?

e.g. Who decides what the patient’s problems are and what therapy they need?

e.g. Who do you think has control during the interaction and the therapeutic activity?

e.g. Does your knowledge/ previous experience of the patient influence the way you interact?

Would you say this was an easy or a difficult interaction and what makes an interaction easy or difficult?

Anything else you would like to add.

Thank the interviewee for participating in the interview. Assure him or her of confidentiality of responses.
Appendix 16: Video-cued recall and reflection - Sample Transcript

Participant 1

Video started

Participant: Trying to keep my tone upbeat just to make her feel comfortable with me. Part of building a rapport with her and I thought she looked very nervous about the whole thing so this general conversation at the beginning was just to make her feel a bit more comfortable and less formal.
Pause: (5 seconds)

Participant: Again, just trying to remove a bit of clutter from around the area from around her as well so she doesn’t feel cluttered which will, you know, may impact on her breathing.
Pause: (3 seconds)

Participant: I am sitting down in front of her so I am not towering over again to make her feel comfortable and calm, and just acknowledging that I know that she had had a bit of an upset morning, and again just trying to acknowledge anything she might be feeling.
Pause: (7 seconds)

Participant: I am holding her hand (laughter) again trying to make her feel a bit more comfortable but trying not to be too far in her face but close enough to be developing that rapport.
Pause: (9 seconds)

Participant: I guess I think it is important to erm, you know I mean these questions are good for me to know but again to get a whole picture and you know I guess to get her feeling that I am thinking about everything, and that I am feeling for her and it is not just about the video.
Pause: (16 seconds)

Interviewer: If at any point you want to stop and go back do if you feel….
Pause: (8 seconds)

Participant: Again, I am not trying to talk too much, you know, just giving, trying to give short simple instructions, you know, having that conversation but making things nice and ordered just to try and help her feel calm.
Pause: (9 seconds)

Interviewer: Do you think you consciously think about that as you are doing it?

Participant: I do at times yes.
Pause: (4 seconds)

Participant: I don’t think I consciously think about it but I know that… that is probably why I do it.
Pause: (15 seconds)
Participant: *Laugh* Just trying to build her confidence *laugh*. Just trying to have that rapport with the son as well because he is a big part of, you know, his mum. If his mum is laughing it is important to be getting him onboard.

Participant: I always give someone a drink, I give them a drink for their chest and I give them a drink to help them feel calm just before I get them up and walking as well. It's normally water but if she wanted tea…. *laugh*.

Pause: (10 seconds)

Participant: I need just to try and offer a simple explanation again as we are trying to give her reassurance and encouragement that she is progressing.

Interviewer: Anything more about your body position about your thoughts or your emotions at the time?

Participant: Erm, I guess you know that I was quite aware of the fact that she was very anxious and she is an anxious lady and this erm is a probably slightly intimidating encounter for her and erm I thought just, you know, by coming down below her level just trying to lessen her perception of it being intimidating, and again, you know, to help her feel relaxed erm I certainly don't think that if someone is breathless and anxious it helps if you stand over them and close to them. I am just trying to provide a good explanation of what is coming. *Laugh* Trying to be quite hard.

Pause: (15 seconds)

Participant: I knew perfectly well what she was on at home I just wanted him to know that I knew.

Pause: (11 seconds)

Interviewer: So what do you think you are doing?

Participant: I am just trying to sort of restore a bit of confidence. The son had been very anxious about her going home and that I knew she was very close to discharge so, you know, I was trying to reinforce to him that she’s been doing very well, and that, you know, we are monitoring this, but it hasn’t really been a problem and that, you know, it was the heart rate I was checking more than the oxygen levels. And I am just trying to give her some instruction, but not too much, and trying to limit, really trying to limit the conversation while she is up, and I think probably while she is up and walking I dropped the tone of my voice a little bit, and I guess probably to just maintain the sense of calm, and to initially, you know, I guess erm feel that the situation is a controlled environment but then to sort of pass over a bit of that control to her once she has got the confidence.

Pause: (4 seconds)

Participant: Erm (4 seconds), so again you know coming to the end of her discharge trying to give her some control over what we are doing erm obviously providing reassurance but, you know, giving her the prompts to stop to catch her breath which I think is important.

Pause: (10 seconds)
Participant: I am in nice and close to her because although (laughter) she doesn’t need it I think its, well I don’t know whether it does or not erm help her to feel safe and comfortable.
Pause: (9 seconds)

Participant: Again, trying to keep the exercise, keep some control to the exercise by giving her some commands but then letting her, you know stop and rest when she feels like she feels she needs to (laughter).

Interviewer: Tell me a bit more about your voice and the words you use, have you thought about it before?

Participant: Erm, I think I try and……
Pause: 3 seconds

Interviewer: Why don’t I pause it?

Participant: Yes

Video paused

Participant: I think that the words I use are fairly sort of friendly but light-hearted words and they are very much my words (laughter) and I think that probably a little bit to do with having the children, in the background of treating children as well, which I sometimes think may not be appropriate to use the words that I use but I think because they are mine, it is about you know, having erm I don’t really know. I know that I try to keep my voice not so quiet so they can’t hear me or can’t understand me, but clear, but calm and fairly quiet really to help them feel calm, erm, and you know, the words I give, you know, the way I phrase words just to try to sort of make them sound positive or to give encouragement erm and then I think it is important that I try continually to give encouragement if, because I think that although yes this is almost the day before discharge, I think that she needs that positive reinforcement, erm you know looking at this I might stand too close to somebody that is feeling very anxious, however you know I don’t see her becoming more anxious as we go along, erm, and I have seen this lady very anxious and very upset and I know this is quite common for her erm which is good but I....

Interviewer: Do you think there was a particular, I mean you were saying about standing too close do you think there is a way of closeness or not closeness one should be with patients?

Participant: I think you know the only thing you have to perceive what you are doing at the time and I certainly know if someone was standing very close to me that would make me a lot more anxious erm but again you know I guess that it something you should be able to judge when you look at a patient, and, you know, you look at their facial expressions, you know some people like you to be a good foot away whatever and talking to them and some people are happy for you to be up close and particularly this lady is fairly unsteady on her feet as well, and her son often supervises her walking so I think it is appropriate that you are close, that I was close.
Participant: If I use my voice like that it helps me feel calm it’s the sort of voice I take when I am angry or it’s the sort of voice I adopt if I am busy and you know that helps me in my mind to slow things down and if I feel like that I am nice and calm then that certainly helps when you are treating a patient, and it certainly doesn’t help if you rush in, and you are in a hurry and specially with these breathless patients.

Participant: (Laughter) Again, just trying to make it fun now.

Participant: Just looking you know I said that because I could see that she was getting tired and acknowledging that you know, I know that normally that would be the most she would ever do, so I think it is important for her to realise that obviously now being very short of breath, and almost going home that this is actually quite normal for her.

Interviewer: Can you comment a bit about touch there?

Participant: Erm It’s just….

Participant: Yes, it’s just my hand normally goes there naturally I don’t know why (laughter). I’ve got no idea why but I guess it’s to try and you know… I think the patient knows how to catch her breath but sometimes I think it is nice if you are there and you are acknowledging that they are short of breath to just have some hands on even if it’s not really a therapeutic hands on, just someone there to help them try and relax, erm but if its, then again I wouldn’t normally sit down and do this with all of my patients, however, sometimes I would just… and then again I mean again this is talking about what I am physically doing, but erm, you know, I would just pop her down while she got her breath but I think that some of this actual hands on technique has helped really well with the patient in her latter few treatments particularly when she was having her panic attack. Then again,
obviously the curtain pulled aside is good for her privacy, but just to have a bit of quiet to let her catch her breath and a drink again.

Interviewer: And your focus on her as well.

Participant: Yes, yes it is to take away the distraction. Just trying not to actually talk too much, but not to sort of make a huge focus on what her numbers are or her sats are doing as well.

Pause: (4 seconds)

Participant: And then just trying to make this... me talking to her very much just us two and trying not to... and that's perhaps why I think why my voice went a bit quieter, because although there were quite a few people it just... this is just to put the focus on her and just try to get her breathing calm, back to normal.

Interviewer: Why do you think you said all that?

Participant: Again, to provide reassurance to both of them both, being quite anxious about almost going home, that things were good and reinforcing that this was her and her at the most she does, having done that things were looking good and hopefully.. I will just turn the machine off to stop it beeping.

Pause: (59 seconds)

Interviewer: Can you tell me about what you are doing now?

Participant: I think just to try and provide an explanation and give her.. help her feel between her breathlessness and activity.

Pause: (20 seconds)

Interviewer: I was just wondering how aware you are about the amount of nodding and direct eye contact, what you just did then is even more, you know you focus so much on the patient, you know that bending down and putting your head round to really make eye contact, you do a huge amount of reassuring.

Interviewer: One moment can we just rewind that a tiny bit if I can.

Participant: Yes.

Video rewinds: (48 seconds)

Interviewer: When you are talking to them you are nodding, you are talking to both of them.

Participant: Yep. (Laughter)

Pause: (10 seconds)

Participant: Erm I mean I am not aware of how much I nod my head but I know that I don’t know that I do it but I can see that I would do it a lot.

Interviewer: Is that making sure that they both are very included?
Participant: Again I think it’s to... sometimes I do it to emphasise my point if I am nodding at them it’s like, I am telling the truth (laughter). I think erm you know I guess it is again means of reassurance I suppose, I think eye contact is important erm and I hope that I provide to all the patients that I see with eye contact, erm I think it comes with being confident around the patient and comfortable around a patient as well, erm but I think its, I mean its all about, you know I think, erm the, I guess getting your patients to trust you, getting your patients to feel confident in you, giving them eye contact, erm but I would hope that I would give eye contact at some point to someone I was treating anyway. I was certainly not aware of doing the nodding.

Interviewer: I think it’s wonderful to watch, I’m also aware of how much extraneous noise is going on that you are not aware of, you know all the noise.....

Participant: (laughter) I say that a lot as well I guess that’s just to acknowledge that... I say it all the time as well and that you know that they know that they get a chance to rest and I think that is important because they then think to themselves right now I can have a little rest, its good to get back to a state of feeling normal and relaxed.

**Background noise**

*Pause: (12 seconds)*

Participant: I’m saying something stupid now. (laughter).

Interviewer: Just generally have you watched yourself much practicing.

Participant: No, no I don’t think I ever have.

Interviewer: What did you make of all that? Did that make you feel uncomfortable, make you feel good?

Participant: No, no didn’t make me feel uncomfortable certainly erm no, it looked better than what I would have thought. It’s awful watching yourself on video.

Interviewer: I have watched this three times and the more I watch it the more I enjoy watching it because it’s demonstrating, you know such nice communication with both her and her son, erm so was there anything that surprised you in there and anything from that you think you thought, has it made you reflect at all? I mean you say you weren’t aware you nodded quite so much.

Participant: No, no but you know erm no I think, I think that I probably know myself because I could almost guess what was coming next even if I hadn’t remembered it, if that makes sense, probably means that I do similar things with most people which is not necessarily a good thing, it might be that is just the way I try to interact with patients and it may be that it doesn’t work for everybody.

Interviewer: Oh yeh and you said that interesting thing about getting up close and I think you know....

Participant: Yes certainly and certainly.....
**Interviewer:** And why you would and why you wouldn’t.

**Participant:** Yeh but I hope I would be able to make that judgement at the time yeh.

**Interviewer:** Did you find it a bit strange?

**Participant:** Yeh and I sounded very Australian.

**Interviewer:** More Australian than you think and would you like to see that again at another time, I mean for yourself.

**Participant:** Yes, yes, yes, yes.

**Interviewer:** So anything that you saw that you thought I must change that or I want to do that differently?

**Participant:** Erm.

**Interviewer:** Are you happy?

**Participant:** I don’t think I was doing anything ridiculous, no erm no.

**Interviewer:** What about your interaction? I mean there were things we talked about with the closeness and the nodding.

**Participant:** I think perhaps that is just a little bit excessive.

**Interviewer:** I don’t think so at all.

**Participant:** It might drive someone a bit crazy though.

**Interviewer:** I don’t think it does.

**Participant:** I don’t really think that…..

**Interviewer:** I think that it was lovely.

**Participant:** She was a fairly straightforward, simple patient for me and she is quiet and she doesn’t... and you know she is not asking difficult questions and you know she is not really talking back either so it was quite a simple patient to do on, erm having seeing that I am fairly happy with what I’ve seen.

**Interviewer:** I think you should be, and just a sort of final thing is interactive behaviour, I mean what do you think are the key things, that you would say to maybe a junior, are important in interactive behaviour with patients?

**Participant:** With any patient?

**Interviewer:** Well, I mean these particular types of patients, anxious patients.
**Participant:** I think it is important that you look like you are in control, I think that is really important and even if you don’t feel like you are in control I think that it is important that you have a way of being able to take control, lots of people have different ways of doing that, erm and I think it is important certainly, to be calm and to be able to provide explanations when people ask you, erm and I think it is important to especially... patients who are short of breath to give clear instructions and not be too wordy, erm I think it is important to not you know what I mean to adopt a position that is appropriate for the patient and if I have got a junior I would say always try and squat down and not stand over them, erm again I would never obviously.. I mean eye contact is really important, erm but not I wouldn’t have said it hope that I would do it basically.

**Interviewer:** Everybody does.

**Participant:** No but perhaps yeh probably to go and see somebody then it makes things seems a lot easier if you are not confident I think I would probably be more confident giving eye contact to a patient I didn’t know because if I was going to treat them as a patient than to a person last that I didn’t know I might not give eye contact to somebody that I don’t know but I would be happy doing that with my patients because I genuinely feel comfortable when I go to a patient or a new patient.

**Interviewer:** In your role as a physiotherapist.

**Participant:** In my role as a physiotherapist, it might not be the same in my role as a human being.

**Interviewer:** Laughing. Why do you think that is different?

**Participant:** I don’t know, I think I am confident with what I do at work and not always confident in a social setting so...

**Interviewer:** It’s interesting isn’t it? You know I mean I agree with you entirely. Is there anything that you would like to add before we wind it up?

**Participant:** No, no I enjoyed the experience.

**Interviewer:** Good, lovely right.
Participant 5

Interviewer: Right, so I am going to start to record now, and as I have said the interview is about just picking up on some of things that came up from your first interview. So it’s about just getting a bit more padding on your thoughts around interactive practice. Alright, so I’ve got the video here for you just to see a little bit of. We’ll just watch a few seconds of it so that you can recall the session. Can you see that well enough?

Participant: Yeah.

Video playing.

Interviewer: Is that enough to just remember what was going on? So what we will do is just pause it and then if at any point you just want to have another little look and a think about what happened let me know. So first of all, how you generally felt about the camera being there and did you notice the camera being there?

Participant: Yes, definitely, yes definitely I noticed the camera was there. So that made me a little nervous that the camera was there, that someone was watching me, yes when I’m interacting with someone else that’s it really, bit nervous.

Interviewer: As it went on did you notice it less?

Participant: I didn’t notice it less, but felt more comfortable, but still aware of it.

Interviewer: Okay, and do you think it affected what you did? Would you have done anything differently do you think?

Participant: No I don’t think so, no not in practice I don’t think I would have done anything different, no.

Interviewer: Having seen yourself on that video and then discussing the interactive practice with me afterwards, has that had any subsequent effects on you?

Participant: Yeah.

Interviewer: Okay, and what effects did it have?

Participant: On how I felt you mean after discussing it with you? I think I thought about it a bit more after the first interview and I also realised that I was quite automatic in my approach to the patient and that was interesting, just reflecting upon that and just made me think a little bit more about how we interact with patients.
Interviewer: And when you say that you were a bit automatic with the patient what do you mean by that?

Participant: I mean the way I interacted just came on automatically, I didn’t really think about that much, it wasn’t a conscious decision I was basically behaving automatically.

Interviewer: Yes, and is that in response to each patient?

Participant: Yes, I think so depending on the type of patient I deal with.

Interviewer: So you would be responding automatically?

Participant: To a particular type of patient I think.

Interviewer: With this lady was there, do you think there was anything particularly automatic because of the type of patient she was?

Participant: Because she is elderly and quite a frail lady and I think I was trying to be a bit more empathetic and just like we discussed the last time I think a sense of touch and just making her feel comfortable, not being as cold because I think some people tend to be a bit more cold and they need that sort of tender loving care and that sort of thing so, yeah, just taking that into consideration.

Interviewer: Okay. So when you are thinking about your interaction with any patient really, not just this patient, what sort of messages do you want to send?

Participant: To the patient?

Interviewer: Yes.

Participant: That we understand what they are going through, empathise with them, also we want us to trust them, that we want them to trust us sorry. Just trying to establish a relationship with the patient and I think that affects our management of the patient and how they respond to us as well and how much they work with us in treatment sessions.

Interviewer: So the way you interact actually has an influence on how well the patient will respond or co-operate?

Participant: I think so.

Interviewer: Okay. When you are sort of preparing to go to see a patient, you talked about this. I mean you said you wanted the patient to be comfortable and relaxed and you mention actually getting the patient relaxed to get more information at one point of it. So now you are saying a lot of it is unconscious but obviously some of that is conscious isn’t it? So just now you say going to see this type of patient, this type of lady you think you have already worked out your approach before you go to see her?
Participant: Yes I think so.

Interviewer: Okay, so yeah.

Participant: On approaching her I can make sure that she fine, make sure she is comfortable, try and maintain eye contact so she is not straining herself, yeah and also like I said using tone of voice and that sort of thing so I suppose it is not completely unconscious, we are conscious of that, I suppose it is a combination really, because we do prepare ourselves beforehand.

Interviewer: Yes, and as I said it was very interesting that you actually said that you wanted to make her more comfortable because you knew she would be more responsive and share a bit more. Throughout the whole session there is lots of observation, lots of monitoring, lots of checking and I just wanted to get a feel from you about what you think you are observing and checking and monitoring, you know what are the different areas and the aspects that you are interested in with a patient like this.

Participant: Ha ha.

Interviewer: Do you want to have the video on? Is it helpful?

Participant: It is actually.

Interviewer: I did think it would be, a lot of people find it so. Okay.

(Video playing)

Participant: I think for this particular patient because the nurses reported that her saturations had dropped and I had to keep a close eye on her saturations and make sure that it is fine during her treatment and that was what I was trying to keep a close eye on and I kept on looking at her sats during the treatment, and also just basically monitoring whether her sats drop in the way she moves and that sort of thing after she is moving about and checking whether her breathing pattern is changing and that sort of thing.

Interviewer: Yeah.

Participant: Just observing.

Interviewer: So they are quite objective markers aren’t they, sort of physiological markers, anything else that you are observing?

Participant: The patient? Her posture, her voice, how much she responds, facial expression as well. I can’t think of anything else.

Interviewer: No that’s fine and then when you are picking up these sort of physiological cues, physical cues some of those physical cues are telling you about her physical state and some of those cues are telling you possibly about her psychological state, so is there anything more sort of around that as well that you know how might you pick up a patients psychological state?
Participant: Well, what she tells me as well that can make quite a good indication of what has been bothering her and what her main problems are and how it affects her functionally as well. Just basically looking at how tense she is and her body language, to tell me what her anxiety levels are, to give me an idea of what she is like, what type of person she is like and also how the disease is affecting her.

Interviewer: Tell me a bit more about that.

Participant: Well just looking at things like depression whether she is quite low in mood and those sort of things as well and yeah basically her thoughts on the disease and the disease process and how it has been affecting her.

Interviewer: Yeah, so very much about her world.

Participant: To go a bit more into her world, her thoughts and feelings.

Interviewer: So trying to understand and gauge a patient’s thoughts and feelings and emotions. You said there she might express them herself and we talked briefly about that you may pick up certain physical signs too. Really thinking specifically about the emotional and psychological side of things, any other things about a patient you might pick up or is it all in just a huge sort of… I mean for me it’s quite interesting that there is just so much going on and you don’t realise but we are actually filtering all of this stuff up here and certain things you know may be significant because they are a physical cue to do with function and physicality but there may be a physical cue to do with a physiological state, do you understand what I am trying to say?

Participant: Yeah, yeah, I know what you mean.

Interviewer: But there is so much.

Participant: Just thinking.

Interviewer: I was just wondering was there any particular specifics that you might notice or do you think it is all quite a sort of mesh of picking up information?

Participant: I think it is a mesh because I think it is all kind of interlinked and just trying to think of anything specific.

Interviewer: There is no problem if its not, I’m just quite interested to think whether you thought that for you that there might be something that was important that you were picking up in particular but don’t worry if there’s nothing it doesn’t matter. And then you are concerned about the patients comfort, so when you are thinking about comfort what are you thinking about in the sense of what? Comforting in what sense?

Participant: Well, just thinking about, well looking at her. If I was going to analyse if someone was comfortable I would look at again, looking at a facial expression, looking at her posture, her breathing rate, ability to talk and that sort of thing.
Interviewer: And how do you perceive what is causing the discomfort?

Participant: Well I could ask the patient firstly and then on assessing the patient further I suppose just to see whether breathlessness is an issue, yes that sort of thing I suppose just looking.

Interviewer: Okay. Now when you go into a situation like this with a patient I think you mentioned that you had a plan in your head or not a plan in your head but that you had some idea about what you were going to do and you were also a bit concerned.

Participant: Her sats had dropped and she was complaining of chest pain as well.

Interviewer: So, going in there, thinking about your interaction what makes you decide to sort of lead the whole session or let the patient take a bit more of the lead, who takes some control in it?

Participant: Well just depending on how the patient responds to questions asked and if the patient pauses and doesn’t have anything else to add then I will just continue to ask the patient a few more questions and give her a chance to respond.

Interviewer: Thinking in a more global sense of the patient. When you are with them what are the particular things for example that might let you let the patient take more of the lead role in maybe walking a bit further, changing their breathing in a different way or… What would allow let you to do that? And what gets you to hold them back?

Participant: Well monitoring objectively and if I feel they are safe then I kind of give them lea way if they can carry on taking the lead and trying to go a little bit further if they felt comfortable with that, yeah.

Interviewer: And do you find that easy to titrate, to work out how much you can let them.

Participant: Yeah usually.

Interviewer: And what is that based on?

Participant: Well I can tell by using an objective measure for example if I am walking a patient and using saturations as a measure, also looking at their breathing, breathing pattern, breathing rate, work of breathing and you can kind of make out whether the patient is struggling, that is enough or if they can go a bit further, and then most patients will stop though when they need to. I mean a lot of them know their bodies really well so they would stop anyway, they know their limits.

Interviewer: So they are quite a good judge.
Participant: They are really good, especially patients with COPD. I think they know their limits a lot of them.

Interviewer: Now, you talk about your position and your posture a bit too, so thinking about your body position in relation to the patient and we did talk a bit about it the last time. A couple of times you said I think I might be a bit too close or something but why would you be too close? Why might you think you are too close?

Participant: Just because some people like some personal space and I think if you get into that personal space that you are uncomfortable so…

Interviewer: Well do you think for this lady it was a problem?

Participant: She seems fine, though actually now looking at it again I can see she seems quite comfortable.

Interviewer: And do you think you were probably picking up that when you were doing this?

Participant: Yes.

Interviewer: So I suppose what I am trying to ask is do you think that you can only judge that sort of how close you can be during the interaction.

Participant: Probably, yep, because I think some patients will give you an automatic reaction and then you know okay back off a little bit.

Interviewer: Can you tell me a little bit about those reactions I am interested in what sort of reactions do you think might…

Participant: Judging from the facial expression and the body language you see they might tense up a bit more if they feel uncomfortable if you are a bit too close or if they feel you are invading their space.

Interviewer: You mentioned a few times about use of voice and watching that again it was very nice just listening to your voice wasn’t it? At the beginning when you introduced yourself. What things about your voice do you think are important?

Participant: Well I think just my tone, voice tone and it wasn’t a very high tone, high pitched voice so just maintaining that tone throughout the session.

Interviewer: Yes.

Participant: For me I think that is important with that patient because I don’t want to kind of get them anxious and because I think voice is really important for me in that situation.

Interviewer: So, it is deliberate.
Participant: Yes, that is deliberate.

Interviewer: Consciousness about your voice and how you use your voice. So you have mentioned tone and you were saying you don’t want it sort of higher pitched.

Participant: So not too low, sort of in-between.

Interviewer: And okay, so what about the speed of your voice.

Participant: Not very fast so slowed down quite a bit just being patient and because I think especially with an elderly patient whose got COPD and she is quite frail, just to try and I think she respond quite well to a slow pace of tone.

Interviewer: What about the volume?

Participant: I think just enough volume for her to be able to hear me quite clearly, not too loud either.

Interviewer: Okay, now talking generally about the non-verbal behaviour because obviously there is your verbal behaviour or your verbal interaction and your non-verbal interaction, so, just thinking a little bit about you with a patient. You mentioned eye contact quite a lot and you obviously feel that is quite important, what do you base that on? Why do you think it is important?

Participant: So that the patient knows I am giving her my full attention and I just think we can maintain a conversation and I am quite engaged in the conversation and showing her that.

Interviewer: Yes, yes, okay, and then body language not necessarily body position any other types of body language?

Participant: Posture I think is very important, if I am quite tense I think that is going to influence her as well and that might trigger her to be tense and more anxious and that sort of thing, yes, so posture and also sense of touch that we discussed before.

Interviewer: So touch in what... so are you talking about therapeutic touch or are you talking about just comforting touch?

Participant: More comforting touch.

Interviewer: And what about gestures?

Participant: I use my hands a lot and explain myself I think.

Interviewer: Are gestures important?

Participant: Yes, acknowledging what the patient is saying, that sort of thing, nodding and yes...
**Interviewer:** And can you remember having watched it, I just wonder whether if we put it on a bit and see, just have a little look at the gesturing. We might see more at the beginning when you were having a chat but still..., hands there.

**Participant:** Nodding a lot.

**Interviewer:** So then you talked about concentrating, their knowing you are attending and you are listening. Tell me what you think about active listening or listening and attending in the way these things are practiced. Why do you think that is important?

**Participant:** Well I think for anyone if I am explaining what my problems are I would like someone to actually not just hear my problems but actually listen to what I have to say so that I can fully understand or they can fully understand what I’m going through and that sort of thing. So just being supportive and listening to what the patient is saying, and for me that would help me as well, because I can basically take the patient’s feelings into consideration and then plan from there and plan that in my treatment, what their main problems are and that sort of thing.

**Interviewer:** So when you are talking to the patient and asking them things what you are saying is you think that maybe not everyone, they may listen but they don’t actually listen to what the patient is saying.

**Participant:** Yeah, yeah, yeah.

**Interviewer:** So what you are trying to do is really understand what the patient’s experience is.

**Participant:** Yes, because I think you could lose a lot if you don’t actually listen to what the patient is saying.

**Interviewer:** That comes clearly over in your previous interview, the importance for you of each individual patient’s own experience and you understanding that, and where do you think that came from? Why do you think you feel like that?

**Participant:** Well, , I suppose I think maybe a person’s background also does play a role in it, but also you might have learnt this as well.

**Interviewer:** So do you think you were actually taught that when you were training?

**Participant:** I think partly but also it could be my background as well and just how to deal with people generally because I think partly learning it and also partly background.

**Interviewer:** So when you are saying your background or you were taught, what, empathetic approach?

**Participant:** Empathetic approach, listening to what people have got to say.

**Interviewer:** This was as you were growing up?
Participant: Placements played a role as well.

Interviewer: Okay, now I just want you to tell me a little bit about what you think about patient autonomy and the patient you know having a choice and making decisions. So, maybe with this lady or just in general terms because I suppose really having tried to understand the patient’s experience is the first step in that isn’t it? So what is it that you understand about patient autonomy or maybe having a sort of collaborative approach to the patient?

Participant: Well I think if we make decisions for patients, we don’t actually know what the patient’s main problem is and we formulate the problem in our own heads thinking this is the problem and come up... it's almost like a dictatorship type relationship and I think the best way to go about is getting a patient involved and asking them because I think sometimes people forget to actually ask the patient what’s your main problem, what is it like for you and trying to... and then based on our assessments as well. Trying to form a relationship with the patient and making a plan from there, making a problem list and then going from there. What’s important to the patient as well is we need to be respect their opinions, respect their choices, asking them what they would like to get out of the treatment and that’s how we will achieve patient satisfaction.

Interviewer: Yes. Now, just thinking about the whole interactive thing and you know, it being about the patient, it appears that a lot of what you are doing is about giving the patient a bit of experiential learning when we are dealing with their treatment. So, trying to get the patient to do things in hospital that we want them to practice at home. So I just really wanted to get a feel from you about how important your interaction is to be able to then put into almost this like a whole process of getting the patient ready for home, ready for life outside. So, with your starting point of understanding the patient’s experience how would you for example see this lady, the process you are going to put her through?

Participant: Well if I understand what the problems are, I mean what are the main problems for her then I can tackle those problems. If breathlessness is an issue for her then just going through positioning things like that to reduce breathlessness, so that would influence my treatment, trying to come up with ways that she can manage breathlessness and incorporate that into her functional activities, and that’s what my plan would be. If it was secretion retention then active cycle of breathing, that sort of thing depending on what the patient says to me and also my assessment.

Interviewer: And how important then do you think your relationship is with the patient is to achieving those.

Participant: It's really important, trying to establish trust with the patient, establishing a relationship with the patient is really important because if I think of me if I were a patient and if I didn’t trust somebody I would never comply with what they told me. Trust is really important.

Interviewer: What do you think you do then to gain a patient's trust, what is it about what you do?
Participant: I think interaction plays a huge role, how you approach a patient at the very beginning but you can tell a lot though how a patient interacts and the patient can also tell a lot by how you interact with a patient so they can form a judgement based on that as well so...

Interviewer: So what are the key things you’d want me to believe about you when I first met you if I was a patient?

Participant: That you can trust me number one. That you can confide in me and, you can share your problems so you need to feel comfortable in sharing information with me and, just basically believing that we are trying our best to help the situation and that sort of thing, supporting the patient to feel supported by me and that's all.

Interviewer: Okay, and again not necessarily with this lady but with patients as they start to get better, just thinking around how much you actually either guide or direct and how much you start reducing that. So just thinking about how you would handover the independence to the patient, how you put that into practice and how you do that with your interaction.

Participant: Well I think at the beginning when I assess the patient and pick up on a few things I feel responsible and just certain things and as we progress treatment I can monitor those sorts of things so not just objective but basically looking at the psychology of the patient and monitoring any progress.

Interviewer: So what might you monitor there do you think?

Participant: Well, if I think with some of my patients as we progress treatment they automatically would say like I would not have to prompt them as much as they’d say oh I’ll go a little further and that sort of thing and they would feel more comfortable doing that and more comfortable doing that I suppose and perhaps looking at those sort of things and we would practice it a lot so that would increase their confidence or if there are any techniques or anything they want to go through and go through with the patient and make sure they are happy doing it on their own and when I had approached the patient at a later stage some patients would automatically say oh I have been doing my exercises I have been doing this I have been doing that and then you know they are trying to participate in therapy and treatment and trying to take it onboard and trying to be independent and self manage.

Interviewer: So picking up a lot of cues from them. Right, so the other area I have been thinking about is creating the right environment for the patient. So, you know what sort of other factors apart from you as the therapist being trustworthy, approachable you know feel that you are going to be able to help me, what other things… that’s what I’d call an environment, that’s supportive, safe and all that. So what other things do you think are important in that environment they can be external things.

Participant: Also respecting the patient’s dignity and that sort of thing and for example I don’t when I draw the curtains for example, just making the person feel
more comfortable, chatting and that sort of thing. I suppose well we don’t have that much control over the actual, whether it’s a quiet environment or it’s not, not that much control but to some extent because there are buzzers going off in the background that would affect the patient interacting with you as well and if there is too many people around that sort of thing, yeah.

**Interviewer:** I mean one of the other things that has come up a bit I don’t know what your thoughts are about this is there is a bit about the clutter as well sometimes.

**Participant:** I think that can get to a patient as well and of course it wouldn’t be safe if there is too much clutter and that sort of thing so trying to organise the environment a bit more.

**Interviewer:** Now just when you go to see a patient, sometimes obviously all we would know about a patient is what we had read in the notes, sometimes we have seen the patient quite a few times so we have already built up some relationship, knowledge both clinical experiential knowledge of that patient. How important do you think it is or does your knowledge of previous experience with a patient make you adapt the way you interact with them so if you have seen them for a time and what things might make you change that?

**Participant:** I think patient’s personalities would influence that because every patient is different so just depending on what a patient has adapted in future treatments for example if we have a difficult patient and if I know he doesn’t like certain things then I just stay away from it, things like that I suppose, just basically getting to know the patient a bit better, that would influence how I would react the next day. I suppose that is normal behaviour.

**Interviewer:** I’m just thinking say if you had known a patient and say you were... you had a student who you were going to get them to treat a particular patient, for example this lady, the sorts of things you might say to that student to some how give them a picture...

**Participant:** Of what she is like?

**Interviewer:** Yes, or the best way for them to develop their relationship.

**Participant:** Okay.

**Interviewer:** It doesn’t necessarily have to be her, whatever you think.

**Participant:** Just describing what type of patient and what type of person the patient is and based on what I know and also how to approach the patient.

**Interviewer:** So tell me a little bit about that, so you are saying different types of people and how might you explain to approach, say somebody, you know I’m just trying to think of an example, say we have got somebody who actually doesn’t think there’s is not much point in doing some of the stuff you are asking them to do so they are a bit reluctant of doing any breathing or walking with you. How would you describe that to the student, that they might be going to see...
Participant: I would say to her that you just need to be aware of this patient he might react a bit, I mean he might be a bit fed up because he is not really keen on physio, I think we would have to explain the benefits and try and reinforce the benefits and ask for feedback from the patient during the treatment to see if he actually thinks it's beneficial or not, maybe use objective measures because that could influence if the patient thinks it might help, erm, just to be aware of the patient’s personality and that he is quite negative, getting him to be a bit more positive about it and realise… it might help.

Interviewer: Would you say this particular interaction was easy or difficult?

Participant: Quite easy I would say, yeah.

Interviewer: And what makes one easy do you think? Well, I think she was quite comfortable with me so it wasn’t difficult relating to her and getting information from her and that made a huge difference and what would make it difficult do you think? What makes one difficult?

Participant: Well I think if she didn’t like me or didn’t trust me she might not be very keen…

Interviewer: Has that happened to you ever?

Participant: I have had some difficult patients, that well I think, I don’t know if its me personally or whether it’s the actually idea of physio that weren’t too keen on, so as soon as I had entered they’d say bye, go away, some patients are really difficult so in that case, it might be, I think it had to do with physio though.

Interviewer: Yes, I’m sure it wasn’t you.

Participant: It can happen if someone doesn’t like the way you behave they wouldn’t be keen on seeing you.

Interviewer: No, no. And would you say that each interaction is unique.

Participant: Yes, I would.

Interviewer: Do you think there are any parts that maybe more routinised.

Participant: I think with breathless patients a lot of them show features and you respond to that in a particular way I think normally we would, there would be an element of the patient personality and actually treating the patient as a unique individual so there would be an element of routinised therapy.

Interviewer: Right, yeah. Is there any particular ones do you think?

Participant: That is routine, …

Interviewer: I suppose you answered that at the beginning you know you said because she was elderly so you’ve got a particular…
Participant: I've already got a picture in my mind I suppose.

Interviewer: You’ve got a collection of behaviours for the elderly and maybe a collection of ones for other ….  

Participant: Younger. 

Interviewer: All the breathless patient maybe they sort of come together or overlap a bit don't they. 

Participant: I mean I think of course research has been done in certain areas and that influences how we behave as well so yeah, also depending on what type of people we are and how we behave in this situation of course. For me it’s a combination of learning it over time.

Interviewer: And maybe just my last question really would be around your observing other therapists and have you seen other therapists that you think are poor interactors? I’m not going to ask for any names or anything but just interested.

Participant: Yes I have. 

Interviewer: Can you describe what makes them poor interactors. 

Participant: I think some of them have got an aggressive tone when they speak to patients and are quite impatient as well, I think it just depends on the work I suppose, if someone is really stressed out they might take it out on a patient and actually try and rush things but with some patients you need to slow things down. So I have seen that with some people, aggressive tone and also being quite distant with the patient. A lot of the patients I have seen don't appreciate that at all, treating the patient like an object more than an individual, than a person Also not introducing themselves and just getting on with things, I have seen interactions.

Interviewer: Would you do anything about it if you saw it? 

Participant: Yes, I would. Definitely, because that would influence assessment it would influence treatment and ultimately patient’s satisfaction as well.

Interviewer: Ok, so anything else you would like to add about…  

Participant: No, I have covered it all I think as far as I can. I have found this experience quite interesting I must say because actually watching myself on a video and watching how I interact with a patient. Yes, it's interesting seeing yourself on video.

Interviewer: Was it a bit of a surprise? 

Participant: Not that much of a surprise, but just useful, I think in teaching it might be useful.
Interviewer: Yes

Participant: influencing someone’s interactions. Yes, definitely.

Interviewer: Is there anything else you would like to add?

Participant: No, I don’t think so

Interviewer: Okay, well thank you.