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Reflection in Physical Therapy Practice:
A Phenomenological Inquiry into Oral and Written Narratives

Submitted by:
Mary Susan Knab

A Dissertation
Submitted in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Lesley University
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Abstract

In today's healthcare system, physical therapists treat an increasingly complex and diverse patient population and face rapidly expanding knowledge, technologies, and evidence for the care they provide. They also face demands for increased efficiency and improved outcomes. Reflection, espoused for its ability to help clinicians convert experience into learning and new knowledge, is widely viewed as being critical to sound clinical practice. There is, however, limited research and little consensus regarding what reflection looks like in the day-to-day practice of physical therapists. This phenomenological inquiry aims to identify the essence of reflection as experienced by physical therapists in clinical practice.

Taking a hermeneutic phenomenological stance, the researcher used six physical therapists' oral and written stories of clinical practice as the window through which to view reflection. Blending thematic, structural and performative approaches to narrative analysis, she examined the content and process of participants' reflection – the *what* and *how* of their reflection.

This study reveals that the content of participants' reflection is invariably about challenges faced in providing optimal care, especially the pivotal role of their relationship with the patient, the need to see the patient as full person and place that full person at the center of clinical decisions. It also reveals that reflection shares essential features with narrative in that it is a situated and inductive way of knowing, iterative in nature (with each revisiting revealing new meanings), and always co-constructed.

In loving memory of my parents,
Anne and Richard Knab,
whose resilience, love of life, and valuing of learning
inspired and nourished me in this journey.

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I am grateful to the many who supported, guided and encouraged me throughout my doctoral education journey. Without them I would not have achieved my goal.

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I owe a special debt of gratitude to Dr. Caroline Heller, my professor, dissertation advisor, and muse, who believed in my resilience, even as I doubted it in

the face of life challenges that threatened to end this academic journey prematurely. I will always be thankful for her wisdom, patience and good humor.

In the end, I would have never arrived at this place without family – sisters, brothers, nephews, nieces – and friends who tolerated *yet another* semester of my being wrapped up in my studies and less present than I'd like, and finally,

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Prologue

In 1986, while practicing as a staff physical therapist on the oncology unit at Kessler Rehabilitation Institute in Portland, ME, I was approached by my supervisor who asked if I had considered applying for his position as he was being promoted to Assistant Director of the PT Department. I'd been aware of Sean's promotion and wondered who would or could fill his shoes. I had not considered throwing my hat into the ring and told him that. His immediate response was, "Why not?"

My response, equally quick, was that I had only four years of experience. That was the only reply called for – or so I thought. Perhaps Sean had forgotten that when I'd arrived two years earlier I'd only been out of school a short while and, to that point, had only practiced in a small community hospital. He hadn't forgotten. I was also aware, as was Sean, that several more-experienced therapists on the unit were considering applying for the position.

His response has stuck with me across all the intervening years. I am reminded of it today as I write this prologue. He said, and I paraphrase,

It's not about the number of years of experience. One clinician can have four years of experience, while another has *one* year of experience times *four*, or times *ten*. I'd take the former any day as my therapist (personal conversation with Sean O'Sullivan, PT, 1986).

That interaction with Sean was the first time I'd considered that my growth as a clinician may not be simply, even primarily, a matter of time.

CHAPTER I. INTRODUCTION AND CONTEXT FOR THIS WORK

The Healthcare Delivery System and Clinical Practice Environment

Health care providers face many challenges in the current health care environment. These challenges include an expanding body of medical knowledge, an aging population facing diverse health problems in large numbers, and shrinking financial resources for medical care. (Wainwright, et al., 2010, p. 76)

In response to these influences, the healthcare delivery system in the United States is changing rapidly. Healthcare providers, including physical therapists, find themselves continually incorporating new knowledge and technology; treating a patient population with changing demographics, health problems, and social needs; and doing so in an environment demanding increased efficiency and productivity – less time and fewer resources available for getting each patient what she needs.

Yet, a quick inspection of the physical therapy profession's core documents reveals its self-identified commitment to society – to “promote optimal health and functioning in individuals by pursuing excellence in practice” (*Standards of Practice for Physical Therapy*, 2007). As such, each therapist's practice is “guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility” (*APTA Guide for Professional Conduct*, 2010). To the physical therapist these words describe the fabric of who he is.

The dilemma is that the challenge of living out those core values in the context of the healthcare delivery environment continues to increase. For her practice to accommodate increasingly complex patient cases and less time with each without compromising her core values, a physical therapist needs to continually change, learn, and develop. As the *Code of Ethics* mandates, physical therapists have a duty to “cultivate practice environments that support professional development, life-long learning, and excellence” (*Code of Ethics for the Physical Therapist*, 2009).

But how? Even a cursory scan of the literature on health professions education and professional development will reveal two things: 1) there is a growing interest in understanding how expert clinicians, recognized by the outcomes of the care they provide and their efficiency in providing it, do what they do, and 2) one habit, or attribute, getting a lot of attention for its ability to foster learning and development of expertise is *reflection* (Atkins & Murphy, 1993; Benner, 1982; Bunkers, 2004; Elstein & Schwarz, 2002; Jensen, Gwyer, Hack, & Shephard, 2007; Mattingly & Flemming, 1994; Schmidt, Norman, & Boshuizen, 1990; Unsworth, 2001). An in-depth read of that same literature reveals an intersection between the two. First, experts, in part, do what they do by virtue of being reflective in their practice. Second, reflection itself is said to foster a clinician’s ability to convert experience into learning, leading to growth in clinical knowledge, an important component of novice to expert development (Davidson, 2008; Jensen & Paschal, 2000; Perry & Perry, 2000).

In this context, *reflection*, and its use by physical therapists in clinical practice, warrants closer examination in order to understand what it is, how it works, and whether it’s possible to teach it.

How I Came to This Work

In the prologue, I was a relatively young clinician treating patients in a rehabilitation hospital setting. It was a period during which my clinical knowledge and skills were growing rapidly. I was learning, becoming a better therapist. In addition, even as I was exploring my ability to learn and develop, I was realizing that a key role of the physical therapist is *teacher*. Certainly teaching my patients how to stand and walk after a stroke required guiding them through the various stages of motor learning. But there was more to my being a teacher. For example, my role was not so much to “do to” my patients as it was to empower them. I quickly came to realize that success in rehabilitation comes when the patient takes the reins in his recovery. Sometimes patients needed information, at other times guidance and coaching, and frequently just encouragement. This translated into my having the most important role of a teacher – empowering another to become. I’ve spent much of the last three decades exploring the intersections between the practice of physical therapy and the teaching-learning process.

Eventually my interest in facilitating learning led to assuming the role of clinical instructor. This meant I had physical therapy students in my clinic for whom, and to whom, I was responsible. I was not merely responsible for what they did with the patients, but also for helping them apply knowledge, develop skill, and make decisions in real-life practice situations. In addition, I needed to help them develop their own styles of teaching and learning in the clinical environment. Like my patients, these student clinicians needed to improve their ability to function in a key life role, and a lesson I’d learned from my patients was reinforced – it wasn’t about me. I was not

the font of wisdom for these students, but rather a companion and guide in their journeys of learning and development.

During that decade, the 1980's, we had ample time with our patients and could accommodate a student's slower process of treating them while still providing comprehensive physical therapy. The same was true when newly graduated therapists joined the staff and needed time to get up to speed.

When I moved into a manager position at the start of the next decade I realized that the hospital I worked in, like so many others, could no longer support the time and resources it took for those "new grads" to become fully functioning members of the team. Even then change was afoot in healthcare, with a growing emphasis on cost reduction leading to pressure to move patients through the system "quicker and sicker" as we used to say.

From the manager vantage point, I gained insight into the demands of practice and began to anticipate challenges we'd face as the healthcare system continued down the cost control path. Clinicians would need to make rapid, accurate clinical decisions based on sound evidence and judgment. They'd need to be proficient teachers and communicators, with the capacity to relate to an increasingly diverse patient population and interdisciplinary healthcare team.

My passion for equipping health professionals with the tools needed to be successful on the front lines of patient care led me to academia. As it turned out, the knowledge, skills and insights I'd developed through my various roles in the clinical environment proved a good match for the academic role I assumed as Director of Clinical Education (DCE) in a newly developing graduate program in physical therapy.

Today, well into my second decade as a physical therapy educator, I remain keenly aware of the reason I first sought a faculty position and have broader insight into the fact that I have a responsibility to my students and the patients they'll encounter once out in clinical practice.

Specifically, I am charged with educating clinicians who will provide quality healthcare to a diverse patient population and contribute positively to the healthcare delivery system. Yet, those of us who educate these next generations of health professionals travel with them through a fraction of their journeys of learning and development. Much of their development, in fact most of it, takes place after they leave our classrooms and enter practice as licensed practitioners. This is as it must be; however, it begs the question: will each graduate of the educational program in which I teach continue to learn and grow in the knowledge and expertise she'll need in order to continue to function effectively in tomorrow's healthcare delivery environment? My desire, of course, is that each will.

This brings me back to the literature, which forms a compelling argument for the notion that, as a physical therapy educator, I should do everything possible to assure that I'm educating clinicians who will employ reflective processes as a routine part of their clinical practice. These habits of mind will help to maximize their learning from each clinical encounter (Fisher & Somerton, 2000; Lockyer et al., 2004; Murray, McKay, Thompson, & Donald, 2000; Jensen & Paschal, 2000). However, even if the charge is clear – educate reflective practitioners – from there the picture becomes cloudy. Despite the large amount written about reflection and reflective practice in a theoretical sense (Dewey, 1933; Schön, 1983; Mezirow, 1991), and though many have

published their methods of infusing it into a curriculum (Atkins & Murphy, 1993; Driessen, van Tartwijk, & Dornan, 2008; Gustafsson, Asp, & Fagerberg, 2007; Mooradian, 2007; Plack & Santasier, 2004; Plack, Driscoll, Blissett, McKenna, & Plack, 2005; Plack et al., 2007; Wald, Davis, Reis, Monroe, & Borkan, 2009; Wong & Blissett, 2007;), there is no commonly held understanding of what *it* is, or even what *it* looks like when it manifests itself in the course of a licensed physical therapist, or other health professional, going about her everyday task of providing patient care (Mann, Gordon, & MacLeod, 2009, p. 610).

Thus I come to the heart of my inquiry. What *is* the truth of the matter when it comes to reflection? I don't toss a word like truth around lightly, as I have come to a point of skepticism about anyone's claim to have discovered *the* truth on any topic. In this way I am aligned with the stance of qualitative researchers in general, and, as I discuss in the chapters that follow, phenomenologists in particular. I want to participate with practicing physical therapists in uncovering the truth, provisional and incomplete as it may be, about reflective practice as it is manifest in their experiences as patient care providers.

Research Question

My primary research question is: *What is reflection as experienced by physical therapists in clinical practice?*

My sub questions reflect my interest in uncovering:

- What *topics* the physical therapist reflects on.
- What his reflective *processes look like* as they unfold.
- Whether and how reflection informs his practice.

Research Approach

I believe my research question is best approached by taking a phenomenological stance since I seek to understand the phenomenon itself – reflection as experienced by physical therapists in clinical practice. In his text on qualitative research design, Creswell (2007) asserts the value of placing one's research firmly within a tradition of inquiry. While he acknowledges that qualitative research often incorporates elements of more than one tradition, he advises novice researchers to begin by attempting to work within just one.

As my research question crystallized, and I considered how best to go about contributing to its answer, I was attracted by descriptions of phenomenology. In distinguishing phenomenology from other qualitative approaches, Creswell (2007) states, "Whereas a narrative study reports the life of a single individual, a phenomenological study describes the meaning for several individuals of their lived experiences of a concept or a phenomenon" (p. 59). In exploring reflection as experienced by physical therapists in clinical practice, I remain cognizant of the fact that it's the phenomenon I'm studying, not the individual participants, though they're the window through which I hope to view it.

Moustakas (1994), a methodologist who theorizes about phenomenological approaches to qualitative research, advises that once a researcher has identified a relevant topic area in which she's interested, the next challenge is to formulate a question. In phenomenology, the question "must be stated in clear concise terms. The key words of the questions should be defined, discussed, and clarified so that the intent and purpose of the investigation are evident" (p. 104).

My research question is: What is *reflection* as experienced by physical therapists in clinical practice?

The working definitions of my key terms are:

- *reflection* (pre-operationally informed by Dewey (1933), Schön (1983), Mezirow (1990), Kolb (2001), and my own clinical practice) denotes a process of turning one's attention and thought to one's decisions and actions, and the thinking behind them, in order to explore and challenge underlying assumptions and attempt to uncover the knowledge implicit in *doing*. While guided by this pre-operational sense of reflection's meaning, throughout the course of this research I strove to hold that definition loosely, so that my participants could inform it based on their lived experiences. Honing the definition of reflection is, in fact, at the very heart of my overarching question.
- *physical therapists in clinical practice* refers to licensed clinicians engaged in evaluating and treating a caseload of patients in an inpatient hospital or ambulatory care setting.
- *as experienced by* denotes my belief that reflection is something that is personally encountered and experienced .

I mean the wording of my research to indicate my openness to "reflection" being experienced differently by each participant.

Personal *Epoche*

What is it? One of the key methodological requirements of phenomenological work is the researcher's charge to examine her own experience of the phenomenon. This serves to identify presuppositions and biases she brings to the inquiry. While reflexivity is a responsibility of all qualitative researchers, the philosophical premise on which phenomenological inquiry is built makes it particularly important.

If we accept that the only way to know a phenomenon is through first-person experience, then the researcher has a dilemma. She can only know her own experience first-hand and it is important that she be as conscious of it as possible. To expand on that knowing of the phenomenon she turns to her participants' experiences. I've encountered two divergent views as to how the researcher should use this awareness of her preconceptions of the phenomenon. Moustakas (1994), in keeping with classic phenomenology based on Edmund Husserl's (1859-1938/2001) work, claims that the onus is on the researcher to engage with participants in as supposition-less a manner as possible. "Husserl called the freedom from suppositions the *Epoche*, a Greek word meaning to stay away from or abstain. ... In the *Epoche* we set aside our prejudgments, biases and preconceived ideas about things" (Moustakas, 1994).

The process used by the researcher to accomplish this is called bracketing. Having made herself aware of her preconception of the phenomenon, the researcher is better able to bracket it and set it aside. However, the researcher's experience is not intended to be set aside and forgotten. It needs to be revisited again and again. Once more, Moustakas (1994) clarifies this point.

The world is placed out of action while remaining bracketed. However, the world in the bracket has been cleared of ordinary thought and is present before

us as phenomenon to be gazed upon, to be known naively and freshly through a purified consciousness. (p.85)

An alternative to this approach is found in the hermeneutic understanding of phenomenological inquiry in which, in lieu of bracketing, the researcher uses her prior experience with the phenomenon as the source of pre-reflection or pre-understanding (Packer, 1985). It is from this position that the researcher appropriately begins.

This brief introduction to phenomenology foreshadows the in-depth discussion of its philosophical roots I offer in the next chapter, but already I conclude that regardless of which approach one espouses – Husserlian or hermeneutic – it is imperative that the researcher carefully examine her experiences of the phenomenon. It will be critical whether she determines the need to bracket them, so she can view the phenomenon unencumbered, or to bring her pre-understanding to bear in interpreting the experiences of participants, or both.

The process of uncovering my own preconception of the phenomenon of interest, reflection as experienced by physical therapists in clinical practice, was well underway before the research question came into focus. Taken forward by years of immersing myself in others' theories about reflection, I'd used my own experience to make sense of the authors' ideas and, in turn, allowed their ideas to help shape my understanding. The remainder of this chapter contains my attempt to articulate a personal *epoche* of this phenomenon.

Making my lived experience visible

Setting the stage. During the course of my doctoral studies, as my interest in reflection grew, I had an opportunity to engage in a phenomenological case study using

myself as the informant. The context was a course I took at the Center for Medical Simulation (CMS).

At the time, with several faculty and clinical collaborators, I'd experimented with using simulation to help students learn by placing them in lifelike patient care situations, recording their performances and debriefing afterward. It proved an effective vehicle for learning. In fact, students wanted more opportunities to engage in simulation than we were able to provide at the time.

I suspected that what made it so powerful was the combination of performing in (experiencing) the physical therapist role, and debriefing, which I viewed as guided reflection. Simulation provided an environment within which students could practice, self-assess, and receive feedback from peers and faculty. Regardless of whether my hypothesis as to *why* it worked was correct, I wanted to use it more extensively. Thus, I enrolled in the CMS instructor course.

The course was largely experiential and, as such, would put me in the role of a learner engaging in simulation. By taking me out of the teacher role, my comfort zone, it would provide an opportunity to experience what it felt like to be a student engaged in simulation. In addition, since most participants were physicians or nurses, CMS used simulation scenarios enacting emergency medical situations. I would be out of my comfort zone on that front as well.

Despite the anxiety I felt, I decided to engage in the simulations and reflect on my experiences deeply and deliberately. Using my CMS experience in this way, I hoped to get a feel for this type of learning from the inside out. It was only later that I

realized I was embarking on a phenomenological inquiry into my own experience of reflection.

Uncovering my personal understanding of reflection. As promised, the course put me back into a learner role. Each evening when I left the course I overflowed with energy – so many thoughts, feelings, questions. Each evening I wrote notes non-stop during, and for some time after, my commute home. As I wrote furiously, the day poured onto the page.

In those notes I captured what occurred during the day. I described my instructors and classmates, documented the sequence of activities including simulations and debriefing discussions, and made notes on the theoretical content we'd covered. Because I was determined to engage as fully and reflectively as possible, I described not only the events and content of the experience, but how I experienced it internally and how I understood it. For example, the first simulation put us in the position of providing emergency care to victims of a serious bus accident. In my notes I described it and talked about the strong emotions it evoked.

Since understanding of my experience in the course grew as I continued to think about it in light of subsequent experiences, those notes were only partially organized. They represented the sequence of my thinking about the course in whatever order it appeared in my mind. For example, if describing what I was thought and felt coming out of day two shed new light on some aspect of day one, I wrote about day one again, trying to understand it differently. Those notes contained my own cyclical structure, representing my meaning making as it unfolded.

Approximately six months after the course, I returned to those field notes to see what they might be able to teach me about learning through simulation, a structured pedagogy that weaves together experience and guided reflection. I also wanted to see what they could reveal about my process of reflection since, by that point, my topic for this research was taking shape.

I began writing the story of my learning experience. The exercise of reviewing my notes and writing a narrative description of my days in the course brought the experience back in memories. As I analyzed that narrative alongside my original field notes, I began to distinguish places in the notes where I'd reflected on the experience from places where I'd recapped it. The latter, in some instances, were places where I'd written what we did, or what was said and by whom. "Marie took charge." "Who can assess the airway and intubate so we can ambu her?" "Petrovich positioned himself at the head and intubated our patient." When I left it at this type of reporting and didn't elaborate, I considered it *recalling* rather than *reflecting*. However, in my notes and the narrative I'd constructed from them, I frequently moved beyond my recollection of events to offer commentary on what I was thinking, or how I'd felt in the moment or its aftermath, or what I speculated may have been going on. I identified those places as reflecting.

The distinction between recall and reflect is supported in the work of Neufeldt, et. al (1996). This team of researchers examined the role of reflection in the growth of social work students. They discussed their finding that, in order for students' reflections to contribute significantly to their development, they need to be "profound rather than superficial" (p. 8). This distinction is consistent with a working definition

of reflection I'd developed even before the simulation course as I'd worked with students in the classroom and clinic. In order to encourage growth in reflective ability, I'd used interactive journals in which I would respond to students' reflections by writing in the margins. When I read a student's report of the day's experiences in clinic and it was just that, a reporting of the facts, I frequently wrote questions such as, "How did you feel afterward?" or, "How did you know to try that approach?" or, "What else did you notice about the patient's response?"

In the phenomenological case study process, I continued to critically review my notes and narrative. I focused on excerpts that appeared consistent with my intuitive sense of being reflective, and I identified descriptors. Through trial and error, I found an approach that seemed to bear fruit. I began trying to discern themes based on descriptors of internal experiences I'd had. For example, time and again I'd written about my emotional states as I participated in simulations or debriefings. On that first commute home I'd written of feeling "anxious as I walked down the hall" heading into that first simulation and experiencing uncertainty as to what was expected of me. As that first scenario about the aftermath of the bus accident played itself out, I recorded feeling inferior, anxious, and confused. Is an activated feeling state part of the essence of learning through medical simulation? Does it relate to reflection?

In future reviews I noticed the extent to which I'd recorded questions. My experience during the course appeared to have stimulated more questions than answers. I seldom, if ever, wrote about something I'd learned with finality; rather, I expressed my wonderings about other meanings of the experiences. I had enrolled in the course hoping to find answers on how to effectively use medical simulation with physical

therapy students and help them develop reflective practice. Perhaps the extent to which my reflective notes contained question after question was part of my answer.

One last characteristic of my reflective notes that stood out as being prevalent and constituting a meaningful theme, was the extent to which they contained my efforts to make connections between what I was experiencing and thinking in the moment and my past attempts at understanding that same thing – some aspect of learning, or reflection and my thoughts about how to facilitate it in my students, or even my understanding of how to respond to a medical emergency.

A summary of my personal epoche. Through analyzing and interpreting my field notes from the course on medical simulation, I identified three themes inherent in my experience with reflection, as attended to across that weeklong course and the months that followed. They were:

1) *Engaging emotionally* – referring to my descriptions of feeling states and attempts to make sense of them based on the present situation, prior experiences and my understanding of myself,

2) *Questioning* – identifying and documenting questions that were triggered by my experiences in the course and reflecting on them afterwards, and

3) *Making Connections* – referring to my attempts to draw connections between a wide range of experiences, thoughts, feelings and knowledge, from within and outside the course.

I present this summary as a way of articulating my personal epoche, as I understood it at the time I embarked on this phenomenological inquiry. It represents at

least part of the pre-formed thoughts and biases about reflection I brought with me into this research process.

Conclusion

The primary aim of this study is to contribute to an understanding of how physical therapists experience reflection in their clinical practice. My reading of the literature on the subjects of reflection, novice-to-expert development and expertise leaves me quite certain that clinicians who engage in reflection in and on their clinical practice learn from it in ways that affect their growth in practice.

My reading leaves me equally uncertain about what we mean by reflection in this context, making it challenging for me, as a clinician and an educator, to know how to foster its growth in myself, the clinicians with whom I practice, and my students. If I can begin to uncover and articulate something of the underlying structure or essence of reflection, it may help lay a foundation upon which I (and others) can take on that challenge.

CHAPTER II. LITERATURE REVIEW

I am conceptualizing this study as a phenomenology of reflection as experienced by physical therapists in clinical practice. Having defined the research question, I *now* situate it in relation to the larger discourses that inform it and to which it may eventually contribute. These discourses include: reflection, including what we mean by it and its relevance to theories about thinking, learning, and the development of expertise in professional practice – specifically within the health professions; phenomenology, as a philosophical and methodological approach to being and knowing; and narrative, as a contextualized way of knowing, vehicle for human identity, and broad approach to inquiry.

I first trace literature about reflection, especially as it is applied within health professions. Next, I address the broad discourse on phenomenology, beginning with its philosophical roots, and briefly tracing its emergent branches, ending my review with a discussion of hermeneutic phenomenology, which lays groundwork for methodological choices I've made in this study and serves as a foundation for later discussions of how human beings come to understand the world around us and our being in the world – ourselves. In the final section I turn to narrative and here, too, review literature that provides philosophical and theoretical foundations for understanding its many uses. I discuss narrative as a way of knowing that stands in contrast to the logico-scientific mode. Finally, I frame narrative approaches to inquiry as they have informed my approach to this study.

Reflection: What Is It and Why Is It Important?

Reflection: What is it exactly? The body of work related to the cognitive process of reflection is large. It could be said to trace its roots to early philosopher's views on the nature of man's ability to think. In a later section of this review I consider some of those roots as they relate to modern thinking about both phenomenology and narrative. In this section I review literature related to reflection from the standpoint of theorists who have influenced efforts in my profession to educate reflective practitioners. I begin with a look at influential 20th century theorists and how their work informs 21st century health professions' practice and education.

Four influential theorists.

John Dewey. In his treatise, *How We Think*, Dewey (1933) begins with a discussion of various meanings of thinking, or types of thought, and sets about differentiating *reflective* thinking from the rest. He discusses commonly held definitions including thought as the random flight of fancies or whatever happens to be in the mind at a given time, with no noticeable chain from one idea or thought to another. The term thinking, in this regard, is often restricted to "things not sensed or directly perceived...as in 'no, I only thought of it' (Dewey, 1933, p.5)." Another meaning of thinking is synonymous with believing, as in "I think it is going to be colder tomorrow" (p. 6). In both of these meanings, Dewey sees no particular educational value of thinking. By contrast, in describing reflective thinking Dewey states, "*active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends* constitutes reflective thought" (p. 9, italics in original).

For Dewey, reflective thinking is the appropriate outcome of educational processes. His argument proceeds as follows: reflective thinking is triggered by some perplexity or doubt, which in turn challenges the mind to inquire as to the solution or truth of the situation, and the stage is set for learning to occur.

Furthermore, reflective thinking is always triggered by one's experience. "General appeals to a child (or to a grown-up) to think, irrespective of the existence of his own experience of some difficulty... are as futile as advice to lift himself up by his boot-straps" (p 15). Once the difficulty is encountered, the mind seeks some way to resolve it. Inquiry has been triggered. The way forward is through formulating a tentative plan or theory that can be tested out. Such theories, however, are based on prior experience with similar or analogous situations and, "it is wholly futile to urge him to think when he has not prior experiences that involve some of the same conditions" (p. 16). Here Dewey points out several potential pitfalls including the tendency to shorten the inquiry and jump to conclusions without critical thought as to their applicability. He concludes that reflective thinking takes place only "when one is willing to endure suspense and to undergo the trouble of searching" (p. 16).

I trace this thinking of Dewey (1933) in some detail because of its vast influence. He foreshadowed, indeed laid groundwork for, much of the subsequent discourse on reflective practice (Boud, Keogh, & Walker, 1985; Schön, 1983; Schön, 1987), experiential learning (D. A. Kolb, 1984; A. Y. Kolb & Kolb, 2009; D. A. Kolb, Boyatzis, & Mainemelis, 2001), critical self-reflection and transformative learning (J. Mezirow, 1991), and reflective practice in the health professions (Atkins & Murphy,

1993; Hancock, 1998; Mann, Gordon, & MacLeod, 2009; Plack & Greenberg, 2005; Williams, 2001).

Donald Schön. Schön (1983, 1987) entered the discourse on reflection some half-century after Dewey, challenging the predominant trend in professional training of his time by claiming that its model, based on technical rationality, in which students were filled with factual knowledge and expected to apply it once they were out in practice, was inadequate. He made the case that professionals needed to be capable of more than applying knowledge, but also of bringing a wisdom to their practice – the element he called the *art* of professional practice. The key to developing this art, according to Schön (1983) was learning to reflect deeply on one's actions and experiences.

To understand Schön's (1983) contributions to defining reflection, we need to consider two types of knowledge – declarative and procedural. The former is the type of knowing that exists cognitively in memory and is able to be explicitly described. Thus it is also known as explicit knowledge; it is knowing *about*, or knowing *that*. Procedural or tacit knowledge, on the other hand, is sometimes called implicit knowledge. It is the type of knowing made apparent in the doing of a task and often cannot be clearly articulated by the knower. It is knowing *how* (Sternberg, 1998).

In contrasting knowledge learned through technical rationality with the knowing he calls the *art* of a profession, Schön (1983) referenced the difference between explicit and implicit knowledge observing that although the former was considered the rigor of a professional knowledge base in the positivistic climate of the time, the latter was

often the more relevant since it was based on the stuff of practice. Of this dilemma, “rigor or relevance”, Schön wrote:

In the varied topography of professional practice, there is a high, hard ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing messes incapable of technical solution. (p. 42)

Schön introduced the term *knowing-in-action* as a label for the type of tacit knowledge that underlies the ability to act. This type of knowledge is important for navigating those “swampy lowlands” of practice, but how is it acquired? The key, according to Schön (1983), is reflection. Reflection occurs when “stimulated by surprise they [practitioners] turn thought back on action and on the knowing that is implicit in action” (p.43). This turning back of thought typically takes the form of interrogating the thinking underlying one’s actions. The practitioner may ask himself, for example “What features do I notice when I recognize this thing? What criteria are those by which I make this judgment? What procedures am I enacting when I perform this skill? How am I framing the problem that I am trying to solve” (p.43)?

When this turning back of thought occurs after the action has taken place, it is reflection-*on*-action. In some instances, the practitioner reflects while still in the very process of acting, which Schön labeled reflection-*in*-action. Expertise, as discussed in the previous section, requires both a procedural knowledge base and a rich store of tacit knowledge; thus, Schön’s work on reflection-on- and -in-practice seems to go to the heart of understanding the role reflection may play in a clinician’s growth in expertise.

Jack Mezirow. Another theorist making a substantive contribution to describing reflection and understanding its role is Mezirow (1990, 1991), whose theory of transformative learning is, in part, based on reflection. Specifically, Mezirow described four levels of action and thought: 1) habitual action, based on tacit knowledge, 2) understanding, which he referred to as thoughtful action, 3) reflection, in which an individual revisits an experience to understand it better, and 4) critical reflection. This last level, critical reflection, is the new piece Mezirow added to Schön's discussion of the topic. In critical reflection, an individual challenges the underlying premises upon which his framing of, and approach to, understanding the problem itself is based. Mezirow (1990) claims it has the potential to result in transformation of one's very perspectives.

Perspective transformation is the process of becoming critically aware of how and why our presuppositions have come to constrain the way we perceive, understand, and feel about our world; of reformulating these assumptions to permit a more inclusive, discriminating, permeable and integrative perspective; and of making decisions or otherwise acting on these new understandings. (p. 14)

David Boud. One final theorist I mention is Boud (1985) who, in his description of reflection delineated both steps one goes through in reflecting, similar to Schön, and levels of reflection, like Mezirow. Not unlike the others, for Boud reflection is triggered by encountering a situation in which the more automatic, tacit, knowing is insufficient and the individual has something to resolve. His model of reflection includes steps of: returning to the experience, attending to feelings, re-

evaluating the experience, and finding a resolution. Boud's levels of reflection take place during re-evaluation. In this step an individual goes through four processes – association, integration, validation and appropriation – each of which takes his reflection to a deeper level. It is by going through all four levels that one maximizes the learning from the experience.

These four theorists – Dewey (1933), Schön (1983), Mezirow (1991), and Boud (1985) – laid the foundation for, and contributed to, the wave of interest in reflective practice that swept across those engaged in professional education beginning in the late 20th century and continuing today. Their work has been applied, examined, and discussed widely in the context of clinical practice in the health professions, including physical therapy, and the search for methods to foster reflective practice in health professions education (Atkins & Murphy, 1993; Bergmann Lichtenstein, 2000; Brown, Matthew-Maich, & Royle, 2001; Fisher & Somerton, 2000; Glaze, 1999; King & Kitchener, 2004; Murray, McKay, Thompson, & Donald, 2000; Shepard & Jensen, 1990; Williams, 2001).

Defining reflection. Despite my familiarity with the literature on reflection, especially as applied to health professions education, I've found myself at a loss to identify a single common definition I could use in my own work. Yet, in order to proceed with educational methods to promote it, wouldn't it be important to know what *it is*?

Karen Mann (2009) and her research team faced this quandary when they set about to do a systematic review of the literature on how reflection and reflective practice were being addressed in health professions education, reporting that a major

challenge to doing the review was the lack of a common, and in many cases even an operational, definition of reflection. Thus, they decided to adopt a number of descriptions from the literature that offer various takes on this complex phenomenon. They selected Dewey's (1933) description, as quoted above, and borrowed Boud's (1985) definition of reflection as a "generic term for those intellectual and affective activities in which individuals engage to explore their experience in order to lead to a new understanding and appreciation" (p. 19).

To further aid her systematic review, Mann (2009) categorized models of reflection based on two variables – whether the model described 1) an *iterative* process, like Schön's and Boud's, and/or 2) a process containing *levels* of reflection, like Boud's and Mezirow's. In the end, Mann's choices related to defining reflection and categorizing theoretical models proposed in the literature support and inform my own work in this area.

I've also noted that reflection and reflective practice seem, at times, to be used interchangeably. No common definition of reflective practice seems to exist either, but, to take a lesson from Mann, I noted several authors whose descriptions of the phenomenon help to inform my understanding of what it *might* look like in physical therapy. Atkins (1993), for example, after an extensive review of the nursing literature, assembled the following list of commonly held characteristics of reflective practice. She determined that it should:

- ... be based in practice; be capable of developing new knowledge; be
- consciousness-raising; help turn experience into learning; raise self awareness;
- develop intellectual skills; liberate individuals from conventional, traditional

ways of thinking; be creative; and be both an adult and experiential learning technique. (p. 121)

In the end, despite influential theorists discussing reflection and its importance to professional practice and learning, there remains no common definition of reflection or reflective practice. The composite picture of reflection I've formed from this review is that it is triggered by some unresolved situation and involves thinking about that experience, whether looking back on it from a future vantage point or thinking about it in real time. It also involves being persistent, as in Dewey's (1933) notion of turning it over in the mind, and attempting to make explicit and to be critical of one's underlying assumptions and beliefs.

Clinical expertise: A case for reflection as part of practice.

The belief that all genuine education comes about through experience does not mean that all experience is equally educative. (Dewey, 1933, p.25)

In this section I trace how the notion of *expertise* is conceived of in the literature on education and development of health professionals. I do so insofar as it relates to my belief that *reflection* – as a process and habit of mind – is a critical tool for physical therapists practicing in today's healthcare delivery system. I then trace in more depth the literature on reflection and its intersection with the development of practical knowledge and expertise. From among the many theorists weighing in on one or both topics, I focus on the work of a subset whose thinking and writing have informed and challenged my own, and who are consistently cited by others as having influenced their work.

The label *expert* can be applied broadly in our society – referring to anyone deemed to have special knowledge or wisdom. Expert, as used here, refers to an individual recognized as such by peers, specifically within the health professions. I focus on the influential work of Patricia Benner as she and her research teams explored expert nursing practice and helped shape her profession's understanding of its development (P. Benner, 1982; P. Benner, 1984; P. Benner, Tanner, & Chesla, 1996; P. Benner & Benner, 1999). I also examine the work of the research team of Jensen, Shephard, Gwyer & Hack (1990, 1992, 1999, 2000, 2007), which has had similar influence within my own profession.

Novice-to-expert development in nursing. Patricia Benner (1982) provided the first understanding of how nurses develop expert knowledge and skill. She has provoked debate and continues to be cited extensively for her research methods and theoretical framework of novice-to-expert development in nursing practice (Carlson, Crawford, & Contrades, 1989; Carnevale, 1997; Darbyshire, 1994; English, 1993; Jensen et al., 2007; Nedd, Galindo-Ciocon, & Belgrave, 2006).

Benner (1984) explored what nurses know and how they came to know it. Choosing not to adopt cognitive psychology's information processing and decision research methodologies and paradigms, as had been applied to the study of medical expertise, Benner took a qualitative approach to her work. She argued that what was missing were "systematic observations of what nurse clinicians learn from their clinical practice" (p 1). Thus, Benner (1984) chose to interview nurses and analyze their written stories of practice as her means of understanding how they perceived and managed their practice environments, made decisions, and took action.

Borrowing a staged model of skill acquisition developed in the field of artificial intelligence by the Dreyfus brothers (Dreyfus & Dreyfus, 1986), Benner (1984) adapted it to nursing and described five stages of development: 1) novice; 2) advanced beginner; 3) competent; 4) proficient, and 5) expert. The details of changes in practice across these phases are relevant to this work on reflection. Novice and beginner nurses tended to understand situations as a series of discreet elements to which they applied rules in order to determine the action that was called for. Nurses reaching the competent stage were able to determine the degree of relevance those facts had to the situation and modify a plan of action based on the specifics of the situation. Those plans would also serve to guide future decisions.

Nurses at the proficient stage rapidly sized up situations, moving various elements to the foreground and background depending on the decisions needing to be made. Action for these nurses was not thought out but presented itself based on prior experience. At the highest level, experts dealt with situations holistically – recognizing patterns based on prior experience and knowing what to do. Benner (1984) used the word *intuitive* to describe the expert nurse's grasp of a situation and best action, causing heated debate in her field (Benner, 1987; Lyneham, 2008).

Expertise in physical therapy practice. The systematic examination of expert practice in physical therapy began in the 1990s when the team of Jensen, et al. (1990, 1992, 1999, 2007) began their in-depth inquiry into how the most expert therapists do what they do.

Jensen, et al. (1992) delineated five attribute dimensions that distinguish the expert from novice therapist: 1) confidence in predicting patient outcomes; 2) ability to

control the environment; 3) evaluation and use of patient illness and disease data – experts used this information as a starting point for individualized examination, while novice clinicians tended to use standardized evaluation forms; 4) focused verbal and non-verbal communication with patients; and 5) relative importance of teaching as compared to hands-on care, teaching being viewed by experts as their most important intervention.

Expanding their inquiry, Jensen, et al. (1999, 2007) proposed a theoretical model of expert practice in physical therapy, which they and others continue to use as a framework for investigation. They contended that “expertise among physical therapists is some combination of multidimensional knowledge, clinical reasoning, skilled movement and virtue” and proposed that “all four...contribute to the therapist’s philosophy or conception of practice” (2007, p. 167).

Multidimensional knowledge refers to experts’ deep understanding of their practice, and understanding that continues to grow through reflecting on clinical experience, using mentors to stimulate thinking, and listening carefully to their patients. The expert physical therapist’s focus tended to be on the practical knowledge from which she acted in day-to-day practice, a finding that’s consistent with the knowledge Benner (1984) found embedded in the practice of expert nurses.

The reasoning and decision-making processes used by expert therapists were ventures in which, with the patient as the trusted source of knowledge about his condition, they engaged in collaborative problem-solving focused on the what the patient identified as his most important needs (Jensen, et al., 1999). The medical diagnosis was incorporated as a supplemental piece of data. In addition, experts used

skilled facilitation of movement and demonstrated a superior ability to perceive and assess movement dysfunction through observation and hands-on skills. Finally, they demonstrated consistently high moral values, doing what they do out of a sense of commitment to and caring about their patients (Jensen, et al., 1999).

Components of these four dimensions form the core, or philosophy, of the expert's practice (Jensen, et al., 2000). For example, one's philosophy of practice might include "the role of practical knowledge learned through reflective practice; core beliefs about patient-centered evaluation and treatment; collaborating and teaching patients and families to maximize function; skillful movement assessment through observation and manual skills; and a commitment to being a moral agent on behalf of patients" (p. 200).

These pictures of expert practitioners in nursing and physical therapy – individuals who use practical knowledge to size up and respond to individual situations in context – seem consistent with one another. At least on face value, they are also consistent with work being done in other fields, including teaching and the practice of medicine in primary and intensive care settings (Fluckiger & Edick, 2006; Ritter, 2003; Smith & Strahan, 2004).

Peppered throughout these discussions of expert development found in the literature are references to reflection. Jensen, et al. (2007) summed it up clearly.

These expert clinicians actively *thought* about what they had experienced and learned. Thus, they were able to develop not only their clinical knowledge and skill; but also a deeper understanding of themselves as clinical practitioners and their professional and human relationships with patients. Reflection appeared to

be such a powerful theme in the development of these expert clinicians that we speculate that this process may be critical to the ongoing development of expertise. (p. 240, italics in original)

Relevance to this study. The relevance to this inquiry of understanding the meaning of expertise in health professions is two-fold. First, it points toward a clinical knowledge, or practical knowledge, that is acquired over time as a nurse or physical therapist accumulates experience and reflects on it. Despite her notion that others can learn from the expert's embedded knowledge if it can be articulated, Benner (1984) remained steadfast in her belief that, ultimately, each nurse learns from her own experience. My interest in reflection had its roots, in part, in my desire to educate physical therapists who would continue to learn across a lifetime in practice and my belief that reflection has something to do with that process.

In addition, the work on expertise has methodological implications. Benner (1984) used nurses' written narratives as a means of uncovering the knowledge embedded in clinical practice, while Jensen, et al. (1999) used think-aloud interviews as experts watched videos of themselves treating patients. Both methods were designed to uncover the embedded knowledge and wisdom upon which an expert was drawing and the reasoning processes she was using. Their methods planted early seeds for my approach to this inquiry as I discuss in the next chapter.

Phenomenology: Philosophy and Method

My aim is to lay a philosophical foundation for both my methodological choices and the ways in which I've come to understand my phenomenon of interest – reflection

as experienced by physical therapists in clinical practice. I draw on the work of several key philosophers, and select scholars who have studied them in-depth – individuals whose work has informed my own understanding of phenomenology. I first address Husserl's (Husserl, 1859-1938/2001; Kockelmans, 1967) phenomenology, then make a detour to classic hermeneutics, and return to phenomenology, by looking at Heidegger (1971) and Gadamer (Gadamer, 1960/1975; Smith, 1987) and the evolution of hermeneutic phenomenology.

Husserlian phenomenology. Phenomenology, as a philosophical movement, originated with Edmund Husserl (1859-1938). Across his lifetime, Husserl shared the evolution of his ideas with his contemporaries, frequently in lecture form. To get a first-hand sense of phenomenology I turned to a translation of one such lecture series, *Analyses concerning active and passive synthesis: Lectures on transcendental logic*, translated by Anthony Steinbock and published in 2001 (Husserl 1859-1938/2001).

In those lectures, Husserl criticized modern science, with its growing specialization, for its departure from the true source of knowledge – logic. To Husserl, logic was the *a priori* science of sciences. He was referring to transcendental, rather than theoretical, logic. Husserl held that genuine theory would only be accomplished “through a clarification of principles that descends unto the depths of the interiority that accomplishes knowledge and theory, i.e., into the depths of transcendental phenomenological interiority” (Husserl 1859-1938/2001).

The Husserlian premise was that real knowing could exist only in going inward, transcending, as it were, theoretical knowing of the world and tapping into a knowing that is based in lived experience. Thus, Husserl's phenomenology is primarily

interested in *subject* as it experiences *object*. Another way of stating this is that phenomenology is “the study of phenomena, as-phenomena-appear-through-consciousness” (Thompson, 1990, p. 232).

In discussing how subject experiences object, Husserl offered the distinction between one’s perception of object, *noesis*, and its very being-ness, or given-ness, *noema*. According to his philosophy, the latter, the *noema*, can only be known through the former, the *noesis*, and the former can only exist because of the latter (Husserl 1859-1938/2001; Kockelmans, 1967).

As an example, Husserl used a familiar object, a table, one’s perception of which at any given time depends on the angle from which one perceives it. However, while one is able to perceive only one view at a time, the table retains all the various characteristics that have allowed one to perceive it differently at other times. Through one’s various experiences of the table, one is able to intuitively see, from one limited view, the thing itself – its given-ness or *noema*. But that given-ness only exists because of the *noesis*, one’s perception of it.

According to Owen’s (1993) review of Husserl’s work, as his philosophy evolved, Husserl defined phenomenology as “being free from all presuppositions of actual existence” and believed one could “be an objective onlooker on one’s own subjectivity to the degree that one ceased to participate in it” (Owen, 1993, p.74). Thus Husserl’s phenomenology came to be more than a philosophy; it is also a methodology for how one can come to know a phenomenon.

As a method, phenomenology seeks to understand the nature of human experience from the perspective of the subjects themselves. Because of the

philosophical tie between noema and noesis, a phenomenon can *only* be known through the lived experience, perception, of it. The phenomenologist, for her part, engages in the phenomenological reduction whereby she explores her presuppositions about the phenomenon's existence in order to set them aside to become the "objective onlooker of [her] subjectivity" (Owen, 1993).

While numerous variations in approaches to phenomenology as method exist, what they have in common, according to Guignon (2012), are: semi-structured interview, immersion in the data set, reduction of the data to themes, and then the relating of themes to the phenomenon under study. In addition, the researcher is required to "bracket" previously held perspectives regarding the phenomenon in order to prevent bias in interviewing the clients or in thematic analysis (Guignon, 2012, p. 98).

Classical hermeneutics. Hermeneutics was originally applied to the interpretation of ancient texts, especially as applied to biblical exegesis. Hermeneutics itself is a theory of interpretation, starting with the recognition that human phenomena are always meaning-laden. And, because humans and what they do are inherently meaning-*ful*, any attempt to understand either must attempt to "grasp the (usually tacit) meanings inhabiting what presents itself in experience. In addition, those meanings are accessible to us because "we ourselves are meaning-endowing beings who are part of a shared lifeworld" – a world suffused with meanings that emerged across the ages and are part of our inheritance (Guignon, 2012, p.98).

In this original sense, hermeneutics is intended to uncover the author's intended meaning, and it is only after the author's meaning is revealed through a rigorous,

iterative process of study, that any process seeking its significance can take place. In classical hermeneutics the author's intended meaning is intrinsic – found in “linguistic signs that are intentional and shareable” – thus, the text's meaning is “unchangeable and cannot be tampered with” (Pieranunzi, 1992, p. 94). Any subsequent search for significance in the context of the modern era is not the same as making new meaning of the text.

Heidegger's philosophy. Heidegger's philosophy is complex and important – the latter in terms of the foundation it provides for hermeneutic phenomenology.

Born in late 19th century Bavaria, Martin Heidegger (1889-1976) was a student of Edmund Husserl and was profoundly influenced by Husserl's phenomenology. Eventually, however, he broke away to follow a different philosophical path. As I did with Husserl, I went to Heidegger's (1971) writing directly. In addition, I turned to several others' discussions of his work for a deeper understanding (Thompson, 1990; Pierenunzi, 1992; Guignon, 2012).

Heidegger's chief philosophical difference with Husserl's work came about through his shift to ontology. Where Husserl remained focused on epistemology – *what* we can know of something and *how* we can come to know it, Heidegger shifted his focus to ontology, the very nature of existence itself. Thus, Heidegger's philosophy departed from traditional phenomenology and moved toward the question of "Being," from which he derived his hermeneutic phenomenology.

“They” and “Authentic Self” Heidegger spoke of "Being" to describe the overall sense of being-in-the-world. When Heidegger talks about "world," he doesn't

mean the physical world we live in. Rather, he means the world as the totality of what is.

The world is not the mere collection of the countable or uncountable, familiar and unfamiliar things that are just there. But neither is it a merely imagined framework added by our representation to the sum of such given things...World is the ever-nonobjective to which we are subject as long as the paths of birth and death, blessing and curse keep us transported into Being. (Heidegger, 1971, p. 44-45, italics in original)

He went on to state that while a stone, plant or animal is world-less, the peasant woman “has a world because she dwells in the overtness of beings, of the things that are. Her equipment, in its reliability, gives this world a necessity and nearness of its own” (p.46).

To understand the difference Heidegger makes, we need to step back and understand the way Heidegger frames “self,” which he borrowed from Aristotle’s view of a human’s *Being* as distinct from the *Being* of other animals. Humans act from two sorts of appetites or motivations. The first is the sheer impulsive appetite that seeks to satisfy urge or desire – Aristotle’s *poiesis*. In this, humans are like all animals. The second type of motivation, however, is governed by reason. It concerns the worthiness of the first order desires. Aristotle called this *praxis* (Guignon, 2012).

According to Guignon (2012), Heidegger’s take on Aristotle was that the human is distinct in its capacity to “assess and motivate its actions in the present in terms of some overarching life-plan” (p. 100). But that life-plan doesn’t reside in his head, like a goal to be attained; rather, the “life-plan for one’s existence is brought to expression

and worked out in the concrete stands we take in actually living out our lives” (Guignon p.100).

So it was that Heidegger distinguished between *two* Beings. The first is the “they,” that is, being part of one’s community as in, for example, dressing or acting “accordingly – as ‘one does’ in our community” (p. 102). According to Guignon (2012),

Heidegger suggests that much of what we do in what he calls ‘average everydayness’ is conditioned by our enculturation into the practices and forms of life of a particular community – the ‘They’ into which we find ourselves thrown. (p.102)

This “average everydayness,” being the *They*, is akin to Aristotle’s *poiesis*, which Heidegger distinguished from being one’s *Authentic Self*, or the “self acting for-the-sake-of-itself,” akin to Aristotle’s *praxis*. This authentic self is the self with an overarching life plan. However, contrary to how it may sound, the authentic self is *not* a way of being that is separated from one’s engaged and communal way of being. Instead, it exists *in the doing* of the everyday communal tasks. One’s life plan doesn’t exist in the *mind* but in the *doing*. If the life plan lived in the mind, like an abstract set of goals, then action would be “purely instrumental,” that is, aimed at accomplishing those pre-conceived goals. Instead, in Heidegger’s philosophy, the life plan comes into being and is worked out, in the concrete stuff of “living out our lives” (Guignon, 2012, p.100).

As human beings, then, we are *always* participants in a wider historical and cultural context, engaged in the practical day-to-day activities according to the norms of

our community, the context in which our life-plan comes into being. According to Heidegger, the *They* and the *Authentic Self* are not properties or attributes; rather, they're ways of being that manifest themselves in a variety of ways, but are always there.

Modes of engagement in the world. For Heidegger, world itself is not just physical, but is constituted, too, by the meanings and situatedness that give us our culture and open our possibilities for being. There are three ways, or modes, that enable us to engage, to be-in-the-world (Packer, 1985).

Heidegger maintains that daily living is holistic. We do not move through the world interacting with it as though it were a set of discrete objects or entities. Rather, we interact with it from a contextual foundation of embedded, shared meanings. In the first mode of operating in the world, *ready-to-hand*, we know how to proceed holistically with a task. It's in the acting itself that we know something (Packer, 1983, p.1023).

Heidegger used the example of a hammer in a woodworking shop to explain this mode. We use the hammer and experience it in relation to our overall task – carpentry. In this mode, the project (carpentry), the tools we use to accomplish it (e.g. the hammer), the outcome of the project, and what the project means to us, are all interconnected. We don't experience the hammer as a distinct entity out of context – we know it in the context of its designed use and the project we undertake. Thus, the ready-to-hand mode is natural, smooth, and wholly contextual. It is embedded with rich meanings that are determined by the confines of our culture (Pieranunzi, 1992, pp. 89-90).

When faced with a problem for which the ready-to-hand mode proves insufficient, we move into the unready-to-hand mode. This mode involves brief problem-solving to facilitate moving ahead with the intent of the project. For Heidegger, this mode is still situated and contextual, but not to the degree of the ready-to-hand mode. In it an attempt is made to understand the manner in which objects, situations, and meanings fit together. To continue with the workshop analogy, the “hammerer” might stop to wonder why the process of hammering is not proceeding smoothly. Perhaps the hammer is too large for the type of nail, or it could be that the doer is rushing and needs to slow down. In this mode of being, the do-er examines the context and attempts to restore the smooth ready-to-hand way of being.

We move into the third mode, present-at-hand, when neither of the above is sufficient to continue the “project.” In the present-at-hand mode the do-er detaches from a situation in order to analyze the action, seeking to understand the problem and how she can solve it. The goal remains completion of the intended project. This mode represents an area of abstract thought and requires more detachment from the immediate context in order for the do-er to perceive discrete entities of which it’s comprised (Packer, 1985).

Hermeneutic phenomenology. Following on Heidegger’s philosophy, we can examine the phenomenological approach that sometimes carries his name – hermeneutic, or Heideggerian, phenomenology. To recap, hermeneutics is the science of interpretation. It starts with the recognition that human phenomena are “always meaning-laden.” Because humans and what they do are inherently *meaningful*, any attempt to understand either must attempt to “grasp the (usually tacit) meanings

inhabiting what presents itself in experience” (Guignon, 2012, p.98, parentheses in original).

In contrast to traditional hermeneutics, in which the author’s intended meaning is considered to be the only valid meaning, in Heidegger’s hermeneutics multiple meanings are accessible to us because “we ourselves are meaning-endowing beings who are part of a shared lifeworld” – a world suffused with meanings that emerged across the ages and are part of our inheritance (Guignon, 2012, p.98).

According to Packer (1985), in hermeneutic phenomenology we gain access to the phenomenon through the “textual structure of everyday practical activity” as opposed to, for example, an abstract system of relations as espoused by rationalists. Thus, the ready-to-hand mode is the “starting place for hermeneutic inquiry” (p. 1086).

Packer (1985) challenges the researcher to rely on, not attempt to eliminate, her own firsthand experience with, and innate understanding of, the phenomena – the actions – under study. Hermeneutic inquiry has a circular structure: it starts from a general sense of what things are all about, uses that background of understanding in order to interpret a particular phenomenon, and, on the basis of that interpretation, revises the initial general sense of what things are all about. The claim of hermeneutic phenomenology is that, in understanding the human, we are always trapped in such a “hermeneutic circle,” though this circularity should be seen as something positive: it is the enabling condition that first gives us access to the human in general (Guignon, 2012, p.98).

Packer (1985) describes this same concept as a relationship between the researcher’s three modes of engagement. As researcher I begin with my ready-to-hand

engagement – my inherent grasp of the situation which, “prior to, and distinct from, propositional knowledge” of the situation, serves as the “grounding for all interpretation” (p. 1089). Interpretation begins when I step back slightly to consider its meaning, transitioning to unready-to-hand engagement. Packer goes on to point out that if we “push interpretation into the present-at-hand mode, we find ourselves left with ‘assertions’: context-free propositions about abstract objects and their predicates.” Once we go there, we’ve moved beyond interpretation in the hermeneutic sense since “interpretation continues to make reference to the historical and personal background, whereas assertion ignores it” (Packer, 1985, p. 1089).

There are two ways, then, in which the ready-to-hand mode is the correct starting point for the hermeneutic investigation of human action. First, it’s in the participant’s ready-to-hand engagement with the phenomenon that we gain a window into the phenomenon. Second, the primary source of a researcher’s grasp of the situation – her own and the participant’s – is through her ready-to-hand mode of engagement. As Packer (1985) put it, “our skillful recognition of social acts, our emotional evaluations, inform us when we observe and study people and their actions” (p. 1089).

Gadamer’s contribution. Hans-Georg Gadamer studied with Heidegger and was influenced by his approach to hermeneutic phenomenology. He is best known for his contribution to the philosophical understanding of the way in which time helps to create the distance needed for interpretation (Gadamer, 1960/1975). Smith (1987) provides an in-depth discussion of the philosophical premise on which this is based. In a thorough discussion of Gadamer’s contribution to hermeneutic phenomenology, he

points out that the “temporal distance that exists in relation to the interpretation and the to-be-interpreted past text is a prominent theme in Gadamer’s writings” (p. 205).

According to Smith, in Gadamer’s philosophy, this temporal distance, or distancing, exists only in order to be overcome by interpretation.

But how is the distance overcome? Participation in the world of the text makes overcoming the distance possible. This participation happens by virtue of the fact that we are historical beings and share something of the social and cultural meaning of the text’s author. The image Gadamer used to represent this is a fusion of horizons, that is, a merging of the horizon of the author, with his original intended meaning, also referred to as the horizon of the text, and the horizon of the reader who is now interpreter. This merging makes it possible for the reader to approach the interpretive task. This fusion leaves only a relation of participation between the reader and the text (Smith, 1987, p.211).

By my understanding, this distancing, overcome though it must be if interpretation is to happen, is not merely an obstacle to interpretation. This separation in time leaves the text in something of an atemporal state, separated from its original context and author’s intended meaning, allowing each interpretation to be a re-temporalization, bringing with it the potential for new meaning. As Smith writes, it’s in interpretation that the “text’s horizon, its ideality of meaning, fuses with that of the interpreter. The re-temporalization of the meaning of a text, therefore, is the outcome of this fusion of horizons” (p. 211).

Conclusion: Why is this important? I go into detail for two reasons – to situate my methodological approach to understanding reflection as experienced by

physical therapists in practice, since I frame my study within the qualitative research genre of hermeneutic phenomenology. In addition, it helps to situate my specific approaches to hermeneutics and meaning-making. As discussed in the next chapter, I have not taken the usual path for doing hermeneutic phenomenology, but have substituted the use of narrative for the more common in-depth interviewing, thereby necessitating shifts in analytical process. Coming to understand something of the philosophy underlying hermeneutics helps to provide a conceptual foundation for my examining participants in the process of reflecting – the ready-to-hand-mode of engagement. It also helps me understand how their telling of their stories – orally and in writing – is their own engagement in a hermeneutic process, for they use the distance of time, with its openness to reinterpretation, to examine past experience. In the end, this understanding helps me situate this phenomenology of reflection in the broader discourse and lays a foundation for the discussion of narrative that follows.

Narrative: A Broad Umbrella

For the purposes of providing a theoretical and philosophical foundation for my research, I address four aspects of narrative: 1) What do we mean by narrative? 2) Narrative as a way of knowing, 3) Narrative as life story and identity development, and 4) Approaches to narrative inquiry.

What do we mean by narrative?

In the sense discussed it in the preceding section, phenomenologists have used the term narrative to refer to text. The term narrative is also used to refer to a *way of knowing*. In this sense, narrative refers to an inductive way of understanding that

stands in contrast to paradigmatic ways of knowing inherent in the positivistic sciences (Bruner, 1986).

Some theorists and researchers differentiate between narrative and story, pointing to *story* as a specific type of narrative; others make no such distinction and use the terms interchangeably (Riessman, 2008). As a broad foundation for the methodological discussion in the next chapter, I draw here on the introduction to narrative offered by psychologist, Donald Polkinghorne (1997), in a paper he delivered at a symposium on phenomenology and narrative psychology. His discussion reveals several commonly held characteristics of storied narrative.

Polkinghorne begins by reminding the reader that storied narratives are “ubiquitous in people’s lives” and pointing out that we tell stories in everyday conversation and engage with them on television, in movies, and in the books we read (Polkinghorne, 1997, p.32). Human beings have a proclivity toward story, an ability to understand the meanings it carries. This ability derives from the character of human experience – a point I address further in the discussion of narrative and identity below.

Polkinghorne (1997) goes on to introduce the commonly held understanding that narrative, or story, involves plot.

Narrative is a type of discourse or textual organization in which multiple actions, happenings, and events are synthesized into a temporal unity or story.

The operation that transforms the many incidents into one story is emplotment.

(p.31)

Narrative accounting, according to Polkinghorne (1997), begins by identifying a setting within which the narrator introduces characters – the location and time in which

the story takes place. It proceeds with one or more episodes, in which characters act in particular ways toward particular ends, and concludes with some indication of how the episodes coalesce into one story (p. 31). Polkinghorne's (1997) outline for narrative is similar to the structure described by Labov (1972), discussed in the methods and data analysis sections of this work.

Story, then, is about human action. Stories are "concerned with human attempts to progress to a solution, clarification, or unraveling of an incomplete situation;" they are "linguistic expressions" of the human capacity to perceive plot – connectedness in life (Polkinghorne, 1997, p.32). Signaling a potentially important link between narrative and reflection, Polkinghorne states that the "narrative operation that produces a coherently emplotted story is a cognitive activity that involves reflective thought" (p.31). He does not expand on this statement, nor have I found other reference to it in his work or that of others. However, his statement is reminiscent of Dewey's (1933) theory that reflective thinking is triggered by some problem or unresolved situation, and Packer's (1985) discussion of unready-to-hand and present-at-hand modes of engagement being needed when procedural knowledge of the ready-to-hand mode proves insufficient for the intended project.

Narrative as a way of knowing. Riessman (2008) points out that viewing narrative as an object for careful study dates back centuries if one is discussing literature, but only into the second half of the 20th century in the social sciences. There are various views as to when and where this "narrative turn" began. What is important is that narrative inquiry in the social sciences began in earnest in the 1980's when

researchers began challenging the traditions of realism and positivism (Riessman, 2008, p.14).

Jerome Bruner (1986) provides a description of narrative as a way of knowing that stands in contrast to positivistic approaches to “knowing.” He contrasts two modes of thinking, each of which has criteria for what constitutes “well formed thought,” and each of which can be used to convince others of something. One is the narrative mode, the other, the paradigmatic or logico-scientific mode (p. 11).

Examples of paradigmatic thinking include logic, math, and the formal processes of the positivistic sciences. With strict rules or devices for carrying out its work, the paradigmatic – logico-scientific – mode draws on reasoned analysis, logical proof, and empirical observation in its quest to discover context-free, generalizable concepts or *truths*. It seeks to explain cause and effect, to predict and control reality, and to create unambiguous objective truth that can be proven or disproved (pp 11-13).

Narrative knowledge, by contrast, is created and constructed through stories of lived experience and the meanings they contain. It helps make sense of the ambiguity and complexity of human lives. Where logical arguments try to convince of their truth, stories seek to convince of their “lifelikeness.” That is, logical argument appeals to procedures for establishing formal and empirical truth, while story “establishes not truth but verisimilitude” (p.11). Where the logico-scientific approach to knowing attempts to eliminate context, narrative delves deeply into the particulars of a situation. Narrative, then, seeks to “put its timeless miracles into the particulars of experience, and to locate the experience in time and place” (p.13).

In his discussion of how little is known about “how to make good stories,” in contrast to all that is known about how logical and empirical thought proceed, Bruner (1986) speculates that this challenge may exist because story needs to simultaneously construct two landscapes – the landscape of action and the landscape of consciousness. The former is where agents, action, goals and resolution reside. The latter, the landscape of consciousness, houses “what those involved in the action know, think, or feel, or do not know, think, or feel” (p. 14). These two landscapes may be what makes narrative so richly complex and compelling.

In the end, it is important to note that Bruner was not arguing that one mode of thought is better than the other, but that both are important to our full understanding of reality.

There are two distinctive ways of ordering experience, of constructing reality.

The two (thought complementary) are irreducible to one another. Efforts to reduce one more to the other or to ignore one at the expense of the other inevitably fail to capture the rich diversity of thought. (p.11)

Narrative and identity. In this section I discuss philosophical and theoretical underpinnings of the concept of life as narrative, and narrative as a vehicle for developing and conveying identity. These concepts lay the groundwork for data analysis and interpretation offered in later chapters.

I remind the reader of the hermeneutic importance of *time*, and the distance it creates between the original context and intended meaning of a text and the text now open to the reader’s interpretation, as laid out by Gadamer (Smith, 1987). It is in this context that I introduce Paul Ricoeur’s (1985) work, *Time and Narrative*, a three-

volume opus published across multiple years. The references here are from the third volume.

Ricoeur (1985) wrestled with the distinction between phenomenological and cosmological time – the question of whether an objective, or cosmological, time actually exists, or whether time exists only in being's experience of it, that is, phenomenological time.

It is difficult to see how we can draw from phenomenological time, which must be the time of an individual consciousness, the objective that, by hypothesis, is the time of the whole of reality. Conversely, time according to Kant immediately has all the features of a cosmological time, inasmuch as it is the presupposition of every empirical change. Hence it is a structure of nature. (p. 244)

As a way to move beyond this seeming impasse, Ricoeur extended his philosophy to include a third type – narrated time. According to Ricoeur (1985), narrated time, “is like a bridge set over the breach speculation constantly opens between phenomenological time and cosmological time” (p.244).

His argument for the existence of narrated time is complex; in it, Ricoeur (1985) uses the genres and processes of history and fiction, and the differences between them, to illuminate the difference between cosmological and phenomenological time – between “historical time reinscribed on cosmic time” and a “time handed over to the imaginative variations of fiction” (p. 245). He points out the importance of the interpenetration of history and fiction – the “crisscrossing processes of a fictionalization

of history and a historization of fiction” (p. 246). This coming together creates narrated time.

Narrative time, according to Ricoeur (1985), does more than bridge the gap between phenomenological and cosmological time. He observes that “an offshoot from this union of history and fiction is the assignment to an individual or a community of a specific identity that we can call their narrative identity” (p. 246). Ricoeur offers the following example of this concept: if one asks “who?” as in “who did this?,” we may well answer with a proper name. But, he asks, what constitutes the permanence of the person we refer to by that name, given that he’s a biological organism and as such continually changing across the span from birth to death? The answer, according to Ricoeur, “has to be narrative” – the appropriate response to the question “who?” is to tell a life story (p.246).

According to Ricoeur (1985), the dilemma caused by the fact that an individual changes over time goes away if, rather than claiming oneself as being “the same,” one makes the claim of being “self-same.” That the self-same identity must be a narrative identity.

Unlike the abstract identity of the Same, this narrative identity...can include change, mutability, within the cohesion of one lifetime. The subject then appears both as a reader and the writer of its own life, as Proust would have it...The story of a life continues to be refigured by all the truthful or fictive stories a subject tells about himself or herself. This refiguration makes this life itself a cloth woven of stories told. (p.246)

An added benefit of Ricoeur's (1985) construct of a narrative identity is that it can also be applied to a community. We can speak of the self-constancy of a community as well as of an individual because "individual and community are constituted in their identity by taking up narratives that become for them their actual history" (p. 247).

As I followed the trail proceeding from Ricoeur's philosophical notion of narrative identity, my search took me to further literature in psychology (Bruner, 1987; Bruner, Charon, & Montello, 2002; Guignon, 2012; Halling, 1997; Polkinghorne, 1991; Polkinghorne, 1997; Randall, 1995). This was not surprising – I'd already discovered Jerome Bruner (1986).

I also discovered conversations in the psychotherapy literature about the nature of therapeutic work being, in part, to engage clients in the development of life-stories that characterize themselves as unified and whole selves (Angus & McLeod, 2004; Parry & Doan, 1994). While it's a vast discipline in itself, and I do not go into this area of the literature any further here, I raise it because it helped me realize that I was thinking too narrowly about the power of narrative as it relates to self and identity. For this view of psychotherapy to be valid, life stories would need to do more than carry and communicate identity, they would need to change or create it. Where did *that* discourse reside? Ricoeur (1985), as we saw above, pointed to this path.

Donald Polkinghorne's (1997) work is helpful here; he took up Ricoeur's philosophy and moved it forward by providing a thorough examination of ways in which narrative can contribute to identity development. Taking on Ricoeur's arguments, Polkinghorne noted that narrative is the discourse form best able to convey

who we are as actors across time. He pointed to how Ricoeur had expanded the idea of narrative identity by borrowing Aristotle's notion of imitation (*mimesis*) – the essential characteristic of narrative emplotment (Polkinghorne, 1997, pp 47-48).

According to Polkinghorne (1997), Ricoeur described narrative mimesis as an unfolding process – “the answer to who one is (that is, one's personal identity) does not appear immediately out of the words of the story of one's life, but only becomes apparent as one circles through the three senses of emplotment” (p. 48, parentheses in original). These three senses, according to Polkinghorne, are Ricoeur's version of Aristotle's mimesis.

The first mimesis derives from the fact that human beings share a pre-narrative understanding of human actions. However, upon examining that understanding, one comes to see it as unfinished – in need of narrative (Polkinghorne, 1997, p.48).

The second mimesis occurs in the production of “language, narratively configured self-story” (Polkinghorne, 1997, p.55). Here, one uses plot to arrange life into a meaningful whole. Narrative is required to “accomplish the move to a unified identity that is inherent, but not yet accomplished, in...pre-narrative existence” (p.55).

In this second sense of mimesis, Polkinghorne (1997) describes narrative in a way that seems to be related to reflection. That is, narrative is a “retrospective, interpretive composition that displays past events in the light of current understanding and evaluation of their significance” (p.57). This sounds like Schön's (1983) reflection-on-action, but Polkinghorne (1997) takes it beyond mere recall of experience, stating that “the creative and constructive nature of narrative composition allows for different stories about the same past events” (p.59). I return to this idea later in

discussing Mishler's (1995) notion that, in narrative, each *telling* results in a different *told*.

The third form of mimesis gets at the heart of what I've been seeking. According to Polkinghorne (1997), in mimesis three, the life story created in mimesis two is taken up by the individual whose life is the subject of the story, and incorporated into his "operating personal identity, the understanding uncovered and created...in the story" (p. 60). Identity is created and expanded by narrative.

Polkinghorne (1997) ends with the following:

We are activities, that is, verbs, not noun-like substances. We are not empty containers, passively accepting and becoming whatever identity our story culture happens to use to fill our container. Our content is our active embodied engagement with others, the world, and our selves. (p.62)

The idea that identity development is related to the creation of life-stories becomes important to the meanings I make of this study's data.

I turn now to contributions Bruner (1987) made to understanding the concept of life as narrative. He begins by covering the now familiar concept that humans have no way other than narrative to describe "lived time," and "the mimesis between life and...narrative is a two-way affair...Narrative imitates life; life imitates narrative" (p. 12). What Bruner adds to the discussion is an examination of the relationship between culture and autobiography. He describes the culturally shaped cognitive and linguistic processes that guide the self-telling of life narrative, suggesting that humans become the narratives by which they tell about their lives. Thus, culture shapes identity.

Numerous other theorists and narrative researchers have expanded upon this discourse on life as narrative and the relationships among life-story, narrative based on experience, and autobiography (Bruner, 2001; Freeman & Brockmeier, 2001; Langellier, 2001; Linde, 1993; Mishler, 1999). I return to the work of several in the coming chapters as they help me understand and discuss this study's findings.

Narrative approaches to inquiry. Narrative inquiry is not one thing, rather, it is a collection of approaches to understanding the meanings contained in narrative. In the introduction to her text on narrative methods applied to social sciences inquiry, Riessman (2008) describes a continuum of ways in which narrative is defined and used in social science research. At one end is the “restrictive definition of social linguistics,” where narrative refers to a “discrete unit of discourse, an extended answer by a research participant to a single question” (p.5); at the other, are “applications in social history and anthropology, where narrative can refer to an entire life story, woven from threads of interviews, observations and documents” (p.5).

I situate my work, in part, in the genre of narrative inquiry because, as discussed in the next chapter, narrative is the window through which I view participants' reflective processes – the phenomenon of interest. In future chapters I discuss literature on narrative inquiry that informed decisions about types of data to collect and approaches to analysis and interpretation. In this section I introduce a framework into which that literature fits.

As a foundation, I return to hermeneutics and the gap between a text and its meaning. Linde (1993) points to the potential to “drown in a sea of equally possible interpretations of any text” and suggests that what prevents it is the fact that, “as social

actors, we make interpretations for a particular purpose within the constraints of a particular social world” (p. 96). She offers the example of a three-way conversation in which any two listeners have slightly different interpretations of what the speaker said, and, because that is as expected, the interaction is able to continue. She refers to this as an important “social resource, since it permits interaction to continue without exact agreement, which is certainly a rare commodity” (p.96).

Linde suggests that what’s true for participants in conversation holds for the researcher studying a text that has been distanced from its original social and cultural context. The investigator cannot determine a “single correct interpretation” but can attempt to produce one or more interpretations that will be adequate for the analytic purposes of the investigation” (p. 96). This is reminiscent of the hermeneutic arguments discussed earlier. Of note, here, is the notion that the researcher brings a specific purpose to her work.

Mishler (1995) incorporated the researcher’s purpose into his development of a typology of models of narrative analysis. Acknowledging the growing diversity of approaches to doing narrative inquiry, Mishler wrote, “I view it as a problem-centered area of inquiry. From that perspective, it will always include a multiplicity and diversity of approaches” (p.88). He developed the typology inductively, sorting studies based on the types of problems addressed and the methods used. That process led Mishler to identify three major categories, which I describe here as a means of situating the aspects of narrative inquiry used in this study.

Reference and temporal order. In this category, Mishler (1995) includes work in which the investigator claims to be connecting the temporal ordering of events in a

narrative account with a sequence of real events. In it he introduces the notion of the “order of the told” – the succession of real events – and the “order of the telling” – the succession of events as represented in the narrative.

Mishler (1995) describes studies in which the investigator claims the text is “recapitulating the told in the telling” (p. 91) – a direct correlation between events as they occurred and as they’re reported. A second approach is taken by investigators claiming to be “reconstructing the told from the telling” (p.96). Here Mishler addresses narrative that is interpreted *not* as a direct recapitulation of events, but as a representation of events as the narrator has come to view them from some future point. In a third variation, Mishler refers to the work of historians, for example, as “making a telling from the told” (p.100). These ways of thinking about *tellings* and *tolds* provide a theoretical framework I apply in this study’s data analysis and interpretation.

Textual Coherence and Structure. In this second category in his typology of models of narrative analysis, Mishler (1995) includes approaches tracing their roots to structuralist models of literary analysis. Within the subset, discourse linguistics, Mishler introduces work such as that done by Labov (1972). I discuss structural analysis in more detail in the context of this study’s data analysis and interpretation.

Narrative functions: Contexts and consequences. Mishler’s (1995) third major category contains approaches to narrative inquiry that focus on the “‘work’ stories do, on the settings in which they are produced, and on the effects they have” (p.107). The first subset in this category includes study of “the narrativization of experience” (p.108). In it Mishler discusses the fact that “a number of psychologists view the

construction of personal narrative as central to a sense of one's self, of an identity" (p.108), which I discussed previously.

Riessman's (2008) text on narrative inquiry is also organized, in part, around a typology of approaches to narrative inquiry – one she developed to aid in teaching graduate students (p. 17). Riessman includes four categories of narrative analysis – thematic, structural, dialogic/performance, and visual analysis – the first three of which I use in this study.

Thematic analysis, according to Riessman (2008), focuses exclusively on the content of the narrative. In this approach, the focus is on Mishler's "told" – what is said or discussed in the narrative (p. 53-54). In contrast, structural analysis focuses on the narrative form in an effort to uncover what it can add to one's understanding of the narrative's meaning, going beyond referential meanings. In other words, the focus in structural analysis shifts to the "telling" (p.77).

Riessman (2008) describes the third category, dialogic/performance analysis, as an interpretive approach to oral narrative that uses elements of both thematic and structural analysis, but adds to them – "if thematic and structural analysis interrogate 'what' is spoken and 'how,' the dialogic/performative approach asks 'who' an utterance may be directed to, 'when,' and 'why,' that is, for what purposes?" (p.105). Riessman refers here to the foundational work of Nessa Wolfson (1978), which I, too, turned to for assistance in analyzing performative aspects of interactions portrayed in this study's data.

Conclusion

In this review I've situated this inquiry into the phenomenology of reflection as experienced by physical therapists in clinical practice within three discourses: reflection, especially as applied to health professions; phenomenology, as a philosophical and methodological approach to being and knowing; and narrative, in several of its meanings – an inductive way of knowing, a vehicle for understanding one's life and identity, and a broad approach to inquiry. Along the way I've foreshadowed connections I make between the literature – within and across discourses – and this study's methods and findings.

CHAPTER III: METHODS

Overview

As I assume is the case for other researchers, I revisited this methods description numerous times – on each occasion revising it so that it would, as accurately as possible, communicate to my readers the means by which I’ve conducted this inquiry. As I return one last time, for now, I’m at the juncture of having analyzed and made interpretive judgments about the meaning contained in my data, and have captured those meanings in writing. It is in this context that I’ve become aware that detailing *what* I did as I engaged in this inquiry is easy compared to understanding and conveying in writing *why* I took the various turns I did. Thus, I frame this methods section as a combined genre – a chronicle of key events and actions, and the story that embodies them.

The phenomenon I explore is *reflection as used by physical therapists in clinical practice*. As I addressed in the previous section, my foray into the work of philosophers and theorists who laid the foundation for understanding and *doing* phenomenology and those who wrote about them – Husserl (1859-1938, translated 2001; Thompson, 1990; Owen, 1993), Heidegger (Guignon, 2012; Johnson, 2000), Ricoeur (1981, 1985), Packer (1985) – informed my decision to position my methodological approach within the framework of hermeneutic phenomenology. That said, I have not followed the typical method for *doing* hermeneutic phenomenology – that is, I did not do in-depth interviews to access and explore the participants’ lived experience of the phenomenon. While retaining the interpretive and iterative aspects of the hermeneutical process, I’ve taken a narrative approach to uncover and understand the lived experience of the phenomenon, using stories of clinical practice written by

participants and conversations they had about those stories as the lens through which I glimpse *reflection* being lived by these physical therapists.

The approach to phenomenology used in this study required multiple layers of methodological choices which can be confusing to follow; therefore, I offer the following diagram and table as aids.

Figure 1. Map of Methods

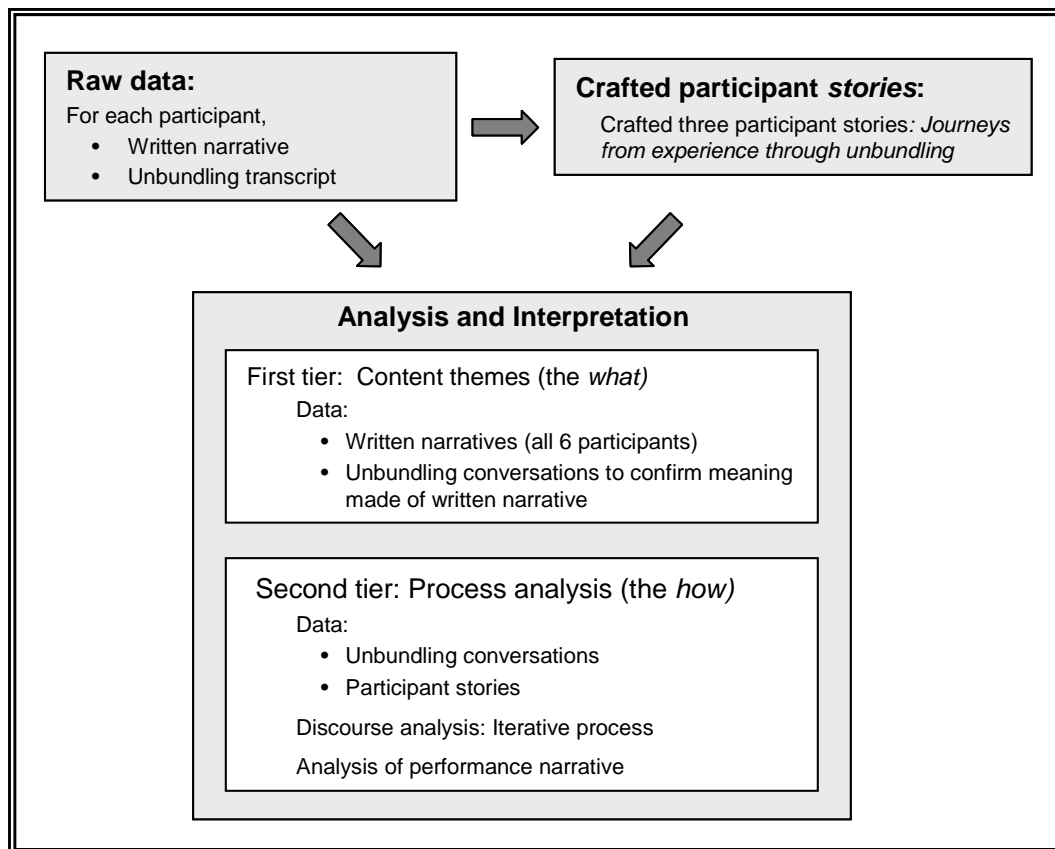


Figure 2. Methods: Table of Contents

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As the map and table indicate, I first provide details of the research setting, participants, and data. After laying these out, I turn to my process of meaning-making – the story of my growing toward narrative methodology.

Research Setting

The setting for this study is the Physical Therapy Services department at Northeast Medical Center, a large academic medical center in the northeastern United States. Located in a large metropolitan area, the center provides inpatient and ambulatory services to many thousands of patients each year in its 950-bed acute care hospital and ambulatory care center, and across five community health centers. The physical therapy department provides services to inpatients at the main hospital and outpatients at the hospital and health centers. Like any research setting, NMC brought with it advantages and disadvantages to this research study.

Advantages and Disadvantages. Since access to any phenomenon is mediated by language, Moustakas (1994) rightly points out that one requirement of phenomenological research is engaging participants who have experienced the phenomenon under study and can put language to it. My experience is that most physical therapists with whom I've practiced inherently reflect in some manner as they go about the everyday tasks of clinical practice, but I also find that most are unable to put precise language to their reflective process.

My belief that therapists do *reflect* in the course of clinical practice is based, in part, on the many conversations I've been privy to in which therapists wrestle with understanding their patients and determining whether they're providing appropriate treatment to them. Schön (1983) might point to such conversations as examples of reflection-on-action, but while some of these therapists would describe the thinking behind such conversations as *reflection*, many wouldn't label it at all. Additionally, the educational and practice literature in physical therapy is filled with references to

reflective practice and reflective practitioners, (Jensen & Paschal, 2000; Plack & Santasier, 2004; Wessel & Larin, 2006; Wong & Blissett, 2007) but the terms are often used differently or without a clear definition of the phenomenon to which they're referring.

Part of the dilemma of language, as I see it, is that reflection is not merely a cognitive but a metacognitive phenomenon (Dewey, 1933; Mezirow, 1990; Schön, 1983). It is abstract – difficult to pin down. When I've asked colleagues to tell me about reflection as they've experienced it, their fallback is often to talk about what happened in a patient encounter – what they did or how they felt. In other words, they modeled it for me, or attempted to. This has been particularly true when I've engaged students and novice clinicians in discussions or writing *about* reflection. It has been my experience that even physical therapists who believe they recognize reflection when they experience it, even distinguishing it from other cognitive tasks such as clinical reasoning or clinical decision-making, are unpracticed at describing it, lacking a language to talk about it.

As I grappled with whether I could overcome the “talking about it” dilemma in order to investigate the phenomenon of reflection at all, I began to work as an educational consultant in the Physical and Occupational Therapy Department at NMC. I'd been a member of the physical therapy faculty at an academic affiliate of NMC for over ten years, but had never practiced physical therapy at NMC. As I began my work at the hospital I realized I'd stepped into a department that embraced, as an explicitly stated component of its professional development for staff, a structured reflective process involving writing about and discussing stories of clinical practice. Virtually

every therapist in the department had this tangible experience of “reflection” and encountered it through a similar process.

This was an approach I had neither seen nor heard about in other clinics, including the hundred or more in which I’d placed physical therapy students over the years. I was convinced I’d encountered a unique opportunity to study the phenomenon of reflection. It put me on the path of having clinicians *show* it rather than *describe* it. The department’s process, which I describe below, had resulted in artifacts, including therapists’ written clinical narratives and videos of clinicians discussing their narratives with a more senior member of the department. My “ah-ha” was that this could provide a window through which I’d be able to *see* physical therapists engaging in reflection, thus exposing the phenomenon to study. I was reminded of Packer’s (1985) argument that the rightful object of hermeneutic phenomenology is the participant’s everyday, ready-to-hand, engagement in the phenomenon (p. 1089). Thus I came to view the act of writing and discussing a story of clinical practice as providing the access I needed to the phenomenon under study.

Another advantage I perceived was that I knew NMC well, understood how physical therapy was practiced there, and was immersed in its culture. In terms of hermeneutical phenomenology, my direct experience with the context in which these reflective acts were occurring resulted in ready access to my own pre-understanding of the phenomenon, a critical pre-requisite to interpretation (Packer, 1985). The final advantage was a practical one. As a member of the physical therapy faculty in a sister organization and an educational consultant at the hospital, I had access to participants and data for this study.

As is often the case, some of the same conditions that facilitate the research process can, at the same time, be disadvantages. The fact that I intended to study the phenomenon of reflection as lived by participants in my own setting made me an insider. While that insider status gave me ready access to understanding the context in which the phenomenon was being experienced, it also increased the challenge of using my pre-understanding to constructively help in my meaning-making rather than overwhelming or obscuring the meaning of the phenomenon as lived by the participants.

I shared the culture of the organization, including the value placed on reflection, and had a pre-existing perception of the reflective process I'd be studying. I also knew my participants and had formed perceptions of them as clinicians. Did I think of some as *reflective* practitioners and others not? I didn't believe so, but was aware that being conscientious about my own reflexivity throughout the research process would be critical.

Creswell (2007), like most qualitative researchers, acknowledges that the researcher brings her "values, biases and understandings" to her work, even stating that "intimate knowledge of a setting may be an asset" (p.114). At the same time he warns against studying one's "own backyard" as the disadvantages, in the end, more often outweigh the advantages. "Unless a compelling argument can be made for studying the 'backyard,' I would advise against it" (p.115), he warns. In the end, I believed I had a "compelling argument" to proceed with NMC as the research setting – despite my insider standing. The decision came down to the fact that the setting and its

participants provided a rare opportunity to see physical therapists engaging in a reflective act.

I have been rigorous in my attention to research standards and my own reflexivity, and as I disseminate the results of this study and add my interpretive voice and those of my participants to the professional discourse on reflective practice in physical therapy, I work to remain transparent with regard to my insider status and will acknowledge the study limitations caused by this setting choice along with the inherent advantages.

Context: The Clinical Recognition Program (CRP) at NMC

CRP Background. Implemented in 2002, the Clinical Recognition Program (CRP) came into existence through the vision and efforts of the leadership in NMC's Patient Care Services division. It is a program designed to recognize and reward clinicians "at the bedside" as they grow in clinical expertise and use it to care for NMC's patients. Developing a program with clearly defined standards for recognition and a valid and reliable process for measuring them in clinicians applying for recognition was a daunting task requiring a collaborative effort of the clinical disciplines comprising Patient Care Services – Nursing; Occupational, Physical, and Respiratory Therapies; Speech and Language Pathology; Chaplaincy; and Social work.

During CRP's development, representatives from these disciplines worked to identify themes of practice that cut across their fields. The group borrowed nurse researcher, Patricia Benner's (1984), qualitative method of analyzing clinical narratives written by those providing patient care. These narratives were short stories based on clinical practice experiences. After individually and collaboratively analyzing 100

narratives, the group identified three cross-cutting practice themes: 1) Clinician-patient relationship, 2) Clinical decision-making, and 3) Collaboration and teamwork.

Adapting Benner's levels of development along a novice to expert continuum, they determined that the CRP would have four levels: 1) Entry, 2) Clinician, 3) Advanced Clinician, and 4) Clinical Scholar.

Each discipline, including physical therapy, then described how these core themes of practice were manifested by its practitioners at each level and defined expectations for recognition. The result was a grid delineating practice standards for each theme at each level. In physical therapy, this task was accomplished through an internal process using focus groups, clinical narratives, and resource documents of the profession (*Guide to physical therapist practice*, 2003; *Standards of Practice for Physical Therapy*, 2007), followed by an external review of its data analysis and practice grid. That reviewer provided the perspective, consistent with the growing literature on expert practice in physical therapy, that NMC clinicians appeared to be describing a fourth practice theme – Movement. Ultimately, that recommendation was accepted as part of the Physical and Occupational Therapy practice grid.

All physical therapists in the department participate in the CRP. Achieving recognition at Entry- and Clinician-levels is mandatory, thus establishing a minimum standard for practice. Pursuing recognition at Advanced Clinician and Clinical Scholar levels is optional and carries reward in the form of a pay raise.

Recognition process. The process of being recognized as practicing at a particular level varies, but in all cases the clinician must write a narrative and discuss it

with either a senior member of the department or representatives of the CRP Review Board.

The written narrative has specific meaning in the context of CRP. It is a short story of clinical practice, typically 3-4 pages in length, that a therapist writes based on a patient she treated during the previous six months. The CRP Website (*Clinical recognition program, accessed, April 18, 2011*) offers the following description:

A clinical narrative is a first person ‘story’ written by a clinician that describes a specific clinical event or situation. Writing the narrative allows a clinician to describe and illustrate her/his current clinical practice in a way that can be easily shared and discussed with professional colleagues (*Instructions for writing the clinical narrative*).

Suggestions for the types of situations to select as the basis of narratives include those that: were particularly demanding; illustrated how the clinician’s intervention made a difference in patient outcomes; or gave the clinician new insight into her role as health care provider. After writing a narrative for the CRP, the therapist meets with at least one other clinician to discuss it, a process referred to at NMC as *unbundling*. From this point the process varies depending on CRP level.

Therapists being recognized at Entry and Clinician levels are evaluated by their clinical supervisors as meeting the criteria for their level. They then write a narrative and meet with the department director to discuss it. Having read the narrative, she makes observations and poses questions in an attempt to facilitate the clinician delving more deeply into the clinical experience about which she chose to write. This is a developmental process but is not used to evaluate level of practice.

This is not the case when applying for recognition at the Advanced-Clinician or Clinical Scholar levels. With rigorous standards and accompanying pay raises, recognition at these levels involves submitting a portfolio and being interviewed by members of an interdisciplinary CRP Review Board – a process that resembles the unbundling process but has the goal of seeking evidence of a level of practice.

Participants

Participant selection. Since all physical therapists at NMC write narratives and participate in the unbundling process, and while each participant's experience of the phenomenon is unique, it seemed that any sample of therapists would suffice in shedding light on the phenomenon I was investigating. However, I felt my data would be richer if my participants had varied clinical experiences – for example, represented practice in inpatient and outpatient settings, or worked with different patient populations such as individuals with primary orthopedic, neurologic or cardiopulmonary problems, or practiced for varying numbers of years.

Why did this matter? Do such attributes make a difference in a physical therapist's lived experience of reflection? Perhaps, perhaps not – that was not my research question. Rather, my desire to vary participant practice experiences grew out of my desire to encounter the experience, *noesis*, of reflection from as broad a perspective as possible so as to more fully reveal its *noema*, or existential being-ness.

In the end, a participant sample meeting all these requirements, in addition to being a pragmatic choice, became evident. In 2010, when it undertook an evaluation of the department's participation in the CRP, the PT and OT Department's program

review team selected six NMC PT's as participants. Those six clinicians varied in the ways I was seeking. In addition, for each there existed data that included a written narrative and a videotape of the unbundling meeting with either the department director or member of the CRP review board.

I contacted these six physical therapists, and after reading and discussing the informed consent form approved by the Institutional Review Boards (IRB) at Lesley University and Northeast Medical Center (NMC), all six therapists along with the senior members of the department who participated in the unbundling conversations – the department director and education coordinator, a member of the CRP review board – consented to participate (see Appendix A for Informed Consent forms).

Participant demographics. As detailed in the table below, the six participants, at the time of writing and discussing the narrative used in this study, had varied lengths and types of clinical practice experience. Each of the two senior members of the department who participated in the unbundling had more than three decades of experience.

Participant	CRP Level	Practice Setting	Patient Population	Experience
Samantha	Entry	Inpatient	General Medical	< 1 year
Joel	Clinician	Outpatient	Orthopedic	2 years
Matthew	Clinician	Outpatient	Orthopedic	9 years
Maureen	Advanced Clinician	Inpatient	Pediatric	7 years
Geoff	Advanced Clinician	Outpatient	Orthopedic	8 years
Kelsey	Advanced Clinician	Inpatient	General Medical	8 years
Participant	Role			Experience
Mark	Director of Physical and Occupational Therapy Services			30 years
Jane	Clinical Education Coordinator for PT and OT Services			31 years

Data Types

For each participant, I accessed two pre-existing types of data: 1) a written clinical narrative, and 2) the video recording of the participant discussing the narrative with a more senior member of the department. For the purpose of this study, I viewed the written narrative as the product of a reflective act, as it stemmed from the clinician recalling and narrating a patient encounter. When that therapist subsequently met with another clinician to discuss his narrative, reflection continued as the narrative expanded and changed in an act of co-construction. I discuss this further in the data analysis section.

In addition to these data, I recorded and transcribed a follow-up interview with three participants approximately 1½ years later, after giving them the opportunity to review the written narrative and video, in which I asked each to respond to the following prompt:

I'm a doctoral student interested in reflection, and as such, am wondering if you'd talk to me about what's going on (or what went on) in your process of writing and talking about a clinical experience.

Data Analysis and Interpretation.

Theoretical foundation. What would typically follow at this juncture is a delineation of methods used for analysis and interpretation of the data. However, before moving to those details, I want to further explore the meanings of narrative and narrative analysis in the context of this research. In this section I present theoretical

underpinnings that informed my choices related to analysis and interpretation of this narrative data.

Growing into an understanding of narrative. The methods I used for this inquiry into reflection, as I've laid them out thus far, include numerous references to *narrative* and my decision to use it to view the phenomenon, reflection, in the experiences of the participants. As I mention above, I write this after engaging in a narrative inquiry process for months, yet I sit at my computer struggling to capture the meaning that *narrative* and *narrative inquiry* – changing, growing constructs for me – have come to hold. My understanding of my inquiry and the means by which I've been exploring the phenomenon of reflection seems akin to a landscape changing with the seasons. In the end, rather than being an indication that I'd gone astray – a possibility I considered more than once – I believe this is completely consistent with narrative inquiry. I see from this vantage point that I've lived into a methodology I'd only vaguely visualized at the outset.

Looking back on my planned methodology for this research, I realize that my first notion of narrative was informed by how the term was actually used in my research setting. That is, narrative was a thing, a story – at NMC, a short written story based on an experience in clinical practice – and I'd come to view it as a product of a reflective process, thus as a window through which I might be able to glimpse reflection.

As my research unfolded, however, my understanding of what it meant and how I was using it in my work expanded. More accurately, as my inquiry unfolded – as I lived it – my conception of narrative was shifting. These shifts consisted of adding layers – other possibilities for how I could understand narrative and use it in my quest

to know the phenomenon of reflection. In service of my quest to understand this phenomenon of reflection, and despite it being accompanied by the uncomfortable sense that I was moving from clarity to foggy – something my foundation in objectivist approaches told me should not be happening in a research process – I allowed it to take me where it would.

Narrative became bigger than a story, or to use Mishler's (1995) term, a *told*. It came to mean the process that resulted in that story – the *telling* – an act of turning experience into story, of communicating the meaning embedded in a lived experience through the human vehicle of story. In the *telling*, then, I was afforded another opportunity to perceive my participants' lived experiences of reflection – a growing *noesis* of reflection's elusive *noema*.

I've begun to uncover and embrace narrative's potential as a means of understanding my participants' stories – the ones they wrote *and* the larger stories they lived in practice. It's inside those larger stories, and through my own use of narrative approaches to understanding the meaning they contain, that I begin to see participants' lived experiences of reflection.

I'm not alone in having traveled a path of growing understanding of the power of narrative and the varying ways it can be conceptualized. In their text, *Narrative Inquiry: Experience and Story in Qualitative Research*, Clandinin & Connelly (2000) undertook to reflect on and describe what it was about narrative that led them to turn to it as the vehicle for doing their work. They summed it up in a way that resonates with my own experience.

We might say that if we understand the world narratively, as we do, then it

makes sense to study the world narratively. For us, life – as we come to it and as it comes to others – is filled with narrative fragments, enacted in storied moments of time and space, and reflected upon and understood in terms of narrative unities and discontinuities. (p. 17)

In the last portion of this quote, Clandinin & Connelly (2000) adopt the notion of continuity as discussed by Bateson (1994) in her reflection on her journey as an anthropologist. I'd always been struck by Bateson's notion of improvisation as a means of relating to a changing, uncertain world. "Zigzag people. Learning to transfer experience from one cycle to the next, we only progress like a sailboat tacking into the wind" (p. 82). Surely Bateson and her quest to see continuity in the seeming discontinuity of life had been one of my early teachers on narrative – in this case life as narrative, life open to many potential interpretations. In the margins of her text (Bateson, 1994, p.83), next to the paragraph in which she challenges adults to work with multiple interpretations of their life histories, I'd written, "Can I compose two life narratives – one based on continuity and one on discontinuity?" And while I don't recall actually taking that challenge, I'd penned an enthusiastic "Yes!" in the margin of the next page where she expanded on this theme: "'Everything I have ever done has been heading me for where I am today' is one version of the truth, but most adults can say as well, 'It is only after many surprises and choices, interruptions and disappointments, that I have arrived somewhere I could never have anticipated'" (Bateson, 1994, p.84).

Bateson's (1994) discussion of continuity, in turn, served as a trigger for me to reconsider Dewey's (1938) thoughts on the nature of experience and the role it plays in

learning. His theory of experience holds that experience arises from the interaction of two principles – continuity and interaction. That is, experience grows out of previous experience and leads to future experience – continuity – and one's present experience is a function of the interaction between past experience and the present situation. Thus, any experiential now has a past and an imagined, yet-to-be-lived, future.

Why pull Bateson (1994) and Dewey (1938) into this discussion of the evolution of my narrative inquiry process? Precisely *because* they help me see that the continuity has been there all along – waiting for me to expand my focus. As Bateson (1994) wrote,

A friend pointed out to me during a period when I was complaining of the discontinuities in my own life that although I had changed my major activity repeatedly, I had always shifted not to something new, but to something prefigured peripherally, an earlier minor theme, so that discontinuity was an illusion created by too narrow a focus and continuity came from a diverse fabric and a broader vision. (p.84)

As I turn now to a description of data analysis and interpretation using the vehicle of narrative inquiry, I will continue to make visible those places of foggy and seeming discontinuity and the new clarity I gained as I learned to trust my peripheral vision and continued to expand my focus.

Not all telling is story. As I attempted to frame in the review of literature, *narrative* is a broad term, used in countless ways – sometimes used interchangeably with *story*, sometimes distinct from story. For the purpose of this research I have bounded the meaning of story or narrative as follows.

Story vs. chronicle of events. For the purposes of this phenomenological inquiry, I use story in the non-fiction, narrative sense of the term as discussed by Phillips (1995) in his work on how narratives are used in organizations. He laid out a two-by-two typology considering fiction/non-fiction on one axis and narrative/non-narrative on the other. I place my working definition there because I am examining participants' writings and talk about lived experiences (non-fiction) in a way that extends beyond a mere chronicling or listing of events.

The distinction between chronicle and story is an important one for this work. As Linde (1993) discusses, the term chronicle is taken from the distinction made by historians who “distinguish between a chronicle (a document recounting events temporally, usually year by year) and a history (a document recounting events not only by time but also by theme)” (p.85). To me this means that story has the potential to convey meaning beyond that contained in a mere listing of events, even one that is chronologically accurate.

Borrowing my own selection of items from Moon's (2010) list of potential ways of delineating story features, in which she drew on her review of literature across multiple disciplines, my working boundaries of story include the following features:

- Story is a form of representation of the products of human mental functioning.
- There is evident coherence and structure...which is usually recognizable to the listener.
- There is usually a purpose for telling a story.
- Story has a beginning-middle-end structure.

- There is something within the story that is out of the ordinary...that makes the story worth telling.
- Something is resolved or transformed between the beginning and end of the story. (Moon, 2010, p.28)

Narrative vs. story. I have found in some of my reading on narrative inquiry that the terms *narrative* and *story* are used, at times, interchangeably. In other instances, a distinction is attempted. According to Riessman (2008) “sociolinguists reserve the term narrative for a general class, and story for a prototypic form.” While a comprehensive review of the differences is beyond the scope of this work, I do abide by the following guides in my understanding and use of narrative. De Fina (2003) describes it this way:

Stories can be described not only as narratives that have a sequential and temporal ordering, but also as texts that include some kind of rupture or disturbance in the normal course of events, some kind of unexpected action that provokes a reaction and or adjustment. (p. 13)

Labov’s (1972) work describing narrative structure came to my attention in reading several authors who used his framework for distinguishing features of stories (Goffman, 1981). As described in Riessman (2008), Labov was particularly interested in describing sequences in the structural elements of narratives that seem to recur in stories based on life experiences. This work is important in informing my own since I am working with clinicians’ stories of their clinical practice experiences.

Labov’s (1972) framework distinguishes six elements of narrative – abstract (optional, provides the point of the story), orientation (provides context – time, place,

characters, situation), complicating action (part of the narrative clauses; event sequence that provide plot, usually with this crisis or turning point), evaluation (narrator's indication of the point of the story; what it means), resolution (outcome of the plot), and coda (ending of the story and bringing things back to present) – each of which serves a specific purpose (Reissman, 2008, p.84). I use these elements in Chapter VI when I analyze Joel's conversation with Mark.

Narrative as performed self. Drawing on the work of Jerome Bruner (1987), I have adopted the philosophical view that the stories of clinical practice told by participants are miniature excerpts of their life stories as physical therapists. Thus, as Bruner (1987) wrote of autobiography, narratives help to structure our perceptual experience, thereby aiding memory, as it also serves to “segment and purpose-build the very events of a life” (p. 15).

This notion fits with Mishler's (1999) discussion of narrative in the prologue to his study of craft artists' narratives of identity. He refers to speaking, narrating life events, as social acts in which we convey identity. This notion of portraying our preferred selves is developed in others' work as well. As Mishler (1999) put it, when speaking “we perform our identity,” and use language as the vehicle for social engagement in which we “tell our stories in particular ways that fit the occasion and are appropriate for our specific intentions, audiences, and contexts” (p. xvi). In this study, as I describe in future chapters, the notion of participants' performing their identities as physical therapists in the way they tell and write their stories seems particularly apt.

Story as co-constructed. The notion that story, and meaning, is always co-constructed warrants a separate mention. As discussed previously, the meaning of any

story is determined by both the teller and listener, author and reader. Rather than being confident that I know the story-teller's intended meaning, I bring my own meaning-making ability to bear in understanding what it means – to me.

Narrative as a method of inquiry and analysis. Narrative inquiry, as a vehicle for understanding the meanings contained in lived experience as communicated in stories grand and small, is nearly as diverse as the stories themselves. Narrative inquiry has been informed by numerous guides who show the diversity of conceptual paths down which one might travel with this work. Mishler (1995), Riessman (2008), Linde (1993), Coles (1989) and Clandinin & Connelly (2000) have helped to shape my understanding of this form of inquiry. I've also been influenced by products of narrative inquiry, including Ribeiro (1994) and Mishler (1999).

Mishler (1995) captures the breadth of narrative inquiry in a series of questions he proposes all those doing narrative inquiry must answer for themselves:

Researchers have different answers for each of many questions: What is narrative? Does it have a distinctive structure? Are there different genres? When are stories told and for what purposes? Who has the right to tell them? What are their effects – cultural, psychological, social? (p.88)

Riessman (2008) refers to narrative inquiry as a “family of methods for interpreting texts that have in common a storied form.” As such, those doing narrative analysis pay attention to elements of story. In narrative analysis the investigator attends to “actors, their sequences of action and particulars of the context in which they take place.” (p. 11).

As I describe in a later section, while informed by the authors discussed here

and in the preceding sections, when faced with my own data and the challenges of making meaning of it, I found my own way by piecing together an idiosyncratic approach using elements from several approaches. As I did, I aimed to remain true to Riessman's (2008) description of narrative analysts as those who "interrogate intention and language – *how* and *why* incidences are storied, not simply the content to which language refers" (p.11).

Analysis versus interpretation. Every qualitative researcher grapples with the question of how to perform and present analysis and interpretation of data to readers. There is no single agreed-upon best method for these phases of research, leaving each to make choices in the best interest of revealing the story the data have to tell. From my first reading of participants' written narratives and viewing unbundling conversations, through transcription, coding, examination of details, and writing of findings, I've been aware that interpretation is the close companion of analysis.

As discussed in the last chapter, hermeneutical approach resonated with my belief that putting aside my experience of reflection is not only impossible but would not be in service of this research. Rather, I hoped to draw on my experience as a physical therapist and reflective practitioner to help me to see and understand the participant's reflective process, as glimpsed in this study's data.

In his discussion of Heideggerian hermeneutic phenomenology, Packer (1985) refers to the importance of drawing on one's pre-understanding of a phenomenon from which to begin her analysis. My pre-understanding of the phenomenon under consideration in this study, *reflection as experienced by physical therapists in clinical*

practice, grew out of years of practice and experience of the setting in which the participants were practicing when this study's data were generated.

I am aware that one of the lenses through which I viewed the data was that of a physical therapist – clinician and educator – affiliated with the research setting. Since physical therapy is a lens I have in common with the participants, I used it to help me understand, or interpret, their stories. However, I also bring the lens of researcher and therefore realize that my insider status could limit the ability to see what the data have to say. For that reason, in addition to using my physical therapist lens, I've done my best to consciously set it aside and analyze participants' narratives in their own right. To this end, I've paid attention to places where the data surprise me, an approach suggested by Packer (1985). I've sought out aspects of the texts that validate *or* refute my initial interpretive impressions – task to which I've remained committed.

Riessman (2008) points out that even the process of preparing a text for analysis requires interpretation on the part of the researcher. She writes, “transcription and interpretation are often mistakenly viewed as two distinct stages of a project” (p. 21), and goes on to discuss the choices a researcher makes regarding, for example, whether and how the interviewer's words and other utterances are represented in the transcript. Their presence, or not, can dramatically change the meaning made of the transcript by its reader. Riessman uses the analogy of a photographer and his photograph to make her point.

Yet the technology of lenses, films, darkroom practices (even before the digital age) has made possible an extraordinary diversity of possible images of the same object. An image reflects the artist's views and conceptions – values

about what is important. Photographers, like interviewers, transcribers and translators, fix the essence of a figure. (Riessman, 2008, p.50)

Interpretive acts permeated my data preparation and analysis. In an attempt to make my process transparent, I disclose having approached data analysis *not* trying to eliminate them, but attempting instead to remain aware of them and employ an analytic process aimed at maximizing their benefit while minimizing their liability. Like the photographer's relationship to his art, I served as the vehicle for uncovering and conveying one view of the meaning my data hold. In preparing the following chapters, I have worked to make myself and my reader aware, to the extent possible, of where analysis ends and interpretation begins.

Preparing the data. I've identified three roles I assumed as the researcher: 1) Thoughtful reader, 2) Interpretive transcriber, and 3) Storyteller.

Thoughtful reader. I began my preparation of the data by reading each participant's written clinical narrative, composed as part of the CRP process. Who are the characters? What is the plot and how does it unfold? Given my familiarity with PT practice and NMC, I began to create my own picture of the participant engaged in the clinical encounters being described. Across numerous readings I paid attention to places where I had questions about what I was reading, instances in which more detail would be needed to picture the encounters and understand the meaning the participant was trying to convey.

As an example, in Samantha's written clinical narrative, following brief introductory comments about how she came to practice physical therapy at NMC, she

launched into telling her story of working with Commander Lawrence, a patient at the hospital.

Mr. Lawrence is a 55-year-old naval commander, admitted to NMC April 10, 2009, following a 3-month ICU stay at an OSH for mesenteric ischemia s/p laparoscopic appendectomy with numerous complications including the need for subtotal colectomy, PEA arrest, need for PEG placement and tracheostomy and multiple re-explorations. Commander L was evaluated by physical therapy in the ICU and transferred to Bailey 12, the floor on which I was the primary therapist, 5 days later.

As a reader and a PT, I recognized in these sentences a familiar sequencing of facts and a writing style typical of how a physical therapist might begin her medical record of a patient's initial evaluation. They comprise the classic *history of present illness*, the succinct reporting of medically relevant facts, the condensed version of what had occurred medically to result in this patient being at NMC and in Samantha's care.

As the first paragraph unfolded, I noted a shift from the medical-ese as Samantha introduced other aspects, including back-story about a communication he'd received from another therapist and the nervousness she'd felt as a result of it.

The therapist who had evaluated Commander L wrote an email to the clinical specialist on my team to explain the patient's long history of hospitalization. In this email, she also touched on the fact that The Commander had at times been very curious as to the training that a

physical therapist receives and had multiple questions regarding the rationale for the care that she had provided. Naturally, as a new clinician, this part of the email made me quite nervous. (See Appendix C for Samantha's complete clinical narrative.)

Interpretive transcriber. I turned my attention to the videotape of the unbundling conversation between that participant and a senior member of the department. I listened and watched as the participant – who I now viewed as author, *teller*, of a clinical story in which she was both narrator and character – discussed her clinical experience and written narrative with another therapist, whom I framed as reader, listener-come-interviewer. After numerous viewings, I transcribed the interaction verbatim. I did this for all six participants.

I am not trained in fine transcription, the type used by a linguistic scholar performing structural analysis of discourse, nor did I think it essential to the analysis I undertook. I made my transcriptions verbatim and noted certain non-verbal cues, such as pauses and head nods, and verbal cues such as laughter, change in tone, and rate of talk. I inserted descriptive notes when a speaker changed her presentation in a way that signaled a shift in how she meant it to be heard, for example, shifting from talking *about* to *performing* story. My process involved three steps: 1) watching a segment of video, 2) listening to the audio and transcribing it, picturing the interaction in my mind's eye, and 3) reviewing video and transcription, inserting notes or cues I found significant.

I offer the following excerpt of Samantha's discussion with Mark. In it, MARK is the director of the PT department, and SAMANTHA is an entry-level PT with

approximately 6 months of experience. Having read Samantha's clinical narrative about her work with Commander Lawrence, Mark meets with Samantha to discuss the narrative further.

MARK: Samantha I want to thank you for taking the time – both writing the narrative and also sharing the experience, uhh, with me. Uh, I often tell staff, if I haven't told you personally, this is, uhh, the best time I get to spend in my work week, uhm, because it, it gives me, uhm, an opportunity to hear our staff's experiences and to see the very good care that they do provide to our patients, so, for that, I want to thank you before we, we get started
mmm, this sounds like it was a powerful experience for you

SAMANTHA: It was, (laughs)

MARK: So [p] do you *haave* a sense of the, the, what made this such a powerful experience?

SAMANTHA: I think, looking back, he was maybe the first patient that I ever had to *truly* challenge me in return. So, I, I always look at it as whenever we work with patients it's challenging to figure out you know what they need, it's, it's always challenging to think about things from different angles, and prioritize, but I think socially he really, he challenged me a way I was never challenged before. He was, questioning, and he was, uhm, I wouldn't say disagreeable, it was more, sort of

MARK: Mmm, hmmm

SAMANTHA: just in his nature to be that person that questions

MARK: Mmm, hmmm

SAMANTHA: So, anything that you told him, anything that you, ah, any information you provided him you needed to be able to back up

MARK: So [p] you kind of set the stage here, in ... another therapist does his initial evaluation

SAMANTHA: yesss

MARK: uhmm, they give you a, your, our usual hand-off note procedure. They describe what you just shared with me, a little bit in writing, which, seems like just the way in which they wrote it set the stage for, be prepared!

SAMANTHA: yes, yes

Storyteller. This final stage of preparing the data for analysis consisted of constructing a holistic narrative of the participant's journey from her clinical experience, to writing the story of that experience and discussing it with a senior member of the department. It combines *preparing* data for analysis and *doing* the work of analyzing and interpreting.

In these larger participant stories, which I crafted for the three participants with whom I did follow-up interviews, I attempted to *show* participants engaged in clinical practice and in telling their stories of a clinical experience – first in writing and then orally in the context of a conversation. These larger stories are an interpretive representation process. They are at the same time the product of data analysis and a narrative form of data I could, in turn, analyze. I used these participant stories in the second tier of analysis described below.

Two-tiered analysis: The what and how of participant reflection. I decided to analyze the data in two tiers as I attempted to answer my primary research question – *what is reflection as experienced by physical therapists in clinical practice?*

In the first tier, I performed a thematic analysis of content revealing *what* participants chose to reflect on when provided an opportunity to step back from their everyday practice, recall an experience, and write about it. My aim was to explore what the content of this reflection might reveal about its nature. In the second tier, focusing on the transcripts of unbundling conversations and the larger participant stories I'd crafted, I examined the reflective journeys of several participants for what they could reveal about the process, the *how*, of a participants' reflection.

First tier: Thematic analysis of content. Riessman (2008) states, "All narrative inquiry is...concerned with content – 'what' is said, written or visually shown – but in thematic analysis, content is the exclusive focus" (p. 53). My idiosyncratic method of thematic analysis was a synthesis of methods proposed by qualitative researchers whose work influenced my own (Fleming & Mattingly, 2000; Riessman, 2008).

I began by reading a participant narrative to get a general sense of the story it told. In subsequent readings I made notes about what the story seemed to be about. I poured over each narrative multiple times before moving to the next. As I did, themes began to emerge within and across participants. I collapsed and expanded themes as I made sense of them and continued this process until no new themes emerged.

Narrative, or story, is always co-constructed. Thus it changes with each telling. My data were co-constructed in two ways. In the written narrative, the first co-construction occurred between the clinician who experienced the situation and, through

the benefit of time and language, the clinician who penned it. An author and reader also co-construct narrative; therefore, I gave myself, as reader, numerous reads in an effort to exhaust the themes contained in participants' written narratives.

In the unbundling, which took the form of a conversational interview, the narrative was again co-constructed, this time orally by the clinician-author (narrator) in dialogue with a senior clinician-reader (listener)-come interviewer. In the first tier of analysis, I watched the videos of these conversations and read their transcripts, open to new content themes that might emerge from the process – none did. Instead, the oral story telling served as a check of my original understanding of content themes I'd identified, and in some cases augmented or deepened that understanding. Occasionally, I drew upon the unbundling conversation to help me clearly represent a theme in the data chapter that follows.

In his work with narrative, Mishler (1995) distinguishes between the *telling* and the *told*, identifying both as important to the meaning of the story. Applying that distinction to this data analysis, in the first tier I focused on the “told” – what the stories were about. While in reality it wasn't a clean separation, I attempted to reserve examining the “telling” for the second tier of analysis and interpretation.

Second tier: Analyzing the process. Having identified what participants had written about – the content of their reflection – and attempted to understand its meaning in relation to the phenomenon of reflection, in the second tier of analysis I turned the spotlight on participants' process – the *how* of their reflecting.

This tier of analysis began when I crafted the holistic narratives of three participants, as described in my discussion of data preparation. Through them, I took a

holistic look at their reflective journeys from clinical experience, to written narrative, to the unbundling process. I used the transcript of unbundling interview, coupled with the written narrative, to craft a larger story of the path each clinician traveled in telling a story from her clinical practice.

I immersed myself in reading narratives, listening to unbundling interactions between participants and either Mark or Jane, and reading transcripts of those interactions. My challenge, I thought, was to understand their meaning in relation to the reflective process employed by these three participants. It wasn't until I returned to the larger stories I'd crafted that I realized it was in them – telling the story of three participants' reflective journey's – that I'd first encountered the sense that rather than listening to talk *about* clinical experiences, or *about* reflection, I was instead witnessing participants *reflecting with* Mark or Jane as they told their stories of clinical experience. As I opened myself to being the hermeneutic vessel for these lived experiences or reflecting, I wondered how to go about unraveling them so I could better see and understand how it was occurring.

Having been immersed in thematic content of analysis, the first thing I noticed was that participant and interviewer talked about topics from the narrative, at times revisiting them several times within the unbundling interview. This generally took the form of retelling aspects of the story, often resulting in expanding some areas or emphasizing different elements. My quest became understanding how this was occurring, hoping it would shed light on the *how* of the reflecting in which these therapists were engaged.

Where the first tier of analysis had focused on the *told*, as it appeared in written narratives, in this phase I followed changes in series of tolds, like a detective following clues. They pointed to places where I should look more deeply at aspects of the *tellings*. For this analytical task, some of linguistic methods of structural analysis – tools and approaches – seemed important.

My initial foray into this analytical process was intuitive and consisted of paying attention to elements of the interaction – the discourse – that jumped out. This is consistent with the spirit of hermeneutic inquiry with which I approached this research. I paid attention to what surprised me, in content or process, what caused me to sit up and take notice and to open my pre-understanding to seeing something new (Packer, 1985).

Framing the unbundling process: Interview or conversation? To this point I've been referring to unbundling interactions as either conversation or interview. This occurred naturally as I wrote about the content I saw in the data – where my attention was on the *told* – and I used terms like conversation or interview without realizing that I was beginning to frame the vehicle being used for the *telling* (Mishler, 1995).

In hindsight, my use of two terms makes sense as the unbundling carries aspects of both forms of talk. Goffman (1981) referred to the common practice in sociolinguistics of using “conversation... in a loose way, as an equivalent of talk or spoken encounter.” He acknowledges, however, the more restricted, common understanding of conversation as a term referring to casual talk among two or more individuals “during which everyone is accorded the right to talk as well as to listen and... is accorded the status of someone whose overall evaluation of the subject matter

at hand – whose editorial comments, as it were – is to be encouraged and treated with respect” (p.14, n 8). I was responding to the ways in which these interactions felt collegial, applying Goffman’s (1981) common understanding of conversation.

On the other hand, the turn-taking in these interactions was frequently one of alternating between Mark or Jane posing a question and the participant responding – more akin to an interview than a conversation. That said, Mishler (1986) reframes interview in a way I found helpful, pointing out that interviewees, when given the opportunity, often “connect their responses into a sustained account, that is, a story” (p. 67). Coles (1989), however, reminds us that the interviewer – by virtue of the questions he poses – is also telling a story.

Our questioning, Dr. Ludwig pointed out to me, had its own unacknowledged story to tell – about the way we looked at lives, which matters we chose to emphasize, which details we considered important, the imagery we used as we made our interpretations. (p.18-19)

Riessman (2008) uses Mishler’s concept when she describes the narrative interview, in which the goal is to generate detailed accounts rather than brief answers. While Riessman was referring to the research interview, I found it useful to apply her ideas to these unbundling interviews. Containing attributes of both conversation and interview, the model includes the use of open-ended questions by the interviewer – senior clinician – and longer turn-taking by the interviewee – participant. Creating opportunity for extended narration requires the interviewer to cede control over the interaction, which encourages greater equality and uncertainty in the conversation. Finally, this shift can “shift power in interviews; although relations of power are never

equal, the disparity can be diminished” (Riessman 2008, p. 24). I return to the matter of power dynamics in future chapters.

Thus I came to frame the unbundling interactions between participants and Mark or Jane as conversational interviews. That said, I continue to use the terms unbundling interview and unbundling conversation interchangeably.

Revisiting content topics. In analyzing the unbundling conversations, I observed that the topic being talked about at any given time was most often one introduced in the written narrative, frequently returning to the same topic more than once during the conversation. It was not surprising to find that the topics were those introduced in the written narrative, since the two engaged in conversation were meeting to discuss it; however, the extent of the looping *did* surprise me.

For this analysis, I took one example of a topic, one narrative element of one participant’s journey from writing through unbundling, and examined it in-depth as it was visited four times. In doing so, I paid attention to who initiated the topic and how the story changed with each revisiting.

Participant use of performance narration.

A tale or anecdote...is not merely any reporting of a past event.

In the fullest sense, it is such a statement couched from the personal perspective of an actual or potential participant who is located so that some temporal, dramatic development of the reported event proceeds from that starting point. A replaying will, therefore, incidentally be something that listeners can empathetically insert themselves into, vicariously re-experiencing what took place. (Goffman, 1974)

Stories are different from other recountings; they're told to get a point across. In my final approach to analyzing *how* stories unfolded in the unbundling conversations, I focused on one particular form of oral storytelling that presented itself repeatedly – performed narrative. In this genre, the speaker structures the experience from her own point of view and dramatizes it, thereby making it accessible to the listener in the vicarious way to which Goffman refers – a way in which the listener can insert himself into the story, as if he were there. This feature was present, in particular, in the conversations between Samantha (narrator) and Mark (listener), and Maureen (narrator) and Jane (listener).

Riessman's (2008) discussion of what she calls dialogic/performance analysis influenced my sense that this avenue of analysis could prove fruitful in my attempt to understand the process of reflection taking place in the unbundling conversations. She describes it as an approach that differs markedly from the detailed methods of thematic and structural analysis, stating instead that it is a "broad and varied interpretive approach to oral narrative that makes selective use of elements of the other two and adds other dimensions" (p.105).

In this study, the approach was indicated in part because of what I noticed occurring in the unbundling conversations – participants acted out portions of their stories. I found that as listener and reader, those performances made the stories not only accessible but particularly open to *my* meaning-making. In fact, the literary theory upon which these approaches to narrative analysis are built lays a solid foundation for the interpretive agency of the reader.

The theoretical underpinnings of performance analysis, as Riessman (2008) traced them, include the following key concepts: By choosing to act out a narrative, the narrator renders it in a way that is multi-voiced. Further, while the narrator's performance can influence how various voices are heard, she "does not have the only word; that is, the authority over meaning is dispersed and embedded" (p.107). By taking the listener inside the action through use of theatrical or dramaturgical elements, the narrator makes room for the listener to become part of the drama. "No longer accepting the narrator as the 'final authority', the social scientist can interrogate particular words, listen to voices of minor characters, identify hidden discourse sections speakers take for granted, and locate gaps and indeterminate sections in personal narrative" (Riessman 2008, p. 107). In the case of this study, those being given room to become part of the drama include Mark and Jane in the unbundling conversations, me as researcher analyzing the data, and you the reader by my sharing the performances in this text.

Riessman's (2008) discussion of a dialogic/performance analysis approach to narrative inquiry made even more sense to me when I considered it in conjunction with Goffman's (1974) notion that "we spend more of our time not engaged in giving information but in giving shows" (p.509). It held the promise of a different avenue for interpreting the meaning contained in participants' narratives, specifically through their performances, fueling the hope that it would shed more light on the reflective process in which I was convinced these participants were engaged.

The method I employed combined a detailed analysis of a segment of unedited dialogue between Mark and Samantha and another between Maureen and Jane; Joel did

not use performance. When analyzing Samantha's and Maureen's use of performance, I first looked at the formal features of performance that were present. I then stepped back and analyzed a section from the conversations I'd crafted in the participant stories for these two participants. In that portion of this analysis, I interrogate my own choices and what they reveal about the meaning that's accessible in that text – and the light it may shed on the social construction of meaning among physical therapists engaged in a joint reflective process.

Evaluation. Finally, after working through the two-tiered analysis noted above, I turned to the follow-up interviews I'd done with three participants. I analyzed transcripts of those interviews as a form of triangulating data and evaluating my own validity as researcher – meaning-maker – when it came to seeing the essence of participants' reflective processes. In those interviews, participants discussed the meaning *they* made of their narrative writing and unbundling experiences and their reflective processes in general.

CHAPTER IV: MEET THE PARTICIPANTS

Geoff

Geoff was a physical therapist practicing in the outpatient setting at NMC and applying for recognition as Advanced Clinician level when he first encountered Judge Callahan, a 65-year-old patient who worked long hours as a judge in the hospital's jurisdiction. He worked just as hard at maintaining a balanced lifestyle. With two grown sons, both of whom had families, the Judge prided himself on being a *young* grandfather who engaged in biking, running, and practicing yoga. He kept up with his grandkids – until the past several months.

Judge Callahan was referred to physical therapy for treatment of a left knee pain, specifically tendonitis. This condition typically results in pain at the front of the knee during weight bearing activities such as running or jumping. In severe cases the pain is present even when walking on level surfaces. Judge Callahan had been experiencing these symptoms, and more. When Geoff greeted him in the waiting room at that first visit, the Judge was seated in a wheelchair and walked back to the exam room using crutches. Geoff was wondering what else was going on – in addition to a patella tendon problem.

Geoff had been practicing physical therapy for eight years, the last six of which had been in the outpatient setting, when Judge Callahan's name showed up as a new patient on his caseload. Geoff was a skilled clinician. In the outpatient department he'd treated countless patients with all types of orthopedic problems – from the relatively straightforward patient presenting with an acute problem at one joint, like a

tendonitis, to the complex patient with multiple joints involved in a chronic condition, like arthritis.

Geoff began his initial examination by learning more from the Judge about the types of activities he was having difficulty with, when they'd started, and how they had progressed or subsided. From that history, he determined that he needed to look at more than the Judge's left leg for the course of his problems, and suspected that his right hip and spine were likely also involved and, in fact, were likely causing his most challenging problems. When he spoke with the Judge about focusing his examination on these areas, Geoff encountered resistance and realized that treating Judge Callahan was going to be challenging for reasons that went beyond his complex orthopedic problems. Geoff navigated the challenges posed by this patient with the skill of an advanced clinician. In the end, he and Judge Callahan had a productive relationship as physical therapist and patient.

Maureen

Like Geoff, Maureen was applying for recognition as an Advanced Clinician level when she wrote the narrative used as data for this study. At that point in her career, Maureen had been a practicing physical therapist for seven years, first in an inpatient rehabilitation hospital and more recently on the inpatient service at NMC. Her choice of a patient situation to write about came quickly to mind when Maureen thought about recent patients who had been challenging for her to manage and from whom she felt she'd learned something about herself as a clinician and her practice of physical therapy.

Fourteen-year-old Sam was admitted to NMC because of a recent period of rapid decline in his pulmonary status and his nutrition. Sam had Cystic Fibrosis (CF), a genetic condition that causes the lungs to secrete mucous in greater amounts than normal, and thickens, making it difficult to expel. It is a chronic disease, typically diagnosed in childhood and managed by a team approach focused on keeping the airways cleared of the thick secretions, efforts to prevent and aggressively treat the lung infections common in these patients, supporting the often insufficient nutritional status caused by the way the disease affects the lining of the gut, and counseling for patient and family since CF has no cure and often leads to a decreased life expectancy.

Maureen had treated many children and adults with CF, and while every patient presents his own unique challenge to the physical therapist, working with Sam and his mom proved particularly so. Accustomed to a parent or guardian being an ally in assuring that recommended treatments are followed, as Maureen quickly learned, she had no ally in Sam's mom. He'd been missing medical appointments and important treatments, to the point that legal action had just been taken against his mother. 51A is a complaint of medical neglect and gets the department of social services involved with the family.

So it was that Maureen came to realize she would need to focus on getting through to Sam himself. Her narrative and subsequent conversation with Jane, the PT department's education coordinator and a member of the CRP Review Board, tell the story of that journey.

Kelsey

Kelsey, too, wrote her narrative for recognition at advanced clinician level. She'd been practicing for 7 years when she began treating Mr. Gleeson, a patient who had a long and complicated course of medical care while an inpatient at NMC. He was so debilitated when she first evaluated him that Kelsey had anticipated a "relatively long road ahead", predicting it would be "four to five months before he would be sufficiently independent to return home." (Kelsey's narrative, Appendix C) As it turned out, Mr. Gleeson ended up being in the hospital for ten months, including bouncing in and out of the intensive care unit (ICU) as his condition would deteriorate then improve somewhat. Kelsey remained his therapist throughout.

One of Kelsey's first challenges was to design a physical therapy program that would help Mr. Gleeson begin to regain some of the strength and conditioning he'd lost during weeks spent in a hospital bed. Particularly challenging was finding a way to do that without putting pressure on the sacral decubitus¹ he'd developed during all that time in bed. This ruled out many of the methods Kelsey might otherwise have used – methods like having Mr. Gleeson sit up in a chair and gradually increasing the time he could tolerate, or working on his ability to rise from sitting to a standing position and hold it, an activity that worked the large leg muscles needed for all sorts of functional activities, including walking.

Instead, Mr. Gleeson could not even come to an upright position without severe pain, let alone tolerate staying there for any significant amount of time. This was despite Kelsey trying all the latest seating systems designed to decrease pressure on the

¹ Sacral decubitus refers to an open wound over the sacrum or tailbone. They're frequently deep, painful and slow to heal.

sacrum and enable patients like Mr. Gleeson to sit without experiencing pain or causing further damage to their wounds. This limitation made working on sit-to-stand maneuvers impossible. As Kelsey wrote, “Mr. G tested my clinical and technical skills as a therapist, forcing me to frequently think ‘outside of the box’ and utilize my problem-solving skills” (Kelsey’s narrative, Appendix C).

In addition to testing her clinical skills, Kelsey needed to be creative in building Mr. Gleeson’s tolerance for working with physical therapy providers other than her. As she observed near the start of her narrative, “When I reviewed Mr. Gleeson’s chart, it was clear to me that this was an individual who had been through a lot in the couple of months before I met him, including the month he had been at NMC.” All he’d been through, and would go through at NMC, made Mr. Gleeson’s already anxious nature even more prominent. As a healthcare provider, Kelsey found that he didn’t offer his trust easily, and even after she’d won it herself she needed to find a way to help Mr. Gleeson accept care from others – therapists and nurses alike who would be essential in helping him carry out the various activities and exercises that would hopefully help him eventually get back on his feet.

Matthew

Matthew had been practicing physical therapy for nine years, one at NMC, when Ana became his patient in the outpatient department, and he wrote his narrative about his experience working with her. This narrative was for recognition at Clinician level in the CRP. Although having many years of experience, Matthew was relatively new to NMC and decided to pursue clinician level initially and reserve Advanced Clinician for a later time.

His patient, Ana, was a young woman of Ecuadorian descent referred for treatment of pain in her back, with pain and tingling extending down one leg. She was otherwise healthy, though overweight. She'd recently taken up running to help her lose weight, but the pain had become severe enough that she'd needed to stop. As Matthew took her history, he asked about her goals for physical therapy. She told him her primary goal was to return to pain-free running and complete the Marine Corps Marathon that fall.

Matthew had a challenging time determining the cause of Ana's pain. In many ways, Ana's presentation was consistent with someone experiencing a bulging or ruptured disc. But not all Ana's symptoms fit that picture and she seemed to respond to treatments addressing core muscle strengthening. Several months later, Ana was still seeing Matthew. Her neurologist was encouraging her to see a neurosurgeon since an MRI had confirmed lumbar disc pathology. Ana put it off, refusing to consider surgery until after the marathon. During all those weeks Matthew had tried in vain to get Ana to ease off on her running so that her back could heal.

Joel

Joel had been in practice for just under two years when he wrote his narrative for recognition at the Clinician level of the CRP. Joel had completed his final student internship at NMC and taken a job afterward in its Berwick Health Center. He treated a caseload of patients with primarily orthopedic conditions, many with spine problems.

As he wrote in his narrative, Mrs. Cheung was a "fifty-three year old Chinese woman who was referred to Physical Therapy by her primary care physician for treatment of her low back and bilateral radicular leg pain" (Joel's narrative, Appendix

C). In other words, Mrs. Cheung had pain that began in her back and traveled down both legs. When Joel greeted her in the waiting room at her initial visit he was surprised to find that she'd arrived by wheelchair. More surprising was the amount of assistance her significant other, Mr. Wong, gave; in fact, he let her do very little for herself. When they got back to the treatment room and Joel asked Mrs. Cheung to transfer from the wheelchair to the chair in the treatment room, he realized what the issue was – he'd noticed in her medical record that she had been newly diagnosed with Parkinson's disease, but had no indication it was as severe as it was.

Joel needed to shift gears in terms of evaluating Mrs. Cheung. He knew he needed to take a step back and look at basic functional activities. He also needed to determine why Mr. Wong was providing so much assistance. Mrs. Cheung would be well served to become more active and self-sufficient, especially since she was home alone all day while he was at work.

Samantha

Samantha is the least experienced physical therapist participant in this study. At the time she wrote the narrative used here as a data source, she'd been out of school for only six months. It was her first experience writing a narrative and she did so as part of the process of being deemed Entry-level – in other words, competent but a beginner. Since I use the story I crafted from her narrative and discussion of that narrative with Mark as the opening portion of the data chapters, I will not introduce Samantha and her patient any further here. That story will do a better job of it.

CHAPTER V: THEMATIC ANALYSIS OF CONTENT

As discussed in the methods section, I chose to analyze the data in two tiers attempting to answer the research question – *what is reflection as experienced by physical therapists in clinical practice?*

The aim in this first tier is to identify *what* participants wrote about when asked to compose a story based on a clinical experience they'd found to be particularly challenging or from which they felt they'd learned something. For purposes of this study, I viewed these narratives as products of a reflective process and performed a thematic analysis of content using all six participants' narratives. The three participant stories I crafted – composites of their reflective journeys from clinical experience through writing and discussing narratives – provided additional data for the thematic analysis. In this chapter I present the themes I identified and discuss the meaning I make of them in terms of what they reveal about the nature of reflection as *experienced by physical therapists*.

I include examples of data that support the thematic conclusions. In the spirit of hermeneutic phenomenology, I am present in the text as both interpreter and narrator and attempt to be transparent in the ways I draw on my experience as a physical therapist, educational specialist in the research setting, and reflective practitioner. Related to the larger structure of this text, I've chosen to weave the three participant stories across this data chapter and the next. I use them as vehicles for conveying the broader context of physical therapy practice in the research setting and for getting to know those three participants and their patients.

In Search of an Organizational Framework

In their narratives, participants wrote about many topics as they looked back on clinical experiences and crafted narratives to convey them. They wrote of interactions with patients, families and other members of the healthcare team, of challenging situations leading them to consult others for help in making a diagnosis or treatment decision, and of the results of these choices and interactions. They wrote about themselves as physical therapists – how they'd felt and what they'd learned while working with these patients. In other words, they represented, in their texts, the actors, including themselves, and actions that formed their narratives' contexts, plots, and lessons.

Seeking to organize findings of this thematic content analysis, I returned to the context in which the narratives were written, one step in the process of advancement through NMC's Clinical Recognition Program (CRP). Returning to the CRP, as I did, after immersing myself in the data and identifying content themes, I recognized the fit between these findings and the CRP.

First, the CRP was developed to acknowledge the clinician and support the growth of her clinical practice. Second, the physical therapy department, representing a participating discipline, had delineated elements of physical therapist practice in a foundational document that has come to be known as the *physical therapy grid* (Appendix B), or simply, the *PT grid*. I found that results of this analysis mirrored these aspects of the CRP – some themes were about the participants in their physical therapist roles while others were about aspects of their practice. And the themes about practice did align with components of practice identified in the grid.

In light of this, I've organized findings into themes about participants' representations of *physical therapy practice*, and themes about *participants' themselves* in their roles as therapists. To further organize the former, I've adopted the framework of the PT grid.

Themes of Physical Therapy Practice: Introduction

The “PT grid.” Developed to provide objective criteria upon which to base determination of a clinician's practice level for the CRP, the PT grid's use by department members has broadened to include assessing oneself and establishing personal developmental goals, mentoring others in clinical practice, or writing a formal performance evaluation. When participants wrote their clinical narratives, they were, in fact, completing a task required by the CRP

NMC's PT grid identifies four major components of practice – Clinician-Patient Relationship, Teamwork and Collaboration (hereafter referred to as Teamwork), Clinical Decision-Making, and Movement. These components are further divided into sub-components, with each containing behavioral statements representing practice expectations. For example, for the major component, Teamwork, the grid identifies subcomponents of *Interdisciplinary Team*, *Support Personnel*, and *System*.

In addition to identifying practice expectations, the grid follows each component of practice across four levels – Entry, Clinician, Advanced Clinician, and Clinical Scholar, delineating expectations for each. When viewed as a whole, the grid paints a picture of how practice is expected to evolve with increasing expertise.

When aligning the thematic content analysis of the clinical narratives with the PT practice grid, my findings can be categorized under two of the four major grid components: 1) Clinician-Patient Relationship; and 2) Clinical Decision-Making. Where relevant and useful, I use the subcomponents of these areas in presenting thematic findings. While their narratives contain references to Teamwork and Movement, participants wrote about these components of practice in service of the other areas, a topic I address in detail later in this chapter.

Practice component vs. level. In analyzing the content of the written narratives, I focused on which *components* participants wrote about without attempting to determine *levels* of practice. For example, I categorized the theme *Discovering the Person*, under the grid component Clinician-Patient Relationship, subcomponent *Communication and Rapport*, but did not break it down into *Communication and Rapport–Entry level* vs. *–Clinician level*. The goal is to illuminate *what* participants wrote about, as representation of what they reflected on, and is not furthered by identifying practice level. I make the assumption that whatever the topic, the participant wrote about it in a manner consistent with his experience. Thus, the phenomenological stance I assumed at the outset holds – I’m exploring physical therapist reflection through the experiences of these participant therapists, each of whom has a unique practice.

That said, I believe it *is* important to take the entirety of the practice grid, components and levels, into account as I consider the meaning I make of this thematic analysis. Developed to provide objective criteria upon which to base determination of a clinician’s practice level for the CRP, its use by department members has broadened to

include assessing oneself and establishing developmental goals, mentoring others in clinical practice, or writing a formal performance evaluation.

When participants wrote their clinical narratives, they knew they were completing a task required by the CRP. For Samantha, Joel, and Matthew, who had already been deemed by their clinical supervisors as meeting the criteria for Entry- or Clinician-level, writing the narrative and meeting with Mark to discuss it was required, but they knew their narratives were not being used to evaluate their practice. This was not the case for Maureen, Kelsey, and Geoff, who were applying for recognition at the Advanced-Clinician level. Application for Advanced-clinician recognition involves submitting a portfolio and being interviewed by an interdisciplinary CRP Review Board. The clinical narrative is required of that portfolio, and the review board *does* evaluate it for evidence of practice consistent with the applicant's discipline-specific criteria, or grid, at the advanced clinician level. Writing a narrative with the knowledge that it would be used in this way could have led Maureen, Kelsey, or Geoff to attempt to "write to the grid."

In summary, I borrow the framework of the practice grid to organize my clinical practice-related findings, aware that the grid is a foundation document of the CRP process, the narratives used for this study were written as part of that process, and aware of the extent to which some participants may have felt their narratives *needed* to demonstrate practice consistent with a specific level.

Practice Component: Clinician-Patient Relationship

Patients come to physical therapists with a range of physical problems – from orthopedic issues affecting limbs or neurologic ones impacting balance, to cardiopulmonary problems limiting participation in activity. In each case, the common denominator is that some condition is limiting the individual's ability to function or participate in his life activities. (*Guide to Physical Therapist Practice*, 2003)

In order to be effective, the physical therapist needs to be able to partner with the patient to identify the source of the functional problem and implement a treatment program. The nature of rehabilitation is such that the physical therapist doesn't *make* the patient well, rather she empowers the patient to take the steps needed to recover and prevent recurrence. Frequently, the process of physical therapy isn't linear. Forward progress stalls. Setbacks occur. At times, trial-and-error is needed to find a treatment to which the problem will respond and the patient will be amenable.

In the end, the therapist's ability to partner with the patient requires a strong relationship. Thus, in many of the current models of physical therapist practice (*Guide to Physical Therapist Practice*, 2003; Jensen, Gwyer, Hack, & Shephard, 2007) and in NMC's physical therapy grid, significant attention is paid to that relationship.

I chose to further subdivide the themes falling under the physical therapist grid component, Clinician-patient relationship, finding that they were consistent with two of its subcomponents: *A) Communication and Rapport*; and *B) Interface with Clinical Decision-Making*. Before examining them, I offer as context the opening portion of the composite story I crafted on Samantha's journey of reflection.

Samantha: Getting to “We” (Part 1)

Anticipating a challenge, in more ways than one, Samantha took a single deep breath and walked through the door conveying as much confidence, she later expressed in her narrative, as she could muster. After all, she *was* the physical therapist assigned to this floor of the hospital, and that made Commander Lawrence her patient. And just as her colleague who had seen the Commander yesterday in the ICU warned, it didn’t take long before this patient threw down the gauntlet.

Five months later as she wrote her entry-level narrative, Samantha looked back uncertain where to begin. What was expected just months into her first job – as a physical therapist at Northeast Medical Center (NMC)? Was this the right case, the *best* case, to showcase her practice? What words should she use? She stared at the blank screen, eventually deciding to stop worrying and start writing. And the story flowed.

Mr. Lawrence is a 55-year-old naval Commander, admitted to NMC following a 3-month [intensive care unit stay at an outside hospital] for mesenteric ischemia²...with numerous complications including need for subtotal colectomy³, PEA arrest⁴, need for PEG⁵ placement, and need for a tracheostomy⁶ and multiple re-explorations⁷. Commander L was evaluated by

² Mesenteric ischemia is a condition caused by lack of blood flow to the mesentery, or thin covering of the abdominal organs, that results in serious infection and can lead to organ failure and death..

³ A subtotal colectomy is a partial removal of the colon, the terminal portion of the large intestine.

⁴ PEA arrest refers to a specific type of cardiac arrest in which contraction of the heart muscle is absent despite. It results in the body’s inability to generate a pulse – to circulate blood.

⁵ PEG, or percutaneous endoscopic gastrostomy, is a type of feeding tube inserted when unable to take in food by mouth.

⁶ Tracheostomy refers to an opening created in the trachea, or windpipe, to enable mechanical ventilator support for breathing and/or manual clearing of secretions via suction.

⁷ Refers to surgical procedures to examine an internal organ – in this case the intestine and abdominal organs

physical therapy in the ICU and transferred to the floor on which I was the primary therapist, five days later. The therapist who had evaluated Commander L. wrote an email to [Doug], the PT clinical specialist on my team, to explain the patient's long history of hospitalization. In this email, she also touched on the fact that Commander L had at times been very curious as to the training that a physical therapist receives and had multiple questions regarding the rationale for the care that she had provided. Naturally, as a new clinician, this part of the email made me quite nervous.

Samantha was writing the first in a series of clinical narratives she would compose as part of her participation in the Clinical Recognitions Program (CRP) at NMC. At this point, with her supervisor Doug's assurance that she was ready, Samantha put her name forward for Entry-level recognition. A required step, it would indicate she was practicing competently – no small feat in this large academic medical center known for treating complex patients from across the United States and around the world. Samantha began with a summary of the patient's recent medical history, the type of account that might begin any PT documentation in the medical record. Readily decoded by those initiated into the culture of medicine, it provided context. By recounting the events that resulted in his referral to physical therapy, it set the stage for the patient's story. It was a familiar genre for Samantha, a comfortable place to begin.

But even as she chose this familiar opening, aware that her readers would be other clinicians, Samantha detoured, introducing her first dilemma. Anticipating it since the moment she received that e-mail from her colleague, Samantha had been

preparing herself for the inevitable – a challenge of her credentials. And it came, but perhaps in a more complex package than she'd expected.

Initially upon meeting Commander L, I was struck not only by his physical impairments, but also by how intimidating an individual he was. Here was this patient, as vulnerable as a human being can be in many ways, receiving all his medications and nutrition through tubes, having to hold his hand over his tracheostomy site to speak clearly and with barely enough energy to sit up at the edge of the bed, and yet, somehow, he was one of the most intimidating people I had ever met.

I started off introducing myself as the primary therapist on the floor and the one who would continue to carry out his physical therapy care, and it was not two minutes into the conversation before Commander L began to question my training and my ability to carry out interventions. As a new graduate with a brand new, barely broken-in license, it was not too difficult for Commander L to rattle my confidence.

Anyone as ill as Commander Lawrence and confined to bed for more than three months, even a robust fifty-something man like the Commander, will be debilitated. A physical therapist's challenge is to identify his functional limitations and their underlying causes – weakness, stiff joints, lack of cardiovascular fitness, etc. – and to engage the patient in treatment aimed at counteracting them and restoring function.

In my experience with students and novice clinicians, their focus is often on the former – diagnosing the problem. This process, at the core of a physical therapist's clinical reasoning, is challenging for these inexperienced clinicians but not

insurmountable. It's amenable to the vast knowledge accumulated during years spent in school. What they fail to anticipate is that it's the ability to engage the patient that frequently poses the greater challenge.

In fact, Samantha was encountering just such an obstacle as she struggled to provide Commander Lawrence with physical therapy that could make a difference in his life. She'd already revealed her *awareness* that relating to him was not likely to be easy given her inexperience and his demanding nature. And, we've heard in her own words how she armed herself with precisely the sort of clinical reasoning I mention above. As a new graduate, that's what she would have had in her arsenal, and she deployed it, even as her confidence was being rattled.

The way the CRP works, therapists write a narrative; a more experienced therapist reads it; and they discuss it. The purpose of the conversation is not to challenge the therapist's competence, but neither is it just to acknowledge the story. Instead, it's part of a mentoring process implemented by Samantha's department with the stated intent of helping therapists, regardless of level, learn from their clinical experience.

Just a few weeks after writing a narrative about her work with Commander Lawrence, Samantha sat in her department director Mark's office to talk about it, and once again, the challenge of relating to Commander Lawrence was front and center, this time placed there by Mark. Samantha reassured him, and perhaps herself, that at least she knew where to begin, even with this complex, challenging, and very ill patient.

“So, as you’re playing this out in your head, what do you arm yourself with?” Mark asked. “What were you ready to tell him? Because you can’t say ‘twenty years’.”

“Right,” Samantha said with a nervous laugh.

“You can say, ‘six months’ and ‘graduated from a good program’,” Mark said, and Samantha’s nod seemed to acknowledge he’d hit the nail on the head. “What were you prepared to tell him?”

“I think, in my head,” Samantha said, “I just sort of told myself *‘all I can do is go in, and see what I see, and say what I know, and speak with him in a way that I would speak with any patient,’*... because as much as you get a hand-off [note] and you get information from the other therapist, I think you have to gather it for yourself.

It was Mark’s turn to offer a knowing nod.

“And so,” Samantha continued, “here I had this information that he was, from what I read, going to be an intimidating individual. So, then it was important for me to clean that slate a little bit, and know that I could go in and just try to develop a rapport, the way I would with any patient, and that if it became challenging, I was going to have to think on the spot a little, but that I could at least explain what an impairment is. I can explain how it can affect him functionally, and we can start from there and sort of build day by day.”

Reading this exchange, we gain deeper insight into Samantha’s awareness of the importance of establishing a relationship with the Commander and entering it with an open mind, uninfluenced by what she’d been told about how difficult he may prove to

be. As her narrative unfolds, Samantha takes us through her experience with Commander Lawrence. The story is compelling, and her ability to write it in a way that conveys the human element, the experience of being patient or clinician, draws the reader in. This is, perhaps, surprising since it isn't a writing genre she'd used in the course of delivering evidence-based healthcare in this academic medical center. As readers we learn just *how* ill the Commander was, and that despite the medical tests and diagnostic prowess of preeminent physicians, he was still without a definitive diagnosis, therefore, without a cure.

In the first few weeks that I worked with Commander L, I struggled with finding a balance between allowing him to maintain some control and still continuing to direct and make changes to the physical therapy plan of care. Commander L remained without a definitive diagnosis for eight weeks... His medications changed numerous times and they [ordered] imaging and lab tests continually in attempts to find the reason behind his initial ischemia. He became frustrated with the many doctors who were overseeing his care and the multiple changes they were making at one time. He became challenging for every member of the team to work with as he insisted on a very set schedule and became very impatient when things did not occur precisely on his timeline. There was a week where he became very detached, keeping his eyes closed most of the time and declining participation in PT, saying that he just felt too exhausted.

Samantha forged ahead, attempting to engage Commander Lawrence in functional activities and exercise – a physical therapy program designed to maintain

and regain strength for the day he might be able to return home, if that day should come.

Finally, eight weeks after admission to NMC, there was a breakthrough. The medical team discovered the cause of the Commander's original problem and subsequent medical complications. They shared the news with the Commander and put in place a hopefully soon-to-be successful treatment regimen. While Samantha doesn't go into detail in her narrative, she informs us that the Commander's psychological state improved with news of a definitive diagnosis and, with it, came his increased participation in physical therapy. Even as this occurred, however, Samantha realized that something was still missing in his level of engagement.

Commander L continued to participate only at a very shallow level. He participated throughout our 30-minute sessions, at times begrudgingly and with continued trepidation regarding changes in the plan of care, but with little to no compliance with his home exercise program. I spoke with Commander L numerous times regarding the importance of his carrying out the exercises on his own for larger improvements and the need for him to take more responsibility. I continued to work with Commander L five times per week, re-evaluating him each week and finding slight improvements in his impairments, but no large gain in his overall function. At this time, I again sought out the help of Doug.

Feeling stuck, Samantha decided to consult Doug, the physical therapy clinical specialist on her team. She desperately wanted to help Commander Lawrence recover but knew that ultimately *he* would need to make it happen. She was missing something

– but what? By asking Doug to consult on the case, Samantha demonstrated her commitment, doing everything she could for Commander Lawrence. In addition to overseeing the physical therapy care provided to patients, Doug’s role included supporting the development of the physical therapists on his team.

After reviewing her documentation in the medical record, Doug discussed the case with Samantha, asking questions about the Commander’s primary limitations, her treatment approach, and how she was monitoring the impact of physical therapy. Samantha found that conversation with Doug helpful, though not in the way she anticipated. He confirmed that she was focusing on appropriate areas and had developed a reasonable plan of care. With that, he suggested that they treat the patient together the next day. Samantha was about to have her attention drawn to her relationship with Commander Lawrence the *person*, rather than to the clinical facts of his case.

During this conversation with Doug, I realized that a large part of the challenge of treating Commander L had become not determining what I wanted to work on and how I wanted to work on it, but really in involving Commander L in those decisions. Doug attended a treatment session with me and we directly approached the subject of Commander L’s goals and where he wanted PT treatment to go. He didn’t have all the answers for us that day, but it changed the dynamic between us (Samantha and the Commander). I realized that while I thought I had been allowing Commander L to maintain some control, I had instead been just giving up my own control over the sessions. Commander L

needed to determine our long-term goals in order for me to be able to truly involve him in his physical therapy.

Samantha packed a lot into that paragraph – her insight into the importance and challenge of involving the Commander in his care, the power of directly asking about his goals, and ultimately, her questions about who was in control of the physical therapy plan of care. Was she or Commander Lawrence? Through the lens of her clinical narrative, we see the issue of *control* complicating Samantha's relationship with this patient. In addition, Samantha was realizing that control was ultimately related to the question of who was determining the patient's physical therapy goals.

Every physical therapy student learns foundational tenets of providing patient-centered care such as: establishing a relationship with the patient is crucial to being effective; or, care should be directed toward the patient's goals. Most students don't challenge their importance, but is that the same as understanding them?

Over the course of my teaching career, I've observed that these common-sense concepts are often discussed one day, taken at face value and, if not forgotten, at least not revisited with the same intentionality as the more complex knowledge and manual skills that comprise so much of physical therapy practice. Why then was Samantha spending time reflecting on them? Was she, in fact, learning something new about their *truth* or what they meant to the success of her practice?

These thoughts and questions ran through my mind as I read and reread this paragraph. Samantha was describing a pivotal moment in her story's plot, but I needed more meat. I didn't find it believable, in much the same way that I don't believe the mystery writer who, after weaving a complex story with multiple twists and turns,

brings everything to a nice neat conclusion in the matter a few pages. I was missing details, context that would help me understand what had occurred and what it had meant to Samantha. *End, Samantha's Story, (Part 1)*

Practice Component: Clinician-Patient Relationship (continued)

Returning to the thematic analysis of content analysis, in this section I reintroduce other participants and their clinical narratives.

A. Communication and rapport. This subcomponent of clinician-patient relationship, in the physical therapy grid, refers to the therapist's ability to establish rapport with patients and their families or caregivers. Rapport-building requires skill in interpreting patients' verbal and non-verbal cues. Likewise, the therapist needs to send verbal and non-verbal messages the patient can decipher, and monitor the ongoing communication for effectiveness.

Two themes revealed in this analysis fall under this grid subcomponent: 1) *Discovering the person*, the finding that a primary aim of participants' communication and rapport-building was getting to *know* their patients, as individuals, in the contexts of their lives; and 2) *Empathizing with the patient*, seen in portions of the narratives in which participants reveal their capacity to *feel with* their patients.

1. *Discovering the person.* Examples of this theme in participants' narratives vary broadly, from the formal recounting of clinical information to richly descriptive examples of the challenges and rewards encountered as they strove to know their patients as real people with life contexts. This is seen, for example, in Maureen's description of Sam as an adolescent boy who wanted to play baseball, liked Chuck Norris, and just happened to have been born with Cystic Fibrosis (CF), a disease causing secretion of thick mucous effecting the lungs and digestive system. I identified three sub-theme of *Discovering the person*: a) *Clinical summary*; b) *Personality and affect*; and c) *Values and beliefs*.

a. Clinical summary. Participants frequently opened their narratives as they would begin a report in the medical record of a patient's initial physical therapy evaluation. They recounted the *chief complaint*, or primary reason for seeking physical therapy, *history of present illness*, a brief timeline summarizing associated medical tests and treatment, and the progression of symptoms, and *social history*, a statement of relevant facts about the patient's work and leisure activities (*Guide to Physical Therapy Practice*, 2003). It is reasonable that participants would begin with the familiar – whether assuming those reading it would require this context or just to help launch the story and get past any writer's block associated with facing this unfamiliar genre. Perhaps some of each. Regardless, this pattern, as seen in *Samantha's Story*, was consistent across participants' narratives.

In his opening paragraph, Matthew, too, provides a succinct rendering of his patient's chief complaint, history of present illness, and social history. He employs the clipped phrasing of medical documentation, complete with the jargon other healthcare providers would expect.

I met Ana at her initial physical therapy evaluation on April 22nd 2008. She was a healthy, although somewhat overweight woman of Ecuadorian descent. She was employed as a regulatory agent for a Cambridge-based biotechnology firm. She reported initially feeling a gradual onset of low back pain (LBP) in 2006. She had gotten an MRI in 2006, which revealed lumbar disk pathology at L5/S1. She reported exercise had helped, such as walking, but had never attended physical therapy. The pain eventually subsided until the fall of 2007 at which time she started jogging. It was during this time that she

became concerned about her weight and decided to take up jogging, with the goal of completing the Marine Corps Marathon in Washington, DC. Her LBP became severe and she developed paresthesia along the posterolateral aspect of her right lower extremity⁸. At this time, she decided to stop running, which helped her LBP, but the paresthesia remained. (Matthew's Narrative, Appendix C)

In these 150 words, like Samantha did of the Commander, Matthew reveals Ana's reasons for seeking physical therapy – low back pain (LBP) and right leg numbness and tingling (paresthesia) – and traces their two year history. As a physical therapist, I recognize the hand of an experienced physical therapist in the succinctness and clarity of this text.

Just as Samantha's opening paragraph didn't remain focused on the medical summary, but began to reveal the Commander's personality by mentioning the email alert she'd received from her colleague who had treated him in the ICU, so, too, Matthew's opening wasn't just medical facts. In the elements that physical therapists refer to as *social history*, he began to reveal an Ana who was more than just a patient presenting with back pain. We learn of her ethnic heritage, determination to keep her weight under control, decision to use exercise to do so, and, importantly, a personal goal she'd set. Ana wanted to run a marathon – the Marine Corps Marathon.

In this final element we begin to see, as Matthew surely did, something of the person behind the patient. While it's not uncommon for active adults to take up

⁸ Paresthesia along the posterolateral aspect of her right lower extremity – a sensation of tingling, burning, pricking, or numbness of the skin, in this case traveling down the outside and back of the right leg.

running, whether for health or pleasure, relatively few set their sites on running a marathon. This speaks of a determined woman willing to push herself.

b. Personality and affect. As participants' narratives unfolded, they revealed more of the patient in human rather than medical terms. This often took the form of helping the reader get a sense of the patient's personality and affect, as with Samantha's description of the tone with which the Commander challenged her about her credentials and how, upon meeting him, she was "struck not only by his physical impairments, but also by how intimidating an individual he was." In addition to how intimidating an individual he was, we learn that there was a point where the Commander "became very detached; keeping his eyes closed most of the time and declining participation in PT, saying that he just felt too exhausted." And after the medical team diagnosed the root cause of his problems, bringing hope for a cure, the Commander began participating in therapy once again but "only at a very shallow level...at times begrudgingly and with continued trepidation regarding changes in the plan of care."

In Geoff's story of working with Judge Callahan, personality comes into play early. When sharing the findings of his initial evaluation with the Judge, who had been referred for left patellar tendonitis⁹, Geoff explained that the pain in the Judge's right hip and leg seemed much more limiting than the left knee pain and, therefore, seemed to be the place to begin. The Judge, however, "in a rigid tone, stressed that he had been referred to physical therapy for treatment of his left knee problem."

Later, after the Judge had been seen by an orthopedic specialist who confirmed that, in fact, he had an arthritic right hip, Geoff decided to lay groundwork for the day

⁹ Patellar tendonitis is the diagnostic term for an inflammation of the tendon that connects the knee cap (i.e. patella) to the tibia or major bone in the lower leg. The condition causes significant pain during the act of bending and straightening the knee, as in walking or climbing stairs.

the Judge might want to consider hip replacement surgery. This was critical because, despite having been treated by Geoff for both his left knee and right hip pain during this episode of physical therapy, “Judge Callahan continued to focus on the diagnosis of patellar tendonitis.” Therefore, Geoff “verbally walked through [his clinical] thought process with [the] use of visual aides to emphasize [his] point.” The Judge’s response was “I know that’s what you think; we’ll see what the doctor thinks when he sees me.”

Kelsey, too, was attuned to her patient’s personality and changes in affect, and used that insight to negotiate the best plan of care. We read that Mr. Gleeson had a long and complex course of treatment as a patient at NMC, complete with multiple stays in the ICU, throughout which Kelsey was his physical therapist. Kelsey devotes a significant portion of text to Mr. Gleeson’s affect and the role it played in his physical therapy treatment. We come to know Mr. Gleeson as an anxious gentleman who did not easily trust the numerous care providers he encountered at NMC, something that would prove challenging for Kelsey despite her success in earning that trust.

Kelsey’s first challenge was to develop a treatment plan that would help Mr. Gleeson begin to regain the strength lost during weeks confined to a hospital bed *and* could be performed despite the sacral decubitus¹⁰ he’d developed. A physical therapist might begin to build patient endurance through small increases in activity, like sitting in a chair for gradually increasing lengths of time. However, because of his painful wound, Kelsey wasn’t able to find a comfortable seating arrangement for Mr. Gleeson. Through trial-and-error she discovered that he *could* tolerate sitting on the edge of his bed, although he was so weak that even maintaining this upright posture for a few

¹⁰ Sacral decubitus refers to an open wound over the sacrum or tailbone. They’re frequently deep, painful and slow to heal.

minutes caused fatigue. The treatment plan, therefore, involved Mr. Gleeson sitting in this position multiple times across the day. For each, he needed the assistance of a health care provider.

The second challenge became getting past Mr. Gleeson's trust issues. Since Kelsey couldn't be present for all the scheduled sitting times, success of this treatment depended on the participation of multiple nurses and therapists. She wrote about navigating this challenge, ultimately finding a solution.

In addition to generalized anxiety, Mr. G expressed a significant lack of trust regarding less familiar caregivers (nurses and therapists), and this greatly impacted his ability to participate in therapeutic activities with such caregivers. In response to this, his treatment frequency was adjusted as needed when a new mobility task was introduced to allow him to complete it more frequently with this therapist [Kelsey herself] as he was adapting to the task. In addition, other nurses and therapists were periodically brought into the room during our sessions to promote the patient's ultimate confidence in their abilities.

(Kelsey's narrative, Appendix C)

In these examples, participants reveal several of the ways in which a patient's personality can impact the therapist's ability to provide care. Their narratives show patients who are more than merely people in need of medical services, but individuals with their own personalities, affects, and ways of relating, to which the therapist must adapt in order to maintain rapport.

c. Values and beliefs. This final subcomponent of *Discovering the person* surfaced as most participants moved beyond revealing the patient's personality, to

sharing insights they gained into the patient's values and beliefs. The portions of text representing this sub-theme seem to me to take the reader closest to the core of who these individuals are as people – in the contexts of their everyday lives, life roles, and yes, health conditions requiring physical therapy.

Having bumped into the Judge's lack of willingness to stray from the diagnosis assigned by his first physician, Geoff stepped back to consider everything he knew about his patient. He wove his growing insight into Judge Callahan, the *person*, into his narrative.

I understood that it was important for Judge Callahan to follow the doctor's orders for PT for his knee problem, despite the fact there was a more limiting issue with his right leg. It seemed to me that he valued a system of hierarchical authority and rules, which could present a barrier to evaluation and treatment of his more limiting problem. (Geoff's narrative, Appendix C)

In this excerpt we see Geoff attempting to understand his patient's behavior and drawing a connection between it and a value system structured around rules and authority – a reasonable hypothesis for this man who had for many years been a “judge in the city court system.” Geoff took it a step further as he considered how those values could impact his ability to provide effective physical therapy, specifically in terms of maintaining rapport with this patient.

I was concerned that if I continued to focus on his right leg, it could negatively impact his confidence in me and our relationship, ultimately jeopardizing his outcome. I initially focused our conversation back to his left knee, restating my understanding of how his original problem with the left knee began and how it

limited him. The conversation naturally progressed to the onset of his right leg pain, giving me better insight into his functional issues that would ultimately drive my examination. (Geoff's narrative, Appendix x)

Near the end of his narrative, Geoff revealed the extent to which he valued and prioritized this patient's belief system.

Along with the direct physical therapy interventions, the art of listening and communication are invaluable tools that I continue to develop throughout my practice. Had I treated Judge C's patellar tendonitis, I believe that he would have had a different outcome. I worked hard to understand the patient, and my communication helped engage his participation in treatment. I realize that successful intervention may require respect and understanding of my patients' values and beliefs that may otherwise present a barrier." (Geoff's narrative, Appendix C)

Matthew provides another example of this theme. He wanted Ana to slow down in order to stop aggravating her back condition, which he'd begun to think was due to a disc problem that may need surgery. As his story unfolds we see him grappling with, on the one hand, the fact that Ana *valued* being active, and on the other, what he knew about the nature of disc disease. He "discussed [with Ana] the pathophysiology of disc degeneration and that the presence of weakness was usually indicative of [a need for] back surgery." However, when Ana told him she would seek surgical opinions but, in the meantime, "wanted to continue PT and remain as active as possible," Matthew agreed to that plan.

Matthew revealed his insight into just how much Ana, the would-be marathoner, valued remaining active when he wrote, “She continued to aggravate her symptoms with activities such as biking. She even spent an afternoon painting a fence in a forward-flexed posture.” This last point would make any physical therapist cringe, and surely did Matthew. It depicts his patient, with her deteriorating disc in the low back, doing precisely the wrong type of activity – one that is sedentary, sustained across a long period of time, and performed in a forward bent position. In the final paragraph of his narrative Matthew continued to reflect on the dilemma of respecting Ana, as Ana, and carrying out his responsibilities to Ana, his patient.

As it is with many of our active patients, it is difficult to get them to slow down their pace and give their bodies the chance to heal. I wish I had been a little more convincing of this [with Ana]. Despite this, what I learned from Ana is to not give up when you have a goal. She could have given up at any point, but through severe periods of back and leg pain, ER visits, MRI’s and surgical recommendations, she never gave up on her goal of running a marathon and starting a healthier lifestyle. (Matthew’s narrative, Appendix C)

2. Empathy. This theme is seen in the ways participants write about their understanding of, or attempts to understand, how it would feel to be in their patient’s shoes. While different from *discovering* who the patient is as a person with a life context, *empathy*, too, relates to understanding that person – this time on an emotional level. Thus, empathy can be viewed as working in service of the therapist’s rapport and communication with the patient.

Whether in Kelsey's opening sentence in which she tells us that in her first read of Mr. Gleeson's medical record it was clear that "this was an individual who had been through a lot in the couple of months before [she] met him, including during the month he had been at NMC," or Maureen's efforts to understand Sam's mom as just wanting her boys to be happy, participants' narratives are peppered with examples of empathy.

In her narrative, Samantha wrote about the Commander's situation, relating on a human level as she informs her readers that for five months, while hospitalized at NMC with no definitive diagnosis, "he has not been home with his wife and children. For five months he has asked for assistance to get out of bed and go to the bathroom. He has given up all of his hobbies, his life's work and his daily routines. And for those five months, he did not know if this was the way that it would always be or if he might some day return to his former life."

Geoff demonstrates self-awareness as he grapples with Judge Callahan's insistence that his left knee pain, not right hip, be the focus of physical therapy treatment. In the midst of it he reveals not just having empathy, but of actively empathizing, making a link between that act and the act of suspending judgment.

Without judgment, I listened to how his [right hip] pain limited him, and empathized with how difficult it must be to have pain walking only short distances [and] impacting most aspects of his life. (Geoff's narrative, Appendix C)

For both Geoff and Samantha, these expressions of empathy appear to stand in contrast to statements of how challenging their patients could be. Samantha's empathy for the Commander tempers her description of how intimidating and demanding a man

he was most of the time. For Geoff, it reveals another way to understand Judge Callahan's stubbornness in holding onto the longstanding medical hierarchy that places the doctor at the top.

Perhaps the empathy seen in their narratives reveals more than just compassionate healthcare providers. Does it also reveal a strategy employed by these participants, in the moment and later as they reflected on these experiences, to moderate the human tendency to judge, or be annoyed by, the patients and families about whom they're writing? Regardless, their empathy appears to have supported their ability to establish and maintain rapport and positive relationships with their patients. I find it noteworthy that they included it in their narratives which, as I've discussed, I view as the product of a reflective process – a point I return to later in discussing the significance of these findings.

Samantha: Getting to “We” (Part 2)

Samantha wrote in her narrative, “Doug attended a treatment session with me and we directly approached the subject of Commander L’s goals, and where he wanted PT treatment to go.” As a reader who is also a physical therapist, I found myself wondering *how* they’d approached it. Given the Commander I’d come to know through Samantha’s story, I suspected it would have been challenging to elicit his goals. Samantha didn’t expand on it, but wrote in her next sentence, “He didn’t have all the answers for us that day, but it changed the dynamic between us.” Again I wondered *how* the dynamic had changed, how she’d recognized it, but Samantha provided no clues. She continued, “I realized that while I thought I had been allowing Commander L to maintain some control, I had instead been just giving up my own control over the sessions. Commander L needed to determine our long-term goals in order for me to be able to truly involve him in his physical therapy.”

That’s an important realization, but I had doubts about whether Samantha knew what she’d written. Somehow it seemed too pat. Did she really *get* it? Would that realization change her practice – with Commander Lawrence and future patients? I couldn’t articulate precisely what Samantha’s *getting it* would have looked like, but surely it would entail more than hearing and witnessing and having the ability to write it in as few sentences as she does in her narrative. Fortunately for me, or at least for my curiosity, Mark, too, had apparently found this paragraph worth probing. As they sat together in his office, Mark chose not to ask the many questions that had run through my head. In fact, he didn’t pose any, choosing instead to make an observation.

“It sounds as though that was somewhat transformational – as you write it here,” Mark said.

“It was. It was,” Samantha said rapidly, with a nodding head. “I think just discussing it was a transformation, even before [Doug] came into the room, because I thought maybe I was missing something *clinically*.

“So we went in together, and, within the first 5 minutes, the patient was questioning Doug – the same sort of *not really* getting into the treatment, not agreeing with it.

“I was beginning to wonder what was happening – *what’s going on here?* – when, all of a sudden, Doug asked the Commander, ‘What are your goals? What do you want to do by the time you leave this hospital? What do *you* want to do?’

“Well, the patient got upset and flustered at that, telling Doug he didn’t know when, or even *if*, he was going to leave the hospital.

“‘I don’t even know *if* I’m leaving the hospital,’” Samantha said, using the demanding Commander Lawrence voice she’d appropriated but making it sound flustered at the same time, “‘Well, uh, I don’t *know* when I’m...’

“And, Doug was very good at bringing him back,” Samantha said in a calm, assured voice, as if she were Doug. “‘Okay, if they told you that you *were* going to leave here in, say, a month, where do *you*

think you can be in that month? Where do you *want* to be? What's *your* goal?'

"And, the patient looked sort of taken aback," Samantha said, pausing as though seeking the right words, "and all of a sudden, I don't know why, but I realized *I* hadn't thought about that at all.

"And when we stepped out of the room at the end Doug said, 'He seems like somebody who just hasn't thought about where he *could* go because he's been so stuck in his sense of having no control over things and in his concern that they're never going to figure out what's going on.'

"I think what Doug and I needed to do," Samantha said in conclusion, "was to start asking ourselves some questions. If he has goals, are they reachable? Can we help him get there? What do we need to do to get him there? And we needed to tie that all back together for Commander Lawrence."

Mark didn't comment on what Samantha had just said, other than to say he wanted to read something to her from her narrative. He selected the excerpt, "I realized that while I thought I had been allowing Commander L to maintain some control, I had instead been just giving up my own control over the sessions"

"That's really insightful," Mark said when he'd finished reading.

"Did that all emerge from that one session with the clinical specialist?"

"I think it all *clicked* from that session," Samantha said. "I think I knew. I *knew* that I was trying to give him some control, because I saw

him as this person who'd lost all control. And though he's intimidating, he's vulnerable. He doesn't know where he's going. He doesn't have any control. The doctors are controlling the medications he takes, and he gets so frustrated by that. And I thought, 'he *needs* some control, and I need to be letting him make some decisions,' and so I think I let him be so strong in making those decisions that I lost me as the professional. I lost me as the person at least assisting with those decisions and providing some education, and some background, and some..."

"...direction." Mark said, nodding, completing her sentence.

"Direction. Yes, exactly," Samantha said with a nod of her own.

Here Samantha provides details that answer my earlier questions. Having eavesdropped on their exchange, I have the sense that I can now see and hear Samantha, the Commander, and Doug. I can *see* Samantha's unfolding realization – from wondering what was going on, to observing Doug ask the patient about his goals, to realizing "all of a sudden" that she "hadn't thought about that at all." It feels authentic.

When Samantha concludes with a recitation of lessons learned – lessons about the relationship between the *patient's* goals driving care and his having some sense of control over it, or of her role as his PT in eliciting those goals and helping to determine whether they're attainable, or, of her responsibility to communicate her thought process to the patient – I'm satisfied that she *gets it*. It feels like she's reflecting on a challenging patient care experience with an interested colleague, and telling the story. Samantha is now, for me, quite believable. ***End, Samantha's Story (Part2)***

B. Interface with clinical decision-making. The PT grid component, Clinician-Patient Relationship, sub-component *Interface with clinical decision-making*, delineates ways in which a physical therapist uses her relationship with the patient to inform decisions about the plan of care. It involves, for example, using “knowledge of the patient and family” and “cluster[ing] information to understand patient’s life roles and functional needs” to inform decisions related to care (PT Grid, Appendix B). It is under this sub-component that I’ve placed the themes: 1) *Primacy of the patient’s goals*, and 2) *Who has control?*

1. Primacy of the patient’s goals. Participants wrote to varying degrees about their patients’ goals and the role that understanding them played in treatment. Samantha included an “ah ha” she’d had about the importance of eliciting those goals – insight gained when she’d observed Doug, a clinical specialist, interact with the Commander. From there she had reinforced for the Commander that the goals driving his care were *his* to set, not hers. This proved to be the key to solidifying their relationship and engaging the Commander in physical therapy.

A careful reading of Samantha’s narrative reveals a subtle but important shift in language. Within one paragraph Samantha moves from, “*I realized that a large part of the challenge of treating Commander Lawrence had become, not determining what I wanted to work on and how I wanted to work on it, but really in involving [him] in those decisions,*” to, “*Commander Lawrence needed to determine our long-term goals in order for me to be able to truly involve him in his physical therapy.*” (Samantha’s narrative, Appendix C, italics not in original)

This is the first place Samantha refers to *our* anything, in relation to her work with this patient. Does this shift in language, perhaps unconscious as she wrote the story, represent a shift in Samantha's approach to the Commander that enabled her to partner with him in treatment *he* saw as important?

Mr. L is now using the stationary bike for aerobic conditioning. Prior to his illness, he was riding a stationary bike for exercise and... enjoyed riding outside as well. We have started using the stairs as an additional mode of aerobic exercise, one that is functional and easily connected to his return to the community. We continue to work on his postural, range of motion and strength impairments, when tied to...his personal goals of returning to jogging for exercise and his work as a professor and with the Navy. He sees these things as a means to an end rather than endless exercises and chores with no benefit to him. (Samantha's narrative, Appendix C)

Maureen and Geoff, too, wrote about their patient's goals in ways that demonstrated how critical they saw them being in relation to their ability to be effective in their physical therapist roles. Where Samantha's narrative revealed a challenging journey to that realization, these other two seemed to have begun there. This may be due to the difference in their years of experience – Maureen and Geoff wrote their narratives for Advanced Clinician level recognition, as opposed to Samantha's Entry level. Regardless, what's important to this study is *not* the fact that they got there faster, but that they, too, wrote about the important role their patients' goals played. Additionally, in their narratives *Primacy of the patient's goal* evolves to include not

just eliciting the patients' goals and using them to drive treatment, but also to the importance of making that process transparent to the patient.

Maureen asked Sam right up front about his goals, and he, as she wrote, "looked at me and asked if I was serious. When he realized I was, he said 'to be on the freshman baseball team.'" From there, her story literally revolved around developing a plan of care that would give him the best chance of being able to play baseball and set him on a path in which exercise and airway clearance would be part of his everyday life – well beyond the goal of playing baseball. I share that story in the narrative I crafted, *Maureen's Story: Teaming up with Sam*, which I've placed at the end of this section.

Another example of the theme, *Primacy of the patient's goals*, can be seen in Judge Callahan asking Geoff if he could return to running. Geoff considered it but "felt that due to the repetitive impact to his hip and lumbar spine, running might not be a suitable form of exercise." Thus, he wanted to suggest alternatives. At this point in his narrative, Geoff shifted to telling the story of a lesson he'd learned with a previous patient.

In the past I have assumed, incorrectly, [a patient's reasons] for exercise, and found the best way to suggest an alternative is to truly understand my patients' motivations. I had one particular experience in which I needed to suggest an alternative exercise for a patient... To demonstrate that I had her best interests in mind, I assumed she was doing a certain activity for health and wellness, and she could achieve that with an alternative [exercise]. This negatively impacted our rapport as her motivation was the personal accomplishment, [not] health and wellness. (Geoff's Narrative, Appendix C)

Thus, before responding to the Judge's question, Geoff asked him why he ran, "to which he explained that it was to stay active and healthy." Discovering that he "had no particular love of running," Geoff suggested "swimming and biking as alternatives to running and other high impact activities." Geoff closes this portion of the narrative by sharing his strategy, employed, in this case, to great success.

Encouraging him to continue exercise and respecting his desire to be active enabled him to hear my suggestion for alternative exercises without defensiveness with the prospect of limiting exercise altogether. (Geoff's Narrative, Appendix C)

Geoff's narrative differs from the rest in the way he walks us through his thought process related to negotiating the Judge's return to aerobic activities. In it Geoff reveals how he consciously used a lesson learned through a mistake made with another patient – not a mistake in exercise prescription, but in assuming he knew *why* the patient was asking about a specific exercise. By sharing this detail Geoff provides a window into his use of Schön's (1983) reflection-in-action: when Judge Callahan asked about running, Geoff considered that earlier lesson and applied it to his decision about how to respond.

As a final example of this theme, Matthew weaves references to Ana's goal of running the Marine Corps Marathon throughout his narrative. At times revealing to us his frustration at her unwillingness to ease up and allow her back to heal, Matthew never challenged Ana on her goal. In fact, whether discussing Ana's decision-making about back surgery, or how they would continue her physical therapy while she sought surgical opinions, Matthew respected this woman's right to her goal. Like Maureen, he

took every opportunity to help her understand the link between her physical therapy and her potential to someday achieve it. In the end, they succeeded together.

Despite minimal training throughout the summer, [Ana] was...determined to at least travel to Washington and begin the Marine Corps Marathon...and stop if she felt she could not go on...She not only began the marathon, she achieved her goal of completing the entire 26.2 miles! Each participant of the marathon was given a small triangular medallion as a reward for completion....Ana presented me with a thank you card and in it was one of these medallions. She told me she asked for three extra, to give to people [who'd] supported her and helped her to achieve her goal. I was lucky enough to be one of those three, in the good company of her mother and her neurologist. (Matthew's narrative, Appendix C)

While the four preceding examples vary in the ways I've pointed out, the common denominator is clear. For each of these participants, the patient's goal, discovered in the context of their clinician-patient relationship, informed key decisions about physical therapy treatment and its potential for a successful outcome.

2. *Who has control?* This second theme is related to the importance of the patient's goals being the primary driver of decisions about their treatment but stands as a separate theme. Questions of *who controls* the physical therapy plan of care permeate participants' writing, revealing several ways in which the issue arises and is played out.

Samantha addressed it when she wrote "in the first few weeks that I worked with [Commander Lawrence], I struggled with finding a balance between allowing him to maintain some control and still continuing to direct and make changes to the physical

therapy plan of care.” In this sentence she framed her dilemma. As a physical therapist it was her responsibility to provide treatment that addressed the Commander’s specific impairments. But he was “challenging for every member of the team to work with...and became very impatient when things did not occur precisely on his timeline,” a behavior Samantha saw coming from his need to assert control over an out-of-control situation.

Samantha wrote, “I realized that while I thought I had been allowing [Commander Lawrence] to maintain some control, I had instead been just giving up my own control over the [physical therapy] sessions.” I found this sentence confusing on first read; there was insufficient information about how Samantha was *giving up* her control. Only when she explained her meaning to Mark did I understand that, in an attempt to give the Commander control, she felt she’d failed to meet her responsibility as his physical therapist to “at least assist with those decisions and provide some education and some background.” It appears that in the early weeks of their work together Samantha had framed control as an either-or proposition – either she had control or the Commander did. By the time she met with Mark, she was beginning to realize there may be some middle ground, that by explicitly using his goals to frame their work together perhaps they could both feel a sense of control.

In Geoff’s work with Judge Callahan, control emerged in the question of whether they’d begin by addressing his left knee or, in Geoff’s opinion, the more limiting issue of his right hip. But Geoff didn’t appear to struggle with the issue as Samantha had. He sized things up quickly, and rather than risk the Judge losing confidence in him and their relationship, decided to cede control over the matter.

Did Geoff really give up control over the decision or just make it appear that way to Judge Callahan? After encountering the Judge's resistance, Geoff, in his own words, "focused our conversation back to the left knee, restating my understanding of how [the] problem...began and how it limited him. The conversation naturally progressed to the onset of his right leg pain, giving me better insight into the functional issues that would ultimately drive my examination."

I do not mean to imply that Geoff intended to deceive the Judge. Instead, what I see in this narrative is a therapist who, rather than continue to confront his patient, returned to a listening mode, thereby reassuring the patient he'd been heard, and trusted the physical therapy process to bring them both to the other problems. Later, Geoff wrote of making a different choice, bringing the topic up again despite how Judge Callahan was likely to receive it. With additional data supporting his original clinical impression, Geoff appeared to be making every effort to meet his responsibility to help his patient get the care he needed – if not immediately, then at some point in the future.

[Judge Callahan] continued to focus on the diagnosis of patellar tendonitis, and I verbally walked [him] through my thought process...[about the underlying issue with his right hip]. I was concerned that [he] might continue to transition through the [medical] system with a diagnosis of knee pain, and be told to continue with PT [rather than] getting the most appropriate treatment for his problem. (Geoff's narrative, Appendix C)

In this choice it appears to me that Geoff was trying to educate the patient and at least plant a seed for the future. He seemed to realize that ultimately the Judge *did* have control – over whether to engage in physical therapy at all, let alone whether to seek

treatment for his right hip problems. Like Samantha, Geoff devoted a fair amount of his text to this issue of control.

Maureen's experience with Sam weaves together all the themes related to *Clinician-patient relationship*. Thus, despite having woven bits of the story into the preceding sections, I now present *Maureen's Story: Teaming Up With Sam* as a composite picture of these thematic findings.

Maureen's Story: Teaming Up With Sam

Maureen had been practicing at Northeast Medical Center (NMC) for 5 years when she submitted her portfolio for consideration by the Clinical Recognition Program (CRP) review board. She was applying for recognition at the Advanced Clinician level. As part of that process Maureen wrote a narrative about an experience she'd had treating a fourteen-year-old boy named Sam who had been diagnosed with Cystic Fibrosis (CF) at a young age. Maureen began her narrative:

Sam is a 14 y.o. boy with CF admitted to NMC from his doctor's office with complaints of worsening cough, shortness of breath (SOB) and fevers for 2 weeks. Sam's mom is a single parent and also has older twin boys with CF. I met Sam on day one of his admission, when I was consulted to evaluate and assist with airway clearance. I have treated many adults and children with CF; however, this admission would present a significant challenge for the family and the healthcare providers involved.

Cystic Fibrosis causes the lungs to secrete large amounts of thick mucous that is difficult to cough up. Even in this era of high-tech medicine and miracle drugs, CF patients frequently require a low-tech, archaic-appearing regimen of assisted airway clearance known as chest physical therapy, or chest PT. The process involves assuming a series of positions designed to take advantage of gravity's help in draining secretions from each major lobe of the lungs – lying on back face-up and face-down, lying on right side then left side, etc. In each position the physical therapist provides several minutes of percussion and vibration, that is clapping on the child's chest wall with cupped hands followed by shaking the chest vigorously as the child exhales.

Despite how these young patients see it, chest PT is certainly not intended to be a form of torture. Left unaddressed, their secretions become a haven for infection-causing bacteria, at best, and block the absorption of sufficient oxygen into the bloodstream, at worst. In addition to daily chest PT, these children are routinely admitted to a hospital for testing and more vigorous “clean out” two or three times a year. Thus, Sam, assigned to Maureen’s caseload on the pediatric service at NMC, was no stranger to hospitals or physical therapists. Not too many years ago, age fourteen would have been near the upper limit of survival for a child with CF. However, while there’s still no cure, advances in medical care have steadily extended life expectancy for those living with the disease, provided they’re conscientious about the prescribed treatment.

It didn’t take long for Maureen to realize that this was not going to be the routine case of a patient with CF, if there was such a thing. Healthcare providers are accustomed to working closely with the parents or adult guardians of these children in addition to the patients themselves. Juggling these multiple relationships was never simple, but Maureen, an experienced therapist, generally navigated the terrain without too many bumps. She quickly realized, however, that there would be nothing smooth about Sam’s case.

During my chart review I became alarmed at the decrease in his PFTs since last taken 6 months ago. Sam had lost a significant amount of weight, had not grown resulting in him completely falling off the growth chart. My chart review also included reading the doctors’, social worker’s, nurses’ and dietitian’s notes containing their grave concern for Sam’s healthcare given the amount of recent

doctor's visits that were cancelled. For this reason, a 51A¹¹ for medical neglect was filed with the Department of Social Services.

Reading this in the medical record caused Maureen to pause momentarily before entering Sam's room that first day, wondering what she'd find.

I went in to evaluate Sam, and he was sitting on his bed, watching TV and texting on his phone, and Mom was also watching TV. I introduced myself to Sam and his mom, and Sam instantly stated that he could not do PT, he was too tired and had stomach pains, all without ever making eye contact.

As that first encounter with Sam and his mom progressed, Maureen realized she'd need to reframe her thinking about the role a parent plays in these situations. While "usually the ones that assist with compliance at home," Maureen had discovered that Mom, in this instance, appeared almost lackadaisical about things. "I started talking to Mom and Sam about what his normal regimen is for airway clearance. Sam simply stated 'chest PT.' Mom elaborated that usually someone comes to the house, but that the boys are sometimes not there."

In fact, Mom came right out and told Maureen that she knew Sam wouldn't have *quantity* of life, so she wanted him to have *quality*, which she defined as not living his life like he was sick. And, despite Maureen's, and others', efforts to convince her otherwise, Sam's mom stuck to her conviction that this was the right approach. If Sam didn't want to participate in some portion of the prescribed care, she supported him in

¹¹ 51A refers to the section of state law that requires healthcare providers, among others, to notify the Department of Social Services in cases of suspected abuse or neglect of a minor or member of another vulnerable population. In this case, the reporting paperwork was filed over concern of medical neglect, that is, the failure to assure that this child receive critical medical services for treatment of his CF.

that. Though she tried mightily, Maureen was not successful in bringing Mom on board as an ally.

Apparently Sam's other healthcare providers had been no more successful – hence the legal filing of the 51A. That process, however, was not the primary plotline of Maureen's narrative. After providing her readers with the family context, Maureen focused on Sam. If Mom wasn't going to help, at least she didn't stand in Maureen's way and agreed she could treat Sam. Maureen decided to see how far she could get working with the fourteen-year-old directly, despite the signals that he was quite done with physical therapy.

Maureen provided a description of her physical therapy evaluation findings in which she listed numerous impairments including lack of muscle bulk, weakness, poor posture. She also cited the results of medical tests revealing rapidly declining pulmonary function and significant weight loss, but departed from the clinical report taking us inside her interaction with Sam.

My evaluation included obtaining his goals. When I asked him, he looked at me, and asked if I was serious. When he realized I was, he said 'to be on the freshman baseball team.' I said, 'if we work as a team, that can be one of our goals,' but he did not appear to believe me during our first meeting.

Physical therapists, as a matter of routine, document patients' goals; therefore, for Sam, this would have become a routine question. What I suspect was different for him in this instance, unfortunately, occurred when Sam asked whether she *really* wanted to know. Maureen accepted the challenge – yes, she really did. Sam admitted

that he wanted to play on his high school baseball team and Maureen agreed to work with him toward that end.

When I read this paragraph for the first time, as a physical therapist, I applauded Maureen's honesty and courage while wondering whether it would backfire. I knew that a fourteen-year-old would likely have taken her response as a promise, which it was. But where I saw a promise that she'd do what she could to help him get there, Sam likely heard Maureen promise that he'd play baseball. In either interpretation, I suspect Sam would have had cause to doubt her honesty. Surely he'd encountered clinicians who, through no mal intent, had promised outcomes on which they hadn't delivered. Even those who promised only to help work *toward* a goal would have been viewed as liars if, in hindsight, the goal hadn't been reached. Maureen's comment, "but he did not appear to believe me during our first meeting," may be the understatement of her entire story.

Apparently Jane, the department's Education Coordinator and a member of the CRP review board, also found this decision worth probing. When they sat together to discuss her narrative, part of the CRP process, Jane elicited a retelling of that portion of the story.

"So", Jane asked, "how did you end up developing a relationship with Sam? How did you gain his trust"?

"That took a little bit," Maureen said, "because physical therapy had been part of his life, and he'd viewed us as 'oh, you're just going to come in and, you know, beat on my chest, and, whatever, I'm just going to lie here' – a passive role. So, I asked him, on day one, I said, 'What are your goals?'

because to me that's so important, especially since I knew he was going to be the one driving his care.

“This was such a critical time, age fourteen, and I didn't want him to say ‘That's it! I'm done with airway clearance. I'm done with my lungs and my overall body.’ I knew where that path would lead. I wanted him to be active in this, so I said, ‘what are your goals Sam?’ And he looked at me as though I had two heads, but he said, ‘to be on the freshman baseball team,’ and I was like, ‘all right, let's work on that,’ and he did *not* believe me. I think he thought I was just talking, and trying to be friends, but after awhile, when I would bring whatever we were doing back to his goal, he realized that I really did care about what he wanted to do. And that empowered him to take a more active role.”

“That was quite a challenging decision to make,” Jane said, “given the fact that Sam was admitted because he'd lost a lot of weight and his PFTs [pulmonary function tests] from the last 6 months looked terrible.”

“Yes,” Maureen said, nodding.

“So how did you know that that was going to be a realistic goal for this patient?” Jane asked.

“I'm lucky to have access to more of the picture,” Maureen said. “I could look back at his previous PFTs, and I could look back on previous hospital admissions to see where he'd been on the growth chart. I knew from the [medical] literature that this was [physically] attainable, that this sharp decline was more because of what he wasn't doing at home.

“And, I thought, he’s fourteen. At baseline, his lungs, yes they’re impaired, but there’s no reason that we can’t improve on that. So, I told him, ‘I don’t know what level you can get to, but let’s start here. Maybe we’ll have to modify the goal, but let’s try.’

“I’ve had other patients who have surpassed my goals. So, I thought if it’s something he wants to work for I’d get a little more out of him”

With that, Maureen concluded her recounting of the thought process that had resulted in her decision to make a pact with Sam that the goal they would work toward, together, would be playing baseball. And so their partnership was launched – Maureen, the PT, partnering with Sam, the patient.

As she planned his treatment program each day, the bargain she’d made with Sam was never far from Maureen’s mind. As his physical therapist it was her job to weigh Sam’s many physical impairments – airway clearance, weakness, posture, deconditioning – in search of those that would be amenable to physical therapy and make the greatest impact on his overall health and function, in this case playing baseball.

For Sam, and any patient with CF, placing airway clearance at the top of the list was non-negotiable. It’s not a stretch to say that beating his respiratory infection would have been a life or death issue for Sam. However, Maureen needed to keep him engaged and willing to participate in physical therapy she knew he disliked and believed didn’t “make a difference anyway.”

Maureen was walking a tightrope and her center of balance seemed to be Sam's stated goal: he wanted to play baseball. Therefore, Maureen framed her treatment as being what he'd need to do if that goal was to have any chance of coming to pass.

Due to the severity of his impairments, I set up a plan of care, which included PT BID¹² for airway clearance, and wanted to add aerobic conditioning as soon as Sam could tolerate it. Aerobic conditioning is an excellent mode of airway clearance, and I anticipated Sam's aerobic capacity was impaired. I discussed the plan of care, including [how it related to] his goal of being on the baseball team, with Sam and Mom, and they were in agreement.

Determining whether Sam could tolerate aerobic exercise was, in part, a matter of making sure the added activity wouldn't undermine the effort underway to help him reverse his weight loss. Maureen worked with the nutritionist and agreed to stop if his weight gain slowed. In addition, however, his lungs needed to be clear enough to support the added oxygen demand, and Sam's lungs weren't there yet. This put Maureen back to searching for a way to engage Sam in chest PT.

There are many methods for airway clearance... The literature supports numerous methods, that are comparable and effective, and the [the evidence suggests that] one that is the *best* is the method that the patient will perform and be compliant with. I explained to Sam why airway clearance is so important, and explained the different options, and allowed him time to process information and ask me questions. He was then willing to try various methods, and our active experimentation began.

¹² BID is the medical abbreviation for something occurring twice a day.

Not only did Sam need a method he liked, or at least didn't despise, but he'd need to continue carrying it out independently. Mom was already on record as not willing to play the role of enforcer. Jane got Maureen to talk more about that challenge.

"Walk me through a little bit about how you thought about airway clearance," Jane said, "and about being fourteen, and trying to set Sam up for success once he was out of the hospital."

"Normally, at fourteen," Maureen said, "you look to the parents or guardian to help with carryover, but that wasn't going to happen. So, from the research, [I knew] there is no gold standard for airway clearance. The best technique is the one that the patient is effective with and will do.

"I knew I had this great toolbox and that I could say 'listen Sam, let's try them. We have at least two weeks here, so let's find one that you're going to do at home because, for two weeks I can assist and your lungs can sound better, but if you're not going to continue at home, what's the point?'

"So we did a lot of active experimentation, and some methods worked well and he was productive¹³, but then he would try it on his own and say, 'I got lightheaded, it didn't work so well.' So even though I knew those were really good methods, I didn't choose them because he wouldn't continue them at home.

"We did a *lot* of active experimentation."

¹³ This use of the term *productive* refers to *productive cough*, that is, one that is strong enough to enable the individual to remove mucous from the lungs, so it can be spit out, or *cleared*.

Jane said, “And was that successful in the end? Did you come up with something that you felt he could manage while he was in the hospital and have a reasonable expectation of being able to carry out at home?”

Maureen’s narrative provides one answer to Jane’s question:

We tried the active cycle breathing technique¹⁴ and although [it was] quite effective, and Sam could clear a lot of secretions, he felt that when he tried it alone, he breathed too fast and felt lightheaded.

I tried the Acapella¹⁵ and it was also very effective, but Sam felt lightheaded with a long exhalation and had a very shallow inhalation. I then combined [the] two methods, active cycle breathing and [use of] the Acapella, to slow him down. This was quite effective, and he had no complaints and was willing to perform [it].

The result delighted Maureen. Not only did Sam agree to airway clearance, he took charge. In their conversation, Jane got Maureen to talk about how that success felt.

“So many times,” Maureen said, “I’d go in and Sam would say, ‘Oh, I woke up and I was pretty congested.’ He was *already* performing the new airway clearance strategy on his own, and it was effective. That was the *best!*”

Eventually Maureen deemed Sam’s lungs ready, and they attempted aerobic exercise. That first day he was able to walk “at a moderate pace for six minutes” before Maureen needed to end the session due to his shortness of breath and racing heart rate.

¹⁴ Active cycle breathing refers to alternating shallow and deep breaths, inhalations of air, and varying the lengths of time for holding them before breathing out.

¹⁵ Acapella is the trade name of an airway clearance device that vibrates the branches of the bronchial tree to loosen secretions in the lung.

It was a start – one they continued to build on. After a week, with daily gains in his ability to walk on the treadmill, Maureen suggested Sam try jogging.

He initially stated he couldn't and that it was impossible. We then talked about what he would need to do for baseball. We talked about running the bases, and making a catch. He was willing to try, and the first time ran for 2 minutes. I continually gave Sam positive feedback, and...created goals for him to achieve that were obtainable, and I was so proud as he started being able to jog for 15-20 minutes.

Maureen educated Sam about the importance of cross-training, and they added sprints to his workout. To make certain he saw the relationship between these exercises and his goal, Maureen had Sam sprint the standard distance between bases on a baseball diamond. She even created games in which she'd throw a baseball and he'd run, catch it or pick it up, and throw it back. Maureen wove in ongoing education teaching Sam to monitor his level of exertion. Thus, Sam was soon in charge of telling *her* when he it was time to rest.

As their work settled into a routine, their relationship flourished, and Maureen became someone in whom Sam confided – an adult to whom it was safe to talk.

Sam continued to use his exercise times to ask questions about CF, clarifying questions about the importance of what he was doing and how this would help him. He started trying to get his brothers to exercise, as well.

During these sessions, Sam would ask me a lot of questions, not only about exercise, but about CF...[he] had this stomach discomfort that was medically worked up many times, and the medical team felt a lot of it was due to stress

and worry...I saw how much Sam trusted me, and I shared stories of how exercise helps with my stress level... and sure enough as his admission progressed his complaints of stomach pain decreased.

Jane was interested in learning about the connection, if any, that Maureen made between her relationship with Sam and his progress. Clearly he was engaged in physical therapy – no small feat – but Maureen seemed most proud of having empowered Sam make a difference in his health and, perhaps, even to envision a future.

“Did you have any strategies,” Jane asked, “that you think made him want to take more responsibility for his health?”

“Hmmm,” Maureen said thoughtfully, “some of the complex social dynamics were that this kid seemed very tough, but he was so nervous inside. And, even though he was the youngest, he felt some of the burden for the family.

“I think he didn’t feel like he had a safe place to ask questions about his health, so he internalized them, and his feelings about CF. But I think, as he was doing better and exercise was helping, he thought that would be a time to ask. And, he wasn’t looking at me when he did. He’d be on the treadmill, or we’d be running drills outside, and he’d say, ‘oh, so if I’m doing this and, say, later in life I need a lung transplant, this is going to help me, right?’ Those weren’t his first questions, but by the end of his hospital stay he was asking a *lot* more questions about later in the progression of CF

“I think it just allowed him a safe haven and I’d give him, you know, honest answers, or tell him who could help with that question. So, I think, I just earned his trust.”

“Well”, Jane said, “when you’re fourteen, it’s hard to see to tomorrow,

let alone thirty. I think that was a formidable challenge – figuring out how to develop some long-term understanding that what he did now was going to be impacting how he might function later.”

“Right,” Maureen said quietly, looking thoughtful and content.

Maureen monitored their progress for signs that the treatments were having an impact not just on Sam’s physical status, but on the larger goal of getting him to take ownership for his well-being. She provided insight into this in her narrative by telling the following story within the story.

I knew that Sam was starting to take responsibility for his own health near the end of two weeks... [He] had about five friends visiting in his room, and it was his exercise time. Most teenagers, when they have visitors, do not want to participate in PT, and I gave him the option of exercising later, as it was a running day. I assured him he could do something else for exercise, or, his friends could come with us. [Instead] he said to his friends, “I have to exercise.” When they said they were leaving, he said he would call them later. Initially he was upset, but I... told him I was so proud of him, and he said that he knew it was important.

Maureen chose that moment to talk with Sam, once again, about his goals. Perhaps she sensed he was ready to take the next step toward assuming the responsibility for *always* having a next goal to strive for.

I asked Sam what his goals were for himself, besides playing baseball. He was initially confused, and when I clarified that he should have goals [of his

own], he started setting them...His [first] goal, in addition to playing baseball, was to run for 30 minutes. And, on day 14, he met it!

Eventually Sam had a discharge date, and Maureen began wrapping up their work together. Wanting him to keep track of his treatment regimen, she set up a binder with monthly calendars covering the next year, indicating on each day whether it should be a day for strength training, aerobic exercise, day off, etc. They even marked, together, the dates for baseball tryouts.

Sam had revealed to Maureen that he loved Chuck Norris, so she'd found a picture of Norris exercising and placed it prominently on the cover of his binder. Sam was so excited when she presented it to him that "he immediately checked off Acapella, since he'd done it at 7:00 that morning."

In addition to creating the binder, when Sam talked about how much he enjoyed running, Maureen told him that CF Foundation provided a running scholarship for college. Finally, after completing her final physical therapy evaluation, Maureen show Sam the measurements revealing his gains in posture, strength, pulmonary status and aerobic conditioning. Sam left the hospital binder in hand.

Maureen worried that, once home, he might fall into old habits. She needn't have, as we learn in the anecdote she included at the close of her narrative.

I saw Sam in the main hallway [one day] when he was going to his [doctor] appointment with Mom, and he was excited [to tell me] that he made the summer [baseball] team, and was even playing, and felt great! He promised me that he usually used the Acapella every day, and was still using the binder to

keep him on track with his exercise program. I am happy to report that he also said that he's training to run a 3 mile road race in his home town.

The End.

Clinician-patient relationship: Summary and discussion. Participants devoted large portions of their narratives to relationships with their patients, the foundations from which they gathered key information about patients' goals, negotiated plans of care, and empowered patients to take control of their own health.

In each participant's narrative we meet a patient who's more than just a patient, who is an individual with a personality, feelings, values, and beliefs. Each depicts a physical therapist narrator seeking to know that patient as a whole person. In addition, many reveal the challenge of weaving that evolving knowledge of the *person* into the care of the *patient* in a way that respects the individual while remaining true to the physical therapist's responsibilities. Finally, participants demonstrated empathy for the situations that led to these individuals needing the services of a physical therapist.

In contrast, participants did *not* appear to wrestle in the same way with discovering the underlying physical causes of the patients' problems, indicating to me that they'd been confident in their abilities to diagnose and treat those problems. Yet, as we saw in Judge Callahan's resistance to changing direction, or Ana's stubbornness about remaining active, or Sam's mom's lack of willingness to force her fourteen-year-old son to do anything he didn't want to do, arriving at a course of treatment agreed upon by therapist *and* patient was not a given.

Participants wrote at length about the importance of eliciting patients' goals and using them to drive decisions about physical therapy care. They wrote about the challenge of balancing their responsibility to provide effective physical therapy with the patients' rights, and ultimate responsibility, to make choices about their own health.

Having practiced physical therapy for many years, I know that the cases presented in these narratives represent the exceptions, not the rule. It's true that a therapist needs to establish rapport, communicate and educate effectively, and negotiate a plan of care with each patient; however, contrary to the way things unfolded in these narratives, the process often flows smoothly. With the therapist's recommendations falling on receptive ears, a relatively simple conversation about the specifics of treatment is frequently all it takes to agree on a plan and move ahead.

What I read in these narratives leads me to believe that participants selected the cases about which they wrote in part because they *do* represent more extreme and challenging versions of this process, situations that had left something unresolved in their minds – perhaps something from which they felt they had more to learn. That would be consistent with Dewey's (1933) notion that reflective thought begins with a feeling that something is unresolved, and Schön's (1983) discussion of reflection being triggered when knowing-in-action is insufficient.

Regardless of their reasons, however, when presented with this opportunity to step back from clinical practice, into a "present-at-hand mode" (Packer, 1985), and write about an experience from which they "felt they had learned something" (*Instructions for writing the clinical narrative, accessed January, 2012.*) each participant explored, to some extent, discovering and developing empathy for the patient as a person, coming to know the patient's goals and using them to inform clinical decisions, and wrestling with questions of who had control– the physical therapist, the patient, or both.

As I sought to situate these findings in the context of physical therapy practice at NMC, I returned to the PT grid. Under **Clinician-Patient Relationship, Interface with clinical decision-making**, it speaks to the role patient expectations should play in determining goals of treatment. The grid describes that the therapist, at any level, “considers knowledge of patient and family” in implementing care. In addition, the Advanced Clinician “clusters information to understand patient life roles [and] functional needs,” and that information “drives examination, evaluation and intervention.” Only at the highest level, Clinical Scholar, does the grid refer explicitly to the *patient’s goals*, stating that the therapist “listens carefully to patients and uses them as a primary source of data,” and, “negotiates realistic goals and intervention plan based on patient’s values.”

Seeking to place the *Who has control?* theme in context, a search of the PT Grid (Appendix B) reveals that control, too, shows up only in the description of practice at the Clinical Scholar level, where it states that the therapist “empowers patients and family to take control of their well-being” and “employs focused patient/family education to that end.”

The grid’s references to the patient’s goals and issues of control don’t appear to match the extent of the challenge they pose in practice, nor do they seem to fit the expectations these participants have of themselves, considering these narratives were at Entry, Clinician, and Advanced Clinician levels. Does this mean the references are too-little-too-late? Perhaps, but it may also indicate that those who drafted the grid got it right. They recognized how challenging these aspects of practice truly are. Regardless,

participants at all levels of practice used much of their reflective writing on these narratives exploring aspects of their relationship with their patients.

Practice Component: Clinical Decision-Making

Physical therapists practice as autonomous healthcare providers with a responsibility to make clinical decisions in the best interest of their patients (*Guide to Physical Therapist Practice, 2003*). They approach each patient with an open mind, even when a medical diagnosis accompanies the referral. This allows them to listen to a patient's version of her problem, gather information to aid their understanding of the underlying causes, and draw on prior experience and current evidence to inform treatment. This process calls for clinical judgments and decisions at every step. Even after implementing a treatment plan, the therapist continues to assess its impact and make ongoing decisions to modify or stay the course.

This need to be continually making decisions requires the physical therapist to be *thinking* at all times. Even as she's *doing* other things, such as listening to the patient, performing tests, palpating a painful spot the patient pointed out, teaching an exercise, or using one of the manual techniques people tend to think of as "physical therapy," she's taking in information and engaging in an ongoing reasoning process. Numerous clinical decision-making models – all designed to help the therapist navigate this complex aspect of practice – have been published and are in use today (Rothstein, Echternach, & Riddle, 2003; Schenkman, M, Bliss, S, Day, L, Kemppainen, S, Morse, J., Pratt, J, 1999; M. Schenkman, Deutsch, & Gill-Body, 2006). In the end, I believe, we develop our own idiosyncratic ways of thinking. However, that is not the

phenomenon I'm studying except to the extent that participants use reflection to aid their decision-making process. For example, some may include moments of what Schön (1983) termed reflection-in-action, or move back and forth between Packer's ready-to-hand and unready-to-hand modes of engagement, a topic I take up later. For the moment, I will suffice to say that decision-making is an inherent part of physical therapy practice.

At NMC, the PT grid addresses this side of practice under the major component, Clinical Decision-Making. Taken as a whole, the delineated expectations portray a clinician who brings his knowledge and clinical reasoning to bear in each patient encounter. Informed by information gathered from the patient, the medical record, and other clinicians, the therapist examines and treats his patient. As was the case with Clinician-Patient Relationship, the grid breaks this cognitive aspect of practice into sub-components, two of which are useful in classifying the results of this thematic analysis: *A) Clinical reasoning*, the ongoing meaning-making resulting from attending to and synthesizing the many data elements that comprise each clinical encounter; and *B) Accountability and responsibility*, which defines the therapist's duty to make decisions in as fully informed a manner as possible, across each episode of care.

A. Clinical reasoning. This sub-component of the PT grid is organized according to the patient management model described in the *Guide to Physical Therapist Practice* (2003) which includes: taking a history to determine the reason the patient is seeking care, examining the patient to gather pertinent information, diagnosing the source of the patient's problem(s), and forming a clinical impression.

These steps enable the therapist to provide a prognosis for rehabilitation, set measurable and achievable goals, and develop a plan of care.

Its grid contains the physical therapy department's attempt to describe what that clinical reasoning *looks like* at NMC. For example, while portrayed in degrees of skill that vary across its four levels, the grid states that the physical therapist, "identifies relationships between impairments and function," or "clusters findings from multiple data sources and identifies meaningful patterns." In addition, "assessments reflect the ability to integrate pathophysiology, co-morbidities and psychosocial issues." It's in this context that I've identified the sub-component, *Clinical reasoning*, as the appropriate container for the themes: 1) *Going in with a plan vs. thinking on my feet*, and 2) *Flexibility*.

1. *Going in with a plan vs. thinking on my feet.* Participants' narratives provide a window through which I've been able to view their clinical reasoning, or, more accurately, their reflections on their reasoning processes as they looked back from the vantage point of time. All participants' narratives revealed something about how they processed information to form plans for evaluation or treatment. In some instances, the processing referred to, or implied, in the narrative occurred before or after the patient encounter, rather than during.

Matthew described putting the pieces together after examining Ana when he wrote, "upon completion of the examination, I hypothesized that the disk pathology was the source of Ana's symptoms." Kelsey's narrative states that she "tried multiple different seating systems with pressure-relieving cushions with the patient, utilizing a range of transfer techniques." This reveals reasoning occurring *before* seeing Mr.

Gleeson, as advanced planning would have been required. These types of statements are peppered throughout all participants' narratives. They tend to show up as statements of fact, without further elaboration or other signals that they represent any particular challenge. In this way, they didn't strike me as revealing the essence of participants' reflective processes, at least not their critical (Mezirow, 1991) or deeper levels (Boud, 1985) of reflection. In other words, they didn't seem to represent problematic or unresolved situations of the type theorists seem to agree frequently trigger reflection (Mezirow, 1991; Schön, 1983; Dewey, 1933).

Several participants, however, described situations that required them to change course in the moment. Geoff and Joel provided examples of this theme in the descriptions of their initial encounters with Judge Callahan and Mrs. Cheung, respectively. Each described being surprised by the fact that the patient he greeted in the waiting room didn't fit what he'd anticipated based on the referring diagnosis. Each took it in stride, processing the new information in the moment and using it to form an alternative plan for evaluating his patient. Were they also using reflection-in-action to quickly challenge an underlying assumption in order to shift gears (Schön, 1983; Mezirow, 1991)?

While describing it as challenging, Joel's portrayal of his initial encounter with Mrs. Cheung reveals both the need for a change in plan and his ability to *think on his feet* in order to meet that need. Mrs. Cheung was referred for treatment of low back pain, and while Joel had noticed in the medical record that she'd been recently diagnosed with Parkinson's Disease, he'd focused primarily on the referring diagnosis of back pain as he anticipated her first visit. Joel's practice at the Berwick Health

Center involved treating primarily patients with orthopedic conditions, many with back pain. When he met Mrs. Cheung, however, he discovered that she had significant movement problems of the type caused by Parkinson's Disease. He wrote the following:

The evaluation was a challenge for me in that I had to adapt my plan in the moment when it was clear that impairment-based tests and measures, as I would normally perform on a low back patient, were not indicated due to the degree of her functional deficits...

I was immediately able to recognize the patient's movement pattern from a prior clinical experience I had... I was able to draw on this experience to recognize that this patient evaluation was going to be very different than my typical lumbar spine evaluation and was going to have to be functionally based. (Joel's narrative, Appendix C)

In the end, Joel began by evaluating Mrs. Cheung's functional movement, as he would with any patient presenting with neurologic dysfunction. He did not do the tests he would have performed if she were the typical patient with low back pain. The fact is, those tests would have required Mrs. Cheung to assume positions and perform movements that, given the severity of her Parkinson's, she couldn't do. Thus, Joel began in the only place he could and proceeded from there, thinking on his feet the whole way.

In Geoff's narrative this theme shows up, also at the beginning of the story and triggered by similar circumstances.

He [Judge Callahan] was referred to an orthopedist, was diagnosed with patellar tendonitis and referred to physical therapy. When I questioned him about needing a wheel chair and crutches, he replied that they help him get around due to recent onset of right leg pain, but that he was referred to PT for his left knee. Despite Judge C's focus on the left knee, I was also concerned about his limited function and use of assistive devices, and knew I would have to [re-]prioritize my examination to better understand how to meet his functional needs. (Geoff's narrative, Appendix C)

In the context of the larger story, as we saw in the previous section, Geoff's challenge was less about determining how he should alter his examination clinically, than about getting Judge Callahan's buy-in, which wasn't easily accomplished. Thus, the situational complexity confronting Geoff required him to integrate, in the moment, his clinical impressions and the messages Judge Callahan was sending about his view of why he was there and what was going on with him.

In the above examples, participants' planned examinations didn't fit the realities of the situations that presented themselves, forcing a change of course. As I analyzed the narratives of all six participants, I noted that they devoted more text to their descriptions of these types of situations than they did to the *before* or *after* processing I discussed earlier. Their texts revealed complexities that made the situations inherently challenging, and to varying degrees, as we saw with Joel and Geoff, they discussed how they reasoned through those complexities to arrive at a course of action.

2. *Flexibility.* This theme is related to the previous one, yet, I believe, distinct enough to warrant its own label. Like *Going in with a plan vs. thinking on my feet*, the

theme, *Flexibility*, is revealed in the ways participants wrote about their clinical reasoning as they looked back on it. However, where the former is revealed in the fact that participants all wrote about a processing of information – before, during, and after the patient encounter – this theme is seen in one particular *quality* of that processing. Over and over, as participants wrote about their clinical reasoning, they revealed a process that was more flexible than rigid, enabling them to shift from one course of action to another. In some cases they wrote about being aware of the flexibility they'd demonstrated, in other cases not.

Near the end of his narrative, describing what he'd learned from working with Mrs. Cheung, Joel wrote explicitly about this theme.

“This patient interaction taught me a lot about being flexible and creative in both evaluation and treatment of patients with significant functional deficits.” Joel realized that he needed to shift gears flexibly and use creativity when working with patients presenting with “significant functional deficits,” but leaves unanswered the question of whether he saw these cognitive traits as necessary when working with his “typical lumbar spine” patients.

Others didn't appear to place restrictions on this aspect of their clinical reasoning. Kelsey, for example, revealed flexibility throughout her story of working with Mr. Gleeson – fraught, as it was, with the need for much experimenting in order to find a treatment approach he could tolerate. She wrote, “[Mr. Gleeson] tested my clinical and technical skills as a therapist, forcing me to frequently think ‘outside of the box’ and utilize my problem-solving skills,” and summarizing their journey together at the end of her narrative, Kelsey revealed, “[Mr. Gleeson] proved to be a very

challenging and rewarding patient for me. Many of the ‘standard’ approaches I initially took with him had to be adjusted significantly given confounding issues, necessitating a greater level of creativity and trial-and-error.”

These examples represent just a sampling of the ways participants included in their narratives reflections on the flexibility of thinking required in practice and where they recognized it in themselves.

B. Accountability and responsibility. The PT grid component, Clinical Decision-Making, sub-component *Accountability and responsibility*, contains practice expectations that the therapist remain attuned to how the treatment of a given patient is proceeding, and when not going as anticipated, that she re-think, re-prioritize and, if needed, seek input from others. The following quote from this section of the grid provides a sense of this aspect of physical therapist practice.

[The physical therapist] experiences a sense of accountability for patient progress toward goals. If not progressing as anticipated, [she] asks [her]self ‘what have I not figured out?’ (PT Grid, Appendix B)

This is the appropriate category for the final two themes, which represent participants’ reflections on their responsibility to make the best possible decisions related to the care they provide their patients: 1) *Wrestling with complexity*, and 2) *Seeking assistance*.

1. Wrestling with complexity. As I discussed in several places, participants chose to write about complex situations. Their patients had varied underlying medical conditions, as in Mrs. Cheung’s Parkinson’s disease and the Commander’s months without a definitive diagnosis. They also presented complexities in terms of a

therapist's diagnosis running contrary to the referring physician's, as was the case with Judge Callahan. Additionally, there were complex psychosocial issues, as with Sam's mother being served with a 51A for medical neglect. Thus, the patient care situations were complex in terms of the contexts in which physical therapy services were being provided and in the challenges of determining the causes of patients' presenting problems and how the therapist could make a difference. That said, I am not surprised that participants' narratives revealed the extent to which they wrestled with these complexities in order to assure, to the best of their abilities, that their patients got what they needed.

For example, in Samantha's work with Commander Lawrence, his medical conditions and physical impairments were not the major challenge; instead, coming to understand the patient's psychological motivation was complex, and Samantha knew she owed it to him to figure that part out. When she met with Mark to discuss her narrative, Samantha expanded on her concern at the time that something wasn't working the way it should. "I think what tipped me off most," Samantha said, "was, though he would...argue it while we were in the treatment program, then he would say 'all right, fine' and would do [the exercises]. Then I would come back the next day and say, 'So, did you work on this yesterday?' [his response:] 'No. I didn't'... I think it became very clear to me that something was blocking him mentally from making progress" (from transcript, Samantha-Mark unbundling conversation). Some clinicians may have been tempted to let the Commander's inconsistent follow-through stand. Having educated him about the importance of exercise, the decision was his to make.

Samantha, however, persisted. She was determined to unravel the complexities of the situation in search of a solution.

Matthew faced complexity in understanding Ana's drive to remain active, despite his recommending that she slow down, and in determining the cause of her back pain. He suspected she may have had a disc problem that would eventually require surgery, but other aspects of how she responded to treatment led him to wonder if it might be more biomechanical – thus, he continued to treat the latter possibility in a way that wouldn't cause harm if the former proved true.

Further examination revealed gluteus medius and maximus weakness, hamstring and piriformis shortening and positive signs for nerve tension. Ana was instructed to continue to perform the prone press-up exercise... [My] intervention was also directed at relieving nerve and muscle tension and promoting lumbo-pelvic-hip stability.¹⁶ (Matthew's narrative, Appendix C)

In both these examples, participants acknowledged that they had a responsibility to the patient to continue to wrestle with these issues. Kelsey provided an example of hanging in there with a patient over an unusually long and complex episode of care. Near the opening of her narrative she wrote,

Considering a multitude of factors, I anticipated a relatively long road ahead for [Mr Gleeson], predicting 4-5 months before he would be sufficiently independent to return home... Unfortunately, and rather unexpectedly, this

¹⁶ This section refers to weakness in hip and leg muscles, as well as nerve irritation down the leg away from the spinal cord and disc, all of which that could have been contributing to this patient's pain. It then describes the hands-on PT treatment and exercises used to address those impairment in an attempt to relieve the patient's pain.

estimate turned out to be quite inaccurate. Ten months later, Mr. G was still my patient at NMC, having never left the hospital. (Kelsey's narrative, Appendix C)

Through those ten months, facing numerous challenges as she sought a treatment plan that would enable him to become more mobile despite the complicating factors of pain and anxiety, Kelsey worked steadfastly with Mr. Gleeson and the rest of the medical team to find solutions.

In her conversation with Jane, Kelsey included details of a time when Mr. Gleeson was back in the ICU in order to receive a special form of hemodialysis¹⁷ due to his failing kidneys. Doctors had inserted a port in his groin by which they performed a constant, very slow, dialysis. This was a life-saving treatment for Mr. Gleeson, but the location of the port forced Kelsey to halt their work together and resulted in him developing significant hip tightness – enough to further complicate his ability to sit. This came up when Kelsey discussed her narrative with Jane.

“That was unfortunate,” Kelsey said to Jane, “but [the groin] was the only place that the team could establish [a port]...I knew that when it came out it was going to be a problem... This is a patient that, at baseline, had just enough [hip mobility] to sit.”

As predicted, when the port was removed, Mr. Gleeson had lost so much flexibility that sitting, at least in a conventional way, was impossible. Kelsey helped him stretch the tight joints, but at the same time knew she “needed to continue, somehow, working on sitting, because every time this patient went back to the ICU and

¹⁷ Hemodialysis refers to any of a number of processes aimed at filtering from the blood the toxins that occur as the normal by-products of human physiology. It is used in cases where the kidneys are not able to keep up with their typical job of taking care of these toxins.

had a setback, it was such an emotional trauma for him, when he had been making so much progress before.”

These examples provide a view of participants’ willingness to wrestle with the changing landscape of complexity, across, in some cases, exceptionally long and challenging periods of working with a patient.

2. *Seeking Assistance.* This theme refers to participants seeking the input of peers, clinical specialists, and colleagues from other disciplines, to inform their clinical decision-making. They sought this input: to help understand and address situations whose complexities went beyond their expertise, to affirm that their thinking about a patient’s case was on target, or to tap the clinical knowledge of someone in a different area of practice. This occurred frequently in the situations portrayed in these narrative since they did fall at the more complex and challenging end of the continuum. I categorize this theme under the sub-component, *Accountability and responsibility*, because of the way it revealed itself – that is, in the context of a participant being conscientious and thorough in her attempt to make certain her patient got what he needed.

Samantha wrote about the several times she consulted Doug, the PT clinical specialist on her team. Just six months out of school when the Commander landed on her caseload, she had her own caseload but would have been consulting her clinical specialist on a regular basis – especially when managing a particularly complex patient. I would guess Doug wasn’t surprised that she sought him out before even introducing herself to the Commander. First, she’d received word from the more experienced therapist who’d evaluated him in the ICU, that Commander Lawrence had challenged

her knowledge and skill. In addition, the physician had suggested that physical therapy try serial casting¹⁸ to help the Commander regain motion in his ankles, lost because of the time he'd been bed-ridden. Serial casting is not a basic skill. Samantha wrote that she hadn't "used serial casting in the past, [so] asked to speak with [Doug]...about how this clinical decision is usually made." In this passage Samantha reveals that she understood her responsibility as a physical therapist to exercise her professional judgment in deciding whether serial casting was likely to be an effective and appropriate treatment for this patient.

In Kelsey's case, the assistance needed was from outside physical therapy. During the stage in which she was experimenting – searching for a way Mr. Gleeson could begin to build his endurance by sitting up – Kelsey knew she didn't need to be alone in that process. She wrote that she'd "tried multiple different seating systems with pressure-relieving cushions...[and used] a range of transfer techniques" and that experimentation had involved "resourcing with the nursing leadership of other units to borrow equipment (specialized recliner chairs, a [special] transfer device, etc)." After discovering that Mr. Gleeson didn't tolerate any of these systems, but *could* tolerate sitting, with help, at the edge of his bed, Kelsey faced the challenge of his extreme anxiety and lack of trust in other caregivers. Again, she turned to a discipline outside of physical therapy to help her find a way she could assure that Mr. Gleeson received the treatment he needed.

I subsequently contacted the psychiatric CNS [Clinical Nurse Specialist]...to arrange for her to observe a therapy session. I wanted to gain practical insight

¹⁸ Serial casting is a treatment aimed at preventing the loss of, or regaining, movement of a joint. It can be used for treating contractures (i.e. limited joint mobility), such as those that can occur at the ankle after long periods of being in bed.

as to how I might handle [this patient's] anxiety differently to maximize his ability to participate in a [physical therapy] session. She was able to offer some successful strategies for me to implement. (Kelsey's narrative, Appendix C)

As was the case with Samantha, Kelsey recognized where expertise other than her own, in this case that of her nursing colleagues, was needed and actively sought it out.

Matthew's narrative provided one other example of this theme. He wrote that after completing Ana's evaluation, he formed a hypothesis, suspecting that she had a disc in her low back pressing on a nerve and causing the pain, numbness and tingling in her leg. He shared a sound rationale, in my opinion. However, he was troubled by one thing that didn't fit the picture. Ana experienced relatively little pain in the low back itself, causing Matthew to keep open the possibility that a disc wasn't the source of her problem. Therefore, he "later posed this question as a discussion point to several therapists in the back staff room." Finding that each had had experience with a patient who had "lumbar disc pathology, with referred symptoms, in the absence of back pain," Matthew proceeded down that path reassured.

In my experience this type of sharing one's thinking and discussing challenging cases with colleagues is commonplace in physical therapy staff rooms. In the context of this study, I ask whether it represents a form of reflecting, with others, that clinicians employ to assure they're providing excellent care.

Clinical decision-making: Summary and discussion.

As I conclude this section, I consider the themes falling under the practice component Clinical-Decision Making in the broader context of theory that helps me understand the findings as they relate to reflection.

Writing about clinical reasoning: An example of theory made visible. In the spirit of viewing the written narrative as a window through which I'm able to glimpse a reflective act, in this section I consider the identified content themes in the context of several key theorists. As I've hinted along the way, I see the themes and the ways they show up in participants' narratives as providing examples of both the Heideggerian modes of engagement as described by Packer (1985) in his discussion of hermeneutic phenomenology, and Schön's (1983) theory of knowing-in-action and description of reflection-*on-* and *-in-*action.

Heidegger described three modes in which we experience the world: ready-to-hand, unready-to-hand and present-at-hand (Packer, 1985, p. 1083). One functions in the ready-to-hand mode when one knows how to proceed holistically, almost automatically, with a task or project. It's in the acting itself that one *knows* how to perform the task. Schön (1983) referred to a similar concept when he wrote about knowing-in-action, that is, tacit knowledge – knowing *how* to do something. Knowing-in-action can be contrasted with the more conscious procedural knowledge – knowing *about* something (Schön, 1983, p.49).

Heidegger's unready-to-hand, as described by Packer (1985) is the mode one moves into when encountering a problem for which the ready-to-hand mode proves insufficient, that is, some modification in approach to the task is required. But Heidegger further distinguishes between this adjusting in the moment, or unready-to-hand, and a third mode of engagement, present-at-hand. In the present-at-hand mode one takes a step back from the activity in which one is engaged in order to examine it from outside the activity, outside the doing (Packer, 1985).

Packer's (1985) discussion of these three modes of engagement indicates to me that unready-to-hand is a middle ground, a realm in which we consciously problem-solve even as we remain engaged in doing. Schön's (1983) description of reflection-in-action sounds much like Packer's (1985) unready-to-hand. A mode of reflection Schön believed professionals need to employ in order to grow in not just the science, but the art, of their professions, reflection-in-action takes places during the very activity that is the subject of reflection. When confronted by contemporaries who claimed that reflection-in-action was illogical because of the link between action and tacit knowledge, Schön (1983) invoked common sense in defense of his concept.

If common sense recognizes knowing-in-action, it also recognizes that we sometimes think about what we are doing. Phrases like 'thinking on your feet' or 'keeping your wits about you' suggest not only that we can think about doing, but that we can think about doing something while we are doing it. (p.54)

I believe all three Heideggerian modes of engagement, and both of Schön's modes of reflection, are evident in this thematic analysis of content. From their narratives we know that Joel and Geoff approached their patients anticipating typical clinical presentations. If their patients had presented as expected, these therapists would likely have continued, uninterrupted, operating in a ready-to-hand mode. I do not see this as a negative; rather, in my experience, it can make for accurate and efficient patient examination and evaluation. It may free the therapist to engage, for example, in small talk – getting to know the patient – even as he proceeds to examine various body parts and explain to the patient what he's doing.

However, instead of presenting as expected, Geoff's and Joel's patients surprised them. Schön (1983) wrote that often, "reflection-in-action hinges on the experience of surprise. When intuitive spontaneous performance yields nothing more than the results expected...we tend not to think about it. But, when intuitive performance leads to surprises...we may respond by reflecting-in-action" (p. 56).

When faced with the surprise of a patient using a wheelchair or crutches to aid mobility, Joel and Geoff demonstrated the ability to think on their feet – to move into the unready-to-hand mode. We saw these clinicians use reflection-in-action as a vehicle for identifying an alternative way forward.

Of particular interest to me is that when asked to write a clinical narrative, that is, when provided with a present-at-hand moment, required though it may have been, each of these clinicians chose to reflect on a situation that had forced them to shift to an unready-to-hand mode. They chose to continue thinking about their thinking, from outside the moment, taking advantage of this present-at-hand mode to consider it further. Is this a coincidence? I suspect not. While I never put the question to either participant, based on Schön's (1983) ideas, I suspect that if these patients had presented no unready-to-hand moments, Joel and Geoff may well have passed them over in favor of a more complex case about which to write.

A professional values context. The four themes falling within the grid component Clinical Decision-Making, with its sub-components of *Clinical reasoning* and *Accountability and responsibility* are: 1) *Going in with a plan vs. thinking on my feet*, 2) *Flexibility*, 3) *Wrestling with complexity* and 4) *Seeking assistance*. When I look at them in combination, I'm struck not so much by what they are, but by what they

are not. They're not primarily about technical knowledge, research evidence, or formal decision-making models discussed in the clinical decision-making literature. That's not to say these participants don't use or value those aspects of decision-making, I suspect they do. It does say that they aren't what their stories of practice were about – they're not what they reflected on.

While I believe I've placed them correctly in the context of the PT grid component, Clinical Decision-Making, I need to move beyond traditional ways of thinking about clinical decision-making in order to understand them. Each has to do with what it takes to make the best possible decisions in the context of today's healthcare delivery system with its: increasing complexity of patients' conditions and rapid pace demanding flexibility and fast accurate decisions; explosion of knowledge demanding skillful use of external resources; and need to be persistent in doing whatever it takes to get the patient what he needs.

I find the larger context in which these themes fit to be professional values and ethics. In a previous section I cited the PT grid language describing how therapists demonstrate a sense of accountability for their patients to the point of asking themselves "what have I not figured out?" when the patient is *not* making expected progress (PT grid, Appendix B). This question's first-person construct speaks of owning this responsibility; in that way it's consistent with the broader context of the profession's core values and Code of Ethics. Governing physical therapy practice writ large, the Code states, "Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary (*Code of Ethics for the Physical*

Therapist, Principle 3). I propose that it's in this context – ethics and values – that these clinical decision-making themes are best understood.

Movement and Teamwork: In service of other two components

The thematic content analysis presented thus far falls within two of the four practice components delineated in the PT grid, Clinician-Patient Relationship and Clinical Decision-Making. I identified no content themes related directly to the other two components, Movement and Teamwork. I do not intend this to mean that I found no references to them in participants' narratives. To the contrary, they contain abundant descriptions of how their patients moved and references to other members of the healthcare team. However, by my interpretation, those references serve as context, or background, for their clinical stories, rather than foreground.

I realize that this interpretation draws heavily on my experience as a physical therapist. I share a common background with the participants and use it, consciously and unconsciously, to help me understand their stories of clinical practice. But my interpretive process cannot end there; if it did, I wouldn't be doing justice to my data. Thus, I examined the texts again, actively working to set aside, or bracket, my physical therapist lens. In doing so, I noticed other aspects of their narrative construction. For example, participants tended to refer to movement and the healthcare team as statements of fact, rarely elaborating on or revisiting them.

Geoff described his patient's movement problems and what he made of them as follows:

[Judge Callahan] reported [that] he experienced right leg pain with standing and walking. It began after relying on his right leg to stand up in order to compensate for the left knee pain. Given his symptoms of right leg pain with weight bearing, I suspected a hip or spine problem... (Geoff's narrative, Appendix C)

But Geoff didn't revisit and expand on the movement aspects of this case the same way he did, for example, the ongoing challenge of how to deal with his assessment's impact on his relationship with Judge Callahan. Thus, the information about movement laid groundwork for the story of the Judge's insistence that they focus on *his left knee*, despite Geoff's impression that his right hip "seemed to be a much more limiting and urgent functional problem." The dilemma, as Geoff portrayed it, was in how to proceed with evaluating and treating this patient in a way that would allow him to maintain rapport and ultimately help him return to a higher level of function, not in deciphering the movement dysfunction.

Kelsey's narrative included several examples of how she worked with other members of the team. She contacted nurse managers to borrow seating equipment, a move she described as demonstrating the "creativity" and "thinking outside the box" required by the presence of Mr. Gleeson's sacral decubitus. In addition, the only way Mr. Gleeson could work on increasing his endurance was by sitting at the edge of the bed, with assistance, for many short stints across the day. And the only way that could happen was through a team effort – fact. Kelsey apparently didn't feel the need to elaborate.

In summary, identifying movement dysfunction and seeking ways to address it

are at the heart of physical therapist practice. In addition, physical therapists at NMC, as elsewhere, practice as part of a team. Thus, I don't find the numerous references to each surprising. That said, they tend to show up as contextual statements of fact, not as the major plot lines of their stories, which I discuss further in the next chapter. This leads me to conclude that participants included movement and teamwork in service of their primary storylines about the challenges and rewards of relating to their patients and making the best decisions possible for their care.

Self in Physical Therapist Role

While most content themes can be categorized within components of the PT grid, two themes do not. The themes, 1) *Feeling* and 2) *Learning*, reveal participants' awareness of their internal experiences as they engaged in clinical practice. The first theme, 1) *Feeling*, is seen in participants' descriptions of their varying emotional states. The other, 2) *Learning*, is comprised of participants' reflections on lessons drawn from these patient encounters and their insights into how they'd grown as physical therapists over time.

1. Feeling. Participants wrote about emotions they experienced while working with their patients. In addition to empathy, or *feeling with* the patient, as discussed under Clinician-Patient Relationship, participants wrote of their feelings about themselves in the process of providing care. Samantha, for example, revealed that, before meeting Commander Lawrence, she'd received an e-mail from the therapist who had evaluated him in the ICU. That therapist had described how curious the Commander had been about "the training that a physical therapist receives and had

multiple questions regarding the rationale for the care that she had provided.”

Samantha revealed her emotional response to that e-mail when she wrote, “naturally, as a new clinician, this part of the email made me quite nervous.”

Maureen wrote of many emotions she experienced while working with Sam from describing herself as feeling “so proud” when he was able to jog for fifteen minutes, or “worried that once home, he might fall back into old habits.” She ended her narrative by relaying an encounter she had with Sam months after he’d left the hospital.

I saw Sam in the main hallway when he was going to his MD appointment with Mom, and he was excited that he’d made the summer [baseball] team, and ...was playing and felt great. He...is still using the binder to keep him on track with his exercise program. I am happy to report that he also said that he is training to run a 3 mile road race in his home town.

In telling the story of deciding he needed to talk with Judge Callahan’s referring physician about his assessment of the Judge’s condition, Geoff wrote that he felt “apprehensive to confront the orthopedist” since he didn’t want to create conflict, and despite being “confident in [his] assessment,” he remained “nervous about being wrong.” In this excerpt, Geoff conveys confidence in his diagnosis along with a sliver of doubt and the worry it caused. He admits to feeling apprehensive and nervous in confronting the physician. In the end, further medical tests revealed that Geoff had been correct. I wonder if he felt affirmed, perhaps even vindicated.

While they comprise only a small portion of participants’ narrative texts, references to their feeling states caught my attention. Considering that stories have characters and plot, this inclusion of feelings added depth to themselves as characters –

physical therapists engaged with their patients in navigating the twists and turns of the plot. I continue to ponder what this aspect of character development means in terms of reflection; in terms of story it's certainly important.

2. Learning. All participants wrote to some extent about their own learning. In some cases they framed it as lessons learned from treating that patient – *a.) Take-away lessons* they would apply to their work with future patients. In other instances they wrote of it as *b.) Seeing how I've changed*. Looking back across their time in practice, they contrasted their care of the patients portrayed in these narratives with the care they may have provided as less experienced clinicians.

a. Take-away lessons. In presenting the data that led to identifying this theme, I cannot improve on the participants' own words and present three examples.

Example one. Near the end of her narrative, Samantha wrote:

I have learned so many things from my time treating Commander Lawrence that it's difficult to fit it all within this one narrative. I learned about the importance of prioritizing the patient's impairments and how that prioritization changes over time. I learned the importance of truly patient-centered care. I learned that communication, like every other PT intervention, must change over time as the patient changes. Above all else, I learned to look at the patient as a whole instead of the sum of his impairments. (Samantha's narrative, Appendix C)

Example two. Joel took a similar approach to ending his narrative, writing about the lessons he'd learned from treating Mrs. Cheung.

This patient interaction taught me a lot about being flexible and creative in both evaluation and treatment of patients with significant functional deficits...

[and has taught me] to look more critically at the patient's functional movement patterns even in [my typical low back pain] patients who present as independent, but have pain with functional tasks. (Joel's narrative, Appendix C)

Lastly, this patient helped me to really understand...that in order to truly help our patients we must see the whole person and not limit ourselves to treating what is written on the patient's prescription.

Example three. Matthew, too, ended his narrative by acknowledging lessons learned for clinical practice but went beyond that by referring to a life lesson his work with Ana had provided.

As it is with many of our active patients, it is difficult to get them to slow down their pace and give their bodies the chance to heal. I wish I had been a little more convincing of this. ... Despite this, what I learned from Ana is to not give up when you have a goal. She could have given up at any point, but through severe periods of back and leg pain, ER visits, MRI's and surgical recommendations, she never gave up on her goal of running a marathon and starting a healthier lifestyle. I'm a better physical therapist and a better person for having worked with her and having watched her persevere. (Matthew's narrative, Appendix C)

b. Seeing how I've changed. In this sub-theme, rather than looking at the experiences about which they'd chosen to write and saying, "This is what I learned *here* that I'll carry to other situations," participants said, "This is what I learned from *past* experience that I see myself applying here." For example, writing about his response to the Judge's question of whether he could resume running, Geoff tells the reader he

paused to consider a prior lesson. He “wanted to suggest alternatives that would minimize the wear to [Judge Callahan’s] hip,” but in the past he’d assumed incorrectly what the “patient’s intentions were for exercise.” From that experience he’d learned “the best way to suggest an alternative is to truly understand my patients’ motivations,” and he proceeded to ask the Judge why he wanted to take up running rather than make any assumptions. From there he was able to negotiate a satisfactory alternative – swimming.

Kelsey summarized quite directly how the care she provided Mr. Gleeson stood in contrast to what she might have delivered as a younger clinician.

In reflection, I clearly handled Mr. Gleeson’s case differently than I would have earlier in my career. I was more confident and vocal in my communication and advocacy for this patient. I thought “outside the box” more with respect to problem-solving strategies, while also upholding my respect for the patient’s ability to make decisions in his care, and to feel respected throughout. I utilized additional resources, including my PT clinical specialist as well as outside consultants, throughout the case to maximize the care I was able to provide.

(Kelsey’s narrative, Appendix C)

Self in physical therapist role: Summary and discussion. Participants including themselves and their feelings in these narratives stands in contrast to the writing they engage in daily as they document in patients’ medical records. In that writing, the self, the narrator, is invisible as she reports the patient’s condition, her clinical impression and treatment decisions. It would be inappropriate to use first person pronouns, let alone infer or make direct statements about one’s own feelings as

the healthcare provider. I'm not challenging the correctness of the medical documentation genre. That said, I find it interesting that, while opening their narratives with the formulaic statements of medical facts, participants launch so smoothly into revealing their feelings. Does this signal some need to share? To explore them further?

According to Dewey (1933), reflection begins with encountering a *problem* and proceeds with the important process of framing it clearly. There's, "a process of intellectualizing what at first is merely an emotional quality of the whole situation. This conversion is affected by noting more definitely the conditions that constitute the trouble" (p. 108). Atkins (1993) observed that uncomfortable feelings can serve as a trigger event for reflection, which takes the form of a critical analysis of both the feelings and the experience. Did Samantha and other participants use feeling states as triggers for further reflection in their narratives? Or were they simply crafting good stories, hoping to draw their readers in by sharing the human side of their situations? Or both?

As Samantha wrote of the nervousness she felt when reading the e-mail from her colleague, she also seemed to normalize it. She referred to it being *natural* that she would be nervous. Are we seeing here her reflective process and something of its power to help transform an experience into new insight? That would certainly be consistent with my own reflective journey viewed through the writing I did about my experience of being a student in the simulation course.

Many theorists – Dewey (1933) and Schön (1983) writing about reflection as a critical part of the educational process; Kolb (1984; 2001) and Sternberg (1998) describing the role it plays in turning experience into learning; and the myriad of

educators and researchers writing about the topic today – implicate the metacognitive act of reflecting in explaining our ability to learn from experience. In addition, narrative, or story, is often crafted for the purpose of helping the listener learn a lesson – hence the construct, *and the moral of the story is...* Is this why participants wrote about the links they made between their patient care stories and lessons they'd learned? That's one possible explanation.

Once again, however, the context in which these narratives were written must be considered. Composed as part of the process for achieving CRP Advanced Clinician recognition, Kelsey's and Geoff's narratives would have been intended to reveal their high levels of practice, perhaps by contrasting them with those of earlier, less experienced selves. These two participants had more experience than the others, and as viewed through the lens of their narratives, were able to see and articulate how they'd grown across their years in practice.

I needed to ask myself whether this CRP context should change the way I viewed the lessons Samantha, Matthew and Joel wrote about, or Geoff's and Kelsey's discussions of how they'd drawn on past learning in caring for Judge Callahan or Mr. Gleeson. I decided to let the themes stand, my rationale being similar to that for choosing the PT Grid as an organizational framework for themes related to practice. That is, while I must carefully consider context in the meaning I make of these narratives, the fact remains that when directed to select an experience he found particularly challenging or from which he felt he'd learned something (*Instructions for writing the clinical narrative, accessed January, 2012*) each participant included his own learning as part of the story.

As I reflect on the title I selected for this thematic category, Self in Physical Therapist Role, I realize that I am foreshadowing an area I will return to later – professional identity. In this chapter I use it as an umbrella under which I place participants' references to feelings they experienced and lessons they learned from those experiences. In the next chapter, as I unravel aspects of the reflective *process*, and later when sharing conclusions I've drawn, I discuss self and identity further in relationship to the view of reflection seen through these participants' narratives.

Thematic Analysis of Content: Summary and Discussion

Participants wrote about – reflected on – elements of physical therapy practice including relationships with patients and clinical decision-making. In addition, they wrote about themselves in their roles as physical therapists, including what they felt and learned as they provided care to their patients.

Framed as the *what* of participants' reflections, the themes uncovered in this analysis tell an interesting story. When classified according to the four major components of the PT grid, a document that grew out of NMC's internal examination of physical therapy practice, participants' narratives were largely about the Clinician-Patient Relationship and Clinical-Decision Making, with references to Movement and Teamwork included in service of those storylines.

So what? What meaning do I make of the fact that these themes surfaced in the narratives written by participants and why is it important? First, what these physical therapists chose to reflect on when provided this opportunity to do so in a written narrative reveals the extent to which they wrestle with aspects of practice having to do

with seeing their patients holistically and empowering *them* to take the reigns in their health and well-being. The literature on expertise in physical therapist practice identifies this as a characteristic embodied by our most expert clinicians (Jensen, et. al, 2007). Perhaps these participants – with six months to many years of clinical experience – are revealing something about the way to get there.

In this phenomenological inquiry, I've framed participants' narratives as the windows through which I'm able to glimpse their reflective practices. Viewing the writing of these narratives as a stepping back from the Heideggerian *ready-to-hand* mode of being in the activity itself, to a *present-at-hand* mode, this analysis suggests that these therapists privilege the pondering of practice aspects related to the interpersonal realm, relationships with their patients, and the metacognitive realm – thinking about their thinking and decision-making – over other aspects of practice including the technical knowledge and skills associated with treating patients with movement dysfunction.

As I've discussed, participants' choices of what to write about seem to validate Schön's (1983) idea of professionals needing reflection in order to develop the *art* of their professions. Getting to know the person who is the patient and allowing that patient's personal goals to drive the physical therapy plan of care does seem to require the spirit, skill and talent of the artist. In addition, participants writing about their thinking, and examining it from the vantage point of the present-at-hand mode, is consistent with what Dewey (1933), Schön (1983) and Mezirow (1990) have to say about the metacognitive act of reflection. They also align themselves with emerging discussions in medicine (Charon, 2001) about the importance of getting to know the

patient's personal story. In combination, I believe these findings are instructive about how to provide the best possible care to each patient one encounters in practice.

Two catch phrases bandied about in relation to today's healthcare delivery are *evidence based practice* and *patient-centered care*. Each is important. I believe, however, that too much emphasis on the former can risk leading to an unbalanced privileging of the science over the art of healthcare, as though the results of the randomized controlled trial alone can reveal the most appropriate treatment for a given situation. Unfortunately the latter, patient-centered care, is too often tossed around without much substance behind it, making it seem a mere platitude. Like mother and apple pie, who can argue its rightness? My concern is that without clear examples of what it looks like, and tangible examples of how it gets lived out and the powerful role it plays in patient outcomes, patient-centered care may never assume its rightful place as the equal partner of evidence-based practice – with the art of the former balancing the science of the latter, and vice versa. Perhaps the true power of these participants' stories is that they do just that – bring patient centered care to life.

I end this discussion of content themes, as I began it, showing you Samantha as she concludes her conversation with Mark.

Samantha: Getting to "We" (Conclusion)

"So, what's the take-away from this experience Samantha?"

Mark asked.

"I think the take-away for me, looking back," Samantha said, "is that the biggest thing that I didn't do from the *very beginning* was look

at it as though I could provide Commander Lawrence the direction [he needed]. And while that's my job, it has to be something that *he* wants. It has to be something that matters to *him*.

“And you know, as a patient, you come in here, and there may be the most frustrating things going on all around you, and you may be feeling like you have no control over anything, but you still have goals. Maybe no one's asked you what they are,” Samantha said, now a roll, “but you *still* have goals. You *have* things you want to accomplish. You have things that *matter* to you on a day-to-day basis, and things that will matter to you when you leave.

“I think, sometimes, we have to ask the question [about goals] more directly and more than once. We all ask it [initially], but I think we should to ask it, *a lot*.”

THE END.

CHAPTER VI: ANALYSIS OF THE REFLECTIVE JOURNEY FROM WRITING THROUGH UNBUNDLING

Introduction

As I immersed myself in reading participants' narratives, watching and listening as they discussed them with Mark or Jane, and reading transcripts of those interactions, I was interested in the light they might shed on participants' reflective processes. I had a sense that, rather than participants talking about their reflections, I was, instead, witnessing participants reflecting with Mark or Jane as they discussed their stories of clinical experience. This seemed significant.

Building on the results of the thematic analysis of content, I wanted to explore *how* the participants, in conversation with Mark or Jane, were accomplishing the reflective process I thought I was seeing. As I mentioned in the methods section, for this tier of analysis, some elements of structural analysis seemed warranted and I employed my own idiosyncratic approach. My first step consisted of turning to the stories I'd crafted for three participants and the videos and transcripts of their conversations with Mark or Jane, paying close attention to elements that jumped out and making notes about *what* and *how* it seemed to be happening.

My attention was repeatedly drawn to two elements that called for further analysis. The first had to do with the ways in which the interactions cycled back, covering similar ground on more than one occasion. I was struck by how the stories changed and how they stayed the same and was reminded of Mishler's (1995) distinction between *telling* and *told*. Once seen, I couldn't *not* see the iterative nature of the process. I experienced shifting foreground and background. I use the term

foreground as it's used in literary studies, where it refers to "what is striking, deviant or unexpected" (Warvik, 2004, p. 99).

The other feature of the unbundling conversations that struck me involved participants *acting* the parts of patients and others in their stories, including themselves. This role-playing allowed me to *see* participants' interacting with their patients and, given the iterative nature of their exchanges with Mark and Jane, how they changed across re-enactments. Once again I had the sense I was watching a reflective process and witnessing the change that could result from it. This performance feature is particularly noticeable in Samantha's and Maureen's interactions with Mark and Jane, respectively.

In this chapter then, I present my analysis and interpretation of these two aspects of the data – the iterative nature of the process, and the performed aspects of narrative.

Reflection: An Iterative Process

Mann, et al. (2009) wrote a systematic review of the literature on how reflection and reflective practice are addressed in health professions education. As I read it, already well into my analysis of this study's data, I nodded my agreement with the report that a major challenge to doing the review was the lack of a common, and in many cases even an operational, definition of reflection – a dilemma I knew well. Wasn't it the very one that had led me down the path to this research topic? However, even in this familiar terrain, I was about to encounter something new.

As Mann, et al (2009) discussed the work of theorists who had become my own close companions – Dewey (1933), Schön (1983), Boud (1985), Mezirow (1991) – she classified their models of reflection based on whether the models of reflection they proposed described 1) an *iterative* process, and 2) a process containing *levels* of reflection, a vertical dimension. The first variable led to my “ah-ha” – it had been staring me in the face from inside my own data, and I hadn’t seen it.

Mann (2009) classified Schön’s (1983) and Boud’s (1985) models as iterative – the former defined reflection-in-action and reflection-on-action, while the latter included phases of: returning to experience, attending to feelings, reevaluating experience, and resolution. Both models resonated with my own clinical experience across decades in practice. Of course reflection is iterative. It was, in fact, so obvious that I’d missed seeing its potential significance. Looking back at my research notes I found numerous places where I’d noted a participant revisiting some aspect of his clinical experience, or re-telling a portion of his story. I realized that a feature of the reflective process was this very iterative-ness. As an aid in sharing the iterative nature of the process, and the meaning I make of it as part of reflection, I use the story I crafted of Joel’s experience with treating Mrs. Cheung.

Joel's Story: A Role for Reflecting With Others (Excerpt 1)

Joel was a physical therapy intern for six months in the outpatient department at Northeast Medical Center (NMC). He applied to NMC because it was an academic medical center known for providing excellent care to its patients and learning opportunities to students. Its physical therapy department had a reputation for rigorous practice standards, which is what Joel wanted to help facilitate his transition from student to practicing clinician. Upon completing the internship, Joel accepted a position in one of NMC's community health centers. Located 8 miles from NMC's main hospital campus, the Berwick Health Center provides a range of primary care and specialty services targeting the needs of the culturally diverse community in which it is located. In addition to the longtime, largely blue collar, Berwick residents, Joel's patients included recent immigrants from Asia and Latin America.

Approximately a year after beginning his position, Joel's ability to manage a full caseload of patients presenting with primarily orthopedic issues, especially back, knee and shoulder problems, had developed to the point where his supervisors believed he met the criteria for *Clinician* level, a step beyond *Entry-level*, in the hospital's Clinical Recognition Program (CRP). Their endorsement of this was based on Joel's increased abilities in the four domains of practice defined by the department: clinician-patient relationship, clinical decision-making, teamwork and collaboration, and movement.

Joel knew that putting himself forward for this level would require writing a clinical narrative based on a patient he'd treated and discussing it with his department director, Mark. Considering his list of recent patients, Joel selected one he thought

provided an opportunity to showcase his growth as a clinician. In the opening paragraph of his narrative Joel wrote: “This narrative is intended to demonstrate the advancement of my practice to that of a *Clinician* as described by the Clinical Recognition Program. The case I will present challenged my ability to manage a patient with multi-system and psychosocial involvement which impacted the patient’s rehabilitation.”

From that introduction Joel introduced his patient, Mrs. Cheung, and takes us with him as he shares her story.

The patient is a fifty-three year old, Chinese woman, Mrs Cheung, who was referred to Physical Therapy by her primary care physician for treatment of her low back and bilateral radicular leg pain.¹⁹ Review of the patient’s medical record also was significant for advancing, recent onset, Parkinson’s disease, a diagnosis that the patient was reluctant to accept, according to her neurologist’s notes. The patient had lumbar images in the [electronic medical record] system demonstrating multiple levels of disc herniation, for which the patient had [undergone] a series of epidural injections with only temporary pain relief.

Having reviewed her medical record, Joel headed to the waiting room to greet Mrs. Cheung. He anticipated meeting a middle-aged woman experiencing back pain and, perhaps, beginning to show signs of the slowed movement that is typical of early Parkinson’s disease. He wasn’t prepared for what he found. Mrs. Cheung had arrived by wheelchair, pushed by her longtime companion, Mr. Wong. When Joel asked her to transfer, that is move from her wheelchair to the chair in his treatment area, he began a

¹⁹ Radicular, when used as a descriptor, refers to pain that travels down one or both arms or legs. It is generally indicative of pressure on nerve roots in or around the spinal column.

mental list of the difficulties he observed – bradykinesia, abnormally slow movement; festinating gait, a walking pattern consisting of small shuffling steps; and increased thoracic kyphosis, a rounding of the chest causing the forward bent position often seen in older women. Joel also noticed how quickly Mr. Wong jumped in to help, at times seeming to hurry Mrs. Cheung along.

Sitting in his office with Joel to discuss the narrative, Mark asked Joel to say more about that beginning.

“Sure,” Joel said, “I think this patient was referred for low back pain and, you know, working in outpatient orthopedics, I don’t typically go out to receive my low back patients and have them in a wheelchair. So that...right off the bat, made me question what was different about this patient than what I normally see in a lumbar spine patient.

“I knew going in that the patient had a Parkinson’s disease diagnosis, as well as low back pain, but the severity of the Parkinson’s wasn’t clear to me. So the fact that she needed to [use] a wheelchair... made me think that the exam was going to be a lot different than my [usual] exam of a lumbar spine patient.”

“So, it sounds,” Mark said, “like you had an idea of how you would have approached this, based on what you had gleaned from the medical record prior to seeing her, and even before you get her back to the treatment room, you’ve shifted how you’re going to [begin].”

“That’s right, yes,” Joel said.

End, Joel’s Story (Part 1)

Iterative process described. *Joel's Story* provides an example of the iterative process. Joel had treated Mrs. Cheung several months before he selected her case as the basis for his narrative. In order to write it he had to re-visit it, at least in memory and perhaps by reviewing his documentation in her medical record. The narrative he composed, however, was not merely a report of what occurred during his time treating Mrs. Cheung; it was not just a temporal recounting of events (Linde, 1993, p.85). Instead, Joel wrote a story, which required him to develop a “sequenced story-line, specific characters and the particulars of a setting” (Riessman, 2008, p.5). Not all elements of the recalled experience made it onto the page as Joel performed the storyteller's function of selecting narrative elements to include and to leave out.

Even to the point we've read thus far, Joel's *told* has been through several iterations due to multiple *tellings* (Mishler, 1995). First, Joel had had his original experience of treating Mrs. Cheung with all its various twists and turns – some we know and some we never will because they didn't make it into the story Joel crafted. Then, with distance of time, Joel recalled his work with Mrs. Cheung, reflected on it, and wrote the story we read in his clinical narrative. That was the first telling of the story to which we are privy – co-constructed between Joel-the-clinician, who lived the experience, and Joel-the-narrator, looking back on that experience and writing his story. Because he was writing it as part of NMC's Clinical Recognition Program (CRP), Joel's reflecting and writing were, very likely, focused on how the story might demonstrate his level of practice and what he'd learned from the experience. The CRP, and his practice of physical therapy at NMC's Berwick Health Center, provided the

context for Joel's telling of the story in the first place and would, therefore, have helped to shape the resultant told.

Joel then sat with Mark to talk about the story. To this point we've read Joel's initial response to Mark's query about the unusual beginning to his work – a second telling of his story, co-constructed by Joel and Mark. By using the vehicle of *Joel's Story*, which I authored, I've shared yet another telling. There will be others still, where Mark and Joel loop back to the same portion of the story.

First, however, in the spirit of reflexivity, I want to acknowledge my awareness of the fact that the conversation portrayed in *Joel's Story*, which I just referred to as a third telling of the story has layered within it several iterations of its own, each with different parties engaged in co-construction and meaning-making. The first layer, by my count, was Joel's verbal response to Mark, captured on video; the second was the transcript I prepared from that video, which although verbatim, was itself the product of interpretive choices about which utterances and nonverbal elements contributed to its meaning. Finally, there is the conversation between Joel and Mark conveyed in *Joel's Story*, which, while adapted from that transcript, represents yet another level of my interpretation and decision-making related to the meaning of the exchange.

In this analysis I deal with the existence of these different layers by sharing data from three sources – Joel's written narrative, the transcript I prepared of the unbundling conversation, and *Joel's Story* which I crafted from the first two. I see this as a form of triangulation and intend it as a means of engaging readers of this report in both meaning-making and in critiquing my trustworthiness as an intermediary narrator.

Analytical framework. As I discussed in the methods section, Labov (1972) developed an often cited and adopted framework distinguishing “sequences and structural parts of narrative that recur across stories about experiences” (Riessman, 2008, p.84). While generally applied to spoken discourse, I found this framework helpful in analyzing participants’ written narratives and the unbundling interviews that followed. The framework distinguishes six elements – abstract, orientation, complicating action, evaluation, resolution, and coda – each of which serves a specific purpose and can be thought of as helping the listener answer a series of questions. I describe each element further as I analyze a portion of Joel’s narrative and unbundling conversation, examining its iterative nature in search of how it informs my understanding of his reflective process.

The first element, the abstract, is optional. When present, it provides the point of the story and helps answer the question, what is this talk *about*? Joel began his written clinical narrative with an abstract, “This narrative is intended to demonstrate the advancement of my practice to that of a *Clinician* as described by the Clinical Recognition Program.” In discourse, orientation clauses typically follow the abstract. They help to establish the story’s Who, What, When, and Where. Joel does this in his written narrative by including a medical summary, “the patient is a fifty-three-year-old, Chinese woman, Mrs. Cheung, who was referred to Physical Therapy by her primary care physician for treatment of her low back and bilateral radicular leg pain.”

Narrative clauses, including the complicating action, come next. Answering the question, “So, what happened?” these clauses contain the event sequence that provides plot, “usually with a crisis or turning point” (Riessman, 2008, p.84). A story typically

has a series of narrative clauses, including one or more complicating actions. In her study of ethical issues arising for nurses practicing in an intensive care unit (ICU) setting, Robichaux (2006) identified a repeating pattern in the stories of clinical practice they told – complicating action, narrative clauses, resolution.

I found a similar pattern in Joel's and other participants' clinical narratives. Perhaps this is because the nature of physical therapy is to identify problems, find their causes, and treat them. An alternative explanation could be that the clinical situations upon which these narratives are based were selected precisely because they represented situations that posed "a particular challenge" or from which the participant felt he'd learned something (*Instructions for writing the clinical narrative.*). The notion that a particularly challenging complicating action would be a feature of the situation a physical therapist chose to write about, coupled with the stance I've maintained that the written narrative is the result of reflection, fits with the notion that reflection is triggered when one encounters a situation in which his ready-to-hand mode of functioning (Packer, 1985), or knowing-in-action (Schön, 1983) proves insufficient.

Joel revealed several complicating actions in his written narrative, which were frequently the very aspects of the story about which Mark chose to inquire in the unbundling conversation. I, too, instinctively carried them forward as I crafted *Joel's Story*. In other words, Mark and I recognized that they were critical to the story. To take one example, as I rendered it in *Joel's Story*, "he'd anticipated meeting a middle-aged woman who was experiencing back pain and, perhaps, beginning to show signs of the slowed movement that is typical of early Parkinson's disease." However, Joel wasn't expecting Mrs. Cheung to arrive "by wheelchair, pushed by her longtime

companion Mr. Wong,” or for Mr. Wong to jump in to help her, at times seeming to hurry Mrs. Cheung along.

At this juncture I alert my reader to a wording convention I will use throughout the rest of this section. I use “clinical narrative” to refer to the clinical practice story a participant wrote; I continue to use “unbundling conversation” or “interview” interchangeably when referring to the interaction between Joel and Mark; and I use the italicized title “*Joel’s Story*” to refer to the larger narrative I crafted of Joel’s journey from clinical experience, through writing and unbundling.

Another narrative element in Labov’s framework is the evaluation, or evaluative clause, in which the narrator indicates “the point of the story or why it’s worth telling” (Linde, 1993, p. 72). Riessman (2008) refers to evaluation as the place where the narrator “steps back from the action to comment on meaning and communicate emotions – the ‘soul’ of the narrative” (p.84). In this data, with regard to complicating actions, evaluative elements help answer the question: what was the challenge – as Joel perceived it?

Linde (1993) cautions the narrative researcher that, where other elements can be described as containing specific linguistic features, evaluation can be expressed in many different ways – including explicit statements of something’s value, subtle word choices, or markers such as tone of voice or use of repetitions for emphasis. In this analysis I attempt to make transparent the markers I used.

As I analyzed Joel’s data, I found that I could trace several complicating actions across multiple retellings of the story. Here, I follow one complicating action

through various iterations of the story. Using Mishler's (1995) distinction, I examined various *tolds* resulting from a series of *tellings* to explore Joel's reflective process.

Complicating action: Parkinson's disease vs. low back pain. In his clinical narrative, the initial *telling*, Joel introduced the complicating action as follows:

The patient presented with parkinsonian symptoms which were more advanced than I expected and were evident when her significant other brought her into the treatment area in a wheelchair and assisted her at a contact guard level to the chair. The patient exhibited significant bradykinesia²⁰ when asked to transfer from the wheelchair to the chair and also had a festinating gait that was evident in those few steps... I was immediately able to recognize the patient's movement pattern from a prior clinical experience I had in which I developed a movement disorders clinic for patients with Parkinson's disease at the California Rehabilitation Institute. I was able to draw on this experience to recognize that this patient evaluation was going to be very different than my typical lumbar spine evaluation and was going to have to be functionally based to gain an appreciation for her movement patterns and how this affects her pain.

This excerpt may be challenging to non-physical therapist readers, but I want to reveal the complicating action in Joel's own words. His writing style is reminiscent of a medical report in its use of terminology, passive voice, and overall formality.

However, Joel deviated from a medical report genre in his use of the first person, "I,"

²⁰ Bradykinesia refers to an overall slowness (*brady*) of movement (*kinesia*). Common in patients with Parkinson's disease, it manifests itself as a delayed initiation of movement, that is "freezing" episodes, as well as an overall slowness in carrying out functional tasks involving movement.

when referring to his reaction to the patient's Parkinson's symptoms – they were “more advanced than *I* expected.”

Several sentences into his narrative, Joel shifted to a more active voice and, I believe, shared his first evaluation as to why the story was worth telling – “I was *immediately able to recognize* the patient's movement pattern *from a prior clinical experience...* I was *able to draw on this experience* to recognize that this patient evaluation was going to be very different than my typical lumbar spine evaluation.” In these evaluative elements, we and Mark are directed to perceive Joel as a therapist who, despite being surprised by his patient's unexpected presenting condition, was able to recognize it and draw on prior experience, thereby knowing how to proceed.

The following excerpt from the transcript of Joel and Mark's unbundling conversation provides access to Joel's second telling of this portion of the story, co-constructed this time with Mark.

MARK: The first thing I want to talk about is, uuuh, is early on as you begin the process of introducing yourself to this patient and having her come with you from the waiting area back to the treatment area, uh, you make some very astute observations just as she's moving from that waiting area to the treatment area. Tell me a little bit about what you were seeing during that process

JOEL: sure

MARK: and how that was starting to shape your thinking about the patient.

JOEL: Sure, um, I think this patient was coming referred for low back pain and, you know, working in outpatient orthopedics, I don't typically go out

to receive my low back patient and have them in a wheelchair. So that certainly, right off the bat, made me question, sort of, what about this patient is different, already, than, you know, what I normally see in a lumbar spine patient. And, um, I knew going into it that the patient had a Parkinson's disease diagnosis as well as low back pain, but I think it wasn't clear to me the severity of the, umm, Parkinson's. And, umm, so the fact that she needed to be transported back to the treatment area in a wheelchair, kind of, right off the bat, made me think that the exam was going to be a lot different than, you know, my typical sort of lumbar spine patient who walks in to see me. It really became something I realized quickly that I was going to have to do, sort of, more, you know, functional mobility testing and kind of a lower-level evaluation

MARK: mmhhmmm

JOEL: than I normally would do – just seeing how she's doing, sort of, you know

MARK: mmhhmmm

JOEL: sit-to-stand and bed mobility. Things like that were going to be very important to assess, ahh, you know

MARK: So, it sounds like you needed to change your whole plan

JOEL: Pretty much, yeah

MARK: From the [p], When you get to the waiting room, it sounds like you had an idea of how you would have approached this

JOEL: Yup

MARK: based on what you had gleaned from the medical record prior to seeing her

JOEL: Yes

MARK: You see her and, even before you get her back to treatment, you, you've shifted how you're going to approach her

JOEL: Yeah

MARK: So, where does that come from? Is that based on experience, err, does that come from, uuuhhh, other, other things?

JOEL: Yeah, I, uuuhh, prior to coming to NMC I had a 10-week clinical, um, in an outpatient neuro setting, and, while I was there, I was involved in developing a movement disorders group

MARK: I see

JOEL: primarily for Parkinson's disease patients, so I had some experience in the past with them and, um, so I was able to recognize a lot of her movement dysfunction pretty quickly as something I'd experienced in the past, you know, it took her probably 5 to 10 seconds to get out of the wheelchair, when asked to transfer, and she had some freezing episodes, and she had just sort of extreme kyphotic posture

MARK: mmmm

JOEL: things that are typical of Parkinson's that I'd experienced in the past

MARK: I see

JOEL: but things that I'd never experienced with a patient being referred for low back pain, you know, so that was, you know, I sort of from past experience knew where to go with this sort of movement disorders evaluation

MARK: Uh huh

JOEL: but it was a challenge to try to think of, okay, where am I going to go to evaluate her back pain? which is really what she's coming to me for, uh, despite this movement disorder she has

Comparing this *told* to the first, I see similarities. When surprised by his patient's initial presentation, Joel had: 1) recognized her Parkinson's symptoms, which were more severe than he'd expected; 2) quickly decided that he needed to change his evaluation to a more "low-level" one; 3) drawn on prior experience with Parkinson's patients to inform both of the first two; and 4) proceeded. Thus, it contains the same complicating action and narrative elements of plot. In addition, while Joel's evaluative elements take a slightly different form in this verbal discourse, their meaning is unchanged. Joel is a competent physical therapist who knew what to do and did it.

In this second *telling*, however, we also have Mark's presence which I believe adds interesting new elements, and in the end, Mark gets Joel to expand on his description of the complicating action.

There are three major ways in which Mark inserted himself. In introducing his opening question, Mark demonstrated that he'd read Joel's narrative, and affirmed Joel's evaluation – "early on, as you begin the process of introducing yourself to this patient and having her come with you from the waiting area back to the treatment area,

uh, *you make some very astute observations* just as she's moving from that waiting area to the treatment area." I can almost hear Joel's sigh of relief at hearing those words, and believe I do see him relax in the video of that meeting. In addition, with Joel on notice that Mark was paying attention and wanted to hear his story, Mark invited Joel to say more about what he observed with Mrs. Cheung in that initial encounter and how it was beginning to inform his thinking.

This elicited from Joel a recap of the initial encounter.

MARK: So, it sounds like you needed to change your whole plan

JOEL: Pretty much, yeah

MARK: From the [p], When you get to the waiting room, it sounds like you
had an idea of how you would have approached this

JOEL: Yup

MARK: based on what you had gleaned from the medical record prior to seeing
her

JOEL: Yes

MARK: You see her and, even before you get her back to treatment, you,
you've shifted how you're going to approach her

JOEL: Yeah

Throughout this portion of the conversation, Mark provided verbal and nonverbal indications that he was listening – numerous “mmm hmmm’s” and head nods, and a concise summary of what Joel had just described, which we know was accurate by Joel’s numerous “yes” responses. But Mark did more than affirm Joel’s

sense of what was going on; he probed for more as he continued, “So, where does that come from? Is that based on experience, does that come from...other things?”

On hearing this question, I wondered whether Mark had specific “other things” in mind, since Joel had already described in his narrative that he’d drawn on prior clinical experience. Joel, however, didn’t provide any additional insights on the question, at least not at that point. What Mark’s question did elicit was an expansion on the crux of the matter when it came to the complicating action. It was not simply that Joel needed to shift his plan and evaluate Mrs. Cheung’s Parkinson’s symptoms rather than her back; instead, “it was a challenge to try to think of, ‘okay, where am I going to go to evaluate her back pain?’ which is really what she’s coming to me for, despite this movement disorder she has.”

Here we see Joel continuing to reflect on his experience with Mrs. Cheung, this time with Mark, and perhaps arrive at a new insight into the nature of the challenge he’d faced when treating Mrs. Cheung.

I turn now to a later excerpt from *Joel’s Story*, a point in the conversation where Joel covers some of this same ground – in no small part due to Mark’s having taken him there. It constitutes what I see as another *telling* of certain elements of the same complicating action.

Joel's Story (Excerpt 2)

“As you move through her examination,” Mark asked, “are you beginning to, for lack of a better word, *reprioritize* what you think her major problems are? You went in, it seems, thinking *low back*, but by the end of that first visit, are you seeing her *Parkinson's* symptoms dominate her *low back* symptoms?”

“Yes, definitely,” Joel said.

Mark decided to probe again for Joel's understanding of how he'd been able to shift gears so readily.

“Okay, tell me about that process,” he said, “do you have any insight into how you developed that flexibility – being in the moment and changing the plan? Because, you still have sixty minutes.”

“Right,” Joel said, nodding.

“You've still ‘*gotta get it done*’,” Mark said, increasing his rate of speaking as if to indicate a clinician in a hurry.

“Right,” Joel said again.

“Where did that flexibility come from – decision-making on-the-fly, if you will?” Mark asked.

“Some of it was past experience, I think,” Joel said. “Some of it, too, was necessity, because in my typical, you know, younger clinician outpatient ortho eval, I tended to do a lot of impairment-based²¹ things, but because of her

²¹ Impairment-based refers to examination of the underlying sources of movement dysfunction. This may include muscle strength, flexibility or the ability to move passively through a range of joint motion, motor control, pain level, etc.

movement problems I just wasn't going to be able to do them. So I spent a lot more time evaluating her sitting, which is where she spent most of her day."

"Yup," Mark said, nodding in what I perceived as encouragement to go further.

"And I think that worked out well for me in the end, because it was a really good way to look at this patient," Joel said. "So, I think some it was experience with that population and I think some of it was just that I couldn't do a lot of those tests and measures that I wanted to jump in there and do, you know?"

Mark had his answer. Joel responded, at least in part, to necessity – his patient simply couldn't perform the movements required for the tests related to low back pain, and she was exhibiting symptoms typical of Parkinson's Disease, which he knew how to evaluate based on a prior clinical experience, so he proceeded down that path. In the end, as we learn later in the story, that combination of factors led Joel down precisely the right path for helping this patient.

End of Joel's Story (excerpt 2)

Complicating action: Parkinson's disease vs. low back pain (continued). In this excerpt, we hear yet another iteration of Joel's story regarding how he'd shifted gears, taking a new approach to Mrs. Cheung's evaluation. In it we learn more about the dilemma he faced upon realizing that in this case he simply was not going to be able to do the impairment-based spine evaluation he was accustomed to doing with patients referred with low back pain. As I analyze this iteration of the story, I also see Joel either realizing the extent to which he pursued the evaluation approach he did out of necessity, or becoming more comfortable with the fact that that's how he'd come to it. Perhaps both.

Looking at the transcript of the conversation, we see even more clearly Joel's growing ability to acknowledge, perhaps accept, that he may not have arrived at that decision had it not been for necessity.

JOEL: Yeah, I mean, some of it was past experience I think. Some of it too, was necessity because , you know, in my typical, you know, kind of 'younger clinician' outpatient ortho eval, you know, I tend to do a lot of impairment based things... isolated muscle testing

MARK: Mmm hmm

JOEL: And passive mobility of the spine, and, those sorts of things, because of her tone and movement impairment, I uh I just wasn't going to be able to do them. So I spent a lot more time, you know, really evaluating her sitting, which is where she spent most of her day

MARK: Mmm

JOEL: And just trying to change her sitting posture, seeing if she could change it, uhm, you know, could I change it? Did that change her pain? You know, things like that were much more functional, uhm, just seeing how safe she was moving

MARK: aahhh

JOEL: Because she's at home a lot by herself

MARK: yep

JOEL: Uuhhh, making sure that she's safe in the home, and

MARK: Mmm hmm

JOEL: And what situations might she get in trouble

MARK: yup

JOEL: How can I counsel her as far as just being safe, because she'd had falls in the past, that she reported on her health uhh status questionnaire, you know, I think, some of it may have been necessity just because I couldn't do some of those things

MARK: Yupp, yupp

JOEL: That I typically do

MARK: yup

JOEL: And I think that worked out well for me in the end because it was a really good way to look at this patient, uhmm, but, so I think some it was experience with that population and I think some it was just that I couldn't really do a lot of those tests and measures that I really wanted to jump in there and do, you know?

At the same time that he seems to acknowledge that he'd stumbled upon the evaluation approach he'd taken with Mrs. Cheung, Joel opens a window onto the fact that this, in the end, proved to be a very good way for him to evaluate this patient. However, he and Mark weren't finished with this aspect of the story. In the course of their conversation, Joel and Mark constructed yet another *told*. It follows a portion of the conversation in which Mark had explored further the issues involving Mrs. Cheung's partner, Mr. Wong, and the ways in which he'd jumped in to help before letting her try to act for herself.

This excerpt reveals the final instance in which Joel covered this familiar ground as he reflected with Mark on his experience. Occurring near the end of their conversation, Mark once again brought Joel back to talking about the fact that he'd changed tactics and asked how he'd learned that flexibility.

MARK: What's really interesting in this is, uhh, is, most of our patients who come to us for spine care don't need physical assistance, and, when I read this, there was kind of two ways in which you needed to be flexible. One, was, the Parkinson's disease is playing a significant role, and now there is a caregiver, somebody else involved in helping her, that you also need to start to incorporate into your management in order to get her to do, uh

JOEL: Right, right

MARK: Uh the things she needs to do for herself. Uhm, when you look back, to your own days as a therapist, did you always have that flexibility in

your treatment approach? So, is this, what I saw here [points to written narrative], is this an evolved practice that you, errr

JOEL: No, definitely, [Joel jumps in cutting Mark off] I think, uhm, I think as I've had more experience, I think, you know, I've been able to be more flexible with this sort of thing. When I first was a therapist, this patient would just have been very overwhelming to begin with, uhm, just with the cultural difference, with multiple diagnoses, uhm, I think I probably wouldn't have been as flexible with changing my evaluation into a more functionally based, uhm, eval, I probably would have tried to do some of those impairment based things

MARK: yeah

JOEL: I really wanted to do kind of deep down and I, uh, and so I think that a place I can definitely see that I've grown, uhm, is my ability to really, you know, within a few minutes of seeing the patient move and discussing, you know, with the patient, uhm, being able to formulate a pretty good evaluation plan to make sure she was safe and get a sense of her overall mobility. Uhm, and I think also, you know, including the caregiver is something that, uhm, initially, I may not have noticed those subtleties, definitely, I probably would have been thinking too much about 'okay, what am I going to do here...' you know, uhm, to get my information that I need about her low back vs. taking a step back and saying, okay, you know, this is how she's moving, and you know, that's an interesting way for him to be doing those things for

her, and then, noticing those things in the beginning, as the eval evolved, realizing she definitely didn't need that much assistance. So those are things I think I probably would not have picked up on, you know, when I first started as a therapist.

In this iteration, we see a Joel aware of the developmental path he'd traveled, and this time, readily acknowledging it. Once again, Mark set this up with his opening. He acknowledged that Mrs. Cheung posed challenges outside Joel's typical patient population, challenges that demanded flexibility. In addition, in the way he worded the question, Mark indicated that Joel had, in fact, demonstrated that flexibility: "did you always have that flexibility in your treatment approach? Is this, what I saw here [points to written narrative], is this an evolved practice that you"... Joel was so eager to jump in that Mark didn't finish his question.

In this exchange, I believe we see a young clinician growing comfortable with the fact that his practice was evolving, or perhaps, that he was evolving as he engaged in clinical practice. He seems able to own his younger self who would have found this patient "overwhelming" with her "cultural difference" and "multiple diagnoses;" who wouldn't have been able to be as flexible, but would likely have "tried to do some of those impairment based things." Joel even went as far as to admit that he still really "wanted to do [them], kind of, deep down." Thus, we have a Joel who could articulate for himself and for Mark how his practice had changed. "I think that a place I can definitely see that I've grown is my ability to really, within a few minutes of seeing the patient move, and discussing with the patient, being able to formulate a pretty good evaluation plan to make sure she was safe and get a sense of her overall mobility."

Again in this exchange we see Mark as the more experienced clinician who, I believe, takes on a role of mentor, facilitator – but of what? Facilitator of Joel's reflection on his experience with Mrs. Cheung and what it might teach him about the evolution of clinical practice? Facilitator of Joel's ability to own the fact that he was still developing and to talk confidently about it with others? Facilitator of Joel's very identity as a physical therapist? I believe I see elements of all these.

In my follow-up interview with Joel two years after he'd treated Mrs. Cheung, portions of the same story were retold. I didn't ask about it directly; instead, after he'd started recalling his work with Mrs. Cheung and his journey of writing a narrative and discussing it with Mark, I asked Joel whether he'd carried anything forward from that experience. The following is a portion of the transcript of his response – one very long turn at talking, throughout which I didn't say a word.

I think that with this particular patient, giving a more functionally based exam was really a huge thing for me. I remember – I'll never forget – coming to NMC as an intern, and they...had us all go...watch one of the more experienced clinicians in this department do an eval...We had a little brief description of the patient, and we had to come up with what we wanted to look at and [I] wrote down this *looong* list [Joel speaking in very animated tone]... And we get there, and she didn't do one of them. Now, in *her* mind she was looking at the patient and she was assessing [all] those things, but...her whole exam was function, you know. This guy wanted to play golf, and so she had him in a golf swing, looking at his hips, and his knees, and his back in those functional positions, and that blew me away, *blew me away*, you know, at that

particular point in my career – you know, level *zero*, you know – where I was starting.

And I think it was interesting to see myself shift to that [way of evaluating], with this patient, right away. So, I was pleased with that. Now, was it as, *as*, functional, and did I gain *everything* that I could have from the exam? Probably not. But I think it was interesting, and it's a way that I have tried to be, to do more – after this patient – to really use function earlier in my exam to help drive my different...tests and measures...

And I looked back and I thought, [p] I remembered that situation when I came in as a student, really, you know, a new intern, and how shocking that was to see the difference in what I had prepared and what really happened. And so, I think, I think I saw myself going in that direction – in a brief way – but...to me, that was sort of a development in my practice, you know, that I didn't really...notice [by] myself, just going through.

I consider this a fourth *telling*. In it Joel relayed how he'd shifted to a more functional approach in his evaluation of Mrs. Cheung, but this time, more than a year and a half after his conversation with Mark, he'd framed it in a much broader context of his own development. Joel now linked it to an experience he'd had as an intern, in which he'd been "blown away" by a more experienced therapist's functional approach to evaluating a patient – a patient with whom intern Joel would have performed a long list of tests and measures. He recognized, in his experience with Mrs. Cheung, that he'd taken a step in that direction and acknowledged he'd been incorporating a more

functional evaluation approach ever since. Finally, he acknowledged that he hadn't noticed that change in himself at the time.

Later in our conversation Joel indicated that it was only when he'd written about it and talked with Mark that he'd been able to see how he'd grown.

JOEL: You know, honestly,...I think until I really wrote this I really didn't *see* that I had, [p] you know, obviously, I did it.

ME: You did it.

JOEL: I did it. So there was something there, you know, that made me make the decisions that I made and kind of change my focus and the exam, and certainly the patient helped with that. There were things I couldn't do; I needed to do something (laugh) so, I had to do *something*. But I think looking back, I don't think I really appreciated sort of [p] you know, how much I shifted from my normal...impairment-based testing until I really wrote it down, looked at it and discussed it. So, that much I can definitely say.

I am amazed that, after so much time had passed, Joel slipped into such a detailed discussion of his experience with Mrs. Cheung. Granted, he'd known that the reason for our conversation was to discuss his experience with writing and unbundling a narrative, but there was something fresh about the way he spoke of it – the lessons he'd learned in working with this patient and where they fit into a larger view of his development as a physical therapist. I have to believe something other than long-term memory was at work. Did it have to do with reflection? With story? With both?

Iterative process: Summary and discussion. This analysis represents one small portion of the story Joel told of his experience working with Mrs. Cheung, the

portion in which he described the complicating action. Although referred for low back pain, Mrs. Cheung presented with a movement dysfunction resulting primarily from her Parkinson's Disease, as well as with back pain, requiring Joel to change his approach to evaluating her. Across a single conversation with Mark, I traced the *telling* of this portion of the story through three iterations, which resulted in three different *tolds*.

To summarize, the complicating action was that although referred for low back pain, Mrs. Cheung had arrived in a wheelchair showing signs of progressing Parkinson's disease, causing Joel to change his approach to her evaluation.

On the first telling, Joel recognized Mrs. Cheung's movement dysfunction as typical of Parkinson's, and because of prior experience, "knew where to go with this sort of movement disorders evaluation."

In the second telling, some of the flexibility he'd demonstrated with Mrs. Cheung's evaluation was due to past experience, but "some of it, too, was necessity." Joel typically did "a lot of impairment-based things," but because of her severe movement dysfunction he hadn't been able to do them with Mrs. Cheung; so, he did what he could.

In the third telling, he'd had more experience, had grown in his ability to be "flexible with this sort of thing." Joel referred to earlier days when "this patient would have been overwhelming," and he wouldn't have been able to shift gears, and instead, would have done the more impairment-based tests he still, admittedly, "really wanted to do deep down." He could see that one of the ways he'd grown was in his ability to form an impression within the first few minutes of talking with a patient and watching

her move, and from there do an evaluation that would allow him to “make sure she was safe and [get] a sense of her overall mobility.”

Across these tellings, Joel’s story changed as he reconstructed it in response to Mark’s questions. By pointing this out I do not mean to imply that his initial presentation was disingenuous. Rather, I’m reminded of the ways in which numerous narrative researchers (Bruner, 1987; Mishler, 1995; Riessman, 2008) describe the telling of stories based on life experience as a means of presenting oneself to others. In the conclusion of this chapter I return to this discussion and the light it may shed on the phenomenon of reflection.

This analysis provides one example of the iterative process I saw play out time and again – in other parts of Joel’s story and in those of other participants’ journeys from clinical encounter to writing through unbundling conversations. It is beyond the scope of this dissertation research to follow the myriad other examples through the same detailed process, although I’ve done so myself with several additional examples as a means of checking this analytical process and my findings.

As evident in the larger narratives I crafted of Samantha’s and Maureen’s reflective journeys and offered in the previous chapter, these participants, too, demonstrated an iterative process. It is visible in Samantha’s multiple tellings, and ultimate reframing, of the role Commander Lawrence’s goals played in her ability to partner with him effectively as his physical therapist. Maureen retold aspects of her story as well – about her decision to place Sam’s goal of playing baseball at the heart of his physical therapy program, despite how ill he was; and about her relationship, or lack

of one, with Sam's mom. Across tellings of the latter, Maureen moved to a place of compassion for this mother of three very sick boys.

As the result of a decision I made about bounding the scope of this study, I mentioned, but did not analyze in depth, Mark and Jane's roles in the iterative process described above – although clearly they were significant. The interplay between their interest in hearing certain aspects of participants' stories and where participants chose to go in following or not following their leads could be a study in itself. I believe that a detailed structural analysis of the discourse between Mark and any one of these participants could reveal a great deal about what I view as a form of *mentoring* – others may have different labels for it. However, that, too, is beyond the scope of this study.

I will end this analysis of the iterative nature of participants' narratives by returning to the conclusion of *Joel's Story* and this complicating action's resolution, another feature of narrative structure. I believe it points to why Joel's experience with Mrs. Cheung remained so vivid for him and the role the story's re-tellings played for him.

Joel's Story (conclusion)

“As I often read in these narratives,” Mark said, “our staff write a summary statement about what this experience has done for them in terms of how they manage patients. And you do this here. You make the statement that this patient experience has affected how you approach all of your low back, spine, patients.”

“Mmm hmm,” Joel said, nodding.

“Can you tell me more about that?” Mark asked, “what this patient did to change what sounds like your treatment philosophy? The way you describe it, it sounds like, ‘I always did things in a certain way. This patient came along and I needed to change my repertoire of how to approach them,’ but part of that repertoire seems to now extend to how you’re managing all your patients.”

“I think when I used to look at a lumbar spine patient, they would tell me what functional activities caused them a problem, and I would say ‘okay,’ and I’d write that down,” Joel said, miming a writing action. “Then I’d have them do the motions, and I would make a note of ‘okay, that was painful,’ or not, or whatever. And I would sort of move along.

“I think this patient really helped me to see that it’s important to look at that, and take a minute to see if you can change that posture, or position, or movement, and think ‘what about it might be causing the problem?’ Because sometimes that can give you all the information that you need, right there – as far as what muscles may be limiting what movement patterns, what joints are limited and causing the aberrant motion, or whatever that might be. And since I sort of *had* to do that for this patient, I

think it kind of opened my eyes a little bit, to say ‘Wow,’ you know, ‘this is really a great way to work with people.’

“Mmm hmm,” Mark said, leaning toward Joel as though listening intently.

“I certainly still do my more impairment based things,” Joel said, “and I think those are important for people who can tolerate it but, you know, in an evaluation, I take a lot more time to *look*. For example, if the patient has pain while sitting, I have them sit and I really look at their sitting posture, and I see if I can get them to change their lumbar spine position, and I see if that makes a change in their pain. And I think that’s really helped.

“I’ve also had the opportunity,” Joel said, Mark now just nodding and letting him talk, “to watch some other therapists who are more experienced and I’ve seen them looking *very* functionally at the patient, and being able to gain *so* much information from that.”

“Yes,” Mark said.

“I think I was missing that,” Joel said. “It’s a little piece I was missing before, with my patients. So that’s been a big change for me.”

The End

Performed Narrative

As I described in the methods section, performed narrative refers to a specific genre in which the speaker structures an experience from her own point of view and dramatizes it, making it accessible to the listener. The speaker engages the listener in a vicarious way that Goffman (1974) describes as one that enables the listener to insert himself into the story, as if he were there (p. 504).

It was only after being surprised by the many places in which participants acted out parts of their stories that I discovered numerous narrative researchers (Goffman, 1974; Wolfson, 1978; Riessman, 2008) who described and discussed performed narrative as a distinct genre. In her operational definition, Riessman (2008) delineates five common structural features of this speech form. While common, the speaker need not use them all in order for the speech act to be considered performed narrative. Riessman's (2008) list includes: 1) direct speech, that is, the narrator speaking as though she *is* the character, 2) asides, or points where the narrator steps out of character to make a comment to the audience, 3) repetition, used for emphasis, 4) expressive sounds and sound effects, used to provide heightened drama and sense of being there, and 5) use of the historical present tense (pp. 112-113).

According to Wolfson (1978) *historical present* refers to use of present tense to refer to past events. It is a feature of performed narrative that has long been recognized, and is common, for example, in telling jokes or giving dramatic performances. In this study, however, Wolfson (1978) examined its use in a specific type of storytelling that occurs in everyday conversational interactions; thus, she

labeled it *conversational historical present* (CHP). To provide an example of performed narrative, I turn to Samantha's interaction with Mark.

The first time I listened to Samantha's conversation with Mark, her story of working with Commander Lawrence came to life for me. I'd already begun to picture it based on numerous readings of her narrative and thought I'd come to understand its meaning. However, as I transcribed Samantha's interaction with Mark, I found myself inserted into the action as it played out between Samantha and the Commander. I needed notations to describe the numerous places where Samantha spoke directly for the various characters, including herself – varying volume, pace of talk, and tone of voice.

Once I'd recognized performed narrative in Samantha's story, despite my not yet having a name for it, instances of the genre in other participants' conversations began to jump out. Evidently it was not just Samantha's idiosyncratic, animated way of talking.

Samantha's reflective journey: Viewed through her performed narrative. I based this analysis on two specific places in which Samantha used performance in her conversation with Mark. In each case, I present an excerpt from the verbatim transcript, followed by a discussion of performance elements that are present and the meaning I make of the performed story. While I preserved elements of Samantha's use of performance in crafting *Samantha's Story*, included within the text of the previous chapter, for this analysis I thought important to return to the original transcript.

Samantha's performed narrative: Analysis of Samantha–Mark, excerpt 1

MARK [referring to Commander Lawrence, Samantha's patient]: He, errr, past his prologue, he gets right to it

SAMANTHA: yup

MARK: And I'm paraphrasing a bit, but he doesn't dance around this, he gets right to it, he wants to know [about your credentials]. So, how did you say it, how did you respond?

SAMANTHA: I think I was in doing my normal tests and measures, sort of looking at ankle range (laugh), you know, I was down at his foot, measuring with the goniometer, when he starts in with

“So, tell me where you went to school?” [in Samantha's normal voice] and he had this, just very demanding tone. And it, it wasn't that he was unfriendly, it was just that he had this very straightforward, military, tone. And

“Tell me where you went to school.” [Samantha in a deep voice], and so I told him

“Where's that?” [asked abruptly, in the patient's deep voice] And (laugh), so you know, (laugh)

MARK: [laughs along with Samantha]

SAMANTHA: Here I am trying to explain where this is

“It's, oh, it's a small school” [spoken in extra high-pitched, low volume Samantha voice]

you know [regular Samantha voice]

‘and it's affiliated with the hospital’ [high-pitched voice]

and

“Where’d you go to school before that?” “What’d you major in?” [deep abrupt patient voice]

Aahh, you know, (laugh) he was shooting off questions and it was almost as if my patient interview became, you know, his interview of me.

This excerpt provides examples of Samantha using features of performed narrative. There are numerous instances of *direct speech* – places where Samantha spoke for her characters, including herself. For example, rather than say, “Commander Lawrence asked me where I went to school,” which would have used past tense consistent with other aspects of a story of something that happened some time ago, Samantha appropriated the use of conversational historical present (CHP), “Tell me where you went to school.”

Samantha’s story continued with an *aside* to the audience, “and so I told him,” where we see her revert to past tense. Then, without pausing, Samantha jumped back into direct speech with the Commander’s come-back, “Where’s that?” Thus, we see three elements typical of performed narrative: direct speech, CHP, and use of asides.

In addition, my transcript notes indicate that Samantha modified her speaking voice in portraying her patient and herself. At first she simply deepened her voice when speaking for Commander Lawrence. Later, she spoke with a deep voice at a clipped pace I referred to as “abrupt” in my notes. I don’t know whether Wolfson (1978) would consider this an example of *sound effects*, another feature of performed narrative, but it certainly had the effect of heightening the sense of drama. Finally, we see Samantha using one other feature, *repetition*, likely for the emphasis Riessman

(2008) describes. For example, Samantha had the Commander ask her twice, in succession, where she went to school. The presence of these elements again qualifies this excerpt as performed narrative.

Continuing in performance genre, Samantha allows us to see her own character in the story: “Here I am trying to explain where this is, ‘It’s, oh, it’s a small school, you know, and it’s affiliated with the hospital.’” Samantha adopted a high-pitched tone of voice and spoke very softly when providing her own character’s direct speech. To my ear, this made her sound like a timid young girl – especially in contrast to the Commander’s deeper booming presence. Samantha continued inserting asides in her normal speaking voice, which made timid Samantha all the more real.

As she wrapped up this segment of performed narrative, Samantha continued playing the Commander, but used past tense asides to communicate what she’d made of it at the time: “‘Where’d you go to school before that? What’d you major in?’ [deep abrupt patient voice] Aahh, you know, (laugh) he was shooting off questions and it was almost as if my patient interview became, you know, his interview of me.”

The overall effect of Samantha’s performance was the sense that she was allowing me in on the extent to which, in those early interactions with Commander Lawrence, she’d felt insecure. And, although I’d previously read in her narrative that “as a new graduate with a brand new, barely broken in license, it was not too difficult for Commander L. to rattle my confidence,” I didn’t understand the extent of that feeling until she effectively allowed me in, through her performance.

Samantha's performed narrative: Analysis of Samantha – Mark, excerpt 2

MARK: As you look back on the early parts of these treatments, ummm, how effective were you in establishing that relationship with the patient, I, err, it's clear you're sensing, 'He's got his way'

SAMANTHA: yeah

MARK: How effective do you think you were?

SAMANTHA: I, I *don't* think I was very effective in the first couple of weeks and that's where the warning signs started to, uh, I think what tipped me off most was, though he would *do* things, so, he would sort of argue it while we were in the treatment program, and then he would say

“All right, *fine!*” [spoken in abrupt, irritated Commander Lawrence voice]

And then he would do it. And then I would come back the next day and say

“So, did you work on this yesterday?” [normal pitch, somewhat low volume, Samantha voice]

“No. I didn't! I didn't come to do that” [abrupt, irritated Commander]

You know

MARK: mmmm

SAMANTHA: And sooo, I'd say, you know

“What held you back? How come you didn't do it?” [performed in Samantha's clinician voice – confident, not bossy]

“Weellll, I just didn't have time. I, you know, I have *all* these things going on, and I have *all* these medications” [in patient's abrupt voice]

And he would become *very* frustrated at what was going on with him. He constantly was frustrated with, you know

“Well *this* doctor’s telling me one thing, and *this* doctor’s telling me another,” [in patient’s abrupt voice, with hand gestures for emphasis]

MARK: mmmm

SAMANTHA: And, you know, I think he just, it became very clear to me that [p] something was blocking him mentally from making progress.

In this excerpt Samantha continued using performance, and to good effect. By doing so, her audience, which included me, and now you the reader, has been afforded access to the action in the vicarious way to which Goffman (1974) referred. In analyzing this excerpt of her speech, I use that access to make meaning of what I’m reading and hearing.

The greatest impact of this segment, for me, is seen in Samantha’s transformation from timid, low-confidence, “young” Samantha, to mature, confident, physical therapist Samantha. We see it take place via the three distinct ways in which she plays herself in the performance. I described the first earlier, citing the exceptionally high pitched, low volume voice Samantha used in playing herself.

The second portrayal came in this excerpt, where my transcript notes read, [normal pitch, somewhat low volume, Samantha voice], as she asked the Commander, “So, did you work on this yesterday?” I interpret this as a growth in confidence, but not a full owning of her role as a health professional. Even her use of the word “so” to begin her question, which has become so commonplace in today’s conversational talk, gave me the sense that this Samantha, while more confident, was not the self-assured

physical therapist I would expect to have walk into my room, if I were a patient at NMC.

Then, in the next words out of Samantha's mouth, she adopted what I recognized and noted as a fully confident clinician tone, as she asked the Commander, "What held you back? How come you didn't do it?" My transcript notes were: [performed in Samantha's clinician voice – confident, not bossy]. The impact of this transformation is made all the more powerful by the proximity in time of these various versions of Samantha's persona, as conveyed by her performing herself in the story rather than describing what she said and how she'd felt at the time.

Example from Maureen's Story. Maureen, too, included performance in her conversation with Jane, although without as much dramatic effect as Samantha. Take the following excerpts from *Maureen's Story* in which, without realizing it at the time, I retained her use of performed narrative. Following my inclusion of an excerpt from her clinical narrative containing the standard clinical report, I pointed out Maureen's transition to writing about her interaction with Sam.

Maureen then departs from this clinical report and takes us inside her interaction with this adolescent.

My evaluation included obtaining his goals. When I asked him, he looked at me, and asked if I was serious. When he realized I was, he said 'to be on the freshman baseball team.' I said, 'if we work as a team, that can be one of our goals,' but he did not appear to believe me during our first meeting.

In this excerpt, we read a portion of Maureen's written narrative in which she'd put forth bits of dialogue between herself and Sam. During the unbundling

conversation, Jane asked Maureen to say more about how she'd managed to establish a rapport with this 14-year-old boy who trusted no healthcare providers. In Maureen's response we see elements of performed narrative, including direct speech, use of CHP, and asides to the audience.

“I wanted *him* to be active in this, so I said, ‘what are your goals Sam?’

And he looked at me as though I had two heads, but he said, ‘to be on the freshman baseball team,’ and I was like, ‘all right, let’s work on that,’ and he did *not* believe me.”

Another example of performed narrative captured in *Maureen's Story* occurred in response to Jane's question about how she'd decided on the best airway clearance technique for Sam.

“I knew I had this great toolbox, and that I could say ‘listen Sam, let’s try them. We have at least two weeks here, so let’s find one that you’re going to do at home because, for two weeks, I can assist and your lungs can sound better, but if you’re not going to continue at home, what’s the point?’

“So we did a lot of active experimentation, and some methods worked well for him and he was so productive²², but then he would try it on his own and say, ‘I got lightheaded, it didn’t work so well.’ So even though I knew those were *really* good methods, I didn’t choose them because he wouldn’t continue them at home.”

These are just two of the places in which Maureen, like Samantha, moved into and out of the use of a performance genre. Of note is the fact that I provided no notes

²² This use of the term *productive* refers to *productive cough*, that is, one that is strong enough to enable the individual to remove mucous from the lungs, so it can be spit out, or *cleared*.

as to change in tone or volume, for Maureen didn't vary these in her performance, relying instead on spoken transitions to signal changes in speaker. Thus, the meaning I take from Maureen's use of the genre is not signaled by the presence of shifts in how she plays herself or Sam, as was the case with Samantha; rather, I find meaning in their absence. Maureen conveys a steady persona – without, for example, an evolution like we saw in Samantha's apparent level of confidence at the start. I returned to the original transcript and recording to check the accuracy with which I conveyed Maureen's performed narrative when I crafted *Maureen's Story*. Sure enough, Maureen's tone remained calm, confident and steady throughout her conversation with Jane, whether performing herself, performing Sam, or describing events.

I wondered whether this was due to a difference in personality between Samantha and Maureen, and must conclude that this is a possibility. But I see another potential reason for the difference. When Maureen treated Sam, wrote her narrative, and discussed it with Jane, she'd been practicing for seven years, compared to Samantha's one, and was being recognized at the Advanced Clinician level in the CRP, compared to Samantha's Entry level. As an advanced clinician, Maureen undoubtedly was more confident in her knowledge and skills as a physical therapist and when interacting with patients – even difficult adolescents. I have no way of knowing for certain, nor am I attempting to distinguish between novice and more expert clinicians in this study, but bringing my understanding of the context to bear, in hermeneutical fashion, I believe it's a reasonable explanation for at least some of the difference seen between the two performances.

Discussion of performed narrative. The above analysis includes examples of performance narrative found in two participants' unbundling conversations. There were others I could have selected. Like Riessman (2008), I wish to point out that by highlighting the performative means by which Samantha and Maureen included themselves in their stories, I do not mean to imply a lack of authenticity in the identities they were portraying. As Riessman (2008) points out, identities are always situated and "accomplished with audience in mind...[they're] constructed in 'shows' that persuade" (p.106).

Nessa Wolfson's (1978) work may provide a context for understanding participants' use of performance in their conversations with Mark and Jane. Wolfson discovered that features of the relationship between speaker and audience, or addressee, had a strong influence on whether, and to what extent, conversational historic present (CHP) and performance were used in everyday conversation. First, it is used only when the speaker and listener share norms for interpretation – when the speaker can be "reasonably certain that his story...can be understood and appreciated by his addressee" (Wolfson, 1978, p.231). This is certainly the case in these examples and can be seen as an indication that Samantha and Maureen recognized that they shared with Mark and Jane a common background – physical therapy practice at NMC and their intersubjective points of reference.

Wolfson (1978) also found that performed narrative was predominantly used when speaker and addressee were of a common status or standing. Her data specifically showed that it was virtually never used when an employee was addressing his employer, though it may be used in the reverse instance. This study differs from

Wolfson (1978) in that regard. Samantha, as we saw, used the genre freely when speaking with Mark, her employer.

Perhaps Samantha's use of performance is better understood in the context of Wolfson's comment that, "the act of performing for another may be seen as a sign of equality and/or solidarity" (p.231), and the reason it's not used by an employee addressing an employer is that it would violate a social norm that recognizes their unequal standing. This opens up another potential interpretation. Perhaps Samantha's use of performance is more correctly viewed as an indication that Mark was successful in framing the interaction as collegial – two colleagues talking about a patient – rather than adopting the institutional frame (Ribeiro, 1994) of employer-employee. This understanding would be consistent with what we saw in Joel's interaction with Mark in the previous section.

Finally, I wonder whether Maureen and Samantha's use of performance in these unbundling interactions with Mark and Jane is more an acknowledgement of their shared identities as physical therapists, or a quest for shared identity, as the case may be. I discuss this notion of identity further in the conclusion to this chapter.

Analysis of the Reflective Journey: Discussion and Conclusion

Evolving identity. In this chapter I've shared the analyses of two aspects of the process I glimpsed – its iterative and performative nature. Both aspects reveal something about how participants in this study use the telling of stories based on life experience to help develop, perhaps even create, identity. I will consider the

underpinnings of this conclusion in the context of work done by three narrative theorists: Bruner (1987), Mishler (1995, 1999) and Riessman (2008).

Coming from a psychological perspective, Bruner (1987) wrote that autobiography, telling the story of one's life, has the power to "structure perceptual experience, to organize memory, to segment and purpose-build the very events of a life" (p. 694). Seen this way, the changes in Joel's various tellings of his story helped him organize his memory of working with Mrs. Cheung and see its purpose. In addition to helping Mrs. Cheung function more effectively in her life, treating her served the purpose of helping him grow as a therapist. Similarly, what if Samantha's changing portrayal of her character in performances of her interactions with Commander Lawrence was helping her in this manner as well? Bruner (1987) takes it a step further, claiming that in the end, "we become the autobiographical narratives by which we 'tell about' our lives."

My data, too, leads me to consider the possibility that Joel and Samantha were in the process of becoming the therapists who, in the end, were confident in their identities as developing clinicians – an aspect of this process also evident when they spoke with me over a year-and-a-half later.

Messages similar to Bruner's (1987) can be heard emanating from Mishler (1995), who, discussing a component of his study of craftspersons, described how he came to view their narratives as "retrospective." The meanings of the career trajectory they shared with him represented how they'd "come to understand them" as they looked back, rather than "what they might have meant at the time." He pointed out that both he as interviewer and analyst, and his respondents, were "engaged in acts of

reconstruction.” They projected images of themselves “as certain kinds of persons” (p. 96).

Riessman (2008), too, wrote of narrative being about identity. As she put it, “we are forever composing impressions of ourselves, projecting a definition of who we are, and making claims about ourselves and the world that we test out and negotiate with others” (p.106). In the context of Riessman’s theory, I ask if Samantha, Joel and Maureen were each negotiating and presenting a preferred self. The first two, as we’ve seen, presented selves that can be viewed as developing and evolving, including, perhaps, growing in their professional identities. Maureen, in many ways, presented the most stable identity of the three, yet even she portrayed a changing self, growing in insight into her professional role, as in her movement toward finding compassion for Sam’s mom.

Story-ing experience vs. reflecting on experience. Once again I must step back to survey where my research has led and ask, “so what?” What light do these analyses shed on the phenomenon of *reflection as experienced by physical therapists in clinical practice*? I’ve moved through much of the chapter drawing on terminology and theory related to narrative or story – how it’s co-constructed, how it changes with each telling, and how it often serves as a performance of self. All the while, however, I’ve sensed a familiar voice in the back of my mind telling me that what I was actually seeing was Joel, Samantha, and Maureen’s *reflective processes*. I recognized it from my pre-understanding of the phenomenon, informed by my own experience with reflection across three decades as a physical therapist.

Perhaps it's more accurate to say that I have come to believe that I was seeing Joel and Mark, Samantha and Mark, and Maureen and Jane, *reflecting together*. The idea of reflection as something that happens *between* individuals – rather than in one individual's cognitive processing – is *not* something I recognize. Certainly talking with colleagues about challenging patient experiences is familiar, but considering talk as reflection itself, is new. The distinction comes into focus for me when I consider my shift in terminology. At the start, I referred to what I was seeing as Mark “*facilitating* a younger clinician's reflection on his or her practice.” Then, I moved to a place of referring to it as Joel and Mark, or Samantha and Mark “*co-constructing* a story of the former's clinical experience and negotiating that story's meaning.” Finally, as analysis of this data nears its conclusion, for now, I call what I see as Joel and Mark, or Samantha and Mark, “*reflecting together* by co-constructing stories of clinical experiences and negotiating their meanings.”

This begs the question, what's the difference between telling the story of an experience and reflecting on that experience? As I mentioned near the start of this chapter, several of the prominent models of reflection portray a process with multiple steps, an iterative dimension, and levels of reflection, a vertical dimension. Schön (1983), for example, described reflection-in-action and reflection-on-action, while Boud (1985) wrote of a reflective process involving: 1) returning to the experience, or recalling it; 2) attending to the feelings experienced during it; 3) reevaluating the experience; and 4) arriving at an outcome or resolution. Both describe iterative processes. An example of the vertical dimension is seen in Mezirow's (1991) four levels of reflection: 1) habitual action, which I see akin to Schön's (1983) knowing-in-

action and Packer's (1985) ready-to-hand; 2) thoughtful action, not unlike Packer's present-at-hand, 3) reflection, which seems similar to Schön's reflection-on-action and Packer's present-at-hand, and 4) critical reflection, in which I hear echoes of Dewey's (1933) notion of reflective thinking always springing from some experience of a problem and the "experiencer's" willingness to step back, identify underlying beliefs or assumptions, and challenge them, even while pursuing a solution.

Certainly, in writing their narratives, that is, in story-ing their experiences, and discussing them with Mark, Joel and Samantha can be seen engaging in all of Boud's steps. We've seen how they: 1) recalled their experiences in order to write about them, 2) revealed feelings – a lack of confidence in Samantha's case; 3) seemed to re-evaluate the experiences, as in Joel's changing representation of why and how he'd shifted his approach to Mrs. Cheung's evaluation; and, 4) arrived at a new outcome – Joel expanding and owning a view of himself as a developing physical therapist and Samantha growing into a confident therapist, even when interacting with the intimidating figure of Commander Lawrence.

It's not surprising that, consistent with these models of reflection, I found an iterative dimension to the process participants engaged in when writing and discussing their narratives. It is also not surprising that I was able to trace changes indicating their changing levels of insight into the situations about which they'd chosen to write, and about themselves in those situations. That, too, is consistent with theorists' views of reflection.

However, as I discussed at the start of this inquiry into the phenomenon of reflection, narrative is the window through which I decided to peek, in an attempt to

glimpse reflection in the lived experiences of my physical therapist participants. That is, in lieu of having participants who could describe their experiences of reflection, I chose to analyze written narratives, which I framed as products of a reflective process, and observe the authors discuss them with another clinician. Is it, then, not equally logical that I'm seeing a reflective process with attributes so consistent with theorists' views of narrative – for example, a co-constructed nature and the fact that each telling results in a new told?

The question I'm left with, then, is both challenging and exciting: Do my perceptions, or *noeses*, of these two phenomena – reflecting-on and story-ing experience – resemble one another so strongly because of my narrative methodology, or because story-ing and reflecting share something of the same being-ness, *noema*? I will return to this question in the next section when I attempt to form some conclusions about the light this inquiry sheds on the nature of *reflection as experienced by physical therapists in clinical practice*.

CHAPTER VII: CONCLUSION

The purpose of this inquiry was to examine the phenomenon of reflection as experienced by particular physical therapists in clinical practice. The preceding chapters describe and discuss how I situated this work among discourses on reflection, phenomenology and narrative; methodological choices I made; and analysis and interpretation of the data. In this closing section, I highlight the major findings and the meaning I've made of them before turning my sight toward the challenge of articulating how I believe these findings may inform our understanding of the essence of reflection, a task I undertake within the acknowledged limitations of this study and in the context of future research toward which it may point.

Summary of Key Findings

In this study, I analyzed narrative data including written stories from participants' clinical practice and their discussions of those narratives with others. Writing them required these therapists to step back from their everyday practice, select a patient and craft a story – to reflect.

Informed by the voices of theorists who have shaped our understanding of reflection, narrative, and phenomenology, I approached participants' narratives, written and oral, as the windows through which I could view physical therapists' reflection. The written narratives, as the products of a reflective process, provided access to the content – the *what* of their reflection. The unbundling conversations provided access to their reflective processes as they unfolded – the *how* of their reflection. In this section I summarize the key findings of data analysis and interpretation.

The *what* of physical therapist reflection. Thematic analysis of content revealed that participants reflected on major components of physical therapy practice, but not all components and not in equal amounts. They also reflected on themselves in their physical therapist roles.

Components of physical therapy practice. Content of participants' reflection was clustered within two components of practice as outlined in the setting's practice framework, Clinician-patient relationship and Clinical decision-making.

Clinician-patient relationship. Participants wrote about the challenges and rewards of relating to their patients, and the impact that had on their ability to be effective in their therapist roles. They wrote about discovering who their patients were as people – with personalities, values, roles that mattered to them, and health problems. Whether a fourteen-year-old boy living with cystic fibrosis, or a young woman with pain traveling down one leg, the patients about whom participants wrote were real people with real lives. Participants wrote about discovering who their patients were in the context of those lives and feeling empathy for them, especially when faced with difficult personalities, patients' family issues or differences of opinion about how to proceed with therapy management. They wrote about these aspects of their relationships in detail.

In addition, participants reflected on the importance of using what they came to know about their patients to inform decisions related to their care. At the heart of that process was uncovering the patients' goals for therapy. Participants demonstrated time and again that it wasn't as simple as asking about goals during an initial encounter; instead, they needed to consistently direct care toward those goals and make it clear to

the patient how the two were related. Maureen, for example, needed to convince fourteen-year-old Sam that she was serious about helping him play baseball, even as she asked him to perform airway clearance measures.

The issue of who was in charge of the plan of care, the therapist or the patient, was related to the importance of the patients' goals. Directing care toward the patient's goal, with the therapist providing her best recommendation but respecting the patient's decision-making role, was key to negotiating this terrain.

Clinical decision-making. Other content themes related to how therapists made the clinical decisions that were part of their everyday practice. Rather than focusing on technical knowledge or formal decision-making strategies, they wrote about their need to be flexible in their thinking and adapt to the situations they found in order to be effective in care.

In addition, participants demonstrated their accountability to their patients, writing about challenges of complexity, the need to problem-solve and seek the assistance of others. Here, too, they demonstrated their commitment to doing what it took to make certain the patient got what he needed, whether that was finding a way to sit up despite a painful wound, or running a marathon despite a bad disc.

Self in physical therapist role. Finally, while it occupied less of their texts, participants also wrote about – reflected on – themselves in their physical therapist roles.

They included descriptions of how they felt at key points in caring for patients – intimidated, happy, frustrated. They also included summaries of lessons learned from that patient and across years in practice.

The *how* of physical therapist reflection. Participants' conversations with a more senior member of the department provided rich fodder for examining aspects of how they went about reflecting. Two characteristics of those interactions seemed most telling – the iterative nature of their processes, and the ways participants performed aspects of the stories were shared.

Iterative process. Between having the clinical experience, writing their story, and discussing it, all participants experienced an iterative process of reflecting. What seemed significant in this finding was not the fact the iterative nature of their process but the extent to which the stories and their meanings evolved as they were revisited. From written texts through several oral versions of the same aspect of a story, participants seemed to grow in their insight into their situations and into themselves.

This growth in insight can be credited to the co-construction of meaning – participant with self in the writing and participant with other in the unbundling – and the notion that each *telling* of a story results in a different *told* (Mishler, 1995) with potential for carrying and revealing new meaning. In addition, the nature of the pairings involved in the unbundling conversations is significant to note since, while the individuals varied, this phase of co-construction always occurred between a less experienced author of the narrative and a more experienced reader-discussant – both physical therapists.

Thus, present in each instance was an intersubjectivity based, in large measure, on the shared world of physical therapy practice in general and practice at NMC in particular. In addition, the more experienced member of the pair had the advantage of greater time in practice and breadth of experience upon which to draw. They would

have brought these to the unbundling conversations both consciously and unconsciously. After all, those conversations took place in the context of a professional development program, and the more experienced member of the pair – Mark or Jane – assumed some responsibility for helping the less experienced clinician reflect as deeply as possible on the situation portrayed in the narrative.

I cannot state definitively the extent to which the make-up of these pairings influenced the reflective process viewed here any more than I can separate these findings from other aspects of the context in which the data were generated. I point it out as something I see as potentially significant to my broader interest in learning how to foster a reflection in novice clinicians and, therefore, as something that may warrant more study.

Performed narrative. Several participants adopted a performance genre in which they acted out characters in their stories, including themselves. On one level, this brought their stories to life, providing increased access for the audience – another member of their department and, for purposes of this analysis, me. As with the iterative process, there were times when their performances revealed participants' changing senses of themselves, as with the increasingly confident-sounding voice Samantha's character appropriated as Samantha played her during her conversation with Mark.

In this aspect of the findings, too, the factor of less experienced therapists interacting with more senior members of the department may be significant since the use of performance can be viewed as a way to overcome an implicit power differential in order to engage more equally in the co-construction of meaning.

I reintroduce this brief recap of data analysis and interpretation findings as groundwork for offering my thoughts on what they mean as a whole. Looking at the findings holistically, I see common denominators. Participants privileged reflection on relationship and decision-making, the latter in the context of navigating the complex and changing landscape of healthcare delivery. These all seemed directed at wrestling with the challenges to their efforts to provide the best care possible. When they reflected on themselves in their physical therapist roles, it was about feelings and continued learning from their experiences – again, ultimately about assuring themselves that they’d be able to meet their patients’ needs.

Evaluation

Follow-up interviews. The follow-up interviews I conducted with three participants did not, in the end, serve quite as I’d hoped in providing a means of triangulating data and validating or correcting the meanings I’d made. Participants spent much time commenting on the structure of the CRP and the PT grid. They discussed ways they felt supported at NMC to reflect on practice and grow. In this sense they affirmed that participants were deeply embedded in the culture of their practice setting.

As seen earlier, Joel used that interview as a vehicle for revisiting his story of working with Mrs. Cheung, but in a broader context of his growth as a therapist. Samantha and Maureen didn’t revisit their stories as directly, although Samantha did acknowledge that after writing her story and discussing it with Mark, she wondered what it would be like to share it with Commander Lawrence – another co-construction.

The most direct relationship to my conclusions is found in Maureen's comments about how she used writing her narrative in a different way than reflecting in general.

I think the actual part of writing a narrative, it forces you to put language to what you're thinking. It forces you to really sit down in a space and have it much more outlined. I think we reflect a lot, but when you actually have to write something and tell the story it just...helps sync your thoughts together. I would need more from Maureen in order to know whether she viewed reflection and writing as inherently separate or related. Her quandary leads me to consider one of the study's major limitations I discuss in the next section.

Return to my *personal epoche*. As another aspect of examining my process, I looked for ways I may have imposed my own experience of reflection on participants' experiences. I return briefly to the personal epoche offered at the beginning of this inquiry. In it I identified three traits of my experience: revisiting feelings, asking questions, and making connections.

I did identify in the content analysis that participants wrote of feelings they experienced while treating their patients, and, certainly in the ways they performed their stories, they revealed their feelings. Questioning did not show up as a finding of this study, at least not in the way it had been part of my experience. Making connections, while present in ways participants linked prior lessons to their present situations, was also not a major finding.

Through this lens, I feel reassured that I did not impose a personal sense of the attributes of reflection on these data. That said, it would be interesting to revisit the narratives I wrote to process my experience of the simulation course, and applying the

same analyses I used in this study, see what they reveal. I may indeed engage in that as a follow-up to this study. But that will have to come later. Now I move to the heart of phenomenology, an attempt to describe the essence of the phenomenon of interest.

The Essence of Reflection as Experienced by Physical Therapists in Clinical Practice: Answering My Research Question

The research question that led to this phenomenological inquiry was: What is reflection as experienced by physical therapists in practice? The goal of phenomenological research is to examine a phenomenon as experienced by participants and seek to distill the findings to the point that its *essence* is revealed. As I've discussed, I did not follow the typical paths of hermeneutic phenomenology; I did, however, maintain both hermeneutic and phenomenological stances in my approach, and it has borne fruit.

In the preceding chapters, I described the philosophical and theoretical underpinnings of phenomenology and narrative and discussed key aspects of the literature on reflection in general and as linked to expertise in the health professions. From that foundation, I described data analysis and interpretation and shared its results, discussing as I went along the meaning I made from it including, as the data's story unfolded, the ways in which it revealed reflection and narrative sharing a common nature.

Now, at the conclusion of this inquiry, I have a sense of what reflection looks like in the lives of these participants. I've come to a perception of it, a *noesis*, and believe the data, and my interpretation of them, have something to offer our

understanding of the phenomenon. In this section I describe the elements this study's data point to as constituting the essence of reflection.

A situated, inductive way of knowing. Reflection is a way of making meaning from experience. Its process delves into the particulars of a situation to find the meaning it holds. It is about finding meaning – *knowing* something – in a situated inductive way. The knowing that grows from reflection does not constitute context-free, generalizable concepts or truths. Reflection is always rooted in experience, and, while participants spoke of using lessons learned in one situation to help inform others, as with Geoff's aside about what he'd learned previously about not assuming why a patient asks about a specific activity, the fit of that lesson to the current situation needs to be assessed based on the particulars of the new experience.

A process of co-constructing meaning. Co-construction of meaning is another aspect of reflection's essence, as experienced by these therapists. In this study, participants engaged in reflective acts of writing stories of clinical experience and discussing them with others. When writing their stories, participants were, at the same time, the individuals who lived the clinical experiences portrayed in the stories *and* the authors telling them, to themselves and others. When others read and discussed them – notably more senior clinicians – they became the readers and listeners who helped negotiate their meaning and identify the lessons they contained.

The reflective process viewed through the lens of this study was also iterative in nature. Because of this combination, each time a story was revisited – reflected upon – new meaning was created. Whether undertaken as an internal cognitive process, an exercise in writing, or a conversation, new insights could grow out of each return visit.

I found this aspect of reflection's essence particularly surprising. Previously I'd viewed reflection as a contemplative act undertaken through internal processing, as in looking back on an experience from some point in the future, considering what had occurred and why, and identifying what it could teach me. When this study's participants wrote stories of practice they appeared to be reflecting in a manner consistent with my prior concept. But what of the reflecting that seemed to be going on in conversation? I've come to believe that this aspect of reflecting – that it is, in part, a social construction of meaning with potential for many variations of lessons to be learned – holds great promise for furthering our understanding of how physical therapists engage in and use reflection in clinical practice.

Story-ing experience: Narrating identity. Another aspect of the essence of reflection revealed in this study is that it is, at its core, a process of putting language to experience. In narrative theory, story-ing of one's life is theorized to have the power to convey, perhaps even to construct, identity (Mishler, 1995; Bruner, 1987). By putting language to their experiences, by telling the stories of those experiences, and by including themselves as characters taking action and engaging with others, participants in this study narrated their identities as physical therapists. Telling those stories numerous times in various modes, participants were seen to grow, for example, into owning their clinical knowledge or accepting themselves as developing rather than complete. Thus, they appeared to be growing in their identities as physical therapists.

Summary: Answering my research question. The phenomenon at the heart of this inquiry, *reflection as experienced by physical therapists in practice*, as revealed by this study's data, is a process – a situated and inductive way of knowing in which

meaning is co-constructed, thereby open to many interpretations. This process results in a product that is narrative in nature; it results in story and, as such, foregrounds narrative elements that carry the point, the meaning of the experience. Thus, reflection as experienced by physical therapists in practice is both a process for meaning-making and the container that holds that meaning.

Study Limitations

In this section I address what I see as the main limitations of this study – aspects of the research setting and the use of narrative as a vehicle for viewing reflection.

Research setting. The research setting had two major limitations. First, it has a strong culture of reflection and a highly structured and unusual approach to fostering it as part of a professional development program. While there are positives in this, I see two aspects that limit what I can say based on this study. As a foundation for participating in the CRP, the physical therapy department articulated its practice in a detailed document, the PT grid, which has fostered a shared view of physical therapy across all department members. Additionally, the CRP uses written narratives and unbundling as a vehicle for revealing practice. While this meant I had access to a setting with a strong narrative and reflective culture, it also meant that the view I had of both the content and process of physical therapists' reflection was shaped by the setting, perhaps more consistently so than would have been the case in other practice settings.

Second, as I discussed in the methods section, I am an insider in this setting, sharing a common clinical practice background with participants, in addition to the

culture of NMC's physical therapy department. In hermeneutic phenomenology the researcher counts on tapping her pre-understanding of the phenomenon as a starting point for interpretation. However, the degree to which I am an insider may have blinded me to other important meaning in these data. I need to remain aware of the ways in which being an insider shaped what I saw in the data.

Narrative approach to hermeneutic phenomenology. Another major limitation of this study is my methodological choice to use narrative as a means of accessing the phenomenon of reflection. Some may say I've deviated from the hermeneutic methodology to the point where I cannot claim that genre of research as an implicit model for my investigation. I've placed it under the hermeneutic phenomenology umbrella for all the reasons laid out in the body of the text and have attempted to moderate the effects of my narrative approach by being as transparent as possible in describing my methods.

Certainly the major implication here is that any provisional claim that the phenomenon of reflection appears to share core elements with narrative was shaped by the window through which I looked. I need to be cognizant of the implication and open to discussing and debating it.

Significance of Study Findings

Even if reflection's apparent similarity to narrative is purely by coincidence for the reasons just described, I believe it's a happy coincidence – an important observation. I say this because of the challenge of clearly defining what reflection is and how it works, the challenge of teaching it to students and fostering it in

practitioners. Perhaps narrative has potential to provide another way we can consider approaching reflection in order to maximize the learning available through our experience and our ability to share that learning with one another.

Another potential significance may belong in the category of future work – or may lay its groundwork. One of the reasons I did not engage therapists in the traditional in-depth conversational interviews typical of hermeneutic phenomenology is that we lacked a language to talk about it. The view of reflection as similar to narrative in its make-up may provide a way to begin having those conversations.

Future Research

As is the case with every research journey, along the way I've needed to determine boundaries for what this study is, and what it is not. In the latter, I believe, are the seeds of some promising future directions for research.

In terms of the phenomenon of reflection, there is a great deal more work needed. Coming out of this work I see further inquiry into the philosophical underpinnings of both narrative *and* reflection warranted as a means of examining – explaining or refuting – a possible connection. In an applied sense, this study points to research in which narrative might be employed as a way of fostering reflection, with its impact carefully examined. I believe my colleagues at NMC may have much to contribute to that work.

Finally, I believe the type of unbundling conversation portrayed in this study warrants further study. What *is* the influence of the reader-discussant's breadth of experience or level of expertise? These unbundling conversations may offer a rich

opportunity to examine a related but different phenomenon – mentoring. An important area for professional development in many arenas, I believe a detailed structural analysis of unbundling could shed important light on a model of mentoring.

This Inquiry: Living Narrative

Thus, as unfinished as it feels, as difficult as it is in this moment to let it go, I must. As Halling (1997) wrote,

These truths that we articulate as researchers, however provisionally, are embodied truths: they are felt in our bones. We speak of that which we know because we have come to know it the hard way and because we care that the topic under study be properly understood. Yet part of the reality of the experience of truth is that it may be elusive. Whatever we say, however much it rings true, we know that it can also be said differently and that different perspectives serve the cause of truth. (p.20)

This work represents one possible *told*, the product of a single *telling* – my telling of this inquiry's story in my own social and historical context. It is nothing more. It is, as well, nothing less. By committing it to writing – crafting a text with words, symbolism, the power of story – I've opened it to countless interpretations based on each reader's co-construction of the narrative it is. In turn, each of those *tellings*, even those I may undertake myself, will hold their own rich, situated truths.

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APPENDIX A

Informed Consent Form

INFORMED CONSENT FORM

Physical therapists' use of reflection in clinical practice: A phenomenological inquiry

Purpose of the Study: The primary aim of this study is to shed light on how physical therapists use reflection in clinical practice, especially as a means of fostering their learning and development.

Benefits of the Study: I am aware that participation in this study will have no direct benefit to me. The broader professional community may benefit from the dissemination of the study results since reflection, and reflective practice, are viewed as valuable professional practices.

What You Will Be Asked to Do: I am being asked to give the researcher my consent to use the data collected in January 2010 as part of the PT Department's review of the use of narratives for professional development. That data includes my written clinical narrative and video of my unbundling conversation. In addition, I will talk with the researcher for approximately 20 minutes to answer a single follow-up question related to my experience with narrative.

Risks: I recognize there is a potential for psychological discomfort related to the investigators viewing the video and reading my narrative. I am aware that if I experience any such discomfort I am free to decline to participate, or withdraw my consent at any point, without risk of negative consequence.

How the Data will be Maintained in Confidence: I understand that at no point will my identity be disclosed by the investigators. The investigator will transcribe my unbundling conversation, after which she will destroy the recording. The transcript, along with my clinical narrative, will contain no personal identifiers. I understand the data will be disseminated and that no names or other personal identifiers will be used.

If You Would Like More Information about the Study: The investigator has offered to/and has answered any questions I have about the study. I have been informed that if I would like more information about this study, during or after its conclusion, I may contact:

Mary Knab, doctoral student at Lesley University. Phone: 781-648-3288, or

Caroline Heller, PhD, dissertation advisor. Phone: 617-349-8663

Lesley IRB: IRB@Lesley.edu

Withdrawal from the Study: I understand that I may withdraw from this study at anytime without risk of prejudice or other negative consequence.

I have read the above and I understand its contents. I agree to participate in the study. I acknowledge that I am 18 years of age or older.

Print or Type Name

_____ Date: ____/____/____ .

Signature

APPENDIX B

Northeast Medical Center (pseudonym)

Physical Therapy Practice Grid

Clinician/Patient Relationship The interpersonal engagement or relational connection between the clinician and the patient and/or family				
	Entry Level	Clinician Level	Advanced Clinician Level	Clinical Scholar
Rapport and communication	<ul style="list-style-type: none"> Is aware of own values and recognizes how one's own values affect interactions and relationships. Demonstrates comfort in establishing and maintaining rapport with patients Beginning to perceive subtleties in patient/family dynamics and incorporate this insight into interactions with both. Provides accurate information/input regarding a patient's PT or OT needs to the health care team. 	<ul style="list-style-type: none"> Is open to other's values Is able to interact effectively with wide variety of patients/families, modifying own communication style as needed Increasingly aware of complex patient/family dynamics and impact on clinical impression. Recognizes importance of patient assuming responsibility for portions of own care. 	<ul style="list-style-type: none"> Respects other's values. Increasingly aware of complex patient/family dynamics and actively seeks to validate perceptions for purpose of factoring it into clinical impression. Recognizes importance of patient assuming responsibility for portions of own care and makes this a key component of intervention strategy. 	<ul style="list-style-type: none"> Respects other's values and suspends judgement Intuitively uses self in the therapeutic relationship as a means to enhance care. Effectively adjusts approach to patient/family communication, thereby maximizing rapport and facilitating open exchange of information. Empowers patients and family to take control of their wellbeing; employs focused patient/family education to that end
Interface with clinical decision making	<ul style="list-style-type: none"> Considers knowledge of patient and family when implementing standards of care. 	<ul style="list-style-type: none"> Effectively gathers pertinent, subjective data from patient/family to make clinical decisions. 	<ul style="list-style-type: none"> Efficiently gathers pertinent, subjective data from patient/family to make clinical decisions Clusters information to understand patient life roles, functional needs. This data drives examination, evaluation and intervention. 	<ul style="list-style-type: none"> Listens carefully to patients and uses them as a primary source of data Negotiates realistic goals and intervention plan based on patient's values.
Advocacy	<ul style="list-style-type: none"> Recognizes need for advocacy and brings individual patient needs to the interdisciplinary team. 	<ul style="list-style-type: none"> Recognizes common advocacy issues across patients. 	<ul style="list-style-type: none"> Recognizes common advocacy issues across patients and seeks assistance to organize and plan approach to achieve advocacy goals beyond the individual 	<ul style="list-style-type: none"> Sees advocacy as a key professional role of the PT/OT. Confidently approaches MD, other health professionals, third

Clinician/Patient Relationship The interpersonal engagement or relational connection between the clinician and the patient and/or family				
	Entry Level	Clinician Level	Advanced Clinician Level	Clinical Scholar
			patient <ul style="list-style-type: none"> Consistently voices and supports professional opinion even if it differs from other interdisciplinary team members. 	party payers, etc. to advocate for patient's needs <ul style="list-style-type: none"> Use knowledge gained with patients to advocate for issues of health/public policy. Consistently identifies patient and systemic needs across disciplines and advocates beyond discipline specific issues.
Cultural competence	<ul style="list-style-type: none"> Recognizes that cultural differences need to be considered in developing clinician-patient relationships. Focus is on identifying cultural norms. 	<ul style="list-style-type: none"> Identifies a variety of cultural factors that may impact treatment goals and outcomes 	<ul style="list-style-type: none"> Understands factors that impact developing rapport with patients of various cultural backgrounds, and considers those factors in developing treatment plan and projecting outcomes 	<ul style="list-style-type: none"> Effectively elicits cultural beliefs and values from patients and integrates these into overall patient management

Clinical Decision Making Understanding attained through formal and experiential learning				
	Entry Level	Clinician Level	Advanced Clinician Level	Clinical Scholar
Self-assessment	<ul style="list-style-type: none"> Developing accuracy in self-assessment within a limited scope of practice (e.g. diagnosis specific) 	<ul style="list-style-type: none"> Recognizes limitations in knowledge and skills. Employs active experimentation as a learning mode and reflection on results directs development of treatment skills. 	<ul style="list-style-type: none"> Accurately self-assesses across a range and complexity of diagnoses. Recognizes limitations in knowledge and skills, and developmental needs for gaining expertise in a more specialized aspect of care. Reflects on results of active experimentation issued as a method to develop treatment skills and achieve outcomes. Able to identify own developmental needs for gaining expertise in a more specialist aspect of care. Analyzes clinical decision making and identifies multiple sources of error. 	<ul style="list-style-type: none"> Continually critically evaluates own decision-making and judgments Accurately identifies boundaries of knowledge and skill and efficiently confers with referral source regarding patient needs Demonstrates exquisite foresight in anticipating own developmental needs, often developing skills outside PT area of specialization.

Clinical Decision Making Understanding attained through formal and experiential learning				
	Entry Level	Clinician Level	Advanced Clinician Level	Clinical Scholar
Clinical Reasoning: <ul style="list-style-type: none"> • Knowledge • Examination • Evaluation/dx • Prognosis • Intervention • Exercise prescription 	<ul style="list-style-type: none"> • Knowledge tends to be compartmentalized into diagnostic categories • Assessments reflect more short-range predictions vs. view of patient at end of episode of care. • Developing skills in prioritization of patient assessment/examination procedures 	<ul style="list-style-type: none"> • Demonstrates a solid knowledge base and framework for practice across a range of patient complexity. Sees diagnosis as a framework to initiate decisions about examination. • Assessments reflect the ability to integrate pathophysiology, co-morbidities and psychosocial issues. Clinical impression is made within the context of individual needs and goals • Clinician begins to predict outcomes across an episode of care. 	<ul style="list-style-type: none"> • Understands the range of variability within diagnosis and integrates data that does not “fit” into clinical decision making. • Clinician confidently and efficiently predicts outcomes beyond a single episode of care and considers the long-term needs of the patient. 	<ul style="list-style-type: none"> • Patient’s medical diagnosis serves to establish context in which examination data are gathered and evaluated, but does not drive the decision making process per se. • Accurately and efficiently clusters findings from multiple data sources and identifies meaningful patterns based on prior experience. • Patient care is outcome driven, with outcomes defined in terms of goals that have been established in conjunction with the patient and his/her identified needs.

Clinical Decision Making Understanding attained through formal and experiential learning				
	Entry Level	Clinician Level	Advanced Clinician Level	Clinical Scholar
Clinical Reasoning (contd)	<ul style="list-style-type: none"> Utilizes other staff as primary source of knowledge and to assist with clinical interpretation of new information Identifies relationship between impairments and function, but may tend to view functional training as an end in itself vs. one way to achieve impairment resolution Demonstrates beginning skills in weighing impact of co-morbidities/anticipated disease progression Recognizes scope of intervention strategies to include direct, compensatory, and consultation. Primarily uses direct intervention methods Consistently plans for patient needs, able to recognize when plan needs revision. Modification of plan is more likely the result of a reflective process than an automatic one. 	<ul style="list-style-type: none"> Takes initiative to identify learning needs and resources. Transfers skills and knowledge to a variety of patient care situations. Efficiently identifies and plans for patients' needs. Sees key impairments as related to functional problems and prioritizes goals and treatments accordingly. Utilizes varied manual techniques along with other methods of intervention to achieve outcomes Continually progresses patient based on ongoing re-assessment. 	<ul style="list-style-type: none"> Takes initiative to identify learning needs and resources. Follows through and shares information with peers in a timely manner. Transfers skills and knowledge confidently into unfamiliar situations and efficiently identifies new learning needs. Efficiently identifies and plans for patients' needs, including patients who will not benefit from PT/OT Anticipates individual variation in patient response and has a variety of options and resources to meet patient needs. Efficiently clusters information from a variety of sources. More selective and efficient utilization of manual techniques, along with other methods of intervention to maximize outcomes given increased managed care pressures. Demonstrates clinically sound risk-taking 	<ul style="list-style-type: none"> Selectively designs and implements exercise program that focuses on most critical issues to be addressed. Recognizes the relative relevance of data from many sources and relies on minimum data set necessary to form decisions. Recognizes when further tests and measures will not add value to the clinical decision making process. Identifies when findings do not fit together and one's PT or OT tools cannot validate the suspected cause of patient's problem. Confidently approaches MD or other health professionals to advocate for patient's needs.

Clinical Decision Making Understanding attained through formal and experiential learning				
	Entry Level	Clinician Level	Advanced Clinician Level	Clinical Scholar
Clinical Reasoning (contd)	<ul style="list-style-type: none"> Provides broad-based treatment approach that includes all patient identified problems that relate to functional limitations. 	<ul style="list-style-type: none"> Treatment approach reflects prioritized problems. Seeks guidance to integrate specific pathophysiology and surgical intervention into the development of exercise programs 	<ul style="list-style-type: none"> Treatment approach is selective and prioritizes problems. Selectively utilizes functional activities to achieve desired outcomes. Specifically integrates pathophysiology and surgical intervention into development of exercise programs. 	<ul style="list-style-type: none"> Highly selective and efficient in the use of manual techniques in combination with other methods of intervention to achieve predicted outcomes given managed care pressures. Demonstrates thorough and consistent foresight in anticipating patients' developmental needs.
Evidence-based practice	<ul style="list-style-type: none"> Recognizes research as the basis of practice Seeks broad-based information, which is diagnosis driven. 	<ul style="list-style-type: none"> Utilizes resources and seeks appropriate assistance to validate research information for sound, clinical decision making. 	<ul style="list-style-type: none"> Through the readings of scientific literature is able to identify current issues and trends in practice Evidence drawn from the literature is actively pursued to support clinical practice. Incorporates research findings into clinical practice. 	<ul style="list-style-type: none"> Articulates theoretical foundation for practice and uses available evidence from a variety of sources to inform clinical decision making Identifies gaps in the available evidence base for practice and helps to bring into focus the research questions critical to moving practice forward.
Accountability and responsibility	<ul style="list-style-type: none"> Recognizes the responsibility and accountability for his/her own clinical practice in relationship to the immediate needs of the patient Sees lack of patient progress as immediately implicating own skills and abilities as less than adequate. Recognizes the need to prioritize and organize care 	<ul style="list-style-type: none"> Assumes responsibility for communicating with and educating other team members, as needed, to facilitate integration of patient's PT and OT needs into current plan of care (including d/c plan). 	<ul style="list-style-type: none"> Able to let go of need to "make every patient better" having learned to share responsibility for care with patient. Life experience and knowledge gained outside of the professional work environment adds to the skill in managing patient care needs. Demonstrates involvement in activities that contribute to the improvement of the unit/department/profession. 	<ul style="list-style-type: none"> Experiences a sense of accountability for patient progress toward goals if not progressing as anticipated asks self "what have I not figured out?" Demonstrates leadership in activities that contribute to the advancement of the unit/department/profession. Demonstrates exquisite foresight in anticipating and pursuing patient's developing needs across entire episode of care.

Clinical Decision Making Understanding attained through formal and experiential learning				
	Entry Level	Clinician Level	Advanced Clinician Level	Clinical Scholar
Education/ Consultation <ul style="list-style-type: none"> Patient/Family Student Consultation 	<ul style="list-style-type: none"> Consistently incorporates patient/family education into treatment plans. Participates in community education. Participates in clinical education program with observational/part-time clinical experiences. Demonstrates basic knowledge of the teaching-learning process. Educates team about professional role 	<ul style="list-style-type: none"> Adapts patient /family education plan based on individual needs. Participates/ assists in the planning of community education Participates in clinical education program with entry-level students and interns. Develops clear objectives and plans student learning activities. Provides feedback of student performance. Consults with other health care team members regarding patient needs for services. 	<ul style="list-style-type: none"> Efficiently adapts patient/family education plan based on individual needs. Participates in clinical education program with all levels of students. Works with individuals that are involved in transitional degree and residency programs. In conjunction with the student, individualizes goals/learning activities. Evaluates student performance against clear standards and communicates strengths/developmental needs to participants. Consults with less experienced staff and peers to maximize patient outcomes. 	<ul style="list-style-type: none"> In consultation with the patient, develops a specific education plan which allows patient to have maximal control Educates PT's/OT's and other disciplines beyond the facility via publications /presentations Works efficiently and effectively with all students/staff on educational and professional development issues. Efficiently/effectively identifies student/staff learning needs and knowledge gaps. Assists in development of learning goals/plans to facilitate development of clinical skills. Achieves credibility; consultation is sought by peers and members of the health care team in planning patient care. Identifies and utilizes appropriate resources to provide outcome-focused consultation. Recognizes common characteristics within specific diagnostic groups and is effective in influencing the development of disease specific management (e.g. pathway development.)

Collaboration/Teamwork Collective work for the good of the patient and family, built on communication of clinical and Ethical understandings between healthcare providers				
	Entry Level	Clinician Level	Advanced Clinical Level	Clinical Scholar
<ul style="list-style-type: none"> Interdisciplinary team 	<ul style="list-style-type: none"> Demonstrates comfort in role as a team member and is developing awareness of professional boundaries. Seeks and values collaborative relationships with other disciplines to enhance patient management Developing skills in negotiation/ managing conflicts in roles Peer development focuses on learning needs of individual peers 	<ul style="list-style-type: none"> Educates team members, as needed, to facilitate integration of patient's PT and OT needs into plan of care 	<ul style="list-style-type: none"> Instills confidence in colleagues Recognizes the need for consultation and institutes referrals that will result in mobilization of resources to meet patient and family needs. Consistently demonstrates the flexibility and ability to accommodate the needs of the service and the patient on a daily basis. 	<ul style="list-style-type: none"> Effective in alerting team to needs of patient that may extend beyond scope of one's clinical practice . Skillfully negotiates conflict to promote collaboration Implements unique and innovative approaches to meeting developmental needs of self and others Views team education as central part of role and integrates into daily routines.
Support Personnel	<ul style="list-style-type: none"> Utilizes a variety of support staff to assist with achievement of patient goals 	<ul style="list-style-type: none"> Assimilates pertinent data, communicates to selected team members and delegates appropriately to achieve desired outcomes. 	<ul style="list-style-type: none"> Efficiently assimilates pertinent data, communicates to selected team members and delegates appropriately to achieve desired outcomes and maximize ability to manage entire caseload. 	<ul style="list-style-type: none"> Clearly defines own role and that of various support personnel and is able to accurately and efficiently match a patient's needs to appropriate support resources to achieve optimal outcomes.
System	<ul style="list-style-type: none"> Contributes to the effective operation of the his/her department Identifies the value of operations improvement activities. 	<ul style="list-style-type: none"> Identifies problems related to practice and/or systems. 	<ul style="list-style-type: none"> Identifies systems or practice issues and potential solutions as part of professional role. Actively participates in operations improvement activities 	<ul style="list-style-type: none"> Challenges and shapes the system to maximize the benefits for patient care. Peer development focuses on elevating the standard of practice as a whole. Leads/coordinates operations improvement activities impacting his/her work area and/or patient population

Movement				
	Entry Level	Clinical Level	Advanced Clinician Level	Clinical Scholar
Motor coordination and skill <ul style="list-style-type: none"> • Palpate • Facilitate vs. inhibit movement 	<ul style="list-style-type: none"> • Developing skills in being able to facilitate desired movement pattern while assisting patients with functional activities • Developing skills of palpation as tools of clinical practice. 	<ul style="list-style-type: none"> • Skills of palpation, observation and guidance play an important role in decision making and are effectively incorporated into clinical practice. • Selects hands-on techniques for the purpose of examination and/or achieving desired patient outcomes 	<ul style="list-style-type: none"> • Efficiently selects and adapts skills of palpation, observation and guidance based on previous experience. 	<ul style="list-style-type: none"> • Employs highly refined skills of palpation, observation and guidance of movement as tools of clinical practice. • Uses hands-on techniques selectively and in a manner that supports rather than detracts from the primary focus, that of understanding the patient's problem.
Analyze movement and respond <ul style="list-style-type: none"> • Judgment • Planned vs. automatic responses 	<ul style="list-style-type: none"> • Developing skill in analyzing movement and identifying normal vs. abnormal movement patterns. • Effectively plans for and applies hands-on techniques. • Recognizes need to modify planned intervention, but specific action may require reflective rather than automatic process. 	<ul style="list-style-type: none"> • Demonstrates skill in identifying key components of movement related to impaired functional performance. Seeks guidance for complex patients. 	<ul style="list-style-type: none"> • Anticipates key components of movement related to improving functional performance. • Demonstrates ability to automatically adjust hand placements to achieve desired patient response 	<ul style="list-style-type: none"> • Analysis of movement is used as a guide to patient care (i.e. linking the movement that is observed or felt to an intrinsic sense of what is "normal" and determining how it relates to the patient's ability to function). • Is able to finely adjust hands-on techniques to meet the needs of individual patient care situations.

APPENDIX C

Participant Narratives

Clinical Narrative for Advanced Clinician

Submitted by: Geoff (pseudonyms used throughout text)

Judge Callahan is a 65 year old judge in the city court system who is married with two grown boys each with families. He enjoys running, yoga, biking and hiking. I met him in January as he was referred to physical therapy for left knee patellar tendonitis. Patellar tendonitis is typically manifested by anterior knee pain during weight bearing activities such as running and jumping, and in severe cases walking. I was surprised to see that he was using a wheelchair and crutches which, based on my previous experience, didn't fit with my framework for patellar tendonitis. During the interview I asked what I could do for him and he replied that he was here for left knee patellar tendonitis. He first noticed left knee and thigh pain in April after a hiking trip in Australia, causing problems standing up and rolling in bed. A physician suggested he work with a personal trainer for exercise. Without improvement, he was referred to an orthopedist, was diagnosed with patellar tendonitis and referred to physical therapy. When I questioned him about needing a wheel chair and crutches, he replied that they help him get around due to recent onset of right leg pain, but that he was referred to PT for his left knee. Despite Judge C's focus on the left knee, I was also concerned about his limited function and use of assistive devices, and knew I would have to prioritize my examination to better understand how to meet his functional needs.

Judge Callahan reported he experienced right leg pain with standing and walking. It began after relying on his right leg to stand up in order to compensate for the left knee pain. Given his symptoms of right leg pain with weight bearing, I suspected a hip or spine problem and wanted to focus the examination. This seemed to

be a much more limiting and urgent functional problem. In a rigid tone, he stressed that he had been referred to physical therapy for treatment of his left knee problem. I understood that it was important for Judge C to follow the doctor's orders for PT for his knee problem, despite the fact there was a more limiting issue with his right leg. It seemed to me that he valued a system of hierarchical authority and rules, which could present a barrier to evaluation and treatment of his more limiting problem. I was concerned that if I continued to focus on his right leg, it could negatively impact his confidence in me and our relationship, ultimately jeopardizing his outcome. I initially focused our conversation back to his left knee, restating my understanding of how his original problem with the left knee began and how it limited him. The conversation naturally progressed to the onset of his right leg pain, giving me better insight into his functional issues that would ultimately drive my examination. Without judgment, I listened to how his pain limited him, and empathized with how difficult it must be to have pain walking only short distances impacting most aspects of his life. I did not want to alienate Judge C, and recognizing his need to participate in his care, I agreed that it was important for us to evaluate and treat his complaint for which he was referred. Given the limitation in his right leg, however, I let him know that we could evaluate both problems in order to provide insight to his doctor. By respecting his values and taking the time to develop a relationship geared towards a meaningful outcome to Judge C, he agreed to evaluation of both problems prioritizing the right leg.

My examination revealed impaired lumbar alignment and very restricted lumbar range of motion that reproduced his right leg pain with right side bending and backward bending. His left hip range of motion was limited in flexion, internal and external

rotation, and reproduced the discomfort in his thigh, while examination of the left knee was normal. I assessed his function with rolling in bed, sit to stand and walking, and found poor body mechanics and movement that contributed to increased compression in his lumbar spine. I felt that his right leg pain was a result of nerve compression in his lumbar spine and very likely aggravated by the way I saw him compensate for his left thigh and knee pain. His left knee/thigh pain seemed to be referred from the hip. Judge C appeared to have considerable stiffness in a pattern that suggested osteoarthritis of the hip, which can often refer pain to the thigh and knee. I shared my findings with Judge C including my suspicions about his lumbar spine, as well as my findings that were related to his ongoing left knee pain. I educated Judge C with more efficient and effective body mechanics to prevent further irritation in his lumbar spine, as well as how to prevent irritation to his left thigh and knee. Given his new complaint, I communicated my findings to the nurse practitioner in Sports Medicine. She was receptive to my input, and agreed that referral to a physiatrist may help clarify his symptoms of lumbar radiculopathy. Prior to his consultation with the physiatrist, I wrote a letter identifying Judge C's problems and our concerns. Physiatry confirmed the diagnosis of lumbar radiculopathy with MRI revealing severe degenerative spondylosis in his lumbar spine with moderate nerve root compression, and physical therapy was recommended.

We directed treatment towards alleviating his right leg pain as this was the more limiting problem. Knowing that his right leg pain was a result of compression on a nerve root in his lumbar spine while weight bearing, treatment was focused on traction

to the lumbar spine, hip flexor stretching and hip joint mobilization. The literature often sites hypomobility of the hips as a contributor to abnormal compressive loading in the lumbar spine, which then contributes to degenerative changes over time. These interventions helped to reduce compressive forces, alleviating the discomfort in his right leg. Over the course of several weeks, the right leg pain completely resolved and his function with walking returned to normal. Concurrently, I suggested alternative movement strategies that would limit the stress to both of his problems, and we shifted the focus to his primary complaint. I felt that his left thigh and knee pain during transitional movements was related to left hip osteoarthritis referring pain down the leg. Plain imaging revealed severe OA in his left hip, passive range of motion to his hip reproduced his thigh and knee pain, and as mentioned previously, physical testing at the knee was normal. Observing his gait, I noticed that he limited the weight on his left leg, shifted his weight to the left during stance on that side, and had a shorter stride on the left. These are common findings with restricted hip motion and/or pain when standing on that limb. The physiatrist also felt his hip could be a source of his left thigh and knee pain, and administered a cortisone injection into the hip, which completely resolved the leg pain for 2-3 days. I was confident in my assessment based on examination, radiographic findings and information from the physiatrist. Judge C, however, held firmly to the initial diagnosis of patellar tendonitis.

Educating Judge Callahan with a better method for sit to stand allowed him to transition to standing without pain, but he continued to complain of left knee pain with rolling in bed. Manual therapy has been compared to exercise in the treatment of hip

OA in a randomized controlled trial, which concluded that manual therapy resulted in better outcomes than with exercise alone. I performed manual distraction and hip joint mobilization to decrease pain and increase range of motion, and developed a general lower extremity exercise program with emphasis on improving his stride and weight transfer during gait. During the treatment, his ROM would increase and become less painful, but this did not carry over into his ability to sleep through the night. Despite changes in his strength and flexibility, and his improved function with standing, his left leg pain at night persisted, a common problem with OA of the hip. While he was fairly functional with pain free ambulation, given the degenerative changes in his spine and hip, I anticipated that he may someday be a candidate for hip surgery. I felt that given his lack of progress, he should see an orthopedist to discuss options related to hip arthritis and with possible replacement in mind.

Judge Callahan continued to focus on the diagnosis of patellar tendonitis, and I verbally walked through my thought process together with use of visual aides to emphasize my point. His response was “I know that’s what you think, we’ll see what the doctor thinks when he sees me.” I was concerned that Judge C might continue to transition through the system with a diagnosis of knee pain and be told to continue with PT versus getting the most appropriate treatment for his problem. I felt that a positive experience and ultimate outcome for Judge C would require coordination and interdisciplinary communication. Despite being confident in my assessment, I was apprehensive to confront the orthopedist given that I was challenging the diagnosis. I was unsure how receptive he would be, and was nervous about being wrong or creating conflict with the surgeon. Regardless, I spoke with the nurse practitioner and finally

with the orthopedist about my findings. Based on my presentation of the patients' course to date, the orthopedist agreed that it seemed suspicious for a hip problem. Eventually, to rule out the knee as a source of pain, Judge C was given a cortisone injection into the knee which failed to alleviate his symptoms. He was referred to the arthroplasty service and was told that a total joint replacement was indeed indicated based on imaging and exam, but that ultimately it was up to him when he is ready.

Judge C asked me if he could return to running. I felt that due to the repetitive impact to his hip and lumbar spine, running might not be a suitable form of exercise. I wanted to suggest alternatives that would minimize the wear to his hip and postpone the need for surgery. In the past I have assumed incorrect intentions for exercise, and found the best way to suggest an alternative is to truly understand my patients' motivations. I had one particular experience in which I needed to suggest an alternative exercise for a patient due to physiological and pathologic limitations. In an attempt to demonstrate that I had her best interests in mind, I assumed she was doing a certain activity for health and wellness, and she could achieve that with an alternative. This negatively impacted our rapport as her motivation was for the personal accomplishment to complete the task versus health and wellness. I understood that he may take pride in his ability to remain active and felt that part of his identity and culture was as an active male who enjoys exercise. I asked Judge C what drove him to run, to which he explained that it was to stay active and healthy, but that he had no particular love to run. I suggested swimming and biking as alternatives to running and other high impact activities. He was receptive to my suggestions. Encouraging him to continue exercise

and respecting his desire to be active enabled him to hear my suggestion for alternative exercises without defensiveness with the prospect of limiting exercise altogether.

Judge Callahan's pain at night persists, but he continues to practice good body mechanics with rising to stand, is able to walk and work without pain. He is satisfied with his ability to participate in low impact aerobic exercise, and his knowledge of his own physical limitations enables him to confidently enjoy his life. Having an agreed upon diagnosis, even without treatment other than self management enables many patients to accept and cope with a particular limitation. Along with the direct physical therapy interventions, the art of listening and communication are invaluable tools that I continue to develop throughout my practice. Had I treated Judge C's patellar tendonitis, I believe that he would have had a different outcome. I worked hard to understand the patient, and my communication helped engage his participation in treatment. I realize that successful intervention may require respect and understanding of my patients' values and beliefs that may otherwise present a barrier. Speaking out when my opinion differed from the team was daunting, and while it led to a positive outcome, I know that every case may not go as well. Never the less, each time I advocate for a patient or present a conflicting opinion, it gets easier, particularly when I know that my motivations are about doing what's best for the patient.

Clinical Narrative for Clinician Level

Submitted by: Joel (pseudonyms used throughout text)

My name is Joel and I am currently in Clinical Practice as a staff Physical Therapist at the NMC Berwick Healthcare Center. My primary patient population is general orthopedic with an emphasis on the shoulder as I spend four hours per week staffing a clinic for the shoulder service, treating complex shoulder patients. This narrative is intended to demonstrate the advancement of my practice to that of a “Clinician” as described by the Clinical Recognition Program. The case which I will present challenged my ability to manage a patient with multi-system and psychosocial involvement which impacted the patient’s rehabilitation.

The patient is a fifty-three year old, Chinese woman, Mrs. Cheung, who was referred to Physical Therapy by her primary care physician for treatment of her low back and bilateral radicular leg pain. Review of the patient’s medical record also was significant for advancing, recent onset Parkinson’s disease, a diagnosis that Mrs. Cheung was reluctant to accept based on her neurology notes. Mrs. Cheung had lumbar images in the system demonstrating multiple levels of disc herniations for which she had a series of epidural injections with only temporary pain relief.

Mrs. Cheung presented with parkinsonian symptoms which were more advanced than I expected and were evident when her significant other, Mr. Wong, brought her into the treatment area in a wheelchair and assisted her at a contact guard level to the chair. The patient exhibited significant bradykinesia when asked to transfer from the wheelchair to the chair and also had a festinating gait that was evident in those

few steps. As Mrs. Cheung transferred and took a few small steps it was clear that her postural extensors had been affected as she stood in an increased thoracic kyphosis and posterior pelvic tilt. I was immediately able to recognize the patient's movement pattern from a prior clinical experience I had in which I developed a movement disorders clinic for patients with Parkinson's disease at New England Rehabilitation Hospital. I was able to draw on this experience to recognize that this patient evaluation was going to be very different than my typical lumbar spine evaluation and was going to have to be functionally based to gain an appreciation for her movement patterns and how this affects her pain

The subjective portion of the evaluation was interesting to me in that Mrs. Cheung downplayed her Parkinson's disease and blamed her movement patterns on her lumbar spine condition which began five years earlier as a result of a car accident. It also seemed that when she had movement difficulty related to her Parkinson's disease she again would describe pain as the reason she was unable to stand or walk. Another interesting observation was Mrs. Cheung's interaction with Mr. Wong, who did not allow Mrs. Cheung to remove her own coat and assisted her excessively from sit to stand. This made me wonder about Mrs. Cheung's independence in the home and psychosocial factors that may influence her daily function as it seemed that Mr. Wong was assisting her more than necessary and showing what appeared to be little patience with her bradykinesia.

Mrs. Cheung reported that her day primarily consisted of sitting, watching television for greater than two hours at a time, and only leaving this position to use the bathroom or go to the kitchen. Mrs. Cheung reported that as she sat longer her pain

levels would reach 9-10/10 in her low back and bilateral legs which was relieved by lying down and slightly by standing. Mrs. Cheungs sitting posture was clearly a contributor to her pain as she was in a significant posterior pelvic tilt, indicating to me that assessment of this pelvic position would be necessary to determine if this was a fixed deformity or if with assistance she could reverse this pelvic position.

Following the subjective portion of the evaluation I wanted to assess Mrs. Cheung's functional status and had her perform sit to stand, which she was able to do independently, however she required 5-10 seconds prior to onset of her movement. Then while in sitting I had Mrs. Cheung attempt to neutralize her spine position which she was unable to do actively, so I manually assisted her at her lumbar spine and chest to a more neutral position. I was pleased Mrs. Cheung's spine position was not fixed, however she was unable to actively maintain the position which we had achieved. I next assessed her's ability to perform bed mobility, for which she required minimum assistance for her lower extremities and also to scoot in bed. Mrs. Cheung's gait was also assessed and she required handheld assist and exhibited multiple freezing episodes.

The evaluation was a challenge for me in that I had to adapt my plan in the moment when it was clear that impairment based tests and measures, as I would normally perform on a low back patient, were not indicated due to the degree of her functional deficits. My primary objective became assuring Mrs. Cheung's safety and gaining an understanding of how advanced her Parkinson's was, and how this impacted her posture and movement patterns. During the evaluation I was able to modify lumbar AROM testing to determine that extension of the lumbar spine caused her decreased back and leg pain. From my clinical and didactic knowledge I understand that some

patients with lumbar disc dysfunction have centralization of their symptoms with extension based exercises. This finding proved to be important in developing a trunk extension based treatment plan to not only allow Mrs. Cheung decreased back/leg pain, but also help to stop progression of her Parkinson's related postural muscle weakness.

The patient evaluation was not the only challenge for me, but the treatment sessions required a level of creativity that was different than my typical orthopedic population. To assist Mrs. Cheung's postural extension we experimented with wedges in sitting and small exercise balls behind her lumbar spine to promote increased lumbar lordosis. We also split many sessions between postural extension exercise and movement related exercise to help her decrease her freezing episodes and better manage them when they occur. We used a metronome program found on the internet to march and walk to, and counting out loud helped Mrs. Cheung to overcome episodes of bradykinesia.

Another important aspect of my treatment of this patient was education and rapport building. Mrs. Cheung's lifestyle was potentially a cause for her rapid decline in function since her Parkinson's diagnosis was established. She presented to me performing no exercise and sitting in front of the television most of the day. The interaction of this patient with her significant other also made it clear that she was doing little for her self in the home. I spent a lot of time in early sessions explaining how exercise could benefit her pain and Parkinson's disease, being sure to describe which symptoms were results of each problem since she was reluctant to admit Parkinson's as a cause for her movement dysfunction. I also discussed with Mrs.

Cheung and Mr. Wong the importance of patience and allowing Mrs. Cheung to perform tasks independently, only assisting if necessary.

An aspect of this case which I found to be very important and personally rewarding was the rapport I was able to build with Mrs. Cheung. Her doctor's notes in LMR painted a picture of a depressed individual who was fixated on her pain and interacted little with members of her healthcare team at her visits. After a few sessions with Mrs. Cheung she expressed her appreciation for my education and attentiveness to her needs and goals. Despite the "masked" face she exhibited, during each session she began to smile and interact more, consistently telling me how much she enjoyed coming to therapy.

Mrs. Cheung was seen initially twice per week and then the frequency was slowly decreased to once every two weeks to promote independent home exercise as her condition unfortunately is progressive and would require self-management. Mrs. Cheung did remarkably well, initially requiring handheld assist to walk, min assist to transfer, and tolerating only seated exercises. On Mrs. Cheung's last day of therapy she walked independently from the waiting room to treatment room with no freezing episodes and with much improved posture. She also was able to independently perform sit to supine and demonstrated good performance of her home exercises. Mrs. Cheung also reported to me that on her own she decided to travel to work with Mr. Wong to practice walking at his office where there was a long hallway with places to rest and she had been doing this a few times per week. Mrs. Cheung was also provided with information regarding Parkinson's exercise videos she could order to give her exercise options other than what we had discussed. Most importantly, she reported her pain on

that last day as a 5/10 in her low back/legs, much improved from the 10/10 she reported on evaluation.

This patient interaction taught me a lot about being flexible and creative in both evaluation and treatment of patients with significant functional deficits. This particular patient had co-morbidities requiring an alteration in my typical framework for a lumbar spine evaluation, from one that is impairment based to functionally driven. I think that this experience has promoted me to look more critically at Mrs. Cheung's functional movement patterns even in patients who present as independent, but have pain with functional tasks as this can be very useful in treatment. Mrs. Cheung also had an interesting psychosocial situation which was causing her to not accept her diagnosis and lose her independence. Lastly, this patient helped me to really understand how important a patient's co-morbidities can be and that in order to truly help our patients we must see the whole person and not limit ourselves to treating what is written on the patient's prescription. As a result of my experiences with this patient I believe that I have become a better therapist and will be more confident in my ability to manage patients with multi-system involvement and psychosocial barriers in the future.

Clinical Narrative for Advanced Clinician Level

Submitted by: Kelsey (pseudonyms used throughout text)

When I reviewed Mr. Gleeson's chart, it was clear to me that this was an individual who had been through a lot in the couple of months before I met him, including during the month he had been at NMC. During my first meeting with Mr. Gleeson, I encountered a very weak and deconditioned patient. My conversations with the nurses who were more familiar with him confirmed this assessment. After this meeting, I reflected on Mr. G's current functional abilities, and used what I know regarding rehabilitation outcomes to prognosticate his rehabilitation potential and functional recovery. Considering a multitude of factors, I anticipated a relatively long road ahead for Mr. Gleeson, predicting 4-5months before he would be sufficiently independent to return home.

Unfortunately, and rather unexpectedly, this estimate turned out to be quite inaccurate. 10 months later, Mr. Gleeson was still my patient at NMC, having never left the hospital. His medical course resulted in multiple transfers in and out of the ICU. He remained very medically complex and ultimately required a tracheostomy while necessitating extended periods of mechanical ventilatory support. Mr. G's case presented many unique challenges for me on several levels throughout his stay.

Mr. Gleeson tested my clinical and technical skills as a therapist, forcing me to frequently think "outside of the box" and utilize my problem-solving skills. He came to NMC with a large, painful sacral decubitus ulcer that left him unable to tolerate sitting in a chair or the act of transferring to a chair. During the course of his admission, I tried multiple different seating systems with pressure-relieving cushions with the

patient, utilizing a range of transfer techniques. These approaches included resourcing with the nursing leadership of other units to borrow equipment (specialized recliner chairs, an Airpal transfer device, etc). Many of these techniques were not successful due to pain, in which case other strategies were attempted. However despite these efforts, for much of his stay, Mr. Gleeson remained unable to tolerate sitting in a chair, in the setting of severe anxiety and pain. In order to minimize deconditioning and promote pulmonary hygiene, while also facilitating the patient's tolerance for upright sitting, I did not want to abandon sitting altogether. Thus, as an acceptable substitute, I developed a schedule of progressive, repetitive edge of bed sitting, with both myself and nursing staff having roles. This ensured Mr. G sat for intervals 3-5 times per day on a surface that he could tolerate with acceptable levels of pain.

Because of Mr. Gleeson's complex hospital course and marked generalized weakness, he lacked the strength to weight-bear through his legs for a significant portion of his admission. During this time, multiple mechanical devices were utilized to facilitate lower extremity weight-bearing including the tilt-table, the Lite Gait, and the ceiling lift with a standing harness. These devices were selected based in part on the patient's location (ICU versus step-down unit) and what equipment Mr. G had access to, as well as varied patient preference and comfort. With these devices included in his regimen (as well as extensive exercises and sheer patient determination), Mr. G ultimately made tremendous progress. He transformed from a patient who could not support his sitting balance or bear any weight through his legs, to one who was standing and walking more than 150ft with a walker.

Pain and anxiety were also large factors during sessions with Mr. Gleeson that necessitated frequent creative problem-solving and management. At various points during his admission, TENS, ice, massage, and compression wrapping were all utilized during physical therapy sessions for pain control. These all showed some positive effects in reducing pain and allowing the patient to participate in greater activity. In addition to generalized anxiety, Mr. G expressed a significant lack of trust regarding less familiar caregivers (nurses and therapists), and this greatly impacted his ability to participate in therapeutic activities with such caregivers. In response to this, his treatment frequency was adjusted as needed when a new mobility task was introduced to allow him to complete it more frequently with this therapist as he was adapting to the task. In addition, other caregivers (nurses, therapists) were periodically brought into the room during our sessions to promote the patient's ultimate confidence in their abilities. This was a technique that did facilitate Mr. G's ability to expand his trust with mobilization to other caregivers.

Beyond clinical problem-solving, communication, collaboration, and advocacy were very important in Mr. Gleeson's case. As noted, Mr. G had poor pain control that was evident from the early days of our relationship. I communicated this directly to the medical team. Unfortunately, because of his tenuous medical status, the medical team felt it was too risky to prescribe the patient pain medication. Over the coming sessions, it became more and more clear that alternative strategies that I was utilizing for controlling Mr. Gleeson's pain with mobility were not adequate as stand-alone interventions, and thus his mobility was being negatively impacted by his poor pain

control. I continued to advocate to the team the need for greater pain control, suggesting additional input from such specialties as pain management and physiatry.

Similarly, Mr. Gleeson expressed anxiety regarding his respiratory status, pain, and potential for falling, in addition to his lack of trust in caregivers. While progressing his physical therapy was clearly a top priority, Mr. Gleeson's anxiety was paralyzing to him at times, creating a significant barrier. I used my own skills (manual and verbal) to try to address these issues with him to the best of my ability. However, realizing that I was not an expert in psychological conditions, I encouraged the team to pursue a psychiatry consult for Mr. G. The patient's medical team was initially reluctant to obtain pain management and psychiatry consults, however I continued to advocate for this given the significant impact these issues were having on therapy. I suggested the support of a psychiatric clinical nurse specialist as an alternative. I subsequently contacted the psychiatric CNS in conjunction with Mr. G's nurse to arrange for her to observe a therapy session. I wanted to gain practical insight as to how I might handle Mr. G's anxiety differently to maximize his ability to participate in a session. She was able to offer some successful strategies for me to implement, and began working with the patient one-on-one. Ultimately, formal consultations in both pain management and psychiatry were obtained.

Over the nearly one year I was involved in his care, I came to know Mr. Gleeson and his family quite well. Having such knowledge of the patient's behaviors, and patterns in therapy enabled me to become a stronger advocate for him than I otherwise would have been. For example, a few isolated members of Mr. Gleeson's team had begun to express frustration in his limited progress early on, and took a very

assertive approach with Mr. G in an attempt to facilitate his recovery. After observing the patient's negative response to such interactions, and discussing this with the psychiatric CNS, I became a vocal advocate that such an approach not be used with this particular patient (the team ultimately concurred). As an alternative, I worked with the psychiatric CNS and Mr. Gleeson's primary nurse to establish suggestions for interacting with the patient that were adopted by the team.

Because of Mr. Gleeson's limited mobility, as well as his expressed anxiety, close collaboration with nursing staff was paramount in his care. I established a regular therapy time, and in coordination with nursing staff, ensured that other interventions (such as hemodialysis) were coordinated around his therapy. I developed a daily activity schedule for the patient, and formulated recommendations for assisting the patient with mobility, posting this information in a separate location in his bedside chart. Any change in Mr. Gleeson's status, or observations of decreased participation or a decline in his mobility were reported back to me. I would then meet with the patient to address the underlying issue. The nursing interest in these recommendations and follow-through was remarkable, and the excellent nursing care and collaboration certainly contributed significantly to Mr. Gleeson's recovery.

Mr. Gleeson proved to be a very challenging and rewarding patient for me. Many of the "standard" approaches I initially took with him had to be adjusted significantly given confounding issues, necessitating a greater level of creativity and trial and error. In reflection, I clearly handled Mr. G's case differently than I would have earlier in my career. I was more confident and vocal in my communication and advocacy for this patient. I thought "outside the box" more with respect to problem-

solving strategies, while also upholding my respect for the patient's ability to make decisions in his care, and to feel respected throughout. I utilized additional resources including my PT clinical specialist, as well as outside consultants throughout the case to maximize the care I was able to provide. Because of the complexity of Mr. Gleeson's case and the length of his admission, all of his representative caregivers needed to take prominent roles in his care. Through a combination of all of our efforts, including most importantly Mr. Gleeson's, the patient had made tremendous progress by the time of his discharge, and was on the path to returning home.

Clinical Narrative for Advanced Clinician Level

Submitted by: Maureen (pseudonyms used throughout text)

Sam is a 14 y.o. boy with cystic fibrosis (CF) admitted to NMC from his doctor's office with complaints of worsening cough, shortness of breath (SOB) and fevers for 2 weeks. Sam's Mom is a single parent, and also has older twin boys with CF. I met Sam on day of his admission, and was consulted to evaluate and assist with airway clearance. I have treated many adults and children with CF, however, this admission would present a significant challenge for the family and the healthcare providers involved.

During my chart review I became alarmed at the decrease in his PFTs (Pulmonary function tests) since last taken 6 months ago. Sam had lost a significant amount of weight, had not grown resulting in him completely falling off the growth chart. My chart review also included reading the doctors', social work, nursing and dietary notes commenting on their grave concerns about Sam's health and the amount of doctor's visits that were cancelled. For this reason, a 51A for medical neglect was filed with the Department of Social Services. Mom was aware, and the medical team and social worker stressed that this was to get Mom some help, as she has 3 very sick boys that she is caring for. This greatly impacted Sam's admission as well as my interactions with Sam and Mom.

I went in to evaluate Sam, and he was sitting on his bed, watching TV and texting on his phone, and Mom was also watching TV. I introduced myself to Sam and his Mom and Sam instantly stated that he could not do PT, he was too tired and had stomach pains, all without ever making eye contact. Mom started asking me about a

machine called “The total gym” that she bought and asked if this would be helpful. I knew as a teenager, that he had to be miserable being admitted to the hospital, especially unexpectedly. In my experience the parents are usually the ones that assist with compliance at home. I started talking to Mom and Sam about what his normal regiment is for airway clearance. Sam simply stated “chest PT.” Mom elaborated that usually someone comes to the house, but that the boys are sometimes not there. As the conversation progressed, I gathered more data, and gained insight into Mom’s beliefs. She stated that Sam is sick, and that he will not have quantity of life, but that she wants him to have quality of life, and not feel that he is sick. Mom stated also, that if Sam turns off his tube feed at night, so he doesn’t feel full in the morning she can’t make him turn it on, or make him take his medications after she reminds him and started becoming defensive. I explained my role was to assist Sam in being able to do those activities he loves without becoming so short of breathe, and help him feel better. At this point Mom and Sam agreed to let me evaluate him, and I discovered multiple cardiovascular and musculoskeletal impairments. Sam presented with abnormal lung sounds, increased resting respiratory rate with low oxygen saturations. He had impaired posture, poor muscle strength. Due to his nutritional status, he had very poor muscle definition, and I knew from reading the literature that patients with CF can also develop osteopenia. My evaluation included obtaining his goals. When I asked him, he looked at me, and asked if I was serious. When he realized I was, he said to be on the freshman baseball team. I said that if we work as a team, that can be one of our goals, but he did not appear to believe me during our first meeting.

Sam was planned to be at NMC for at least 2 weeks of IV antibiotics to assist with the infections in his lungs. Due to the severity of his impairments, I set up a plan of care, which included PT BID for airway clearance, and wanted to add aerobic conditioning as soon as Sam could tolerate it. Aerobic conditioning is an excellent mode of airway clearance, and I anticipated that Sam's aerobic capacity was impaired. I discussed the plan of care that included his goal of being on the baseball team, with Sam and Mom, and they were in agreement.

Sam portrayed a very tough exterior, but throughout the course of our treatments, he was able to trust me and open up a lot. I learned that although, he is the youngest, he takes the responsibility for the family and worries a lot about being a burden to his Mom. I also had many conversations with Mom in terms of education around importance of airway clearance for Sam. Mom's interpretation continued to be that too many medical interventions would make Sam feel that he was sick, and she wanted to focus on quality of life. I tried to convey that if Sam was more compliant with his airway clearance and tube-feedings he would feel better, and stay out of the hospital longer, resulting in an improved quality of life. However, Mom was having a very difficult time with this idea, and would interpret it as forcing Sam to do something, and Mom wanted him to be happy. Although, when a patient is 14, the parent/guardian usually is very helpful with carryover of information, especially as many teenagers rebel at this age. I knew that for Sam, this was not his best option, thus chose to engage Sam about the importance of PT.

There are many methods for airway clearance, and Sam was familiar with percussion and vibration when he did receive home services. Sam reported to me that

he also did not like this method, and his perception was that it did not make a difference. The literature supports numerous methods, that are comparable and effective, and the one that is the “best” is the method that the patient will perform and be compliant with. I explained to Sam, why airway clearance is so important, and explained the different options and allowed him time to process information and ask me questions. He was then willing to try various methods, and our active experimentation began. I coordinated Sam’s airway treatment with the respiratory therapist. Sam received Dornase, a nebulizer that is most effective 60-90 min after receiving it, and is administrated by respiratory therapy, and this was coordinated so that I could treat Sam at the approp time. We tried postural drainage, in which Sam would position himself in various positions to allow the mucous to work with gravity and drain out. This was also done in conjunction with percussion and vibration to assist with loosening the mucous. Sam, did not like this method. I wanted Sam to be independent with a method, that could be done anywhere and not be reliant on another person. We tried the active cycle of breathing technique (breathing at varying depths (shallow/deep) and with varying inspiratory holds). Although, the active cycle breathing was quite effective, and Sam could clear a lot of secretions, he felt that when he tried alone, he breathed too fast felt lightheaded. I tried the Acapella, an airway clearance device, that vibrates the bronchial trees to loosen secretions and this was also very effective, but Sam felt lightheaded with a long exhalation and had a very shallow inhalation. I then combined 2 methods, active cycle breathing and the Acapella to slow him down and this was quiet effective and he had no complaints and was willing to perform this method. This was done over many sessions and practice time, I knew it was time well invested in order to find a method

that Sam could and would perform. I knew that if he was involved and had input he would be adherent.

After his 3rd day in the hospital Sam was gaining weight nicely, and I was concerned about his strength and anticipated aerobic capacity impairments. I spoke with the dietician about his calories, and weight gain. He needed to gain weight, and I did not want to be exercising him at a level that would be a detriment and result in greater calorie expenditure. She informed me they were going up on the density of his calories and continue with daily weights, and we discussed that if he stayed the same or lost weight in a given day, we would cut back on his exercising. But if he continued to make gains, than I could continue my exercise prescription. During his hospitalization I continued to communicate with the dietician.

I was not sure how much Sam would be able to exercise so I performed a modified Bruce protocol to assess his aerobic capacity, and explained to him that we would do this again as he neared discharge to measure his progress. Sam was only able to exercise for 6 min, due to DOE (dyspnea on exertion) and his HR was at 85% of max. I calculated Sam's target heart rate for aerobic conditioning which he would reach with moderate paced walking. After exercise, he mobilized a lot of secretions. Sam made gains nicely adding incline on the treadmill and increasing his speed. During his aerobic conditioning I measured his hemodynamic response including HR, BP, RR and oxygen saturations and his perception of DOE and RPE (rate of perceived exertion). I started early teaching Sam how to use these scales appropriately. So he could independently guide his exercise level post discharge.

I prescribed an exercise program to improve his posture as he was forward flexed with rounded shoulders which can impact his ventilatory system. Sam had strength impairments and we devised a strength training program. We started using dumbbells in front of a mirror so he could see his posture and this was a great way for Sam to receive feedback. Sam was making excellent gains in aerobic conditioning, via treadmill walking, I suggested he start jogging. He initially stated he couldn't and that it was impossible. We then talked about what he would need to do for baseball. We talked about running the bases, and making a catch. He was willing to try and the first time ran for 2 min. I continually gave Sam positive feedback, and it was great to see him start to develop self confidence and the way he carried himself. I created goals for Sam to achieve that were obtainable, and I was so proud as he started being able to jog for 15-20 minutes.

During these sessions, Sam would ask me a lot of questions not only about exercise, but about CF. He again reported that he did not want to worry his Mom, and he thinks when he gets so upset his stomach hurts. Sam has had his stomach discomfort that was medically worked up many times, and the medical team felt a lot of it was due to stress and worry. They encouraged Mom to take him to a Social Worker/psychiatrist, and Sam was willing. However, mom reported that she took him with her appointments so he could talk when she saw her Psychiatrist and that she was convinced that there was a medical problem. I saw how much Sam trusted me, and I shared that I stories of how much exercise helps with my stress level and when I worry, and sure enough as his admission progressed his complaints of stomach pain decreased.

I educated Sam about cross-training, and we started running sprints the length between bases, and created games that I would throw a baseball outside, and he would have to run and catch it, pick up and throw it back. Sam was also using the DOE/RPE scales indicating to me when he needed to rest.

Sam continued to use his exercise times, to ask questions about CF, clarifying questions about importance of what he was doing, and how this would help him. He started trying to get his brothers to exercise, as well. I knew that Sam was starting to take responsibility for his own health near the end of 2 weeks even after hearing the disappointing news that his admission was being prolonged for continued care. Sam had about 5 friends visiting in his room, and it was his exercise time, and most teenagers, when they have visitors do not want to participate in PT. I gave him the option of exercising later, as it was a running day. I assured him he could do something else for exercise, or his friends could come with us. He said to his friends, “I have to exercise”, and when they said they were leaving, he said he would call them, and initially he was upset, but I praised him so much, and told him I was so proud of him, and he said that he knows it is important. At this time, I asked Sam what his goals are for himself, besides playing baseball. He was initially confused, and when I clarified that he should have goals he and he started setting them for himself. His goal, in addition to playing baseball was to run for 30 min and on day 14 he met it!

Sam verbalized that he really enjoyed running, and I encouraged him to keep it up, and I informed him that the CF foundation has a running scholarship for college. Every 7 days I re-evaluated Sam’s impairments and Sam made excellent gains in posture, strength, pulmonary/ventilator status and in aerobic conditioning. I re-assessed

him with the modified Bruce protocol and this time he was able to complete the protocol (22 min). I educated Sam on the importance of continuing all that he was doing at home. I talked with Sam with what worked best, a calendar system, or check off system with a list. Sam wanted a calendar system, and we discussed weekly, daily or monthly views. I needed Sam involved, as I knew if he took responsibility in its development that he would be more likely to be adherent. I set up a monthly calendar for the year, and in each day we put airway clearance technique/Acapella, and then alternated his strength program, aerobic conditioning, days for baseball tryouts and days off. However, the Acapella was on every day. I included sheets for him to track distance run, HR, DOE his strength program that we had been doing and stretches. Sam loved Chuck Norris, so I found a picture of him exercising and placed on the cover of his binder, and Sam was so excited and even checked off Acapella, as he had done it at 7 in the morning.

Sam was discharged on day 16, with DSS involved and I was worried that once home, he might fall back into old habits. I had given him the name of one of our outpatient PTs, who sees patients for the CF clinic to further assist with carryover at home. I saw Sam in the main hallway when he was going to his MD appt with Mom, and he was excited that he made the summer team, and even was playing and felt great. He promised me that he usually using the Acapella every day, he is still using the binder to keep him on track with his exercise program. I am happy to report that he also said that he is training to run a 3 mile road race in his home town.

Clinical Narrative for Clinician Level

Submitted by: Matthew (pseudonyms used throughout text)

I met Ana at her initial physical therapy evaluation in April 2008. She was a healthy, although somewhat overweight woman of Ecuadorian descent. She was employed as a regulatory agent for a Cambridge-based biotechnology firm. She reported initially feeling a gradual onset of low back pain (LBP) in 2006. She had gotten an MRI in 2006, which revealed lumbar disk pathology at L5/S1. She reported exercise had helped, such as walking, but had never attended physical therapy. The pain eventually subsided until the fall of 2007 at which time she started jogging. It was during this time that she became concerned about her weight and decided to take up jogging, with the goal of completing the Marine Corps Marathon in Washington, DC. Her LBP became severe and she developed paresthesia along the posterolateral aspect of her right lower extremity. At this time, she decided to stop running, which helped her LBP, but the paresthesia remained. At the time of examination she continued to complain more of paresthesia and leg pain than LBP. She rated the paresthesia and leg pain 8/10 at its worst and 3/10 at its best. Aggravating factors included running and staying in one position for too long. Relieving factors included moving around or changing positions. Her goal was to return to pain-free running and complete the Marine Corps Marathon that fall.

Examination revealed a flattening of the lumbar lordosis in standing. Active range of motion testing peripheralized her paresthesia with backward-bend, left side-bend and right rotation. Neurological testing revealed normal strength in both lower

extremities but slightly diminished sensation to light touch along the S1 dermatome. There was a diminished ankle-jerk reflex on the right and a positive reproduction of nerve tension with ankle dorsiflexion in approximately 75° of straight leg raise on the right. There was centralization of symptoms with the prone press-up exercise.

Upon completion of the examination, I hypothesized that the disk pathology was the source of Ana's symptoms due to neurological involvement and centralization of symptoms with the prone press-up exercise. I was somewhat confused by the minimal complaints of LBP at this time. I later posed this question as a discussion point to several therapists in the back staff room. Everyone expressed some degree of experience with lumbar disc pathology with referred symptoms in the absence of back pain. Ana was instructed in the prone press-up exercise for her home exercise program, and was instructed to follow-up in physical therapy twice a week. She agreed to this plan.

Ana returned for follow-up approximately one week later stating that her lower extremity symptoms were now more intermittent in nature, but the press-up exercise could occasionally cause her symptoms to peripheralize. Her symptoms were now localized from the mid-thigh to the mid-calf posteriorly. Still confused at the lack of LBP and now somewhat peripheralized symptoms, I began to question the potential of some type of peripheral nerve entrapment. Further examination revealed gluteus medius and maximus weakness, hamstring and piriformis shortening and positive signs for nerve tension. Ana was instructed to continue to perform the prone press-up exercise only if they are able to centralize her symptoms and to stop if there is any form of peripheralization. Intervention was also directed at relieving nerve and muscle tension

and promoting lumbo-pelvic-hip stability. After a few sessions of PT, she felt that she was beginning to manage her symptoms and returned to running with only minor occurrences or lower extremity paresthesia.

Ana returned to PT in late May after a long business trip to South America. She reported she had been doing well up until this time, and was even able to complete a half-marathon while she was away. Upon return to the United States, her leg symptoms had extended from the buttock to the mid-calf. She blamed this on the long plane flight home. Intervention was still directed at relieving nerve and muscle tension and promoting lumbo-pelvic-hip stability and centralization with the press-up exercise. She was advised to stop running but encouraged to walk for exercise.

In late June and July, she consulted her neurologist who advised that Ana consider surgery, yet to this she was opposed. I performed a re-assessment on Ana, which revealed continued neurological involvement with decreased sensation to light touch along the S1 dermatome and a diminished ankle jerk reflex. She had also developed S1 myotomal weakness and a positive slump test. She underwent an MRI exam, which revealed a worsening of the L5/S1 disc prolapse as compared to her prior MRI. I discussed with her the pathophysiology of disc degeneration and that the presence of weakness was usually indicative of back surgery. Ana told me that she was planning on getting several opinions from area neurosurgeons, but that she wanted to continue PT and remain as active as possible. We were able to continue to centralize her symptoms, but I had a hard time convincing her to modify her lifestyle. She continued to aggravate her symptoms with activities such as biking. She even spent an afternoon painting a fence in a forward-flexed posture. Intervention was now directed

specifically toward centralization of symptoms with manual therapy techniques, extension exercises in standing and prone and simple low-level lumbo-pelvic-hip stability exercises. She was advised to limit herself to walking and stability exercises. By early August we were able to centralize her symptoms and restore lower extremity strength to within normal limits. There was hope!

After a brief reprieve from PT, her symptoms exacerbated again which required an emergency room visit. By late August, Ana had consulted with two neurosurgeons. One recommended surgery and the other an epidural corticosteroid injection, which she declined. At this point she started to present with a laterally shifted posture. Manual therapy techniques were utilized to correct the lateral shift and continue to centralize symptoms. She was also instructed in a home correction for laterally shifted posture.

By mid-September, she had consulted with one more neurosurgeon who recommended back surgery. Her symptoms had, again, begun to improve and centralize in response to manual techniques and her home exercise program. She felt she was now able to manage her symptoms on her own and was even able to run again for short distances. Despite this, she elected to schedule back surgery for December. She felt she was too young to undergo these debilitating periods of back pain and wanted to be able to live an active life as any woman in her 30's would.

We continued a manual therapy program, specific exercise to promote centralization and lumbo-pelvic-hip stability exercises. Her symptoms were, for the most part, under control. Despite minimal training throughout the summer, she was now determined to at least travel to Washington and begin the Marine Corps Marathon with her friend and stop if she felt she could not go on. Ana returned to see me on

October 31st. She not only began the marathon, she achieved her goal of completing the entire 26.2 miles! Each participant of the marathon was given a small triangular medallion as a reward for completion. On this day, Ana presented me with a thank you card and in it was one of these medallions. She told me she asked for three extra to give people that supported her and helped her to achieve her goal. I was lucky enough to be one of those three, in the good company of her mother and her neurologist.

Ana elected to undergo surgery this December. There was a post-surgical complication, which led to a second surgery. She is now doing well and is currently under my care. This was not an easy case to manage. As it is with many of our active patients, it is difficult to get them slow down their pace and give their bodies the chance to heal. I wish I had been a little more convincing of this. Because of the minimal back pain early on, I also wasn't entirely convinced the source of Ana's pain was the intervertebral disc. It took the presentation of weakness in early June to be convinced of this. I should have been a little more focused on the centralization of symptoms with lumbar extension exercises and not with soft tissue mobilization and muscle lengthening exercises. The use of the Oswestry Disability Index, an outcome tool I now commonly use, would have been helpful to better monitor Ana's progress. Despite this, what I learned from Ana is to not give up when you have a goal. She could have given up at any point, but through severe periods of back and leg pain, ER visits, MRI's and surgical recommendations, she never gave up on her goal of running a marathon and starting a healthier lifestyle. I'm a better physical therapist and a better person for having worked with her and having watched her persevere.

Clinical Narrative for Entry-Level

Submitted by: Samantha (pseudonyms used throughout text)

I had many expectations prior to beginning my year-long internship at NMC. Though I did not have a previous clinical experience at Northeast Medical Center, while attending school and through living in the area, I was very aware of the strong reputation for medical care and clinical expertise that this hospital holds. Throughout my internship, I realized the true meaning of that word “expertise” and just how much should be encompassed in the care that physical therapists provide.

Mr. Lawrence is a 55-year-old naval commander, admitted to NMC in April, following a 3-month ICU stay at an OSH for mesenteric ischemia s/p laparoscopic appendectomy with numerous complications including the need for subtotal colectomy, PEA arrest, need for PEG placement and tracheostomy and multiple re-explorations. Commander L was evaluated by physical therapy in the ICU and transferred to the floor on which I was the primary therapist, 5 days later. The therapist who had evaluated Commander L wrote an email to the clinical specialist on my team to explain the patient’s long history of hospitalization. In this email, she also touched on the fact that the Commander had at times been very curious as to the training that a physical therapist receives and had multiple questions regarding the rationale for the care that she had provided. Naturally, as a new clinician, this part of the email made me quite nervous.

In addition, the therapist who had evaluated Commander L documented an impairment in dorsiflexion range of motion and was suggesting the use of serial casting versus a more dynamic splinting method as intervention. Having never used serial

casting in the past, I asked to speak with the clinical specialist on our team, Doug, about how this clinical decision is usually made. In this meeting, we decided it would be best for me to initiate treatment with Commander L on this first day by introducing myself, beginning to develop a rapport and continuing with the original plan of care prior to making any changes. At the time, I saw this as good advice as it would give me more time to perform further testing and gather more data, however now I realize how much more there was behind that decision.

Initially upon meeting Commander Lawrence, I was struck not only by his physical impairments, but also by how intimidating an individual he was. Here was this patient, as vulnerable as a human being can be in many ways, receiving all his medications and nutrition through tubes, having to hold his hand over his tracheostomy site to speak clearly and with barely enough energy to sit up at the edge of the bed, and yet, somehow, he was one of the most intimidating people I had ever met.

I started off introducing myself as the primary therapist on the floor and the one who would continue to carry out his physical therapy care and it was not two minutes into the conversation before Commander L began to question my training and my ability to carry out interventions. As a new graduate with a brand new, barely broken in license, it was not too difficult for Commander L to rattle my confidence.

In the first few weeks that I worked with Commander Lawrence, I struggled with finding a balance between allowing him to maintain some control and still continuing to direct and make changes to the physical therapy plan of care. The Commander remained without a definitive diagnosis for 8 weeks while on Phillips house. His medications changed numerous times and they performed imaging and lab

tests continually in attempts to find the reason behind his initial ischemia. He became frustrated with the many doctors who were overseeing his care and the multiple changes they were making at one time. He became challenging for every member of the team to work with as he insisted on a very set schedule and became very impatient when things did not occur precisely on his timeline. There was a week where he became very detached; keeping his eyes closed most of the time and declining participation in PT, saying that he just felt too exhausted.

Finally, almost 8 weeks to the day after his admission to *NMC*, a diagnosis was made and medical intervention took a turn once again, but with more direction. This definitive diagnosis caused a change in Commander L almost immediately. He now had a reason for the many months he had spent in hospitals and there was now an actual plan in place. He could see light at the end of the tunnel. They were predicting 4-6 more weeks in the hospital, which is not a short period of time, but it is at least a set period of time.

The improvement in Commander L's psychological state with news of a diagnosis led to improved participation in PT once again, however He continued to participate only at a very shallow level. He participated throughout our 30-minute sessions, at times begrudgingly and with continued trepidation regarding changes in the plan of care, but with little to no compliance with his home exercise program. I spoke with Commander L numerous times regarding the importance of his carrying out the exercises on his own for larger improvements and the need for him to take more responsibility. I continued to work with The Commander five times per week, re-

evaluating him each week and finding slight improvements in his impairments, but no large gain in his overall function. At this time, I again sought out the help of Doug.

Doug read through my documentation and we met to discuss what I felt were his 3 main impairments, how I was measuring those impairments objectively and what interventions I was using to try to make a change. During this conversation with Doug, I realized that a large part of the challenge of treating Commander L had become, not determining what I wanted to work on and how I wanted to work on it, but really in involving Him in those decisions. Doug attended a treatment session with me and we directly approached the subject of Commander Lawrence's's goals and where he wanted PT treatment to go. He didn't have all the answers for us that day, but it changed the dynamic between us. I realized that while I thought I had been allowing Commander L to maintain some control, I had instead been just giving up my own control over the sessions. Commander L needed to determine our long-term goals in order for me to be able to truly involve him in his physical therapy.

Commander Lawrence is a patient who has been in the hospital for 5 months now. For 5 months he has not been home with his wife and children. For 5 months he has asked for assistance to get out of bed and go to the bathroom. He has given up all of his hobbies, his life's work and his daily routines. And for those 5 months, he did not know if this was the way that it would always be or if he might some day return to his former life. And for those 5 months, I did not truly know what long term goals were realistic and appropriate. I had made the decision early on that Commander L would benefit from rehab, but now that there was a timeline of 4-6 more weeks, I realized that this next 4-6 weeks would be Commander L's rehab, only it would take place at *NMC*.

Commander L is now using the stationary bike for aerobic conditioning. Prior to his illness, he was riding a stationary bike for exercise and reports that he enjoyed bike riding outside as well. We have started using the stairs as an additional mode of aerobic exercise, one that is functional and easily connected to his return to the community. We continue to work on his postural, range of motion and strength impairments, when tied to function and his personal goals of returning to jogging for exercise and his work as a professor and with the Navy. He sees these things as a means to an end rather than endless exercises and chores with no benefit to him.

I have learned so many things from my time treating Commander Lawrence that it's difficult to fit it all within this one narrative. I learned about the importance of prioritizing the patient's impairments and how that prioritization changes over time. I learned the importance of truly patient-centered care. I learned that communication, like every other PT intervention, must change over time as the patient changes. Above all else, I learned to look at the patient as a whole instead of the sum of his impairments.